

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

 FY2006 X **FY 2006-2007** **FY 2005-2007**

STATE NAME: Missouri

DUNS #: 780871430

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Division of Comprehensive Psychiatric Services

STREET ADDRESS: 1706 E. Elm Street, P.O. Box 687

CITY: Jefferson City

STATE: MO

ZIP: 65102

TELEPHONE: 573 751-8122

FAX: 573 751-7815

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Dorn Schuffman TITLE: Director

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Division of Comprehensive Psychiatric Services

STREET ADDRESS: 1706 E. Elm Street, P.O. Box 687

CITY: Jefferson City

STATE: MO

ZIP CODE: 65102

TELEPHONE: 573 751-3070

FAX: 573 526-7926

III. STATE FISCAL YEAR

FROM: 7/1/2005

TO: 6/1/2006

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Brooke Dawson TITLE: Mental Health Manager II

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Division of Comprehensive Psychiatric Services

STREET ADDRESS: 1706 E. Elm Street P.O. Box 687

CITY: Jefferson City

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EMAIL: brooke.dawson@dmh.mo.gov

Missouri

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

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Missouri

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Executive Summary

Missouri, like many other states, has experienced the effects of an extended overall economic slowdown over several years. A limitation on general revenue growth has caused the Department of Mental Health to face core budget reductions, withholds, and staff layoffs for several consecutive years. This has required the Department to focus on protecting current services and programs, while attempting to maximize the use of other funding sources.

The Department of Mental Health and Division of Comprehensive Psychiatric Services have met these challenges by cooperating with other State Agencies on enhancing services, programs, and developing new and innovative ways to serve consumers. Initiatives within the Department have been developed to look at quality assurance, practice guidelines, recovery, and prevention of illness and disability. Legislation passed in 2004 formalized a children's comprehensive mental health plan offering families access to mental health care without relinquishing custody of their child. As we move into 2006 efforts to provide quality services to adults with serious mental illness will take shape through the use of programs and projects like the Medication Risk Management Project (MRM) and Procovery. The State Plan for Children, Youth, and Adults will provide an overview of the programming, services, and initiatives the Department and Division have developed to serve Missouri's citizens with mental illness and severe emotional disturbances.

Involvement and inclusion of consumers, providers, and advocates in the planning, monitoring, and evaluation of programs continues to be a high priority for the Department. Advocates and consumers are involved with a variety of activities. Consumers and advocates serve on a variety of committees and workgroups lending experience and advice to the Department in prioritizing needs and developing responsive policies and programs. Throughout adversities and challenges, the Missouri Department of Mental Health has continued to pursue its vision - Missourians shall be free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities, and alcohol and other drug abuse. The Division of Comprehensive Psychiatric Services continues to strive to meet its goals to provide accessible community-based services, quality residential services, available and affordable housing, and family-focused children's services.

Attachment A

**COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING
AGREEMENTS**

FISCAL YEAR 2006

I hereby certify that Missouri agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State²¹ will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2006, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

21. The term State shall hereafter be understood to include Territories.

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

- (A) the principle State agencies with respect to:
 - (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
 - (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
- (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
- (D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
- (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Governor

Date

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 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 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).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
 Office of Grants Management
 Office of the Assistant Secretary for Management and Budget
 Department of Health and Human Services
 200 Independence Avenue, S.W., Room 517-D
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

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

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 under signed, 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, sub-grants, 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)

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.

<p>5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE</p> <p>Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.</p> <p>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.</p>	<p>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.</p> <p>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.</p> <p>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.</p>	
<p>SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</p>	<p>TITLE</p> <p>Deputy Director of Administration</p>	
<p>APPLICANT ORGANIZATION</p> <p>Missouri Department of Mental Health</p>		<p>DATE SUBMITTED</p>

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ Congressional District, if known: _____	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____	
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10.a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
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**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

Page

of

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Standard Form – LLL -A

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity 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 a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

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

Approval Expires: 08/31/2007

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
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.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Deputy Director of Administration	
APPLICANT ORGANIZATION Missouri Department of Mental Health		DATE SUBMITTED

Approval Expires: 08/31/2007

Missouri

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

Public Comment of the State Application/Plan

The 2006 Mental Health Block Grant was publicly reviewed on June, 23, 2005 and July 28, 2005. The CPS State Advisory Council reviewed the Draft Document during a public meeting and the following comments/changes occurred.

1. The State Advisory Council proposed a formation of a data committee within the SAC to help review and understand Missouri's data concerning mental health prevalence, treatment and prevention.
2. Last year's "Areas Needing Attention" was reviewed, progress noted and new areas for attention were identified.
3. PROCOVERY training and implementation was discussed and made a part of the Block Grant.
4. Performance Indicator Tables were reviewed and accepted.

The finished Mental Health Block Grant Application and State Plan will be posted to the DMH web site for further comment. Comments collected after the Block Grant due date of September 1, 2005 will be compiled and used to amend the current Block Grant if necessary. Comments will also guide the completion of the 2007 Mental Health Block Grant Application and formation of the State Mental Health Plan.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Calculated FY 1994

\$14,716,201

Actual FY 2004

\$34,064,999

Actual FY 2005

\$35,533,990

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Actual FY 2003	Actual FY 2004	Actual/Estimate FY 2005
<u>\$167,450,767</u>	<u>\$175,259,904</u>	<u>\$175,934,622</u>

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(Optional)
Vivian Russell	Consumers/Survivors/Ex-patients(C/S/X)		1827 Crader Drive Jefferson City,MO 65109 PH:(573) FAX:	
Ruth Brandon	Consumers/Survivors/Ex-patients(C/S/X)	NAMI - Columbia	1201 Paquin Street Apt.313 Columbia,MO 65201 PH:(573) 817-3386 FAX:	
Linda Clarke	Family Members of adults with SMI	Federation of Families for Children;s MH	8 Akin Court St. Peters,MO 63376 PH:(636) 294-0125 FAX:	
Geody Frazier	Consumers/Survivors/Ex-patients(C/S/X)		2541 Van Brunt Blvd. Kansas City,MO 64128 PH:(816) 231-5226 FAX:	
Karren Jones	Consumers/Survivors/Ex-patients(C/S/X)	NAMI - Missouri	1210 Linden Drive Apt. 13 Jefferson City,MO 65109 PH:(573) 636-6188 FAX:	
Donna Lay	Family Members of Children with SED	NAMI - Missouri	7416 State Route W West Plains,MO 65775 PH:(417) 277-5473 FAX:	
Helen Minth	Consumers/Survivors/Ex-patients(C/S/X)	St. Louis Empowerment Center	3427Gravois St. Louis,MO 63118 PH:(314) 865-2112 FAX:	
Susan Pijut	Family Members of adults with SMI	NAMI - Missouri	620 Apple Glenn Court Arnold,MO 63010 PH:(636) 461-1928 FAX:	
Robert Qualls	Consumers/Survivors/Ex-patients(C/S/X)	NAMI - Missouri Southwest Chapter	1701 S. Campbell Ave Springfield,MO 65807 PH:(417) 864-7119 FAX:(417) 864-5011	
LuAnn Reese	Family Members of Children with SED	Transitions - SOC St Louis	5400 Arsenal Dome Building A-121 St. Louis,MO 63139 PH:(314) 877-0139 FAX:(314) 644-8348	
Fran Scott	Consumers/Survivors/Ex-patients(C/S/X)	NAMI - Missouri	4483 Lindell Blvd. Apt. 638 St. Louis,MO 63130 PH:(314) 535-5107 FAX:	
Betty Taylor	Consumers/Survivors/Ex-patients(C/S/X)		494 Munger Lane Apt 19 Hannibal,MO 63401 PH:(573) 321-2199 FAX:	
Ethel Wesson	Consumers/Survivors/Ex-		5618 Indiana Kansas City,MO 64130 PH:(816) 361-2298	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(Optional)
	patients(C/S/X)		FAX:	
Mariann Atwell, MD	State Employees	Department of Corrections	2729 Plaza Drive P.O. Box 236 Jefferson City,MO 65102 PH: (573) 526-6523 FAX:	
Karia Basta	State Employees	Dept. of Mental Health	1706 East Elm P.O. Box 687 Jefferson City,MO 65102 PH: (573) 751-8208 FAX:(573) 751-9207	
Anna Maria Bellatin	Providers	Mattie Rhodes Center	1740 Jefferson St. Kansas City,MO 64108 PH:(816) 471- 2536 FAX:	
Joanne Fulton	Providers	LCSW	1400 Stonehaven Road Columbia,MO 65203 PH:(573) 446-6290 FAX:	
John Harper	State Employees	Dept. of Elementary & Secondary Education	3024 DuPont Circle Jefferson City,MO 65101 PH:(573) 526- 7040 FAX:	
Sandra Levels	State Employees	Dept. of Social Services	P.O. Box 6500 Jefferson City,MO 65102-6500 PH:(573) 751-9290 FAX:	
Bobbie Meinershagen	State Employees	North St. Francois County R-1 School District	1218 Mill Street Leadwood,MO 63653 PH:(573) 431-6700 x6 FAX:	
Janet Munsterman	Providers	Supported Community Living	2201 N. Elm Suite C Nevada,MO 64772 PH:(417) 448-3463 FAX:	
Sarah Stanton	Providers	Truman Medical Center	2211 Charlotte Kansas City,MO 64108 PH:(816) 404-5700 FAX:	
Erica Stephens	Providers	Missouri Protection & Advocacy	925 South Country Club Drive Jefferson City,MO 65109 PH: (573)-893-3333 FAX:	
Suzanne Taggart	Providers	Pathways Community Behavioral Healthcare	P.O. Box 104146 Jefferson City,MO 65110-4146 PH:(573) 634-2516 FAX:	

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	24	
Consumers/Survivors/Ex-patients(C/S/X)	9	
Family Members of Children with SED	2	
Family Members of adults with SMI	2	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	0	
TOTAL C/S/X, Family Members and Others	13	54.17%
State Employees	5	
Providers	6	
Vacancies	1	
TOTAL State Employees and Providers	11	45.83%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

Council Composition Footnotes

The SAC is currently looking for a provider from the Southeastern portion of our State.

Missouri

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law: Reviewing plans and submitting to the State any recommendations for modification; Serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; Monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State; The role of the Planning Council in improving mental health services within the State.

The role of Missouri's Mental Health Planning Council

The mission of the Comprehensive Psychiatric Services State Advisory Council (CPS/SAC) for the Division of Comprehensive Psychiatric Services is to advise the Division in the development and coordination of a statewide inter-agency and inter-departmental system of care for children and youth with serious emotional disorders and adults with mental illness and their families. Council members are primary consumers, family members, providers and State agency representatives.

The State Advisory Council convenes monthly. The group continues to work on issues pertinent to mental health services and their consumers. The State Advisory Council has decided to disband designated workgroups in favor of identifying important issues and assigning membership to address those issues. Current Ad-hoc committees include:

- The Facilities Group, looking at ways to make first time consumers and their families more comfortable with the hospitalization process;
- The Data Group, working to define meaningful data collection and reporting;
- The Monitoring Group, working to provide consumer assistance in monitoring Mental Health programs across the state; and
- The Statewide Consumer Conference Group, to develop a plan for holding a statewide caucus/conference for Mental Health Consumers.

Members of the State Advisory Council serve on other Department and Division workgroups and committees such as: The Transformation Grant Workgroup, The Library Grant Workgroup and the Olmstead Stakeholders Group, to name a few. Other State Advisory Council activities funded by the Block Grant include Mental Health Awareness Day, participation in advocacy training for consumers across the state and participation at the Department of Mental Health's Spring Training Institute. Several State Advisory Council members prepared and presented topics for the 2005 Spring Training Institute. These activities provide consumers with training and networking opportunities allowing for better communication with their communities, local authorities and legislators.

Article I – Mission

The State Advisory Council (SAC) shall be responsible for advising the Division of CPS in the development and coordination of a statewide inter-agency/inter-departmental system of care for persons with mental illness, their families and children/youth with serious emotional disturbances.

Article II – Responsibilities

In order to accomplish this mission the SAC shall:

1. Advise CPS in the development of models of services and long range planning and budgeting priorities.
2. Identify statewide needs, gaps in services, and movement toward filling gaps.
3. Provide education and information about mental health issues.
4. Monitor, evaluate, and review the allocation and adequacy of mental health services within the state.

Article III – Organization

- A. The Director of the Division of Comprehensive Psychiatric Services shall appoint up to 25 members to the State Advisory Council for Comprehensive Psychiatric Services.
- B. The terms of office for members shall be overlapping terms of a full three (3) years. A member of the State Advisory Council for Comprehensive Psychiatric Services may serve an additional three-year term if properly nominated and approved by the State Advisory Council and the Division Director.
- C. Members shall have a professional, research, or personal interest in the prevention, recovery, evaluation, treatment, rehabilitation, and system of care for children/youth with serious emotional disturbance and persons affected by mental disorders and mental illness and their families. The Council shall include representatives from the following:
 1. Non-government organizations or groups and state agencies concerned with the planning, operation or use of comprehensive psychiatric services.
 2. Representatives of primary and secondary consumers and providers of comprehensive psychiatric services, who are familiar with the need for such services.
- D. The membership composition of the State Advisory Council shall follow the guidelines set forth in P.L. 102-321 as follows:
 1. At least 13 of the members of SAC shall be self-identified consumers defined as follows:

- a. Primary Consumer: A person who is an active or former recipient of mental health, substance abuse and/or developmental disabilities services, regardless of source of payment. Parents, family members, and/or legal custodians/guardians of children and youth are primary consumers if they are actively engaged in the treatment planning and/or delivering services and supports for the child or youth.
 - b. With respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council.
 - c. With respect to the membership of the Council, the ratio of individuals with Serious Mental Illness to other members of the Council is sufficient to provide adequate representation of such individuals in the deliberations of the council.
2. At least 12 of the members of SAC shall be providers defined as follows:
- a. System Customer: An entity/service delivery system, which uses, purchases and/or coordinates with mental health, substance abuse and developmental disabilities services provided by the Department of Mental Health. Representatives of the following state agencies are mandated: mental health, education, vocational rehabilitation, criminal justice, housing, social services, and Medicaid. The remainder could be representatives of mil tax boards, community agencies, faith sector, family members, and advocates.
- E. The Council shall be representative of the state's population, taking into consideration their employment, age, sex, race, and place of residence and other demographic characteristics of the state, determined essential by the Council and Director.

Article IV – Membership Nominations

- A. Nominations for vacant council positions shall be accepted from any individual or organization.
- B. Vacancies, when they occur, shall be announced and publicized.

Article V – Officers

- A. The Council shall elect the chairperson and vice-chairperson every two years. The chairperson shall mentor the chair elect for 6 months or the first three meetings of the State Advisory Council. Nominations shall occur in November and elections in January, except in cases of extraordinary circumstances.

- B. The chairperson shall preside at all meetings of the Council and appoint all committees and task forces. The vice-chairperson shall preside at meetings in the chairperson's absence, and act for the chairperson when he/she cannot attend.

Article VI – Committees

A. Project Committees:

1. Project Committees shall be formed as they are needed. These Committees shall address block grant planning and special issues identified by the State Advisory Council or the Division as topics relevant to the Mental Health Service Delivery System.
2. Project Committee members will report to the full council at each council meeting.
3. A Committee will disband when work is done on its particular issue.

B. Executive Committee:

1. The membership of the Executive Committee shall consist of the chairperson of the Council, the vice-chairperson of the Council, immediate past chairperson, and chairpersons of any project committees.
2. The Executive Committee shall meet at the call of the chairperson, upon request of three or more of the committee members, or a call of the Division Director. A quorum shall consist of a majority of Executive Committee members.

- C. The Committee chairpersons shall preside at all committee meetings and shall be appointed by the Council chairperson or, in his/her absence, the vice-chairperson.

- D. The Chairperson shall be an ex-officio member of all committees and task forces.

Article VII – Meetings

- A. The Council shall meet at least every ninety days at the call of the Division Director or the Council chairperson.
- B. A quorum requires the attendance of at least 50% of the members of the Council.
- C. When necessary, a telephone poll may be conducted to complete the quorum necessary for action and to conduct other Council matters in a timely manner, and such action shall be included in the minutes of the next regularly scheduled meeting.

- D. All Council sessions are public meetings as defined by the Sunshine Law, “Any meeting, formal or informal, regular or special, of any governmental body at which any public business is discussed, decided, or public policy formulated.”

Article VIII – Meeting Attendance

Absence from three (3) consecutive meetings in any calendar year without prior notification shall be considered as a resignation from the Council.

Article IX - Miscellaneous

- A. Compensation: Each member shall be reimbursed for reasonable and necessary expenses including travel expenses pursuant to the travel regulations for employees of the Department, actually incurred in the performance of his/her official duties.
- B. Amendments: Any Council member may present amendments for consideration at any meeting. Such amendment will be voted on at the next regular meeting and requires a 2/3 majority to amend the bylaws. In circumstances where amendments to the bylaws are time sensitive, a vote may be taken by telephonic or electronic means.
- C. The Division Director shall:
 - 1. Serve as the primary Departmental consultant to the State Advisory Council.
 - 2. Provide the Council and committees with Division staff for technical assistance and secretarial support.

Approved 10/21/04

Missouri

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Overview of the State Mental Health System

The Department of Mental Health (DMH) is the Missouri agency authorized to develop and implement the public mental health delivery system. It operates under a seven member Commission appointed by the Governor. The Commission is responsible for appointing the Department Director and advising on matters relating to its operation.

The DMH has three operating divisions: Division of Comprehensive Psychiatric Services (CPS), Division of Alcohol and Drug Abuse (ADA), and the Division of Mental Retardation and Developmental Disabilities (MRDD). Each of the three Divisions has its own State advisory structure, target populations and mission.

The Department Director appoints the Director of the Division of CPS. There are four regional hospital systems comprised of eleven (11) CPS inpatient facilities. Each hospital system has a single chief executive officer (CEO) and each facility within a hospital system has its own chief operating officer (COO). For the provision of community based services, Missouri's 114 counties and the City of St. Louis are subdivided into 25 mental health service areas, each with an Administrative Agent (AA). AA's are community mental health centers responsible for the assessment and provision of services to persons in their designated area and for providing follow-up services to persons released from State-operated inpatient services.

Missouri

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Summary of areas identified in the previous State Plan as needing particular attention, including significant achievements in its previous fiscal year.

Areas needing Attention

The previous State Plan was reviewed by the Comprehensive Psychiatric Services State Advisory Council (CPS/SAC). The CPS/SAC identified the following areas needing attention:

- **Financial limitations** continue to cut into the administration of State mental health services. The Missouri DMH needs to prevent or minimize cuts to core funding affecting direct consumer care.
- **Recovery** should be a focus for the Department and Division. Staff and consumers should be provided training to support and enhance recovery-based programs and services.
- **Education efforts** continue through partnership with other Department of Mental Health advisory councils and advocates to continue addressing stigma and negative stereotypes regarding mental illness and to educate new legislators on issues affecting consumers and their quality of life.

Significant Achievements

Mental health consumers in Missouri took the lead on Mental Health Awareness Day in 2005. Partnering with providers and other advocacy agencies across the state they came together to develop presentations for legislators and the general public. Many brought booths and information to the Capitol for the day. Constituents invited their legislators to visit their booths and collect information from service providers from across the State.

- **Procovery.** Three Missouri Mental Health Service Providers have agreed to pilot a project featuring Procovery, a method of self-help that many consumers have reported as helpful and hopeful. There are also several Procovery Circles in Missouri Communities that do not have pilot projects.
- **Medication Risk Management.** MRM is designed to help the State develop disease management strategies for Medicaid recipients diagnosed with Schizophrenia, who are at highest risk for adverse medical and behavioral outcomes, and whose combined behavioral and medical care expenditures can be significantly higher than other Medicaid recipients.
- **Mental Health Transformation** State Incentive Grant Application. Missouri has applied for this SAMHSA grant. Obtaining the grant to support the Mental Health Transformation underway in Missouri will improve our ability to move forward with transformation described in the President's New Freedom Commission Report. Receiving this grant could greatly improve the rate of change across our State.

The Missouri Department of Mental Health began using an Organized Health Care Delivery System (OHCDS) in 2005. This change in the Department's Medicaid status allowed us to secure additional federal funding to address financial limitations. The OHCDS allows us to continue our Access Crisis Intervention (ACI) Program. The

current situation with budget cuts and withholds for the coming fiscal year would have ended ACI.

As we look to 2006 and beyond we hope to see an Anti-Stigma Campaign affecting change across the state. Individuals with Mental Health issues should be welcomed in their community and be afforded the right to work and live as valued members of the community.

Missouri

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

New Developments and Issues that affect Mental Health Service Delivery in Missouri, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

Community Psychiatric Rehabilitation Programs (CPRP), funded through the Medicaid Rehabilitation Option, are being enhanced using a new treatment model. CPRP has traditionally followed the case management model in Missouri. We are now moving to a multi-disciplinary, continuous treatment team approach. Examples of services which may be offered are;

- Substance Abuse Services
- Psychotherapy
- Outreach and Engagement

The DMH received a SAMHSA CoSIG grant. This grant allows us to modify the infrastructure to support the delivery of integrated services to persons with Mental Illness/Substance Abuse disorders. Training in how to administer the pre-screening instruments is complete. Providers participating in the Co-SIG project are beginning to identify individuals in need of treatment for alcohol and drug abuse as well as treatment for mental illness. The Missouri Institute of Mental Health will conduct a survey in August of 2005 to gather feedback on the use of the pre-screening instruments.

Missouri's Governor and Legislature are in the process of Transforming State Government. Changes have occurred in the eligibility requirements for Medicaid which has in turn affected many of this Department's consumers. Missouri has passed legislation that will end the Medicaid program in 2008. A Medicaid Reform Commission has been appointed by the Governor and will come up with a replacement for our current system by 2008. Legislative focus groups are forming and meeting with the intention of hearing public testimony around a number of topics including how to replace the State's Medicaid system. The Department of Mental Health's consumers and advocates recognize the need for changes and are working to inform and educate their legislators concerning their needs and concerns.

Finally, there is a new emphasis on the Community Mental Health Centers/Administrative Agents acting as the entry and exit point for individuals referred for admission to and discharge from DMH acute and long term facilities. This furthers efforts to provide seamless services to consumers entering and exiting the Mental Health system in Missouri.

Missouri

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

Legislative Initiatives and Changes

The 2005 legislative session ended May 13, 2005. The final version of the Department of Mental Health budget continues to present challenges to the agency to meet the needs of the citizens it serves. Several specific service sites, initially slated for cut backs by the legislature, were either restored to full or partial funding. Mental health advocates from across the state impressed upon their legislators the importance of services provided by both inpatient and community mental health providers.

Legislation passed in 2005 that affects the Department of Mental Health includes:

Senate Bill 539 changes Missouri's Medicaid program in a number of ways. This act reduces income levels for eligibility and eliminates some optional services, including the medical assistance for the working disabled (MAWD) and general relief medical assistance programs. It also calls for the Missouri RX program to enroll consumers in one of two formularies. The act establishes the "Medicaid Reform Commission" to study and review the current Medicaid program and make recommendations for reforms. The commission will consist of ten members, five from the House and five from the Senate. Additionally, the directors of the Departments of Social Services, Health and Senior Services, and Mental Health shall serve as ex-officio members of the commission. The commission shall make recommendations to the General Assembly by January 1, 2006 on reforming, redesigning and restructuring a new innovative healthcare delivery state Medicaid system to replace the current state Medicaid system, which will sunset on June 30, 2008.

HCS HB 462 & 463 are based on recommendations of the state suicide prevention plan developed by the DMH and other state and local agencies. Provisions of the bill provide some immunity from civil liability for treatment professionals and others who provide suicide interventions at the scene of a threatened suicide; allow treatment professionals to release mental health information if it would reduce the likelihood of a suicide being attempted and establishes a State Suicide Prevention Council to advise the Office of Child Mental Health

Missouri's Governor and Legislature are in the process of Transforming State Government. Legislative focus groups are forming and meeting with the intention of hearing public testimony around a number of topics including how to replace the State's Medicaid system. The Department of Mental Health's consumers and advocates recognize the need for changes and are working to inform and educate their legislators concerning their need and concerns.

Missouri

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

A brief description of regional/sub State programs, community mental health centers and resources of counties and cities, as applicable, to the provision of mental health services within Missouri.

The DMH Division of CPS operates eleven facilities, providing acute, long term rehabilitation and residential care for youth and adults as well as forensic, sexual predator and corrections services for adults.

Missouri's 114 counties and the City of St. Louis form 25 mental health service areas each with an administrative agent. These administrative agents are responsible for the assessment and services to persons in their assigned area and to provide follow-up services for persons released from State operated inpatient facilities. Children and youth are provided services in the same way through contracts with administrative agents and State operated children's facilities. Supported community living programs provide services for persons who do not have a place to live or need more structured services while in the community. These programs range from nursing homes to apartments and other living accommodations in the community. Persons in these programs are provided support through case management and community psychiatric rehabilitation programs.

Eleven (11) counties and the city of St. Louis have passed Mental Health Mil Taxes and have Mil Tax Boards. Despite support for educational funds to promote mil tax propositions, there has been no success in the past year in passing mil taxes in additional counties. The Division maintains regulatory and quality control of services purchased by local boards through enforcement of certification standards for those services.

Missouri

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

Description of how the Missouri Department of Mental Health provides leadership in coordinating mental health services within the broader system.

The DMH is the State agency authorized to develop and implement the public mental health service delivery system in Missouri. Key to the successful delivery of services is leadership and collaboration with other State agencies including the Department of Social Services, Department of Health and Senior Services, Department of Elementary and Secondary Education, Department of Corrections, and Division of Insurance. Programs and projects that DMH is involved in with these agencies are the following:

- Comprehensive System Management Team,
- MC + Managed Care,
- Family Investment Trust,
- Interdepartmental Initiative for Children,
- Caring Communities,
- Olmstead Act,
- Mental Health Courts,
- Licensure and Certification, and
- HIPAA compliance issues.

The DMH in conjunction with the Department of Social Services developed a Level IV Plus Partnership. This interagency agreement allows the Department of Social Services to identify youth in its custody who are in need of mental health services and supports and who are currently in residential care (at payments that exceed the Division of Family Services' contracted Level IV rate) and transition them back into their communities. These youth have serious emotional disturbances and may also experience developmental disabilities and drug and/or alcohol problems.

The Division embraces the importance of **employment and contribution** as critical to recovery of mental health consumers. In addition to ongoing efforts to create work programs and pre-vocational services in inpatient settings, the Department has designated a cross-Divisional work team to address systemic vocational development work in community settings. The team has developed a working plan that establishes priorities and tasks to develop more work opportunities for individuals with mental illness, serious emotional disturbances, and other disabilities. A major initiative with the Division of Vocational Rehabilitation is to promote development of work programs in each administrative agent across the State. Grants have been made available through the Missouri Division of Vocational Rehabilitation to prepare agencies for CARF accreditation in vocational areas and to promote expertise and infrastructure within mental health agencies to support individuals in vocational development, particularly supported employment. Upon completion of the final year in March 2001 of a four-year establishment grant, these efforts have led to the development of 15 specialized supported employment programs. Seven of these are operated by community mental health centers and the rest are administered by Comprehensive Psychiatric Rehabilitation Programs primarily located in rural areas. All programs have made the commitment to provide supported employment services as a vendor for Vocational Rehabilitation upon completion of the grant funding. In addition to systemic development, there has been significant emphasis on improving referral relationships and procedures to assure access

by Department of Mental Health consumers. As a result, Vocational Rehabilitation now shows a total of 18,535 DMH consumers receiving their services. A break down of persons served is located elsewhere in this document. (Appendix C Table B)

During fiscal year 2004, the Department of Mental Health and the Division of Vocational Rehabilitation Services partnered in sponsoring a workshop on supported employment. The DMH received training and technical assistance through PATH. Through this resource, information was provided on best practices for employment of persons who are homeless and have a mental illness or co-occurring disorder. In fiscal year 2005, the DMH and VR partnered again to write a grant application for a Missouri Mental Health Employment Project. The National Institute of Health grant was awarded to Missouri and we will be moving forward with expansion of Supported Employment across the State.

The **Personal Independence Commission (PIC)** has completed its third year of work. As established in Executive Order 01-08, which was signed by Governor Bob Holden on April 10, 2001, the PIC is charged with advising the Governor on necessary policy and program changes to assure that Missourians of all ages and disabilities have access to a range of community support services. The PIC includes individuals with disabilities, family members of people with disabilities, senior citizens, advocacy groups, the lieutenant governor, four members of the general assembly and representatives from the Departments of Social Services, Mental Health, Health and Senior Services and Elementary and Secondary Education.

Tasks this year focused on implementing the Special Projects Team Action Plan in the areas of common application/assessment information, transition from institutions, assuring community options, and the Real Choice Systems Change grant.

The Department of Mental Health has participated actively in Missouri's planning and implementation efforts related to the Olmstead decision. Department staff and consumers have been actively involved and at the table in the development of Missouri's Olmstead plan. A report from the National Conference of State Legislatures listed the State of Missouri as one of the four leading states that stand out as having comprehensive and effectively working Olmstead Plans. Internal efforts are underway to implement sections of the plan that relate specifically to Department compliance. Recent activities funded by the Olmstead grant include a one-day workshop on dual diagnosis (MI/MR) for CPS and MRDD staff. In October, seventy DMH staff will attend the Annual conference of the National Association for the Dually Diagnosed in St. Louis.

The Department has been awarded financial assistance from CMHS that will be used to support staff participation in cross-disability coalitions related to Olmstead, particularly as they relate to housing development, a critical barrier to community transition for many consumers. This will integrate well with the Department's housing team that has been working actively to promote housing development through development of HUD funding proposals, participation in efforts to shape the State's comprehensive housing plan, and providing technical assistance to local providers in their development efforts.

The Division has established a collaborative partnership between CPS and ADA provider organizations to improve access and referral of individuals with **co-occurring disorders**

to services. The Department promulgated “core rules” in 2001 that provide common standards across both Divisions, where possible, that are supplemented by specialized standards unique to the population served. These common standards support seamless services in administration and intake that had not been possible before these rules were put in effect. In addition, the Department of Mental Health has developed practice guidelines for individuals with co-occurring disorders and is enhancing current community rehabilitation programs to support service models proven to be more effective in serving this population.

The Department continues to develop and expand its leadership role in mental health and risk communications related to disasters and the potential for terrorism in the U.S. In the last two years, the DMH has:

- Been notified of approval for the continuation of its \$100,000 SAMHSA planning grant to continue development of its statewide mental health response plan for natural and manmade disasters;
- Continued its close partnership with the state public health authority to conduct joint planning, response and exercise activity to assure that responses to public health emergencies include a mental health component; and
- Provided mental health outreach materials and public education materials after the severe storms, tornadoes and flash flooding that affected more than 37 Missouri counties and other parts of the Midwest in May, 2003.

The DMH leadership role is an important public mental health authority role that recognizes responsibility to populations in addition to target populations, including the general public, disaster survivors, and emergency responders. In the coming year, efforts will focus on revising the state’s disaster mental health response plan to incorporate substance abuse response, training related to disaster mental health and cultural competence in disaster services, dissemination of a communication plan based on risk communication technologies, and continuing participation in statewide terrorism exercises, including large-scale regional exercises with the Strategic National Stockpile.

Missouri

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Overview of the State Mental Health System

The Department of Mental Health (DMH) is the Missouri agency authorized to develop and implement the public mental health delivery system. It operates under a seven member Commission appointed by the Governor. The Commission is responsible for appointing the Department Director and advising on matters relating to its operation.

The DMH has three operating divisions: Division of Comprehensive Psychiatric Services (CPS), Division of Alcohol and Drug Abuse (ADA), and the Division of Mental Retardation and Developmental Disabilities (MRDD). Each of the three Divisions has its own State advisory structure, target populations and mission.

The Department Director appoints the Director of the Division of CPS. There are four regional hospital systems comprised of eleven (11) CPS inpatient facilities. Each hospital system has a single chief executive officer (CEO) and each facility within a hospital system has its own chief operating officer (COO). For the provision of community based services, Missouri's 114 counties and the City of St. Louis are subdivided into 25 mental health service areas, each with an Administrative Agent (AA). AA's are community mental health centers responsible for the assessment and provision of services to persons in their designated area and for providing follow-up services to persons released from State-operated inpatient services.

Missouri

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Summary of areas identified in the previous State Plan as needing particular attention, including significant achievements in its previous fiscal year.

Areas needing Attention

The previous State Plan was reviewed by the Comprehensive Psychiatric Services State Advisory Council (CPS/SAC). The CPS/SAC identified the following areas needing attention:

- **Financial limitations** continue to cut into the Administration of State mental health services. The Missouri DMH needs to prevent or minimize cuts to core funding affecting direct consumer care.
- **Continued expansion of services** for children and youth in need of treatment of co-occurring disorders.
- **Transitioning youth** into the adult system of care continues to need attention. The Missouri DMH needs to address the needs of the young adult as they age out of the youth system and provide continued support and treatment when necessary.

Significant Achievements

In 2004 legislation creating a Comprehensive Children's Mental Health System was signed into law by the Governor. During 2005, the Department of Mental Health, partnering with other child serving agencies, formed a Comprehensive Children's Mental Health Management Team that operates both on state and local levels to serve children, youth and their families in a comprehensive and all inclusive manner.

- **Mental Health Transformation State Incentive Grant Application.** Missouri has applied for this SAMHSA grant. Obtaining the grant to support the Mental Health Transformation underway in Missouri will improve our ability to move forward with transformation described in the President's New Freedom Commission Report. Receiving this grant could greatly improve the rate of change across our State.
- **The Office of Comprehensive Child Mental Health** was established within the Department of Mental Health. This office will assure the implementation of the Comprehensive Children's Mental Health Service System and will be advised by a newly formed Comprehensive Child Mental Health Clinical Advisory Council.

Missouri

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

New Developments and Issues that affect Mental Health Service Delivery in Missouri, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

Children's System of Care legislation has created opportunities to serve Missouri's children within their own communities and through a local Comprehensive System Management Team (CSMT). A System of Care grant, awarded last year, now brings the total to three grants for the State and these allow Missouri to move forward with community services for children and youth.

In December of 2004 the Department of Mental Health submitted a plan to the General Assembly as called for by SB 1003. The Comprehensive Children's Mental Health Services System Plan provides a description of how Missouri's publicly funded child serving agencies, working in partnership with families, advocates and providers will improve the delivery of mental health services and supports. This plan describes a public mental health model of service provision and constituted the formation of the Office of Comprehensive Child Mental Health. SB 501 passed in 2005 describes the formation and function of this office and a stakeholders advisory group. The major goal/vision of the Plan is *"Every child who needs mental health services and supports from the public mental health system will receive them through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. Missouri's public mental health services system for children shall be easily accessible, culturally competent, and flexible to individual needs, accountable to those it serves and shall result in positive outcomes for children and families."*

Missouri

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

Legislative Initiatives and Changes

The 2005 legislative session ended May 13, 2005. the final version of the Department of Mental Health budget continues to present challenges to the agency to meet the needs of the citizens it serves. Several specific service sites, initially slated for cut backs by the legislature, were either restored to full or partial funding. Mental health advocates from across the state impressed upon their legislators the importance of services provided by both inpatient and community mental health providers.

Legislation passed in 2005 that affects the Department of Mental Health includes:

SB 501 establishes the Office of Comprehensive Child Mental Health, within the Department of Mental Health. The office shall assure the implementation of the Comprehensive Child Mental Health Service System. The bill also establishes a “Comprehensive Child Mental Health Clinical Advisory Council” to advise the Office of Child Mental Health.

SB 500 revises the First Steps Program with services delivered through a regional system that will encourage participation of local service providers, including DMH programs. Payments will be sought from third-party payers where applicable. Cost participation fees shall be applicable to families, based on a sliding scale.

The First Steps Program was initially cut from Missouri’s budget. Legislators revised the program rather than cutting it after hearing testimony from Missouri citizens concerning the need for this program. The new program has a co-pay for families who are financially able to contribute.

Missouri

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Please see Adult Plan concerning regional and sub-State programs.

Missouri

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

please see "Description of State Agency's Leadership" in the Adult section.

Missouri

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

Strengths and weaknesses of the service system

The Department of Mental Health must list as a strength it's adaptability in times of financial difficulties. The Division of Comprehensive Psychiatric Services continues to move forward with the introduction of programs that encourage recovery and assist consumers with identifying their needs and taking charge of their own recovery. In April of 2005, the Division welcomed Kathleen Crowley and the Health Action Network into Missouri to pilot Procovery in selected areas. Procovery concepts are being introduced in both rural and urban settings through Community Psychiatric Rehabilitation (CPR) Programs. Procovery promotes use of each individual's personal goals as targets for predicting success in treatment and recognizes that individuals who have experienced an illness are expert in their abilities to help others recover. Though Procovery is available to all consumers, adoption of the Procovery model within the CPR programs also helps staff members work on their own goals as helpers, employees and professionals in the field of human services. Studies conducted by the Health Action Network of the Procovery model show marked improvement rates for consumers. There is also reason to believe that Procovery helps organizations with improving services and staff retention.

The Department of Mental Health recognizes that collecting and using meaningful data has been a challenge. The DMH asked the Change and Innovation Agency to help us develop a more meaningful consumer survey. Focus groups were conducted throughout Missouri and over 600 consumers and stakeholders provided information for this effort. Seven system-wide issues emerged from the focus groups. Areas identified as needing attention include:

- **After Care;** a need for follow-up after leaving treatment or in-patient services.
- **Repeat Clients;** if treatment needs to be repeated it should be responsive to the individual rather than repetition of the same treatment regimen.
- **One-on-one time with the counselor;** adults and youth both requested more time with their counselor and the ability to see a counselor on an as-needed basis
- **Quality of Information;** consumers want up to date information concerning their illness and the treatment and educational materials given them.
- **Inpatient Quality of Life;** consumers cite lack of activities designed to get them out into the community and state the a lack of staff available to coordinate and supervise outside activity is often the reason cited for not taking outings.
- **Speed and Access to the System;** Referral sources would like to see more emergency beds available and would like to see their referrals receive more than an initial assessment in a timely manner.
- **Staff Attitudes;** Consumers wish to be treated with respect and dignity at all times.

Results from these focus groups have helped shape our new system for collecting and using consumer input. Consumer satisfaction surveys have been developed and distributed to all Community Psychiatric Rehabilitation Programs. Consumers will be asked to complete the survey through the month of August. The University of Missouri, Kansas City, will analyze the raw data for the state and for individual providers and

should have statewide data analysis completed by December. The data analysis will provide important information for DMH as we identify areas for training and will inform the monitoring process with data for each program across the state.

Other systems established by the Department of Mental Health that strengthen the service system include: The **Office of Prevention** as part of a **Prevention Initiative**. The mission of this initiative is to enhance the health and well being of Missouri's children and youth, adults, and families through comprehensive approaches to reduce the incidence and prevalence of mental retardation and developmental disabilities; alcohol and drug abuse; and mental illness and serious emotional disturbances. The Department of Mental Health works to accomplish this mission by:

- Developing policies directed at changing community norms, attitudes, and laws
- Researching and deploying evidence-based preventive interventions to prevent the onset of disorders and disabilities
- Developing and implementing public education programming to promote mental health and reduce stigma
- Implementing continuous quality improvement strategies and outcome evaluations to ensure that interventions are timely, relevant, and effective
- Conducting staff development and training programs for agency and provider personnel on best practices

A risk and protective factor framework is employed to identify disorders and disabilities and preventive interventions. The initial activities under the Office of Prevention have included development and submittal of a youth violence prevention grant application and development of a proposal concept for preventive interventions with the children of substance abusing mothers. Suicide prevention activities are associated with both the Division of Comprehensive Psychiatric Services and the Office of Prevention. Prevention programming addressing developmental disabilities and public education addressing stigma are anticipated in the coming year.

Missouri

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Analysis of unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them

In 2004, the Capacity Development committee comprised of Department of Mental Health staff, providers and consumers/family members, identified growth and development needs related to areas of the service array. The needs arose due to resource limitations and historical under-funding. However, among the areas that appear to be in especially short supply are housing subsidies and supports, acute care beds, community-based crisis alternatives to hospitalization, specialized treatment options for long-term services to adults and children and youth with challenging behaviors and symptoms, and mental health services for youth in the juvenile justice system. During periods of funding constraints, these gaps will be experienced as a result of high demand and over-utilization of scarce inpatient services.

The Capacity Development committee undertook its work by scanning the other states for methodologies to identify capacity needs for mental health service needs. For children's services, Friedman and Pires have established and promoted models for sizing components of care and the committee utilized their models to project capacity targets for Missouri's children. However, there is no generally accepted standard or model for sizing adult services. Although some states have used computer simulation technology, the cost of such an effort was prohibitive and the committee pursued an expert consensus panel of Missouri providers, consumers and policy-makers to project capacity using a process similar to that devised by Friedman. A review of literature and comparison to other states' experiences regarding need for services was conducted and Ciarlo census-based epidemiological figures were used to project need in the adult system. These projections are being compared to existing capacity to identify gaps in service delivery.

In 2005 the Change and Innovation agency was asked to survey consumers, providers and other stakeholders at the community level to determine current perceived services needs and gaps in the Mental Health system. As noted in the Strengths and Weaknesses section this project provided the DMH with a wealth of information and informs our new consumer satisfaction survey. It also helps us identify some future remedies for problems identified. Supported employment programs and development of more consumer run drop-in centers in rural as well as metropolitan areas are needed additions to Missouri's current service system.

The DMH continues to face resource limitations and funding cuts. Additional challenges facing the current system include transitioning the youth population into adult services and providing continued education and practical training for direct care workers both in the community and facilities.

Missouri

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

A statement of Missouri's priorities and plans to address unmet needs

Priorities include:

- decentralization of Supported Community Living, so that individuals are served in their community by local service providers who are trained and knowledgeable;
- development of a plan to serve aging individuals with mental health problems; and
- retaining and training committed caring staff who provide direct care services.

Priorities are being addressed through continued decentralization of the SCL services so that community providers deliver services directly and seek guidance and assistance only through SCL. The Supported Community Living staff has taken on Safety and Basic Assurance Surveys, Certification Surveys and other monitoring duties in their areas of service. The Departments' system of care also recognizes the need to:

- Employ a diverse, culturally and linguistically competent workforce.
- Provide pre-service and in-service training and professional development activities for all staff and governing board members to ensure understanding and acceptance of values, principles, and practices governing cultural and linguistic competence (including families, youth, and peer professionals, etc.);
- Provide orientation training, mentoring, and other supports for all volunteers to ensure understanding and acceptance of values, principles, and practices governing cultural and linguistic competence; and
- Incorporate areas of awareness, knowledge, and skills in cultural and linguistic competence into position descriptions and performance evaluations for all staff.

Missouri

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

The President's New Freedom Commission on Mental Health's final report "Achieving the Promise: Transforming Mental Health Care in America" states that "successfully transforming the mental health service delivery system rests on two principles:

- **First, services and treatments must be consumer and family centered**, geared to give consumers real and meaningful choices about treatment options and providers-not oriented to the requirements of bureaucracies.
- **Second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience**, not just on managing symptoms."

In 2005 the Missouri Department of Mental Health and the Division of Comprehensive Psychiatric Services brought Kathleen Crowley and the Health Action Network, Inc. to Missouri to pilot the PROCOVERY Program. PROCOVERY is an approach (developed by Kathleen Crowley) to healing based on hope grounded in practical everyday steps that individuals can take to move forward. PROCOVERY gives all caregivers a framework to do what superior caregivers do intuitively. PROCOVERY brings together three groups of people who are often at odds with one another --- consumers, family members and staff. PROCOVERY is a clear, unwavering belief in the possibilities of overcoming illness with a clear implemental framework of practical strategies and actions. There are 8 principles which include a focus forward and not backward; focus on life not illness; an individual can "just start anywhere"; and, keeping hope alive. To support the principles, there are 12 identified strategies which include gathering, utilizing and maximizing support; taking practical partnering steps; managing medication collaboratively; and sticking with procovery during crises and using those times to initiate procovery. A rural and an urban site were chosen for pilot programs and Hope Seminars were held to kick off the program. Consumers and providers are embracing this program model and independent Procovery Circles, (consumer led support groups) are forming across the state. Many service providers indicate that they are anxious to begin using the Procovery model in their own programs.

Missouri continues to move forward with administrative restructuring. Decentralization of Supported Community Living Programs is underway, giving the community programs the ability to provide direct services to consumers with training, support and oversight provided by the DMH.

Hospital systems, formed in FY 2003 continue developing processes for coordination with community providers on an administrative/planning level as well as a service level. In FY 2006 the thrust will be coordination of care with community providers.

In response to national recognition of suicide as a worldwide public health problem, collaborative planning efforts began in Missouri that resulted in the passage of legislation in 2003 that mandates the development of a statewide suicide prevention plan. The Missouri Suicide Prevention Plan has been developed with broad input from public health experts, mental health providers, suicide survivors and twelve town hall meetings

conducted in communities across Missouri. The recommendations have been developed using reviews of research, experience of other states in suicide prevention and experience gained in suicide prevention efforts in Missouri. Broad community input was sought to tailor the scientific knowledge and national experience to address the specific needs of Missouri communities and organizations.

The planning process united various organizations and brought together partners who each play a role in identifying and solving the problem. The Plan was designed to assist stakeholders in providing services where most needed and where gaps in service exist, this avoiding duplication and competition by suggesting ways to coordinate activities. The Plan was developed to raise awareness of the suicide problem not only among the agencies and groups involved in the planning process, but also among the general population. The Plan has been written in such a way as to be applicable to all groups and populations. And lastly, the Plan encourages individual communities to develop customized strategies and implement them in a manner that fits their local needs and recourses. All Missourians are urged to act on these recommendations to help reduce the preventable tragedy of suicide.

The Missouri Department of Mental Health (DMH), in collaboration with the Missouri Medicaid Program, is offering the Missouri Mental Health Medicaid Pharmacy Partnership to evaluate the use of mental health medications and to offer education when opportunities exist to improve prescribing practices. The program, which is adjunctive to other efforts in the state, aims to reduce health-care costs to Medicaid patients. The Behavioral Pharmacy Management System (BPMS) assists state mental health and Medicaid agencies to improve behavioral health prescribing practices for Medicaid recipients with psychiatric illnesses. The goals are;

- Improve the quality of behavioral health prescribing practice based on best-practice guidelines;
- Improve patient adherence to medication plans; and
- Reduce the rate of spending on Medicaid behavioral drugs

Medication Risk Management (MRM) is another partnership program. While BPMS focuses on physician prescribing practice, MRM is designed to help states develop disease management strategies for Medicaid recipients diagnosed with Schizophrenia, who are at highest risk for adverse medical and behavioral outcomes, and whose combined behavioral and medical care expenditures can be significantly higher than other Medicaid recipients. MRM's goals are;

- Medication adherence improves
- ER and acute care events decrease
- Medical misadventures decrease
- High cost service events decline

Finally, Missouri has received a Supported Employment grant from the National Institute of Health. National leaders in the field will conduct Fidelity Assessments to inform a

Guiding Coalition. The Coalition will develop a strategic plan for training and technical assistance to Missouri providers who serve consumers in need of supported employment.

Missouri

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

A brief description of the comprehensive community-based public mental health system that Missouri envisions for the future.

The Department of Mental Health is working towards a system that connects community based consumer driven services to the hospital systems serving the community. The future of the mental health system will have the community services surrounding the hospital systems. Consumers will enter the hospital system for acute care or long term care through the Administrative Agents. Discharge planning to ensure care coordination and success will occur prior to re-entry into the community. Care coordination teams will work on behalf of the client to facilitate successful community tenure. This vision of the future embraces the Department of Mental Health's stated values of: access to services, individualized services and supports, and quality services through monitoring, staff training and ongoing technical assistance.

Coupled with this effort the Department of Mental Health will use satisfaction surveys annually and these will inform and guide the Division in the delivery of community based services. Data from these surveys will be used to help providers build on their strengths, recognize their weak areas and plan training and support to address consumer need.

The Department of Mental Health has been working to put a new data collection system in place. When completed this system will help us track information about evidenced based practices used throughout our system. It will provide users with an electronic record and it will keep accurate accounting of consumers using State Mental Healthcare.

Missouri's mental health system wants to shift emphasis from a largely disability focused model to a public mental health approach that addresses the mental health of the entire population across the whole lifespan. Adopting a public mental health approach means that the state and local communities shift from a diagnosis and disability-driven view to one which emphasizes prevention and risk reduction in addition to treatment and recovery supports. Consequently, in order to transform the mental health system in Missouri, two critical needs must be addressed. 1) Lack of a comprehensive prevention infrastructure and strategy for reducing stigma. Missouri is working towards a strategy to incorporate the promotion of good mental health and the prevention of mental health problems across the entire lifespan. The anti-stigma campaign is part of this strategy. 2) Lack of formal infrastructure for local ownership of, and investment in, mental health. The mental health system is currently very centralized, yet many aspects of promoting and protecting public health have long been recognized, and effectively administered, as shared state and local responsibilities. Although Missouri counties have the option to fund and administer mental health and substance abuse services, only 13 of the 114 counties and City of St. Louis have chosen to do so. Therefore, to elevate the importance of mental health to the same level as health, the development of an infrastructure that balances state authority and local investment in a mental health system is needed.

Finally, the Division of Comprehensive Psychiatric Services is excited about the introduction of PROCOVERY to Missouri Mental Health consumers. Legislative changes will reduce the number of individuals able to access services with Medicaid.

to a point where we will serve the neediest. Individuals who are not able to access funding for treatment will have consumer networks through Procovery Circles and consumer help lines.

Missouri

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

Strengths and Weaknesses of the Children's Service System

The Office of Comprehensive Child Mental Health (OCCMH) was created through legislation in 2005 through SB 501 and is incorporated into statute through 630.100 RSMo. The OCCMH is under the supervision of the Director of the Department of Mental Health in providing leadership across the three divisions of DMH in developing and implementing the Comprehensive Children's Mental Health Services Plan. Additionally, the OCCMH has an external role in provision of technical assistance and training to all departments participating in the Comprehensive Children's Mental Health Service System as outlined in SB 1003.

As outlined in SB 501 the OCCMH shall:

1. Assure oversight and monitoring for the implementation of the comprehensive child mental health service system plan;
2. Provide support, technical assistance and training to all departments participating in the development and implementation of the comprehensive child mental health services system established under 630.097 RSMo;
3. Develop and coordinate service system, financing and quality assurance policy for all children's mental health services within the department of mental health;
4. Provide leadership in program development for children's mental health services within the department of mental health, to include developing program standards and provide technical assistance in developing program capacity;
5. Provide clinical consultation, technical assistance and clinical leadership for all child mental health within the department and to other child-serving agencies participating in the comprehensive child mental health system;
6. Participate in the work of the coordinating board for early childhood;
7. Participate in interagency child mental health initiatives as directed; and
8. Provide staff support and leadership to the state comprehensive system management team established under section 630.097 RSMo.

Additionally, SB 501 establishes within the Department of Mental Health a Comprehensive Child Mental Health Clinical Advisory Council as appointed by the Director of DMH.

The ability of the DMH to consult with and inform all child serving agencies strengthens our service system. Changes to Missouri's Medicaid system may be a cause for concern. Medical, optical and dental services for children are becoming more limited. The new Medicaid legislation removes dental care, eye examinations, some durable medical equipment and some home care services from the menu of services available to children. Mental health service providers have traditionally helped people without Medicaid or other medical insurance pay for services through fund raising on the local or community level. An increase in individuals needing additional services will tax this system and leave many without needed care.

Missouri

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Analysis of unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them

The DMH continues to face resource limitations and funding cuts. Additional challenges facing the current system include transitioning the youth population into adult services. A particularly difficult population to transition are youth with sexual issues between the ages of 16 and 23. There are few resources in the State to address the needs of this population. In response, individuals within the Department of Mental Health have organized a workgroup to look at this problem and develop useful resources.

Missouri

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

A statement of Missouri's priorities and plans to address unmet needs

Priorities include:

- continuing development of systems and services to help youth transition to the adult service system; and
- retaining and training committed caring staff who provide direct care services.

Priorities are being addressed through continued development of a comprehensive system of care for children and youth in Missouri. Transitioning youth are assisted with application for services in adult service settings and given services while a diagnosis is formulated. The Departments' system of care also recognizes the need to:

- Employ a diverse, culturally and linguistically competent workforce;
- Provide pre-service and in-service training and professional development activities for all staff and governing board members to ensure understanding and acceptance of values, principles, and practices governing cultural and linguistic competence (including families, youth, and peer professionals, etc.);
- Provide orientation training, mentoring, and other supports for all volunteers to ensure understanding and acceptance of values, principles, and practices governing cultural and linguistic competence; and
- Incorporate areas of awareness, knowledge, and skills in cultural and linguistic competence into position descriptions and performance evaluations for all staff.

Missouri

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

The President's New Freedom Commission on Mental Health's final report "Achieving the Promise: Transforming Mental Health Care in America" states that "successfully transforming the mental health service delivery system rests on two principles:

- **First, services and treatments must be consumer and family centered**, geared to give consumers real and meaningful choices about treatment options and providers-not oriented to the requirements of bureaucracies.
- **Second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience**, not just on managing symptoms."

Missouri developed and passed legislation in 2004 calling for a System of Care to serve children, youth and families. In a System of Care (SOC), mental health services (psychiatric, mental retardation/developmental disabilities, alcohol and drug abuse) as well as other services and supports are organized in such a way as to enable children with the most complex needs to remain in their homes, schools and communities. System of Care brings the right people together—at multiple levels—to develop resources and remove barriers for children with complex needs that might otherwise fall through the cracks. Children with the most challenging mental health issues, particularly those who are involved with multiple agencies will have a local coordinated team of individuals that will work to meet with the family's needs for as long as is necessary. This team is referred to as the Family Support Team. Many such teams (though perhaps under different names) already exist for children with complex needs. In addition to the Family Support Team, a System of Care brings a Local System of Care Policy Group into plan. The Local SOC Policy Group's functions include reviewing and identifying policy (local and state) that may be creating a barrier to children getting their needs met. It is also responsible for contributing appropriate resources from its member agencies (for example, dollars or in-kind services), to assist in meeting the needs of a child being served in System of Care.

Who participates in System of Care?

State Level Coordination

- 1. Family Members**
- 2. Family-run Organizations**
- 3. Child Advocacy Organizations**
- 4. Department of Social Services (DSS)**
 - › Division of Youth Services (DYS)
 - › Children's Division (CD)
 - › Division of Medical Services (DMS)
- 5. Courts and Office of State Courts Administrator (OSCA)**
- 6. Department of Health and Senior Services**
 - › Division of Community and Public Health

7. Department of Mental Health (DMH)

- > Division of Comprehensive Psychiatric Services (CPS)
- > Division of Alcohol and Drug Abuse (ADA)
- > Division of Mental Retardation and Developmental Disabilities (MRDD)

8. Local Representation

- > Juvenile Court
- > Children's Division

Local Level Coordination

System of Care at the local level includes representatives from the aforementioned state agencies as well as a variety of individuals representing many different organizations and interests.

Missouri

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Child – A brief description of the comprehensive community-based public mental health system that the State envisions for the future

Missouri's mental health system wants to shift emphasis from a largely disability focused model to a public mental health approach that addresses the mental health of the entire population across the whole lifespan. Adopting a public mental health approach means that the state and local communities shift from a diagnosis and disability-driven view to one which emphasizes prevention and risk reduction in addition to treatment and recovery supports. Consequently, in order to transform the mental health system in Missouri, two critical needs must be addressed. 1) Lack of a comprehensive prevention infrastructure and strategy for reducing stigma. Missouri is working towards a strategy to incorporate the promotion of good mental health and the prevention of mental health problems across the entire lifespan. The anti-stigma campaign is part of this strategy. 2) Lack of formal infrastructure for local ownership of, and investment in, mental health. The mental health system is currently very centralized, yet many aspects of promoting and protecting public health have long been recognized, and effectively administered, as shared state and local responsibilities. Although Missouri counties have the option to fund and administer mental health and substance abuse services, only 13 of the 114 counties and City of St. Louis have chosen to do so. Therefore, to elevate the importance of mental health to the same level as health, the development of an infrastructure that balances state authority and local investment in a mental health system is needed.

The promotion of mental health and the prevention of mental illness is a goal of the comprehensive children's mental health system. Promoting positive mental health and preventing the onset and progression of behavioral disorders can reduce deaths and injuries. The Missouri School-Based Initiative, Missouri SPIRIT, is a pilot program demonstrating the efficacy and effectiveness of implementing evidence-based prevention programs in schools. Information from the first two years of the program strongly suggests that there are not only reductions in alcohol and other drug use, but also improvements in school climate – including, reductions in violent behavior among high school students and reduced numbers of children with 10 or more absences per year. SPIRIT is demonstrating that evidence-based programs, implemented with some fidelity, can, not only reduce behavioral disorders, but also improve school environment. The DMH proposed budget for FY2006 includes a request for funds to expand the SPIRIT project to additional schools.

The DMH has also received a grant to develop and implement a “strategic prevention framework.” The purpose of the grant is to develop and implement a statewide infrastructure for substance abuse prevention, mental health promotion, and mental illness prevention. The strategic prevention framework consists of the following five steps: conduct needs assessments; build state and local capacity; develop a comprehensive strategic plan; implement evidence-based prevention policies, programs and practices; and monitor and evaluate program effectiveness, sustaining what has worked well.

A primary goal of the Comprehensive Children's Mental Health System is to insure that

children who need mental health services and supports receive them earlier, rather than later. Early identification and intervention will allow these children to be helped within the community and before the need for institutional services. Early treatment is only possible when children in need are identified early in the progression of their illness. The comprehensive system will emphasize early identification through intensive campaigns to teach physicians and providers, school personnel and parents how to identify a child in need of mental health services and how to obtain appropriate services.

Missouri

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Criterion 1 Adult - Establishment of System of Care

The State's *Revised Statutes of Missouri 2004* RSMo 630.020 set Departmental goals and duties. It states:

“1. The Department shall seek to do the following for the citizens of this state:

(1) Reduce the incidence and prevalence of mental disorders, developmental disabilities and alcohol or drug abuse through primary, secondary and tertiary prevention;

(2) Maintain and enhance intellectual, interpersonal and functional skills of individuals affected by mental disorders, developmental disabilities or alcohol or drug abuse by operating, funding and licensing modern treatment and habilitation programs provided in the least restrictive environment possible;

(3) Improve public understanding of and attitudes toward mental disorders, developmental disabilities and alcohol and drug abuse.

2. The department shall make necessary orders, policies and procedures for the government, administration, discipline and management of its facilities, programs and operations.”

Missouri

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

Criterion 1 Adult – Available Services

The **Community Psychiatric Rehabilitation Program (CPRP)** serves adults in their communities. Treatment planning is done with the consumer to maximize use of resources and individualize service provision.

Expansion of the Community Psychiatric Rehabilitation Program for both adults and children and youth has been a priority. The CPRP program is a client-centered approach that emphasizes individual choices and needs; features flexible community-based services and supports; uses existing community resources and natural support systems; and promotes independence and the pursuit of meaningful living, working, learning, and leisure-time activities in normal community settings. The program provides an array of key services including evaluations, crisis intervention, community support, medication management, and psychosocial rehabilitation. Medical and Dental Care for individuals receiving Mental Health services in the state of Missouri are provided through community providers unless an individual is hospitalized and in need of services (in which case the hospital provides services).

Community support workers assist children, youth and adults in accessing needed care within their community. In Kansas City, MO and St. Louis, MO, people are able to visit a dentist through the dental schools located in those cities. While medical care is more easily accessible in most areas, some individuals, living rurally must travel to larger communities to be seen and treated for medical or dental conditions. Few private practice dentists in Missouri will accept Medicaid or provide services at no or low cost.

Though medical care is becoming more readily available in many communities it is still a challenge to find competent medical or dental care in the most rural areas of Missouri.

Program expansion since CPRP's inception brings us to the current consumer use:

Adults served in FY 05 26,027

Children and youth served in FY 05 3,614

(This count is determined by counting clients with a CPR service billed to either Medicaid or POS in FY05).

Because CPRP is a Medicaid supported program under the rehabilitation option, the federal government pays approximately 60 percent of the costs for clients with Medicaid eligibility. In 2001, the DMH promulgated "core rules" that provide common standards across the Divisions of CPS and ADA, where possible. These are also supplemented by specialized standards unique to the population served. Subsequently, in State FY 2003 a committee of provider and consumer representatives met and developed draft recommendations to enhance the CPR program in several key areas, including the development of continuous treatment teams, increased physician involvement in service planning, and incorporating both substance abuse services and vocational supports more fully into the program. The division has established a collaborative partnership between CPS and ADA provider organizations to improve access and referral of individuals with co-occurring disorders to services.

Missouri received a State Incentive Grant for treatment of individuals with Co-Occurring Substance Related and Mental Disorders (COSIG) in the fall of 2003. Provider pairs for the pilot project have been identified in both rural and urban areas. As the work of the grant moves forward, providers are preparing to assess consumers as they usually would, screen for co-occurring disorders and make appropriate treatment decisions and referrals based on the assessment and screening findings. COSIG sites are in the process of hiring or identifying qualified staff members to work with individuals identified as having co-occurring disorders. CPR programs not identified as COSIG providers will be enhancing service delivery with an expanded array of services to include group and individual counseling at their own pace over the next year.

The Division of CPS continues to move forward with a **recovery-based care** model and has funded contracts for the development of consumer-run services ranging from **warm-lines to drop-in centers** for the past four years. Four contracts are currently in place for peer phone support services (warm-lines) in various sites throughout the state. Each warm-line is operated by mental health consumers. These services are intended to reduce feelings of social isolation and loneliness. The consumers answering the phone lines do not provide crisis intervention services but are trained to provide support, friendship and assistance over the telephone to other mental health consumers. Additionally, seven contracts are in place for consumer-run drop-in centers in a variety of settings statewide. These drop-in centers offer services such as, self-care education, support groups, peer-support, community integration activities, socialization skills education and recreational opportunities. The centers operate at a minimum of three days per week. Center staff members are primary mental health consumers who complete training sessions that pertain to the programs and initiatives of that particular center. The DMH has developed a formal monitoring process for consumer operated services to assure quality services and has applied the process during the last fiscal year.

In addition, the **Community Support Assistant Training and Certification Program** has been implemented. The goal of this program is to place mental health consumers into Community Support Assistant (CSA) positions after completing the training and certification program. The Division is currently in the process of developing a revised core curriculum that the CSA will complete prior to working with consumers. Continuing education will be spread over the next six months to two years. The Division has funded CSA positions and there are currently 11 positions filled with consumers who have completed the training program and continue to work. Other services for adults that will continue to be provided, and enhanced when possible, are the following:

- **Targeted Case Management** includes the following services: arrangement, coordination, and assessment of the individual's need for psychiatric treatment and rehabilitation, as well as other medical, social, and educational services and supports; coordination and monitoring of services and support activities; and documentation of all aspects of case management services, including case

openings, assessments, plans, referrals, progress notes, contacts, rights and grievance procedures, discharge planning, and case closure.

- **Residential** – Residential services provide a variety of housing alternatives to meet the diverse needs of clients. Funds are used to support the cost of such housing services as nursing facilities, residential care facilities, group homes, and supported housing. Contractual arrangements are made to obtain these residential services in the community. As individuals move into more normalized housing alternatives, they require intensive and flexible services and supports in order to maintain that housing. Provisions of these services and supports will enable these individuals to successfully live and work in their communities.
- **Housing Options** – Within the past 3 years the DMH Housing Team has collaborated with community providers to develop semi-independent apartments through the HUD 811 process. This option targets those individuals who need additional supports in order to transition to independent living. During the current funding cycle, several CPS providers are submitting HUD applications to develop Safe Havens, low –demand housing for those with co-occurring mental illness and substance abuse disorders.
- Emergency services for consumers are provided through **Access Crisis Intervention (ACI)**. Service providers are trained by the Administrative Agents to respond to crisis calls. To ensure quality services that are delivered on a consistent basis the Division developed an administrative rule that governs the ACI program. ACI programs are certified to provide crisis services.

Missouri

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Criterion 2 Adult – Estimate of Prevalence

Please refer to Appendix B, Table A “2001 Estimated Census Data and Prevalence Rates” and Appendix C, Table B “Characteristics of Clients Served” for complete information.

Definition of the Population

For the purposes of this plan, “adults suffering from severe, disabling mental illness” are defined as individuals, 18 years of age and older, who meet each of the following three criteria:

- 1) Disability: There must be clear evidence of serious impairment in each of the following areas of behavioral functioning.
 - a) Social role functioning – ability to functionally sustain the role of worker, student or homemaker; and
 - b) Daily living skills – ability to engage in personal care (grooming, personal hygiene, etc.) and community living activities (handling personal finances, using community resources, performing household chores, etc.) at an age-appropriate level.
- 2) Diagnosis: A primary diagnosis of one of the DSM-IV Diagnostic and Statistical Manual of Mental Disorders, (Fourth Edition, Revised in 1994) listed below, but such diagnosis may coexist with other DSM-IV diagnoses in Axis I or other areas.
 - a) Schizophrenic disorder (295.1,2,3,6 or 9)
 - b) Delusional (paranoid) disorder (297.10)
 - c) Schizoaffective disorder (295.7)
 - d) Bipolar disorder (296.4,5,6 or 7)
 - e) Atypical psychosis (298.90)
 - f) Major depression, recurrent (286.3)
 - g) Dementia or Other Organic Condition complicated with Delusional Disorder, Mood Disorder or Severe Personality Disorder (290.20, 290.21, 290.12, 290.13, 290.42, 290.43 or 294.10)
 - h) Obsessive-compulsive disorder (300.30)
 - i) Post-traumatic stress disorder (309.89)
 - j) Borderline personality disorder (309.83)
 - k) Dissociated identity disorder (300.14)
 - l) Generalized anxiety disorder (300.02)
 - m) Severe phobic disorder (300.21,22 or 23)
- 3) Duration: The individual exhibiting the disability specified in 1 (above) resulting from the DSM IV disorder specified in 2 (above) must meet at least one of the following criteria:
 - a) Has undergone psychiatric treatment more intensive than outpatient care more than once in his/her lifetime (e.g. crisis response services, alternative home care, partial hospitalization or inpatient hospitalization).

- b) Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
- c) Has exhibited the disability specified in 1 (above) for a period of no less than a year.

Missouri

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Criterion 2: Mental Health System Data Epidemiology-Quantitative Targets

Please refer to Appendix B, Table A “2001 Estimated Census Data and Prevalence Rates” and Appendix C, Table B “Characteristics of Clients Served” for complete information. For the definitions of the population to be served please see Part C, section III narrative for criterion 2 titled Estimate of Prevalence. As indicated by the data table below, the DMH has achieved the goals stated in this section in FY03 and FY04 by exceeding the expected baselines.

The DMH, Division of Comprehensive Psychiatric Services has consistently met and exceeded targets to serve the Serious Mentally Ill individuals in Missouri at the rate of 14.4% of the estimated prevalence rate. For the future we will raise our target to 16% of the estimated prevalence rate.

Missouri

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

Criterion 4: Targeted Services to Rural and Homeless Populations

The Missouri Association for Social Welfare (MASW) completed a census of homeless shelters in 2001. (The survey conducted was a point-in-time count.) The census data was be used by the Missouri Department of Economic Development as part of its Consolidated Plan to the US Department of Housing and Urban Development. That report showed 16,425 people being sheltered per day, an increase of 42% since the 1998 census. The sheltered homeless constitute a minority of homeless people. Numbers for the total homeless population (that is, including people living on the streets and places not designed for human habitation, people living in homeless shelters and people who are doubled-up living arrangements with family and friends because they no longer have their own homes) were derived by applying an annualizing factor developed by Dr. Renee' Jahiel, New School of Social Work, New York, and the relative percentages of sheltered to unsheltered and hidden homeless populations in a national study by Dr. Bruce Link & Associates, Columbia University and Dr. Martha Burt, Urban Institute, Washington D.C. This methodology results in 45,700 homeless persons per day and 87,250 homeless persons per year. Unfortunately there has not been a new census in Missouri since 2001. MASW is preparing to conduct a new census and is seeking the funding to do so at this writing. According to the 2003 – 2004 Homeless Children and Youth Census Report conducted by the Missouri Department of Elementary and Secondary Education, there are approximately 12,839 school-age children and youth that are homeless.

The following is a listing of programs and services available to assist persons with mental illness who are homeless:

- **PATH Grant** – This is a federal entitlement grant available to all states and territories to provide outreach and case management services to homeless individuals who are mentally ill and who may also have co-occurring substance abuse problems. PATH funds are used to continue services provided by the agencies originally funded through the Mental Health Services for the Homeless (MHSH) Block Grant. In 2001, a new provider was added in St. Louis and in 2002 a provider serving the rural Southeast area has been added with additional PATH funding. A rural Southwestern area provider was added in 2003. This provider has doubled their use of PATH funding in two years time and continues to provide excellent service to the area's homeless population.
- **Shelter Plus Care** is a program designed to link rental assistance to supportive services on a long-term basis for homeless persons with disabilities, (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families who are living in places not intended for human habitation (e.g., streets) or in emergency shelters. The program allows for a variety of housing choices, and a range of supportive services funded by DMH, in response to the needs of the hard-to-reach homeless population with disabilities. Currently DMH has twenty-three (23) Shelter Plus Care grants. These grants provide rental assistance for over 1900 individuals and their families throughout fifty different counties expending over 6.5 million a year in rental assistance and 9 million in supportive services.

- **Access** – The Division of CPS received General Revenue funds to continue the outreach program initially started through the Access Demonstration Grant project, a five-year federal grant that recently expired.

Missouri

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

Criterion 4 Adult – Rural Area Services

The state of Missouri has a primarily rural geography that creates disparities in service access. Rural areas are characterized by high levels of poverty, little access to specialty health care, low educational levels, and isolation imposed through geography and/or culture (Fox, Merwin, & Blank, 1995; Bachrach, 1983; Heyman, 1982). Of the 25 service areas in Missouri, 16 are designated rural or semi-rural according to definitions based on boundaries of Metropolitan Statistical Areas adopted by DMH/CPS. Approximately 15% of the state's population live in rural areas, and 25% are concentrated in small towns and cities. Three-fourths of Missouri's counties are considered mental health professional shortage areas (Missouri Foundation for Health, 2002). The unique and complex characteristics of rural communities call for a specific plan to be developed with local communities to address these issues.

The special needs of rural and semi-rural areas are a challenge to all human services, especially in the areas of transportation, recruitment and retention of staff, and access and availability of services. Rural human services can be effectively addressed by interagency collaboration, involvement of local community leaders, and natural supports. Each of the 25 Administrative Agents are required to provide the key services that insure availability and access to mental health services. Some service areas have enhanced availability because independent Community Psychiatric Rehabilitation agencies are also established within their boundaries. All administrative agents that contract with CPS are required to have cooperative agreements with the State operated inpatient hospitals, and the primary CMHC has the responsibility of serving as the point of entry for anyone in that area receiving CPS services. Particular care is given to the screening of involuntary commitments to State facilities and coordination of services for consumers released from State facilities. Missouri is always challenged in its attempts to be equitable between rural and urban areas in the distribution of resources. Funding for community support services are distributed to provider agencies based on a set formula taking into account area population adjusted for the number of individuals at or below the poverty level.

Administrative agents who serve rural communities across Missouri find that satellite offices in rural areas help them provide care for more individuals. These providers often have staff members that rotate between sites to see consumers. Several rural service providers are using tele-psychiatry to their most rural office sites. This method of linking consumers with their physician is new and there are problems with having a computer link available when a consumer and physician are available for the appointment. Continued use will over time, produce better care for rural consumers.

Missouri

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Criterion 5 Adult - Resources for Providers

The Missouri Department of Mental Health (DMH), in collaboration with the Missouri Medicaid Program, is offering the Missouri Mental Health Medicaid Pharmacy Partnership to evaluate the use of mental health medications and to offer education when opportunities exist to improve prescribing practices. The program, which is adjunctive to other efforts in the state, aims to reduce health-care costs to Medicaid patients.

Principles

The Partnership must:

- Make use of existing data sets (Medicaid and DMH);
- Be supportive of existing treatment system and providers;
- Be educational in nature; and
- Be based on continuously updated best practice guidelines.

Service Providers across the State also have access to trainings at low or no cost through the Missouri Institute of Mental Health. Among the array of trainings and services operated by this Department of the University of Missouri Medical School is CETV. Providers and staff can access trainings on the internet and receive CEU's for a nominal fee. The web site for CETV is <http://www.mimhcetv.com/welcome/welcome.html>.

Another resource is Missouri's **strategic planning process** is based on *Managing for Results*. The *Managing for Results* initiative is a management tool for the Governor and his cabinet to help keep government focused on results and to drive meaningful improvements for citizens. This effort encourages fact-based decision making and innovation the initiative also recognizes the need for agencies to work together to drive significant improvements. The *Missouri Strategic Planning Model and Guidelines* was developed by the Interagency Planning Council to foster and assist State agencies in the use of a common strategic planning model that includes shared terminology and action calendars. These guidelines provide an outline for Missouri's planning principles and written plan components. The planning model provides measurement tools for evaluation of State government performance.

The Division of CPS also provides an annual budget to provide training. One of the premiere training events in the state of Missouri is the annual Spring Training Institute. The Division of Alcohol and Drug Abuse and the Division of Comprehensive Psychiatric Services provide a three day event each May that allows direct care staff members an opportunity to receive information and training about the most up-to-date treatment methodologies for a low conference cost. The Division of Mental Retardation and Developmental Disabilities also partners with the other Department of Mental Health Divisions by holding their annual Autism Conference at the same venue on overlapping dates.

Missouri

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

Criterion 5 Adult - Emergency Service Provider Training

The Department continues to develop and expand its leadership role in mental health and risk communications related to disasters and the potential for terrorism in the U.S. In the last year, the DMH has:

- Completed revision of its community mental health plan for disaster mental health including the incorporation of substance abuse as a response component of the plan;
- Continued its close partnership with the state public health authority to conduct joint planning, training, response and exercise activity to assure that responses to public health emergencies include a mental health component. Key accomplishments include –
 - Development and presentation of basic psychological first aid training for paraprofessionals and mental health professionals
 - Conducting train-the-trainer workshops for health care workers related to preparedness for mental health issues in public health emergencies and terrorism
 - Identification and development of an annotated outline and bibliography for mental health components of hospital preparedness plans;
- Leadership and resource development related to both Special Needs Population and Human Services Annexes to the Missouri State Emergency Operations Plan; and
- Compilation and development of public education and outreach materials for all-hazards plan for mental health needs.

The DMH leadership role is an important public mental health authority role that recognizes responsibility to populations in addition to target populations, including the general public, disaster survivors, and emergency responders. In the coming year, efforts will focus on continuing participation in statewide terrorism exercises, including a third large-scale regional exercise with the Strategic National Stockpile, continuing leadership with a planning group addressing elementary and secondary education collaboration with public mental health to address planning and resource development for traumatic violence or disaster events in schools, and continuing emphasis on general preparedness that promote resilience and readiness for everyone including those with special needs.

Missouri

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Criterion 5 Adult – Grant Expenditure Manner

The 2005 Block Grant will be expended at the same rate as indicated in Appendix A, page 97, within this document.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Access to Services

Population: Adults with SMI

Criterion: Criteria 2 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	7,521	7,487	7,218	7,300	7,300
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal:	Increase access to acute care service for adults served by the Division and continued to reduce the length of stay in State inpatient hospital settings.
Target:	1. Increase access to acute care beds;
Population:	Adults with SMI
Criterion:	Criteria 2 and 3
Brief Name:	Inpatient census, admission rates and lengths of stay.
Indicator:	1. Number of admissions to acute care facilities
Measure:	CTRAC
Sources of Information:	CTRAC
Special Issues:	The total number of adults that are served by the Division is expected to remain stable or increase as the system of care expands, but the relative overall utilization and average length of stay in State-operated psychiatric hospitals is expected to decrease as community-based alternatives are developed. Admissions to acute care facilities may increase as beds become available. The recidivism rate of re-admission is expected to decrease. Adult SMI admissions are frequently linked to involuntary commitments and forensic issues beyond the control of CPS. Though resources increased for FY2005 budget and appear to be remaining stable with the 2006 budget, withholds and reductions for 2003 and 2004 continue to have an impact on system access and capacity.
Significance:	An important outcome of the development of a community-based system of care is that reduced utilization of State-operated psychiatric hospital beds, increased access to acute care beds and a reduced average length of stay.
Action Plan:	continue to strengthen coordination between hospitals and community providers.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days

Population: Adults with SMI

Criterion: Criteria 1 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	7.10	6.10	8.70	10.76	N/A
Numerator	0	798	--	--	--
Denominator	0	13072	--	--	--

Table Descriptors:

Goal:	Increase access to acute care service for adults served by the Division and continue to reduce the length of stay in State inpatient hospital settings.
Target:	Continue to achieve a level of less than the baseline of 10.76% for the percentage of adults readmitted to State psychiatric care within 30 days of discharge;
Population:	Adults with SMI
Criterion:	Criteria 1 and 3
Brief Name:	Inpatient census, admission rates.
Indicator:	Percentage of adults readmitted to State psychiatric inpatient care within 30 days of discharge
Measure:	CTRAC
Sources of Information:	CTRAC
Special Issues:	The total number of adults that are served by the Division is expected to remain stable or increase as the system of care expands, but the relative overall utilization and average length of stay in State-operated psychiatric hospitals is expected to decrease as community-based alternatives are developed. Admissions to acute care facilities may increase as beds become available. The recidivism rate of re-admission is expected to decrease. Adult SMI admissions are frequently linked to involuntary commitments and forensic issues beyond the control of CPS. Though resources increased for FY2005 budget and they appear to be stable in the 2006 budget, withholds and reductions for 2003 and 2004 continue to have an impact on system access and capacity.
Significance:	An important outcome of the development of a community-based system of care is that reduced utilization of State-operated psychiatric hospital beds, increase access to acute care beds and a reduced average length of stay.
Action Plan:	continue to strengthen coordinated discharge planning between hospitals and community providers.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Practices

Population: Adults with SMI

Criterion: Criteria 1 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	24,181	26,027	25,000	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal:	Provide services to adults with serious mental illnesses through Evidence Based Practices.
Target:	Develop a baseline number of individuals with serious mental illness who receive CPR services annually.
Population:	Adults with SMI
Criterion:	Criteria 1 and 3
Brief Name:	Evidence Based Practices
Indicator:	Number of individuals with SMI receiving CPR program services.
Measure:	The data is gathered from provider billing reports.
Sources of Information:	Billing information and participating service sites.
Special Issues:	The Division has started new projects and service models to respond to consumer needs and the transition to Evidence Based Practices. Missouri currently provides five (5) Evidence Based Practices. Missouri defines some Evidence Based Practice models differently from the Federal Definition but has used Evidence Based Practices to model our programs. Numbers reported above are individuals receiving Community Psychiatric Rehabilitation (CPR) Services. Consumers receiving this service may also be receiving one or more of the other EBPs available in our service array.
Significance:	An important outcome of the development of a community-based system of care for adults with SMI is the increased access to services that meet their needs and are evidenced based. Missouri is moving towards Evidence Based Practice with the help of Federal Grants and community providers' interest and willingness to participate.
Action Plan:	continue to add evidence based practices to the array of services offered in Missouri.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons

Population: Adults with SMI

Criterion: Criteria 1 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	14,834	33,667	33,897	33,500	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal:	Provide community support services to all eligible adults with SMI
Target:	Maintain the baseline for the number of persons with SMI who are receiving CPS-funded case management/community support services
Population:	Adults with SMI
Criterion:	Criteria 1 and 3
Brief Name:	Community support services
Indicator:	Number of persons with SMI who receive CPS-funded case management/community support services.
Measure:	The data is gathered from provider billing reports. Previously POS CPR clients were the only case management/community support services counted. Beginning in 2004 we are reporting all POS and Medicaid consumers for adults in the service system.
Sources of Information:	Billing information
Special Issues:	The total number of individuals receiving case management/community support services is impacted by financial fluctuations and staff attrition and turnover.
Significance:	An important outcome of the development of a community-based system of care for adults with SMI is the increased access to intensive case management services that help them effectively navigate the mental health system of care.
Action Plan:	maintain current levels of funding support to provide this level of service and support providers in reducing staff turnover rates.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Client Perception of Care

Population: All adults receiving Community Psychiatric Services during a chosen month each year.

Criterion: Criteria and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	86.43		75	75	N/A
Numerator	3855	0	--	--	--
Denominator	4460	0	--	--	--

Table Descriptors:

Goal:	survey adults receiving Mental Health Services from providers funded by the Department of Mental Health.
Target:	75 percent of adults surveyed about satisfaction with services report that they are satisfied or very satisfied with the services they receive.
Population:	All adults receiving Community Psychiatric Services during a chosen month each year.
Criterion:	Criteria and 3
Brief Name:	Satisfaction with Services
Indicator:	Respondents to an annual satisfaction survey conducted one month out of the year at all CPR program sites.
Measure:	The data is gathered from each CPR provider in the State. Each provider surveys all consumers using any service during a chosen month each year.
Sources of Information:	Provider reports.
Special Issues:	The Department of Mental Health did not conduct state-wide consumer surveys during 2004. The Change and Innovation Agency, Inc. conducted focus groups across the State during 2004 and developed a satisfaction survey to be used in August of 2005. We plan to report results of this survey in December of 2005 in the Implementation Report.
Significance:	The purpose of conducting focus groups and compiling the data from those groups was to find issues that consumers, providers and stakeholders wish to see the Department address so as to improve services. Six areas, described in earlier narrative, were identified and the 2005 consumer satisfaction survey was designed to gauge the Department's improvement in those areas.
Action Plan:	implement new system for data collection and assessment so that we may address specific areas identified by consumers, providers and stakeholders as areas needing attention.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days

Population: Adults with SMI

Criterion: Criteria 1 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	12	12.30	12.30	12	12
Numerator	0	7566	--	--	--
Denominator	0	93256	--	--	--

Table Descriptors:

Goal:	continue to reduce the length of stay in State inpatient hospital settings.
Target:	Maintain the baseline of 12.5 for the average length of stay for adults admitted to State-operated inpatient hospitalization.
Population:	Adults with SMI
Criterion:	Criteria 1 and 3
Brief Name:	Inpatient census, lengths of stay.
Indicator:	Average length of stay for adults admitted to State-operated inpatient hospitalization.
Measure:	CTRAC
Sources of Information:	CTRAC
Special Issues:	The total member of adults that are served by the Division is expected to increase as the system of care expands. Changes in Missouri's Medicaid system may cause a number of consumers to become ineligible for the Medicaid program which may increase the relative overall utilization and average length of stay in State-operated psychiatric hospitals. The recidivism rate of re-admission is expected to decrease.
Significance:	An important outcome of the development of a community-based system of care is the reduced utilization of State-operated psychiatric hospital beds. A reduction in Medicaid eligible consumers may increase the number of consumers in need of hospitalization.
Action Plan:	Maintain baseline.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: EBP - Supported Employment

Population: Adults with SMI

Criterion: 1 & 4

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	236	292	300	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal: Provide services to adults with serious mental illnesses through Evidence Based Practices.

Target: Increase the number of individuals finding and holding employment through supported employment services.

Population: Adults with SMI

Criterion: 1 & 4

Brief Name: Evidence Based Practices

Indicator: Number of individuals participating in Missouri's Supported Employment Program.

Measure: The data is gathered from the Division of Vocational Rehabilitation.

Sources of Information: Vocational Rehabilitation. The Missouri State Rehabilitation Council, 2004 Annual Report.

Special Issues: The Division has started new projects and service models to respond to consumer needs and the transition to Evidence Based Practices. Numbers reported for individuals receiving Supported Employment are obtained through Missouri's Vocational Rehabilitation program.

Significance: An important outcome of the development of a community-based system of care for adults with SMI is the increased access to services that meet their needs and are evidenced based. Missouri is moving towards Evidence Based Practice with the help of Federal Grants and community providers' interest and willingness to participate.

Action Plan: increase the number of consumers served through Supported Employment.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: EBP - MH/SA Services

Population: Adults with SMI

Criterion: 1

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	960	960	960	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal:	Provide services to adults with serious mental illnesses through Evidence Based Practices.
Target:	Provide integrated treatment for individuals with SMI and Alcohol or other drug abuse or dependence.
Population:	Adults with SMI
Criterion:	1
Brief Name:	Evidence Based Practices
Indicator:	Number of individuals participating in treatment through the Co-SIG grant for treatment of co-occurring disorders.
Measure:	Numbers reported are available slots for treatment under the Co-Sig grant. Agencies providing Co-SIG and self-management services report client numbers.
Sources of Information:	Billing information and participating service sites.
Special Issues:	The Division has started new projects and service models to respond to consumer needs and the transition to Evidence Based Practices. Numbers for people receiving MH/SA services and Self-Management services are reported for 2005 by counting the number of individuals the Co-SIG sites are required to serve to fulfill their study requirements.
Significance:	An important outcome of the development of a community-based system of care for adults with SMI is the increase access to services that meet their needs and are evidenced based. Missouri is moving towards Evidence Based Practice with the help of Federal Grants and community providers' interest and willingness to participate.
Action Plan:	This year the Co-Sig sites have screened 186 consumers for Co-Occurring disorders. of the consumers screened at least 89% screened positive for co-occurring disorders.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: EBP - Self-Management Services

Population: Adults with SMI

Criterion: 1

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	1,100	1,100	1,200	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal: Provide services to adults with serious mental illnesses through Evidence Based Practices.

Target: Increase the number of individuals receiving service to promote illness self-management.

Population: Adults with SMI

Criterion: 1

Brief Name: Evidence Based Practices

Indicator: Number of individuals participating in services provided by peers and funded through DMH. Phone support and peer drop-in centers.

Measure: The data is gathered from provider billing reports. Agencies providing self-management services report client numbers.

Sources of Information: Billing information and participating service sites.

Special Issues: The Division has started new projects and service models to respond to consumer needs and the transition to Evidence Based Practices. Numbers for people and Self-Management services are reported for 2005 by counting the number of individuals reported in attendance at peer support sites across the state.

Significance: An important outcome of the development of a community-based system of care for adults with SMI is the increased access to services that meet their needs and are evidenced based. Missouri is moving towards Evidence Based Practice with the help of Federal Grants and community providers' interest and willingness to participate.

Action Plan: Next year we hope to report information concerning the Procovery pilot sites along with the self-help centers numbers.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: EBP - Supported Housing

Population: Adults with SMI

Criterion: 1

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	425	2,215	2,000	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal: Provide services to adults with serious mental illnesses through Evidence Based Practices.

Target: Maintain or increase the number of individuals with SMI receiving supported housing services.

Population: Adults with SMI

Criterion: 1

Brief Name: Evidence Based Practices

Indicator: Number of individuals receiving all Supported Housing Services.

Measure: The data from 2004 was gathered from shelter + care reports. In 2005 we began counting all individuals receiving housing assistance who are served by a DMH Administrative Agent (AA) or an affiliate of an AA.

Sources of Information: counts reported to Supported Community Living by AAs.

Special Issues: The Division has started new projects and service models to respond to consumer needs and the transition to Evidence Based Practices.

Significance: An important outcome of the development of a community-based system of care for adults with SMI is the increased access to services that meet their needs and are evidenced based. Missouri is moving towards Evidence Based Practice with the help of Federal Grants and community providers' interest and willingness to participate.

Action Plan: continue to look for resources to support our individuals with SMI living in the community

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 1: Rural children receiving mental health services

Population: Adults with SMI

Criterion: Targeted services to rural and homeless populations.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	18.89	20.40	20.60	20.60	N/A
Numerator	0	40311	--	--	--
Denominator	0	197678	--	--	--

Table Descriptors:

- Goal:** Maintain access and capacity of mental health services to adults with SMI who live in rural areas.
- Target:** Maintain the percentage of adults with SMI living in rural areas who are receiving CPS-funded mental health services.
- Population:** Adults with SMI
- Criterion:** Targeted services to rural and homeless populations.
- Brief Name:**
- Indicator:** Percentage of adults with SMI in rural areas receiving CPS-funded mental health services.
- Measure:** Gathered from provider billing reports.
- Sources of Information:** Data from service providers.
- Special Issues:** Access to mental health services for individuals living in rural areas depends on the level of funding available for community-based services and on efforts to equalize funding across service areas.
- Significance:** A comprehensive system of care includes equal access for all people living in rural areas.
- Action Plan:** continue current level of funding to rural area providers.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 1: Expenditures per capita

Population: Adults with SMI.

Criterion: Management systems.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	58.14	67.32	68.29	68	N/A
Numerator	0	283362507	--	--	--
Denominator	0	4209334	--	--	--

Table Descriptors:

Goal:	Maintain existing community-based services and increase effectiveness through State GR and/or other resources.
Target:	Maintain access to and improve the effectiveness of services to individuals in the community.
Population:	Adults with SMI.
Criterion:	Management systems.
Brief Name:	Financial Resources
Indicator:	1. Mental health expenditures per capita. 2. Mental health expenditures per person served.
Measure:	Annual CPS expenditures will be divided by the Missouri Populations. Annual CPS expenditures on adults will be divided by the number of adults served during the same time period.
Sources of Information:	Population data and expenditure reports.
Special Issues:	The spending authority for the State match for Targeted Case Management has been shifted from DMH to the State Medicaid Agency and will no longer be reflected in DMH expenditures as in the past. The level of services and clients served will not be affected.
Significance:	Developing and maintaining a system of care and equitable allocation of resources are essential in providing mental health services to the target population.
Action Plan:	

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 2: Expenditures per person served.

Population: Adults with SMI

Criterion: Management systems.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	4,724	5,040	4,939	4,900	N/A
Numerator	0	283362507	--	--	--
Denominator	0	56219	--	--	--

Table Descriptors:

Goal:	Maintain existing community-based services and increase effectiveness through State GR and/or other resources.
Target:	Maintain access to and improve the effectiveness of services to individuals in the community.
Population:	Adults with SMI
Criterion:	Management systems.
Brief Name:	Financial Resources
Indicator:	Mental health expenditures per person served
Measure:	Annual CPS expenditures on adults will be divided by the number of adults served during the same time period.
Sources of Information:	Population data and expenditure reports.
Special Issues:	The spending authority for the State match for Targeted Case Management has been shifted from DMH to the State Medical Agency and will no longer be reflected in DMH expenditures as in the past. The level of services and clients served will not be affected.
Significance:	Developing and maintaining a system of care and equitable allocation of resources are essential in providing mental health services to the target populations.
Action Plan:	

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator #1; Percentage of adults receiving services

Population: Adults diagnosed with SMI.

Criterion: Criterion 2: Mental Health System Data Epidemiology

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	21.59	23.40	24	24	N/A
Numerator	0	56219	--	--	--
Denominator	0	239932	--	--	--

Table Descriptors:

- Goal:** Provide mental health services to the target population.
- Target:** Maintain the number of adults with SMI receiving services.
- Population:** Adults diagnosed with SMI.
- Criterion:** Criterion 2: Mental Health System Data Epidemiology
- Brief Name:** Estimates of SMI prevalence and target populations.
- Indicator:** Percentage of adults with serious mental illness who receive CPS-funded services. Special Population indicators: For all illustrative indicators shown under Criterion 1 and 2 estimations of performance on the same indicators for significant sub-populations, including breakouts by: gender; ethnicity; race; sub-state geographic areas.
- Measure:** Estimates of SMI prevalence consistent with federal methodology.
- Sources of Information:** CTRAC data systems and federal SMI prevalence methodology.
- Special Issues:**
- Significance:** The Criterion demonstrates the overall unmet needs for adults with SMI.
- Action Plan:**

Missouri

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Criterion 1: Child - Establishment of System of Care

The State's "Revised Statutes of Missouri 2004" RSMo 630.020 set Departmental goals and duties; It says; "1. The Department shall seek to do the following for the citizens of this state:

(1) Reduce the incidence and prevalence of mental disorders, developmental disabilities and alcohol or drug abuse through primary, secondary and tertiary prevention;

(2) Maintain and enhance intellectual, interpersonal and functional skills of individuals affected by mental disorders, developmental disabilities or alcohol or drug abuse by operating, funding and licensing modern treatment and habilitation programs provided in the least restrictive environment possible;

(3) Improve public understanding of and attitudes toward mental disorders, developmental disabilities and alcohol and drug abuse.

2. The department shall make necessary orders, policies and procedures for the government, administration, discipline and management of its facilities, programs and operations.

Missouri

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

Criterion 1: Child - Comprehensive Community-Based Mental Health Service Systems

The Missouri Statute provides for the establishment and implementation of rules for community based programming and an integrated system of care for individuals with mental illness. Services available to children, youth and families in Missouri are:

- **Community Psychiatric Rehabilitation (CPR)** – Provides a range of essential mental health service to children and youth with serious emotional disturbances. These community-based services are designed to maximize independent functioning and promote recovery and self-determination. In addition, they are designed to increase the interagency coordination and collaboration in all aspects of the treatment planning process. Ultimately, the services help to reduce inpatient hospitalizations and out-of-home placements. Community Support services are the heart of CPR programming. Individuals access medical and dental care along with other critical services with the assistance of their community support worker. The CPR program is also developing strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to Community Substance Treatment and Rehabilitation (CSTAR) programs in their community or service area. CSTAR programs use research based treatment modalities to address problems with substance abuse and addiction. CPR and CSTAR programs cooperate to develop a treatment plan to meet each individual's needs. The Community Support Worker is often the person coordinating services and finding resources needed to pay for critical medical, dental or other related services. In January 2002, The Division of Comprehensive Psychiatric Services added an "intensive" level of care to the Community Psychiatric Rehabilitation (CPR) program and implemented a Provisional Admission category in CPR. These two changes allow expanded services under the CPR program service umbrella. Children and youth are able stay in the community when they experience an acute psychiatric condition and need time limited intensive services through the CPR program. The Provisional Admission allows 90 days for providers to enroll a child or youth who meets the disability, but not the diagnostic requirements so that a comprehensive evaluation may be completed. If the agency determines that an eligible diagnosis cannot be verified, then there is time to transition the individual to appropriate programs and services. In March of 2003, CPR eligibility codes for children and youth were expanded with three new diagnoses. They are: Major depressive disorder, single episode; Bipolar disorder, not otherwise specified; Reactive attachment disorder of infancy or early childhood.
- **Intensive Targeted Case Management (ITCM)** – Children already admitted to the system are eligible for ITCM. The service supports children and families by linking them to the service system and coordinating the various services they receive. Case managers work with the families, treatment providers and other child-serving agencies to assist the children to remain in or progress toward least-restrictive environments.

- **Day Treatment** - offers an alternative form of care to children with SED who require a level of care greater than can be provided by the school or family, but not as intensive as full-time inpatient service. Day treatment may include vocational education, rehabilitation services, individual and group therapies and educational service.
- **Residential Treatment** - These services consist of highly structured care and treatment to youth on a time-limited basis, until they can be stabilized and receive care in a less-restrictive environment or at home.
- **Family Support** - A treatment plan driven service that is designed to develop a support system for parents of children with a serious emotional disturbance and/or acute crisis. This service provides parent-to-parent guidance that is directed and authorized by the treatment plan. Some of the activities provided in this service are: problem solving, emotional support, disseminating information, and linking to services.
- **Treatment Family Homes** - This service provides individualized treatment within a community-based family environment with specially trained foster parents. It allows out-of-home services for those children who need them. Children are able to remain in their own community and often in their home school districts. Training for these homes was developed in collaboration with the DOSS and agreements at the local level allow for these homes to be used by both child serving agencies.

Medical and dental care for individuals receiving Mental Health services in the state of Missouri are provided through community providers unless an individual is hospitalized and in need of services (in which case the hospital provides services). In Kansas City, MO and St. Louis, MO, people are able to visit a dentist through the dental schools located in those cities. While medical care is more easily accessible in most areas, some individuals, living rurally must travel to larger communities to be seen and treated for medical or dental conditions. Many community providers rely on donations to assist with the payment of medical and dental services for their consumers. Providers are finding it difficult to raise more donations to cover consumers who no longer qualify for Medicaid.

Eligibility requirements for Medicaid in Missouri are changing. There is a reduction of Family Coverage to Temporary Assistance Eligibility levels of 17 to 22% of the federal poverty level. The level of allowable income for elderly and disabled individuals in Missouri is 85% of the federal poverty level. Implementation of new Premiums and Affordability test in the State Children's Health Insurance Program will also affect the number of children able to access health care using Medicaid funding.

Youth preparing for jobs are referred to the local Vocational Rehabilitation services through an agreement with Community Psychiatric Services providers and Vocational Rehabilitation.

The Department of Elementary and Secondary Education (DESE) and its Division of Special Education is the State's lead agency on the Individuals with Disabilities Education Act (IDEA). The Division of Special Education is funded primarily through the Federal Government and implements programs that support IDEA. A comprehensive system of personnel development has been developed and implemented which is coordinated, as appropriate, with each district's Professional Development Committee and Comprehensive School Improvement Plan and includes a needs assessment and description of the activities established to meet the identified needs in the areas of: a) number of qualified personnel available to serve all students with disabilities; b) appropriate in-service training of staff; c) required training for paraprofessionals; d) dissemination of relevant research, instructional strategies, and adoption of effective practices.

Furthermore, in 2000 the Missouri Department of Mental Health (DMH), Division of Comprehensive Psychiatric Services (CPS) and the Curators of the University of Missouri – Columbia (University) entered into a unique contract. The contract has been continually renewed each year since 2000 and remains a viable and notable collaboration, the Center for the Advancement of Mental Health Practice in Schools (the Center). The Center is a partnership between the College of Education of the University and the DMH intended to:

- Assure that University trained teachers and school administrators are well grounded in the principles of, and effective approaches to: (1) mental health promotion, (2) early identification and intervention in public mental health problems, and (3) collaboration with the public mental health system in serving children and youth with serious emotional disorders and their families.
- Prepare school-based mental health practitioners with training to offer families, children and youth mental health services and supports within the school environment; and
- Promote the development of best practices in public mental health promotion and prevention, early identification and intervention, and treatment services and supports in the school setting

In 2004-2005 the Center completed a number of significant accomplishments:

- The Center has continued to educate school based personnel through an online graduate degree program with a focus in mental health. Student can progress toward either a Master's degree or a post Master's Educational Specialist degree. To date, there are 47 graduate students, (23 Masters and 24 Educational Specialists) enrolled in the formal degree programs from around the State of Missouri, the United States and overseas.
- The Center's online courses are taught by a variety of doctoral level professionals from around the United States, including ESCP faculty. These professionals range from a variety of disciplines including medicine, nursing, law, psychology, psychiatry, special and general education and educational leadership. Sample course titles include: Building Resiliency and Optimism, Wellness Management

for School Personnel, Psychiatric Disorders in the Classroom and Youth Violence and Bullying.

- Courses are also taught at the undergraduate level to increase the mental health knowledge and skills of preservice teachers by applying psychological research for today's educator.
- This year, the Center was proud to graduate its first two graduating classes from the online graduate degree program totaling 12 students.
- Center staff continue to develop a number of specific academic content modules which represent knowledge/competency-based needs designed to directly assist individuals on their job. The Center is currently developing and translating these modules into sanctioned online coursework also available for student continuing education credit.
- Center staff delivered a number of scholarly presentations at the Ninth National Advancing School-Based Mental Health conference on activities and issues impacting state, national and global mental health school issues in Dallas, Texas.
- Five Center proposals were accepted for representation at the Ninth Annual National Conference on Advancing School-Based Mental Health Programs, scheduled fall 2005 in Cleveland, OH.
- Center staff provided in-service trainings on *Creating Mentally Healthy Classrooms* to select teachers in Missouri.
- Center staff designed and integrated a weekly leadership group with middle school students at risk for exhibiting bullying behaviors.
- 21 ESCP graduate students have rotated through the Center as paid graduate research assistants. Example duties include program design, curriculum development, providing consultation and other outreach services to agencies, schools and families, teaching, research, etc.

In other educationally related collaborations, the Missouri DESE and DMH combined efforts to apply for a Shared Agenda grant sponsored jointly by the (NASDSE), Policy Maker Partnership (PMP) and (NASMHPD). Fortunately, Missouri received one of the awards. Missouri became one of only six states in the nation to receive this particular grant, the Shared Agenda Seed Grant. NASMHPS/PMP awarded \$10,000 for a children's mental health planning grant to enhance the state's ability to build collaboration across mental health, education and family serving organizations in developing a Shared Agenda. The awarded funds are to support activities that engage stakeholders in dialogue, strategic thinking and active planning. The concept paper, *Mental Health, Schools and Families Working Together for All Children and Youth: Toward a Shared Agenda*, is expected to guide the discussion and provide initial recommendations for consideration by stakeholders.

Thirteen regional focus groups were conducted to generate the final report. Throughout the focus group discussions, participants were explicitly asked for their recommendations for creating a shared agenda in Missouri, at both the state and local levels. These recommendations were subsequently compiled and offered for review at a final gathering of focus groups participants held at the University. As a result, recommendations for combating the barriers to a shared agenda emerged from several sources: the original

focus group discussions, the final meeting of participants, University personnel responsible for conducting and analyzing the focus groups, and government officials from both DMH and DESE.

The full report from the Shared Agenda Project is available at:

<http://schoolmentalhealth.missouri.edu/focusgroup/recommendations.htm>

Missouri

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Criterion 2: Mental Health System Data Epidemiology

Missouri's estimate of prevalence and definition is consistent with federal definition and methodologies. Based upon a 7% prevalence rate, we estimate that approximately 100,000 Missouri youth experience SED, however, not all of these youth seek services from the public sector. We expect a presentation rate of 49,777 children with SED seeking services. The number of children and youth who receive CPS-funded services has consistently increased in the past several years. The Division served 13,928 children and youth during FY 2004. Please refer to the Appendix B Table A "2001 Census Data and Prevalence Rates" and Appendix C, Table B "Characteristics of Consumers Served" for more information. The current definition of a youth with SED is consistent with the Federal Definition of SED. SED is defined in Missouri as:

1. Children and youth under 18 years of age.
2. Children and youth exhibiting substantial impairments in their ability to function at a developmentally appropriate level due to the presence of a serious psychiatric disorder. They must exhibit substantial impairment in two or more of the following areas:
 - Self-care including their play and leisure activities;
 - Social relationships: ability to establish or maintain satisfactory relationships with peers and adults;
 - Self-direction: includes behavioral controls, decision making, judgment, and value systems;
 - Family life: ability to function in a family or the equivalent of a family (for a child, birth through six years, consider behavior regulation and physiological, sensory, attention, motor or affective processing and an ability to organize a developmentally appropriate or emotionally positive state);
 - Learning ability;
 - Self-expression: ability to communicate effectively with others.
3. Children and youth who have a serious psychiatric disorder as defined in axis I of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). An "exclusive" diagnosis of V Code, conduct disorder, mental retardation, developmental disorder, or substance abuse as determined by a DMH-CPS provider does not qualify as a serious emotional disturbance. Children from birth through three years may qualify with an Axis I or Axis II diagnosis as defined in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC-3).
4. Children and youth whose inability to function, as described, require mental health intervention. Further, judgment of a qualified mental health professional should indicate that treatment has been or will be required for longer than six months.
5. Children and youth who are in need of two or more State and/or community agencies or services to address the youth's serious psychiatric disorder and improve their overall functioning.

Serious emotional disturbance occurs more predictably in the presence of certain risk factors. These factors include family history of mental illness, physical or sexual abuse or neglect, alcohol or other substance abuse and multiple out of home placements. While these risk factors are not classified as specific criteria in the definition of serious emotional disturbance, they should be considered influential factors.

Missouri

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

The Department of Mental Health achieved the goals stated in this section in 2003 and 2004 by exceeding the expected baselines. Missouri hopes to serve at least 10.9% of Missouri children and youth determined to have a serious emotional disorder. Prevalence is estimated at 7% of the total population of children and youth in Missouri. Appendix C, and Table A “2001 Estimated Census Data and Prevalence Rates” and Appendix C, Table B “characteristics of Consumers Served” show the number of children and youth who receive services from the DMH Division of CPS.

Missouri

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

Criterion 3: Child – Children’s System of Care, Children’s Services

Efforts continue on the development of a **comprehensive system of care** for children and youth. A system of care is a comprehensive array of mental health and other necessary services which are organized in a coordinated way to meet the multiple and changing needs of children, youth and their families. However, a system of care is more than an array of services, it is a philosophy about the way in which children, youth and families receive services. The common philosophy of child-centered, family-focused and community-based services permeates the entire process. Partnerships between families, providers, communities, regions and the State are fundamental to an effective system of care.

The current climate regarding children’s mental health issues suggests that this is an optimal time to implement a statewide system of care initiative. A landmark piece of legislation was passed during the 2004 legislative session. SB 1003, a collaborative effort of DMH and the Department of Social Services (DOSS), formalizes a children’s comprehensive mental health plan that offers families access to mental health care without relinquishing custody of their child. The legislative initiative builds upon Missouri’s system of care teams and SAMSHA Cooperative Agreement sites, as well as the 503 Project. The Office of Comprehensive Child Mental Health (OCCMH) was created through legislation in 2005 through SB 501 and is incorporated into statute through 630.1000 RSMo.

For more than ten years, the DMH, its advocates, family advocates, and providers have worked together to develop **local systems of care**. These efforts have often taken different forms but are based on the process of interagency staffing and collaboration and adhere to the common philosophy mentioned previously. The DMH is in the process of building upon and expanding these current efforts within all three of its Divisions. The strength of systems of care is not necessarily new funding or services, but is in the provision of better coordination of services. The DMH is working towards integration of services across Divisions as well as across State child serving agencies for those consumers with the most severe mental health needs including children with dual diagnoses. Consequently, a new position was created within the department. The Clinical Director for Children, Youth and Families was created and filled to enhance clinical services for children with needs from multiple divisions. The DMH in conjunction with the DOSS developed a Level IV Plus Partnership. This interagency agreement continues and allows the DOSS to identify youth in its custody who are in need of mental health services and supports and who are currently in residential care (at payments that exceed the Division of Family Services’ contracted Level IV rate) and transition them back into their communities. These youth have serious emotional disturbances and may also experience developmental disabilities and drug and/or alcohol problems.

A number of significant activities have occurred with system of care thus far including:

- Development of a **Comprehensive Children’s Mental Health Management Team** whose functions include oversight, coordination, and technical assistance to ensure implementation of a comprehensive children’s mental health system. This committee

consists of representatives from: **The Department of Social Services; Children's Division, Division of Youth Services and Division of Medical Services, The DESE; Division of Vocational Rehabilitation and Division of Special Education, The Department of Public Safety, The DMH; Divisions of Alcohol and Drug Abuse, Comprehensive Psychiatric Services, and Mental Retardation and Developmental Disabilities, The Office of State Court Administrators, Juvenile Court, and parents and parent advocacy groups and representatives from each of the geographic local systems of care.** This group meets at least once a month.

- Development and implementation of a quality service review process for assessing the level of success of children living in their communities who are served by the local system of care groups.
- The DMH has been awarded two six-year federal grants from the SAMHSA to support system of care development through creation of an integrated interagency community-based system of care for children with severe emotional disturbance and their families. One grant serves six rural southwest counties: Greene, Christian, Taney, Stone, Barry and Lawrence and the other serves the St. Louis area. Local project development for the southwest counties is managed through partnerships with two Department of Mental Health Administrative Agents: [Burrell Behavioral Health](#) and the [Clark Center](#) and the St. Louis project is managed by [BJC Behavioral Health Community Services](#) and [Hopewell Center](#). Lessons learned through these projects will be infused into Missouri's comprehensive children's mental health system.

The DMH is involved in extensive activities regarding children, youth and families. Each of the three divisions provides/purchases service and supports for children, youth and families, as well as participating in interdepartmental work that address a wide variety of issues. While each division will maintain its primary focus in service delivery for children, youth and families, the department is committed to a departmental system. Therefore, activities, policies, and service development include system of care development. They are coordinated within the department under the direction of the Department of Mental Health Deputy Director. This better assures easy access and coordinated care for children, youth and families served by the Department and provides consistency in standard setting and interagency work. The following are programs and initiatives that involve working with other child serving agencies to provide comprehensive services:

Missouri Juvenile Justice Information System (MOJJIS) is the response to statute which intends to have the divisions of circuit courts and the departments of social services, mental health elementary and secondary education and health share information regarding individual children who have come into contact with or been provided service by, the courts and cited departments. The Department of Mental Health participates in this effort while maintaining compliance with HIPAA and AOD Confidentiality Laws.

Juvenile Justice Advisory Group (JJAG) provides leadership and education to the people of Missouri in the area of juvenile justice and ensures the safety and well being of all youth, their families and community. JJAG serves as the conduit for federal, state and local education, treatment and prevention services. This group

advises the Governor and the Department of Public Safety, which maintains compliance with the Juvenile Justice and Delinquency Prevention Act of 1974. **Missouri Alliance for Youth** is a partnership between the Department of Mental Health and Juvenile Justice. Comprised of multiple stakeholders, the focus is to improve knowledge of and services for youth with mental health needs involved in the juvenile justice system. This partnership introduced the MO MAYSI project, a mental health screening tool for the juvenile justice system. It collects statewide data on mental health indicators for youth through all stages of the juvenile justice system. Additionally, the Alliance supports seven demonstration projects across the state which partner local juvenile offices with community mental health centers to develop and evaluate services for youth with mental health needs at risk of or currently involved in the juvenile justice system. In 2005 Missouri was awarded a Challenge Grant of \$10,000.00. These dollars will be used to train and support interdisciplinary teams. In fact some of the grant has already been used to hire a consultant to help established teams work more effectively. Additionally, technical assistance will be purchased to bring new interdisciplinary teams into being across the state. **Respite.** Temporary care given to an individual by specialized, trained providers for the purpose of providing a period of relief to the primary care givers.

Missouri

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Criterion 3: Child – Geographic Area Definition

Children and youth with SED are able to access services throughout Missouri. There are nine CSMTs providing System of Care services to children and youth with severe and/or multiple mental health problems. As funding becomes available the Office of Comprehensive Child Mental Health will continue to expand the system of care services.

Missouri

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

Criterion 4: Child -- Targeted Services to Rural and Homeless Populations

The Missouri Association for Social Welfare (MASW) completed a census of homeless shelters in 2001. (The survey conducted was a point-in-time count.) The census data was be used by the Missouri Department of Economic Development as part of its Consolidated Plan to the US Department of Housing and Urban Development. That report showed 16,425 people being sheltered per day, an increase of 42% since the 1998 census. The sheltered homeless constitute a minority of homeless people. Numbers for the total homeless population (that is, including people living on the streets and places not designed for human habitation, people living in homeless shelters and people who are doubled-up living arrangements with family and friends because they no longer have their own homes) were derived by applying an annualizing factor developed by Dr. Renee' Jahiel, New School of Social Work, New York, and the relative percentages of sheltered to unsheltered and hidden homeless populations in a national study by Dr. Bruce Link & Associates, Columbia University and Dr. Martha Burt, Urban Institute, Washington D.C. This methodology results in 45,700 homeless persons per day and 87,250 homeless persons per year. Unfortunately there has not been a new census in Missouri since 2001. MASW is preparing to conduct a new census and is seeking the funding to do so at this writing. According to the 2003 – 2004 Homeless Children and Youth Census Report conducted by the Missouri Department of Elementary and Secondary Education, there are approximately 12,839 school-age children and youth that are homeless.

The following is a listing of programs and services available to assist persons with mental illness who are homeless:

- **PATH Grant** – This is a federal entitlement grant available to all states and territories to provide outreach and case management services to homeless individuals who are mentally ill and who may also have co-occurring substance abuse problems. PATH funds are used to continue services provided by the agencies originally funded through the Mental Health Services for the Homeless (MHSH) Block Grant. In 2001, a new provider was added in St. Louis and in 2002 a provider serving the rural Southeast area has been added with additional PATH funding. A rural Southwestern area provider was added in 2003. This provider has doubled their use of PATH funding in two years time and continues to provide excellent service to the area's homeless population.
- **Shelter Plus Care** is a program designed to link rental assistance to supportive services on a long-term basis for homeless persons with disabilities, (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families who are living in places not intended for human habitation (e.g., streets) or in emergency shelters. The program allows for a variety of housing choices, and a range of supportive services funded by DMH, in response to the needs of the hard-to-reach homeless population with disabilities. Currently DMH has twenty-three (23) Shelter Plus Care grants. These grants provide rental assistance for over 1900 individuals and their families throughout fifty different counties expending over 6.5 million a year in rental assistance and 9 million in supportive services.

- **Access** – The Division of CPS received General Revenue funds to continue the outreach program initially started through the Access Demonstration Grant project, a five-year federal grant that recently expired.

Missouri

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

Criterion 4: Child-Geographic Area Definition

Most of Missouri's geographic area is comprised of rural regions. Of the 25 service areas, 6 are designated as semi-rural and 10 are designated as rural according to the definitions based on the boundaries of Metropolitan Statistical Areas that have been adopted by CPS. It is estimated that 15% of Missouri's population live in rural areas with 25% concentrated in small towns and cities. The special needs of rural and semi-rural areas are a challenge to all human services, especially in the areas of transportation, recruitment and retention of staff, and access and availability of services. Rural human services can be effectively addressed by interagency collaboration, involvement of local community leaders, and natural supports. Each of the 25 Administrative Agents are required to provide the key services that insure availability and access to mental health services. Some service areas have enhanced availability because independent Community Psychiatric Rehabilitation agencies are also established within their boundaries. All administrative agents that contract with CPS are required to have cooperative agreements with the State operated inpatient hospitals, and the primary CMHC has the responsibility of serving as the point of entry for anyone in that area receiving CPS services. Particular care is given to the screening of involuntary commitments to State facilities and coordination of services for consumers released from State facilities. Missouri is always challenged in its attempts to be equitable between rural and urban areas in the distribution of resources. Funding for community support services are distributed to provider agencies based on a set formula taking into account area population adjusted for the number of individuals at or below the poverty level.

Missouri

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Criterion 5: Child – Resources for Providers

The Missouri Department of Mental Health (DMH), in collaboration with the Missouri Medicaid Program, is offering the Missouri Mental Health Medicaid Pharmacy Partnership to evaluate the use of mental health medications and to offer education when opportunities exist to improve prescribing practices. The program, which is adjunctive to other efforts in the state, aims to reduce health-care costs to Medicaid patients.

Principles

The Partnership must

- Make use of existing data sets (Medicaid and DMH)
- Be supportive of existing treatment system and providers
- Be educational in nature
- Be based on continuously updated best practice guidelines

Service Providers across the State also have access to trainings at low or no cost through the Missouri Institute of Mental Health. Among the array of trainings and services operated by this Department of the University of Missouri Medical School is CETV. Providers and staff can access trainings on the internet and receive CEU's for a nominal fee. The web site for CETV is <http://www.mimhcetv.com/welcome/welcome.html>.

Another resource is Missouri's **strategic planning process** is based on *Managing for Results*. The *Managing for Results* initiative is a management tool for the Governor and his cabinet to help keep government focused on results and to drive meaningful improvements for citizens. This effort encourages fact-based decision making and innovation the initiative also recognizes the need for agencies to work together to drive significant improvements. The *Missouri Strategic Planning Model and Guidelines* was developed by the Interagency Planning Council to foster and assist State agencies in the use of a common strategic planning model that includes shared terminology and action calendars. These guidelines provide an outline for Missouri's planning principles and written plan components. The planning model provides measurement tools for evaluation of State government performance.

The Division of CPS also provides an annual budget to provide training. One of the premiere training events in the state of Missouri is the annual Spring Training Institute. The Division of Alcohol and Drug Abuse and the Division of Comprehensive Psychiatric Services provide a three day event each May that allows direct care staff members an opportunity to receive information and training about the most up-to-date treatment methodologies for a low conference cost. The Division of Mental Retardation and Developmental Disabilities also partners with the other Department of Mental Health Divisions by holding their annual Autism Conference at the same venue on overlapping dates.

Missouri

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

Criterion 5: Child – Emergency Service Provider Training

Missouri currently faces challenges to provide psychiatric care in some of the most rural areas of the state.

The following programs and projects have been implemented to increase the effectiveness of services:

- A joint training effort between the Division, the National GAINS Center and the Office of State Courts Administrator exploring issues of providing treatment and services to juveniles who have co-occurring diagnoses for drug addiction and mental illness and who have experienced the Juvenile Justice System. The training for staff, family members and advocates is designed so attendees will be able to go into each area of the State and train provider staff.
- Developing a consumer education program providing education structure, support group, and outreach services.
- Providing comprehensive mental health training services to the law enforcement community including characteristics of mental illness, coping with cultural and age diversity, and understanding medications and side effects.
- Training case managers, community support workers, substance abuse counselors, psychiatric aides and social workers to be better educated on diagnosing, treatment approaches, and working more effectively with individuals with mood disorders, personality disorders and obsessive compulsive disorders.
- Developing a more active role for consumers, families and community providers in the discharge planning process.
- Promoting the use of the more effective newer generation of psychotropic medication.
- Expanding eligibility criteria for the Comprehensive Psychiatric Rehabilitation Program so more individuals can participate in this Medicaid program.

Missouri

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Criterion 5: Child – Grant Expenditure Manner

The 2005 Block Grant will be expended at the same rate as indicated in Appendix A, page 97, within this document.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Access to Services

Population: Children and youth with SED.

Criterion: Criteria 2 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator		751	749	750	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal:	maintain admissions to children's psychiatric facilities.
Target:	Provide in-patient services to 750 children and youth each year.
Population:	Children and youth with SED.
Criterion:	Criteria 2 and 3
Brief Name:	Inpatient census, admission rates.
Indicator:	Children and youth admitted to State-operated acute inpatient hospitalization.
Measure:	Inpatient utilization information is obtained from CTRAC.
Sources of Information:	CTRAC
Special Issues:	The total number of children and youth that are served by the Division is expected to remain stable or increase as the system of care expands. The hope is that the relative overall utilization and average length of stay in State-operated psychiatric hospitals will decrease as community-based alternatives are developed. Recent funding limitations and changes in funding for Foster Care may have a negative impact on this indicator.
Significance:	A major outcome of the development of a community-based system of care is the reduced re-admission to State-operated psychiatric hospital beds and a reduced average length of stay.
Action Plan:	Develop and support community based resources to help reduce length of hospital stays for children and youth in the Missouri Mental Health System.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days

Population: Children and youth with SED

Criterion: Criteria 1 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	6.50	3.30	6.50	7.90	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal:	Reduce the length of stay in State inpatient hospital settings by providing comprehensive community-based services and supports.
Target:	Achieve a level of less than the baseline of 7.9% of children and youth readmitted to State psychiatric inpatient care within 30 days of discharge.
Population:	Children and youth with SED
Criterion:	Criteria 1 and 3
Brief Name:	Inpatient census, admission rates and lengths of stay.
Indicator:	Percentage of children and youth readmitted to State psychiatric inpatient care within 30 days of discharge.
Measure:	Inpatient utilization information is obtained from CTRAC.
Sources of Information:	CTRAC
Special Issues:	The total number of children and youth that are served by the Division is expected to remain stable or increase as the system of care expands. Providing a seamless transition from community to inpatient care and then back to community will help the DMH reduce recidivism.
Significance:	A major outcome of the development of a community-based system of care is the reduced re-admission to State-operated psychiatric hospital beds and a reduced average length of stay.
Action Plan:	continue to provide strong support to providers and facilities through the Supported Community Living program.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Practices

Population: Children and Youth with SED

Criterion: Criteria 1 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	2,832	3,614	3,000	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal: Provide services to children and youth with serious emotional disorders through community psychiatric rehabilitation.

Target: Develop a baseline number of individuals with SED who receive CPR services annually.

Population: Children and Youth with SED

Criterion: Criteria 1 and 3

Brief Name: Evidence Based Practices-CPR

Indicator: Number of children and youth with SED receiving CPR program services.

Measure: The data is gathered from provider billing reports

Sources of Information: Billing information

Special Issues: The total number of children and youth that are receiving CPR programming is impacted by financial and staff attrition and turnover.

Significance: Increased participation in the evidenced practice now in Missouri as CPR helps children and youth and families stay in their community and maximize their ability to function within their community.

Action Plan: The Department of Mental Health, Division of Comprehensive Psychiatric Services currently provides 3 Evidence Based Practices to Children, Youth and Families using the State Mental Health System. In years to come we hope to add consumer self-help to the list. We will do this by expanding the PROCOVERY program to CPR programs serving children, youth and families.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons

Population: Children and youth with SED.

Criterion: Criteria 1 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	8,819	10,107	8,951	8,000	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal:	Increase the number of SED children and youth receiving intensive case management services, an Evidence Based Practice.
Target:	Set baseline for children and youth with SED receiving targeted case management, community support and other case management services.
Population:	Children and youth with SED.
Criterion:	Criteria 1 and 3
Brief Name:	Case management
Indicator:	Number of children and youth with SED receiving CPS-funded case management services.
Measure:	Data is gathered from provider billing reports.
Sources of Information:	Billing information
Special Issues:	The total number of individuals that are receiving case management is impacted by financial fluctuations and staff attrition and turnover. Service providers were cautious with State dollars in FY 2005, knowing that the Department of Mental Health Budget anticipated further reductions and withholds. Some reductions were restored to the Budget allowing providers to increase service provision late in the fiscal year.
Significance:	An outcome of the development of a community-based system of care for children and youth is maintenance of access to intensive case management and CPR services that can help children and youth and their families effectively navigate the mental health system of care.
Action Plan:	Assist providers in securing relevant training for staff.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Client Perception of Care

Population: Children and youth with SED

Criterion: Criteria and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	78	87	75	N/A	N/A
Numerator	0	420	--	--	--
Denominator	0	365	--	--	--

Table Descriptors:

Goal:	Maintain access to a comprehensive, seamless, integrated system of care that recognizes and supports consumers and parents/caregivers as having expertise in meeting the needs of children and youth with serious emotional disturbance.
Target:	Develop a baseline average consumer satisfaction survey score of parents of children and youth with SED who are satisfied with services.
Population:	Children and youth with SED
Criterion:	Criteria and 3
Brief Name:	consumer satisfaction
Indicator:	Percent of parents of children and youth with SED receiving services who are satisfied with those services.
Measure:	Data is gathered from consumer satisfaction surveys distributed at a point in time.
Sources of Information:	Consumer satisfaction surveys.
Special Issues:	The Department of Mental Health reviewed the way it was collecting consumer satisfaction ratings and the categories rated in 2004. There was a concern that the process did not rate what consumers, stakeholders, providers and the community found most important. During FY 2005 the Department gathered information with the help of the Change and Innovation Agency, Inc. through community focus groups throughout the state. A new consumer satisfaction form has been developed incorporating the findings of the focus groups. The first results from these new surveys should be available when the Implementation Report is filed.
Significance:	The DMH is now conducting a satisfaction survey based on what consumers, providers and stakeholders indicated as areas that need attention. We anticipate a drop in the percent of individuals satisfied or highly satisfied because we are looking at areas that appear to need improvement.
Action Plan:	report on data in December with the submission of the implementation plan and continue to improve our methodology for collecting information about consumer satisfaction.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days

Population: Children and youth with SED.

Criterion: Criteria 2 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	14.90	16.90	21.20	25	N/A
Numerator	0	12758	--	--	--
Denominator	0	751	--	--	--

Table Descriptors:

Goal:	Reduce the length of stay in State inpatient hospital settings by providing comprehensive community-based services and supports.
Target:	Maintain an average length of stay of less than 30 days for children and youth admitted to State-operated acute inpatient hospitalization.
Population:	Children and youth with SED.
Criterion:	Criteria 2 and 3
Brief Name:	Inpatient census, admission rates and lengths of stay.
Indicator:	Average length of stay for children and youth admitted to State-operated inpatient hospitalization.
Measure:	Inpatient utilization information is obtained from CTRAC.
Sources of Information:	CTRAC
Special Issues:	The total number of children and youth that are served by the Division is expected to remain stable or increase as the system of care expands. The hope is that the relative overall utilization and average length of stay in State-operated psychiatric hospitals will decrease as community-based alternatives are developed. Recent funding limitations and changes in funding for foster care may have a negative impact on this indicator.
Significance:	A major outcome of the development of a community-based system of care is the reduced re-admission to State-operated psychiatric hospital beds and a reduced average length of stay.
Action Plan:	Develop and support community based resources to help reduce length of hospital stays for children and youth in the Missouri Mental Health System of Care.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator #1 percent of SED children/youth receiving services

Population: Children and youth with SED

Criterion: Mental health systems data epidemiology.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	12.36	14.30	15.30	14	N/A
Numerator	0	14286	--	--	--
Denominator	0	99555	--	--	--

Table Descriptors:

Goal:	Provide mental health services to children and youth with SED.
Target:	Maintain the percentage of children and youth with SED who receive CPS-funded services.
Population:	Children and youth with SED
Criterion:	Mental health systems data epidemiology.
Brief Name:	Estimates of SED prevalence and target populations.
Indicator:	Percentage of Missouri children and youth with SED who receive CPS-funded services; Special Population Indicators: For all illustrative indicators shown under Criterion 1 and 2, estimation of performance on the same indicators for significant sub-populations, including breakouts by: a) Gender, b) Ehtnicity, c)Race, d) Sub-state geographic areas, e) For children and adolescents, age sub-grouping.
Measure:	Estimate of SED prevalence based on federal guidelines; a Division-generated sample (Child Behavior Check List-CBCL and Youth Status Report) that tracks psychiatric pathology, functionality, and demographics is collected on children and youth at admission, every six months and at discharge.
Sources of Information:	CTRAC, CBCL and Youth Status Report
Special Issues:	The Division uses a sampling method effecting the data collection from the CBCL and Youth Status Report. For children/youth the CBCL continues to be used as the symptom/functioning tool. The Youth Status Report, developed by COSC continues to be used as well.
Significance:	The information above demonstrates the overall unmet need for Missouri children and youth with SED.
Action Plan:	

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 1: Rural children receiving mental health services

Population: Children and youth with serious emotional disturbances (SED).

Criterion: Criterion 4: Targeted Services to Homeless and Rural Populations.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	11.96	13.90	14.50	14.50	N/A
Numerator	0	11354	--	--	--
Denominator	0	81683	--	--	--

Table Descriptors:

Goal:	Ensure that children and youth with SED living in rural areas receive services.
Target:	Maintain the number of children and youth in rural areas receiving CPS-funded mental health services.
Population:	Children and youth with serious emotional disturbances (SED).
Criterion:	Criterion 4: Targeted Services to Homeless and Rural Populations.
Brief Name:	Rural and Homeless Children and Youth with SED.
Indicator:	Percentage of rural children and youth with SED who receive CPS-funded mental health services.
Measure:	Generated reports from CTRAC.
Sources of Information:	CTRAC, CBCL, and Youth Status Report
Special Issues:	Increased access to mental health services for individuals living in rural areas depends on the level of funding available for community-based services and on efforts to equalize funding across service areas.
Significance:	A comprehensive system of care includes equal access for people living in rural areas.
Action Plan:	

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 1: Expenditures per capita

Population: Children with SED

Criterion: Management systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	28.31	36.06	38.35	38	N/A
Numerator	0	51287001	--	--	--
Denominator	0	1422210	--	--	--

Table Descriptors:

Goal:	Maintain exiting community-based services and increase effectiveness through State general revenue and/or other resources.
Target:	Maintain access to and improve the effectiveness of services to individuals in the community.
Population:	Children with SED
Criterion:	Management systems
Brief Name:	Financial Resources
Indicator:	Mental health expenditures per capita
Measure:	Annual CPS expenditures will be divided by the Missouri population
Sources of Information:	Population data and expenditure reports.
Special Issues:	The spending authority for the State match for Targeted Case Management has been shifted from DMH to the State Medicaid Agency and will not be reflected in DMH expenditures as in the past. The level of services and clients served will not be affected.
Significance:	Developing and maintaining a system of care and equitable allocation of resources are essential in providing mental health services to the target population.
Action Plan:	

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 2: Expenditures per person served.

Population: Children with SED

Criterion: Criterion 5: Management Systems and Expenditures per Person Served

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	3,271.79	3,590.02	3,469.92	3,400	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal: Maintain existing community-based services and increase effectiveness through State general revenue and/or other resources.

Target: Maintain access to and improve the effectiveness of services to individuals in the community.

Population: Children with SED

Criterion: Criterion 5: Management Systems and Expenditures per Person Served

Brief Name: Financial Resources

Indicator: 2. Mental health expenditures per person served.

Measure: Annual CPS expenditures on children will be divided by the number of children served during the same period.

Sources of Information: Population data and expenditure reports.

Special Issues: Legislative changes in State Medicaid spending and State children's services may impact this indicator in 2006.

Significance: Developing and maintaining a system of care and equitable allocation of resources are essential in providing mental health services to the target population.

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 6: Evidence Based Practice Consumer Satisfaction

Population: Children and youth with SED

Criterion: 1 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	82	81	75	75	N/A
Numerator	0	420	--	--	--
Denominator	0	341	--	--	--

Table Descriptors:

Goal:	Maintain access to comprehensive, seamless, integrated systems of care that recognize and support consumers and parents/caregivers as having expertise in meeting the needs of children and youth with serious emotional disturbance.
Target:	Develop a baseline average consumer satisfaction survey score of parents of children and youth with SED who are satisfied that their treatment plans have what they want on them.
Population:	Children and youth with SED
Criterion:	1 and 3
Brief Name:	consumer satisfaction
Indicator:	percent of parents of children and youth with SED receiving services who are satisfied that their child's treatment plan has what they want on it.
Measure:	Data is gathered from consumer satisfaction surveys distributed at a point in time.
Sources of Information:	Consumer satisfaction surveys.
Special Issues:	The Department of Mental Health reviewed the way it was collecting consumer satisfaction ratings and the categories rated in 2004. There was a concern that the process did not rate what consumers, stakeholders, providers and the community found most important. During FY 2005 the Department gathered information with the help of the Change and Innovation Agency, Inc. through community focus groups throughout the State. A new consumer satisfaction form has been developed incorporating the findings of the focus groups. The first results from these new surveys should be available when the Implementation Report is filed.
Significance:	The DMH is now conducting a satisfaction survey based on what consumers, providers and stakeholders indicated as areas that need attention. We anticipate a drop in the percent of individuals satisfied or highly satisfied with treatment planning because we are looking at areas that appear to need improvement.
Action Plan:	Report on data in December with the submission of the Implementation Plan and continue to improve our methodology for collecting information about consumer satisfaction.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 1a: SOC children/youth living in out of home placement

Population: Children and youth with severe and/or multiple mental health problems living in their community served by SOC and CSMT.

Criterion: 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator		20	27.70	25	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal:	Children with severe of multiple mental health problems will achieve success living in their communities. Missouri will increase children's access to the System of Care (SOC) through the Comprehensive System Management Team (CSMT)
Target:	Children and youth living in out of home placement.
Population:	Children and youth with severe and/or multiple mental health problems living in their community served by SOC and CSMT.
Criterion:	3
Brief Name:	System of Care
Indicator:	Number of children in State custody who have been placed out of the home as noted by last assessment from reviews and discharges only.
Measure:	A Division-generated sample (CBCL and Youth Status Report) that tracks psychiatric pathology, functionality and demographics will be collected on children and youth served by the SOC.
Sources of Information:	Youth Status Reports and Child Behavior Check List.
Special Issues:	The children's System of Care is gaining ground with passage of several new legislative bills addressing how children should be served in the State system. The Office of Comprehensive Children's Mental Health continues to coordinate services for children and youth with serious and/or multiple mental health problems on both the state and local levels.
Significance:	The President's New Freedom Commission on Mental Health identifies 6 goals in transforming the mental health system. Particularly relevant to children's services is goal 2, "Mental Health Care is Consumer and Family Driven. REcognizing the fragmentation of services for children and youth with severe and/or multiple mental health problems the Report from the commission calls for program efforts to overlap. Goal 4, "Early Mental Health Screening, Assessment and referral to Services are Common Practice" recommends the promotion of mental health in young children and the improvement and expansion of school mental health programs. The DMH is implementing a system of care as one of its top strategic goals. The development of adequate capacity for all child-serving agencies must address developing the capacity to shift from residential to community-based services.
Action Plan:	

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 1b: Percentage of days SOC children/youth are in home/homelike settings

Population: Children and youth with severe and/or multiple mental health problems living in their community served by the SOC and CSMT.

Criterion: 3 System of Care

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator		82.30	77.90	75	N/A
Numerator	0	2123	--	--	--
Denominator	0	2580	--	--	--

Table Descriptors:

Goal:	Children with severe or multiple mental health problems will achieve success living in their communities. Missouri will increase children's access to Systems of Care (SOC) through the CSMT.
Target:	Maintain the number of days that children and youth with severe and/or multiple mental health problems live in their home or a homelike setting specific to children in state custody.
Population:	Children and youth with severe and/or multiple mental health problems living in their community served by the SOC and CSMT.
Criterion:	3 System of Care
Brief Name:	System of Care
Indicator:	3
Measure:	Percentage of days that children and youth with severe and/or multiple mental health problems who are in State custody and served by the SOC and CSMT.
Sources of Information:	Youth Status Report and Child Behavior Check List.
Special Issues:	Missouri's child and youth serving agencies do not have a common information sharing system as yet. Data about interagency involvement is self-reported indicated on the Youth Status Report. Indicators were developed specifically for the SOC.
Significance:	see previous SOC indicator table "Significance".
Action Plan:	Continue assisting children and youth with severe and/or multiple mental health problems to live in homes or homelike settings.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator 2: SOC children/youth expelled from school

Population: Children and youth with severe and/or multiple mental health problems living in their community and served by the SOC and CSMT.

Criterion: 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator		3.10	.60	N/A	N/A
Numerator	0	19	--	--	--
Denominator	0	611	--	--	--

Table Descriptors:

Goal:	Children with severe and/or multiple mental health problems will achieve success living in their communities.
Target:	Maintain number of days that children and youth with severe and/or multiple mental health problems who are served by the SOC and the CSMT.
Population:	Children and youth with severe and/or multiple mental health problems living in their community and served by the SOC and CSMT.
Criterion:	3
Brief Name:	System of Care
Indicator:	Number of children and youth expelled or suspended from school as seen by last assessment
Measure:	A Division-generated sample (CBCL and Youth Status Report) that tracks psychiatric pathology, functionality and demographics collected on children and youth served by the SOC.
Sources of Information:	Youth Status Report and Child Behavior Check List.
Special Issues:	See previous special issues sections for Criterion 3.
Significance:	See previous significance section for Criterion 3.
Action Plan:	Continue to support children and youth in their communities so that they are able to maintain consistent school attendance.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator 3: Number of System of Care Teams

Population: Children and youth with severe and/or multiple mental health problems living in their community served by the SOC.

Criterion: 3 System of Care

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	7	9	9	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal: Children with severe and/or multiple mental health problems will achieve success living in their communities. Missouri will increase children's access to Systems of Care through the Comprehensive Children's Mental Health System.

Target: Increase statewide access to to the System of Care for children and youth served by multiple State departments.

Population: Children and youth with severe and/or multiple mental health problems living in their community served by the SOC.

Criterion: 3 System of Care

Brief Name: System of Care

Indicator: Number of System of Care Teams in Missouri

Measure: Number of SOC teams active in the State.

Sources of Information: Count of teams in the State.

Special Issues:

Significance: With the addition of each new SOC team more of Missouri's children and youth are able to access services readily within their own communities.

Action Plan: Continue to add SOC teams as funds are available.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Indicator # 5: Therapeutic Foster Care

Population: Children and youth with SED

Criterion: 1 and 3

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Actual	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	100	100	N/A	N/A
Numerator	0	0	--	--	--
Denominator	0	0	--	--	--

Table Descriptors:

Goal: Increase the number of SED children and youth receiving services through the Evidence Based Practices.

Target: Set baseline for children and youth with SED receiving Therapeutic Foster Care Services.

Population: Children and youth with SED

Criterion: 1 and 3

Brief Name: Therapeutic Foster Care

Indicator: Number of SED children and youth in Therapeutic Foster Care.

Measure: data gathered from provider billing reports.

Sources of Information: Billing information

Special Issues: Missouri is using the State definition of Therapeutic Foster Care.

Significance:

Action Plan: Develop a consistent system to track SED children and youth using Therapeutic Foster Care.

Child - Goals Targets and Action Plans Footnotes

Missouri's CPR program meets the federal definition of evidence based actice.

Homeless children and youth, when identified, are included within the CPS target population. However, there currently exists no systematic way to determine and track homelessness.

Missouri

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.