

# Missouri

## UNIFORM APPLICATION FY 2010 - STATE PLAN

### COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

(generated on 9-1-2009 11.33.23 AM)

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

## **Introduction:**

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant ( 45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane. Rockville. MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

# Table of Contents

<b>State:</b>
Missouri

Face Page	pg. 4
Executive Summary	pg. 5
Certifications	pg. 10
Public Comments on State Plan	pg. 21
Set-Aside For Children Report	pg. 23
MOE Report	pg. 24
Council List	pg. 26
Council Composition	pg. 35
Planning Council Charge, Role and Activities	pg. 36
Adult - Overview of State's Mental Health System	pg. 48
Adult - New Developments and Issues	pg. 65
Adult - Legislative Initiatives and Changes	pg. 74
Adult - Description of State Agency's Leadership	pg. 78
Child - Overview of State's Mental Health System	pg. 84
Child - New Developments and Issues	pg. 86
Child - Legislative Initiatives and Changes	pg. 89
Child - Description of State Agency's Leadership	pg. 91
Adult - Service System's Strengths and Weaknesses	pg. 95
Adult - Unmet Service Needs	pg. 105
Adult - Plans to Address Unmet Needs	pg. 107
Adult - Recent Significant Achievements	pg. 113
Adult - State's Vision for the Future	pg. 118
Child - Service System's Strengths and Weaknesses	pg. 120
Child - Unmet Service Needs	pg. 126
Child - Plans to Address Unmet Needs	pg. 129
Child - Recent Significant Achievements	pg. 133
Child - State's Vision for the Future	pg. 140
Adult - Establishment of System of Care	pg. 143
Adult - Available Services	pg. 145
Adult - Estimate of Prevalence	pg. 152
Adult - Quantitative Targets	pg. 154

Adult - Outreach to Homeless	pg. 156
Adult - Rural Area Services	pg. 162
Adult - Older Adults	pg. 167
Adult - Resources for Providers	pg. 170
Adult - Emergency Service Provider Training	pg. 176
Adult - Grant Expenditure Manner	pg. 179
Table C - MHBG Transformation Expenditures Reporting Form	pg. 181
Table C - Description of Transformation	pg. 182
Adult - Goals Targets and Action Plans	pg. 184
Child - Establishment of System of Care	pg. 203
Child - Available Services	pg. 209
Child - Estimate of Prevalence	pg. 216
Child - Quantitative Targets	pg. 218
Child - System of Integrated Services	pg. 220
Child - Geographic Area Definition	pg. 226
Child - Outreach to Homeless	pg. 229
Child - Rural Area Services	pg. 231
Child - Resources for Providers	pg. 233
Child - Emergency Service Provider Training	pg. 236
Child - Grant Expenditure Manner	pg. 238
Child - Goals Targets and Action Plans	pg. 240
Planning Council Letter for the Plan	pg. 257
Appendix A (Optional)	pg. 259

**FACE SHEET**  
**FISCAL YEAR/S COVERED BY THE PLAN**  
**X FY2010       FY 2010-2011**

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: 573-526-5890

FAX: 573-751-7815

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

NAME: Keith Schafer, Ed.D.    TITLE: Director

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT:

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: 07/01/2009

TO: 06/30/2010

**IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION**

NAME: Rosie Anderson-Harper, M.A.    TITLE: State Planner

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: 573-526-5890

FAX: 573 751-7815

EMAIL: rosie.anderson-harper@dmh.mo.gov

# Missouri

## Executive Summary

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

## Executive Summary

The Department of Mental Health (DMH) submits this Fiscal Year 2010 Mental Health Block Grant Application on behalf of the State of Missouri following guidelines published by the Substance Abuse and Mental Health Services Administration and the Center for Mental Health Services. The Block Grant State Plan was developed and evaluated by persons served, family members, advocates, DMH staff, representatives from various state agencies, and direct service providers.

The goal of DMH is to work in partnership with the Center for Mental Health Services to develop a comprehensive plan that will advance the goals and recommendations of the President's New Freedom Commission on Mental Health Report, *Achieving the Promise: Transforming Mental Health Care in America* and will result in a service system that is consumer driven and based on the principles of recovery and resilience.

Missouri continues to be a Midwestern primarily rural state with a historically agricultural economic base. The population of Missouri from the United States Census Bureau is estimated at 5,800,310. Two urban areas exist in the state on the east and west sides. In the eastern area of the State is St. Louis with a population of 2,068,218. To the west is Kansas City with a population of 662,959. The city of Springfield in the southwest portion of the State has experienced growth over the past several years and is becoming the third larger urban area.

Missouri has experienced the effects of the economic slowdown this year. A limitation on general revenue growth has caused the DMH to face core budget reductions. The State has sought funding through various sources and has thoroughly investigated Federal grant sources. Emphasis has been placed on implementing evidence-based practices to create greater efficiency and effectiveness.

Fiscal management of mental health services is coordinated with other human services departments, the Medicaid agency, and the Governor's Office. The DMH has been designated as an Organized Health Care Delivery System, which allows reimbursement for some of the administrative services provided for Medicaid. Budgetary planning is formalized and includes consumer and public input.

The Mental Health Authority for Missouri, the Division of Comprehensive Psychiatric Services (CPS), has begun initiatives that are enhancing the system effectiveness and supporting transformation. DMH was awarded a Mental Health Transformation grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2006. The children's mental health system is undergoing changes mandated by the 2004 Missouri Children's Mental Health Act that laid the groundwork for a comprehensive statewide system of care. Missouri's Medicaid program was renamed MO HealthNet August 28, 2007. CPS guided the direction of the revised legislation called MO HealthNet within the context of system transformation.

CPS is beginning to adopt a public health approach. Coupled with a strong and effective linkage with the MO HealthNet program, CPS has moved toward greater integration of mental health services with other healthcare, vocational, and housing services. Other significant achievements

for the Division are its suicide prevention efforts and the focus on evidence based practices (EBP).

The DMH CPS has met challenges by cooperating with other state agencies to enhance services and programs and develop new and innovative ways to serve consumers. Initiatives within the department have been developed to look at quality assurance, EBPs, 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. The next step is to assure treatment for youth with co-occurring disorders and address the transition from youth to adult services. As the DMH moves into FY 2010, efforts to provide quality services to adults with serious mental illness will take shape through Mental Health Transformation activities. The use of programs and projects like the Medicaid Pharmacy Partnership, suicide prevention, and Peer Specialist Certification has begun the change to a public health model of care that supports recovery. The Block Grant State Plan provides 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 that will be described in more detail in the planning council section of the Block Grant. 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. A Director of Consumer Affairs is working to assure safety of consumers. The Mental Health Block Grant Planning Council is engaged and energized, working to improve consumer involvement. In conjunction with the Planning Council, CPS is providing education and advocacy training and is incorporating consumers and family members in its monitoring of the service system.

Missouri DMH CPS has made great strides in State Fiscal Year 2009 on implementing EBPs.

- CPS is measuring fidelity to Integrated Dual Disorders Treatment (IDDT) and twenty community mental health centers are working towards full fidelity.
- Assertive Community Treatment (ACT) is being implemented in six agencies across the state. ACT pilot sites have developed their teams, enrolled consumers and are implementing the model. ACT teams are using the Comprehensive Outcome Measure system.
- CPS has been awarded a Johnson & Johnson grant to continue the progress on expanding Supported Employment opportunities for individuals with mental illness.
- Progress is being made on easy access to physical and mental health services in the same location through our community mental health center and federally qualified health center initiative. Seven sites have been funded for three years for co-location of services and six sites received one-time funding for planning.
- Dialectical Behavior Therapy introductory and advanced training has occurred throughout the state.

The CPS is attempting to improve its data management to support system transformation. A client information system continues to be developed to provide an improved ability to track

services, outcomes, and costs of services. The DMH also has a Data Infrastructure Grant (DIG) targeted toward improving data quality and conducting outcomes studies.

Core services for Community Psychiatric Rehabilitation Program (CPRP), targeted case management, and supported community living are provided in a community-based and consumer-centered manner. These services are being provided within an enhanced structure. System improvements include integration of mental health treatment with substance abuse services and physical healthcare, the use of continuous treatment teams, and improved coordination between inpatient and community providers. Within the context of its Olmstead planning, CPS has made a concerted effort to incorporate a greater use of housing and vocational services within the mix of supports in the system. In addition, the State received a five year Co-occurring State Incentive Grant in 2003. This grant was used to further improve integration of mental health and substance abuse services. The CPS has also received grant funding to improve coordination of services for individuals involved with the criminal justice system.

The core services are enhanced by crisis services. Access Crisis Intervention, begun in 1995, provides a crisis telephone number, mobile response, and short-term residential care. CPS has also expanded its funding and support for consumer-operated programs, including Drop-In Centers and Warm Lines. The CPS provides technical assistance to the Drop-In Centers to implement the fidelity of the Consumer Operated Services Program (COSP).

Homeless outreach services are provided through the Projects for Assistance in the Transition from Homelessness program. The State also coordinates Shelter Plus Care services to provide additional long-term supportive services for disabled homeless individuals.

The most significant issue in children's services has been the development of the statewide comprehensive system of care. There was strong bipartisan support for legislation that mandated system-of-care development and created the Office of Comprehensive Child Mental Health to oversee the development and to provide technical assistance to all departments participating in the comprehensive system.

Children's core services are case management, psychiatry, medication management, and crisis services. Additional services provided in some areas include CPRP, treatment family homes, and day treatment. Co-occurring treatment services are also provided. Progress has been made toward the implementation of the comprehensive children's system of care plan. Thirteen Children's System of Care Teams are operating statewide. A quality service review found the anticipated goals of system integration are largely being met, with the bulk of youth who have complex and intensive needs receiving services that are appropriate and coordinated. Cross-system initiatives are being implemented in a number of areas, including schools, juvenile justice, child welfare, and physical health agencies. The key ingredient in the success of the pilot sites is the use of Family Support Teams that involve parents and youth. Legislation also created a stakeholder oversight body made up predominantly of family members and advocates. CPS and other stakeholders have also successfully communicated the needs of youth with serious emotional disturbance (SED) and their families to the Legislature. This resulted in State laws aimed at reducing the need for parents to relinquish custody of youth for them to receive

treatment. A significant strength of the children's system is that youth are rarely placed in facilities outside Missouri.

CPS effectively manages contracts with providers and collects data to evaluate these contracts. Reporting required for Block Grant and other purposes is monitored. Missouri's Mental Health Grant Monitoring Report dated June 2006 found services funded by the Block Grant are expended for the intended purposes. The annual State single audit resulted in no findings for the Block Grant.

The Missouri Department of Mental Health has continued to pursue its vision:



**Hope \* Opportunity \* Community Inclusion**

*Missourians receiving mental health services will have the opportunity to pursue their dreams and live their lives as valued members of their communities.*

CPS continues to strive for excellent services that are consumer and family driven. Block Grant funding from the Center for Mental Health Services continues to be a vital component in the improvement of community-based services in Missouri.

## **Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS**

FISCAL YEAR 2010

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 State<sup>1</sup> 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 2010, 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:

---

<sup>21</sup>. 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  
Kent Schaefer, Ed.D., Director  
XXXXXXXX

Date

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 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 workplace 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 workplace 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, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

**5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

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

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

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

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

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

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

## DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB  
0348-0046

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

<b>1. Type of Federal Action:</b>  <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	<b>2. Status of Federal Action</b>  <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. Report Type:</b>  <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change  <b>For Material Change Only:</b> Year _____ Quarter _____  date of last report _____
<b>4. Name and Address of Reporting Entity:</b>  <div style="display: flex; justify-content: space-between;"> <span>Prime</span> <span>Subawardee</span> </div> <div style="margin-left: 150px;">Tier _____, if known:</div>  Congressional District, if known: _____		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>    Congressional District, if known: _____
<b>6. Federal Department/Agency:</b>    	<b>7. Federal Program Name/Description:</b>    CFDA Number, if applicable: _____	
<b>8. Federal Action Number, if known:</b>  	<b>9. Award Amount, if known:</b>  \$ _____	
<b>10. a. Name and Address of Lobbying Entity</b> <i>(if individual, last name, first name, MI):</i>    	<b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>    	
<b>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.</b>		
Signature: _____  Print Name: _____  Title: _____  Telephone No.: _____ Date: _____		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)
<b>Federal Use Only:</b>		

## 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.

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, re- gulations and policies governing this program.

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

# 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 Comments on the State Plan**

In accordance with Section 1941 of the Block Grant legislation, the State of Missouri has provided ample opportunity on an ongoing basis for public comments on the State Plan. The fiscal year 2005, 2006, 2007, 2008 and 2009 State Plans are posted on the DMH website at <http://www.dmh.mo.gov/cps/rpts/blockgrant/blockgrant.htm> with instructions to send comments to the department. The 2006, 2007 and 2008 Implementation Reports are also posted on the DMH website for comment.

The Mental Health Planning Council for Missouri has instituted a regular review of the Block Grant at their monthly open meetings. Meeting agendas are posted to the DMH website at least 24 hours before the open public meetings. Block Grant Discussion is clearly labeled on the agendas, thus giving the general public opportunity to attend the meeting and make comment. The Planning Council regularly engaged in discussion about evidence-based practices, mental health transformation, and budget throughout the fiscal year 2009. The Planning Council has direct access to the Department and Division Directors, at meetings and by phone/email/DMH blog, to offer opinions and comments on the adequacy of mental health services within the State.

The Planning Council was emailed copies of the draft State Plan for comment. The June, July and August 2009 meetings provided specific time for discussion of the draft State Plan. All comments have been considered and incorporated where applicable.

## 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	Actual FY 2008	Estimate/Actual FY 2009
<u>\$14,716,201</u>	<u>\$27,076,216</u>	<u>\$28,899,982</u>

### 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 2007	Actual FY 2008	Actual/Estimate FY 2009
<u>\$117,728,866</u>	<u>\$130,806,271</u>	<u>\$136,681,726</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**

<b>Name</b>	<b>Type of Membership</b>	<b>Agency or Organization Represented</b>	<b>Address, Phone and Fax</b>	<b>Email(If available)</b>
Anderson, Barbara K.	Consumers/Survivors/Ex-patients(C/S/X)		5577 Connecticut St. Louis,MO 63139 PH:314-781- 5492 FAX:	bkanderson1@mybluelight.com
Bussabarger, Mary Louise	Family Members of adults with SMI		1914 Princeton Dr. Columbia,MO 65203 PH:(573) 445- 4147 FAX:	
Chase, Stewart	Providers	ReDiscover	901 NE Independence Avenue Lee Summit,MO 64086 PH:816-246- 8000 FAX:816-246- 8207	sachase@rediscovermh.org
Clarke, Linda	Family Members of Children with SED		8 Akin Court St. Peters,MO 63376 PH:(636) 294- 0125 FAX:	lindaclarke@charter.net
Cushing, Heather J.	Family Members of Children with SED		106 Distinction Lake St. Louis,MO 63367 PH:314-608- 1206 FAX:	hjcushing@gmail.com
Evers, Randall L.	Consumers/Survivors/Ex-patients(C/S/X)		209 Pierce Street Jefferson City,MO 65101 PH:573-353- 2162 FAX:	synkronicite@yahoo.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
------	--------------------	------------------------------------	------------------------	---------------------

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Giovanetti, Scott	State Employees	Mental Health	Department of Mental Health 5400 Arsenal Street St. Louis,MO 63139 PH:314-877-0372 FAX:314-877-0392	scott.giovanetti@dmh.mo.gov
Greening, Andrew B.	Providers	Preferred Family Healthcare	900 East La Harpe Street Kirksville,MO 63501 PH:573-248-3811 FAX:573-248-3080	agreening@pfh.org
Hagar-Mace, Liz	State Employees	Housing	1706 East Elm P.O. Box 687 Jefferson City,MO 65102 PH:(573) 522-6519 FAX: (573) 526-7797	liz.hagar-mace@dmh.mo.gov
Hamilton, Sandra J.	Family Members of Children with SED		12333 Bristol Avenue Grandview,MO 64030 PH:(816) 767-8393 FAX:	Shami226165@aol.com
Harper, John	State Employees	Vocational Rehabilitation	3024 DuPont Circle Jefferson City,MO 65101 PH:(573) 526-7040 FAX: (573) 751-1441	john.harper@vr.dese.mo.gov
			43 Catamaran Drive Lake St.	JudyWilga@charter.net

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Hawkins, Robert	Consumers/Survivors/Ex-patients(C/S/X)		Louis,MO 63367 PH:636-352-6648 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Johnson, Jessica	Consumers/Survivors/Ex-patients(C/S/X)		1118 London Drive Columbia,MO 65203 PH:(417) 343-1634 FAX:	ladyhawc77@yahoo.com
Johnson, Kimberly	State Employees	Medicaid	P.O. Box 6500 Jefferson City,MO 65102-6500 PH:(573) 751-3277 FAX:	Also Represents Department of Social Services
Jones, Karren	Consumers/Survivors/Ex-patients(C/S/X)	NAMI of Missouri	1210 Linden Drive Apt. 13 Jefferson City,MO 65109 PH:(573) 636-6188 FAX:	mocamiks@j@yahoo.com
Lay, Donna	Family Members of Children with SED		7416 State Route W West Plains,MO 65775 PH:(417) 277-5473 FAX:	jd3031@socket.net
Markway, Ph.D., Gregory	State Employees	Criminal Justice	2729 Plaza Drive P.O. Box 236 Jefferson City,MO 65102 PH:(573) 526-6523 FAX: (573) 526-8156	greg.markway@doc.mo.gov
Meachum-Cain, Glenda	State Employees	Other	Department of Health and Senior Services 930 Wildwood Jefferson City,MO 65102 PH:(573) 751-6064 FAX:	glenda.meachum-cain@dhss.mo.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
------	--------------------	------------------------------------	------------------------	---------------------

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Minth, Helen	Consumers/Survivors/Ex-patients(C/S/X)	St. Louis Empowerment Center	3024 Locust St. Louis,MO 63118 PH:(314) 652-6100 FAX: (314) 652-6103	hminth@sbcglobal.net
Qualls, Robert	Consumers/Survivors/Ex-patients(C/S/X)		2145 W. Brower Springfield,MO 65802 PH:(417) 831-2985 FAX:	robert-qualls@sbcglobal.net
Riley, Jerome	Consumers/Survivors/Ex-patients(C/S/X)		1248 Linden, Apt. 3 Cape Girardeau,MO 63703 PH:573-339-6148 FAX:	jriley@cccntr.com
Robbins, John	State Employees	Education	Department of Elementary and Secondary Education 205 Jefferson Jefferson City,MO 65102 PH:(573) 522-1488 FAX: (573) 526-4261	john.robbins@dese.mo.gov
Stephens, Erica	Providers	Missouri Protection & Advocacy	925 South Country Club Drive Jefferson City,MO 65109 PH:(573)-893-3333 FAX: (573) 659-0677	erica.stephens@mo-pa.org
Thomas,	Others(not state)	UMKC - Institute for	1706 East Elm Jefferson City,MO 65102 PH:573-751-	tish.thomas@dmh.mo.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Tish	employees or providers)	Human Development	8076 FAX:573-751-9207	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Thomason, Qiana	Providers	Swope Health Services	3801 Blue Parkway Kansas City,MO 64130 PH:816-922-7645 FAX:816-922-7683	QThomason@swopecommunity.org

**TABLE 2. Planning Council Composition by Type of Member**

Type of Membership	Number	Percentage of Total Membership
<b>TOTAL MEMBERSHIP</b>	25	
Consumers/Survivors/Ex-patients(C/S/X)	8	
Family Members of Children with SED	4	
Family Members of adults with SMI	1	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	1	
<b>TOTAL C/S/X, Family Members and Others</b>	14	56.00%
State Employees	7	
Providers	4	
Vacancies	0	
<b>TOTAL State Employees and Providers</b>	11	44.00%

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.

# 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.

<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

## **Planning Council Charge, Role and Activities**



The role of the Missouri Mental Health Planning Council is to improve mental health services within the State. The mission of the planning council known as the Division of Comprehensive Psychiatric Services State Advisory Council (CPS/SAC) 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 CPS/SAC serves as the block grant planning council for Missouri and was first established in 1977 by a Governor's Executive Order. Missouri Revised Statutes, Chapter 632 Comprehensive Psychiatric Services, Section 632.020 currently stipulates the requirements for the advisory council.

By Federal law, State Planning Councils have the following duties:

1. Review State plans and submit any recommended modifications to the State.
2. Serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems.
3. Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

### **Reviewing Plans and Submitting Recommendations**

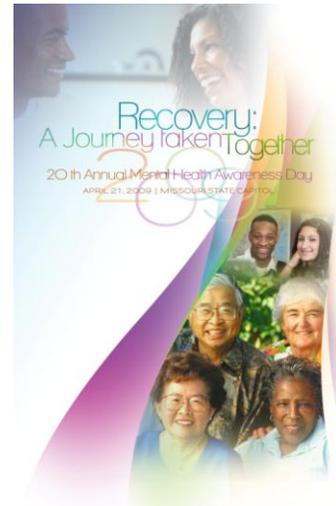
The State of Missouri is committed to ensuring the voice and perspective of mental health consumers inform the provision of mental health services throughout the state. The CPS/SAC has played an active role in developing and fulfilling this commitment by convening on a monthly basis to review plans and discuss mental health services. The division director or his designee routinely reported on the department budget to maintain an informed council and solicit input from council members on spending the limited dollars available. The letter from the CPS/SAC Chair outlines the review of the Mental Health Block Grant State Plan with no recommendations for modifications.

### **Advocacy**

The CPS/SAC serves as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems. CPS/SAC advocacy activities include promoting the Peer Specialist training and certification; planning and implementing Mental Health Awareness Day; participation in the Department of Mental Health's Annual Spring Training Institute, Anti-Stigma Public Education Campaign, Mental Health Transformation activities, and Procovery to name a few. Presentations were provided at monthly meetings on topics such as Mental Health Block Grant, Budget Priorities, Performance/Outcome Data, Evidence-Based Practices, Tobacco Cessation, Suicide Prevention, Prevention, Mental Health Elderly Issues, Consumer Involvement in Monitoring Community Agencies, Mental Health Transformation, Consumer Operated Drop-In Centers, Wellness Recovery Action Planning, Peer Specialist Certification, Olmstead and PATH grants, Protection and Advocacy, Mental and Physical Health Connection including the Morbidity and Mortality Study, Person Centered Planning, Housing, Employment, Mental Health Promotion and Education Work, Consumer/Family/Youth Summit, Dialectical Behavior Therapy Overview, Mil

Tax Boards, Children's Mental Health, Older Adult Mental Health Care, Department of Elementary and Secondary Education Guidance and Placement Services Overview, Veterans Services at State and Federal Level, Standard Means Test, Federally Qualified Health Centers/Community Mental Health Centers Initiative, Minority Health and Aging, State Fiscal Year 2011 Budget Development, and Midwest Special Needs Trust.

**Mental Health Awareness Day 2009**, *Recovery: A Journey Taken Together*, at the State Capitol on April 21st was a huge success. Over 450 consumers and advocates converged on the Missouri State Capitol for educational opportunities and advocacy. The event included a welcome from Helen Minth, Chair of the State Advisory Council; Robert Qualls, Mental Health Champion; and Dr. Joe Parks, Director of the Division of Comprehensive Psychiatric Services. A workshop on *Citizen Advocacy: What You Need to Know* was presented by Cindi Keele, Executive Director of NAMI Missouri; Tim Harlan, Board President of NAMI Columbia; and Susan Crane Lewis, Executive Director Mental Health America of the Heartland. Health screenings for blood pressure and Glaucoma were available.



The First and Third Floor Rotunda of the Missouri State Capitol hosted twenty-two mental health and physical health related exhibits.

The Capitol Steps speakers included Mayme Miller from Governor Nixon's Office, Senator Charlie Shields, Representative Sarah Lampe, Representative Rebecca McClanahan and Keith Schafer, Director of the Department of Mental Health. Members of the State Advisory Council for the Division of Comprehensive Psychiatric Services, Lincoln University Cooperative Extension/Paula J. Carter Center on Minority Health & Aging, and DMH volunteers staffed the event to assure it ran smoothly.

Media Recognitions were presented to five organizations for their longstanding partnership with the department to reduce the stigma of mental illness through public education:

- JCTV
- KDHX TV
- Time Warner Broadcasting - Positive Profiles TV Show
- Carter Broadcasting KPRT Radio
- KJFF Radio Festus

Music was provided by the Lincoln University Marching Band and free pizza and ice cream for participants rounded out the celebratory event. Many individuals with mental illness and their families made appointments with their legislators to share their personal stories. Individuals participated with intensity and passion to help those suffering from mental illness.

### **Monitoring, Reviewing and Evaluating**

The CPS/SAC monitors, reviews and evaluates State services through several means.

1. CPS/SAC members review the Block Grant and on a continuous basis review the data gathered by the DMH. The June, July and August 2009 meetings focused on discussion and review of the Block Grant proposal.

2. CPS/SAC meetings often include presentations on the budget, current programming, grants, and initiatives for the purpose of allowing input and feedback on the adequacy of mental health services within the State.
3. CPS/SAC meetings include monthly conversations with the Department and Division Directors or designees allowing feedback and ideas to be presented directly to decision makers.
4. CPS/SAC members are full team members for certification surveys of the community mental health centers. These reviews evaluate the quality of care from a consumer/family perspective. Six organizations have been reviewed with the Consumer/Family Monitors as team members this past year. Approximately fourteen community mental health centers will receive the certification visits this year with the Consumer/Family Monitors.

The goal of the CPS/SAC is to improve mental health services within the State of Missouri.

### **Mental Health Transformation**

The Office of Transformation in the Missouri Department of Mental Health was established to address concerns regarding the state's mental health service delivery system. President George Bush's [New Freedom Commission on Mental Health](#) final report, issued in July 2002, identified weaknesses at the state and federal levels in mental health care, reporting on a system that is "broken and fragmented."



The state of Missouri was awarded a Mental Health Transformation Grant by the Substance Abuse and Mental Health Services Administration for five years, effective October 2006. The grant, which could total \$14 million over the five years, is supporting building an infrastructure required for transformation, such as planning, workforce development, evidence-based practice implementation, and technology enhancements. The primary focus of the first year was the development of a Comprehensive State Mental Health Plan by the Transformation Leadership Workgroup. The Plan was submitted to SAMHSA and approved in June 2008.

The CPS/SAC members were involved in many Office of Transformation work groups addressing transformation activities. The New Freedom Commission Report recommends six broad goals for a transformed public mental health system that would promote recovery:

1. Americans understand that mental health is essential to overall health;
2. Mental health care is consumer and family- driven;
3. Disparities in mental health services are eliminated;
4. Early mental health screening, assessment and referral are common practice;
5. Excellent mental health care is delivered and research is accelerated; and,
6. Technology is used to access mental health care and information.

A statewide Transformation Leadership Working Group has been formed. Two consumer members and two State agency members of CPS/SAC were included. Six Transformation Work Groups were formed; one for each New Freedom Commission goal. CPS/SAC members were on multiple work groups. The CPS/SAC sponsored thirteen Public Meetings around the State to

obtain public feedback on the draft plan. A CPS/SAC member co-hosted the meeting in their area of the State. The Office of Transformation Director continues to attend CPS/SAC meetings to provide updates on the plan implementation and obtain input from members. CPS/SAC members co-hosted thirteen statewide RESPECT Seminars to reduce stigma and assist individuals in telling their recovery story. One CPS/SAC member has been trained in Mental Health First Aid as part of the Mental Health Transformation Show Me Series. CPS/SAC members are on several of the next step working groups to develop the transformation implementation details.

To ensure Missourians understand that mental health is essential to overall health, CPS/SAC members have promoted the SAMHSA/Ad Council *What a Difference a Friend Makes* anti-stigma public education campaign in their local communities. The department contracted with the Missouri Institute of Mental Health to conduct a telephone survey of 1000 homes to gather information about public views of mental illness. The results of the survey are guiding decision making on targeting the anti-stigma activities. Individual CPS/SAC members have participated in radio and television spots to provide information to their communities about mental illness and recovery. Members have presented to local groups about the mental health transformation initiative. A video of recovery stories was created and shown at the Missouri State Fair. Two CPS/SAC members were filmed.



The DMH provides services to about 170,000 Missourians each year, many of whom are making major progress in overcoming the challenges of mental illnesses, substance abuse, and developmental disabilities. Unfortunately, few of their personal stories are known. To address this, the department recognized the accomplishments of three of these individuals with the second annual Mental Health Champions recognition. Three persons were selected from statewide nominations as Mental Health Champions. A member of CPS/SAC was selected for the Champions award. The nominees were representative of individuals with mental illnesses, developmental disabilities, and persons in recovery from substance or gambling addictions. They were persons who have overcome their personal challenges to make life better for others and for their communities. The second Mental Health Champions Banquet was held April 1, 2009, at the Capitol Plaza Hotel in Jefferson City. Videos of the Mental Health Champion awardees can be viewed at <http://www.dmh.mo.gov/news/MHChampions.htm>

"They are persons who inspire others. For years I have seen firsthand many inspiring stories of people doing exceptional things while overcoming their illnesses, developmental disabilities or substance abuse problems. This recognition is long overdue. One major way to break down the stigma that affects the people we serve is to bring their strengths and contributions to the forefront." - *Mental Health Director, Keith Schafer.*

To ensure mental health care is consumer and family driven, consumer members have been selected for membership on such groups as the Comprehensive System Management Team (CSMT), Comprehensive Children's Mental Health Services System Stakeholder's Advisory Group (SAG) among others. Both the CSMT and the SAG have consumer parent representatives from the CPS/SAC to ensure a connection and sharing of information between the groups. Procovery has been implemented across the State including specific training for consumers,

including CPS/SAC members, on starting and maintaining Procovery Circles. These committees are in addition to the Transformation Work Groups mentioned above. Several of the CPS/SAC members are also members of the National Alliance for the Mentally Ill (NAMI). There have been several collaborative activities with NAMI Missouri regarding reducing stigma. An attorney from the Missouri Protection and Advocacy organization is a member of CPS/SAC. In 2009, a Veteran's representative was added to the council. A staff person with the Centers for Medicare and Medicaid Services Person Centered Planning grant has been added as a member of the SAC. She keeps the SAC updated on progress and requests their feedback at meetings.

To ensure early mental health screening, assessment and referral are common practice, members of the CPS/SAC have actively participated in the Crisis Intervention Team training for law enforcement. This training teaches law enforcement appropriate interventions for individuals with mental illness they meet on the streets. In the coming year, the council would like to focus some attention on this initiative and to assess activities that could enhance or expand this programming.

To ensure excellent mental health care is delivered and research is accelerated, CPS/SAC has had discussions on evidenced based practices including Integrated Dual Disorders Treatment, Assertive Community Treatment, Dialectical Behavior Therapy, and Supported Employment for adults and Comprehensive System of Care for children. Jean Campbell, a nationally recognized consumer/researcher, is assisting the department in the transformation process. She offers a consumer voice in transformation. She has provided a presentation to CPS/SAC on ways to accelerate the multi-state Consumer Operated Service Programs (COSP) findings into practice. One of the Consumer Operated Drop-In Center Executive Directors actively participates on CPS/SAC. Additionally, one of the CPS/SAC members is working on the Juvenile Justice Grant for the Children's Initiative in promoting the evidence based practice of Trauma Focused Cognitive Behavioral Therapy. One of the CPS/SAC consumer members participated in the evaluation team of the Requests for Proposals for the physical and behavioral health collaboration contract awards. One of the CPS/SAC members implemented the physical and behavioral health collaborations within an organization and frequently reported to the council on progress.

To ensure technology is used to access mental health care and information, the CPS/SAC members have tested and given feedback on the state-wide "Network of Care" web-based system to facilitate consumer information and access to mental health services. The Network of Care website has been approved as meeting SAMHSA's mental health transformation goals. Council members have promoted use of the Network of Care site and the My Folder component. My Folder includes recorded messages from Mary Ellen Copeland on the use of the Wellness Recovery Action Plan. Consumers are currently being trained on the resources available in Network of Care and how to train their peers on using the resources.

### **Planning Council Goals**

The CPS/SAC wants to focus their energies the next three years on enhancing the consumer and family voice in decision making. The council was led through an "Affinity Exercise" by a trained facilitator to establish priorities. The group narrowed the list of items of importance to three goals to focus on for FY 2009-2011:

1. Consumer Impact on the System
2. Advocacy/Awareness, Reduce Stigma and Increase Education
3. Consumer Provided Services.

### **Consumer Impact on the System**

The CPS/SAC made formal recommendations to the Division Director for consumers and family members to be involved in the contracted community agency certification process. The recommendation included:

1. Community Based Monitoring Committee Vision, Mission and Goals
2. Community Based Monitoring Committee Recommendations
3. Consumer Monitors for Certification Visits Employee Considerations
4. Job Description Consumer Surveyor/Consumer Monitor
5. Memorandum of Understanding (Agreement Between Missouri Department of Mental Health and Hourly or Intermittent Employee Assigned to Certification)
6. Consumer Monitors for Certification Visits Estimated Budget

The Division Director approved the recommendations. CPS/SAC developed a survey tool with interview questions and training curriculum for consumer monitors. Six agencies have received certification surveys in 2008-2009 with the consumer/family monitors. The feedback has been positive from both service providers and monitors. CPS will continue to have a consumer/family monitor as a member of the certification team on the fourteen certification visits planned for 2009-2010.

CPS/SAC members have continued promoting that consumer and family members should be included on all policy making committees within the Department of Mental Health and in the community agencies.

### **Advocacy/Awareness, Reduce Stigma and Increase Education**

CPS/SAC will continue to plan and implement the Mental Health Awareness Day activities in efforts to reduce stigma and raise awareness of the general public and legislators. The department has paid the expenses of all CPS/SAC members to participate in the annual Spring Training Institute for the past several years and will continue to do so. The goal is to promote leadership and knowledge of evidenced based practice for consumer leaders. Council members presented at Spring Training Institute 2008 on Peer Specialist Certification. In 2009, the Spring Training Institute was cancelled due to budgetary concerns. However, the CPS/SAC had made recommendations for speakers and were involved in the planning. The Spring Training Institute will occur in 2010 and the CPS/SAC will be involved in the planning.

With the assistance of the Missouri Mental Health Foundation, a public service announcement to raise public awareness of mental health recovery was created. The Robert Qualls, CPS/SAC member, Public Service Announcement is available for viewing at <http://www.dmh.mo.gov/>. The PSA is being shown on television stations statewide.

Several members of the CPS/SAC were involved in planning the first statewide consumer/family/youth conference with the Office of Consumer Affairs that occurred in November 2008. A second annual consumer/family/youth conference is planned for August 23-25, 2009. CPS SAC members played a major role in planning the conference. Over 300

individuals have registered for the 2009 event. CPS/SAC members will continue their involvement in this annual event. Additionally, a Missouri Youth Advisory Council has formed with input from CPS/SAC.

CPS/SAC is reaching out to other advisory councils. A member of the State Rehabilitation Council for the Division of Vocational Rehabilitation was a guest at a CPS/SAC meeting. The CPS/SAC Chair and Co-Chair have been invited to attend one of their meetings.

### **Consumer/Peer Specialist Provided Services**



CPS/SAC members researched and chose a Peer Specialist training and certification model. Based on the CPS/SAC recommendations CPS has adopted the Appalachian Consulting Group “Georgia Model” for Peer Specialist training. The Division is moving the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. One primary strategy in transforming the system is to recognize the power of consumer as providers. Recognizing consumers as providers is taking root in the mental health system. Emerging evidence strongly supports the need for peer support services as a cost- effective and complementary adjunct to professional mental health services and supports. Peer support services can move the system to focus less on illness and disability and more on wellness. To accomplish this goal, Missouri has provided equal weight to expertise gained through the “lived experience” as is done with any other credential or knowledge base. A Peer Specialist can share lived experiences of recovery, share and support the use of recovery tools and model successful recovery behaviors. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. Additionally, Peer Specialists can help consumers connect with other consumers and with their community at large.

With the oversight of the CPS/SAC, three Peer Specialist Basic Trainings have been conducted in 2008-2009. The week-long training has been conducted by Randy Johnson an Appalachian Consulting Group trained consumer and an employee of the Mental Health America of the Heartland. He has trained three additional Missouri Peer Specialist Trainers, two of which are CPS/SAC members. To date 90 individuals have been trained and 36 have reached the goal of Certified Missouri Peer Specialist status. Twenty community mental health centers have sent individuals to the training and 12 have certified peer specialists working in their agencies. Six Consumer Operated Services Program Drop-In Centers and Warm Lines sent individuals to the training. Additionally, the Veteran’s Administration, residential providers, Services for Independent Living, and a substance abuse treatment agency have sent individuals to the training. Two Peer Specialist Supervisor Trainings were conducted. In 2009-2010, three additional Peer Specialist Basic Trainings and three Supervisors trainings will be planned. Additionally, there are plans for a more cohesive network to be formed with regular conference calls of the trained individuals to provide ongoing support and consultation.

The CPS/SAC members are individually and collectively committed to improving the outcomes of individuals served in the mental health system. It is characteristic of membership to be involved locally in their communities as well as on the State level.

# BYLAWS OF THE STATE ADVISORY COUNCIL FOR COMPREHENSIVE PSYCHIATRIC SERVICES

## *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:

- A. Advise CPS in the development of models of services and long range planning and budgeting priorities.
- B. Identify statewide needs, gaps in services, and movement toward filling gaps.
- C. Provide education and information about mental health issues.
- D. 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

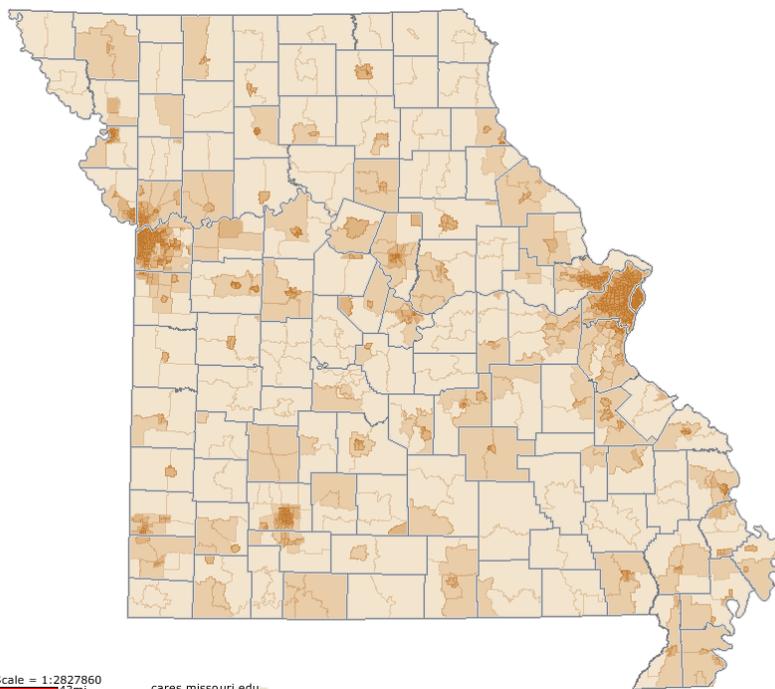
## Adult - Overview of State's Mental Health System

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

Named after the Siouan Indian tribe meaning "town of the large canoes", Missouri is a Midwestern State, but its culture has some Southern influences, especially in the lower third of the state and away from the urban centers. Missouri earned the nickname "Gateway to the West" because it served as a departure point for settlers heading to the west. It was the starting point and the return destination of the Lewis and Clark Expedition.

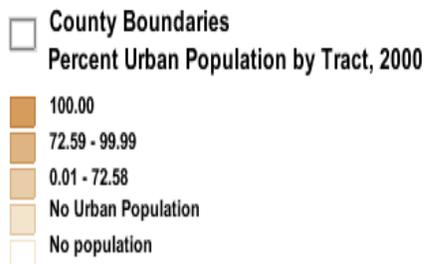
As of 2006, Missouri had an estimated population of 5,842,713. For Census year 2000, Missouri's demographic makeup was as follows: Caucasian (84.9 percent) (Caucasian, non-Hispanic (83.8 percent)), African American (11.2 percent), Hispanic (2.1 percent), Asian (1.1 percent), Native American (0.4 percent), Other race (0.9 percent), and Mixed race (1.5 percent). German Americans are a large ancestry group present in most of Missouri. In southern Missouri, most residents are of British ancestry. African Americans are populous in the City of St. Louis and central Kansas City as well as in the southeastern bootheel and some areas of the Missouri River Valley, where plantation agriculture was once important. Missouri Creoles of French ancestries are concentrated in the Mississippi River valley south of St. Louis.



State Capital: Jefferson City  
 Governor: Jay Nixon  
 Population: 5,842,713 (2006)  
 Area: 68,886 sq miles  
 Counties: 141 + 1  
 Cities > 100K: (2005)  
     445K Kansas City  
     344K St Louis City  
     159K Springfield  
     110K Independence  
 Counties > 250K: (2006)  
     1,001K St Louis  
 County  
     664K Jackson  
 County  
     339K St Charles  
     255K Greene

Map Scale = 1:2827860  
 0 43mi

cares.missouri.edu



The Bureau of Economic Analysis estimates that Missouri's total state product in 2003 was \$195 billion. Per capita personal income in 2003 was \$29,464, 27<sup>th</sup> in the nation. Major industries include aerospace, transportation equipment, food processing, chemicals, printing/publishing, electrical equipment, light manufacturing, and beer. Tourism, services, and wholesale/retail trade follow manufacturing in importance.

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 Mental Health Commission appointed by the Governor. The Commission is responsible for appointing the Department Director with confirmation by the state Senate and advising on matters relating to its operation. Commissioners are appointed to four-year terms by the Governor, again with the confirmation of the Senate. The commissioners serve as principle policy advisors to the department director. The Commission, by law, must include an advocate of community mental health services, a physician who is an expert in the treatment of mental illness, a physician concerned with developmental disabilities, a member with business expertise, an advocate of substance abuse treatment, a citizen who represents the interests of consumers of psychiatric services, and a citizen who represents the interests of consumers of developmental disabilities services.

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 and target populations.

The Department Director appoints the Director of the Division of CPS. There are four regional hospital systems comprised of nine CPS inpatient facilities. Each hospital system has a single Regional Executive Officer (REO) 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. The Office of Comprehensive Child Mental Health (OCCMH) was established within DMH. This office assures the implementation of a Comprehensive Children's Mental Health Service System and is advised by the Comprehensive Child Mental Health Clinical Advisory Council.

There are several State agencies in the Missouri governmental system that DMH collaborates with to assure quality services are provided to consumers; primarily the Department of Social Services (DSS). Missouri DSS is the Medicaid authority for the State. Additionally, the DMH works closely with the Department of Corrections, Department of Health and Senior Services, Department of Elementary and Secondary Education, Department of Public Safety, and Office of State Court Administrators.

## Missouri DMH Overview Statistics

### Department of Mental Health

- Annual budget: \$1.1 billion -- 53% GR, 43% Federal, 4% Other Funds
- DMH contracts with over 1,600 providers employing over 30,000 people in communities statewide.
  - Certifies 674 providers
  - Licenses 405 community facilities and programs
- Community Based Services = 67% of total budget and serve 95% of all DMH clients.
- DMH employs 8,800 people statewide.
- State operated services = 27% of total budget and serve 5% of all DMH clients.

### Comprehensive Psychiatric Services

- 9 state operated facilities
  - 7 State psychiatric hospitals for adults with SMI
  - 2 Child psychiatric hospitals for children with SED
- 77,244 unduplicated consumers served in FY09



## Mission

**Prevention, Treatment, and  
Promotion of Public Understanding**  
for Missourians with mental illnesses,  
developmental disabilities, and addictions.

## Vision

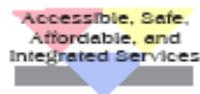
**Hope ▼ Opportunity ▼ Community Inclusion**

*Missourians receiving mental health services will have the  
opportunity to pursue their dreams and live their lives as  
valued members of their communities.*

## Values



Missourians who participate in mental health services are welcomed and equally included in education, work, housing, and social opportunities in their communities.



Missourians with mental health needs easily access safe, affordable, and integrated medical and behavioral services.



Missourians participating in mental health services are active partners in designing their services and supports.



The effectiveness of Missouri's mental health services is measured by meaningful outcomes experienced by the people receiving them.



Missourians receive mental health services from competent, motivated, and highly valued staff serving as effective stewards of the public trust.



Emphasizing prevention and early intervention strategies avoids or minimizes the mental health problems of Missourians.



Missourians participating in mental health services are valued for their uniqueness and diversity and respected without regard to age, ethnicity, gender, race, religion, sexual orientation, or socio-economic condition.

January 2008

The DMH Division of CPS operates nine facilities, providing acute, long term rehabilitation and residential care for youth and adults as well as forensic, sexual predator and corrections services for adults. The number of statewide psychiatric beds in 2008 was 1,558.

CPS is responsible for statewide mental health services. It operates two children and seven adult hospitals. CPS contracts with 26 community-based agencies to provide psychiatric rehabilitation services. ADA contracts with 44 community based organizations to provide the full spectrum of substance related services (prevention through inpatient/residential care), and it funds services at two of the acute-care hospitals and one of the long-term care hospitals. There are a total of 33 ADA-only community contract agencies, 15 CPS-only contractors, and 11 agencies with both a CPS and ADA contract, that operate close to 200 treatment sites throughout the state. The certification standards of care contain core rules, adopted in 2001, which apply to both ADA and CPS programs. Collaborative annual reviews of joint contracted community organizations are conducted by CPS and ADA staff.

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. A map of the service areas and listing of corresponding community service provider follows the narrative in this section.

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.

Twelve (12) counties and the city of St. Louis have passed Mental Health Mil Taxes and have Mental Health Boards. Six (6) counties have passed a Children's Services Tax to provide an array of treatment and prevention services. Six additional counties have formed task forces to propose ballot issues in the next year. Five (5) counties are participating in a program that facilitates the use of federal funds to expand the amount of funds and services available in the county.

The Division works closely with county boards and local organizations to increase the number of counties offering mental health services. The Division hired a Community Development Manager to work closely with the local Mil Tax Boards and local organizations to increase the number of counties with mil tax monies for mental health services. The Division maintains regulatory and quality control of services purchased by local boards through enforcement of certification standards for those services.

The department continued its suicide prevention efforts by contracting with seven agencies that serve as Regional Resource Centers to provide suicide prevention services across the state. The Resource Centers have engaged community partners to develop and implement local strategies, provide public education and training, offer support for survivors, and promote proven practices to help with preventing suicide within their designated service areas.

The department's Access Crisis Intervention (ACI) line is staffed by mental health professionals who can respond to your crisis 24 hours per day and 7 days per week. They will talk with consumers about their crisis and help determine what further help is needed, for example, a telephone conversation to provide understanding and support, a face-to-face intervention, an appointment the next day with a mental health professional, or perhaps an alternative service that best meets your needs. They provide resources or services within the community to provide ongoing care following a crisis. All calls are strictly confidential.

The goals of ACI are:

- To respond to crisis by providing community-based intervention in the least restrictive environment, e.g., home, school.
- To avert the need for hospitalization to the greatest extent possible.
- To stabilize persons in crisis and refer them to appropriate services to regain an optimal level of functioning.
- To mobilize and link individuals with services, resources and supports needed for ongoing care following a crisis, including natural support networks.

The department funds five Drop-In Centers for persons with mental illness. Jean Campbell, Ph.D., principal investigator of the COSP Multi-site Research Initiative, continues to work as a consultant to determine the fidelity of the Drop-In Centers to peer support evidence based practices as determined by the Fidelity Assessment/Common Ingredients Tool (FACIT). Results of the findings are helping each program to improve the quality of services delivered. An additional five contracts have been awarded for peer support phone lines.

### **Drop-In Center Services**

#### **Depressive and Bipolar Support Alliance of Greater St. Louis "St. Louis Empowerment Center"**

3024 Locust

St. Louis, MO 63103

Phone: (314) 652-6100

Fax: (314) 652-6103

Contact: Helen A. Minth

Email: [hminth@sbcglobal.net](mailto:hminth@sbcglobal.net)

**Mental Health America of the Heartland**

739 Minnesota Avenue  
Kansas City, KS 66101  
Agency phone: (913) 281-2221  
Fax (913) 281-3977  
Contact: Petra Robinson  
Email: [probinson@mhah.org](mailto:probinson@mhah.org)  
Website: [www.mhah.org](http://www.mhah.org)

**NAMI of Southwest Missouri  
“The Hope Center”**

1701 S. Campbell  
Springfield, MO 65807  
Phone: (417) 864-7119  
Phone: (417) 864-3027  
Toll free: 1-877-535-4357  
Fax: (417) 864-5011  
Contact: Dewayne Long  
Email: [eburke@namiswmo.com](mailto:eburke@namiswmo.com)  
Website: [www.namiswmo.com](http://www.namiswmo.com)

**Self-Help Center**

7604 Big Bend Blvd., Suite A  
St. Louis, MO 63119  
Phone: (314) 781-0199  
Fax: (314) 781-0910  
Contact: Nancy S. Bollinger  
Email: [selfhelpcenter@selfhelpcenter.org](mailto:selfhelpcenter@selfhelpcenter.org)  
Website: [www.selfhelpcenter.org](http://www.selfhelpcenter.org)

**Truman Behavioral Health  
“Consumer Run Drop-In Center”**

3121 Gillham Road  
Kansas City, MO 64109  
Phone: (816) 404-6382 (evenings)  
Phone: (816) 404-6386 (days)  
Fax: (816) 404-6388  
Contact: Sherri Redding  
Email: [sherri.redding@tmcmed.org](mailto:sherri.redding@tmcmed.org)  
Website: [www.trumanmed.org/sections/content.aspx?SID=28](http://www.trumanmed.org/sections/content.aspx?SID=28)

## Warm Lines/Peer Phone Support Services

### **Mental Health America of the Heartland**

**“Compassionate Ear Warm line”**

**Phone: (913) 281-2251**

**Toll free: 1-866-WARMEAR (1-866-927-6327)**

739 Minnesota Avenue

Kansas City, KS 66101

Agency phone: (913) 281-2221

Fax (913) 281-3977

Contact: Petra Robinson

Email: [probinson@mhah.org](mailto:probinson@mhah.org)

Website: [www.mhah.org](http://www.mhah.org)

### **Community Counseling Center’s**

**Consumer Advisory Board**

**Phone: (573) 651-3642**

**Toll free: 1-877-626-0638**

402 S. Silver Springs Road

Cape Girardeau, MO 63703

Agency phone: (573) 334-1100

Fax: 573-651-4345

Contact: Judy Johnson

Email: [jjohnson@cccntr.com](mailto:jjohnson@cccntr.com)

### **NAMI of Missouri**

**Phone: (573) 634-7727**

**Toll free: 1-800-374-2138**

3405 West Truman Blvd., Suite 102

Jefferson City, MO 65109

Agency phone: (573) 634-7727

Fax: (573) 761-5636

Email: [mocami@aol.com](mailto:mocami@aol.com)

Website: [www.mo.nami.org](http://www.mo.nami.org)

### **NAMI of Southwest Missouri**

**“The Hope Center”**

**Phone: (417) 864-3027**

**Toll free: 1-877-535-4357**

1701 S. Campbell

Springfield, MO 65807

Agency phone: (417) 864-7119

Fax: (417) 864-5011

Contact: Dewayne Long

Email: [eburke@namiswmo.com](mailto:eburke@namiswmo.com)

Website: [www.namiswmo.com](http://www.namiswmo.com)

**Depressive and Bipolar Support Alliance of Greater St. Louis  
“Friendship Line”**

**Phone: (314) 652-6105**

**Toll free: 1-866-525-1442**

2734 Gravois

St. Louis, MO 63118

Agency phone: (314) 865-2112

Fax: (314) 652-6103

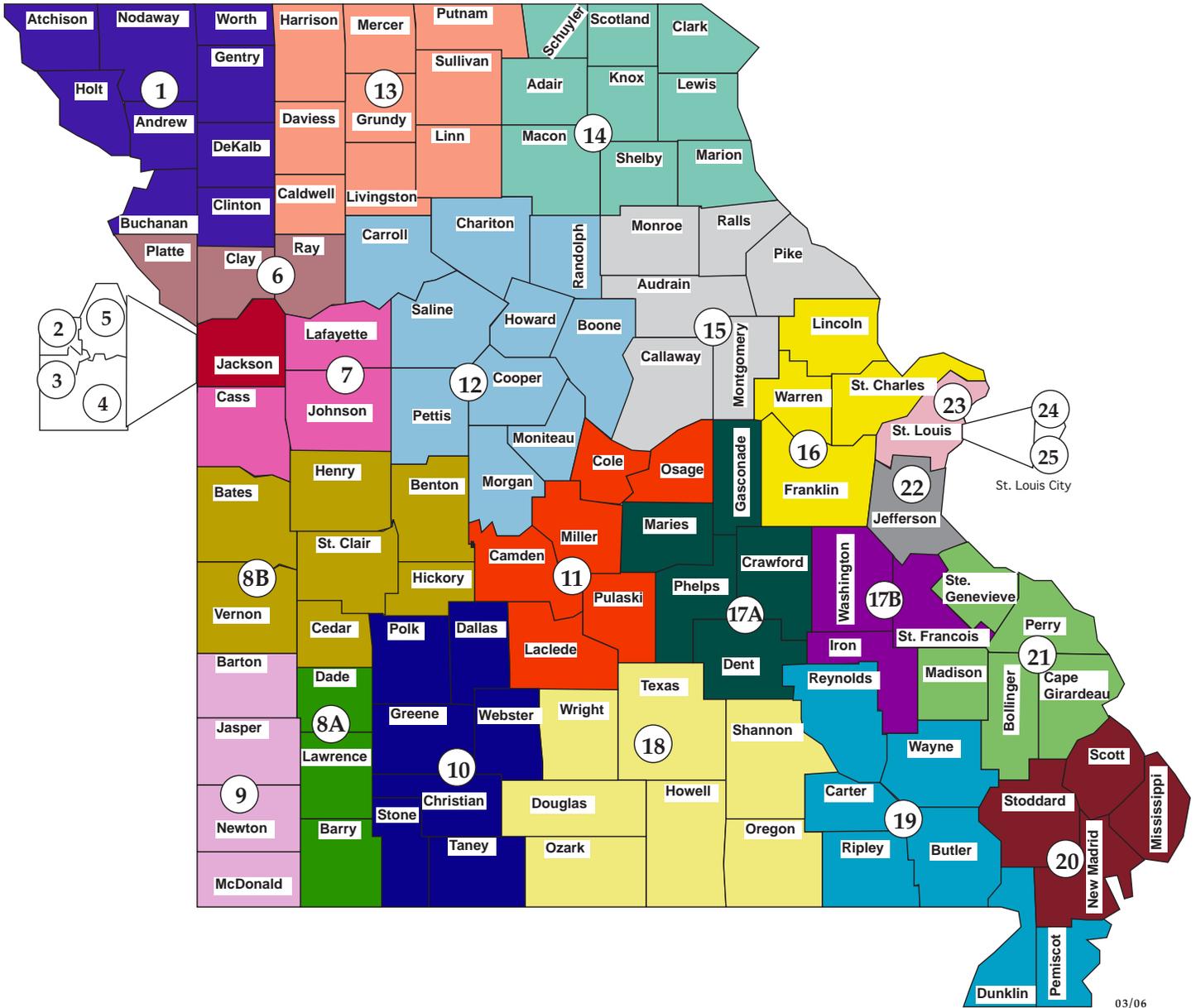
Contact: Helen A. Minth

Email: [hminth@sbcglobal.net](mailto:hminth@sbcglobal.net)

# MISSOURI DEPARTMENT OF MENTAL HEALTH

## Division of Comprehensive Psychiatric Services

### Administrative Agents



**Missouri Department of Mental Health  
Division of Comprehensive Psychiatric Services  
ADMINISTRATIVE AGENTS & AFFILIATES**

<u>Service Area</u>	<u>Service Area</u>
<p><b>1 Family Guidance Center</b> 724 North 22<sup>nd</sup> Street St. Joseph, MO 64506 Garry Hammond, Executive Director 816-364-1501 Fax: 816-364-6735 Email: <a href="mailto:gghammond@familyguidance.org">gghammond@familyguidance.org</a></p> <p><b><u>Affiliated Center (#1)</u></b> <b>Community Recreation and Resocialization, Inc.</b> 525 S. 10<sup>th</sup> Street St. Joseph, MO 64501 Martha Goodding, Executive Director 816-233-0430 Fax: 816-233-3795 Email: <a href="mailto:crr@stjoewireless.net">crr@stjoewireless.net</a></p>	<p><b>6 Tri County Mental Health Services</b> 3100 NE 83<sup>rd</sup> Street Kansas City, MO 64119-9998 Thomas H. Cranshaw, Executive Director 816-468-0400 Fax: 816-468-6635 Email: <a href="mailto:tomc@tri-countymhs.org">tomc@tri-countymhs.org</a></p> <p><b>7 Pathways Community Behavioral Healthcare, Inc.</b> 520C Burkarth Road Warrensburg, MO 64093 660-747-1605 Fax: 660-747-1638 Mel Fetter, President/CEO 660-890-8054 Fax: 660-318-3117 Email: <a href="mailto:MeIF@pbhc.org">MeIF@pbhc.org</a></p>
<p><b>2 Truman Medical Ctr Behavioral Health</b> 2211 Charlotte Kansas City, MO 64111 Marsha Morgan, Executive Director 816-404-5700 Fax: 816-404-5731 Email: <a href="mailto:marsha.morgan@tmcmcd.org">marsha.morgan@tmcmcd.org</a></p>	<p><b>8A Clark Community Mental Health Center, Inc.</b> <b>Consumer Service Contact:</b> 417-235-6610 1701 N. Central Monett, MO 65708 <b>Mailing Address:</b> 104 W. Main Street – P. O. Box 100 Pierce City, MO 65723 Frank Compton, Chief Executive Director 417-476-1000 (x236) Fax: 417-476-1082 Email: <a href="mailto:comptonf@clarkmentalhealth.com">comptonf@clarkmentalhealth.com</a></p>
<p><b>3 Swope Health Services</b> 3801 Blue Parkway Kansas City, MO 64130 Gloria Joseph, Executive Director 816-922-7645 Fax: 816-922-7683 Email: <a href="mailto:gjoseph@swopecommunity.org">gjoseph@swopecommunity.org</a></p>	<p><b>8B Pathways Community Behavioral Healthcare, Inc.</b> 1800 Community Drive Clinton, MO 64735 Mel Fetter, President/CEO 660-890-8054 Fax: 816-318-3117 Email: <a href="mailto:MeIF@pbhc.org">MeIF@pbhc.org</a></p>
<p><b>4 ReDiscover</b> 901 NE Independence Avenue Lee's Summit, MO 64086 Alan Flory, President 816-246-8000 Fax: 816-246-8207 Email: <a href="mailto:alflory@rediscovermh.org">alflory@rediscovermh.org</a></p>	
<p><b>5 Comprehensive Mental Health Services</b> 10901 Winner Road, PO Box 520169 Independence, MO 64052 William H. Kyles, Executive Director 816-254-3652 Fax: 816-254-9243 Email: <a href="mailto:iking@thecmhs.com">iking@thecmhs.com</a> <a href="mailto:wkyle@thecmhs.com">wkyle@thecmhs.com</a></p>	<p><b>9 Ozark Center</b> 3006 McClelland, PO Box 2526 Joplin, MO 64803 Paula Baker, MS, Chief Executive Officer 417-781-2410 Fax: 417-781-4015 Email: <a href="mailto:pfbaker@freemanhealth.com">pfbaker@freemanhealth.com</a></p>

**Service Area**

**10 Burrell Behavioral Health**  
1300 Bradford Parkway  
Springfield, MO 65804  
Todd Schaible, Ph.D., President/CEO  
417-269-5400  
Fax: 417-269-7212  
Email: [todd.schaible@coxhealth.com](mailto:todd.schaible@coxhealth.com)

**11 Pathways Community Behavioral Healthcare**  
1905 Stadium Blvd.  
PO Box 104146  
Jefferson City, MO 65110-4146  
Bob Whittet, Vice President  
Mel Fetter, President/CEO  
573-634-3000  
Fax: 573-634-4010  
Email: [bwhittet@pbhc.org](mailto:bwhittet@pbhc.org)  
[Melf@pbhc.org](mailto:Melf@pbhc.org)

**Affiliated Center (#11)**

**New Horizons Community Support Services**  
2013 Williams St.  
Jefferson City, MO 65109  
Chi Cheung, Exec. Director  
573-636-8108  
Fax: 573-635-9892  
Email: [ccheung@mo-newhorizons.com](mailto:ccheung@mo-newhorizons.com)

**12 Burrell Behavioral Health – Central Region**  
601 Business Loop 70 West, Suite 202  
Columbia, MO 65201  
Allyson Ashley, Acting Director  
Todd Schaible, Ph.D., President/CEO  
(Acting Director)  
573-777-7550  
Fax: 573-777-7587  
Email: [Allyson.Ashley@coxhealth.com](mailto:Allyson.Ashley@coxhealth.com)

**Affiliated Center (#12)**

**New Horizons Community Support Services**  
1408 Hathman Place  
Columbia, MO 65201-5551  
Chi Cheung, Executive Director  
573-443-0405  
Fax: 573-875-2557  
Email: [ccheung@mo-newhorizons.com](mailto:ccheung@mo-newhorizons.com)

**Service Area**

**13 North Central MO Mental Health Center**  
1601 East 28<sup>th</sup>, Box 30  
Trenton, MO 64683  
Lori Irvine, Executive Director  
660-359-4487  
Fax: 660-359-4129  
Email: [lori@ncmmh.org](mailto:lori@ncmmh.org)

**14 Mark Twain Behavioral Health**  
917 Broadway  
Hannibal, MO 63401  
Mike Cantrell, Executive Director  
573-221-2120  
Fax: 573-221-4380  
Email: [mcantrell@mtbh.org](mailto:mcantrell@mtbh.org)

**Affiliated Center (#14)**

**Preferred Family Healthcare, Inc.**  
900 E. LaHarpe  
Kirksville, MO 63501  
660-665-1962  
Michael Schwend, CEO  
Fax: 660-665-3989  
Email: [mschwend01@pfh.org](mailto:mschwend01@pfh.org)

**Affiliated Center (#14)**

**Comprehensive Health Systems, Inc.**  
*(Serving Marion County)*  
12677 Heavenly Acres Dr  
New London, MO 63459  
PO Box 468 *(Billing Address)*  
Hannibal, MO 63401  
Lynn Mercurio, CEO  
573-248-1372  
Fax: 573-248-1375  
Email: [lmercurio@chsservices.net](mailto:lmercurio@chsservices.net)

**15 East Central MO Behavioral Health Service dba Arthur Center**  
321 West Promenade  
Mexico, MO 65265  
Terry Mackey, President  
573-582-1234  
Fax: 573-582-7304  
Email: [tmackey@arthurcenter.com](mailto:tmackey@arthurcenter.com)

**Service Area**

**Affiliated Center (#15)**

**Comprehensive Health Systems, Inc.**  
12677 Heavenly Acres Dr  
New London, MO 63459  
PO Box 468 (Billing Address)  
Hannibal, MO 63401  
Lynn Mercurio, CEO  
573-248-1372  
Fax: 573-248-1375  
Email: [lmercurio@chsservices.net](mailto:lmercurio@chsservices.net)

**16 Crider Health Center**  
1032 Crosswinds Court  
Wentzville, MO 63385  
Karl Wilson, Ph.D., President/CEO  
636-332-6000 or 1-800-574-2422  
Fax: 636-332-9950  
Email: [kwilson@cridercenter.org](mailto:kwilson@cridercenter.org)

**17A Pathways Community Behavioral Healthcare**  
1450 E. 10<sup>th</sup> Street,  
PO Box 921  
Rolla, MO 65401  
David Duncan, Vice President  
Mel Fetter, President/CEO  
573-364-7551  
Fax: 573-364-4898  
Email: [dduncan@pbhc.org](mailto:dduncan@pbhc.org)  
[melf@pbhc.org](mailto:melf@pbhc.org)

**17B BJC Behavioral Health**  
Southeast Site  
1085 Maple Street  
Farmington, MO 63640  
Mark Stansberry, Director  
Karen Miller, Associate Director  
573-756-5353  
Fax: 573-756-4557  
Email: [kfm6775@bjc.org](mailto:kfm6775@bjc.org)

**Affiliated Center (#17)**

**SEMO Community Treatment Center**  
512 E. Main  
P.O. Box 506  
Park Hills, MO 63601-0506  
Barron E. Pratte, PhD, President/CEO  
573-431-0554  
Fax: 573-431-5205  
Email: [bpratte@semoctc.org](mailto:bpratte@semoctc.org)

**Service Area**

**Affiliated Center (#17)**

**Mineral Area CPRC**  
203 South Washington  
P.O. Box 510  
Farmington, MO 63640  
Vicky Winick, Director  
573-756-2899  
Fax: 573-756-4105  
Email: [secretaryvickie@hotmail.com](mailto:secretaryvickie@hotmail.com)

**18 Ozarks Medical Center Behavioral Healthcare**  
Carol Eck, Director  
909 Kentucky  
West Plains, MO 65775  
417-257-6762  
Fax: 417-257-5875  
Email: [carol.eck@ozarksmedicalcenter.com](mailto:carol.eck@ozarksmedicalcenter.com)  
(Satellite Office)

**Mountain Grove Medical Complex**  
1604 N. Main  
Mountain Grove, MO 65711  
517-926-6563

**19 Family Counseling Center**  
925 Highway VV  
PO Box 71  
Kennett, MO 63857  
Myra Callahan, Executive Director  
573-888-5925  
Fax: 573-888-9365  
Email: [myra@familycounselingcenter.org](mailto:myra@familycounselingcenter.org)

**20 Bootheel Counseling Services**  
760 Plantation Blvd.  
PO Box 1043  
Sikeston, MO 63801  
Cheryl Jones, Executive Director  
573-471-0800  
Fax: 573-471-0810  
Email: [cjones@bootheelcounselig.com](mailto:cjones@bootheelcounselig.com)

**21 Community Counseling Center**  
402 S. Silver Springs Road  
Cape Girardeau, MO 63703  
John A. Hudak, Executive Director  
573-334-1100  
Fax: 573-651-4345  
Email: [sfoster@cccctr.com](mailto:sfoster@cccctr.com)

**Service Area**

**22 Comtrea Community Treatment**  
227 Main Street  
Festus, MO 63028  
636-931-2700  
Administrative Office:  
Stephen Huss, Ph.D., President/CEO  
Comtrea  
21 Municipal Dr.  
Arnold, MO 63010-1012  
636-931-2700 Ext. 345  
Fax: 636-296-6215  
Email: [wecare@comtrea.org](mailto:wecare@comtrea.org)

**23 BJC Behavioral Health**  
1430 Olive, Suite 500  
St. Louis, MO 63103  
Mark Stansberry, Director  
314-206-3700  
Fax: 314-206-3721  
Email: [mes2294@bjc.org](mailto:mes2294@bjc.org)

**BJC Behavioral Health**  
North Site  
3165 McKelvey Rd.  
Suite 200  
Bridgeton, MO 63044-2550  
Mark Stansberry, Director  
314/206-3900  
FAX: 314-206-3995  
Email: [mes2294@bjc.org](mailto:mes2294@bjc.org)

**BJC Behavioral Health**  
South Site  
343 S. Kirkwood Rd.  
Suite 200  
Kirkwood, MO 63122-6915  
Mark Stansberry, Director  
Phone: 314-206-3400  
FAX: 314-206-3477  
Email: [mes2294@bjc.org](mailto:mes2294@bjc.org)

**24 Hopewell Center**  
1504 S. Grand  
St. Louis, MO 63104  
Amanda Murphy, Ph.D., Exec. Director  
314-531-1770  
Fax: 314-531-7361  
Email: [amurphy@hopewellcenter.com](mailto:amurphy@hopewellcenter.com)

**Service Area**

**25 BJC Behavioral Health**  
1430 Olive, Suite 500  
St. Louis, MO 63103  
Mark Stansberry, Director  
314-206-3700  
Fax: 314-206-3708  
Email: [mes2294@bjc.org](mailto:mes2294@bjc.org)

**Affiliated Centers (#25)**

**Places for People, Inc.**  
4130 Lindell Blvd.  
St. Louis, MO 63108-2914  
Francie Broderick, Exec. Director  
314-535-5600  
Fax: 314-535-6037  
Email: [fbroderick@placesforpeople.org](mailto:fbroderick@placesforpeople.org)

**Independence Center**  
4245 Forest Park Ave.  
St. Louis, MO 63108  
J. Michael Keller, Executive Director  
314-533-4245  
Fax: 314-533-7773  
Email: [mkeller@independencecenter.org](mailto:mkeller@independencecenter.org)

**ADAPT of Missouri**  
2301 Hampton  
St. Louis, MO 63139  
Bill Lertz, MSW, Executive Director  
314-657-3200  
Fax: 314-781-3295  
Email: [billlertz@adapt.us](mailto:billlertz@adapt.us)

**Community Contacts for Incidents Involving  
Administrative Agents and Affiliates**

**Brooke Dawson**

1706 E. Elm  
Jefferson City, MO 65102  
[brooke.dawson@dmh.mo.gov](mailto:brooke.dawson@dmh.mo.gov)  
Phone: 573-751-8122  
Fax: 573-751-7815

*(Central Region)*

**Scott Giovanetti**

Dome Building  
5400 Arsenal  
St. Louis, MO 63139  
[scott.giovanetti@dmh.mo.gov](mailto:scott.giovanetti@dmh.mo.gov)  
Phone: 314-877-0372 (St. Louis)  
Fax: 314-877-0392 (St. Louis)

*(Eastern Region)*

**Connie Kirbey**

2201 N. Elm St.  
Nevada, MO 64772  
[connie.kirbey@dmh.mo.gov](mailto:connie.kirbey@dmh.mo.gov)  
Phone: 417-448-3400  
Fax: 417-667-6526

*(Western Region)*

Revised: October 2, 2008



# 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.

## Adult – New Developments and Issues

### Mental Health Transformation

The Mental Health Transformation grant has provided infrastructure funding for developing and implementing a Comprehensive State Mental Health Plan throughout Missouri based on the six goals of the President's New Freedom Commission (NFC) Report. The process is recovery oriented, trauma informed and culturally competent. This five year grant (October 1, 2006 - September 30, 2011) supports infrastructure required for transformation such as planning, workforce development, EBP implementation and technology enhancements.

The *Comprehensive State Mental Health Plan* was submitted to SAMHSA and approved in June 2008. The complete plan can be found on the Internet at <http://www.dmh.mo.gov/transformation/FINALVERSIONJULY12008.pdf>.

Also on the Internet is the *Needs Assessment and Resource Inventory for Mental Health* at [http://www.dmh.mo.gov/transformation/FinalNARIO4-18-08\\_001.pdf](http://www.dmh.mo.gov/transformation/FinalNARIO4-18-08_001.pdf).

In Appendix A of this document is the Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update. This document is also on the website at <http://www.dmh.mo.gov/transformation/TransformationReports.htm>.

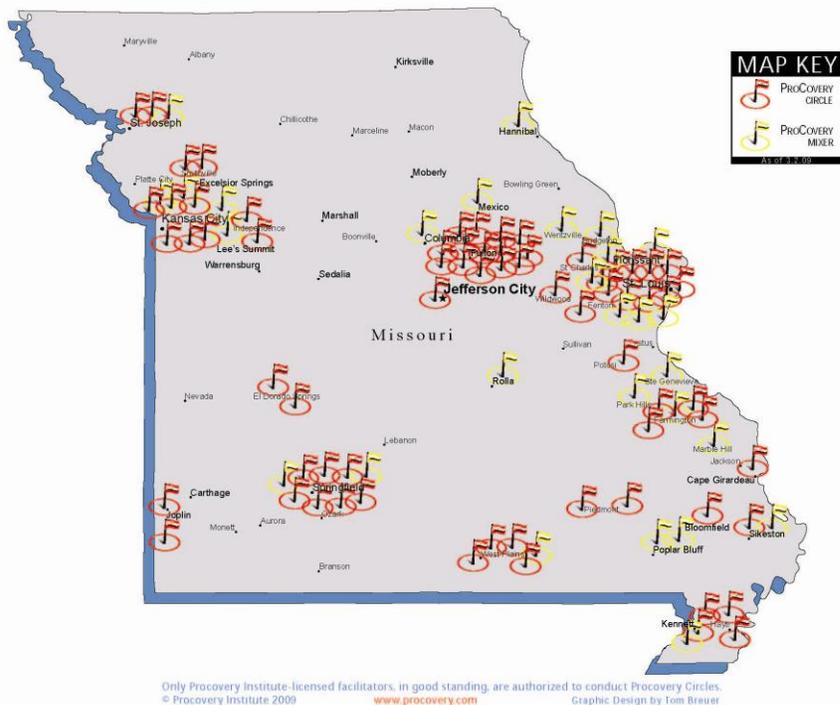
Transformation has implemented the Missouri Mental Health Show Me Series designed to improve public knowledge, eliminate stigma and empower people to move their lives forward regardless of their illness or disability. The series uses three curriculums: RESPECT Seminars, Mental Health First Aid, and Procovery.

- Creating Communities of Hope begins with RESPECT. Joel Slack, founder of Respect International, LLC, developed the RESPECT Seminar to promote the powerful impact that respect (and disrespect) has on a person recovering from a psychiatric disability. Joel presents personal experiences and shows that RESPECT impacts all of us in our daily lives. His message is relevant to anyone interested in gaining a consumer's perspective regarding mental health and the relationship between service provider and patient. Thirteen free public seminars were provided throughout Missouri in 2008-2009 with over 750 participants. Joel has also conducted four trainings through the RESPECT Institute, a five-day training program designed to teach consumers how to share their own personal stories to educate others. Two additional RESPECT Institutes are planned for Kansas City and St. Joseph this year.
- Most Missourians understand first aid and what to do if someone is choking, not breathing or exhibiting signs of another health emergency. However, few people know basic interventions if they encounter a person experiencing a mental health emergency even though they are likely to encounter such situations as well. In Australia, Betty Kitchener and Anthony Jorm developed Mental Health First Aid (MHFA) to teach basic first aid interventions for common mental health problems such as anxiety, bipolar disorder, depression, substance use disorder, or a crisis situation such as suicidal behavior, post trauma distress, drug overdose, panic attack, and the like. Participants in a

MHFA course demonstrated improved confidence in providing initial help, increased help given, and reduced stigma regarding mental health disorders resulting in international adoption and adaptation. Missouri is working collaboratively with a team from Maryland and the National Council of Community Behavioral Healthcare to launch the American version of Mental Health First Aid. The draft MHFA-USA manual, standards, and business plan have been developed with national partners. Missouri initiated roll-out of the program with three 12-hour pilot courses and one 40-hour instructor training through September. Two instructors were identified and trained to begin pilot training in Missouri. A grant application was submitted to demonstrate and evaluate program implantation to target populations. Preliminary draft of a combined youth/adult manual is being reviewed.

- Missouri Department of Mental Health is administering statewide implementation of recovery services through the Procovery™ program, following the completion of a successful demonstration pilot and extensive statewide foundational planning. The Procovery™ program, developed by Kathleen Crowley, author and Executive Director of Procovery Institute, emphasizes a hope-centered, forward-focused, and skills-based partnership of the client, the family, the service provider, and the community. It includes eight principles for resilience in healing, 12 strategies for action, and a highly structured system, known as the Procovery Circle, for group training and support. Below is a map of the existing Procovery Circles in Missouri.

**MISSOURI PROCOVERY CIRCLES® NOW STATEWIDE!**



Missouri Transformation efforts to promote and support young people who desire to be a voice and a force for mental health issues in the state has resulted in the publication of [\*The Missouri Youth Movement Transforming Youth Involvement Through Youth Voice in Public Policy\*](#), a report that outlines the value of a youth voice in the formation of public policy. Fifteen young people from all regions of the state had a hand in the development of this document. Missouri is working with youth consultants from the state of Washington to establish a state Youth Leadership Initiative. An initial planning meeting, held August 13, 2008, hosted 12 young people representing all regions of the state. Membership is comprised of both youths who receive mental health services and those who do not. Selecting the name Missouri Youth REACH (Responding through Empowerment and Action to Create Communities of Hope), the group discussed its role in providing leadership to give youths a voice in mental health programming. Parents and guardians also are involved, discussing in separate sessions their leadership and support roles for their children. Young people and adults alike were excited with the outcomes and plan to have regular meetings to get an organization off the ground.

### **Federally Qualified Health Centers/Community Mental Health Centers (FQHC/CMHC) (NFC Goal 1)**

Physical care is a core component of basic services for persons with serious mental illness (SMI) which should include preventive healthcare and ongoing management and integration of both mental illness and physical care. Individuals with SMI often have difficulty accessing health care and turn to the ER for care.

According to the Morbidity and Mortality in People with Serious Mental Illness Technical Report, individuals with mental illness die 25 years earlier than the general population. “Their increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.” (Report on NASMHPD website at [http://www.nasmhpd.org/general\\_files/publications/med\\_directors\\_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf](http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf))

In FY 2003 there were 19,700 Missouri Medicaid recipients with a diagnosis of schizophrenia. The combined pharmacy and health care costs for the top 2000 recipients exceeded \$100 million, compared to \$45 million for the bottom 10,000. Other characteristics of these top 2000 recipients included:

- Higher incidence of co-occurring chronic medical conditions
- Lower medication adherence
- Higher incidence of co-occurring alcohol and other drug abuse problems
- Lack of a stable “Medical Home”
- More complex medical plans

(Source: Parks, Pollack-2005-Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities)

The DMH wants to assure physical healthcare to persons with serious mental illness as a core component of their basic services with access to preventive healthcare and ongoing integration and management of medical care. Among this population are individuals released from DOC who are uninsured. Integration of mental health/substance abuse services with management of

chronic health conditions has been shown to improve self management and patient healthcare outcomes. (Source: 2006-Reynolds-NCCBH-Behavioral Health and Primary Care)

Seven sites (each site includes one CMHC and one FQHC in collaboration) were selected to implement this budget item funded through State General Revenue. The Department is working with the Community Health Centers on integrated services through a collaborative process to target the uninsured population. Family Practice Nurses are located at the CMHC for primary care clinics for the uninsured. Targeted Case Manager/Community Support Workers are located in FQHC for behavioral health referral/linking/support. Seven sites have been funded for three years for co-location of services and six sites received one-time funding for planning.

The Missouri Coalition of Community Mental Health Centers has received a grant from the Missouri Foundation for Health to provide training and technical assistance to each of the sites in developing an integrated approach to the delivery of health and mental health services. The grant will provide: (1) Facilitation to implementation partnerships between the community mental health center(s) and the community health center(s); (2) Identification and facilitation of other appropriate partnerships to deliver integrated services; and (3) Technical assistance in infusing mental health information into medical residency programs, targeting primary care and internal medicine; and the infusion of health information into training programs for psychologists, social workers and counselors.

An article was published in the May 2009 journal *Psychiatric Services*, State Mental Health Policy section, on lessons learned with the project titled *Mending Missouri's Safety Net: Transforming Systems of Care by Integrating Primary and Behavioral Health Care* written by Dorn Schuffman, M.A., Benjamin G. Druss, M.D., M.P.H., and Joseph J. Parks, M.D.

Missouri plans to continue the progress toward full implementation at all seven locations. One of the six planning grant locations has integrated the FQHC and CMHC without additional dollars from the department. This location has been highlighted in the local newspaper and is fully operational.

### **Integrated Dual Disorders Treatment (IDDT) (NFC Goal 5)**

At least 50% of adults with serious mental illness (SMI) also have a co-occurring substance abuse (SA) disorder. Persons with co-occurring SMI/SA disorders have poor outcomes when served in traditional treatment programs where each disorder is treated by a separate team of providers. The evidence based treatment model of care for persons with co-occurring SMI/SA disorders that is recommended by SAMSHA is Integrated Dual Disorders Treatment (IDDT). In the IDDT model persons receive coordinated, integrated treatment by a single multidisciplinary team including trained specialists in co-occurring disorders.

CPS has encouraged the community mental health centers to adopt this evidence based practice by offering new billing codes for co-occurring treatment. The codes allow for flexibility of services based on individual consumer need even though new monies are not available. The new Medicaid approved billing codes are for co-occurring individual counseling, co-occurring group education and group counseling and a supplemental assessment for substance abuse disorders. Twenty agencies with 32 locations statewide have committed to implementing IDDT to fidelity

of the model. CPS staff has visited each program to review the baseline fidelity. The second round of fidelity visits has begun. CPS will continue to conduct fidelity reviews on an annual basis and require action plans from the agencies for planning on full fidelity.

### **Assertive Community Treatment (ACT) (NFC Goal 5)**

The Missouri General Assembly approved funding the EBP of ACT for SFY 2008. Planning meetings occurred with treatment providers to work out implementation issues. Six agencies are currently contracted to provide ACT. The agencies have developed their teams and have enrolled consumers. DMH has worked with agency staff to identify the high end users of crisis services. Over the next two years, DMH will work on implementing and expanding the number of teams using the ACT model. A Missouri variation of the Comprehensive Outcome Measure Program is being used to measure client outcomes on a quarterly basis. Experts from the field such as Michelle P. Salyers, Ph.D., from the ACT Center of Indiana, have made numerous technical assistance visits to Missouri. Additionally, members from each ACT team and CPS employees have shadowed ACT teams in Minnesota to observe how ACT is implemented.

### **Department of Corrections Collaboration (NFC Goal 3)**

CPS has a joint project with Department of Corrections to provide services to mentally ill persons recently released from correctional facilities through the CMHCs. The Department of Mental Health has added a service code for “Intake Screening-Corrections” to allow for the pre-release planning and intake screening of persons with serious mental illness being discharged from correctional facilities in the DMH/DOC Mental Health 4 project.

Intake Screening-Corrections MH4 occurs prior to discharge from the correctional facility and all face-to face, indirect, and travel costs are built into the cost of the service unit. Service activities include the following:

1. Orientation of the inmate and solicitation of enrollment in the project.
2. Conducting an intake session, reviewing inmate history of mental health services and medications prior to and during incarceration, and providing clinical information to CMHC psychiatrists and other clinicians who will serve the transitioning inmate upon release.
3. Participation in the development of transition plans with the inmate and correctional treatment staff.
4. Scheduling immediate services for the offender to receive from CMHC staff during the first week following release.

### **Peer Specialist Certification (NFC Goal 2)**

CPS has adopted the Appalachian Consulting Group “Georgia Model” for Peer Specialist training and certification. It is the intent of the Division to move the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. Certified Peer Specialists are a part of this process. CPS contracted with Larry Fricks to provide the first training in Missouri. Ike Powell and Beth Filson of his staff conducted the first training on September 29 through October 3, 2008. CPS has four individuals trained to be the Missouri trainers. Two more week-long Peer Specialist Basic Trainings were conducted in March and

July of 2009. Two Peer Specialist Supervisors trainings have also been conducted. Twenty community mental health centers have sent individuals to the training and 12 have certified peer specialists working in their agencies. Six Consumer Operated Services Program Drop-In Centers and Warm Lines sent individuals to the training. Additionally, the Veteran's Administration, residential providers, Services for Independent Living, and a substance abuse treatment agency have sent individuals to the training. Additionally, CPS has contracted with Wichita State University to provide the web site support for the training and certification process. The web site is [www.peerspecialist.org](http://www.peerspecialist.org).

CPS has trainee 90 individuals with the peer specialist training. Thirty-six individuals have passed the certification exam and reached the credential for Certified Missouri Peer Specialist. The Medicaid reimbursement rate was increase recently to incentivize the hiring of Peer Specialists in the CMHCs. The rate is comparable to the community support worker rate. In 2009-2010, three additional Peer Specialist Basic Trainings and three Supervisors trainings will be planned. Additionally, there are plans for a more cohesive network to be formed with regular conference calls of the trained individuals to provide ongoing support and consultation.

### **Dialectical Behavior Therapy (NFC Goal 5)**

Dialectical Behavior Therapy introductory and advanced training has occurred throughout the state.

#### DBT Introductory 2-Day Training

January 24-25, 2008 – (Joplin) – 35 Trained  
March 26-27, 2008 – (St. Louis) – 101 Trained  
April 10-11, 2008 – (Kansas City) – 200 Trained  
April 14-15, 2008—(Cape Girardeau)—85 Trained  
July 21-22, 2008 – (Kansas City) – 212 Trained  
July 24-25, 2008 – (Columbia) – 233 Trained  
September 30, October 1, 2008 (Farmington)—30 Trained  
October 30-31, 2008 – (Kansas City) – 210 Trained  
January 26-27, 2009 – (St. Louis) – 340 Trained  
February 24-25, 2009 – (Marshall) – 88 Trained  
March 16-17, 2009 – (Kirksville) – 81 Trained  
April 1-2, 2009 – (Sikeston) – 83 Trained  
June 8-9, 2009 – (St. Louis) – 37 Trained  
August 3-4, 2009—(Kansas City)—15 Trained

#### **Total Trained 1750**

#### Advanced DBT Training

June 17-19, 2009 – (Kansas City) – 75 Trained  
June 29-July 1, 2009 – (Columbia) – 95 Trained  
July 8-10, 2009 – (St. Louis) – 101 Trained  
September 9-11, 2009 (Sikeston)—15 Trained

#### **Total Trained 286**

### **Person Centered Planning (NFC Goal 5)**

Missouri was one of the 17 states awarded funds for the Centers for Medicare and Medicaid Services Person-Centered Planning (PCP) Implementation Grant. Projects and initiatives are focused on the Divisions of Developmental Disabilities and Comprehensive Psychiatric Services (CPS). This summary will provide an overview of CPS activities. Grant funds supported the following training programs:

- Mental Health First Aid (grant director is a certified instructor);
- Wellness Recovery Action Planning (WRAP) workshops – one held in March for Peer Support Specialists and another held July 28 & 29 for state hospital and community mental health center employees in the Central Region;
- The PCP grant will support a WRAP Facilitator Education Course (in the initial planning phase);
- The PCP Project Director participated in a series of CPS Documentation & Compliance seminars for community mental health center program directors and regional supported community living personnel. Over 500 people received training on the philosophical foundation of resilience, recovery, and person-centered treatment planning along with information on documentation and compliance; and
- Neal Adams, MD and Diane Grieder, M.Ed have been providing consultation with CPS Central Office and selected CMHC's related to person-centered treatment planning. They will be assisting with a learning collaborative in Kansas City this Fall to help agencies implement PCP.

### **Missouri Mental Health Foundation (NFC Goal 1)**

The Missouri Mental Health Foundation (MMHF) was created in 2007 to provide a singular focus on raising awareness and public understanding to the many issues that impact individuals and families who are living with mental illness, developmental disabilities and substance abuse. The Foundation is dedicated to changing the attitudes of the general population about mental health conditions and helping those who experience them build hope for a brighter future.

The Foundation is a 501(c) 3 entity to allow for the handling of charitable, tax deductible contributions. While the MMHF was created by the Department of Mental Health, it is operated separately and has its own Board of Directors. The Foundation already has its own part-time Executive Director, Debra Walker.

Increasing public awareness and understanding of mental health disorders will help dissolve stigma and open doors to treatment and equal opportunity for participation in schools, communities and the workforce. Supporting the Foundation is your opportunity to make a difference in *Changing Attitudes and Building Hope* for some of Missouri's most vulnerable citizens.

“The positive and negative perceptions that shape the way people are treated by others can make all the difference. The general public's lack of understanding about mental health conditions and developmental disabilities keeps many Missourians on the sidelines of society and in the shadow of life. The stigma surrounding mental health conditions keeps people from seeking treatment. Stigma shapes public policies that limit treatment options. Battling this stigma is the commitment of the Missouri Mental Health Foundation. They may be considered unemployable

and a burden on the rest of society. But what these people really need is **HOPE**. Hope for the opportunity to participate in all segments of the community. That is what makes them, their families and the community better.”

The Missouri Mental Health Foundation has assisted with the two Mental Health Champions banquets and award ceremonies. The goal is of the foundation is to identify potential fundraisers and contributors to the foundation for implementation of long-term success and sustainability of projects.

# Missouri

## Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

## Adult – Legislative Initiatives and Changes

### SFY 2010 Budget

Despite the struggling Missouri economy, DMH fared better than expected in the SFY 2010 budget process, guided by Governor Nixon’s strong budget recommendations for DMH:

- The Governor limited DMH core cuts to \$19.7 million General Revenue (GR) or about 3.2% of DMH’s \$616.5 million GR core. Cuts were taken primarily by closing state acute psychiatric inpatient beds and concurrently expanding inpatient psychiatric beds at community hospitals in Columbia and Kansas City. DMH supported this recommendation to avoid the loss of client services and to maximize Medicaid reimbursements available to community hospitals but not state facilities.
- Despite the necessity of the core cuts, Governor Nixon and his budget office, recommended over \$36 million in new GR for DMH programs in SFY 2010, with an additional \$47 million in federal matching reimbursement for Medicaid-eligible individuals. Legislative budget deliberations brought diverse perspectives that ultimately shaped the DMH budget passed by the Legislature. The tables on the following pages reflect the DMH “wins and losses” in the SFY 2010 budget.

**Table 1: Key New DMH Decision Items Passed by the Legislature in SFY 2010**

<b>Budget Item</b>	<b>GR Increase</b>	<b>Federal Increase</b>	<b>Total-New Items</b>
Medicaid Caseload Growth -- Cost to Continue from FY 2009	\$8,411,556	\$15,072,477	\$23,484,033
FY 2010 Medicaid Caseload Growth Expansion	\$7,000,000	\$12,541,979	\$19,541,979
Replacement of core funding lost through federal regulation changes in billing by DMH for “Organized Health Care Delivery System” (one-time funding from Federal Budget Stabilization Fund)		\$2,679,546	\$2,679,546
Increased medication funding for non-Medicaid CPS and ADA consumers	\$2,863,897		\$2,863,897
Increased food and medical care funding for DMH facilities	\$935,929		\$935,929
Missouri Sexual Offender Treatment Center (MOSOTC) cost of continuation and expansion funding	\$1,342,495		\$1,342,495
MO HealthNet and DMH Mental Health Partnership Technology (one-time funding from Federal Budget Stabilization Fund)		\$1,250,000	\$1,250,000
Veterans Initiative		\$783,162	\$783,162
Housing -- Federal Grant Expansion		\$615,057	\$615,057

**Table 2: SFY 2010 Governor Recommended Items for DMH Not Funded by the Legislature**

<b>Recommended Item</b>	<b>GR Amount</b>	<b>Federal Amount</b>	<b>Combined Total</b>
Medicaid expansion coverage for families below 50% of poverty with mental health problems	\$2,162,751	\$3,875,080	\$6,037,831

As reflected in Table 2, the failure to reach agreement on increasing health care coverage for low income working families has a dramatic impact on DMH, which serves many individuals among this population -- particularly in ADA and CPS. Because these clients are not Medicaid eligible, DMH has to cover the costs of their services with GR dollars only.

**Table 3: DMH SFY 2010 Core Cuts**

<b>Budget Item</b>	<b>GR Loss</b>	<b>Federal Loss</b>	<b>Total Loss</b>
Governor's Recommended Core Cuts (not including one-times and Medicaid match adjustments): <ul style="list-style-type: none"> <li>• Closure of Mid-MO Mental Health Center*</li> <li>• Closure of units at Western MO MHC*</li> <li>• Core cuts to DMH Central Office</li> </ul>	\$16,513,439	\$266,235	\$16,779,674
Legislative core cut in CPS GR Non-Medicaid funding	\$500,000		\$500,000

*\* Acute inpatient psychiatric services in these areas will be available through community hospitals after June 30, 2009.*

**Conversion of state-operated acute psychiatric inpatient services to community hospitals:**

This conversion was crucial for the state because:

- The federal Medicaid program reimburses psychiatric acute inpatient services when provided through community hospitals in which fewer than 50% of their beds are for psychiatric services. In contrast, Medicaid does not fund state psychiatric hospitals, which are designated as "Institutions for Mental Disease" and are prohibited from billing for Medicaid reimbursement for otherwise eligible individuals, ages 22 through 64.
- Many states have already discontinued the operation of large, stand alone state psychiatric acute centers and moved toward better integration of medical and behavioral health.

DMH had hoped to use the GR savings accruing from this change to strengthen its community mental health and addiction services. This is no longer possible in light of the required core cuts. Had the change not occurred, \$15 million in community services core cuts would have been necessary.

### **Economic Projections for 2010-2011**

- Missouri's SFY 2009 annual revenue growth estimates were dramatically reduced as the fiscal year progressed, requiring additional DMH withholding above normal 3% reserves in the amount of \$10,796,180 in January and a later withhold of \$653,061 in April. In all, DMH took \$21.3 million in total withholding in SFY 2009.
- Originally, state revenues were projected to grow by approximately 3% this year, but as the global economic downturn became more evident, the Governor and Legislature revised SFY 2009-2010 economic forecasts downward and are now estimating that revenues for SFY 2009 will fall 5% below SFY 2008 levels and SFY 2010 will see very weak growth above revised SFY 2009 levels, if at all.

### **Key Mental Health Budget Development Themes for SFY 2011**

DMH's Executive Team, with support from the Mental Health Transformation Initiative, has identified the following key themes for SFY 2011:

1. Timely access to mental health services—getting immediate help to those in need;
2. Increasing the mental wellness and productivity of all Missourians—a population based public mental health approach;
3. Preserving the mental health safety net—assuring safe, high quality mental health services and supports;
4. Increasing public support and understanding for people and their families who suffer from addiction disorders, developmental disabilities and mental illnesses; and
5. Re-designing services for individuals inappropriately served in Missouri nursing homes.

There was no new legislation other than the budget bills related to the department.

# 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.

## **Adult - Description of State Agency's Leadership**

Though its functions date back to 1847, the Missouri Department of Mental Health was first established as a cabinet-level state agency by the Omnibus State Government Reorganization Act, effective July 1, 1974.

State law provides three principal missions for the department: (1) the prevention of mental disorders, developmental disabilities, substance abuse, and compulsive gambling; (2) the treatment, habilitation, and rehabilitation of Missourians who have those conditions; and (3) the improvement of public understanding and attitudes about mental disorders, developmental disabilities, substance abuse, and compulsive gambling.

### **Mental Health Transformation**

To both achieve the promise of “**Hope\*Opportunity\*Community Inclusion**” and promote movement toward achieving positive mental health in “**Communities of Hope**” for all Missourians, our vision of a transformed system is:

*Communities of Hope throughout Missouri support a system of care where promoting mental health and preventing disabilities is common practice and everyone has access to treatment and supports essential for living, learning, working and participating fully in the community.*

Missouri's progress in system transformation and cross-agency collaboration was a key factor in SAMHSA's award—specifically, the creation and initial implementation of the Comprehensive Mental Health Plan and System for Children mandated through Senate Bill 1003. Missouri's Transformation Initiative built upon this work and includes a structure to create a Comprehensive Mental Health Plan to address Missourians' mental health needs across the lifespan.

Missouri has initiated, with bipartisan legislative and chief executive support, several significant initiatives that serve as building blocks to achieve our transformation vision—including the passage of legislation mandating mental health insurance parity; implementation of a coordinated statewide approach to suicide prevention; and legislation requiring the creation of a unified, accountable children's mental health system across all child-serving departments. This latter initiative resulted in the development of Missouri's first comprehensive mental health services plan for children.

Transformation of the state's mental health system is a high priority. A Human Services Cabinet Council (the “Council”) was established; composed of cabinet-level directors of the Departments of Mental Health, Health and Senior Services, Social Services, Elementary and Secondary Education, Corrections and Public Safety. State information technology director also participates on the Council to support the work of the grant. The purpose of the Council is to review cross-department policy and operations related to human services; the Governor's Chief of Staff chairs the Council. In addition to the Council, the Governor has appointed to the Mental Health Transformation Working Group (MHTWG) and, in partnership with the Council, to

develop and implement a comprehensive state mental health plan.

The Council serves as the governing body of the MHTWG and receives regular reports from the MHTWG, reviews and approves all recommended plans and policy changes, and assures consistency with and alignment of MHTWG activities with the activities and recommendations of the Government Review Commission and other Governor initiatives. The Council links the MHTWG with both the Governor and the Government Review Commission; thereby helping to assure that mental health transformation is effectively integrated and aligned with the key priorities and initiatives of the state.

Senior leadership from the following state agencies have been designated to serve on the Working Group: Department of Social Services (DSS), the state Medicare, Medicaid, and child welfare agency; Department of Health and Senior Services (DHSS); Department of Corrections (DOC); Department of Elementary and Secondary Education (DESE), the agency in which vocational rehabilitation is located; the Office of Administration (OA/IS), the agency that administers the state's computer systems; and the DMH director of CPS, who is comparable to the state mental health commissioner, the Directors of the Divisions of Alcohol and Drug Abuse and Mental Retardation/Developmental Disabilities. In addition to senior representation from the aforementioned departments, the Governor's Health Policy Analyst and the chair of the State Advisory Council for the DMH CPS—the division that administers the Community Mental Health Services Block Grant—have also been appointed to the Workgroup. Other appointees to the Workgroup include youth and adult consumers and family members and senior representatives from the Office of State Courts Administrator (OSCA) and the state Housing Commission. The MHTWG members are representative of the racial/ethnic diversity of Missouri.

The initial charge of the MHTWG was to:

- conduct a thorough statewide needs assessment,
- develop a comprehensive state mental health plan,
- identify and implement policy, organizational, and financing changes required to effectively carry out the state plan,
- coordinate policy actions with other state and federal initiatives and fully incorporating the Comprehensive Children's Mental Health Services Plan into all planning activities, and
- establish workgroups to address specific policy areas and to implement policy decisions.

More than 240 workgroup members appointed by the Governor met in six content groups for 44 half-day meetings from February through June 2007 to identify priorities to transform Missouri's mental health system. The TWG reviewed these priorities from public and private sector workgroup members in July.

All the priorities were accepted and several identified for Year One, 2008. Fourteen public meetings were held throughout Missouri in August and September 2007 to get local feedback. All of this information was considered as content for the initial comprehensive plan. Workgroups have been meeting to fully implementation the objectives identified.

The MHTWG has accomplished the initial goals. A plan was developed and approved by SAMHSA in June 2008. The statewide needs assessment was approved by SAMHSA in June 2008. In October 2008, a Federal FY09 Plan Update to Missouri's Comprehensive Plan for Mental Health was submitted. The Plan Update is contained in Appendix A.

The TWG is emphasizing a public health approach, focusing on prevention and early intervention for Missourians across the lifespan. Transformation is about partnering with the public and private sector as well as state and federal agencies to maximize mental health funds and services to meet local needs and create Communities of Hope. The TWG is committed to an open and transparent process. For regular updates and information, please visit the Transformation website at <http://www.dmh.mo.gov/transformation/transformation.htm>.

### **National Report Morbidity and Mortality in People with Serious Mental Illness**

Joseph Parks, M.D., Director of the Division of Comprehensive Psychiatric Services and Chair NASMHPD Medical Directors Council, was lead author of a report from eight states — Maine, Massachusetts, Rhode Island, Oklahoma, Missouri, Texas, Utah and Arizona — that was presented at a meeting of state hospital directors in Bethesda, Maryland. Featured in the national publication USA Today, the report finds adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that has widened since the early 1990's when major mental disorders cut life spans by 10 to 15 years. The collaborative project with FQHC and CMHC for co-location of staff will help to address the physical health issues as will the implementation on the ACT programs.

### **The Missouri Suicide Prevention Plan**

Developed under the leadership of the DMH, Missouri's state-wide Suicide Prevention Plan continues to be implemented. DMH staff continues to support the Suicide Prevention Advisory Committee which meets on a regular basis. The plan can be viewed on the DMH website at <http://www.dmh.mo.gov/cps/issues/suicideplan.pdf>.

### **Smoking Cessation Activities**

The Missouri Foundation for Health granted DMH funding to complete an assessment of tobacco use by consumers of mental health services. The actual survey work was subcontracted to MIMH and conducted during 2008. A total of 586 Missourians receiving services through mental health centers funded by the Department of Mental Health and 177 DMH-contracted psychiatric, substance abuse, and developmental disabilities provider agencies completed surveys on smoking practices. In addition, 345 consumers at three regional DMH developmental disabilities centers took part in the study by completing questionnaires.

Some results include:

- 64% of Missourians who receive psychiatric services and/or alcohol and drug abuse services regularly use tobacco products. This is more than twice the number of the

Missouri general adult population (25%). Nine percent of consumers with developmental disabilities reported tobacco use compared with a state rate of 25%.

- The rate of tobacco use among Missouri consumers of mental health services is 20% higher than rates among persons with mental illnesses nationally. It is estimated that persons with mental illnesses consumed around 50% of all tobacco products in the nation.
- 15% of consumers surveyed have quit using tobacco, compared to 50% of the general population nationally.
- 56% of Missouri consumers who regularly use tobacco would like to quit.

The next step is to develop a plan to prevent and reduce tobacco use by consumers. DMH has been notified that the Foundation has approved the Department's proposal for developing a plan in conjunction with the Missouri state tobacco prevention plan.

Details of the *No Butts About It* assessment are available in the PDF documents listed below.

- [Tobacco Use by Missouri Consumers of Mental Health Services](#)
- [Review of the Literature on Tobacco Use and Consumers of Mental Health Services](#)
- [Developmental Disabilities Tobacco Policies, Practices and Use](#)
- [Comprehensive Psychiatric Services and Alcohol and Drug Abuse Tobacco Policies, Practices and Use](#)
- [Tobacco Policies and Practices of Mental Health Providers](#)

In a demonstration of leadership, all state operated psychiatric facilities have gone smoke free, as well as, DMH central office. Smoking is not allowed anywhere on state hospital or central office grounds. Assistance has been provided to staff and consumers with the desire to quit smoking.

### **Other State Agency Leadership Examples**

Several collaborative state agency initiatives have been advanced including:

- Cross-departmental efforts to assure that correctional inmates in need of mental health or substance abuse treatment have ready access to services upon their release from prison
- Cross-departmental initiative to promote the use of best practices in the prescribing of psychiatric medications for Medicaid recipients.

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,
- Missouri HealthNet,
- Interdepartmental Initiative for Children,
- Olmstead Act,
- Mental Health Courts,
- Licensure and Certification, and
- HIPAA compliance issues.

DMH embraces the importance of employment as critical to recovery of mental health consumers. DMH and Division of Vocational Rehabilitation (DVR) have a long history of working collaboratively to assure individuals with psychiatric disorders have access to employment. Over the past fifteen years, DMH and DVR have collaborated on training, joint programming, and promoting of EBP. More recently, DMH and VR partnered to write a grant application for a Missouri Mental Health Employment Project. The National Institute of Health grant was awarded to Missouri and a Stakeholders group was formed. The Institute for Community Inclusion from Boston, Massachusetts, provided experience and expertise. Joe Marrone and Susan Foley conducted a survey to discover strengths and weaknesses with the current methods of providing supported employment services to the Department's consumers. The survey informed the Stakeholders group about current best practices and gaps in the system. DMH applied for the second phase of the NIH grant funding to continue to enhance our supported employment programming. While this grant was not awarded, DMH and DVR did receive a Johnson & Johnson grant for Supported Employment. Pilot sites have been chosen and technical assistance from Dartmouth University has begun.

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 Plan. Internal efforts are underway to implement sections of the plan that relate specifically to Department compliance. The Department was awarded financial assistance from CMHS that was used to support staff participation in cross-disability coalitions related to Olmstead, particularly related to housing development, a critical barrier to community transition for many consumers. This integrated 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 Department of Mental Health as the public mental health authority leads the mental health response to disasters within Missouri. The Department continues to plan for its own facilities and for a statewide response. In addition, DMH is working cooperatively with other state agencies to plan for disasters and public health emergencies as well as to develop and provide training. Collaboration occurs with DHSS, Department of Public Safety, Department of Agriculture, universities, school personnel, clergy, public health nurses, and mental health centers.

# 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.

See Overview of State's Mental Health System in Adult section

# 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.

## **Child - New Developments and Issues**

See also Child Strengths and Weaknesses section for additional details.

Children's System of Care legislation has created opportunities to serve Missouri's children within their own communities and supported by the Comprehensive System Management Team (CSMT). There have been four SAMSHA cooperative agreements within Missouri since this federal initiative was started. Each cooperative agreement was for a six year period. The first was awarded to the St. Charles County community through Crider Center for Mental Health in 1997. The remaining three were awarded to the DMH to implement in the selected community (Show-Me Kids, 2002; Transitions, 2003; and Circle of Hope, 2006). This latest site focuses on integration of schools, physical health and mental health.

The Custody Diversion Protocol was developed through the shared efforts of DMH, DSS, courts and family members and implemented statewide in January, 2005 following extensive training of Children's Division (CD) staff, DMH provider staff and juvenile justice officers. In February of 2005, the CD was able to implement a Voluntary Placement Agreement (VPA) through an amendment to the state's IV-E plan. This allowed the CD to enter into a contract with parents to fund a child's out of home placement for a maximum of 180 days if deemed appropriate through a DMH level of care assessment without having to take custody. This VPA is only available in conjunction with the Custody Diversion Protocol. This initiative continues to be successful with 901 or 96% of the children referred diverted from state custody. Representatives of the DMH and Children's Division presented on the development of the protocol and its results at the 2008 Georgetown Training Institutes. CPS continues to partner with Children's Division (child welfare) to improve the Custody Diversion Protocol so that families do not have to voluntarily relinquish custody solely to access mental health services.

In 2007 CPS in conjunction with its provider network provided an alternative eligibility criteria for Community Psychosocial Rehabilitation based on the youth's functioning using the Child and Adolescent Functional Assessment Scale (CAFAS<sup>®</sup>). Youth who have a SED diagnosis and have a total score of 100 on the CAFAS, reflecting impaired functioning in multiple domains, are eligible for the intensive community-based service packet. Implementation of the CAFAS to determine eligibility in the intensive-community based services (Children's Community Psychosocial Rehabilitation/CPR) became statewide in January of 2009 and is accessible electronically to all division providers. The intent was to move towards basing eligibility more on functional impairments as opposed to purely diagnostic criteria. The treatment plan generated by the CAFAS has been approved for use by the Division.

Additionally CPS was able to add to its array of services through the Medicaid eligible CPR program four new services. The services of Family Support, Family Assistance, Day Treatment and Psychosocial Rehabilitation for children were added to enhance the existing array of services. While no new funding was allocated to providers for the provision of these services, the Medicaid eligibility of these services will enable the state to maximize the current general revenue dollars thereby increasing the capacity and accessibility of services across the state. Policies, protocols and training curriculum have been developed for each of these services to ensure and support quality.

CPS has been increasing its participation as an active partner for the early childhood population in participation on the state planning team for the State Maternal and Child Health Early Childhood Comprehensive Systems Initiative (ECCS) to implement the MCHB Strategic Plan for Early Childhood Health. CPS co-chaired the workgroup on Social and Emotional Development with the Executive Director of the State HeadStart Collaboration Office and continues to function as the lead agency on implementation of the state strategic plan for this goal. Additionally, CPS represents the Department on the governor appointed Coordinating Board for Early Childhood. In June of this year, DMH in partnership with the Center for the Advancement of Mental Health Practices in Schools through joint SEED and Transformation grant funding held an Early Childhood Mental Health Summit, where early childhood providers and state policy makers were brought together to outline the infrastructure needs to create a universal support system for social and emotional development of the early childhood population. Three top priorities were identified:

- Create a state-wide coordinated education program related to family involvement, engagement, and empowerment
- Map where are current dollars being spent and identify specific gaps related to healthy social and emotional development
- Identify common/cross-system child indicators for healthy social/emotional development.

In 2005 the Departments of Health and Senior Services and Mental Health partnered on what was identified as the Bright Futures: Promoting Resiliency in Children through Partnerships. This was originally designed to provide a series of regional trainings based on the Bright Futures mental health curriculum and tools to enhance collaboration between local public health nurses, school nurses and counselors and community providers of mental health services. Through consultation and work with Georgetown's Center for Child and Human Development Child Maternal and Child Health three different trainings were provided across the state building on the public health model, family engagement and collaboration. This grassroots effort grew to the development of a multi-agency state strategic team to devise a plan to assist communities in support of schools to address the social and emotional development of children. Through continuous and growing partnerships it has morphed into a major initiative that is now working with communities in providing training, technical assistance and support funding to create continuous surveillance systems that allow a community to identify their mental wellness and health priorities; developing effective policies to address these priorities; and ongoing monitoring systems to assess the real impact of the policies. Children's leadership has attended multiple public health training academies to become immersed in this model and shape its application to children's mental health. The public health model is now being vetted to state mental health leadership to guide the transformation of the mental health system. Several initiatives are looking at how the state can partner with community entities such as children's and/or mental health tax boards to create a connected continuum of care ranging from promotion to prevention, early identification and intervention to enhancing services for youth with significant needs. One model being developed, in partnership with the Department of Elementary and Secondary Education, is in the area of school mental health services in partnering with schools who have implemented Tier 1 of the Positive Behavior Interventions and Supports with fidelity and wish to move on enhancing services at the Tier 2 and Tier 3 levels (Targeted and Intensive respectively).

# Missouri

## Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

There were no legislative initiatives in SFY 2009 and no plans for significant legislation related to children's mental health services in SFY 2010. See Adult Plan section on Legislative Initiatives and Changes for budget information.

# 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.

## **Child - Description of State Agency's Leadership**

The Department of Mental Health, Division of Comprehensive Psychiatric Services has the responsibility of overseeing the operations, and continuous quality improvement of a system of care for youth with serious emotional disorders and their families. In this role, the Division of CPS works closely with the Office of Comprehensive Child Mental Health that addresses cross-divisional and cross-departmental policy issues as well as supports the Comprehensive System Management Team (see below). The Division also partners actively with the Office of Transformation in moving the system towards a public health model.

### **Transforming Children's Mental Health Services**

As fully outlined in previous reports, in 2004 the Missouri General Assembly, recognizing the need to reform children's mental health services and responding to the call of the President's New Freedom Commission Report passed, and the Governor signed, Senate Bill 1003, which required the development of a comprehensive plan for children's mental health services. SB1003 called for the establishment of a Comprehensive System Management Team (CSMT) to provide a structure responsible for interdepartmental children's mental health policy and to act as a linkage between the state and local management structures. Membership is comprised of state child-serving agencies, families, advocacy organizations and local system representatives. To guarantee broad input from Missouri's diverse stakeholders, especially families of children with mental health needs, SB1003 established a Stakeholders Advisory Group (SAG). The SAG is charged with providing feedback to the CSMT regarding the quality of services, barriers/successes of the system, advocacy, public relations for the system, use of data to drive decision-making, and identification of emerging issues. At least 51% of the members represent families and youth.

Senate Bill 501 was passed in legislation in 2005 creating the Office of Comprehensive Child Mental Health within the DMH. Under the Director of DMH and as incorporated into statute through 630.1000RSMO, the Office's mission is to provide leadership in developing and implementing the Comprehensive Children's Mental Health Service System. Staff within the Office is responsible for: leading implementation of the Comprehensive Child Mental Health Services System; preparing an annual report on the status of Missouri's child mental health system; providing staff for the CSMT, SAG and the Comprehensive Child Mental Health Clinical Advisory Council; and providing clinical and system technical assistance and consultation to all departments. The divisions within DMH continue to maintain responsibility for day-to-day operations for their respective populations, and the Division of CPS remains a lead partner with the Office of Comprehensive Child Mental Health.

The DMH received notice in October, 2006 that Missouri had been awarded a Mental Health Transformation State Incentive Grant: Creating Communities of Hope. The model for Missouri's application and plan was based on the work that had been accomplished in the children's system in moving towards a system of care that was based on the public health model. Children's Services within the Division of CPS take an active leadership and partnership role within the implementation of Missouri's Transformation plan. The Proof of Concept for Children's Mental Health is around a state initiative to evaluate the impact of Family Support

services. Other partnerships with the Office of Transformation include the Show Me Bright Futures initiative, Early Childhood, infrastructure development for evidence based practices and creation of trauma-informed systems.

The Department of Mental Health has been the recipient of three SAMHSA Cooperative Agreements for children that have been managed through the Division. Show-Me-Kids in the Southwest region of the state recently graduated. Transitions in the St. Louis Metropolitan area is completing its final work through carryover funds. Circle of Hope is in its third year in the Northwest region of the state focusing on integrating and enhancing physical health and mental health services within the school environment. The Division provides leadership and consultation to these initiatives and works towards expanding the lessons learned to other areas of the state.

### **Collaborative Initiatives**

#### **Strategic Prevention Framework State Incentive Grant**

Missouri's Strategic Prevention Framework State Incentive Grant addresses the prevention of risky (defined as binge and underage) drinking in the age group 12-25. Eighteen local coalitions, one statewide coalition, and one campus-based coalition offer evidenced based prevention programming to their communities, based upon a data-driven assessment of community needs. In addition, coalitions are implementing environmental strategies designed to decrease risky drinking by changing the environment in which the problem behavior occurs. Coalitions are also heavily involved in increasing the capacity of their communities to address alcohol use among youth and young adults. Capacity building efforts include acquiring additional data and resources and building community readiness, cultural responsiveness, and sustainability.

Training is offered to key coalition stakeholders to increase their ability to meet the problem head on. Coalitions participated in the Statewide Prevention Conference in Jefferson City last December. Coalition staff and selected members have attended state and national conferences on prevention, project management, and evaluation. State SPF SIG staff provide technical assistance and monitoring via site visits, monthly reports, telephone conferences, and e-mail.

There were 31 evidence-based programs implemented by the original 18 SPF SIG coalitions during Year 2 (FFY08). Examples of evidence-based programs commonly selected by the coalitions include Positive Action, Guiding Good Choices, and Protecting You/Protecting Me. Of the programs with usable data, 71% had positive outcomes, that is, post-test scores improved over pre-test scores for the majority of participants. There were 35 environmental strategies implemented by the original 18 SPF SIG coalitions during Year 2 (FFY08). Examples of environmental strategies commonly selected by the coalitions are Community Trials Intervention to Reduce High Risk Drinking, Social Hosting Laws, and Responsible Beverage Service Training. Of the strategies with usable data, 66% had positive outcomes, that is, the desired outcomes were achieved. Additional technical assistance has been provided by state staff to local coalition staff in light of the high percentage of strategies with missing or inadequate data.

## Other Collaborative Initiatives

The Division works collaboratively with several departments to meet the needs of children and families.

- Cross-departmental initiative to promote the use of best practices in the prescribing of psychiatric medications and insure better care coordination for children in state custody placed in residential treatment centers;
- Coordinating Board for Early Childhood which is charged with developing a comprehensive statewide long-range strategic plan for a cohesive early childhood system; identify legislative recommendations to improve services for children from birth through age five; promote coordination of existing services and programs across public and private entities; promote research-based approaches to services and ongoing program evaluation; and to identify service gaps and advise public and private entities on methods to close such gaps. Additionally, Division staff chair the workgroup on the Social and Emotional Development for the Early Childhood Comprehensive System Maternal/Child Health Grant.
- The Division has developed a working partnership with the state Medicaid authority, Missouri HealthNet, to improve the quality of services provided to recipients. This has included active participation in the standing Non-Pharmaceutical Prior Authorization Group and participation in clinical audits of Medicaid managed care behavioral health services. Through this partnership providers now have access electronically to services provided to individual consumers to help in the coordination of care.
- CPS continues its collaboration on the Show Me Bright Futures Initiative that was initially developed as a training project but has now blossomed in to the basis of moving to a public health model for children's mental health. The Department received a grant through the Missouri Foundation for Health to work with specific communities to implement the public health model in regards to social and emotional wellness of children.
- CPS continues to partner with Children's Division (child welfare) to improve the Custody Diversion Protocol so that families do not have to voluntarily relinquish custody solely to access mental health services. To date 901 or 96% of the children referred have been diverted from state custody.
- The Division is working with the Office of Transformation/DMH, who has been assigned the responsibility for management of the SAMSHA Transformation Cooperative Agreement, on the proof of concept for Family Support Services. The focus is three-fold: to determine the impact that Family Support Services has on empowering parents as advocates for their child; impact of Family Support on the child with a SED in regards to their functioning in several areas; the impact Family Support has on other children in the family in supporting resilience. Data will also address the types and "dose" of the service.

# Missouri

## Adult - Service System's Strengths and Weaknesses

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

## **Adult – Service System’s Strengths and Weaknesses**

### **Strengths**

Strengths identified by the Mental Health Planning Council were as follows: peer specialist initiative, Consumer/Family/Youth Conference, consumer operated services of warm-line peer phone support and drop-in centers, expansion of evidence based practices, behavioral and medical health collaborations, Mental Health First Aid, RESPECT Seminars, collaboration with other state agencies, emphasis on wellness, disaster training and preparedness, new initiatives on veterans issues, Network of Care website, advocacy, person centered planning grant, mental health champions award and banquet, and anti-stigma public education efforts. (See also sections on Recent Significant Achievements; New Developments and Issues; Planning Council Charge, Role and Activities; and Description of State Agency Leadership.)

### **Evidence Based Practices**

The DMH understands the importance of implementing evidence based practices to assure excellent care is delivered in Missouri. Integrated Dual Diagnosis Treatment (IDDT), Assertive Community Treatment (ACT) and Supported Employment (SE) for adults are the focus for enhancement and fidelity to the evidence based models. The DMH has worked cooperatively with the Missouri Foundation for Health, a private funding source, to provide additional dollars for IDDT services. The foundation has awarded grants to DMH-only providers, both mental health and substance abuse, for co-occurring services in the amount of 4 million dollars per year for 3 years. Currently 20 agencies with 32 locations have been approved for IDDT services with a fidelity review. ACT programs have been funded for six sites in Missouri. Supported Employment services continue in cooperation with Division of Vocational Rehabilitation. The department received a Johnson and Johnson grant. Technical assistance and fidelity to the SE model are being provided through cooperation with the Dartmouth University national experts. Dialectical Behavior Therapy training is occurring throughout the state on both the beginning and advanced level. Illness Management and Recovery is in the beginning stages of development as the division moves the Psychosocial Rehabilitation (PSR) programs to a wellness and recovery focus. An enhanced PSR billing rate is being offered to treatment providers for using the IMR fidelity model of treatment.

### **FQHC/CMHC Initiative**

DMH has focused on the physical health as well as the mental health of consumers. Federally Qualified Health Centers and Community Mental Health Centers (FQHC/CMHC) collaboration is occurring in seven locations statewide to co-locate medical and behavioral health staff. Six agencies received planning grants. A recent May 2009 article published in Psychiatric Services called Mending Missouri details the lessons learned and progress made on this initiative.

### **Integration of Behavioral and Medical Healthcare**

The Health Care Optimization (HCO) project with Medicaid has evolved. HCO is a disease management approach for Medicaid recipients diagnosed with mental illness, who are at highest risk for adverse medical and behavioral outcomes. These complicated patients commonly have combined behavioral and medical care expenditures can be significantly higher than other

Medicaid recipients. HCO technology creates an integrated health profile (IHP) for each patient to:

1. communicate with behavioral health and physical health providers, as well as case managers and other essential care providers;
2. includes comprehensive and current information across medical, behavioral, and pharmacy treatment and provides information to healthcare providers regarding these complex patients' services utilization history, acute care history, pharmacy history and poor treatment adherence history; and
3. includes best practice prescribing guidance and timely medication adherence updates based on pharmacy claims.

The DMH in conjunction with the MO HealthNet Division was awarded the American Psychiatric Association Bronze Achievement Award in 2007 for the nationally recognized Missouri Mental Health Medicaid Pharmacy Partnership Project. It is the only state to ever receive the award. Dr. Joe Parks, the Medical Director for the Department, works with the Department of Social Services on this project that examines the prescribing practices of psychiatrists. Through the partnership, Medicaid pharmacy claims are routinely examined to determine the prescribing patterns of psychiatrists and primary care physicians. The DMH then shares the results of the review along with current best-practice standards to encourage modification of prescribing patterns.

The DMH and MO HealthNet Division Partnership initiative to improve the prescribing of psychiatric medications for all MO HealthNet-eligible individuals saves Missourians \$36 million per year off trend. The project promotes evidence-based prescribing practices to outlier physicians and has significantly reduced pharmacy costs and hospitalizations without resorting to mandatory restriction on medications.

Dr. Joseph Parks is a key contributor to the National Association of State Mental Health Program Directors (NASMHPD) Issue Papers and Technical Reports. As President of NASMHPD Medical Directors Council, he has brought national attention to the report *Morbidity and Mortality in People with Serious Mental Illness*. "The report reviewed the causes of excess morbidity and mortality in this population and made recommendations to improve their care. This increased morbidity and mortality is largely due to treatable medical conditions caused by modifiable risk factors such as smoking, obesity, substance abuse, psychotropic medication side effects, and inadequate access to medical care. Recent evidence reveals that the incidence of serious morbidity (illness) and mortality (death) in the population with serious mental illnesses has increased. In fact, people with serious mental illnesses are now dying 25 years earlier than the general population. That report asserted that State Mental Health Authority (SMHA) stakeholders needed to embrace two guiding principles:

- *Overall health is essential to mental health.*
- *Recovery includes wellness."*

Dr. Parks' recent collaborative effort with NASMHPD includes the reports:

- *Principles of Antipsychotic Prescribing for Policy Makers, Circa 2008. Translating Knowledge to Promote Individualized Treatment*
- *Obesity Reduction and Prevention Strategies for Individuals with Serious Mental Illness*

- *Measurement of Health Status for People with Serious Mental Illnesses*

Dr. Parks is a national speaker on these and other topics and consults with other states on implementing best practices on integration of behavioral and medical healthcare.

### **Consumer Operated Services Programs (COSP)**

The DMH continues its partnership with Missouri Institute of Mental Health to accelerate multi-state Consumer Operated Service Programs (COSP) findings into evidenced-based practice. Jean Campbell, Ph.D. principal investigator of the COSP Multi-Site Research Initiative continues to work with the department to move toward this goal. The department funds, through competitive bid, five drop-in centers and five warm lines.

During the past year utilizing the FACIT (Fidelity Assessment Common Ingredient Tool), the drop-in centers completed a self-assessment for year one. Two consumers at each drop-in center were trained to administer the FACIT. Concurrently, the FACIT was revised as a tool specific to warm lines. This revised tool was field tested on each of the five warm lines.

During the next year with contracts awarded to the same programs, a training curriculum will be developed to train consumer evaluators. Each program will designate a consumer evaluator who will attend training on how to administer the FACIT and, in lieu of self-assessment, the evaluators will administer the FACIT to other programs funded by the department. The overall goal is to develop training designed for drop-in centers and warm line staff on how to implement and maintain a continuous quality improvement process within their programs. Ongoing training is expected to continue throughout the year. The consumer evaluators will be paid a stipend for time spent on this project.

The COSPs have formed a coalition called SCOPE (Supporting Consumer Operated Programs Enhancements). All COSPS participate in a monthly teleconference to share ideas and provide input to the process. Members share the responsibility of facilitating these meetings; developing an agenda, and taking minutes. Members made a presentation at the Real Voices/Real Choices Consumer Conference in August 2009.

Approximately two review on-site visits per program were accomplished by the department in collaboration with MIMH and Jean Campbell. In addition to the 20 review visits, technical assistance has been provided by telephone and email. MIMH maintains a listserv that allows for continued communication and networking of the COSPS.

### **Suicide Prevention**

Since the federal declaration that suicide is a serious public health concern and the accompanying call to action for individual states, Missouri DMH has accepted the responsibility to provide both leadership and technical assistance on mental health promotion within Missouri communities, and has recognized suicide as a leading public health concern. The Missouri delegation to the national suicide prevention conference in Reno, Nevada, completed a state-wide plan of suicide prevention strategies. Implementation has included passing legislation relative to suicide prevention and establishing a Governor-appointed Suicide Prevention Advisor Committee. A subsequent award of a three-year federal grant to prevent suicide in youth up to

age 25 has enabled this high risk group to receive targeted services. DMH utilizes this SAMSHA funding in conjunction with block grant funding to provide state-wide suicide prevention services tailored to local needs and supplemented with local support. Strategies include gatekeeper training, policy change, a focused initiative on college campuses, regional Resource Centers, survivor support groups, promotion of the National Suicide Prevention Lifeline, incentive awards geared to meet local needs, incorporating suicide prevention information in distance learning courses, raising public awareness through print and electronic media, and conferences.

The fourth annual *Show-Me You Care About Suicide Prevention* conference occurred on July 30-31, 2009, and approximately 230 individuals participated. The conference, which was co-sponsored by the Department of Mental Health, Lincoln University and the Missouri Institute of Mental Health helped to increase awareness and education. Attendees included educators, health-care providers, mental health care providers, military personnel, survivors and others. For more information on the suicide prevention activities in Missouri go to <http://www.dmh.mo.gov/cps/issues/suicide.htm>.

### **Prevention**

During 2008, one of the six value statements endorsed by DMH related to Prevention and Early Intervention demonstrating the understanding that emphasizing prevention and early intervention strategies avoids or minimizes the mental health problems of Missourians.

The Office of Prevention within DMH utilizes the Institute of Medicine's definition of prevention including universal, selective and indicated while working with the framework of risk and protective factors. The mission of the Office of Prevention is: "*To enhance the health and well being of Missouri's children and youth, adults, and families through comprehensive approaches that reduce the incidence and prevalence of developmental disabilities; alcohol and drug abuse; and mental illness.*" The Office 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
- 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 and prevention strategies
- Coordinating with prevention initiatives within other state departments.

During 2008, The Office of Prevention acquired and is overseeing the implementation of a grant from the Missouri Foundation for Health to determine the actual tobacco usage for consumers of mental health services. Prevention staff has made presentations on prevention to DMH employees and attendees at the Spring Institute and have emphasized the need for a strong prevention component in the Department's policies and procedures.

Prevention staff has been active in the development of a state-wide plan to prevent child abuse and neglect. A partnership was established with the Missouri Center for Safe Schools and the

Missouri Department of Health and Senior Services to begin a three plan to develop a cadre of individuals certified in the Olweus Bullying Prevention Program throughout the state. With the first training held in Kansas City in April 2008, each new trainers was then available to up to three school buildings that were willing to implement the Olweus syllabus, a SAMHSA model program with demonstrated short term and long term results.

The Office of Prevention has continued to act as a resource for the Department by convening regular meetings with staff from all three Divisions to exchange information and ideas as well as discuss prevention research and the practical application of that research. Prevention staff has been involved in the Transformation initiative and are seeking ways to link prevention initiatives with all aspects of treatment activities. Upcoming Transformation activities will focus on moving the state from the current position of fragmented programming for prevention (often excellent) to a *system of prevention*.

Another Transformation activity targeting prevention is the implementation of Mental Health First Aid, a 12-Hour course to teach members of the public how provide help to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate professional treatment is received or until the crisis is resolved. This evidence based program demonstrates a reduction in stigma, an increase in the amount and quality of assistance given during the crisis time.

Prevention staff was active in a stigma initiative for the Department. This involved establishing an entity called the Missouri Mental Health Foundation as an alternative funding source for private donations, a banquet to celebrate the accomplishments of those individuals who have made significant contributions to their communities, and selecting three individual “Champions” who exemplify accomplishments among us in their daily life and work within communities.

Another focus within Transformation is facilitating a public health approach to mental health. This represents a shift from a focus on the individual to a tactic that is primarily interested in the health of the population as a whole and the links between health and the physical and psychosocial environment. And the public health approach is broader than prevention; strategies encompass Surveillance, Health promotion, Prevention, Evaluation of Services, Risk & Protective Factors.

A focus on prevention involves outlining a long range plan to move from a culture responding to crisis to a culture of prevention. Embedding prevention in policy and practice is a strategy designed to move operations from a reactive mode of operation to one that stresses proactive approaches. In Missouri, as in the rest of the nation, the landscape of family and community life is changing rapidly. Our agencies and institutions are morphing in ways not anticipated a decade ago. Key concerns focus on issues of children and youth. There is significant support for promoting well-being and preventing harmful behavior. DMH has an environment of change that can support prevention.

### **Mental Health Transformation**

The Office of Transformation in the Missouri Department of Mental Health was established to address concerns regarding the state's mental health service delivery system. President George

Bush's New Freedom Commission on Mental Health final report, issued in July 2003, identified weaknesses at the state and federal levels in mental health care, reporting on a system that is "broken and fragmented."

The state of Missouri was awarded a Mental Health Transformation Grant by the Substance Abuse and Mental Health Services Administration for five years, effective October 1, 2006. The five year grant will help support building an infrastructure required for transformation, such as planning, workforce development, evidence-based practice implementation, and technology enhancements. The primary focus of the first year is the development of a Comprehensive State Mental Health Plan by the Transformation Leadership Workgroup.

The Transformation Leadership Working Group, established by Governor Matt Blunt through Executive Order 06-39, includes senior leaders from the departments of Mental Health, Social Services, Health and Senior Services, Corrections, Public Safety, and Elementary and Secondary Education, along with mental health consumers, family members, and other stakeholders. Gov. Blunt named Diane McFarland, former director of the Division of Comprehensive Psychiatric Services in the Department of Mental Health, to serve as workgroup chair. The group's actions were guided by its Initial Work Plan, which outlines its organizational structure and role, as well as its purpose and vision.

More than 230 public and private sector leaders volunteered their expertise in six content workgroups. These workgroups met in 44 half-day meetings in Jefferson City between March — June 2007 to develop recommendations as part of six Transformation content workgroups:

- [Consumer and Family Driven Services](#)
- [Disparities are Eliminated](#)
- [Easy, Early Access](#)
- [Evidenced-based practices](#)
- [Mental Health is Essential to Overall Health](#)
- [Technology](#)

Their recommendations were summarized in [Final Workgroup Recommendations: Report to Transformation Working Group](#). The TWG met in July and August to review these recommendations and develop priorities for the coming year. These priorities were discussed in the 13 public meetings in Missouri in August and September 2007.

The MHTWG has accomplished the initial goals. A plan was been developed and approved by SAMHSA in June 2008. Additionally, a Needs Assessment and Resource Inventory for Mental Health was submitted to and approved by SAMHSA. See Appendix A for both documents.

Since approval of the plan, five cross-departmental implementation work groups chartered by the Transformation Work Group (TWG) have begun their work to lead implementation of some of the Transformation priorities. The groups will focus on Employment, Evidence-Based Practices, Housing, Mental Health and Aging, and Mental Health Promotion and Education. Information about these work groups, their charters, and membership is available on the Office of Transformation web site. The Office of Transformation web site

([www.dmh.mo.gov/transformation/transformation.htm](http://www.dmh.mo.gov/transformation/transformation.htm)) has been reorganized to include a calendar of events and highlights the Show-Me series.

The St. Louis Regional Health Commission's Behavioral Health Steering Committee held the second of three sessions entitled *Seeing the Person, Not the Label*, on August 19, 2008. The series explores issues of cultural competence, stigma, and respect in public and private health settings. A third session, scheduled for October 21, is designed to provide tools for dealing with these issues in the work setting. The group continues to work on a Respect Policy for the region.

Approximately 500 persons have participated in the four-hour community Respect Seminars in eight locations from May through July 2008. Five additional seminars occurred in August and September, and one, four-day Respect Institute is occurred on August 25-28, 2008 in St. Louis.

The first Mental Health First Aid instructor training in Missouri occurred September 28- October 3, 2008 in Jefferson City. Because there are more qualified applicants than training slots (22) available, a second instructor training was conducted. Betty Kitchener, founder of Mental Health First Aid in Australia, assisted with Missouri's trainings.

A consumer, family, and youth leadership summit, with the theme "Real Voices/Real Choices," occurred in the Fall of 2008. The aim of the summit was to bring together individuals and families from within and outside the mental health system to formally launch the Real Voices/Real Choices initiative and serve as a springboard for the statewide conference that occurred in August 2009.

### **Procovery**

Missouri Department of Mental Health is administering statewide implementation of recovery services through the Procovery™ program, following the completion of a successful demonstration pilot and extensive statewide foundational planning. The Procovery™ program, developed by Kathleen Crowley, author and Executive Director of Procovery Institute, emphasizes a hope-centered, forward-focused, and skills-based partnership of the client, the family, the service provider, and the community. It includes eight principles for resilience in healing, 12 strategies for action, and a highly structured system, known as the Procovery Circle, for group training and support.

The Procovery™ program was brought to Missouri in April 2005 as an urban-rural demonstration program in the St. Louis, Farmington, Poplar Bluff, and Kennett regions. The pilot far surpassed initial expectations of eight to 12 Procovery Circles, with 1,075 staff, clients, family, and community members completing full-day core Procovery trainings, and more than 80 Procovery Circles established across diverse urban and rural settings. From June 2005 to June 2007 there have been more than 4,170 Procovery Circle meetings with an average attendance of 8.6 persons.

Evaluation of the demonstration pilot by the Missouri Institute of Mental Health concluded that the Missouri Procovery Demonstration Program was a promising catalyst of system transformation. The success of Procovery Circles to instill hope and a forward focus among mental health consumer members means that statewide implementation of this program could

facilitate progress towards an integrated system response to growing demands from consumers for recovery-based services and supports to secure jobs, housing, and training.

The Director of Community Services Operations for CPS, is leading the newly established CPS Missouri Procovery™ program development team. An intensive planning process was instituted in 2007 to identify the lessons learned from the first year of implementation, and to establish an institutionalization process that cost-effectively would take advantage of agency strengths and address areas of weakness. This planning was central to ensuring fidelity and accountability as CPS expands and institutionalizes this innovative program. Two important areas of focus in the 2008 were (1) using Procovery as a vehicle for front-line training and retraining in recovery and engagement principles and techniques, to support both staff and those they serve; and (2) piloting Procovery as a vehicle for medical and behavioral health integration and collaboration. An added element was developing continuing education units for Procovery Circle Facilitator meetings, which provide ongoing training, coaching, and mentoring to build a continually growing base of trained facilitator expertise across Missouri.

More information on the Procovery™ program in Missouri is available at [www.procovery.com](http://www.procovery.com).

### **Office of Consumer Affairs**

The Missouri Department of Mental Health has a Director of Consumer Affairs. The individual is a former consumer of mental health services and has brought a consumer driven services focus to the position.

### **Crisis Intervention Teams**

Jail diversion programs were piloted including Police Crisis Intervention Teams (CIT) in the greater Kansas City and St. Louis areas. The DMH was the recipient of a SAMHSA Targeted Capacity Expansion (TCE) Jail Diversion grant that provided the foundation of a pre and post booking jail diversion program in St. Louis County. Kansas City has also been awarded a SAMHSA TCE Jail Diversion grant and coordinates the program with the local community mental health center. CIT training in Kansas City, Lee Summit and St. Louis City and County, has resulted in hundreds of law enforcement officers being certified as CIT officers.

More than 1,500 local police officers across the state have voluntarily participated in Crisis Intervention Team (CIT) training, allowing officers to better respond to persons in crisis due to mental illness and to get them to treatment, as opposed to arrest and incarceration. CIT officers have responded to more than 7,400 mental health crisis calls with an arrest rate below 5%.

### **Disaster Services**

The Department of Mental Health as the public mental health authority leads the mental health response to disasters within Missouri. The Department continues to plan for its own facilities and for a statewide response. In addition, DMH is working cooperatively with other state agencies to plan for disasters and public health emergencies as well as to develop and provide training. This has led to earlier screening for mental health issues in first responders and survivors of disasters.

### **Network of Care Website**

The DMH contracted for a state-wide “Network of Care” web-based system to facilitate consumer information and access to mental health services. The Missouri Governor launched the Network of Care website in 2006 at the State Capitol and it continues to be enhanced and promoted.

### **Increasing Housing Options For DMH Clients**

Many DMH consumers require housing supports to reduce stays in institutional and residential treatment and to avoid homelessness. Between 2005 and 2007, the DMH Housing Unit leveraged approximately \$12 million for home rehabilitation, construction, and rent subsidies for DMH consumers. DMH also administered federal Shelter Plus Care grants exceeding \$16.8 million for more than 1,250 individuals. The rate of homeless individuals maintaining stable housing for longer than a year increased from 68% to 75%. The DMH Housing Team was recognized by HUD in 2006 with its Best Practices Award for its efforts on behalf of DMH consumers.

### **Services to Families of Veterans**

In SFY 2009, the legislature approved dollars for the DMH to provide counseling services to families of Veterans. Training was conducted in September 2008 for the staff identified in specific CMHCs to familiar them with issues facing Veterans and their families. BATTLEMIND curriculum was chosen for implementation.

The DMH Housing Unit also administers in partnership with St. Patrick Center in St. Louis a Veteran’s Administration Grant Per Diem program. The grant provides transitional housing and supportive services for 50 homeless veterans with mental illness and/or substance abuse issues.

### **Weaknesses**

The DMH recognizes that collecting and using meaningful data is a challenge. The DMH is developing the Customer Information Management, Outcomes, and Reporting (CIMOR) management information system. The CIMOR system should allow for easier collection of consumer specific data and usable reports.

Some of the weaknesses mentioned by the Mental Health Planning Council were as follows: lack of adequate mental health professionals (i.e. psychiatrists, nurses, etc.) in rural areas, lack of public transportation in rural areas, lack of child psychiatrists, and disappointment in legislature not funding the budget item to enhance school based mental health.

# 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.

## **Adult – Unmet Service Needs**

**Financial limitations** continue to cut into the administration of State mental health services. The Missouri DMH goal is to prevent or minimize cuts to core funding affecting direct consumer care. Missouri's current economic condition will prove problematic in the coming fiscal year. Annual state revenue growth in SFY 2010 continues to be lower than projected. The Legislature cut the core FY 2010 budget for CPS by \$500,000. Given the above, DMH and its advocates should not expect SFY 2011 DMH budget to be comparable to SFYs '08 and '09. With the limited funding, maintaining adequate coverage for psychiatric care has been an issue, especially in rural areas.

DMH's Executive Team, with support from the Mental Health Transformation Initiative, has identified the following key themes for SFY 2011:

1. Timely access to mental health services—getting immediate help to those in need;
2. Increasing the mental wellness and productivity of all Missourians—a population based public mental health approach;
3. Preserving the mental health safety net—assuring safe, high quality mental health services and supports;
4. Increasing public support and understanding for people and their families who suffer from addiction disorders, developmental disabilities and mental illnesses; and
5. Re-designing services for individuals inappropriately served in Missouri nursing homes.

# Missouri

## Adult - Plans to Address Unmet Needs

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

## **Adult – Plans to Address Unmet Needs**

### **Goal 1: Americans Understand that Mental Health is essential to Overall Health**

#### **Need for Better Mental Health and Medical Service Interface**

Seven sites (each site includes one CMHC and one FQHC in collaboration) were selected to implement a budget item funded through State General Revenue. The Department is working with the Community Health Centers on integrated services through a collaborative process to target the uninsured population. Doctors and Family Practice Nurses are located at the CMHC for primary care clinics for the uninsured. Targeted Case Manager/Community Support Workers are located in FQHC for behavioral health referral/linking/support. Seven sites have been funded for three years for co-location of services and six sites received one-time funding for planning.

### **Goal 2: Mental Health Care is Consumer and Family Driven**

#### **DMH Facilities Efforts to Move Residents to Community Placement**

The DMH has prioritized moving difficult to place residents from hospital to community placement. A critical need exists in long-term care facilities for a subset of consumers whose clinical needs exceed the capacities of existing services in the community, but who do not present a significant public safety risk. Many have already failed previous attempts at community placement and were returned to the hospital. Additionally, some continue to pose some risk of engaging in problematic behaviors that would be unacceptable in existing community placements. Thus, a gap has been identified within our current array of services. Specifically, the gap is that DMH does not offer community-based residential alternatives with high enough levels of oversight and supervision as well as intensive treatment and rehabilitation opportunities for such individuals. As a result, these consumers are required to remain in state hospitals for prolonged periods of time, the most costly alternative, until they are determined to be ready for release to existing community services.

One solution for assisting these individuals with returning to the community safely and successfully is the development of Transitional Community Programs (TCP's) to fill the gap between state hospital settings and existing community services. Such programs will provide higher levels of oversight and supervision than is typically provided currently in community settings and also will meet the special clinical needs of such consumers. These programs will afford opportunities to consumers who do not pose a risk to public safety, but who do not meet the criteria for release to existing community services. These consumers often continue to exhibit challenging behaviors and ongoing symptoms; however, with adequate staffing, oversight, and intensive clinical services could live in the community safely. TCP's could not only serve to assist consumers with transitioning from state hospitals to the community, but also could avoid unnecessary re-hospitalizations by providing a temporary alternative setting for consumers currently in the community who are in danger of returning to inpatient care due to their clinical status or need for increased supervision.

The Division of Comprehensive Psychiatric Services has developed and is implementing a Transitional Community Program. While the Department envisions a statewide system, the approach is piloting in a limited number of sites. Treatment services will be provided within the Assertive Community Treatment model to allow intensive services for these high need consumers. An Application for a Demonstration Project was issued and a program is starting in the Northwest region of the State. CPS is exploring other potential sites that are contiguous to state hospitals.

### **Goal 3: Disparities in Mental Health Care are Eliminated**

#### **Special Populations With Unmet Mental Health Needs**

- **Missouri Seniors**

In response to these debilitating effects of depression in older adults, the Mental Health and Aging Workgroup voted to encourage the development of Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), an evidence-based intervention effective with both major and subclinical depression. To this end, the Workgroup, with assistance from Washington University, is sponsoring an informational forum to be held in September 2009. Nancy Wilson (Baylor School of Medicine) and Alixe McNeill (VP, National Council on Aging), both leading lights in the development and dissemination of Healthy IDEAS, will be explaining the program at this statewide meeting of agencies that might be interested in implementing Healthy IDEAS. Through a competitive process, agencies wanting to implement Healthy IDEAS will be provided with resources to defray many of the startup costs associated with the program. Also, funds may be available to assist with the clinical component of the program. Specifics will be explained at the forum. These resources will be made available through funds from the Mental Health Transformation State Incentive Grant program and the Division of Comprehensive Psychiatric Services.

- **Missouri Military Personnel Involved in the Iraq and Afghanistan War**

DMH has been meeting with representatives from Veteran's Affairs to coordinate mental health services for Veteran's and their families. The VA identified services to families of veteran's as a gap in their services. DMH requested a fiscal year 2009 budget item for Services to Families of Veterans. Specialized services are available for family members (parents, spouses, and children) of all branches of the National Guard and Reserve Components who are awaiting or have returned from deployment to Operation Enduring Freedom (Afghanistan), Operation Iraqi Freedom or Kosovo. These services are also available to discharged active duty veterans from these three operations. Therapy sessions are provided by licensed mental health professionals who are trained to understand the impact of deployment on families. All clinicians are trained in BATTLEMIND, allowing them to focus their attention on the unique service needs of families and veterans.

The FY 2009 budget request included a Veteran's Housing Initiative. This funding allows for housing assistance for Missouri's Veterans. The Veteran's Affairs Grant allows the Department to apply for a Homeless Providers Grant and per diem program, from the Department of Veterans Affairs, to fund community agencies providing an array

of services to homeless veterans. An additional Rental Assistance and Housing Coordination component provides rental assistance and housing coordination for disabled veterans that are engaged in services at targeted areas around the state.

The DMH co-sponsored a successful conference in March 2007 titled *Mental Health Needs of Returning Soldiers and Their Families*. Nationally recognized speakers:

1. Provided theoretical overview and hands-on treatment practicum in dealing with treatment of returning soldiers and their families.
2. Identified current mental health issues of returning soldiers and their families.
3. Developed a plan for additional services to meet the current and future mental health needs of returning soldiers and their families.

#### **Goal 4: Early Mental Health Screening, Assessment and Referral to Services is Common Practice**

##### **Need to Link Critical Mental Health Services to other Human Service Programs**

DMH and Department of Corrections (DOC) are working on coordinated discharge planning and access to community treatment services on discharge from incarceration. DOC in collaboration with DMH has identified money for CMHCs to provide services to mentally ill persons for pre-release planning and intake screening of persons with serious mental illness being discharged from correctional facilities. CPS has added a new service code to the CMHC contracts to pay for services prior to discharge from prison.

The new service activities for Intake Screening-Corrections include the following:

1. Orientation of the inmate and solicitation of enrollment in the project.
2. Conducting an intake session, reviewing inmate history of mental health services and medications prior to and during incarceration, and providing clinical information to CMHC psychiatrists and other clinicians who will serve the transitioning inmate upon release.
3. Participation in the development of transition plans with the inmate and correctional treatment staff.
4. Scheduling immediate services for the offender to receive from CMHC staff during the first week following release.

#### **Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated**

##### **System Quality of Care Issues**

Assertive Community Treatment (ACT) is a necessary part of the service array to serve a specific portion of adults with the most serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring alcohol and drug diagnoses, 3) have involvement with the criminal justice system, and 4) are homeless/unstably housed. Planning meetings occurred with treatment providers to work out implementation issues. Six agencies are currently contracted to provide ACT. The agencies have developed their teams and have enrolled consumers. DMH has worked with agency staff to identify the high end users of crisis services. Over the next two years, DMH will work on implementing and expanding the number of teams using the ACT model. A Missouri

variation of the Comprehensive Outcome Measure Program is being used to measure client outcomes on a quarterly basis. Experts from the field such as Michelle P. Salyers, Ph.D., from the ACT Center of Indiana, have made numerous technical assistance visits to Missouri. Additionally, members from each ACT team and CPS employees have shadowed ACT teams in Minnesota to observe how ACT is implemented.

### **Co-Occurring Psychiatric and Substance Use Disorders Treatment**

CPS has encouraged the community mental health centers to adopt this evidence based practice by offering new billing codes for co-occurring treatment. The codes allow for flexibility of services based on individual consumer need even though new monies are not available. The new Medicaid approved billing codes are for co-occurring individual counseling, co-occurring group education and group counseling and a supplemental assessment for substance abuse disorders. Twenty agencies with 32 locations statewide have committed to implementing IDDT to fidelity of the model. CPS staff has visited each program to review the baseline fidelity. The second round of fidelity visits has begun. CPS will continue to conduct fidelity reviews on an annual basis and require action plans from the agencies for planning on full fidelity.

### **Supported Employment**

Meaningful work experiences are often central to an individual's recovery process. Thus, in order to most effectively assist consumers in realizing their employment goals providers must collaborate with Division of Vocational Rehabilitation (VR) vendors to offer evidence-based supported employment services. Using the SAMHSA toolkit and the Dartmouth University experts to facilitate the development of such services, CPS plans to implement system change. The guiding principles for supported employment services for individuals with psychiatric disorders are:

- Eligibility is based on consumer choice.
- Supported employment is integrated with treatment.
- Competitive employment is the goal.
- Job search starts soon after a consumer expresses interest in working.
- Follow along supports are continuous.
- Consumer preferences are important.

The goal of CPS/VR is to provide CPRP clients with the choice to be employed in the competitive workforce. Strategies are being explored and developed to increase application of the Supported Employment evidence based practices.

## **Goal 6: Technology is used to Access Mental Health Care and Information**

### **Customer Information Management, Outcomes and Reporting (CIMOR) System**

The CIMOR system has been built to provide stakeholders better access to data and provide information for performance measurement. While DMH was originally funded to implement the system internally, the provider system was in need of additional dollars to upgrade their information systems. The department received new general revenue state funds for "Technology Enhancements for Community Providers." Each community

provider received additional funding in FY2008 to upgrade their information system (both software and hardware), improve data integrity, and hire or staff Information Technology consultants and personnel to move forward with the CIMOR initiative.

### **Behavioral Pharmacy Management**

Pharmacy claims from the Division of Medical Services are transmitted to Comprehensive NeuroScience for monthly analysis to identify the prescribing patterns falling outside nationally recognized best practice guidelines. The number of prescribers, both psychiatrist and primary care, mailed to monthly will vary from 1500-3000 a month. Prescribers receive a letter identifying areas of prescribing concern, patient specific information, and care considerations recommending evidence based alternative prescribing approaches. The project alerts all Missouri physicians whose patients whose patients were prescribed multiple drugs of the same chemical class concurrently from different physicians. Prescribers also receive a report of all psychiatric medications their patients have received in the previous 90 days including dates, dosage, prescriber (including those other than themselves) and dispensing pharmacy. Prescribers are offered telephone consultation by psychiatrists with specific psychopharmacology expertise. This program will also provide information regarding prescribing practices to community mental health centers, nursing homes, and long-term care pharmacies.

### **Health Care Optimization**

The Health Care Optimization (HCO) project with Medicaid has evolved. HCO is a disease management approach for Medicaid recipients diagnosed with mental illness, who are at highest risk for adverse medical and behavioral outcomes. These complicated patients commonly have combined behavioral and medical care expenditures can be significantly higher than other Medicaid recipients. HCO technology creates an integrated health profile (IHP) for each patient to:

1. communicate with behavioral health and physical health providers, as well as case managers and other essential care providers;
2. includes comprehensive and current information across medical, behavioral, and pharmacy treatment and provides information to healthcare providers regarding these complex patients' services utilization history, acute care history, pharmacy history and poor treatment adherence history; and
3. includes best practice prescribing guidance and timely medication adherence updates based on pharmacy claims.

# 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.

## **Adult - Recent Significant Achievements**

DMH has had many recent significant achievements highlighted below. See also the Adult New Developments and Issues section.

**Mental Health Transformation** - Mental Health Transformation is underway in Missouri to move forward with recommendations described in the President's New Freedom Commission Report. A Transformation Leadership group was appointed by the Governor. Six working groups were formed and met on each New Freedom Commission goal. Public meetings were conducted statewide and a final plan was submitted and approved by SAMHSA in June 2008. RESPECT Institutes facilitated by Joel Slack have occurred statewide with the purpose of reducing stigma and increasing acceptance of recovery. Mental Health First Aid has also been adopted and rolled-out.

**Integration of Behavioral and Medical Healthcare** – DMH has focused on the physical health as well as the mental health of consumers. FQHC/CMHC collaboration is occurring in seven locations statewide to co-locate medical and behavioral health staff. Six agencies received planning grants.

The Health Care Optimization (HCO) project with Medicaid has evolved. HCO is a disease management approach for Medicaid recipients diagnosed with mental illness, who are at highest risk for adverse medical and behavioral outcomes. These complicated patients commonly have combined behavioral and medical care expenditures can be significantly higher than other Medicaid recipients. HCO technology creates an integrated health profile (IHP) for each patient to:

1. communicate with behavioral health and physical health providers, as well as case managers and other essential care providers;
2. includes comprehensive and current information across medical, behavioral, and pharmacy treatment and provides information to healthcare providers regarding these complex patients' services utilization history, acute care history, pharmacy history and poor treatment adherence history; and
3. includes best practice prescribing guidance and timely medication adherence updates based on pharmacy claims.

**Evidenced Based Practices** – DMH has focused on implementing multiple EBPs statewide with a focus on measuring fidelity to the models. The EBPs include IDDT, ACT, Supported Employment, and DBT. Illness Management and Recovery is the most recent EBP promoted statewide. An enhanced psychosocial rehabilitation reimbursement rate has been implemented for community mental health centers. Medically necessary activities using the IMR model and other manualized approaches to wellness can receive the higher billing rate.

**Trauma-Informed Care** – CPS hired a staff person to focus on implementation of the evidence based practice of Dialectical Behavior Therapy (DBT). She has trained 1750 individuals in the two-day DBT introductory training and 286 individuals in the advanced DBT training.

**Suicide Prevention** - The DMH continues to implement suicide prevention services according to the legislative mandates and grant guidelines. The Suicide Prevention Advisory Committee has met regularly and is taking action. The group has supported efforts on college campuses as well as directing the Department to work collaboratively with federal initiatives to prevent suicides among veterans. Annual Suicide Prevention Conferences have brought in national speakers.

### **National Awards for Excellence and Innovation**

Missouri's mental health providers are frequently honored by their home communities for contributions - the awards are too numerous to list. Included here is a partial listing of the national awards that the Department of Mental Health and community mental health centers have received in the past few years.

- **American Psychiatric Association Bronze Achievement Award- Behavioral Pharmacy Management Program; Missouri Mental Health Medicaid Pharmacy Partnership Project – 2006** In recognition of a groundbreaking program that continuously monitors statewide Medicaid pharmacy data and provides feedback to prescribers, encouraging them to modify their prescribing patterns to achieve best-practices standards
- **SAMHSA Science to Service Award -2008** Since 2003, the Behavioral Pharmacy Management Program (BPM) has been improving the psychiatric medication prescribing practices of thousands of Missouri physicians. The improved prescribing has resulted in better adherence, reduced inappropriate medication usage and reduced hospitalizations for many thousand patients and saved millions of dollars in healthcare costs. Behavioral Pharmacy Management (BPM) developed by a public private partnership between Missouri Department of Mental Health, Missouri Medicaid, and Comprehensive Neuroscience, Inc (CNS) utilizes the evidence based medicine approach of applying the available evidence for a specific individual clinical decision point in a manner consistent with physician and patient values. The intervention is educational, voluntary and protects patient-physician autonomy in making individual clinical decisions.
- **Utilization Review Accreditation Commission (URAC) 2008 Best Practices in Consumer Empowerment and Protection Award** to Missouri Department of Mental Health, Missouri HealthNet, Comprehensive NeuroScience, Inc. and Eli Lilly and Company as Silver Award winners in the Health Information Technology category for the Behavioral Health Pharmacy Management (BPM) program. The program also received an Honorable Mention Award in the Integrated Care Coordination category.
- **Tri-County Mental Health Services (Kansas City Area) – Drug Enforcement Administration Special Agent Michael Scalise** in 2009 presented Amy Tusso, a certificate of appreciation from the DEA for Tusso's leadership efforts in combating substance abuse in the Liberty area community. Tusso is the chair of the Liberty Alliance for Youth (LAFYI) and prevention coordinator for the Liberty School District. Comprised of community volunteers, LAFYI is funded with the support of Tri-County Mental Health Services.

- **Truman Medical Center Behavioral Health** (Kansas City) – Awarded the 2009 National Association of Public Hospitals and Health Systems (NAPH) President’s Vulnerable Population Award.
- **Swope Health Services** (Kansas City) – In 2008 received national recognition from the National Center for State Courts (NCSC) for the Jackson County Mental Health Court Diversion Program. Programming is located within Kansas City Municipal Court, Lee’s Summit Municipal Court and the Jackson County Circuit Drug Court. Mental Health Court was subsequently selected for inclusion in the NCSC research project funded by the Bureau of Justice Assistance (BJA).
- **Burrell Behavioral Health** – (Central and Southeastern Missouri) 2008 (awarded in 2009) SAMHSA, Science and Service Award from the Department of Health and Human Services for our efforts with Integrated Dual Disorders programming within both our adult transitional services and homeless services programs in Springfield and Columbia; National Council of Behavioral Healthcare Award of Excellence --- Community Provider; National Council of Behavioral Healthcare Award of Excellence --- Children’s Continuum of Care; National Council of Behavioral Healthcare Award of Excellence --- Lifetime Achievement Award for CEO.
- **Independence Center** (St. Louis) –Eli Lilly Reintegration Award in 2000. They also received a 2008 Focus St. Louis “What’s Right with the Region” Award for Improving Racial Equality and Social Justice. Their new facility was recognized by the Landmarks Association of Greater St. Louis for Best Adaptive Reuse of a Historic Property.

### **Journal Articles, Reviews, and Commentary**

Missouri’s mental health professionals are active in the research needed to move our system forward. These experts are the drivers between science and implementation. Here is compilation of some of the journal articles, reviews, and published commentary for the past five years by the authors who are active in Missouri.

- **Mending Missouri’s Safety Net: Transforming Systems of Care by Integrating Primary and Behavioral Health Care** – Schuffman, Druss, Parks
- **Government Perspective** –Joe Parks, M.D
- **Implementing Practice Guidelines: Lessons from Public Mental Health Settings** – Joe Parks, M.D.
- **Impact of the CATIE Findings on State Mental Health Policy**- Parks, Radke, Tandon.
- **Program and System Level Interventions to Address Tobacco Amongst Individuals with Schizophrenia**- Ziedonis, Parks, Zimmerman, McCabe.
- **Smoking Cessation in Patients with Psychiatric Disorders**- Gelenberg, deLeon, Evins, Parks, Rigotti
- **Attention Shaping: a Reward-Based Learning Method to Enhance Skills Training Outcomes in Schizophrenia** –Silverstein, Spaulding, Menditto, Savatz, Liberman, Berten, and Starobin.

- **Trajectories of Seclusion and Restraint Use at a State Psychiatric Hospital-** Beck, Durrett, Stinson, Coleman, Stuve, Menditto.
- **The Use of Logistic Regression to Enhance Risk Assessment and Decision Making by Mental Health Administrators-**Menditto, Linhorst, Coleman, Beck
- **Collaboration in Action- The Discipline of Managing Value in Collaborative Health Care** Schaible, Thomlinson, Susan
- **Building a Stronger Workforce in Rural America-**Brian Martin, MBA
- **Differences Between Urban and Rural Cultural Competency Issues in Missouri-** Thomlinson, Maples, Rimel
- **Using Best Practices to Manage Psychiatric Medication Under Medicaid-** Parks, Surles
- **Pharmacy Costs: Finding a Role for Quality-** Ning, Dubin, Parks
- **When is Antipsychotic Polypharmacy Supported by Research Evidence: Implications for QI -** Goren, Parks, Ghinassi, Milton, Oldham, Hernandez, Chan, Hermann
- **Implementation of Monitoring and Management Guidelines for Second-Generation Antipsychotics –**Michael J. Sernyak, M. D.
- **Missouri Mental Health Medicaid Pharmacy Partnership Project-**A successful Partnership to Improve Prescribing Practices.
- **Impact of Staff Attention on Predicting Post-Discharge Community Tenure of Psychiatric Inpatients-**Coleman, Paul, Schatschneider
- **Restructuring for Partnerships Between Disability and Generic Service Systems: Mental Health and Vocational Rehabilitation; Mental Health and TANF –** Virginia Selleck, Ph.D.
- **A preliminary study on findings of psychopathy and affective disorders in adult sex offenders-**Stinson, Becker, Tromp
- **Self-Regulation and the Etiology of Sexual Deviance: Evaluating Causal Theory-**Stinson, Becker, Sales
- **Assessing Sexual Deviance: A Comparison of Physiological, Historical, and Self-Report Measures-**Stinson, Becker
- **The State of the Art: Psychiatric Rehabilitation As it Ought to Be -- Principles and Practice of Psychiatric Rehabilitation, An Empirical Approach By Patrick Corrigan -** Virginia Selleck, Ph.D.
- **Tipping the Balance Toward Strength?** R. Paul Thomlinson's review of *Investing in Children, Youth, Families and Communities: Strength-Based Research and Policy*. Maton, Schellenbach, Leadbeater, and Solarz.
- **Are the Kids Alright?** R. Paul Thomlinson's review of *America's Teenagers-Myths and Realities: Media Images, Schooling, and the Social Costs of Careless Indifference*, Nichols and Good

# 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.

## **Adult – State’s Vision for the Future**

The Missouri Department of Mental Health will continue to transform and *Create Communities of Hope*. Much progress has been made in the past year that will continue over the next several years. Missouri is committed to meeting and exceeding the expectations of the New Freedom Commission goals. The Comprehensive State Mental Health Plan will guide the Department over the next five years. See Appendix A for the Mental Health Transformation Action Plan Update. Implementation of the plan will build upon successful services and initiatives already provided.

Missouri’s mental health system wants to transform 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.

The department envisions consistent state-wide implementation of evidence-based practices at a high level of fidelity to the SAMHSA toolkits. As Integrated Dual Disorders Treatment, Supported Employment, Assertive Community Treatment, Dialectical Behavior Therapy and Illness Management & Recovery expand to additional agencies, the need to enhance data systems to measure progress continues to be crucial. As this implementation unfolds, the department will continue to require agencies to develop individualized person-centered treatment plans in conjunction with the consumers. Only through individualized treatment planning driven by the consumers and families can recovery be achieved.

# Missouri

## Child - Service System's Strengths and Weaknesses

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

## **Child - Service System's Strengths and Weaknesses**

### **Strengths**

See Child Plan sections New Developments and Issues, Description of State Agency's Leadership and Recent Significant Achievements for additional details on service system strengths.

#### **CAFAS**

The Child and Adolescent Functional Assessment Scale (CAFAS) is designed to measure impairment in the day-to-day functioning in children and adolescents in kindergarten through the 12<sup>th</sup> grade who have, or are at risk for emotional, behavioral or psychological problems. There are 8 subscales on the CAFAS measuring functioning at home, school/work, community, behavior towards others, moods/emotions, self-harm, thinking and substance use. In addition to the scales noted above, the CAFAS includes two Caregiver subscales that assess how the child's material needs are met and the family's psychosocial resources relative to the child's needs. With the use of the CAFAS strengths and goals can also be identified that culminate in the creation of a treatment plan tied to the child's specific needs and strengths. Implementation of the CAFAS to determine eligibility in the intensive-community based services (Children's Community Psychosocial Rehabilitation/CPR) became statewide in January of 2009 and is accessible electronically to all division providers. The intent was to move towards basing eligibility more on functional impairments as opposed to purely diagnostic criteria. The treatment plan generated by the CAFAS has been approved for use by the Division. Although still working on insuring valid data input, reports can and are being generated at the state level to begin the use of the CAFAS in Quality Improvement Initiatives. Individual providers are using the CAFAS to assess progress in treatment, classify cases to guide specific treatment protocols, creation of a treatment plan, to aid in determination of service need or level of care and as an outcome measure. Agencies are also beginning to use this for continuous quality improvement to insure effective and meaningful services for children/adolescents are provided. The CAFAS is one of the outcome measures for the SAMHSA Children's Proof of Concept to measure the impact of Family Support (see below) on children's functioning. The Division will also begin training this year on the Preschool and Early Childhood Functional Assessment Scale as we begin to develop services for young children.

#### **Family Support**

This service focuses on the development of a support system for parents of children with serious emotional disorders. Activities are directed and authorized by the child's treatment plan. Activities include: assisting and coaching the family to increase their knowledge and awareness of the child's needs; enhance problem solving skills, provide emotional support; disseminate information; linkage to services and parent to parent guidance. The individual providing family support works closely with the wrap around facilitator and care coordinator to obtain outcomes at the family level.

This service was added to our Community Psychiatric Rehabilitation Program in January 2008 to be eligible for funding under Medicaid. This year concerted efforts have been directed towards developing core curriculum and competencies for Family Support Workers and offering

statewide trainings to Family Support Workers and agency supervisors to integrate this service into the continuum of care. Quality and fidelity will be monitored through the CPR certification process.

### **Treatment Family Home**

Comprehensive Psychiatric Services (CPS) is in the process of refining and enhancing their Treatment Family Home model. While Treatment Family Homes has been a key community based service within CPS for many years, its implementation and funding mechanisms have varied across the state. The leadership, marketing, and referral process is also diverse.

In order to provide a more consistent, cohesive Treatment Family Home (TFH) service across the state, CPS is redesigning its model to maximize therapeutic effectiveness while minimizing restrictiveness through consultation with Mary Grealish, M.Ed., Community Partners, Inc. The main focus is to switch to a more professional model with active treatment implementation and management through the TFH. This year the Division has worked on development of the Missouri “Toolkit for Treatment Family Home Care” and revising and updating contracts consistent with the toolkit. In this next year the Division will certify Treatment Family Home train-the-trainers and provide training to providers on the “Toolkit”. Additionally implementation of the toolkit will be monitored through CPS annual compliance review.

### **Quality Service Review**

As a mechanism to measure the development and implementation of a high quality service system based on system of care principles and practices Missouri selected the Quality Service Review (QSR). The QSR, designed by Dr. Ivor Groves and adapted to Missouri, measures the quality of interactions between frontline practitioners, children and their families and the effectiveness of the services and supports provided. This process has a strong history in Missouri as it has been used by the Department of Social Services (DSS) for Practice Development Review (PDR).

The process used for measurement is a qualitative evaluation method that uses two primary sources of information, in-depth child qualitative reviews and stakeholder interviews, to assess the effectiveness of the system as well as its impact on children and families who are being served by the System of Care (SOC) in meeting their treatment, behavioral and educational objectives and goals. The QSR basically outlines and measures the implementation of the state’s model of practice for children’s mental health. To test the system, a sample of children is drawn from the children currently being served by the system of care and trained reviewers review the record and conduct interviews with the child, parent, and other people and agencies that are providing services to the child. In addition, the review team leader conducts focus groups with parents, staff from the child-serving agencies, SOC leadership, and Family Court. During the focus groups, the team leader gathers information about how effectively the agencies work together, how satisfied parents are with how the system performs, and how well frontline therapists and staff are able to accomplish their jobs. The focus groups also identify the barriers they encounter in either receiving services or in delivering appropriate services.

The QSR has been applied to areas of the state in which a sanctioned system of care team functions. The results of the review are shared with the community stakeholders as well as with

the SOC team to guide the focus of community priorities in enhancing the system of care. All results are forwarded to the state Comprehensive System Management Team (CSMT) to identify strengths and weaknesses and to inform future policy development related to funding, practice and coordination. Although funding to support this review process is remains tenuous, the CSMT has confirmed their view that the QSR is the guiding light to the status of the system and will guide their work in future policy and practice development.

### **Public Health Model of Children's Mental Health**

The Division's Children's Services has led the way for the Department in examining and implementation of a public health model. This was initiated through a partnership with the Department of Health and Senior Services four years ago to implement a training initiative for school nurses on mental health issues. Through continuous and growing partnerships it has morphed into a major initiative that is now working with communities in providing training, technical assistance and support funding to create continuous surveillance systems that allow a community to identify their mental wellness and health priorities; developing effective policies to address these priorities; and ongoing monitoring systems to assess the real impact of the policies. Children's leadership has attended multiple public health training academies to become immersed in this model and shape its application to children's mental health. The public health model is now being vetted to state mental health leadership to guide the transformation of the mental health system. Several initiatives are looking at how the state can partner with community entities such as children's and/or mental health tax boards to create a connected continuum of care ranging from promotion to prevention, early identification and intervention to enhancing services for youth with significant needs. One model being developed, in partnership with the Department of Elementary and Secondary Education, is in the area of school mental health services in partnering with schools who have implemented Tier 1 of the Positive Behavior Interventions and Supports with fidelity and wish to move on enhancing services at the Tier 2 and Tier 3 levels (Targeted and Intensive respectively).

### **Suicide Prevention**

The Missouri Suicide Prevention Project continued to combine funding from the Federal Block Grant with that of the State Youth Suicide Prevention Grant from SAMHSA to operate the seven Regional Resource Centers around the state. These Regional sites experienced their most successful period to date, during this grant year. All sites saw a large increase in the number of inquiries and requests for services. In addition to providing gatekeeper training the sites continued to offer a wide range of other services, including survivor support groups, depression screenings, facilitating local coalitions, etc.

As the end of their contracts approached it appeared that many of the sites would be able to offer at least a limited amount of continued services. However out of necessity most sites were intending to greatly scale back their service area, leaving a majority of counties across the state without a provider for these services. Since October 2008, the Suicide Prevention Project has awarded new contracts and expanded the number of regional sites to 14. Establishing additional service providers around the state will ultimately benefit all counties, especially the most rural ones, beyond the contract period.

During the grant year over 600 gatekeeper training presentations were conducted to nearly 9,000 individuals. These sessions ranged from the one-hour QPR (Question, Persuade & Refer) program to the two-day ASIST (Applied Suicide Intervention Skills Training) workshop.

The National Suicide Prevention Lifeline was heavily promoted through the distribution of magnets, stickers, wallet cards and a new billboard campaign.

260 people attended the “*Show-Me You Care About Suicide Prevention*” conference held in Jefferson City on July 14, 2008. The conference, which was co-sponsored by the Department of Mental Health, Lincoln University and the Missouri Institute of Mental Health helped to increase awareness and education. Attendees included educators, health-care providers, mental health care providers, military personnel, survivors and others. The fourth annual *Show-Me You Care About Suicide Prevention* conference occurred on July 30-31, 2009, and approximately 230 individuals participated. For more information on the suicide prevention activities in Missouri go to <http://www.dmh.mo.gov/cps/issues/suicide.htm>.

In the spring of 2009, the Project hosted a QPR Instructor Certification course, establishing 23 new trainers throughout the state, and also hosted a two-day “Strategic Planning for Suicide Prevention” workshop, which was well attended by representatives of many community groups from around the state.

### **Medicaid Partnership**

Through the leadership of the Division Director, the Division has an active partnership with Missouri HealthNet Division, the Medicaid division for the Department of Social Services, to enhance the quality of both fee-for-service and managed care behavioral health services.

Specific activities include:

- Expansion of access to providers through CyberAccess, an electronic database that allows providers to access service history and results to improve coordination of care with physical health and across behavioral health providers;
- Active participation in development of policies for behavioral health fee-for-service to work towards enhancing quality of services and transition to evidence based practices;
- Planning in regards to grant applications to increase access to training of evidence based practices and creation of trauma-informed services and systems
- Participation in MO HealthNet care coordination audit of managed care behavioral health contracts
- Improving access to screening of the early childhood population as well as shaping services towards best practice guidelines

### **Weaknesses**

Missouri faces several challenges in delivery of mental health services for children. Similar to national trends, there is a significant dearth of access to psychiatry, let alone child psychiatry. The Division has developed funding streams that allow enhancements to standing rates for psychiatry which assists the community providers; however, the need still far exceeds the

availability particularly for specialized populations such as early childhood or co-occurring Mental Illness/Developmental Disabilities.

The lack of psychiatrists is particularly crucial in the rural areas of the state, with approximately 2/3 of the state deemed as having a shortage of mental health providers. Surveillance shows that several counties in the state have no psychiatry, social work/counselors or psychologists. This severely limits access and challenges service delivery.

Although the Division has worked closely with the Children's Division (child welfare) in supporting youth who are placed out of their family home due to abuse or neglect, programs targeting truly homeless youth are still only available in certain areas of the state. Current planning efforts for transition age youth will target those who are homeless in developing models and supports for outreach.

# 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.

## Child – Unmet Service Needs

Childhood mental illness can be debilitating and can seriously impact the quality of a child and family's life. The U.S. Surgeon General's 2000 Report on Mental Health reported that almost 21 percent of children ages 9-17 have a diagnosable mental or addictive disorder associated with at least minimum impairment. Also, an estimated 11 percent of children ages 9-17 suffer from a major mental illness that results in significant impairments at home, at school and with peers.

Children with mental health needs are more likely to have trouble at school and more likely to become involved with the juvenile justice system. Nationally, 48 percent of students with serious emotional disturbances drop out of high school compared with 24 percent of all high school students. Of those students with a serious emotional disturbance (SED) who drop out of school, 73 percent are arrested within five years of leaving school. (U.S. Department of Education) School failure contributes to truancy, inability to work productively as adults, and a greater risk of involvement with the correctional or juvenile justice system (DMH Strategic Plan).

A high percentage of youth involved with the juvenile justice system have mental health needs. A survey of 1,450 Missouri youth detained in the juvenile justice system showed that 32 percent reported a history of previous mental health services; 18 percent reported being prescribed some type of psychotropic medications; and 10.4 percent of youth were prescribed more than one psychotropic medication (MO MAYSI PROJECT REPORT, 2003).

At any given time during 2000, the Children's Division had over 12,000 children in out-of-home placement. It was estimated that approximately 2,000 of these children had a serious emotional disturbance. The joint DMH and DSS report to the Governor in response to SB266 estimated that approximately 600 children may be currently in the child welfare system, not because of abuse or neglect issues, but because of the need for mental health care. (Smith, 2004)

The growing need for mental health services continues to strain the limited resources of the system. Most of the resources available under the current system target the needs of the most serious cases.

Estimates of the percentage of U.S. children suffering from SED range from 5% to 9%. According to the National Survey of Children's Health (NSCH, 2003), 8.7% of children and youth (ages 4 – 17) in Missouri have moderate or severe difficulties in the areas of emotions, concentration, behavior, or the ability to get along with others, compared to 9.2% of the national MO MAYSI Project: An examination of the mental health needs of youth in the juvenile justice system using the Massachusetts Youth Screening Instrument – 2nd Edition (2003) Jefferson City: Missouri Department of Mental Health and the Missouri Alliance for Youth: A Partnership between DMH and Juvenile Justice.

Smith, A. and Associates, LLC (2004). *Children in State Custody Solely for Mental Health Needs and More Comprehensive Strategies for System of Care Development: Study and Recommendations*. A Report to the Missouri Departments of Mental Health and Social Services. Jefferson City.

U.S. Department of Education Office of Special Education (2000). *Twenty-second annual report to congress on the implementation of the Individuals with Disabilities Education Act*. Available online at: [www.ed.gov/offices/OSEP/Products?OSEP2000AnlRpt/index](http://www.ed.gov/offices/OSEP/Products?OSEP2000AnlRpt/index)

U.S. Department of Health and Human Services. (1999) *Mental Health: A Report of the Surgeon General – Executive Summary*. Rockville, MD. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

population of children of the same age. The National Health Interview Survey (NHIS, 2005), reported that 5.4% of children ages 4 to 17 had severe difficulties in 2004. The variation in the statistics reported by NHIS (2005) and by NSCH (2003) is due to the inclusion of both moderate and severe emotional disturbance by the NSCH, while the NHIS only includes severe emotional disturbances. The table below shows the estimated number of Missouri children with moderate and/or severe emotional and behavioral difficulties.

**Estimated Percent (Number) of Missouri Children (Aged 4-17) with Serious Emotional Disturbance, 2005**

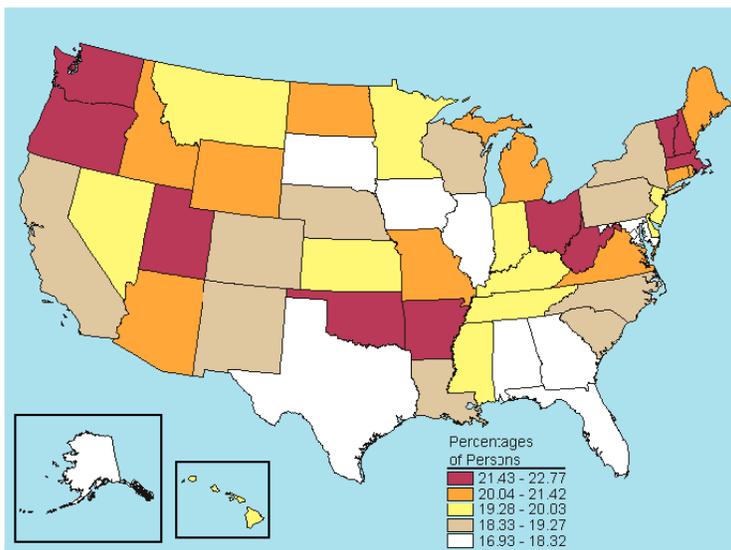
	<b>Estimated Missouri Child Population 2005</b>	<b>Prevalence of ,Moderate or Severe' SED</b>	<b>Prevalence of ,Severe' SED</b>
<b>Percent (Number)</b>	1,076,206	8.7% (93,629)	5.4% (54,115)

Source: Prevalence of Moderate or Severe SED based on an 8.7% one year prevalence rate estimated by the National Survey of Children’s Health (NSCH, 2003). Prevalence of Severe SED is based on 5.4% one year prevalence estimate by the National Health Interview Survey (NHIS, 2005).

The transition from adolescence to adulthood includes both physical and mental developmental challenges that result in particular vulnerability to mental illness among youth transitioning to adulthood. The term ,transitional youth’ has been used to refer to youth as young as 16 years of age, but in this study it refers to individuals between the ages of 18-25.

Based on state averages from the 2004 and 2005 NSDUH, it is estimated that approximately 21.3% of Missouri transitional youth aged 18-25 (approximately 91,402 young adults) suffer from SPD in any given year (Wright, Sathe, and Spagnola, 2007). This is compared to approximately 10.0% of adults aged 26-64. The figure below compares Missouri to the rest of the nation. Missouri’s rate of SPD for transitional youth is higher than the national average.

**Percent of Youth Aged 18-25 with Serious Psychological Distress in Past Year**



Source: National Survey on Drug Use and Health, 2004 and 2005.  
Map Prepared by: SAMHSA, Office of Applied Studies

# Missouri

## Child - Plans to Address Unmet Needs

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

## **Child – Plans to Address Unmet Needs**

State policymakers, families, and practitioners are increasingly concerned about the mental health needs of children in Missouri. Providing appropriate and effective services to meet their needs is a high priority. Senate Bill 1003 was enacted into law in 2004 to require the development of a unified, comprehensive plan for children's mental health services. Missouri's mental health services system for children will be accessible, culturally competent, and flexible enough to meet individual and family needs; and family-centered and focused on attaining positive outcomes for all children. There has been a growing emphasis on being able to intervene earlier yet still have the ability to meet the needs of youth with multiple and complex needs.

The transformation of children's services uses as its foundation the public health model to meet the mental health needs of children. This is a departure from the medical model used in Missouri and most other states. The public health model presented in the comprehensive children's plan consists of three components:

- **Surveillance and assessment of mental health needs**, including risk factors, demographics, access in care, and rates of disease;
- **Policy development**, including financing, inter-agency collaboration, and policy initiatives; and
- **Monitoring of the service delivery system**, insuring services are evidence-based/effective and organized by developmental stages through a matrix of services, health promotion, quality, access to care, and evaluation and monitoring.

### **Surveillance and Assessment of Mental Health Needs**

The Department of Mental Health continues to work with other child-serving agencies and departments to create data systems that can capture meaningful data, enhance the sharing and matching of data across systems and increase the use of data analytics to inform both policy and clinical decision-making. One example is the work the DMH has done with MOHealthNet (Medicaid) in their development of the CyberAccess system. This system allows for real-time monitoring of all services provided and allows for enhanced health monitoring and shaping towards best practices. Additionally as Missouri moves closer to implementation of the public health model, the state has been accessing and utilizing other data surveys and systems to identify risk factors associated with mental illness. One long standing example is the Missouri Student Survey, a web-based instrument used by schools to examine drug usage, violent behaviors and risk and protective factors.

As noted in other sections, the Show-Me Bright Futures Initiative which is based fully on the public health model will not only teach communities how to use existing data, but how to create surveillance systems specific to their community using a number of different approaches such as field interviews and behavioral tracking.

Specifically the Division is institutionalizing the use of the CAFAS as a required outcome measure for services which will allow CPS and its network of providers to track the major needs of children, youth and families, develop evidence based services and programs directed towards those needs, and assess the impact of those interventions. Through state and local reports based

on the CAFAS, specific population of youth can be identified and subsequently evidence based practices implemented to meet the specific need for a community or the state.

Additionally, the Division is working towards an expansion of the use of the Quality Service Review (QSR) as a “surveillance” tool not only of outcomes for children and youth but also as surveillance of the service system and its implementation with fidelity to system of care philosophy and best practices for children.

### **Policy Development**

The Comprehensive System Management Team (CSMT) has been tasked with the operational oversight of the comprehensive children’s mental health service system (630.097 RSMo) and to act as a linkage between the state and local management structures. Membership is comprised of state child-serving agencies, families, advocacy organizations and local system representatives. The CSMT has spent the last year identifying the current screening processes within the early childhood system, strengthening partnerships between mental health and the Department of Elementary and Secondary Education (DESE) through mutual support in conferences and trainings as well as discussions related to implementation of a school mental health model without new funding, and institutionalizing a practice model for mental health that can be integrated within all child-serving systems.

With further support and expansion of the Quality Service Review, the CSMT will be using the data generated in local sites to identify common weaknesses to prioritize areas of attention related to policy development. The CSMT will also be working with the local interagency policy teams to insure that locally they are identifying their specific weaknesses and strengths and addressing those through the local Policy Teams. Generally speaking then, the QSR will be the surveillance of the system to guide interagency policy development at the local and state level.

Examples would include if the QSR shows locally or statewide poor transition planning, training and services could be developed or revised to insure that care coordinators and others working with families and children know what is meant by a transition and how to plan effectively. Another example using the CAFAS data could help direct training and implementation of specific evidence based practices so that it meets an indentified need in a local or regional site. For example, if most children from Area A show a high rate of “Thinking” issues on the CAFAS, then strengthening services for children with psychotic symptoms would be more effective than adding an EBP specific to delinquency or substance use.

### **Monitoring of the Service Delivery System**

The focus for the coming year continues to be on both expanding the service capacity statewide and continuing to create the infrastructure to support the system. There will be several approaches to monitoring the service delivery system including both the QSR as well as the CAFAS as previously identified. The plan would include both of these tools being used to monitor quality and access at both the state and local levels. Additionally, the Division is creating a more focused monitoring system for its providers. Through this the Division will be able to better insure the provision of quality services and enhanced fiscal responsibility. As these surveillance and monitoring systems become fully actualized, the Division will look for

additional opportunities to expand the service array as well as the target population on its own and through partnerships with other state and community agencies. As noted with the examples given under Policy Development, with repeated utilization of the monitoring tools over time, progress (or lack thereof) can be identified to insure policy interventions have been effective.

# 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.

## **Child – Recent Significant Achievements**

The Missouri Department of Mental Health (DMH) continues to make progress towards a more comprehensive community based children's mental health system of care. In addition to the significant achievements outlined in Section II Child – Service System's Strengths and Weaknesses, there are many other significant achievements to highlight.

### **Progress to Date**

Building a comprehensive mental health system to meet the needs of Missouri's children encompasses more than just adding services. As outlined in the 2004 comprehensive children's plan, reform involves major work in three broad areas: the ongoing capability to assess children's mental health needs statewide, the policy and infrastructure to support reform, and the expanded capacity of the service delivery system.

Work of this complexity and magnitude takes time. The plan puts forth a vision of what the fully developed system will look like and lays out a 5 year road map for achieving this system. The plan focuses the work in the first two years on Planning and Transition activities. Currently we are right on target with meeting the short term goals and objectives as set forth in the plan. The following report provides a description of this progress over the last year and the focus for the coming year. The report is organized to correspond to the plan with a discussion of activities related to families retaining custody first, then a description of progress in building the infrastructure and services within a system of care, followed by what is being put in place to assure the system is working for children and families.

### **Families Retaining Custody**

CPS continues to partner with Children's Division (child welfare) to improve the Custody Diversion Protocol so that families do not have to voluntarily relinquish custody solely to access mental health services. The Custody Diversion Protocol was developed through the shared efforts of DMH, DSS, courts and family members and implemented statewide in January, 2005 following extensive training of Children's Division (CD) staff, DMH provider staff and juvenile justice officers. In February of 2005, the CD was able to implement a Voluntary Placement Agreement (VPA) through an amendment to the state's IV-E plan. This allowed the CD to enter into a contract with parents to fund a child's out of home placement for a maximum of 180 days if deemed appropriate through a DMH level of care assessment without having to take custody. This VPA is only available in conjunction with the Custody Diversion Protocol. To date 901 or 96% of the children referred have been diverted from state custody. This has been considered a very successful initiative and the process the state partners went through to develop and implement the protocol was presented at the 2008 Georgetown Training Institute in Nashville.

### **Building Infrastructure to Support a System Of Care**

Through the leadership of the Division Director, the Division has an active partnership with Missouri HealthNet Division, the Medicaid division for the Department of Social Services, to

enhance the quality of both fee-for-service and managed care behavioral health services.

Specific activities include:

- Expansion of access to providers through CyberAccess, an electronic database that allows providers to access service history and results to improve coordination of care with physical health and across behavioral health providers;
- Active participation in development of policies for behavioral health fee-for-service to work towards enhancing quality of services and transition to evidence based practices;
- Planning in regards to grant applications to increase access to training of evidence based practices and creation of trauma-informed services and systems
- Participation in MO HealthNet care coordination audit of managed care behavioral health contracts
- Improving access to screening of the early childhood population as well as shaping services towards best practice guidelines

#### Policy Development & Administration

SB1003 called for the establishment of a Comprehensive System Management Team (CSMT) to provide a management function with operational oversight of children's mental health policy and to act as a linkage between the state and local management structures. Membership is comprised of state child-serving agencies, families, advocacy organizations and local system representatives. The CSMT and its committees continue to meet monthly. The recent focus has been in the area of developing a cross-system practice model; examining data collected from local system of care sites to assess impact and trends; and reviewing the current screening practices and tools for social and emotional functioning of the 0-5 age population across the state. Each of these tasks is with the intent to bring forward needed changes in policies and practice. For example as part of the Early Childhood Comprehensive System plan's goal on Social and Emotional Development, the CSMT took on the task of surveying current practice to identify gaps not only in screening/identification but to map where connections need to be made regarding universal and targeted interventions.

#### Financing

DMH submitted a budget item in the last legislative session in support of school mental health. This was not selected for funding. Although efforts continue to advocate for this budget item in the next legislative session, some steps have been achieved to make available additional funding options in support of school mental health. Previously MoHealthNet (Medicaid) would allow billing only for mental health services delivered at the school identified through an Individualized Education Plan with the school making the match. Through work with MoHealthNet, DMH was able to expand funding for such services to youth who are not eligible for special education services but still need mental health services if the school has entered into collaboration with the local community mental health center or mental health provider, again with the school or other community resource making the match. This not only created a funding stream not previously available to a population of youth, but also continues to emphasize and support collaborative partnerships between mental health and schools.

CPS was also able to expand the array of services available through Community Psychosocial Rehabilitation Program that are eligible for MOHealthNet funding. These services include Family Support, Family Assistance, Day Treatment and Psychosocial Rehabilitation. Although

no additional general revenue dollars were provided, it is hoped that through creating a mechanism the limited resources can be used through its maximum potential to support access and capacity to these services.

## **Array of Services and Supports**

### Functional Assessment

The Child and Adolescent Functional Assessment Scale (CAFAS) has been selected as a functional tool to enhance meaningful eligibility requirements for community psychosocial rehabilitation services. CPS has a computer based system to allow statewide access for its providers and to create both local and statewide databases. In addition to determining eligibility based on functioning, the CAFAS allows for active management of services by periodically assessing progress towards specified goals, designing treatment plans which link problematic behavior with a target goal and related strengths, assessing outcomes, and provide a quality assurance tool. All providers have been trained by CPS to train their agency staff on rating of the CAFAS. The target date for statewide implementation is January 2009 was achieved.

### Evidence Based Practice

Through a field demonstration grant from the Office of Juvenile Justice and Delinquency Prevention CPS and the Office of State Courts Administrator have provided training to five sites on guidelines to improve the quality of mental health assessments for juvenile/family courts. Additionally each of these sites selected an evidence based practice to implement to enhance the service array for youth at risk of or involved in the juvenile justice system with mental health needs. The practices selected included Dialectical Behavior Therapy, Trauma-focused Cognitive Behavior Therapy, Motivational Interviewing, Too Good for Drugs and Reconnecting Youth.

As part of the state's Transformation Grant, a workgroup has been convened to outline the infrastructure needs of the state to implement and sustain evidenced based practices. The respective adult and children's clinical directors are co-chairs of this interagency committee.

### Prevention

The Show Me Bright Futures initiative has continued work through the state strategic team to identify mechanisms and funding to assist local communities in application of a public health approach to the social and emotional well-being of children. The Department received a grant through the Missouri Foundation for Health to work with specific communities to implement the public health model in regards to social and emotional wellness of children. The plan is to work with three to four communities to increase knowledge and skills in assessment and surveillance of children's needs, communities supporting schools in reaching children and families and implementation of evidenced based practices that meet the identified needs of that community. Additionally, DMH has provided training for school personnel on the Olweus Bullying Prevention Program. As noted above, one community mental health center has been working with schools in implementation of the Too Good for Drugs curriculum. The CSMT has a Prevention committee that surveyed the state for current screening tools and practices in the area of early childhood social and emotional development. The Division will begin training this year on the Preschool and Early Childhood Functional Assessment Scale as we begin to develop services for young children.

### Early Childhood

DMH continues to be an active partner on the Early Childhood Comprehensive System state team, and providing leadership on the goal related to social and emotional health. In conjunction with the Center for Mental Health Practices in Schools through their SEED grant an Early Childhood Mental Health Summit was held in June of 2008. This summit brought together early childhood providers and state policy administrators to identify the infrastructure needs to incorporate a universal approach for the social and emotional well being of our youngest population. From this summit three priority goals were set:

- Create a state-wide coordinated education program related to family involvement, engagement, and empowerment
- Map where are current dollars being spent and identify specific gaps related to healthy social and emotional development
- Identify common/cross-system child indicators for healthy social/emotional development.

Additionally, DMH is represented on the statutorily defined Coordinating Board for Early Childhood (CBEC) and has provided fiscal and staff support in its first year of functioning. The past year's goals for the CBEC have included development of recommendations related to implementation of a statewide Quality Rating System, increasing state funding for Early Headstart, and adjustment of the childcare subsidy formula. Some success was achieved in all of these areas during the last legislative session. For the next year, the Board has identified increased funding for mental health consultation, development of pre-k recommendations for the state and support of a sustained P-20 Council as possible priorities.

### Juvenile Justice Activities

The Division continues to lead a state level mental health/juvenile justice policy team to identify and address issues related to the mental health needs of youth at risk of or currently in the juvenile justice system. A grant funded partnership exists between the Office of State Courts Administrator and the Division to improve the quality of assessments provided on youth involved in the juvenile justice system, to develop evidence based practices geared towards this population of youth and develop/enhance community collaboration. Five sites were selected to receive training on assessments, provided dollars to train on their selected evidence based practice, and consultation and technical assistance to enhance the local infrastructure to sustain these practices. In 2008, 113 individuals representing child welfare, juvenile justice and mental health were trained on the Assessment Guidelines. A survey sent out six months later, showed that the majority of respondents felt they had gained knowledge about when to refer, what can be learned from mental health assessments, were better able to use the information provided by the assessment, and how to use the assessment to guide service provision. One hundred and thirty-nine therapists in two communities were trained and certified on Trauma-Focused Cognitive Behavioral Therapy. Another community provided training to 181 staff on Dialectical Behavior Therapy, with a core adolescent team receiving targeted training to provide therapy. Forty-eight juvenile officers and therapists received training in motivational interviewing and Strengthening Families and a final community provided training to 22 school and mental health staff on Too Good for Drugs and/or Reconnecting Youth.

The Mental Health/Juvenile Justice Policy Group is now focusing on creating a continuum of services for youth with problem sexual behaviors. The first step was developing guiding

principles, values and practices to insure a common vision. As this step is being completed, the group has begun the process of examining different best practices that can be developed and accessed by juvenile justice, child welfare, mental health, schools and families. MO HealthNet serves on this group to aid in leveraging Medicaid dollars in support of best practices.

Missouri Juvenile Justice Information System (MOJJIS) is the response to statute which directs 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 Federal Drug and Alcohol Confidentiality Laws.

#### School Based Activities

DMH has on contract a Childhood Education Specialist to continue work on enhancing collaborations with the Department of Elementary Education and local schools with community mental health providers. Although a budget item was presented, it was not approved to begin implementation of school mental health services. Efforts continue to find mechanisms and models to support school mental health services across the continuum.

#### Evaluation and Monitoring for Quality Services

SB1003 requires that the Children's Comprehensive Mental Health System be outcome based. In order to track child outcomes, system effectiveness and assure that the system provides high quality service to children and their families, the child-serving agencies and child advocates joined in this effort selected the *Quality Service Review (QSR)*. The QSR, designed by Dr. Ivor Groves and adapted to Missouri, measures the quality of interactions between frontline practitioners, children and their families and the effectiveness of the services and supports provided. This process has a strong history in Missouri as it has been used by the Department of Social Services (DSS) for Practice Development Review (PDR).

The QSR is a practice-based review looking at both the current status of randomly selected children served by the system and the performance of the system that serves those children. The QSR is conducted only in sanctioned system of care sites with nine sites participating to date. In FY08 the CSMT continued to conduct baseline QSRs in newly developed system of care sites with two reviews in St. Louis City/City and Pike/Lincoln Counties. Eighteen children and youth were reviewed by thirty-eight reviewers from around the state representing families, mental health, Children's Division, Division of Youth Services and the University of Missouri. All of the children reviewed had multiple agency involvement with over fifty percent having a co-occurring psychiatric diagnosis and developmental disability. Of the children reviewed, 78% showed a favorable status for the child and family with over 80% showing recent progress in meaningful relationships with family, risk reduction, school/work progress and symptom reduction. The service system function rated favorably in 67% of the reviews reflecting strong interagency teamwork and effective case management. Three-quarters of the youth are on three or more psychotropic medications with half receiving four medications or more. This is consistent with findings from the previous seven reviews. Additionally three major cross-site issues were identified: the need for improved engagement of child and family, planning for service transitions and independence; and improved communication with school personnel.

### Application of Knowledge Gained From Federally Funded Missouri System of Care Sites

Since 1998 Missouri has entered into partnerships with the federal government to serve as incubators specific to individual community needs for system of care. “The Partnership for Children and Families” was initiated in 1998 in St. Charles County. In 2002, six counties in southwest Missouri came on line with “Show Me Kids”. “Transitions – St. Louis System of Care in St. Louis City/County was developed in 2003. Most recently Buchanan and Andrew counties kicked off the “Circle of H.O.P.E.” in 2006. Although each of these sites has a different emphasis on system of care, already there are broad learnings that can be applied around the state. Examples: The “Partnership” produced a social marketing tool titled “Stats Blast” that illustrates the cost effectiveness and clinical effectiveness of system of care. “Stats Blast” is now being transformed into a statewide document that all sites can use for social marketing and educational purposes.

One of the notable learnings from the “Show Me Kids” site is how they developed a family organization through a request for proposal process. This success is a blueprint for other sites in developing and supporting family organizations. The “Transitions” site is certifying high fidelity wraparound trainers that in the near future can begin training not only in St. Louis but throughout the state. “Transitions” is also piloting a merged DMH Quality Service Review with the Children’s Division Performance Development Review. This blending of resources will not only save costs but will gather more information for both agencies. Finally, “Transitions” is about to begin a prevention effort whereby children in the custody of Children’s Division will receive a mental health screening in an attempt to intervene early before mental health issues have become severe. This too can be a model not only for prevention but for enhanced partnerships between mental health and child welfare. These are just some examples of how Missouri is benefiting from the federal SAMHSA cooperative agreements.

### Family Involvement Activities

Family and Youth Involvement at all levels of system development, monitoring, evaluation and service delivery is an essential component in building a comprehensive children’s mental health system. In order to have meaningful family and youth involvement, there must be a commitment to provide family members and youth the training, support and mentoring that they need to become active and informed participants as they promote systems change.

Efforts continue both at the policy and service level to engage families in the process and empower their voice and impact on the system. Family Leadership Training has been provided by the State Coordinator for Family Support to increase the number of family members who have the skills, knowledge and desire to work in shaping state and local policies. As noted previously, Family Support service has been included in the Community Psychosocial Rehabilitation array of services. A training curriculum has been approved based on the work of John Vandenberg. With this training CPS hopes to insure the quality and increase access to this service. Through the Transformation Grant, a statewide annual Consumer, Family and Youth Summit was held. Over 350 consumers, family and youth participated in this successful event planned and implemented entirely by and for consumers, families and youth.

# 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 – State’s Vision for the Future**

“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.” (*Comprehensive Children’s Mental Health Plan, 2004*)

The Comprehensive Children’s Mental Health Plan continues to articulate the State’s Vision for the Future. An effective children’s mental health services system in Missouri is a key element in the overall health and safety of the state. An effective system is crucial for thousands of children to realize success at home, at school and in their communities. Continued improvement of the children’s mental health system represents a sound investment in the future.

The following principles of practice guide the system and were established by the legislature as part of the Comprehensive Children’s Mental Health Act. The Comprehensive Children’s Mental Health System shall:

- Be child centered, family focused, strength-based, and family driven, with the needs of the child and family dictating the types and mix of services provided, and shall include the families as full participants in all aspects of the planning and delivery of services;
- Provide community-based mental health services to children and their families in the context in which the children live and attend school;
- Respond in a culturally appropriate and competent manner;
- Emphasize prevention, early identification and intervention;
- Include early screening and prompt intervention and assure access to a continuum of services;
- Assure a smooth transition from child to adult mental health services;
- Coordinate a service delivery system inclusive of services, providers, and schools;
- Be outcome based; and
- Address unique problems of paying for mental health services for children and assure funding follows children across service delivery systems.

## **Desired System Results**

The transformation of the children’s mental health system from one focused on those with severe emotional disturbances to one focusing on promoting and sustaining mental health and providing appropriate care along the continuum of need will yield the following results.

- All of Missouri’s children will receive the mental health services they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first.
- Missouri’s mental health services system for children will be easily accessible, culturally competent, flexible and adaptable to individual needs, and result in positive outcomes for the children and families it serves.
- No parent will have to relinquish custody of their child solely in order to access needed mental health services.

- Any child in Missouri can be screened for mental health needs at the first sign, request of a parent, or a child serving entity; and screening for mental and behavioral health will be a routine practice for all pediatric health care providers.
- Education and information on promoting mental health, risks and signs of mental illness, where to get help, information about their child's illness and availability of support and outreach to families and communities will be available.
- Missouri's state child-serving agencies will have the ability to share data across multiple agencies permitting joint quality decision making about patterns of care, service needs, quality and cost effectiveness.
- Mechanisms for comprehensive, integrated system governance and management will be established at the state level and will reflect the cultural diversity of Missouri and will be inclusive of families and youth.
- A broad-based Stakeholder Advisory Group with at least 51% family representation will provide ongoing input into system design, implementation and evaluation.
- Sufficient and flexible funding will be available to promote a more efficient system of prevention activities, services and supports.
- An Individualized Plan of Care and care coordination will be available to all children, as needed.
- All children and families will have access to the appropriate level and mix of individual and community support representatives and professional staff who join together to support the family and ensure implementation of a cohesive Individualized Plan of Care.
- A local system in which agencies, providers and practitioners coordinate care with one another, with other systems and with community leaders in addition to representatives of families and youth will be available.
- All areas of the state will have available an array of services addressing prevention and treatment, and ensuring a smooth transition to adult services when necessary; services will be based on effective and evidence-based programs and practices.
- The system will have the ability to respond to the unique needs of children within special populations including but not limited to autism, co-occurring behavioral and substance abuse and/or developmental disabilities, effects of experiencing trauma and other populations, including racial and ethnic minorities that are particularly at risk or have special service or access needs.
- The system will have a plan for creating adequate numbers of appropriately trained, and culturally competent, behavioral health care staff who are appropriately distributed across the state.
- Implementation of a statewide process for measuring the effectiveness of services and supports and that ensures the system is operating in accordance with its operating principles.

# 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: Comprehensive Community-Based Mental Health Services System Establishment of System of Care**

Current activities related to the comprehensive system of care for adults are detailed in Section II of this Application. Those activities include a commitment to consumer and family driven services in a public health model of care. In particular Missouri has begun an emphasis to improve integrated dual diagnosis treatment for persons with co-occurring mental illnesses and substance abuse disorders. Additional emphasis has been placed on integration of medical and behavioral health care.

The State's Revised Statutes of Missouri 2008 RSMo 630.020 set the 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.

## **Adult Plan**

### **Criterion 1: Comprehensive Community-Based Mental Health Services System**

#### **Available Resources**

The continuing goal of Missouri DMH is to keep individuals out of inpatient hospitalizations and in the community. To attain that goal the department offers an array of community-based services for individuals with co-occurring mental health and substance use disorders.

### **Health, Mental Health, and Rehabilitation Services**

#### **Community Psychiatric Rehabilitation Program (CPR)**

The CPR program is a consumer and family driven 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 to persons with severe, disabling mental illnesses. Services include evaluations, crisis intervention, community support, medication management, and psychosocial rehabilitation. Because CPR is a Medicaid supported program, the federal government pays approximately 60 percent of the costs for clients with Medicaid eligibility.

Expansion of the CPR for adults has been a priority. The CPR 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.

CPR provides medication and medication related services for persons who could not otherwise afford it. Approximately half of CPS clients have their medication costs covered through Medicaid. The cost of medications is a major barrier to accessing medication services. Psychiatric medication is the primary treatment for severe mental illness. New medications are the most rapidly advancing area of technology in clinical treatment of mental health. The new medications have fewer side effects and are therefore much more acceptable to clients and more effective on treating psychosis. The older medications would cause sedation, constipation, dry mouth, urinary retention, blurred vision, light-headedness, restlessness and movement disorders, as well as being deadly if taken in overdose.

The Department's current data indicates a forty-seven percent (47%) decrease in overdose deaths due to the new generation of antidepressants. The Department has also seen a thirty-seven percent (37%) decrease in the use of medications to treat the side effects of early generation anti-psychotics.

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.

### **Outpatient Community-Based Services**

Outpatient services provided in an individual's community offers the least-restrictive environment for treatment. An evaluation and treatment team provides services utilizing the resources of the individual, his/her family, and the community. Outpatient programs offer individual, group, and family therapy, medication management, etc.

### **Targeted Case Management**

Targeted Case Management services are intended to assist individuals in gaining access to psychiatric, medical, social, and educational services and supports.

### **Day Treatment/Partial Hospitalization**

Day treatment offers the least-restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than outpatient services can provide, but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services, and educational services. The focus is on developing supportive medical and psychological and social work services.

### **Residential Care/Community Placement**

Moderate-term placement in residential care provides services to persons with non-acute conditions who cannot be served in their own homes. A residential setting has more focused goals of providing a structured living environment in which to develop functional adaptive living skills, self-esteem, self-control of impulses, social skills, insight into personal issues, and enhanced family interactions.

### **Inpatient (Hospitalization)**

Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for persons who may be dangerous to themselves or others as a result of their mental disorder.

### **Employment Services**

Employment services are accomplished through referral of individuals to Division of Vocational Rehabilitation (DVR) services and long term supports by community support workers (CSW). Administrative Agents are encouraged to work collaboratively with the local DVR office to address the employment needs of consumers. Seven Administrative Agents/Affiliates provide supported employment services funded by vocational rehabilitation. All Administrative Agents are allowed to bill CSW services to provide clinical integration of employment into the individualized treatment plan.

### **Housing Services**

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 independent housing alternatives, they require intensive and flexible services and supports in order to maintain that housing. Provisions of these services and supports enable these individuals to successfully live and work in their communities.

To increase housing options within the past five 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. Several CPS providers have submitted HUD applications to develop Safe Havens, low-demand housing for those with co-occurring mental illness and substance abuse disorders. See also the section on Outreach to Homeless for more details on housing options.

### **Educational Services**

Psycho-Social Rehabilitation (PSR) services help persons with psychiatric disabilities to learn or relearn social and vocational skills and to acquire the supports needed for family, school and community integration. In order to help the participant gain or regain practical skills for community/family living, service activities include teaching, improving and encouraging adaptive skills in diet, personal hygiene, cooking, shopping, budgeting, completing household chores, family, peer and school activities, and use of transportation and other community resources. Educational activities may use an individual or group approach and should teach participants how to manage their disabilities and medications when appropriate, recognize individual stress signals, and utilize family and community resources when needed. People who wish to pursue employment, complete high school, or higher education are given supports and linked with agencies and programs that can help them.

### **Substance Abuse Services**

CPS has developed strategies to help adults with substance abuse/addiction. CPS has added co-occurring substance abuse assessment, individual counseling, group education, and group counseling to the menu of services available at agencies following the Integrated Dual Disorders Treatment (IDDT) model. Many agencies are moving forward on taking a more active approach to addressing the substance use issues of the SMI population that they serve. With funding received from the State for FY2008, six Assertive Community Treatment teams were added statewide. This will also increase the availability of substance abuse treatment for individuals served by CPS.

Some agencies in the contemplative stages of organizational change or who have individuals needing intensive substance abuse services refer adults identified as having a co-occurring disorder to Comprehensive 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 goal is that all agencies will

provide integrated treatment for individuals identified with psychiatric and substance use disorders.

### **Medical and Dental Services**

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). Federally Qualified Health Centers, local health departments and free health clinics provide medical services around the state. With the new cooperative FQHC/CMHC initiative, physical and mental health care is more coordinated for individuals with psychiatric disorders. Individuals can receive their medical services in the same location as their behavioral health services.

Community support workers assist children, youth and adults in accessing needed care within their community. In Kansas City and St. Louis, Missouri 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 some rural areas of Missouri.

### **Support Services**

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 six years. Five 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, five 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 partnership with Missouri Institute of Mental Health to accelerate multi-state Consumer Operated Service Programs (COSP) findings into practice. The self assessment process has been completed of the five Consumer Drop-In Centers around the state.

### **Services provided by local school systems under the Individuals with Disabilities Education Act**

Services provided by local school systems under the Individuals with Disabilities Education Act are detailed in the Child Plan, Criterion 1: Comprehensive Community-Based Mental Health Services, Available Services section of the Block Grant Application.

### **Case Management Services**

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.

### **Services for Persons with Co-occurring (substance abuse/mental health) Disorders**

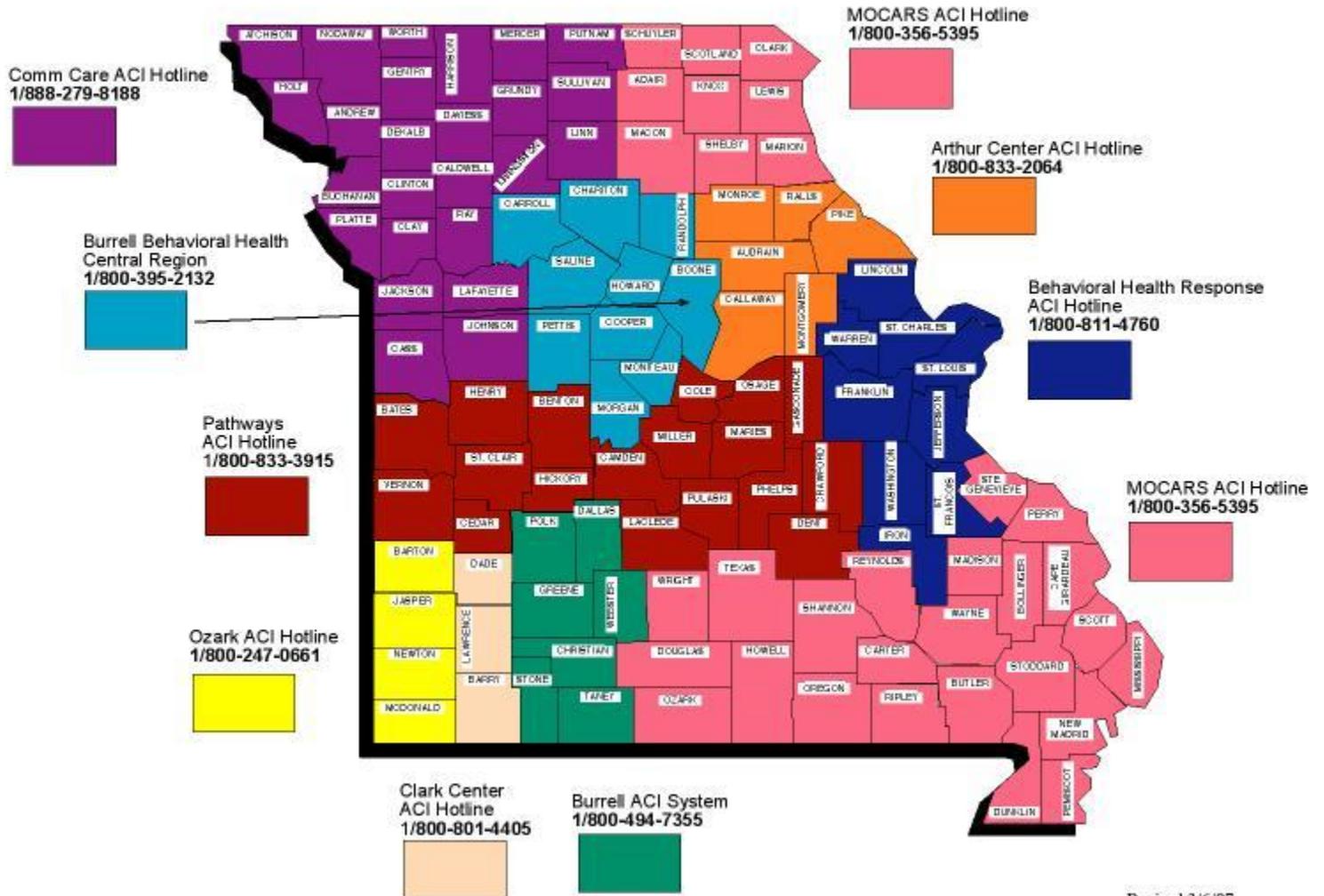
CPS has had a successful year for implementation of IDDT at the community mental health centers. Twenty agencies with thirty-two locations have committed to providing treatment for co-occurring psychiatric and substance abuse disorders according to the IDDT model. CPS has conducted fidelity reviews of the agencies to establish a baseline score. Follow-up reviews are occurring to determine progress on meeting fidelity. A shift in attitudes and services provided to the SMI population is occurring. The CPR programs have added staff and services for the co-occurring population.

### **Other Activities Leading to Reduction of Hospitalization**

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.

The ACI line is staffed by mental health professionals who can respond to crisis 24 hours per day and 7 days per week. They will talk with individuals about their crisis and help them determine what further help is needed, for example, a telephone conversation to provide understanding and support, a face-to-face intervention, an appointment the next day with a mental health professional, or perhaps an alternative service that best meets their needs. They refer to other resources or services within the community to provide ongoing care following a crisis. All calls are strictly confidential.

# Access Crisis Intervention (ACI) Hotlines



Revised 3/6/07

# 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

Missouri Department of Mental Health  
 2008 Estimated Census Data and Prevalence Rates  
 FY2009 Clients Served By Service Area

SA	Tot. Est. Popn 2008	Adults	Children	Adlt at 5.4%	Child at 7%	SMI Adults FY09	SED Child FY09	Rural Adult	Rural Child
01	180,914	140,985	39,929	7,613	2,795	1,563	767	1,563	767
02	0			0	0	4,852	911		
03	0			0	0	2,055	637		
04	0			0	0	2,115	596		
05	0			0	0	1,638	358		
KCsub	668,417	498,025	170,392	26,893	11,927	1,467	438		
KC	668,417	498,025	170,392	26,893	11,927	12,127	2,940		
06	325,048	242,792	82,256	13,111	5,758	3,157	652	3,157	652
07	183,358	137,632	45,726	7,432	3,201	872	434	872	434
08	191,058	146,447	44,611	7,908	3,123	1,996	747	1,996	747
09	208,195	154,210	53,985	8,327	3,779	3,500	1,047	3,500	1,047
10	504,718	387,184	117,534	20,908	8,227	3,418	1,098	3,418	1,098
11	233,461	178,409	55,052	9,634	3,854	1,381	436	1,381	436
12	324,530	250,410	74,120	13,522	5,188	2,950	1,069	2,950	1,069
13	77,935	59,644	18,291	3,221	1,280	1,212	417	1,212	417
14	105,259	81,747	23,512	4,414	1,646	1,532	402	1,532	402
15	118,752	91,622	27,130	4,948	1,899	1,984	545	1,984	545
16	534,294	396,617	137,677	21,417	9,637	2,336	835	2,336	835
17	203,361	157,166	46,195	8,487	3,234	3,050	618	3,050	618
18	123,393	94,855	28,538	5,122	1,998	1,493	205	1,493	205
19	129,767	98,189	31,578	5,302	2,210	2,302	403	2,302	403
20	101,303	76,952	24,351	4,155	1,705	1,524	729	1,524	729
21	133,972	103,820	30,152	5,606	2,111	5,655	938	5,655	938
22	217,679	163,263	54,416	8,816	3,809	1,693	338	1,693	338
23	763,776	763,776	0	41,244	0	209	49	209	49
24	0			0	0	3,281	594		
25	0			0	0	2,765	267		
STLsub	354,361	266,391	87,970	14,385	6,158	1,028	230		
STL	354,361	266,391	87,970	14,385	6,158	7,074	1,091		
Out of State						64	1		
Unknown						381	10		
TOTAL	5,683,551	4,490,136	1,193,415	242,467	83,539	61,473	15,771	41,827	11,729
RURAL (EXCLUDES COUNTIES 095 & 510)	4,660,773	3,725,720	935,053	201,189	65,454				

# Missouri

## Adult - Quantitative Targets

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

See Goals, Targets and Action Plans section

# Missouri

## Adult - Outreach to Homeless

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

## **Adult and Child Plan**

### **Criterion 4: Targeted Services to Rural and Homeless Populations Outreach to Homeless**

#### **Estimates of Homelessness**

The 2007 data consists of point-in-time counts of both sheltered and unsheltered homeless in Missouri. The data is from HUD's 2007 Continuum of Care Homeless Assistance Programs. According to the HUD Second Annual Homeless Assessment Report to Congress dated March 2008, there are 8,798 estimated homeless in Missouri.

#### **PATH Grant**

Missouri has both urban and rural Projects for Assistance in Transition from Homelessness (PATH). The PATH Grant 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 (MHS) Block Grant. In 2001, a new provider was added in St. Louis and in 2002 a provider serving the rural Southeast area was added with additional PATH funding. A rural Southwestern area provider was added in 2003. In 2008 technical assistance for the implementation of SSI/SSDI Outreach, Access and Recovery (SOAR) began for PATH providers in 4 areas of the State targeted as pilot sites for the SOAR initiative. Ten PATH Program staff from across the State attended the SOAR Train the Trainer events and began training with assistance from Policy Research Associates in the pilot areas. In 2009 Ms. Kendra Daniels, with Truman Medical Center, Behavioral Health's PATH program accepted the duties of State SOAR Coordinator. She is organizing four SOAR trainings across the State. This effort is being supported in part with PATH Grant dollars. Data collected from PATH agencies and others dealing with Missouri's homeless will be added to the national database. Missouri PATH programs meet quarterly to share information and expertise and participate in ongoing training developed to address their needs. PATH programs are monitored annually by the State's PATH Coordinator.

#### **Homeless Veterans**

Homeless veterans and those who help them received a significant boost in their efforts when the U.S. Department of Veterans Affairs (VA) made 55 new awards to public and private nonprofit organizations that assist homeless veterans. Among the new grantees is the Missouri Department of Mental Health, which has partnered with St. Patrick's Center to provide transitional housing with an extensive list of support services to 50 veterans throughout the St. Louis metropolitan area.

#### **Shelter Plus Care**

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, Missouri has 30 Shelter Plus Care grants.

### **United States Department of Housing and Urban Development Missouri Continuum of Care Homeless Assistance Programs**

On February 19, 2009 the U.S. Department of Housing and Urban Development (HUD)) announced the results of their 2008 annual competition for homeless assistance fund through the Continuum of Care (CoC) process.

Missouri's nine CoC's received a total of just under \$27.8 million out of a nationwide total of \$1.4 billion in HUD funds awarded, or about 2% of the total. The Department of Mental Health's Shelter Plus Care grants accounted for over \$10.6 million in renewals of existing grants and four new grants, or 39% of the total federal funding statewide.

DMH applied for and received funds for four new Shelter Plus Care programs. Two new grants in the City of St. Louis will fund 30 units for chronically homeless individuals and 20 units for homeless families. A new grant in St. Louis County and one in Kansas City, will also house chronically homeless individuals.

The amounts awarded to individual Missouri Continuums by HUD consist of the following:

Missouri Balance of State \$4,490,619  
St. Louis City \$10,212,635  
Kansas City \$8,093,599  
St. Joseph \$845,848  
Springfield \$887,243  
St. Louis County \$2,539,177  
Joplin \$574,128  
St. Charles \$153,153  
State Total \$27,796,402

### **MHDC Housing Trust Fund Awards**

On December 12, 2008, the Commissioners of the Missouri Housing Development Commission announced a total of \$4,244,189 in awards from the Missouri Housing Trust Fund (MHTF). Awards were made in the areas of homeless prevention (\$2,442,124), construction and rehabilitation (\$751,770 with a good percentage as match to HUD funded Supportive Housing Permanent Housing projects), rental/mortgage assistance (\$225,475) home repair (\$442,380), and operating matching funds (\$332,440 which also provide the match requirement for HUD SHP grants). All funds must serve households at or below 50% of Area Median Income (AMI) and, at least 50% of the funds must serve households at or below 25% of AMI. Several DMH providers are the recipients of Missouri Housing Trust Funds. MHTF is an important resource in the state for matching various grants funded under the HUD Continuum of Care.

It is important to note that the 2008 amount awarded was \$1 million dollars less than the previous year. The Missouri Housing Trust Fund has been shrinking over the last two years and predicted to decrease even further for 2009. The MHTF is funded through a document recording

fee (\$3) on real estate transfers. Due to the decline in the economy and housing market, less funding has been generated. The minimal \$3 fee has also been the same since the MHTF was passed in 1993. Efforts are underway by the Coalition for the Missouri Housing Trust Fund to increase the fee and/or create other funding sources. The DMH Housing Unit is a part of that effort.

### **Homeless Prevention and Rapid Re-housing Program**

The DMH Housing Unit has been working closely with providers throughout the state to access Homeless Prevention and Rapid Re-housing Program (HPRP) funds allocated under the American Recovery and Reinvestment Act. The State of Missouri received \$12,011,062 in HPRP funding. In addition, St. Louis City received \$8,156,188; St. Louis County \$2,188,750; Kansas City \$3,628,139; Springfield \$551,673; and St. Joseph \$727,371. DMH housing staff provided comments at the HPRP Consolidated Plan hearings regarding the number of people with mental illness who are homeless and at risk of homelessness in need of the housing assistance, mental health services and employment services provided by this program. State HPRP funding has been allocated by formula to counties in the state. DMH Housing staff are offering technical assistance to DMH service providers applying for HPRP funding.

### **DMH Rental Assistance Program**

The DMH Rental Assistance Program (RAP), funded by state General Revenue, is different from most of the department's federal housing money in that the dollars can serve households where the children have a mental health issue/disability. In federal programs, such as Shelter Plus Care, the head of household or adult (18 or over) in the household must have the disability. The DMH Housing Unit has found that they receive requests for Shelter Plus Care where the family is homeless or at risk of becoming homeless; however, it is the children in the household who are disabled, so federal program dollars cannot be used. With RAP, housing assistance can be provided for these children and their families. In fact, one of the target populations for RAP is families where a child or children are disabled and they do not qualify for other housing assistance.

### **Missouri Department of Mental Health Housing Unit**

The mission of the Department of Mental Health's Housing Unit is to assist Missourians challenged by mental illnesses, substance abuse/addictions and developmental disabilities in obtaining and maintaining safe, decent and affordable housing options that best meet their individual and family needs. The DMH Housing Unit believes that housing is a key to helping Missourians with disabilities and their families attain self-determination and independent living.

The vision of the Housing Unit is that all Missourians challenged by mental illnesses, substance abuse/addictions and developmental disabilities have housing options that are affordable and accessible, integrated into communities, and provide real choice.

DMH Housing works with all three of DMH's divisions to help link mental health services consumers to rental assistance through the Shelter Plus Care program. They also make efforts to expand housing options for mental health services consumers in the state; assist in creating partnerships between housing developers and non-profit agencies in the development of

affordable rental units statewide; and work to increase rental assistance and homeownership opportunities for mental health services consumers.

The Department of Mental Health participated in the production of a comprehensive guide to state and federal housing assistance resources. "Missouri's Guide to Housing Assistance Programs" includes information on rent subsidy programs, first-time home buyers programs and renovation assistance programs. It also has detailed contact information for dozens of agencies all over the state that provide housing assistance in a variety of forms.

The DMH Housing Unit webpage has additional information on services and resources available in Missouri at <http://www.dmh.mo.gov/ada/housing/housingindex.htm>

	<p>This page has links to agencies and resources that may be able to help you with finding a place to live, paying your rent or energy bill, fixing your home, buying a home, or finding emergency shelter. <b>Updated 4/8/09</b></p>
	<p>Here DMH service providers may download the DMH Application for Shelter Plus Care rental assistance for mental health consumers who are homeless and disabled. The page explains the scope of the program and how DMH operates its 26 Shelter Plus Care grants. <u>To obtain the most current version of the DMH Application for Shelter Plus Care, go <a href="#">here</a>.</u> <b>Updated 4/7/09</b></p>
	<p>This page has links to funding sources, technical assistance and information for people and agencies involved in or interested in developing affordable housing or supportive housing for people with disabilities. <b>Updated 3/4/09</b></p>
	<p>"Housing News" is a quarterly newsletter with articles for renters, homeowners, people with disabilities, housing providers, people who want to develop affordable housing for people with and without disabilities, and for anyone interested in housing issues generally. <b>Updated 1/30/09</b></p>



Here you'll find full contact information for each member of the DMH Housing Team and information about each person's area of expertise. **Updated 8/6/08**

# Missouri

## Adult - Rural Area Services

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

**Adult and Child Plan**  
**Criterion 4: Targeted Services to Rural and Homeless Populations**  
**Rural Area Services**

Having mental health problems can be tough no matter where you live but it can be worse for those living in rural Missouri. Mental illness and its complications and lack of access to care have been identified as major rural health concerns at the national and state level. There are more than 1.5 million individuals living in rural Missouri. While they have the same kinds of mental health problems and needs for services as individuals who live in metropolitan areas, they are less likely to seek mental health treatment or to have access to needed services. (Rural Mental Health Matters)

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. 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). In 2000, poverty rates in Missouri counties ranged from a low of 4% to a high of 30%. Of the 46 Missouri counties having poverty rates higher than 15%, 31 were rural and 10 were urban/suburban counties.<sup>1</sup> The poverty, in part, stems from the nature of available jobs. Jobs are often part-time or temporary and are less likely to pay benefits.<sup>2</sup>

To address Goal #3 of the New Freedom Commission Report, Missouri strives to Eliminate Disparities in Mental Health Care. The unique and complex characteristics of rural communities called for a specific plan to be developed with local communities to address these issues. Thus, the DMH participated in the Rural Mental Health Care Access Assessment.

**Rural Mental Health Care Access Assessment**

A Rural Mental Health Task Force was formed as a result of a two-year grant project funded by National Library of Medicine. The grant was written by the Mid-Missouri Area Health Education Center (Mid-MO AHEC) in collaboration with the Missouri Rural Health Association (MRHA). A DMH representative actively participated on the task force. A Rural Mental Health Matters report was written for state policy makers, mental health professionals, community leaders and local mental health advocates. The reports and Internet web site assist rural Missourians in accessing and evaluating health information via the web at <http://www.morha.org>. It contains an assessment of mental health resources in Missouri and makes recommendations for individual actions and community collaborations.

---

<sup>1</sup> Hobbs D. (2004) State Overview -- Population with Income below the Federal Poverty Level 1990-2000. Office of Social and Economic Data Analysis. <http://oseda.missouri.edu/>

<sup>2</sup> Flora CB. (2004) Child Poverty in the Rural North Central Region. *Rural Development News*. Ames, Iowa: North Central Regional Center for Rural Development. Ames, Iowa. 27 (1) 1-2

The Missouri Department of Mental Health has primary responsibility for the mental health of Missourians. It uses its limited funds to provide a safety net for the poor, uninsured, or those whose private benefits run out during the course of their illness. The following is a brief listing of available resources for mental health care in Missouri.

Psychiatric Hospitals -- The psychiatric hospitals in Missouri are a mix of private, not-for-profit and state operated facilities. Most of these facilities are located in communities along the I-70 corridor. The largest facility is a state hospital in Callaway County (463 beds); the smallest is in Vernon County and has 40 beds. Seventy-five percent of psychiatric hospitals (1,287 beds) are in metropolitan counties.<sup>3 4</sup>

Psychiatric Hospitals and Residential Treatment Centers for Children and Adolescents -- There are three psychiatric hospitals specifically designed to meet the needs of children and adolescents. In addition, at least two adult psychiatric hospitals have child/adolescent units. A number of residential treatment centers for children and adolescents provide additional services to children and their families. Most of these facilities are located along the I-70 corridor with large concentrations in Kansas City and St. Louis.<sup>4</sup>

General Hospitals with Psychiatric Units or Beds -- General hospitals with specialty psychiatric units or psychiatric beds are also part of the mental health care system. Based on Missouri Department of Health and Senior Services data, there are 46 general hospitals in Missouri that have psychiatric units or staffed psychiatric beds.<sup>3</sup> Of the 1,346 staffed beds in these hospitals, 85% are in metropolitan counties. Only four of the most rural counties have hospitals with psychiatric units or beds – Butler, Dunklin, Howell, and Vernon. It is worth noting that 41 Missouri Counties do not have a hospital and another 42 counties with hospitals have no staffed psychiatric beds. In general, metro counties are more likely to have hospital-based services.

Outpatient Care and Multi-service organizations – Mental health services are provided in many small cities and rural areas through outpatient clinics and multi-service organizations. It is not uncommon for a mental health center in a metro or urban area to have branch offices in surrounding rural communities.<sup>4</sup> Due to budget constraints some of these branch offices are only open on a part-time basis and many are able to provide services to only those with serious mental illnesses. While these outpatient and multi-service organizations have greatly helped to expand mental health care services, there are still some Missouri counties without services locally. This is particularly the case in south central Missouri where there is a cluster of counties with no mental health services.

Substance Abuse Treatment Centers – The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey of facilities providing substance abuse treatment. In 2003, 237 substance abuse treatment facilities in Missouri responded to N-SSATS. This represented a 92% response rate. Of these facilities, 69% were private non-profits, 23% were

---

<sup>3</sup> Missouri Department of Health and Senior Services, Community Data Profiles - Hospitals (updated 5/12/04) <http://www.dhss.mo.gov/GLRequest/CountyProfile.html>

<sup>4</sup> Substance Abuse and Mental Health Services Administration. Mental Health Services Locator. U.S. Department of Health and Human Services <http://www.mentalhealth.org/databases/kdata.aspx?state=ND>

private for profits and about 8% were owned or operated by the local, state or federal government. Outpatient treatment is the most common service provided; 93% of facilities provide outpatient treatment, 30% provided residential care and 5% provide hospital inpatient services. According to the survey there were 17,117 in substance abuse treatment on March 31, 2003 in these 237 facilities. Seventy-one out of Missouri's 115 counties have substance abuse treatment services available in the county. Metro and urban/suburban counties are more likely to have services available than are rural counties. About 70% of metro counties and 73% of urban/suburban counties have services in the county; this compares to 47% of rural counties.<sup>5</sup> In addition, individuals living in metro and urban/suburban counties have access to more providers and a greater variety of services.

Primary care providers – Particularly in rural Missouri, primary care providers and medical clinics are the first point of contact for many individuals with mental health disorders. Rural residents prefer receiving mental health care in primary care settings because it helps maintain confidentiality.<sup>6</sup> Federally Qualified Health Centers, many of which are located in small and rural communities, are required to provide mental health services or arrange for such care. Seven sites (each site includes one CMHC and one FQHC in collaboration) were selected to implement a budget item funded through State General Revenue. The Department is working with the Community Health Centers on integrated services through a collaborative process to target the uninsured population. Doctors and Family Practice Nurses are located at the CMHC for primary care clinics for the uninsured. Targeted Case Manager/Community Support Workers are located in FQHC for behavioral health referral/linking/support. Seven sites have been funded for three years for co-location of services and six sites received one-time funding for planning.

Many rural counties not only have a shortage of mental health providers they also have a shortage of physicians. In 2000, Missouri had 22.4 active physicians per 10,000 population; the national rate was 22.9. Furthermore, physicians were not evenly distributed throughout the state. On average, there were 11.2 physicians per 10,000 population in non-metro counties. This compared with 27.7 physicians per 10,000 in Missouri's metro counties. It is worth noting that 28 counties had fewer than 4 physicians per 10,000 population.<sup>7</sup>

Telehealth – When mental health treatment is needed, clinical services typically take place face-to-face between a mental health provider and a patient. Direct patient care includes assessment, psychotherapy, crisis intervention, patient education, case management, and medication support. Telehealth does not change the nature of these interactions but allows them to occur at a distance.<sup>7</sup> Telehealth is being used to provide mental health services in Missouri. Medicaid does reimburse for telehealth services.

---

<sup>5</sup> Substance Abuse and Mental Health Services Administration. N-SSATS State Profile Missouri 2003. U.S. Department of Health and Human Services <http://www.dasis.samhsa.gov/webt/NewMapv1.htm>

<sup>6</sup> Gamm L, Stone S, and Pittman S. Mental Health and Mental Disorder - A Rural Challenge. In *Rural Healthy People 2010: A Companion Document to Healthy People 2010* (VOL 2) Eds. Larry Gamm, PhD, Linage Hutchison, MBA, Betty Danby, Ph.D. Alicia Dorsey, Ph.D. The Texas A&M University System Health Science Center School of Rural Public Health Southwest Rural Health Research Center, College Station, Texas

<sup>7</sup> Hicks, L. (2002) Changes in Physician Population, 1990 – 2000. *TrendLetter*. University of Missouri. Office of Social and Economic Data Analysis. <http://osed.missouri.edu/>

State Protection and Advocacy Agency -- Each state has a protection and advocacy agency that receives funding from the Federal Center for Mental Health Services. This federally mandated program protects and advocates for the rights of people with mental illness, and investigates reports of abuse and neglect in facilities that care for or treat individuals with mental illness. In Missouri, the Protection & Advocacy for Individuals with Mental Illness Program (PAIMI) is administered by Missouri Protection and Advocacy. For more information about MO P&A call 800-392-8667 or e-mail [mopasjc@socket.net](mailto:mopasjc@socket.net). On the Internet go to [www.moadvocacy.org](http://www.moadvocacy.org)

Voluntary Associations -- Two of the most recognized voluntary associations in Missouri are the National Alliance for the Mentally Ill of Missouri (NAMI) and the National Mental Health America. NAMI of Missouri has active chapters throughout Missouri and offers a range of services including help lines, family and patient support groups, public and professional education, and information about legislation affecting the lives of persons with mental illness. The Mental Health America has affiliates in St. Louis and Kansas City. The Mental Health America of Greater St. Louis (MHA) is a not-for-profit, corporation serving St. Louis city and county and St. Charles, Lincoln, Warren, Franklin and Jefferson counties. The Mental Health America of the Heartland serves the bi-state Kansas City metro area. Programs vary from affiliate to affiliate but include housing and financial management for persons with mental illness, teen suicide and violence prevention, peer support, self help groups, advocacy, community and professional education, and information and referral for families, consumers and professionals.

Community Mental Health Centers -- 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.

# Missouri

## Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

## **Adult Plan**

### **Criterion 4: Older Adults**

A Mental Health and Aging Workgroup was initiated by the Transformation Working Group (TWG) and continues to meet. Membership in the group includes each of the three divisions in the Department of Mental Health (Comprehensive Psychiatric Services, Alcohol and Drug Abuse, and Developmental Disabilities); the Department of Health and Senior Services (DHSS), which includes the State Unit on Aging; the Missouri Association of Area Agencies on Aging (MA4); the Missouri Centers for Independent Living (CILs); the MO HealthNet Division (the state Medicaid agency) in the Department of Social Services (DSS); the Department of Corrections (DOC), and others, including consumer representation.

This Workgroup has identified depression in older adults as a priority. Members recognize that depression in older adults results in increased mortality, increased health care costs, decreased quality of life, increased physical disease, and increased severity of physical disease. Severity of depression in older adults is the strongest predictor of suicidal thoughts. Depression has been shown to be closely linked to chronic heart disease and also has been linked as both causing and worsening the severity of type 2 diabetes. Depression in older adults is directly associated with increased health care costs, including increased home health care, skilled nursing facility placement, physician charges, hospital admissions, and medical equipment usage. However, treatment of depression can help to reverse many of these negative outcomes. Treatment can lead directly to enhanced functional ability and can cut health care costs.

In response to these debilitating effects of depression in older adults, the Mental Health and Aging Workgroup voted to encourage the development of Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), an evidence-based intervention effective with both major and subclinical depression. To this end, the Workgroup, with assistance from Washington University, is sponsoring an informational forum to be held in September 2009. Nancy Wilson (Baylor School of Medicine) and Alixe McNeill (VP, National Council on Aging), both leading lights in the development and dissemination of Healthy IDEAS, will be explaining the program at this statewide meeting of agencies that might be interested in implementing Healthy IDEAS. Through a competitive process, agencies wanting to implement Healthy IDEAS will be provided with resources to defray many of the startup costs associated with the program. Also, funds may be available to assist with the clinical component of the program. Specifics will be explained at the forum. These resources will be made available through funds from the Mental Health Transformation State Incentive Grant program and the Division of Comprehensive Psychiatric Services.

In conjunction with both the Healthy IDEAS initiative and the need to develop resources for older adults suffering from late onset mental illness, the Division of Comprehensive Psychiatric Services is promulgating a change in the Code of State Regulations (CSR) that will expand the list of eligible diagnoses for participation in the Community Psychiatric Rehabilitation Program (CPRP) for person aged 60 and over. Heretofore, major depression recurrent was a qualifying diagnosis, but not major depression single episode. Because older adults may develop late onset depression without earlier episodes, the rule change will enable a greater number of older adults to be eligible for treatment from Community Mental Health Centers (CMHCs) and other

agencies participating in the CPRP. This enables Medicaid funding for treatment for those persons who are Medicaid recipients. Agencies participating in the CPRP will also be able to use their DMH allocations to cover the cost of treatment of older adults suffering from single episode depression who are not Medicaid recipients.

# Missouri

## Adult - Resources for Providers

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

**Adult Plan**  
**Criterion 5: Management Systems**  
**Resources for Providers**

**Financial Resources**

Missouri has experienced the effects of the economic slowdown this year. A limitation on general revenue growth has caused the DMH to face core budget reductions. Emphasis has been placed on implementing evidence-based practices to create greater efficiency and effectiveness.

Fiscal management of mental health services is coordinated with other human services departments, the Medicaid agency, and the Governor's Office. The DMH has been designated as an Organized Health Care Delivery System, which allows reimbursement for some of the administrative services provided for Medicaid. Budgetary planning is formalized and includes consumer and public input. DMH partners with the treatment provider community to alert them to upcoming budget issues and cuts. DMH gives providers time for planning on upcoming budgetary cuts whenever possible. The Missouri Coalition for Community Mental Health Centers is actively involved in the legislative budget process, advocating for their priorities.

The State has sought funding through various sources and has thoroughly investigated Federal grant sources. In 2008 Missouri moved from 9<sup>th</sup> place to 8<sup>th</sup> place in total discretionary funding from SAMHSA. The Missouri Institute of Mental Health has collaborated with DMH to apply for many of these grants.

The DMH has an effective relationship with the State Medicaid Authority (Department of Social Services, MO HealthNet). Approximately 1,000,000 persons in Missouri are eligible for Medicaid, and approximately 40,000 of the 50,000 active mental health consumers in the CPS caseload are Medicaid eligible.

The DMH CPS has met challenges by cooperating with other state agencies to enhance services and programs and develop new and innovative ways to serve consumers. Initiatives within the department have been developed to look at quality assurance, EBPs, 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. The next step is to assure treatment for youth with co-occurring disorders and address the transition from youth to adult services. As the DMH moves into FY 2010, efforts to provide quality services to adults with serious mental illness will take shape through Mental Health Transformation activities. The use of programs and projects like the Medicaid Pharmacy Partnership, suicide prevention, and Peer Specialist Certification has begun the change to a public health model of care that supports recovery.

Several changes with the State Medicaid Authority have allowed maximization of revenue. The Missouri Department of Mental Health began using an Organized Health Care Delivery System (OHCDS) in 2005 to allow billing for administrative services provided for Medicaid. This change in the Department's Medicaid status allowed additional federal funding to be secured to

address financial limitations. The OHCDs allows continuation of the Access Crisis Intervention (ACI) Program.

The Mental Health Block Grant, PATH Grant, Olmstead Grant, Mental Health Mil Tax Boards, discretionary grant awards from SAMHSA, Medicaid, general state revenue and other community funding all help fund mental health services in Missouri.

The total budget for Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services is \$ \$423,994,629 for State Fiscal Year 2010. The federal Block Grant portion of the budget is \$6,842,569. Please refer to the *Grant Expenditure Manner* section for detail on Fiscal Year 2010 Block Grant Expenditure Proposal.

## Staffing

### Rural Mental Health

According to the Rural Health Matters Report, Missouri has a mental health workforce shortage. “In 2000, Missouri had 8.9 non-federal psychiatric patient care physicians per 100,000 population; below the national rate of 12.1. Of the 497 non-federal MD’s providing psychiatric patient care in Missouri, 11 had practices in rural counties. Twenty-six had practices in urban/suburban counties and the remainder (460) had practices in metro counties.<sup>1</sup> Psychologists, social workers, counselors and nurses are also part of the mental health workforce. Based on Missouri Department of Economic Development data, in 2002 there were 1,479 licensed psychologists, 4,721 licensed clinical social workers and 2,579 licensed professional counselors practicing in Missouri.<sup>2</sup> Nurses with special psychiatric training made up a smaller portion of the mental health work force. Most mental health professionals practiced in the metro areas of Missouri and clustered in four areas of the state, St. Louis, Kansas City, Springfield and Columbia. For example, almost 90% (3,691) of licensed clinical social workers practice in metropolitan counties. Residents living in rural areas of the state were least likely to have access to mental health professionals. This was consistent with national trends.<sup>3</sup> About 4% of licensed psychologists, 4% of licensed clinical social workers and 7% of licensed professional counselors had practices in rural Missouri. In reality, these numbers might be somewhat higher because rural residents report that mental health providers from urban communities do come to rural areas to provide care. It is worth noting that most Missouri counties (94 out of 114) are classified as Mental Health Professional Shortage Areas (MHPSA) which means that there are not enough mental health providers in the county to meet the needs of the population. In addition, urban core areas in St. Louis City and Kansas City have these

---

<sup>1</sup> Department of Health and Human Services. (2003) Women's and Minority Health Database, 2003-2004. (CD based) Washington, DC: Office of Public Health and Science.

<sup>2</sup> Missouri Division of Professional Registration. Downloadable files of licensed qualified professionals. Missouri Department of Economic Development. <http://www.ded.mo.gov/regulatorylicensing/>

<sup>3</sup> U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health, 1999.

designations even though the cities themselves do not. Ninety-six percent of Missouri's rural counties are MHPSA. This compares to 62% of metro counties and 83% of urban/suburban counties.”<sup>4</sup>

Staffing in rural areas of the state continue to challenge service providers. Innovative telepsychiatry programs have been implemented at several Administrative Agents including Clark Community Mental Health Center and Pathways Behavioral Health. Located in rural Missouri, both organizations have experienced difficulty accessing psychiatric services. Through telepsychiatry they have provided high quality psychiatric services that otherwise could not have been provided.

#### Community Psychiatric Rehabilitation Programs

Direct care staff members for CPR programs are hired by each program following the personnel policies described in the CPR Program Handbook. Each program must maintain personnel policies, procedures, and practices in accordance with local, state and federal law and regulations. Each program must assure that an adequate number of qualified staff is available to support the required CPR functions, and that staff possess the training, experience and credentials to effectively perform their assigned services and duties. Personnel policies and procedures must be in place to promote effective hiring, staff development, and retention of qualified staff. All direct care staff working in the CPR program must have a background screening conducted in accordance with state standards 9 Code of State Regulations (CSR) 10-5.1090. The state CSR requirements for mental health agencies can be found on the Secretary of State's website at <http://www.sos.mo.gov/adrules/csr/current/9csr/9csr.asp>.

Each agency must appoint a director for the CPR program and this director should be a mental health professional. If the director is not a mental health professional the agency must identify a clinical supervisor who is a mental health professional. Qualifications and credentials of staff shall be verified prior to employment, with primary source verification completed within ninety (90) days.

Agencies certified to provide CPR services to children and youth under the age of 18 must have a director with at least two (2) years of supervisory experience with child and youth populations. If the director does not meet that requirement the agency must designate a clinical supervisor for children and youth services who is a mental health professional, has at least two (2) years of supervisory experience with child and youth populations, and has responsibility for monitoring and supervising all clinical aspects of services to children and youth.

The CPR program must have and implement process for granting clinical privileges to practitioners. Each treatment discipline shall define clinical privileges based upon identified and accepted criteria approved by the governing body. The process shall include periodic review of each practitioner's credentials, performance, and education and the renewal or revision of clinical privileges at least every two (2) years. The initial granting and renewal of clinical privileges will be based on the listed criteria in the CPR Program Handbook and renewal or

---

<sup>4</sup> U.S. Department of Health and Human Services (2005) Health Professional Shortage Areas. Health Resources and Services Administration Ad-Hoc Database Query Selection. <http://belize.hrsa.gov/newhpsa/newhpsa.cfm>

revision of clinical privileges shall also be based on relevant findings from the program’s quality assurance activities and the practitioner’s adherence to the policies and procedures established by the CPR program.

The CPR program shall establish, maintain and implement a written plan for professional growth and development of personnel. All training plans shall minimally incorporate the required topics established by the DMH. In addition, the program shall obtain psychiatric consultation in the development of training plans. Minimum requirements, general orientation and training, community support training, the training of volunteers and the description of training documentation are outlined in the CPR Program Manual.

### **Training**

#### Training and Human Resource Development Needs Assessment

In June 2005, Organizational Leadership Programs (OLP) associates of the University of Missouri-Columbia contracted with the Missouri DMH to assess current training and human resource development needs among DMH employees and contractors throughout the state of Missouri. The summary of findings will be used to guide the DMH Executive Team’s effort to generate a plan of action to address current training needs.

As a piece of the needs assessment, a Web Survey was completed of employees and contract providers. Training was rated as very important. A list of the priorities for training topics is listed below.

All items with scores of 3.5 or higher are reported below. This reflects more urgency (1 = not urgent, 5 = very urgent)

<b>Clinical / Direct Consumer Care</b>	<b>Mean</b>
Handling Difficult Behavior	<b>3.90</b>
Crisis Intervention/Critical Incidents	<b>3.80</b>
Critical Incident Reporting and Documentation	<b>3.76</b>
Co-Occurring Disorders/Dual Diagnosis	<b>3.74</b>
Clinical Best Practices	<b>3.73</b>
Consumer Treatment Planning (e.g., person-centered)	<b>3.73</b>
Trauma and Abuse Issues	<b>3.66</b>
Special Populations (e.g., geriatric, children, sex offenders)	<b>3.63</b>
Relationships with Consumers	<b>3.60</b>
Assessment Skills	<b>3.57</b>
Counseling/Therapy	<b>3.56</b>
Abuse and Neglect (consumer)	<b>3.54</b>

The department has provided technical assistance and training on many evidence based practices to the community treatment providers. Treatment providers have received extensive training on Integrated Dual Disorders Treatment, Assertive Community Treatment, Supported Employment, Motivational Interviewing Skills, Dialectal Behavior Therapy and Trauma Informed Care. This

addresses many of the areas identified in the needs assessment noted above. The children's service providers have received extensive training on Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Twenty-four therapists have become certified in TF-CBT in the Central region of the state and 19 therapists have become certified in the Western region.

The Missouri Foundation for Health has also funded significant training and technical assistance for treatment providers on co-occurring psychiatric and substance abuse disorders.

#### Spring Training Institute

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. In 2008, over 1180 professionals, administrators and consumers participated in the training. While the 2009 conference was canceled due to budget issue, planning is underway for the May 2010 event.

#### Missouri Institute of Mental Health

Service Providers across the State also have access to trainings at low 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 are web-based and on-line trainings in addition to the face-to-face regional trainings.

# Missouri

## Adult - Emergency Service Provider Training

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

**Adult and Child Plan**  
**Criterion 5: Management Systems**  
**Emergency Service Provider Training**

The Department of Mental Health as the public mental health authority leads the mental health response to disasters within Missouri. The Department continues to plan for its own facilities and for a statewide response. In addition, DMH is working cooperatively with other state agencies to plan for disasters and public health emergencies as well as to develop and provide training.

Disaster Services includes a coordinator, assistant coordinator and a part-time administrative assistant as funded in collaboration with the Department of Health and Senior Services (DHSS) grant funding awarded through the Assistant Secretary for Preparedness Response (ASPR). The ASPR Grant supports deliverables to DHSS and DMH including planning and training activities, exercise participation, interagency coordination, risk communication message development and crisis management. DMH staff also responds to disasters through participation at the State Emergency Operations Center.

**In the last year the DMH has:**

- Continued to partner closely with other state level entities:
  - Department of Health and Senior Services: The Office of Disaster Readiness (ODR) continues to be an active participant of the Special Needs committee. A webinar was provided for DMH regional managers regarding special needs planning and sheltering.
  - Provided an introduction to Psychological First Aid at the Public Health Conference and the SEMA Conferences.
  - Worked with DHSS to develop mental health specific materials to address a pandemic situation.
  - Department of Public Safety, State Emergency Management Agency(SEMA)
    - Developed the mental health annex for the Emergency Response and Information Plan (ERIP). Missouri's online emergency planning template for schools, institutions of higher education and day care agencies.
    - Exhibition of Mental Health TIPS and other information for first responders for coping in emergency and disaster situation was offered to the annual SEMA conference with an attendance of 500+ attendees.
- Developed and led various trainings using curriculum jointly developed with St. Louis University Heartland Centers that included:
  - *Disasters and Mental Health: A Basic Approach for Healthcare*
  - *Disasters and Mental Health: A Basic Approach for School Personnel*
  - *Disasters and Mental Health: A Basic Approach for Pastoral Care.*
  - From August 10, 2008 to August 9, 2009, The Office of Disaster Readiness provided training to 1196 individuals.
  - Development and provision of *Psychological First Aid Train-the-Trainer* course for hospital staff, public health care workers and mental health was provided through the sponsorship of the St. Louis Area Regional Response System (STARRS) twice, February 10 and 11, 2009.

- Train-the-Trainer programs in *Psychological First Aid* was provided to the Department of Social Services Mass Care Planning Team (seven individuals) who will in turn train the 2,800 Social Service Family Support Division staff who respond to local disaster situations.
- *Mental Health Planning for Higher Education Train the Trainer* course was provided April 9, 2009 for the regional Access Crisis Intervention Providers to prepare them to work with their local colleges and universities
- Crisis Counseling Mid-term and Final Training for the FEMA Immediate Services Grant, LifeRAFT (Rebuilding After Flood Times)for crisis counselors and grant administrators and from the Northeast region.

**Disaster Services Continuing Projects: Future Plans**

The Office of Disaster Readiness will continue to provide the Disasters and Mental Health/Psychological First Aid courses to healthcare providers, school staff and pastoral care. Efforts will continue to provide specialized presentations to targeted groups to respond to the needs of hospital and health care staff to assist in the provision of responsive mental health services and to plan for meeting the needs of their staff in times of disaster or terrorism events.

# 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

Department of Mental Health  
Division of Comprehensive Psychiatric Services  
State Fiscal Year 2010 Estimated Block Grant Expenditures

Provider	Adult	Youth	Total
Adapt of Missouri	\$ 43,672	\$ -	\$ 43,672
Alliance for the Mentally Ill	\$ 4,990	\$ 690	\$ 5,680
East Central MO BH (formerly Arthur Center)	\$ 66,489	\$ 10,860	\$ 77,349
Bootheel Counseling Services	\$ 93,038	\$ 68,339	\$ 161,377
Burrell Center	\$ 743,846	\$ 9,642	\$ 753,488
Clark Community Mental Health	\$ 39,684	\$ 2,476	\$ 42,160
Community Counseling Center	\$ 1,266	\$ 175	\$ 1,441
Community Health Plus - St. Louis	\$ 1,740,425	\$ 144,910	\$ 1,885,336
Community Network for Behavior	\$ 3,951	\$ 546	\$ 4,498
Community Treatment	\$ 197,599	\$ 18,200	\$ 215,800
Comprehensive Mental Health	\$ 59,201	\$ 12,967	\$ 72,168
County of Nodaway Committee	\$ 1,338	\$ 185	\$ 1,523
Crider Center for Mental Health	\$ 431,741	\$ 68,467	\$ 500,208
Comprehensive Psychiatric Services CO	\$ 275,989	\$ 38,156	\$ 314,146
Dexter Community Regional	\$ 827	\$ 114	\$ 941
Family Counseling Center	\$ 172,660	\$ 12,674	\$ 185,334
Family Guidance Center	\$ 93,590	\$ 1,759	\$ 95,349
Hopewell Center	\$ 288,082	\$ 63,966	\$ 352,048
Kids Under Twenty One	\$ 6,946	\$ 960	\$ 7,907
Mark Twain Mental Health	\$ 210,521	\$ 1,625	\$ 212,147
North Central	\$ 150,855	\$ 7,299	\$ 158,154
Ozark Center	\$ 273,291	\$ 33,237	\$ 306,528
Ozark Medical Center	\$ 136,754	\$ 20,715	\$ 157,469
Pathways Community Behavioral Health	\$ 611,329	\$ 7,075	\$ 618,404
Preferred Family Health Care	\$ 10,292	\$ 1,423	\$ 11,715
Prevention Consultants of Missouri	\$ 5,019	\$ 694	\$ 5,713
ReDiscover Mental Health	\$ 59,907	\$ 44,862	\$ 104,769
Swope Parkway Mental Health Center	\$ 52,195	\$ -	\$ 52,195
Tri-County Mental Health Services	\$ 14,118	\$ 194,181	\$ 208,299
Truman Behavioral Health	\$ 322,540	\$ 56,439	\$ 378,979
	<u>\$ 6,112,156</u>	<u>\$ 822,636</u>	<u>\$ 6,934,792</u>

Note: Block Grant dollars are used for community based treatment services for SMI adult and SED children population and suicide prevention.

**Table C. MHBG Funding for Transformation Activities  
State: Missouri**

	<b>Column 1</b>	<b>Column 2</b>	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the <i>actual</i> <b>or</b> <i>estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY2010	
		<b>Actual</b>	<b>Estimated</b>
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	<input checked="" type="checkbox"/>	150,000	
GOAL 2: Mental Health Care is Consumer and Family Driven	<input type="checkbox"/>		
GOAL 3: Disparities in Mental Health Services are Eliminated	<input checked="" type="checkbox"/>	916,000	
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	<input type="checkbox"/>		
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	<input type="checkbox"/>		
GOAL 6: Technology Is Used to Access Mental Health Care and Information	<input type="checkbox"/>		
<b>Total MHBG Funds</b>	N/A	1,066,000	0

\*Goal 5 of the Final Report of the President’s New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research ... Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

# Missouri

## Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Goal 1: Americans Understand that Mental Health is Essential to Overall Health  
\$150,000 is for Suicide Prevention.

Goal 3: Disparities in Mental Health Services are Eliminated \$916,000 is for  
New Medications.

For the Mental Health Transformation, State of Missouri, Comprehensive Plan for  
Mental Health, Federal FY 2009 Action Plan Update see Appendix A.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	58,926	58,945	61,473	58,926	58,926
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Increase access to services
- Target:** Maintain the number of adults with SMI receiving mental health services above FY2007 level
- Population:** Adults with SMI
- Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services
- Indicator:** Number of adults with SMI receiving CPS funded services
- Measure:** No numerator or denominator on this performance indicator
- Sources of Information:** CIMOR
- Special Issues:** Mental health services are underfunded both nationally and in the State of Missouri. Due to the economic crisis, the Missouri DMH budget took a \$500,000 core reduction in SFY 2010. The target is set at the 2007 number of adults with SMI receiving services due to the reduction in budget and uncertainty regarding the ability to continuously increase the numbers served. Additionally, the number may be reduced due to the privatization of two acute care psychiatric hospitals in Missouri.
- Significance:** Due to fiscal constraints, Missouri CPS is only meeting 25% of the estimated prevalence of SMI.
- Action Plan:** The DMH and CPS will continue to explore funding opportunities to meet the mental health needs of Missourians. CPS will continue to utilize funding on evidence based practices to wisely use the limited funding in an efficient and effective manner.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	8	7.46	6.96	6.96	6.96
Numerator	581	501	--	--	--
Denominator	7,260	6,719	--	--	--

Table Descriptors:

**Goal:** Reduce 30 day readmission percentage to state psychiatric hospital inpatient beds

**Target:** Reduce or maintain 30 day readmission percentage to state psychiatric hospital inpatient beds

**Population:** Adults with SMI

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults readmitted to state psychiatric hospitals within 30 days of discharge

**Measure:** The numerator is number of clients readmitted to state psychiatric hospitals within 30 days of discharge. The denominator is total discharges from state psychiatric hospitals in year.

**Sources of Information:** CIMOR

**Special Issues:** Adult SMI admissions are frequently linked to involuntary commitments and forensic issues beyond the control of the department.

**Significance:** Community Psychiatric Rehabilitation programs serve adults with Severe Mental Illness within their community with the goal of reducing admissions and readmissions into State psychiatric hospital beds. The program provides medication and psychiatric services in the community. The program provides case management activities and community support, linking individuals with appropriate programs and services within their community, providing experiential training in social and professional settings, and helping individuals access treatment and follow a treatment regimen.

**Action Plan:** State hospitals and community service providers will continue collaborative activities to keep individuals out of the state hospitals and receiving services in the community. The evidence based practice of Assertive Community Treatment works with the most vulnerable population. The six ACT teams will continue to focus on keeping their clients in the community. Additionally, Peer Specialists will work to transition clients from the hospital to the community and encourage engagement in the community treatment program.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	26.71	23.66	22.07	22	22
Numerator	1,939	1,590	--	--	--
Denominator	7,260	6,720	--	--	--

Table Descriptors:

**Goal:** Reduce percentage of readmission for adults to State psychiatric hospitals within 180 days

**Target:** Reduce or maintain the percentage of readmission to State psychiatric hospital beds within 180 days

**Population:** Adults with SMI

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults readmitted to State psychiatric hospitals within 180 days of discharge

**Measure:** The numerator is number of clients readmitted to State psychiatric hospitals within 180 days of discharge.  
The denominator is total discharges from State psychiatric hospitals in year.

**Sources of Information:** CIMOR

**Special Issues:** The method of determining the measure changed this year. The data previously considered 18 months of data and this year only considers 12 months of data. The FY 2007 and FY 2008 Actual data was recalculated.

Adult SMI admissions are frequently linked to involuntary commitments and forensic issues beyond the control of the department.

**Significance:** CPRP serve adults with Severe Mental Illness within their community with the goal of reducing admissions and readmissions into State psychiatric hospital beds. The program provides medications and psychiatric services in the community. The program provides case management activities and community support, linking individuals with appropriate programs and services within their community, providing experiential training in social and professional settings, and helping individuals access treatment and follow a treatment regimen.

**Action Plan:** State hospitals and community service providers will continue collaborative activities to keep individuals out of the state hospitals and receiving services in the community. The evidence based practice of Assertive Community Treatment works with the most vulnerable population. The six ACT teams will continue to focus on keeping their clients in the community. Additionally, Peer Specialists will work to transition clients from the hospital to the community and encourage engagement in the community treatment program.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	2	3	4	4	4
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Increase the number of Evidence Based Practices utilized in the Missouri mental health system

**Target:** Increase and maintain the number of Evidence Based Practices utilized in the Missouri mental health system

**Population:** Adults with SMI

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of Evidence Based Practices utilized in the Missouri mental health system

**Measure:** No numerator or denominator.

**Sources of Information:** Department of Mental Health, Division of Comprehensive Psychiatric Services

**Special Issues:** Missouri has been implementing the EBP of Supported Employment for years. In 2007, the Integrated Dual Disorders Treatment EBP was added. In 2008, Assertive Community Treatment started implementation in the State. In 2009 Illness Management and Recovery has been added to the EBP implemented in Missouri. Missouri is also implementing Dialectical Behavior Therapy across the state. DBT is an EBP, but not one recognized by the Block Grant application.

**Significance:** CPS has the Evidence Based Practice of Supported Employment implemented in multiple agencies across the State. CPS has implemented in 20 agencies and 32 sites the Integrated Dual Diagnosis Treatment since fiscal year 2007. The level of fidelity to the EBP toolkit model has been assessed for both EBP. Assertive Community Treatment is the third EBP in process of implementation. Six ACT teams are operational and data is being collected. The ACT Teams have received technical assistance and initial visits to discuss fidelity. Over the next year, monitoring visits will be implemented to assess baseline ACT fidelity.

**Action Plan:** CPS continues working towards integrating employment activities into all consumer individualized treatment plans, when appropriate, in the Community Mental Health Center system. CPS will use the Johnson and Johnson Supported Employment grant to provide technical assistance to providers to continue the process of enhancing fidelity. CPS will continue working to consistently implement Integrated Dual Diagnosis Treatment and Assertive Community Treatment evidence based practices in the mental health system to fidelity of the models. Illness Management and Recovery is the new EBP implemented to the SAMHSA Toolkit model. CPS will continue to monitor fidelity and assure best practice implementation.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	1,078	6.63	6	6	6
Numerator	N/A	3,908	--	--	--
Denominator	N/A	58,941	--	--	--

Table Descriptors:

- Goal:** Increase the percentage of individuals receiving Evidence Based Practice of Supported Employment
- Target:** Increase or maintain the percentage of individuals receiving Evidence Based Practice of Supported Employment
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of individuals receiving the Evidence Based Practice of Supported Employment through cooperative services between the Community Mental Health Centers (CPS vendors) and Missouri Division of Vocational Rehabilitation
- Measure:** The numerator is number of individuals receiving Supported Employment through cooperative services between the Community Mental Health Centers and Missouri Division of Vocational Rehabilitation. The denominator is the number of adults with SMI served with CPS funds.
- Sources of Information:** Missouri Department of Elementary and Secondary Education, Division of Vocational Rehabilitation
- Special Issues:** The Division of CPS received a Johnson & Johnson grant to provide Supported Employment training and technical assistance.
- Significance:** The Division of Comprehensive Psychiatric Services and the Division of Vocational Rehabilitation have a strong working relationship.
- Action Plan:** The Divisions of CPS and VR will continue to strengthen their partnership for the purpose of increasing the number of clients with psychiatric illness finding and maintaining competitive employment. The divisions will continue to cooperate on the Johnson and Johnson grant to assure supported employment training for providers. Benefits Planning training has already occurred for community support workers as concerns regarding loss of benefits are a major barrier for the SMI population if they return to work. This training will continue and expand as will training on fidelity to the model.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Assertive Community Treatment  
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	0	.51	1.14	1.16	1.18
Numerator	0	152	--	--	--
Denominator	N/A	29,884	--	--	--

Table Descriptors:

**Goal:** Increase the percentage of individuals receiving the evidence based practice of Assertive Community Treatment

**Target:** Increase the percentage of individuals receiving the evidence based practice of Assertive Community Treatment incrementally

**Population:** Adults with SMI

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of individuals receiving the evidence based practice of Assertive Community Treatment

**Measure:** The numerator is the number of individuals receiving Assertive Community Treatment. The denominator is the number of individuals receiving Community Psychiatric Rehabilitation services.

**Sources of Information:** CIMOR

**Special Issues:** Assertive Community Treatment teams started in Missouri in 2008. Individuals have been enrolled, multidisciplinary teams have formed and ACT services are being provided. Training and technical assistance from CPS has been provided for the ACT team providers.

**Significance:** CPS will slowly increase the number of individuals receiving ACT services as money becomes available and teams become fully functional.

**Action Plan:** CPS will continue to identify high end users of services (crisis, emergency room, homeless, etc.) and place them in ACT services as appropriate. CPS will continue to provide technical assistance and training to providers as they fully implement ACT. CPS will measure fidelity over the next year of the six existing ACT teams.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	1.39	3.20	3.30	3.40
Numerator	N/A	414	--	--	--
Denominator	N/A	29,884	--	--	--

Table Descriptors:

- Goal:** Increase the percentage of adults with SMI receiving evidence based integrated treatment for co-occurring psychiatric and substance use disorders
- Target:** Increase the percentage of individuals receiving the evidence based practice of Integrated Dual Disorders Treatment (IDDT)
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of individuals billed by providers to CPS receiving the evidence based practice of Integrated Dual Disorders Treatment
- Measure:** The numerator is number of individuals being billed by providers to one of the four co-occurring IDDT billing codes.  
The denominator is the number of adults served in the Community Psychiatric Rehabilitation programs.
- Sources of Information:** CIMOR
- Special Issues:** CPS is measuring fidelity to the IDDT model. Not all of the clients receiving co-occurring psychiatric and substance use services are billed to CPS. There are other funding sources such as the Division of Alcohol and Drug Abuse and the Missouri Foundation for Health that pay for co-occurring services. These individuals are not captured in this data.
- Significance:** The projected number for SMI adults receiving IDDT services billed to CPS is 1056. This is a significant increase over the the FY 2008 number of 414.
- Action Plan:** CPS will continue to implement IDDT services to fidelity. Twenty agencies with 32 locations have voluntarily implemented IDDT in their community mental health centers. CPS will continue to monitor IDDT fidelity on an annual basis. CPS will continue to provide technical assistance and training on the IDDT model. CPS will continue to collaborate with the Missouri Foundation for Health as they provide training with Drs. Ken Minkoff and Christine Cline on co-occurring disorders treatment. CPS will continue to collaborate with the Missouri Institute of Mental Health as they provide co-occurring treatment fidelity reviews for Missouri Foundation for Health grant funded programs.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	90.44	91.77	91.49	87	87
Numerator	1,163	4,792	--	--	--
Denominator	1,286	5,222	--	--	--

Table Descriptors:

- Goal:** Clients reporting positively about perception of care
- Target:** The target is that Missouri will exceed the national average rate of 87% of the respondents to the Consumer Satisfaction Survey will be satisfied or very satisfied with the services received.
- Population:** Adults receiving Community Psychiatric Services funded by CPS
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of adults satisfied or very satisfied with services
- Measure:** The numerator is the number of clients reporting being "satisfied" or "very satisfied" with the services provided.  
The denominator is the total number of clients surveyed.
- Sources of Information:** Consumer Satisfaction Survey
- Special Issues:** The Consumer Satisfaction Survey is conducted on a continuous basis using a revised form of the MHSIP.
- Significance:** Consumers were generally satisfied with services.
- Action Plan:** The department will continue to use the revised MHSIP to gather consumer satisfaction data. The data will be analyzed and used to measure consumer outcomes.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	16.52	14.26	15.20	15	15
Numerator	492	544	--	--	--
Denominator	2,979	3,814	--	--	--

Table Descriptors:

**Goal:** Increase or maintain the percentage of consumers employed

**Target:** Increase or maintain the percentage of consumers employed

**Population:** Adults with SMI

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

**Indicator:** Percentage of adults with SMI receiving CPS funded services working or involved in educational activity

**Measure:** The numerator is the number of adults with SMI working or involved in educational activity. The denominator is the total number of adults working and not working in sample.

**Sources of Information:** Adult Status Reports

**Special Issues:** An Adult Status Report sample is used to obtain this percentage. The low sample size (less than 3815) can lead to fluctuations in percentages based on small actual number changes. As CPS refines the new CIMOR database, the hope is that data will be more accurate and easily collected. Data will eventually be obtained and analyzed on every consumer rather than a sample.

The economic downturn and high employment rates both nationally and in Missouri may also effect this percentage in the future thus effecting targets.

**Significance:** Nationally and in Missouri the numbers of adults with severe mental illness who are competitively employed is fairly low.

**Action Plan:** DMH will continue to implement EBP of Supported Employment with the goal of increasing the number of individuals with psychiatric illness who are competitively employed. CPS has provided Benefits Planning training in conjunction with VR for community support workers in the community mental health centers. CPS will continue to focus on reducing barriers to the SMI population working in competitive employment. One of the barriers is perception regarding the loss of benefits if employed. CPS and VR are working to assure accurate information is available to consumers to make informed decisions regarding work.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	4.90	4.74	5	5
Numerator	N/A	254	--	--	--
Denominator	N/A	5,181	--	--	--

Table Descriptors:

**Goal:** Decrease the percentage of adults with SMI receiving treatment involved in the criminal justice system

**Target:** Decrease or maintain the percentage of adults with SMI receiving treatment who are involved in the criminal justice system below 5%

**Population:** Adults with SMI

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults with SMI receiving treatment involved in the criminal justice system

**Measure:** The numerator is the number of adults completing the criminal justice questions on the consumer satisfaction survey arrested in the last 12 months.  
The denominator is the total number of adults completing the criminal justice questions on the consumer satisfaction survey.

**Sources of Information:** Consumer Satisfaction Survey

**Special Issues:** CPS is using a modified MHSIP for the Consumer Satisfaction Survey. CPS has collected only two years of data for this performance indicator. The target has been set a maintaining a percentage below 5%, as this is a fairly new indicator and CPS believes the data can realistically stay below the rounded up number. Sample size is low and can fluctuate due to small actual number changes.

**Significance:** A low number of adults with SMI have been arrested in the past 12 months.

**Action Plan:** CPS will continue to support mental health courts to encourage consumers to live healthy lifestyles free of criminal activity. CPS will continue to support the Crisis Intervention Team collaboration with police departments to appropriately handle mental illness behaviors in the community.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	77.34	76.43	76.70	76.70	76.70
Numerator	2,495	2,977	--	--	--
Denominator	3,226	3,895	--	--	--

Table Descriptors:

- Goal:** Increase stability in housing
- Target:** Increase or maintain the percentage of consumers living in home or home-like settings
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of adults with SMI living in their own home or home-like settings
- Measure:** The numerator is the number of adults with SMI sampled living in home or home-like settings. The denominator is the total number of adults with SMI sampled living in all settings.
- Sources of Information:** Adult Status Reports
- Special Issues:** An Adult Status Report sample is used to obtain this percentage. As CPS refines the new CIMOR database, the hope is that data will be more accurate and easily collected. Data will be obtained and analyzed on every consumer rather than a sample.
- Significance:** Currently DMH has thirty Shelter Plus Care grants. These grants provide rental assistance for over 1900 individuals and their family members throughout fifty different counties spending over \$6.5 million a year in rental assistance and \$9 million in supportive services. 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.
- Action Plan:** DMH will continue to support housing options that offer independent housing in the consumers community of choice. DMH provides an array of housing options from residential care facilities to independent housing. Funding is competitively received through Shelter Plus Care grants, Missouri Housing Development Commission Housing Trust Funds, Rental Assistance Program, PATH grants, State general revenue dollars, supportive community living, and most recently Homeless Prevention and Rapid Re-housing Program funds.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	68.65	68.10	68	68
Numerator	N/A	3,517	--	--	--
Denominator	N/A	5,123	--	--	--

Table Descriptors:

- Goal:** Increase or maintain the social supports/social connectedness reported by consumers of CPS services
- Target:** Increase or maintain the social supports/social connectedness reported by consumers of CPS services
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of consumers reporting social connectedness on the Consumer Satisfaction Survey
- Measure:** The numerator is the number of consumers reporting social connectedness on the Consumer Satisfaction Survey.  
The denominator is the number of consumers completing the Consumer Satisfaction Survey.
- Sources of Information:** Consumer Satisfaction Survey
- Special Issues:** CPS has started using a modified MHSIP for the Consumer Satisfaction Survey. Targets are being set with only two years of data to review. The low sample size can lead to fluctuations in percentages based on small actual number changes.
- Significance:** 68% of consumers report being socially connected
- Action Plan:** Additional Consumer Satisfaction Surveys will be collected and data analyzed over time.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	70.10	69.56	69	69
Numerator	N/A	3,564	--	--	--
Denominator	N/A	5,084	--	--	--

Table Descriptors:

- Goal:** Improve level of functioning
- Target:** Improve or maintain consumer reported level of functioning
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations
- Indicator:** Percentage of consumers reporting improved level of functioning on Consumer Satisfaction Survey
- Measure:** The numerator is the number of consumers reporting improved level of functioning on the Consumer Satisfaction Survey.  
The denominator is the total number of consumers responding to the Consumer Satisfaction Survey.
- Sources of Information:** Consumer Satisfaction Survey
- Special Issues:** CPS has recently started using a modified MHSIP for the Consumer Satisfaction Survey. Targets are being set with only two years of data to review. The low sample size can lead to fluctuations in percentages based on small actual number changes.
- Significance:** Almost 70% of consumers report improved level of functioning on the Consumer Satisfaction Survey.
- Action Plan:** Additional Consumer Satisfaction Surveys will be collected and analyzed over time.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Case Management Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	51,442	52,688	56,256	56,260	56,270
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Provide case management/community support services to eligible adults with SMI

**Target:** Increase the number of individuals receiving case management/community support services

**Population:** Adults with SMI

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

**Indicator:** Number of individuals receiving case management/community support services

**Measure:** There is no numerator or denominator.

**Sources of Information:** Services billing database

**Special Issues:** Funding was designated for the Assertive Community Treatment model of care. CPS has six ACT programs with outreach to underserved populations.

**Significance:** Case management/community support work along with medication management have been shown to reduce the rate of hospitalization. The DMH provides case management to eligible adults with SMI within the CPS system to reduce hospitalizations and allow individuals to live productive lives in their communities. The majority of the individuals receiving case management/community support are participating in the Comprehensive Psychiatric Rehabilitation Programs.

**Action Plan:** CPS will continue to provide case management/community support services to large numbers of SMI adults. The ACT teams will specifically focus on the hard to reach/engage population that are high utilizers of community resources.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** EBP Integrated Dual Disorders Treatment

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	0	16	20	20	20
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Increase the number of community agencies working towards fidelity to the EBP Co-Occurring Disorders: Integrated Dual Disorders Treatment model
- Target:** Increase and maintain the number of community agencies working towards fidelity to the EBP Co-Occurring Disorders: Integrated Dual Disorders Treatment model
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Number of community agencies working towards fidelity to the EBP Co-Occurring Disorders: Integrated Dual Disorders Treatment model
- Measure:** No numerator or denominator
- Sources of Information:** Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services
- Special Issues:** The Co-Occurring State Incentive Grant (COSIG) allowed CPS to provide intensive technical assistance and training to community agencies to implement the IDDT EBP. CPS is collaborating with the Missouri Institute of Mental Health for evaluation of some of the programs. Fidelity measurement is being conducted on a regular basis to assure fidelity to the IDDT model. Funding is also provided to the agencies for co-occurring disorders treatment from the Missouri Foundation for Health.
- Significance:** CPS is adding agencies to the list of IDDT providers as assurance that fidelity is being strived for and action plans are in place.
- Action Plan:** CPS will continue to provide technical assistance, training and evaluation to community agencies to increase the number providing IDDT to fidelity.

# 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.

## **Child Plan**

### **Criterion 1: Comprehensive Community-Based Mental Health Services System Establishment of System of Care**

#### **Department of Mental Health State Statute**

The State's Revised Statutes of Missouri 2008 RSMo 630.020 set the 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.”

#### **Comprehensive Children's Mental Health Service System State Statute**

The State's Revised Statutes of Missouri 2008 RSMo 630.097 and 630.1000 set the Departmental Comprehensive Children's Mental Health Service System:

“Comprehensive children's mental health service system to be developed--team established, members, duties--plan to be developed, content--evaluations to be conducted, when.

630.097. 1. The department of mental health shall develop, in partnership with all departments represented on the children's services commission, a unified accountable comprehensive children's mental health service system. The department of mental health shall establish a state interagency comprehensive children's mental health service system team comprised of representation from:

(1) Family-run organizations and family members;

(2) Child advocate organizations;

(3) The department of health and senior services;

- (4) The department of social services' children's division, division of youth services, and the division of medical services;
- (5) The department of elementary and secondary education;
- (6) The department of mental health's division of alcohol and drug abuse, division of mental retardation and developmental disabilities, and the division of comprehensive psychiatric services;
- (7) The department of public safety;
- (8) The office of state courts administrator;
- (9) The juvenile justice system; and
- (10) Local representatives of the member organizations of the state team to serve children with emotional and behavioral disturbance problems, developmental disabilities, and substance abuse problems.

The team shall be called "The Comprehensive System Management Team". There shall be a stakeholder advisory committee to provide input to the comprehensive system management team to assist the departments in developing strategies and to ensure positive outcomes for children are being achieved. The department of mental health shall obtain input from appropriate consumer and family advocates when selecting family members for the comprehensive system management team, in consultation with the departments that serve on the children's services commission. The implementation of a comprehensive system shall include all state agencies and system partner organizations involved in the lives of the children served. These system partners may include private and not-for-profit organizations and representatives from local system of care teams and these partners may serve on the stakeholder advisory committee. The department of mental health shall promulgate rules for the implementation of this section in consultation with all of the departments represented on the children's services commission.

2. The department of mental health shall, in partnership with the departments serving on the children's services commission and the stakeholder advisory committee, develop a state comprehensive children's mental health service system plan. This plan shall be developed and submitted to the governor, the general assembly, and children's services commission by December, 2004. There shall be subsequent annual reports that include progress toward outcomes, monitoring, changes in populations and services, and emerging issues. The plan shall:

- (1) Describe the mental health service and support needs of Missouri's children and their families, including the specialized needs of specific segments of the population;
- (2) Define the comprehensive array of services including services such as intensive home-based services, early intervention services, family support services, respite services, and behavioral assistance services;

- (3) Establish short- and long-term goals, objectives, and outcomes;
  - (4) Describe and define the parameters for local implementation of comprehensive children's mental health system teams;
  - (5) Describe and emphasize the importance of family involvement in all levels of the system;
  - (6) Describe the mechanisms for financing, and the cost of implementing the comprehensive array of services;
  - (7) Describe the coordination of services across child-serving agencies and at critical transition points, with emphasis on the involvement of local schools;
  - (8) Describe methods for service, program, and system evaluation;
  - (9) Describe the need for, and approaches to, training and technical assistance; and
  - (10) Describe the roles and responsibilities of the state and local child-serving agencies in implementing the comprehensive children's mental health care system.
3. The comprehensive system management team shall collaborate to develop uniform language to be used in intake and throughout the\* provision of services.
4. The comprehensive children's mental health services system shall:
- (1) Be child centered, family focused, strength based, and family driven, with the needs of the child and family dictating the types and mix of services provided, and shall include the families as full participants in all aspects of the planning and delivery of services;
  - (2) Provide community-based mental health services to children and their families in the context in which the children live and attend school;
  - (3) Respond in a culturally competent and responsive manner;
  - (4) Emphasize prevention, early identification, and intervention;
  - (5) Assure access to a continuum of services that:
    - (a) Educate the community about the mental health needs of children;
    - (b) Address the unique physical, behavioral, emotional, social, developmental, and educational needs of children;
    - (c) Are coordinated with the range of social and human services provided to children and their families by local school districts, social services, health and senior services, public safety, juvenile offices, and the juvenile and family courts;

- (d) Provide a comprehensive array of services through an integrated service plan;
- (e) Provide services in the least restrictive most appropriate environment that meets the needs of the child; and
- (f) Are appropriate to the developmental needs of children;
- (6) Include early screening and prompt intervention to:
  - (a) Identify and treat the mental health needs of children in the least restrictive environment appropriate to their needs; and
  - (b) Prevent further deterioration;
- (7) Address the unique problems of paying for mental health services for children, including:
  - (a) Access to private insurance coverage;
  - (b) Public funding, including:
    - a. Assuring that funding follows children across departments; and
    - b. Maximizing federal financial participation;
  - (c) Private funding and services;
- (8) Assure a smooth transition from child to adult mental health services when needed;
- (9) Coordinate a service delivery system inclusive of services, providers, and schools that serve children and youth with emotional and behavioral disturbance problems, and their families through state agencies that serve on the state comprehensive children's management team; and
- (10) Be outcome based.

5. By August 28, 2007, and periodically thereafter, the children's services commission shall conduct and distribute to the general assembly an evaluation of the implementation and effectiveness of the comprehensive children's mental health care system, including an assessment of family satisfaction and the progress of achieving outcomes.”

Missouri State Statute 630.1000

“Office of comprehensive child mental health established, duties--staff authorized.

630.1000. 1. There is hereby established in the department of mental health an "Office of Comprehensive Child Mental Health". The office of comprehensive child mental health, under the supervision of the director of the department of mental health, shall provide leadership in

developing and implementing the comprehensive child mental health service system plan established under section 630.097. The office shall:

- (1) Assure oversight and monitoring of 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 service system established under section 630.097;
- (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 providing 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.

2. The departments participating in the comprehensive child mental health service system established under section 630.097 shall designate staff to represent their respective department on the state comprehensive system management team.”

# 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.

## **Child Plan**

### **Criterion 1: Comprehensive Community-Based Mental Health Services Available Services**

State statute allows the DMH to provide for the establishment and implementation of rules for community based programming and an integrated system of care for individuals with mental illness. Services are available to children, youth and families in Missouri as categorized below.

#### **Health, Mental Health, and Rehabilitation Services**

**Community Psychiatric Rehabilitation (CPR)** provides a range of essential mental health service to children and youth with serious emotional disorders. These community-based services are designed to maximize 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. At intake children and youth are required to have a medical examination. Community Support Workers with the CPR program keep track of medical conditions and record changes as they occur. Individuals access medical and dental care along with other critical services with the assistance of their community support worker. The CPR program has developed strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to Comprehensive 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. In 2007 the Division of CPS agreed to expand CPR eligibility for children through using a functional assessment in combination with a diagnosis of a serious emotional disorder. The Child Adolescent Functional Assessment Scale was selected as the functional tool. Children who have any serious emotional disorder and a CAFAS score of 100 or higher qualify for CPR services. The CAFAS is also used to identify the priority for treatment along with the impact of services provided.

Community Support Services within the CPR program provide a range of support to consumers in the community. Support begins with discharge planning at the institutional level or with

admission and intake in the community. Families and youth plan and direct the supportive services that they receive and are assisted with community integration so that they are able to draw on natural and family supports within their community. In FY08 the Division worked with MOHealthNet (Missouri's division that manages Medicaid) to add 4 additional services to CPR. These services include Family Support, Family Assistance, Day Treatment and Psychosocial Rehabilitation for children.

### **Educational services and Employment services**

**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 services. Day treatment includes, rehabilitation services, individual and group therapies and, as needed, vocational education, and occupational therapy.

### **Housing Services**

**Residential Treatment** 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** is a treatment plan driven service that is designed to develop a support system for parents of children with a serious emotional disorder. This service provides parent-to-parent guidance. Some of the activities provided in this service are: problem solving, emotional support, disseminating information, and linking to services.

**Treatment Family Homes** provides individualized treatment within a community-based family environment with specially trained treatment 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.

### **Substance Abuse Services**

The CPR program has developed strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to 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. CSTAR Adolescent Treatment Programs are specialized for youth needs. Early intervention, comprehensive treatment, academic education, and levels of care are important in averting chronic substance abuse and resulting problems that might otherwise follow a young person for a lifetime. The specially trained staff of adolescent CSTAR programs utilize individual, group and family interventions.

## **Medical and Dental Services**

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, Missouri and St. Louis, Missouri, people are able to visit a dentist through the dental schools located in those cities. While medical care is 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.

## **Support Services**

Several of the System of Care federal grant programs, Show-Me Kids and Transitions, have parent support programs. Their purpose is:

- to support families of children/youth with serious emotional disorders, by providing information, training, and networking opportunities;
- to provide family voice at all levels of the System of Care;
- to partner with other organizations, agencies, and key stakeholders; and
- to promote change that leads to positive outcomes for children/youth and their families.

The Division of Comprehensive Psychiatric Services (CPS) has a service that is designed to provide support to parents called Family Support. This service may involve a variety of related activities to the development or enhancement of the service delivery system. Activities are designed to develop a support system for parents of children who have a serious emotional disorder. Activities must be directed and authorized by the treatment plan. Activities may include, but are not limited to, problem solving skills, emotional support, disseminating information, linking to services and parent-to-parent guidance. An eligible provider is an individual that meets the requirements specified in the CPS Family Support Model and has successfully completed the required Family Support training as approved and provided by the Department of Mental Health, Division of Comprehensive Psychiatric Services.

Additionally, CPS has a contract with National Alliance for the Mentally Ill (NAMI) of Missouri for parent support programming. NAMI of Missouri offers support, information and technical assistance to families served by the department. NAMI of Missouri provides an 800 number HELpline service accessible to urban, rural and impoverished parents. NAMI has resource libraries for families of children with SED. NAMI's contract requires them to provide support groups. NAMI trains support group facilitators for peer support groups for families of children and adolescents with SED. They have used the Family-to-Family model of peer support facilitator training to train support volunteers. Family-to-Family has been identified by the Substance Abuse and Mental Health Administration as an evidence based exemplary practice. Research indicates that families' participation in multiple family groups reduces the families "subject burden" and incidence of relapse and hospitalization.

In 2007, NAMI was awarded a Statewide Family Network Grant through SAMHSA. This grant helps to provide parents, families and youth with a unified aggregate platform from which to engage decision makers. It enables NAMI and other family organizations within Missouri to identify, recruit, train and support parents and youth in their quest for a comprehensive system of care with families needs at the center. NAMI's support groups for parents, foster parents and custodial grandparents of children and adolescents with SED are active in St. Louis, Kansas City, Springfield, Rolla, and Jefferson City. Family members of children currently participate in general family support groups in other areas of the State.

### **Services Provided by Local School Systems Under the Individuals with Disabilities Education Act**

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; and d) dissemination of relevant research, instructional strategies, and adoption of effective practices.

The Missouri Department of Mental Health (DMH), Division of Comprehensive Psychiatric Services (CPS) and the Curators of the University of Missouri – Columbia (University) has collaborated on the Center for the Advancement of Mental Health Practice in Schools (the Center). The Center was established through a partnership between the DMH and the University Department of Educational, School and Counseling Psychology (ESCP) to respond to the needs and to the shift in the priorities of federal and state agencies pertaining to policy, practice and research concerning child and adolescent mental health. The center was initiated, in part, as a response to the shift in the priorities of federal and state agencies pertaining to policy, practice, and research concerning child and adolescent mental health. This shift recognizes prevention as a fundamental element in supporting our nation's youth in facing developmental challenges, psycho-social issues, and environmental stressors within the school system and community.

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

The first online program of its kind nationally is the result of this unique partnership. ESCP has two graduate programs accredited by the American Psychological Association; the master's program includes 24 hours of required course work and nine hours of electives, for a total of 33 hours. The educational specialist requires a total of 30 credit hours. Each course emphasizes the prevention of mental health problems-within schools, families and communities-and the promotion of positive mental well-being for all children and adolescents, to make you a better, more effective educator, administrator or health services professional.

The Center's online courses are taught by a variety of doctoral level professionals from around the United States. 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 in Children and Adolescents, Wellness Management for School Personnel, School-wide Positive Behavioral Support, and Youth Violence and Bullying: Prevention and Reduction. 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.

For more information go to: <http://schoolmentalhealth.missouri.edu/about.htm>

### **Case Management Services**

Intensive Targeted Case Management (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. CPR programming also provides case management through the treatment team approach. Each member of the team contributes to treatment planning.

### **Services for Persons with Co-Occurring (Substance Abuse/Mental Health) Disorders**

Youth identified as having a co-occurring disorder are referred to 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. CSTAR Adolescent Treatment Programs are specialized for youth needs. Early intervention, comprehensive treatment, academic education, and levels of care are important in averting chronic substance abuse and resulting problems that might otherwise follow a young person for a lifetime. The specially trained staff of adolescent CSTAR programs utilize individual, group and family interventions.

## **Other Activities Leading to Reduction of Hospitalization**

Implementation of the Comprehensive Children's Mental Health Plan is moving Missouri towards children receiving the mental health services they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. The vision is that Missouri's mental health services system for children will be easily accessible, culturally competent, flexible to individual needs, and result in positive outcomes for the children and families it serves. *By providing comprehensive community services, the department can reduce hospitalizations for Missouri's children and youth with SED.*

Additionally, Missouri has thirteen state-approved System of Care (SOC) sites for children and youth services. In a SOC, all local child-serving agencies bring needed expertise and resources to the planning process to meet a child and family's individual needs. The child service delivery system is supported by a local policy/administrative team that address barriers to accessing needed services and monitor trends to aid in policy and service development.

Missouri has funded system of care cooperative agreements within the state. The overarching goals for these sites are to:

- expand the capacity for community based services and supports,
- create an infrastructure for cross agency individualized care planning,
- incorporate culturally and linguistically competent practices for serving children, and
- promote full participation of families and youth in service planning and in development of services and supports.

For each of the sites, local project development is managed through partnerships with community agencies including local family organizations, the community mental health center, the DD Regional Office, the local office of the Children's Division, local juvenile office, the Division of Youth Services, local schools, local county health offices, as well as individual youth and families in the community.

# 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

See Adult Plan section Estimate of Prevalence columns for Child Estimate of Prevalence

# Missouri

## Child - Quantitative Targets

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

See Goals, Targets and Action Plans section

# 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.

## **Child Plan**

### **Criterion 3: Children's Services System of Integrated Services**

Missouri's 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 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 Comprehensive Children's Mental Health State Management Team continues to function as 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 Department of Elementary and Secondary Education: Division of Vocational Rehabilitation and Division of Special Education; The Department of Public Safety; The Department of Mental Health: Divisions of Alcohol and Drug Abuse, Comprehensive Psychiatric Services, and Mental Retardation and Developmental Disabilities; The Department of Health and Senior Services; Office of State Court Administrators; juvenile offices; parents; parent advocacy groups; and representatives from each of the geographic local systems of care. This group meets at least once a month.

There are many current initiatives that cross many state department lines including Show Me Bright Futures; Early Childhood Comprehensive System and the related Coordinating Board for Early Childhood. Additionally, at the start of the current fiscal year, DMH closed inpatient psychiatric units in two regions of the state including two children's units. Due to the different funding streams for children as opposed to adults for state operated facilities, the dollars supporting one children's unit will remain within the community to enhance the existing system and create a safety mechanism for children with extreme and complex needs. A stakeholders' group was convened to make recommendations to the Division regarding what those services might look like. In addition to representatives from the community mental health centers, others involved in this group included juvenile officers, judges, child welfare administrators, private hospitals, providers for those with developmental disabilities, schools, advocacy organizations, HeadStart and family members.

## Social Services

CPS works closely with three divisions of the Dept. of Social Services: Children's Division (child welfare); Division of Youth Services (youth adjudicated as delinquent and committed to state custody); and Missouri Health Net (Medicaid agency).

Children's Division: The Children's Division has been concerned over the lack of oversight they have in mental health services provided to children/youth in their custody either through Medicaid funding or through Comprehensive Treatment Services funding (general revenue). CPS along with MO HealthNet (Medicaid) worked with the Children's Division to devise a quality improvement initiative that holds treatment providers more accountable for planning, providing and documenting effective clinical services. An additional area of clinical concern for the Children's Division was the number and types of medications children in residential treatment centers were prescribed. Modeled after a similar initiative for adults that helped in changing prescribing practices, CPS contracted for creation of an Integrated Health Profile for each child in Children's Division Custody in a residential placement based on Medicaid billing information. This profile includes information in regards to type and dose of medications prescribed as well quality indicators and red flags related to each medication or the combination of the medications. Some examples of quality indicators are more than three concurrent psychotropic medications for those under age 12, more than five psychotropic medications in a 90 day period, or more than two antipsychotic medications concurrently prescribed. Other information contained in the profile are physical health concerns to aid in integration of services. The Integrated Health profile also contains information regarding primary care physician, treating psychiatrist, case worker to aid in coordination of care. CPS has also been in discussion with the Children's Division to enhance their approach for children who have experienced trauma. Based on the Child Welfare Trauma Training Toolkit, CPS has proposed PRIOR to provision of training to case workers, that Regional Administrators be trained and then review policies to insure that there is meaningful and sustainable change. CPS continues to lead the Department of Mental Health in collaboration with Children's Division to implement, monitor and as necessary revise the Custody Diversion Protocol to prevent parents from having to voluntarily relinquish custody solely to access mental health services.

Division of Youth Services: The Missouri Division of Youth Services (DYS) has been touted as an exemplary model for working with youth adjudicated as delinquent. Many states have come to Missouri to learn and attempt to learn from this Division. Two initiatives have been created to help youth with mental health needs that have been committed to the DYS. The first is to enhance communication and collaboration specifically across the system. CPS and its providers now meet with the DYS twice a year to explore system issues and to enhance on-going communication around planning for youth. This was started in part as DYS had a contract for ten residential beds with a provider for youth with serious emotional disorders that were unable to benefit from the group process built into the DYS system. Concerns were raised related to the adequacy and effectiveness of these residential services and CPS offered to provide clinical consultation and case management for these ten youth. DYS, based on their identified need also wished to expand their capacity to be able to serve similar youth more effectively. Although a proposal was developed that created an array of specialized services ranging from home and community based to specialized residential with proposed leveraging of funds, due to the economic status of the state, this was not implemented. However, CPS has continued to work

with DYS to find other means to enhance their capacity for this population of youth, including provision of training to staff on Dialectical Behavior Therapy which may be incorporated into their existing programs.

Missouri HealthNet: CPS has multiple joint initiatives with the Medicaid agency for Missouri. The majority address quality of care both for managed care and fee-for-service. MO HealthNet started a case management review of the behavioral health managed care providers. CPS serves on the review teams to provide clinical expertise. Additionally CPS staff several MO HealthNet workgroup related to creation of Dashboard indicators, case management, etc. MO HealthNet also is gradually bringing in a quality initiative for fee-for-service care. In this initiative, prior authorization is required to guide care to effective interventions, towards best practices related to diagnostic or age groups, and to insure appropriate documentation and coordination with other stakeholders. CPS staff serves on these standing committees.

### **Educational Services**

For two years CPS has been exploring the implementation of a school mental health model. A CPS provider was able to successfully convince legislators to provide approximately \$900,000 for a school mental health program in one community. Although CPS was initially challenged by the legislators to develop a state model with similar levels of funding the following fiscal year, continued support was not sustained and the budget item requested was denied for a state model. CPS remains committed to creating an effective state school mental health model that builds on a strong partnership with families, schools and communities. The Show Me Bright Futures, although not a school program, encourages communities to interact with their community schools to support healthy social and emotional development. This year a strong dialogue was initiated with the Department of Elementary and Secondary Education (DESE) to learn more of their plans, goals and outcomes for students. DESE has worked for the past year to create the Missouri Integrated Model which merges components of three-tiered models in enhancing school responsiveness, academic performance as well as development of students. DESE has long supported the implementation of Positive Behavioral Interventions and Supports and is well on its way across the state in schools having Universal Tier 1 environments in place. CPS in planning with DESE has developed a model with leveraged Medicaid funding to help those schools/districts that have implemented Tier 1 to move on to implementation of Tier 2 and 3 for those youth who are at risk or already displaying social and emotional impairments. The model proposed allows for local development and governance with an effective partnership between the school or district, community mental health center and families. This allows for a model that serves all youth at their level of need, independent of their special education status.

### **Services provided under the Individuals with Disabilities Education Act**

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. See Child Plan Criterion 1: Comprehensive Community-Based Mental Health Services Available Resources for more detail.

### **Juvenile Justice Services**

The Division continues to lead a state level mental health/juvenile justice policy team to identify and address issues related to the mental health needs of youth at risk of or currently in the juvenile justice system. A grant funded partnership exists between the Office of State Courts Administrator and the Division to improve the quality of assessments provided on youth involved in the juvenile justice system, to develop evidence based practices geared towards this population of youth and develop/enhance community collaboration. Five sites were selected to receive training on assessments, provided dollars to train on their selected evidence based practice, and consultation and technical assistance to enhance the local infrastructure to sustain these practices. In 2008, 113 individuals representing child welfare, juvenile justice and mental health were trained on the Assessment Guidelines. A survey sent out six months later, showed that the majority of respondents felt they had gained knowledge about when to refer, what can be learned from mental health assessments, were better able to use the information provided by the assessment, and how to use the assessment to guide service provision. One hundred and thirty-nine therapists in two communities were trained and certified on Trauma-Focused Cognitive Behavioral Therapy. Another community provided training to 181 staff on Dialectical Behavior Therapy, with a core adolescent team receiving targeted training to provide therapy. Forty-eight juvenile officers and therapists received training in motivational interviewing and Strengthening Families and a final community provided training to 22 school and mental health staff on Too Good for Drugs and/or Reconnecting Youth.

The Mental Health/Juvenile Justice Policy Group is now focusing on creating a continuum of services for youth with problem sexual behaviors. The first step was developing guiding principles, values and practices to insure a common vision. As this step is being completed, the group has begun the process of examining different best practices that can be developed and accessed by juvenile justice, child welfare, mental health, schools and families. MO HealthNet serves on this group to aid in leveraging Medicaid dollars in support of best practices.

Missouri Juvenile Justice Information System (MOJJIS) is the response to statute which directs 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 Federal Drug and Alcohol Confidentiality Laws.

## **Substance Abuse Services**

The CPR program has developed strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to 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. CSTAR Adolescent Treatment Programs are specialized for youth needs. Early intervention, comprehensive treatment, academic education, and levels of care are important in averting chronic substance abuse and resulting problems that might otherwise follow a young person for a lifetime. The specially trained staff of adolescent CSTAR programs utilizes individual, group and family interventions.

## **Health and Mental Health Services**

Over the last few years, CPS has been building a collaborative relationship with the Dept. of Health and Senior Services around several different initiatives, several of which have already been mentioned in other sections and include Show Me Bright Futures which provides support for communities to apply the public health approach to children's mental health in teaching how to do surveillance to identify needs, institute policies/interventions to address these needs, and to provide monitoring and assurances that these policies/interventions have the intended impact. Another strong partnership is around the Early Childhood Comprehensive System which identifies social and emotional development as a major goal and is devising ways to enhance knowledge regarding social and emotional wellness as well as identifying young children in their natural environments (early learning centers, pediatricians, families) who may need targeted assistance.

Community Support Workers assigned to children and youth receiving services assure that consumers receive physical healthcare. CSWs will make medical appointments for children and youth and assist families in gaining transportation to appointments if this is a barrier. The most recent initiative is to screen for metabolic syndrome, which is a combination of medical disorders that greatly increase the risk of developing cardiovascular disease and diabetes, specifically: obesity, hypertension, lipid level, and blood glucose and/or HgbA1c. This a high priority for this particular population since studies show persons with serious mental illness die 20-25 years earlier than others. Often the causes of death are related to cardiovascular disease and diabetes. CPS has made this screening an annual requirement for all persons enrolled in the Community Psychiatric Rehabilitation (CPR) program who are also on antipsychotic medication. With the growing number of youth on antipsychotic medications as well as the growing number of youth with obesity and developing diabetes CPS believes this is a critical health intervention for children and youth as well as adults.

# Missouri

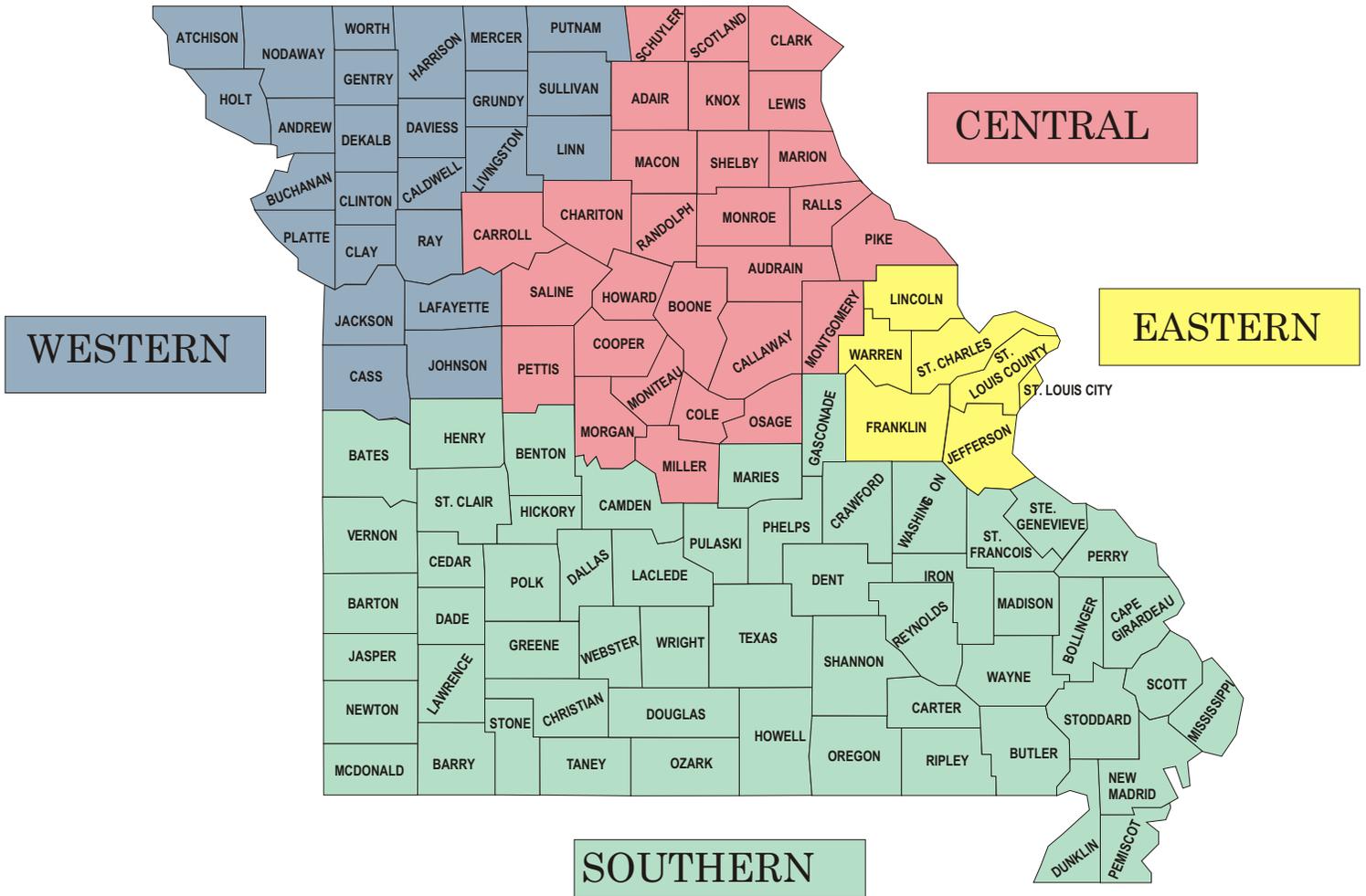
## Child - Geographic Area Definition

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

# MISSOURI DEPARTMENT OF MENTAL HEALTH

## Division of Comprehensive Psychiatric Services

### CHILDREN'S SERVICE AREAS



#### CENTRAL

Beth Ewers-Strope  
 Area Director  
 1706 East Elm  
 Jefferson City, MO 65101  
 Phone: 573-751-7622  
 Fax: 573-751-7815  
[beth.strope@dmh.mo.gov](mailto:beth.strope@dmh.mo.gov)

#### EASTERN

Al Eason  
 Area Director  
 Dome Building  
 5400 Arsenal  
 St. Louis, MO 63139  
 Phone: 314-877-3371  
 Fax: 314-877-0392  
[al.eason@dmh.mo.gov](mailto:al.eason@dmh.mo.gov)

#### SOUTHERN

Betty Turner  
 Area Director  
 1903 Northwood Drive  
 Suite 4  
 Poplar Bluff, MO 63901  
 Phone: 573-840-9275  
 Fax: 573-840-9191  
[betty.turner@dmh.mo.gov](mailto:betty.turner@dmh.mo.gov)

#### WESTERN

Bonnie Neal  
 Area Director  
 821 E. Admiral  
 Kansas City, MO 64141  
 Phone: 816-889-3458  
 Fax: 816-889-3325  
[bonnie.neal@dmh.mo.gov](mailto:bonnie.neal@dmh.mo.gov)



# Missouri

## Child - Outreach to Homeless

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

## **Child – Outreach to Homeless**

See Adult Plan section on Outreach to Homeless for details on services to families.

### Services to Homeless and Abuse Youth

Synergy Services currently provides emergency shelter for homeless & abused teens at Synergy House. On any given night in Greater Kansas City there are 2,000 “unattached” teens living on the streets, sleeping in cars, or “couch surfing” with friends because they do not have a safe place to live. Many are abused and neglected kids who have run away from home or been thrown out by their family.

Synergy is building Kansas City’s only Homeless Youth Campus. Located just 10 minutes from downtown, the campus includes a new shelter and resource center. The shelter will double the number of kids that can be housed each night, while the resource center will help young people heal and grow through music, poetry, dance, exercise, painting, pottery, and academic advancement. The center will offer young people mental health counseling, medical and dental care, life-skills training, a computer lab, showers, lockers, an interactive learning center and the opportunity for leadership development and community service. With emphasis on fostering environmental responsibility, the entire campus will be built to meet L.E.E.D. certification and will educate young people in green collar work as they assist in sustaining the campus as a carbon-neutral environment.

Synergy Services provides Therapeutic Services on a sliding scale fee basis. No one is denied care due to an inability to pay. Synergy's trained and caring therapeutic staff helps strengthen families and prevent abuse and violence by specializing in four primary areas: marriage and family treatment, domestic violence, sexual abuse treatment and adolescent sex offender treatment. Counseling services include:

- Individual, Marriage and Family Therapy.
- Support and Therapeutic Groups including Art and Play Therapy, Parenting Classes and Survival Skills for women.
- Substance Abuse Services including assessments, screenings, referrals and counseling for children, teens and their parents.
- Positive Alternatives to Aggression in Relationships, is a therapeutic support program for perpetrators and survivors of domestic violence.
- Parenting Support Classes offers *Practical Parenting* a skill-building program focusing on the basics of parenting or *Active Parenting of Teens* an acclaimed parenting program that offers a proven approach to working with adolescents.

# Missouri

## Child - Rural Area Services

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

See Adult Plan section on Rural Area Services

# Missouri

## Child - Resources for Providers

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

## **Child – Resources for Providers**

See also the Adult Plan section on Resources for Providers.

### **Financial Resources**

DMH submitted a budget item in the FY 2009 legislative session in support of school mental health. This was not selected for funding. Although efforts continue to advocate for this budget item in the next legislative session, some steps have been achieved to make available additional funding options in support of school mental health. Previously MO HealthNet (Medicaid) would allow billing only for mental health services delivered at the school identified through an Individualized Education Plan with the school making the match. Through work with MO HealthNet, DMH was able to expand funding for such services to youth who are not eligible for special education services, but still need mental health services if the school has entered into collaboration with the local community mental health center or mental health provider, again with the school or other community resource making the match. This not only created a funding stream not previously available to a population of youth, but also continues to emphasize and support collaborative partnerships between mental health and schools.

CPS was also able to expand the array of services available through Community Psychosocial Rehabilitation Program that are eligible for MO HealthNet funding. These services include Family Support, Family Assistance, Day Treatment and Psychosocial Rehabilitation. Although no additional general revenue dollars were provided, it is hoped that through creating a funding mechanism the limited resources can be used to maximum potential to support access and capacity to these services.

### **Staffing**

Agencies certified to provide CPR services to children and youth under the age of 18 must have a director with at least two (2) years of supervisory experience with child and youth populations. If the director does not meet that requirement the agency must designate a clinical supervisor for children and youth services who is a mental health professional, has at least two (2) years of supervisory experience with child and youth populations, and has responsibility for monitoring and supervising all clinical aspects of services to children and youth.

Missouri faces several challenges in delivery of mental health services for children. Similar to national trends, there is a significant dearth of access to psychiatry, let alone child psychiatry. The Division has developed funding streams that allow enhancements to standing rates for psychiatry which assists the community providers; however, the need still far exceeds the

availability particularly for specialized populations such as early childhood or co-occurring Mental Illness/Developmental Disabilities.

The lack of psychiatrists is particularly crucial in the rural areas of the state, with approximately 2/3 of the state deemed as having a shortage of mental health providers. Surveillance shows that several counties in the state have no psychiatry, social work/counselors or psychologists. This severely limits access and challenges service delivery. Several agencies have implemented tele-psychiatry services in attempts to bridge this challenge and provide services in rural areas.

### **Training for Mental Health Service Providers**

The department has provided technical assistance and training on many evidence based practices to the community treatment providers. Treatment providers for children and youth have received extensive training on Motivational Interviewing Skills, Dialectal Behavior Therapy and Trauma Informed Care. The children's service providers have received considerable training on Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Twenty-four therapists are certified in TF-CBT in the Central region of the state and nineteen therapists are certified in the Western region.

The annual Spring Training Institute has a regular track for Children and Youth topics. The Spring Training Institute for 2009 was canceled due to fiscal constraints, but there are plans for the conference on May 20 and 21, 2010.

# Missouri

## Child - Emergency Service Provider Training

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

See Adult Plan section on Emergency Service Provider Training

# 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

See Adult Plan section for Grant Expenditure Manner column labeled Youth

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	15,969	16,517	15,771	15,772	15,773
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Increase access to mental health services for children/youth

**Target:** Increase the number of children/youth receiving CPS funded services

**Population:** Children and youth with SED

**Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services

**Indicator:** Total number of children/youth receiving CPS funded services

**Measure:** No numerator or denominator

**Sources of Information:** CIMOR

**Special Issues:** Mental health services for children/youth are underfunded both nationally and in the State of Missouri. While our goal is always to increase the numbers served, due to the national and state level economic downturn, the numbers of children/youth served may stay level or possibly decrease in the coming year.

**Significance:** Due to fiscal constraints, Missouri is only meeting the mental health needs of 16% of the estimated prevalence of children/youth with severe emotional disorders. With core budget cuts, it will be difficult to maintain the numbers of children/youth served in Missouri.

**Action Plan:** CPS will continue to build community based services for children and youth with SED based on Missouri's Comprehensive Children's Mental Health Plan. CPS will continue to explore alternative funding sources, expand the use of EPB to accomplish efficiencies, and collaborate with other State departments/organizations to maximize funding options.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	6.12	6.87	6.35	6.70	6.70
Numerator	53	46	--	--	--
Denominator	866	670	--	--	--

Table Descriptors:

- Goal:** Reduce the rate of readmission within 30 days to State psychiatric hospital beds
- Target:** Maintain readmission within 30 days to State psychiatric beds lower than the national average rate of 6.70%
- Population:** Children and youth with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of children and youth readmitted to State psychiatric inpatient care within 30 days of discharge
- Measure:** The numerator is number of children and youth readmitted to State psychiatric hospitals within 30 days of discharge.  
The denominator is total discharges for children and youth from State psychiatric hospitals.
- Sources of Information:** CIMOR
- Special Issues:** Missouri has maintained a 6% rate of readmission within 30 days to State psychiatric hospital beds.
- Significance:** A major outcome of the development of a community-based system of care is the reduced readmission to State-operated psychiatric hospital beds.
- Action Plan:** Develop and support community based resources to help reduce readmission rates for children and youth in the Missouri mental health system of care.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	19.53	19.40	17.65	17.65	17.65
Numerator	108	130	--	--	--
Denominator	553	670	--	--	--

Table Descriptors:

- Goal:** Reduce the rate of readmission to State psychiatric hospital beds within 180 days
- Target:** Maintain or decrease the rate of readmission to State psychiatric hospital beds within 180 days
- Population:** Children and youth with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of children and youth with SED readmitted to State psychiatric hospitals within 180 days of discharge
- Measure:** The numerator is number of children and youth readmitted to State psychiatric hospitals within 180 days of discharge.  
The denominator is total discharges for children and youth from State psychiatric hospitals.
- Sources of Information:** CIMOR
- Special Issues:** CPS makes every effort to keep children/youth out of the inpatient setting and safe in their communities.
- Significance:** A major outcome of the development of a community-based system of care is the reduced readmission to State-operated psychiatric hospital beds and a reduced average length of stay.
- Action Plan:** CPS will develop and support community based resources to help reduce readmission rates for children and youth in the Missouri mental health system of care. Through the Comprehensive Children's System of Care collaborations, the department will efficiently use resources and enhance services to children and families.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	1	1	1	1
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Provide one Evidence Based Practice of Therapeutic Foster Care Programs to children and youth with SED
- Target:** Maintain the number of EBP for children in Missouri
- Population:** Children and Youth with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of Evidence Based Practices approved by SAMHSA for the Block Grant utilized in Missouri
- Measure:** Number of Evidence Based Practices approved by SAMHSA for the Block Grant utilized in Missouri (No numerator or denominator)
- Sources of Information:** Missouri Department of Mental Health
- Special Issues:** The Department of Mental Health meets the federal definition for Therapeutic Foster Care listed in the Block Grant application. Therapeutic Foster Care Programs licensing requirements define program as "Family living arrangement, a residential facility operated in the owned or leased permanent residence of the licensee, serving no more that three (3) residents who are integrated into the licensee's family unit. The facility does not normally use direct-care staff other than members of the household."
- Significance:** The Department of Mental Health licenses 115 Treatment Family Homes of which 65 are specifically for children and youth with SED. The remaining homes are specific to the developmental disability population.
- Action Plan:** The Department of Mental Health, Division of Comprehensive Psychiatric Services currently provides one evidence based practice to children, youth and families using the State licensed Therapeutic Foster Care Programs.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Therapeutic Foster Care  
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	149	1.31	.85	.85	.85
Numerator	N/A	127	--	--	--
Denominator	N/A	9,661	--	--	--

Table Descriptors:

- Goal:** Maintain the percentage of children and youth with SED receiving the Evidence Based Practice of Therapeutic Foster Care
- Target:** Maintain the percentage of children and youth with SED receiving the Evidence Based Practice of Therapeutic Foster Care
- Population:** Children and youth with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of children and youth with SED receiving Therapeutic Foster Care
- Measure:** The numerator is the number of children and youth in Therapeutic Foster Care.  
The denominator is number of children and youth with SED diagnosis receiving CPS funded services.
- Sources of Information:** Supported Community Living Regional Offices and Children's Area Directors
- Special Issues:** The department is refining the measurement to a centralized Statewide manner for Therapeutic Foster Care to assure accuracy and consistency of numbers served.  
  
The explanation for the decrease in usage is for two fiscal years the Treatment Family Home program had developed more capacity for the program than the funding could support. CPS had to bring the capacity in line with the allocation. CPS developed a standard based on traditional funding patterns and told each of the four Eastern region CMHC that they were funded for a population based number of slots. Usage beyond that funding would have to come out of their Children's budgets. It has impacted the usage of TFH and has brought the service within funding limits.  
  
Additionally, inconsistencies in contracts with providers were found leading to resubmission of all contracts. New Therapeutic Foster Care homes were not being recruited as CPS made adjustments to the system that has led to decrease projected numbers.
- Significance:** The department meets the definition of Therapeutic Foster Care provided in the application instructions with the Treatment Family Homes.
- Action Plan:** Treatment Family Home Action Plan:

CPS is in the process of refining and enhancing their Treatment Family Home model. While Treatment Family Homes has been a key community based service within CPS for many years, its implementation and funding mechanisms have varied across the state. The leadership, marketing, and referral process is also diverse. CPS plans to continue implementing greater fidelity to the model.

In order to provide a more consistent, cohesive Treatment Family Home service across the state, CPS is redesigning its model to maximize therapeutic effectiveness while minimizing restrictiveness. Accomplishment of this task will involve the following steps:

1. Develop a Missouri “Toolkit for Treatment Family Home Care”
2. Revise and update contracts consistent with the toolkit.
3. Certify Treatment Family Home train-the-trainers.
4. Provide training to providers on the “Toolkit”.
5. Monitor provider implementation of “Toolkit” through CPS annual compliance review.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy  
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy  
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	83.68	84.72	87.34	84	84
Numerator	159	610	--	--	--
Denominator	190	720	--	--	--

Table Descriptors:

- Goal:** Maintain high level of consumer satisfaction
- Target:** Maintain level of consumer satisfaction higher than or equal to the national average rate of 84%
- Population:** Children and youth with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of parents of children with SED satisfied or very satisfied with services received
- Measure:** The numerator is number of parents of children and youth with SED receiving services who are satisfied or very satisfied with those services.  
The denominator is total number of parents of children and youth with SED receiving services who responded to the consumer satisfaction survey.
- Sources of Information:** Consumer Satisfaction Survey (Youth Services Survey for Families)
- Special Issues:** The data is preliminary. CPS has recently implemented the Youth Services Survey for Family (YSS-F) recommended by SAMHSA.
- Significance:** Parents of children with SED were satisfied with services received at a high rate.
- Action Plan:** CPS will continue to receive the YSS-F survey results implemented on a continuous basis.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	96.81	94.82	95.01	94	94
Numerator	668	805	--	--	--
Denominator	690	849	--	--	--

Table Descriptors:

- Goal:** Children and youth will return to or stay in school
- Target:** Children and youth will return to or stay in school equal to the national average rate of 94%
- Population:** Children and youth with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of children and youth returning to or staying in school
- Measure:** The numerator is the number of children/youth attending school at time assessment was completed.  
The denominator is the total number of children/youth in sample.
- Sources of Information:** Child/Youth Status Report
- Special Issues:** The Child/Youth Status Report is a sample of the total number served. With the management information system (CIMOR), CPS eventually plans to collect data on all consumers served by the division.
- Significance:** According to the President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America, "the mission of public schools is to educate all students. However, children with serious emotional disturbances have the highest rates of school failure. Fifty percent of these students drop out of high school, compared to 30% of all students with disabilities. Schools are where children spend most of each day. While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success, schools must be partners in the mental health care of our children." Missouri's Comprehensive Children's Mental Health System is working if over 94% of children and youth with SED are returning to or staying in school.
- Action Plan:** CPS will continue to revise the management information system to improve collection of data on all consumers served. CPS will continue to support children and youth with SED in their communities to maintain consistent school attendance.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	19.81	19.55	23.50	23	23
Numerator	265	182	--	--	--
Denominator	1,338	931	--	--	--

Table Descriptors:

**Goal:** Decrease the percentage of children and youth with SED involved in the Juvenile Justice system

**Target:** Decrease or maintain the percentage of children and youth with SED involved in the Juvenile Justice system

**Population:** Children and Youth with SED

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of children and youth with SED involved with Juvenile Justice

**Measure:** The numerator is the number of children and youth involved with Juvenile Justice. The denominator is the total number of children and youth in sample.

**Sources of Information:** Child/Youth Status Report

**Special Issues:** The Child/Youth Status Report is a sample of the total number served. With the management information system (CIMOR), CPS eventually plans to collect data on all consumers served by the division.

**Significance:** 76% of the children and youth with SED are not involved with the Juvenile Justice system. Sample size is small and effected by small changes in actual numbers.

**Action Plan:** CPS will continue to revise the management information system to improve collection of data on all consumers served.

The Division continues to lead a state level mental health/juvenile justice policy team to identify and address issues related to the mental health needs of youth at risk of or currently in the juvenile justice system. A grant funded partnership exists between the Office of State Courts Administrator and the Division to improve the quality of assessments provided on youth involved the juvenile justice system, to develop evidence based practices geared towards this population of youth and develop/enhance community collaboration. Five sites were selected to receive training on assessments, provided dollars to train on their selected evidence based practice, and consultation and technical assistance to enhance the local infrastructure to sustain these practices. In 2008, 113 individuals representing child welfare, juvenile justice and mental health were trained on the Assessment Guidelines. A survey sent out six months later, showed that the majority of respondents felt they had gained knowledge about when to refer, what can be learned from mental health assessments, were better able to use the information provided by the assessment, and how to use the assessment to guide service provision. One hundred and thirty-nine therapists in two communities were trained and certified on Trauma-Focused Cognitive Behavioral Therapy. Another community provided training to 181 staff on Dialectical Behavior Therapy, with a core adolescent team receiving targeted training to provide therapy. Forty-eight juvenile officers and therapists received training in motivational interviewing and Strengthening Families and a final community provided training to 22 school and mental health staff on Too Good for Drugs and/or Reconnecting Youth.

The Mental Health/Juvenile Justice Policy Group is now focusing on creating a continuum of services for youth with problem sexual behaviors. The first step was developing guiding principles, values and practices to insure a common vision. As this step is being completed, the group has begun the process of examining different best practices that can be developed and accessed by juvenile justice, child welfare, mental health, schools and families. MO HealthNet serves on this group to aid in leveraging Medicaid dollars in support of best practices.

Missouri Juvenile Justice Information System (MOJJIS) is the response to statute which directs 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 Federal Drug and Alcohol Confidentiality Laws.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	78.85	80.88	78.11	78	78
Numerator	1,055	753	--	--	--
Denominator	1,338	931	--	--	--

Table Descriptors:

- Goal:** Increase stability in housing for children/youth
- Target:** Increase or maintain stability in housing for children/youth
- Population:** Children and youth with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of children and youth with SED living in home or home-like setting
- Measure:** The numerator is the number of children and youth with SED living in home or home-like setting.  
The denominator is the total number of children and youth with SED in the sample.
- Sources of Information:** Child/Youth Status Report
- Special Issues:** The data is taken from a small sample of total consumers served. This can lead to fluctuations in the outcomes based on small number size. Additionally, the current budget cuts may affect this number.
- Significance:** State policymakers, families, and practitioners are increasingly concerned about the mental health needs of children in Missouri. Providing appropriate and effective services to meet their needs is a high priority. Senate Bill 1003 was enacted into law in 2004 to require the development of a unified, comprehensive plan for children’s mental health services. When fully implemented, this plan will ensure that all of Missouri’s children receive the mental health services and supports they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. Missouri’s mental health services system for children will be accessible, culturally competent, and flexible enough to meet individual and family needs; and family-centered and focused on attaining positive outcomes for all children.
- Action Plan:** The department will continue to place children and youth with SED in a home or home-like setting whenever possible.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	83.43	86.47	N/A	N/A
Numerator	N/A	594	--	--	--
Denominator	N/A	712	--	--	--

Table Descriptors:

**Goal:** Increase percentage of families reporting Social Supports/Social Connectedness

**Target:** Increase or maintain percentage of families reporting Social Supports/Social Connectedness

**Population:** Children and youth with SED

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of families reporting Social Supports/Social Connectedness

**Measure:** The numerator is number of families reporting social connectedness on the YSS-F consumer satisfaction survey.  
The denominator is the total number of responses to the YSS-F consumer satisfaction survey.

**Sources of Information:** Consumer Satisfaction Survey (YSS-F)

**Special Issues:** The data is very preliminary. CPS has recently implemented the Youth Services Survey for Family (YSS-F) recommended by SAMHSA. As additional data is gathered and analyzed, targets can be set.

**Significance:** 86.47% of families of children/youth reported feeling social support/social connectedness

**Action Plan:** CPS will continue to receive the YSS-F survey recently implemented on a continuous basis. Targets will be set after additional surveys are received

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	60.96	64.50	N/A	N/A
Numerator	N/A	434	--	--	--
Denominator	N/A	712	--	--	--

Table Descriptors:

**Goal:** Improve children/youth level of functioning

**Target:** Increase percentage of children/youth with improved level of functioning

**Population:** Children and Youth with SED

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations

**Indicator:** Percentage of children/youth with improved level of functioning

**Measure:** The numerator is the number of reported child/youth with improved level of functioning.  
The denominator is the total number of responses on the consumer satisfaction survey.

**Sources of Information:** Consumer Satisfaction Survey (YSS-F)

**Special Issues:** The data is very preliminary. CPS has recently implemented the Youth Services Survey for Family (YSS-F) recommended by SAMHSA. As additional data is gathered and analyzed, targets can be set.

**Significance:** Preliminary data

**Action Plan:** CPS will continue to receive the YSS-F survey recently implemented on a continuous basis. Targets will be set after additional surveys are received.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	11	13	13	13	13
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Increase or maintain the number of Children's System of Care local teams

**Target:** Increase or maintain the number of Children's System of Care local teams

**Population:** Children and youth with SED

**Criterion:** 3:Children's Services

**Indicator:** Number of Children's System of Care local teams

**Measure:** No numerator or denominator

**Sources of Information:** Missouri's Comprehensive Children's Mental Health System of Care staff

**Special Issues:** State policymakers, families, and practitioners are increasingly concerned about the mental health needs of children in Missouri. Providing appropriate and effective services to meet their needs is a high priority. Senate Bill 1003 was enacted into law in 2004 to require the development of a unified, comprehensive plan for children's mental health services. When fully implemented, this plan will ensure that all of Missouri's children receive the mental health services and supports they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. Missouri's mental health services system for children will be accessible, culturally competent, and flexible enough to meet individual and family needs; and family-centered and focused on attaining positive outcomes for all children.

**Significance:** The Department of Mental Health has thirteen System of Care sites operating in Missouri in FY2008. 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.

**Action Plan:** Continue to add and maintain Children's System of Care local teams as funding becomes available

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Rural children receiving mental health services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	14.20	14.59	17.92	17	17
Numerator	12,206	12,548	--	--	--
Denominator	85,958	85,958	--	--	--

Table Descriptors:

- Goal:** Increase or maintain the percentage of children and youth with SED in rural areas receiving CPS funded mental health services
- Target:** Increase or maintain the percentage of children and youth with SED in rural areas receiving CPS funded mental health services
- Population:** Children and youth with SED
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** Percentage of children and youth with SED in rural areas receiving CPS funded mental health services
- Measure:** The numerator is the number of children and youth with SED in rural areas served by CPS. The denominator is the prevalence at 7% of children and youth with SED in rural areas.
- Sources of Information:** CIMOR; billing database; federal census and prevalence table
- Special Issues:** 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.
- Significance:** Mental illness and its complications and lack of access to care have been identified as major rural health concerns at the national and state level. The Division of CPS is committed to providing mental health services to rural Missourians.
- Action Plan:** CPS will maintain mental health services to children and youth with SED in rural and semi-rural areas of the state.

# Missouri

## Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

---

**State Advisory Council  
For  
Comprehensive Psychiatric Services**



Missouri Department of Mental Health  
1706 E. Elm St., P.O. Box 687  
Jefferson City, MO 65102  
Telephone: 573-751-8017  
Fax: 573-751-7815  
www.dmh.mo.gov

---

August 27, 2009

Barbara Orlando  
Grants Management Specialist  
Substance Abuse and Mental Health Services Administration  
Division of Grants Management, OPS  
1 Choke Cherry Road, Room 7-1091  
Rockville, MD 20857

Dear Ms. Orlando:

The State Advisory Council for the Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services, has reviewed the State Plan for the FY 2010 Community Mental Health Services Block Grant Application. The State Advisory Council is committed to Mental Health Transformation and assures that the system is consumer and family driven. We approve of the state plan written under our guidance.

The State Advisory Council has been very involved in transforming the mental health system in Missouri to be more consumer and family driven. I, along with other consumers, am on the Leadership Transformation Working Group. Council members have promoted and achieved the inclusion of consumers and family members in surveying the quality of care during certification visits of the community mental health centers in order to offer a consumer/family perspective. We are involved in the Peer Specialist training and certification process being implemented statewide. We support the continued services of consumer operated Drop-In Centers and Warm Lines. We were involved in a Consumer/Family/Youth Committee planning a state-wide summit which has led to an annual conference gathering consumers of all three divisions. We are excited by changes in the system that we have endorsed.

We will continue to work with Comprehensive Psychiatric Services staff in monitoring the implementation of the State Plan and the Mental Health Transformation process. We appreciate our involvement in the Block Grant development and would like to express appreciation to SAMHSA and the Center for Mental Health Services for making these funds available.

Sincerely,

Helen Minth, Chair  
CPS State Advisory Council

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, national origin, disability or age of applicants or employees.

# 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.



State of Missouri



# Comprehensive Plan for Mental Health

**Federal FY 2009 Action Plan Update**

*Creating Communities of Hope*





Missouri's Mental Health Transformation Initiative and this publication are supported by grant number 6 U79 SM57474-01-1 from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Transformation State Incentive Grant (MHT SIG) program. The contents are solely the responsibility of the authors and do not necessarily represent the official views of SAMHSA. When referencing this document, please use:

*Cooperative Agreements for Mental Health Transformation State Incentive Grants. Request for Applications No. SM-05-009. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update.*

To ensure 24/7 availability and widest distribution, the *Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update* is available electronically at:  
<http://www.dmh.mo.gov/transformation/transformation.htm>

**MATT BLUNT**  
GOVERNOR

**KEITH SCHAFER, Ed.D.**  
DIRECTOR



**STATE OF MISSOURI**  
**DEPARTMENT OF MENTAL HEALTH**

1706 EAST ELM STREET  
P.O. BOX 687  
JEFFERSON CITY, MISSOURI 65102  
(573) 751-4122  
(573) 751-8224 FAX  
[www.dmh.mo.gov](http://www.dmh.mo.gov)

**MARK STRINGER**  
Director  
DIVISION OF ALCOHOL AND DRUG ABUSE  
(573) 751-4942  
(573) 751-7814 FAX

**JOE PARKS, M.D.**  
DIRECTOR  
DIVISION OF COMPREHENSIVE  
PSYCHIATRIC SERVICES  
(573) 751-8017  
(573) 751-7815 FAX

**BERNARD SIMONS**  
DIRECTOR  
DIVISION OF DEVELOPMENTAL DISABILITIES  
(573) 751-4054  
(573) 751-9207 FAX

October 17, 2008

Marian K. Scheinholtz, Public Health Advisor  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road, 6-1010  
Rockville, MD 20857

Dear Mariann:

On behalf of the Mental Health Transformation Working Group (TWG), I am pleased to present the **Federal FY09 Plan Update** to Missouri's Comprehensive Plan for Mental Health 2008-2013 approved by SAMHSA in June, 2008.

The Plan Update was reviewed and approved by the TWG this past week and serves as a supplemental document to the Comprehensive Plan. It provides a detailed update to **Part 3-Initial Action Plan** that includes the following:

- A brief summary of progress through September 2008 for each of the sixty-one action items included in the initial action plan and the two new action items approved by the TWG earlier this year; and
- Updates to implementation steps, measures and timelines for the federal Fiscal Year 2009 timeframe.

As you will see from this update, Missouri has made significant progress in a very short timeframe across the numerous action items outlined in the Comprehensive Plan. As always, we appreciate the ongoing leadership and support of SAMHSA on this very important national initiative and look forward to continuing this productive partnership in the year ahead.

Sincerely,

A handwritten signature in cursive script that reads "Diane McFarland".

Diane McFarland  
Project Director & Chair  
Missouri Mental Health Transformation Working Group

cc: Governor Matt Blunt  
Mental Health Transformation Working Group  
Human Services Cabinet Council  
Alan Kauffman, SAMHSA State Advisor

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, religion, national origin, disability or age of applicants or employees.



MISSOURI'S  
VISION

**Communities of Hope** throughout Missouri support a system of care where promoting mental health and preventing disabilities is common practice *and* everyone has access to treatment and supports essential for living, learning, working and participating fully in the community.

**Background & Overview**

Through a bipartisan, cross-agency, public-private effort spearheaded by the Governor-appointed Transformation Working Group (TWG) and funded by the federal Substance Abuse Mental Health Services Administration (SAMHSA), Missouri created its first **Comprehensive Plan for Mental Health** <http://www.dmh.mo.gov/transformation/FINALVERSIONJULY12008.pdf> to address the mental health needs of Missourians across the lifespan.

Hundreds of Missourians dedicated their time and expertise to create the plan through participation in workgroups, focus groups, interviews, and public hearings throughout the state. What emerged was a **shared vision and common agenda** for a transformed mental health system in Missouri. The common agenda is reflected through the **six strategic themes, six goals, and twenty-one objectives** outlined on the following pages. Core strategies were developed for each of the objectives, along with an initial action plan containing 61 priority action items. The Comprehensive Plan was adopted by Missouri leaders and submitted to SAMHSA in March 2008.

**This document serves as a *Plan Update and Supplement*** to Missouri's Comprehensive Plan that was approved by SAMHSA in June 2008. **It updates Part 3 Initial Action Plan** that contained a detailed outline of the 2008 priority actions linked to the goals, objectives, and strategies contained in Part 2 of the Plan.

It is important to note that the Action Plan is designed to provide a general roadmap that outlines the major routes and intersections to a transformed mental health system in Missouri *as we know them today*. However, true transformation is more about the journey than the roadmap itself. By necessity it requires an openness and readiness to shift gears, forge new and unknown territory, and quickly adjust to an ever-changing landscape.

Missouri has enthusiastically embarked on this journey, as reflected in this update, and significant progress has been made across the original priority actions. In FFY2008, the TWG approved two additional action items bringing the total to 63. Several timelines, implementation steps, and measures also were modified to respond to an ever-changing environment and to seize new opportunities that emerged.

Each of the 63 action items has been reviewed and updated as necessary to reflect both the progress to date and changes to the implementation steps for the next fiscal year. The legend of abbreviations used in the Action Plan is contained in the Appendix.



Missouri Comprehensive Plan for Mental Health  
Federal FY 2009 Action Plan Update

 <b>MISSOURI MENTAL HEALTH TRANSFORMATION STRATEGIC THEMES</b> Creating Communities of Hope <i>Moving Missouri Toward a Public Health Approach</i> 		
MOVE FROM:		MOVE TO:
CULTURE OF CRISIS/ RISK OF HARM		CULTURE OF HOPE/ FIRST DO NO HARM 
NO WHERE TO GO		EASY, EARLY AND EQUAL ACCESS 
DISABILITY FOCUS		WELLNESS FOCUS WITH PREVENTION AND EARLY INTERVENTION 
BUREAUCRACY/ PROVIDER DRIVEN CARE		CONSUMER DIRECTION AND EMPOWERMENT 
POCKETS OF EXCELLENCE		UNIVERSAL BEST PRACTICES 
FRAGMENTED & CENTRALIZED SYSTEM		SHARED OWNERSHIP & INVESTMENT (STATE-LOCAL, PUBLIC-PRIVATE) 



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

<b>GOAL 1: MISSOURIANS UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH</b>	<b>OBJECTIVE 1.1:</b>	INCREASE PUBLIC UNDERSTANDING AND REDUCE STIGMA OF MENTAL ILLNESS, SUBSTANCE ADDICTIONS AND DEVELOPMENTAL DISABILITIES.	
	<b>OBJECTIVE 1.2:</b>	DEVELOP AND IMPLEMENT A STATE-WIDE PREVENTION FRAMEWORK THAT ADDRESSES COMMON RISK AND PROTECTIVE FACTORS.	
	<b>OBJECTIVE 1.3:</b>	INTEGRATE PUBLIC, PRIMARY AND MENTAL HEALTH CARE PRACTICES.	
<b>GOAL 2: MISSOURI'S MENTAL HEALTH CARE IS CONSUMER AND FAMILY DRIVEN</b>	<b>OBJECTIVE 2.1:</b>	INCREASE CONSUMER DECISION-MAKING AND SELF-DIRECTION OF INDIVIDUALIZED PLANS OF CARE.	
	<b>OBJECTIVE 2.2:</b>	EXPAND AND INTEGRATE PEER AND FAMILY SUPPORT SERVICES INTO THE SYSTEM OF CARE.	
	<b>OBJECTIVE 2.3:</b>	CREATE A CULTURE OF RESPECT, DIGNITY & WELLNESS AS THE MILIEU IN WHICH ALL MENTAL HEALTH SERVICES ARE PROVIDED.	
	<b>OBJECTIVE 2.4:</b>	INCREASE THE NUMBER OF CONSUMERS FULLY PARTICIPATING IN THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF THE SYSTEM.	
<b>GOAL 3: MENTAL HEALTH DISPARITIES ARE ELIMINATED IN MISSOURI</b>	<b>OBJECTIVE 3.1:</b>	IMPROVE ACCESS TO QUALITY CARE IN RURAL AND GEOGRAPHICALLY REMOTE AREAS.	
	<b>OBJECTIVE 3.2:</b>	IMPROVE ACCESS TO CULTURALLY COMPETENT CARE	
	<b>OBJECTIVE 3.3:</b>	INCREASE CONSUMER ACCESS TO PROGRESSIVE EMPLOYMENT OPPORTUNITIES IN INTEGRATED COMMUNITY SETTINGS.	
	<b>OBJECTIVE 3.4:</b>	INCREASE CONSUMER ACCESS TO SAFE AND AFFORDABLE HOUSING IN INTEGRATED COMMUNITY SETTINGS.	
<b>GOAL 4: EARLY SCREENING, ASSESSMENT AND REFERRAL TO SERVICES ARE COMMON PRACTICE</b>	<b>OBJECTIVE 4.1:</b>	PROVIDE TIMELY OUTREACH, SCREENING AND REFERRAL TO CARE THAT IS AGE AND CULTURALLY APPROPRIATE.	
	<b>OBJECTIVE 4.2:</b>	PROVIDE MENTAL HEALTH CONSULTATION AND SERVICES IN EARLY CHILDHOOD AND SCHOOL SETTINGS.	
	<b>OBJECTIVE 4.3:</b>	EXPAND COMMUNITY CAPACITY TO REDUCE AVOIDABLE USE OF EMERGENCY ROOMS, HOSPITALS AND OTHER INSTITUTIONAL CARE.	
<b>GOAL 5: EXCELLENT MENTAL HEALTH CARE IS DELIVERED AND RESEARCH IS ACCELERATED</b>	<b>OBJECTIVE 5.1:</b>	DEVELOP THE MENTAL HEALTH WORKFORCE	
	<b>OBJECTIVE 5.2:</b>	EXPAND EVIDENCE-BASED PRACTICES (EBPs) ACROSS THE STATE.	
	<b>OBJECTIVE 5.3:</b>	APPLY RESEARCH EVIDENCE MORE QUICKLY AND INVEST IN RESEARCH FOR NEW AND PROMISING PRACTICES.	
	<b>OBJECTIVE 5.4:</b>	DEVELOP AND IMPLEMENT A COMPREHENSIVE QUALITY MANAGEMENT SYSTEM.	
<b>GOAL 6: MISSOURI COMMUNITIES ARE PROFICIENT IN MEETING LOCAL MENTAL HEALTH NEEDS.</b>	<b>OBJECTIVE 6.1:</b>	CREATE CONSISTENT & FLEXIBLE POLICY/PRACTICES ACROSS STATE AGENCIES THAT ARE INFORMED BY CONSUMERS & LOCAL NEEDS.	
	<b>OBJECTIVE 6.2:</b>	CREATE AND/OR EXPAND LOCAL PUBLIC-PRIVATE COLLABORATIVES TO IMPROVE SERVICE ACCESS, CAPACITY AND INTEGRATION .	
	<b>OBJECTIVE 6.3:</b>	EXPAND THE ROLE AND CAPACITY OF COMMUNITIES TO IDENTIFY THEIR NEEDS, PROMOTE MENTAL HEALTH & CREATE OPPORTUNITIES FOR CONSUMER INCLUSION.	



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008							
1.1 1.2	<p><b>Mental Health Promotion and Public Education Workgroup:</b> The TWG chartered a cross-departmental workgroup to promote the understanding that mental health is essential to overall health, to examine the state's capacity to deliver mental health services within the framework of a public health approach, and to make policy recommendations. The next step is to establish two subcommittees:</p> <ul style="list-style-type: none"> <li>to increase mental health literacy and reduce stigma</li> <li>to review current prevention efforts and make recommendations for a prevention system and framework</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI	DD	ADA	ALL √	CY&F	ADULT	OA	ALL √	TWG	C E	9	Medium	√											<p>The workgroup was chartered and the first meeting was held in August. One subcommittee has been established to address Mental Health First Aid.</p>
MI	DD	ADA	ALL √																						
CY&F	ADULT	OA	ALL √																						
1.1 2.3	<p><b>Respect Seminars &amp; Institute:</b></p> <ul style="list-style-type: none"> <li>Continue statewide training and organizational consultation to build culture of respect.</li> <li>Offer three sessions to train consumers and families through the four-day Respect Institutes.</li> <li>Begin development of Peer Speakers Bureau in Missouri as component of public information campaign in partnership with advocacy organizations.</li> <li>Link with Mental Health Promotion and Public Education Workgroup.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI	DD	ADA	ALL √	CY&F	ADULT	OA	ALL √	DMH OOT& Mental Health Promotion and Public Education Workgroup	C E	2	Medium	√										<p>13 Public seminars were held across state through September with over 750 participants. One community institute was held with four graduates. <b>The Respect Seminar was also a key component of the Reducing Stigma and Increasing Cultural Competency Pilot in the eastern region of the state (see separate action item)</b></p>	
MI	DD	ADA	ALL √																						
CY&F	ADULT	OA	ALL √																						

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
1.1 1.3 5.3	<p><b>Mental Health First Aid:</b></p> <ul style="list-style-type: none"> <li>Implement evidence-based 12-hour mental health literacy training program as part of public education campaign.</li> <li>Work with state of Maryland, National Council of Community Behavioral Health Care, and SAMHSA to convert training curricula and certification standards for use in United States. Train initial cohort of trainers.</li> <li>Continue to identify populations and implement training across state.</li> <li>Identify and apply for match funding to expand training.</li> <li>Develop business plan for long-term sustainability. This includes both a Missouri-specific plan and national plan with H-USA partners.</li> <li>Continue to work with national partners and SAMHSA on finalizing and implementing national evaluation.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td>√</td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL	√		√		CY&F	ADULT	OA	ALL				√	DMH OOT & Mental Health Promotion and Public Education Workgroup	C E	2	Medium	√											<p>Have developed draft MHFA-USA manual, standards, and business plan with national partners. Initiated roll-out of program in Missouri with three 12-hour pilot courses and one 40-hour instructor training through September. Identified and trained two instructors to begin pilot training in Missouri. Grant application submitted to demonstrate and evaluate program implantation to target populations. Preliminary draft of a combined youth/adult manual is being reviewed.</p>
MI	DD	ADA	ALL																														
√		√																															
CY&F	ADULT	OA	ALL																														
			√																														
1.1 2.3 3.2 5.1	<p><b>Reducing Stigma and Increasing Cultural Competency Pilot:</b></p> <ul style="list-style-type: none"> <li>Continue roll-out of initial pilot in eastern region to change current culture of health care system by addressing barriers to quality care related to stigma and cultural competency. Provide organizational consultation and seminars to implement regional respect policy guidelines with targeted organizations. Evaluation will guide state-wide expansion in partnership with MO Coalition of CMHCs.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td>√</td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL	√		√		CY&F	ADULT	OA	ALL				√	<p>SLRHC Behavioral Health Steering Team &amp; Workgroup</p> <p>DMH OOT &amp; Divisions of CPS and ADA</p>	A C E	2	Medium	√										<p>The St. Louis RHC Steering Team has sponsoring a three-part series, entitled <i>Seeing the Person Beyond the Label. That includes training on respect and cultural competency.</i> The first two sessions took place in June and August 2008. Participants represent 35 area agencies. The steering team also has begun the process of instituting a regional respect policy by developing guidelines.</p>	
MI	DD	ADA	ALL																														
√		√																															
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
1.1	<p><b>Mental Health Foundation:</b></p> <ul style="list-style-type: none"> <li>Continue to develop public-private partnership for permanent Missouri Mental Health Foundation that supports public education, stigma reduction and consumer empowerment initiatives.</li> <li>Develop and incorporate into separate 501C3 and establish Board of Directors.</li> <li>Identify potential fundraisers and contributors to foundation and implement for long-term success and sustainability of fund projects.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OLDER ADULT</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OLDER ADULT	ALL				√	DMH & Midwest Special Needs Trust	C	9	Medium	√											An initial foundation was established through the Midwest Special Needs Trust. Fund raising has been initiated and a part-time executive director hired. First major event co-sponsored by DMH and MHF was the Mental Health Champions Awards Banquet April 16, 2008.
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OLDER ADULT	ALL																														
			√																														
1.1	<p><b>Network of Care:</b></p> <ul style="list-style-type: none"> <li>Establish work plan and measurable outcomes in terms of NoC usage, updated resource information, expanded transparency, and safety promotion.</li> <li>Increase consumer use of network of care and personal folder options through training of local consumer leaders affiliated with mental health organizations to assist other consumers in accessing and using system.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td>√</td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL	√	√			CY&F	ADULT	OA	ALL				√	DMH Director's Office, Divisions of CPS & DD	C	9	Medium	√										Internal contacts/leads assigned and an initial work plan was developed to increase organization and consumer use of system initiated. Training of consumers with 2 local mental health organizations has begun. NoC information made available to 211 system.	
MI	DD	ADA	ALL																														
√	√																																
CY&F	ADULT	OA	ALL																														
			√																														
1.1	<p><b>Transformation Communications and Accountability Plan:</b></p> <ul style="list-style-type: none"> <li>Initiate new website for Missouri Mental Health Transformation.</li> <li>Produce regular briefings on key issues, successes and progress through prepared media releases, newsletters and other communications</li> <li>Produce annual report.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH OOT	A	N/A	Medium	√										Initial enhancements of website completed and a new website is under development. Bi-weekly and other reports have been initiated. Annual report completed as part of plan update. Press releases have been produced regularly.	
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008							
1.2	<p><b>Suicide Prevention E-Learning:</b></p> <ul style="list-style-type: none"> <li>Finalize the content/design of a graduate level course in suicide prevention; make available online for academic credit.</li> <li>10 one-hour modules will be vetted in October for the final time</li> <li>Make these modules available on line for ease of access.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI	DD	ADA	ALL √	CY&F	ADULT	OA	ALL √	DMH, DHSS & University of Missouri	C	2	Low												The Center for Mental Health in Schools at the University of Missouri has continued to tweak the content of the graduate level course in suicide prevention. The number of one-hour modules has been expanded to 10 and have PowerPoint presentations to accompany them. They will be vetted in October. A university committee has reviewed all of these for the ability to sustain student interest and recommended some changes on this basis.
MI	DD	ADA	ALL √																						
CY&F	ADULT	OA	ALL √																						
1.2	<p><b>Suicide Prevention Elderly Pilot:</b></p> <ul style="list-style-type: none"> <li>Identify a geographical area for the pilot program with a Suicide Prevention Resource Center and an AAA willing to work together and a CMHC with capacity to meet referral needs.</li> <li>The Suicide Prevention Resource Center will offer suicide prevention training to individuals designated by the AAA to include drivers for Meals on Wheels, home health aides, companions, AAA staff, families and friends and spouses, interested community members.</li> <li>Referrals and results will be documented by those trained to inform the evaluation, identify lessons learned, and ensure help is activated in response to need.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI	DD	ADA	ALL √	CY&F	ADULT	OA	ALL √	DMH OOT	C E	9	Medium											Reviewing proposal submitted by local CMHC in partnership with AAA and community health center.	
MI	DD	ADA	ALL √																						
CY&F	ADULT	OA	ALL √																						

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
1.2	<p><b>NO BUTTS About It:</b></p> <ul style="list-style-type: none"> <li>Distribute results of the assessment</li> <li>Await an expected invitation from the Missouri Foundation for Health to develop a plan, based on assessment results, to prevent tobacco use by consumers of mental health services. Identify other sources to fund plan initiation as necessary.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH & DHSS	C	9	Medium/Low												Funded via a grant from the Missouri Foundation for Health and implemented by MIMH through a subcontract, the NO BUTTS ABOUT IT assessment phase is complete. The expected project outcome is to determine the use of tobacco by those who are consumers of mental health services across the three divisions.
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														
1.1 1.2 1.3 4.2 6.2	<p><b>Higher Education Mental Health Homeland Security Initiative:</b></p> <p>Foster collaborative relationships on college campuses across the state to implement recommendations to involve mental health expertise in emergency planning for campuses;</p> <ul style="list-style-type: none"> <li>Education/training on how to access 24/7 mental health services by campus authorities and students, either CMHCs and/or on campus expertise;</li> <li>Education/training on linkages for activating civil commitment if needed.</li> <li>Pilot MHFA training for campus personnel and students</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td>√</td> <td></td> <td></td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL		√			<p>Homeland Security Taskforce, Department of Higher Education and Public Safety Subcommittee</p> <p>DMH Directors Office</p>	C	2	Medium											The Homeland Security Task Force, Higher Education, and Public Safety Committee are meeting every 6 to 8 weeks. One project is to develop a website with a mental health subsection to facilitate 24/7 access to services. Higher Education has agreed to piloting Mental Health First Aid on two campuses in 2009.	
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
	√																																
1.3 4.3 6.2	<p><b>Disaster Services and Special Needs Shelters:</b></p> <ul style="list-style-type: none"> <li>DMH disaster services staff will continue to participate in quarterly meetings.</li> <li>Develop process of creating a template for local public health authorities and emergency operations centers to request mental health assistance for activated special needs shelters.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	Special Needs Committee DHSS DMH	C	9	Medium	COMPLETE										The newest revision of Annex X, the Special Needs Annex to the Missouri State Emergency Management Operations Plan, was finalized in March 2008. A Special Needs Sheltering Standard Operating Guide (SOG) for local and county emergency management was prepared and distributed as a local template in July 2008.	
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008																
1.3	<b>CMHC-FQHC Collaborative Care Pilot:</b> Continue 7 collaborative care pilots between federally qualified health centers (FQHC s) and community mental health centers (CMHC s). Evaluation will guide needed policy changes and additional expansion. Submit budget request to fund 5 additional collaboratives in SFY2010.  <b>Initial Target Population:</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">MI</td> <td style="width: 25%;">DD</td> <td style="width: 25%;">ADA</td> <td style="width: 25%;">ALL</td> </tr> <tr> <td>√</td> <td></td> <td>√</td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL	√		√		CY&F	ADULT	OA	ALL				√	<b>DMH Division of CPS, Missouri Coalition of CMHC s, Missouri Primary Care Association</b>	C E	3 4 8	Medium													Seven pilots implemented and evaluation started. Six Mini-grants given to applicants not awarded contract to support planning efforts between partner agencies. Evaluation has begun. New DMH budget item developed to fund 5 additional collaboratives.
		MI	DD	ADA	ALL																													
		√		√																														
CY&F	ADULT	OA	ALL																															
			√																															
1.3	<b>Integration of Mental Health to Health Care Home Model (DMH NET):</b> <ul style="list-style-type: none"> <li>▪ Community Mental Health Centers to be trained to serve as health care homes for individuals with serious mental illnesses under the MO HealthNet Plan;</li> <li>• Continue to provide disease management services for Medicaid-eligible individuals with mental illnesses and co-occurring physical health conditions; and</li> <li>• Continue to provide data analysis and educational materials to health care providers regarding good psychiatric prescribing practices.</li> </ul> <b>Initial Target Population:</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">MI</td> <td style="width: 25%;">DD</td> <td style="width: 25%;">ADA</td> <td style="width: 25%;">ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL	√				CY&F	ADULT	OA	ALL				√	<b>DMH &amp; DSS Division of MO HealthNet</b>	A E	4 5	Medium												Negotiations have been held with DMH, MO-HealthNet, and the Coalition of Community Mental Health Centers and approval has been given for CMHCs to be designated Health Care Homes. Training of CMHC s is underway. Implementations of disease management services have been initiated. Data analysis and educational materials have been refined and implemented.	
		MI	DD	ADA	ALL																													
		√																																
CY&F	ADULT	OA	ALL																															
			√																															

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
2.1 2.3 2.4	<p><b>Person-Centered Planning:</b> Enhance Person-Centered Planning within the Division of DD and implement Person-Centered Planning principles and process within the CPS provider system.</p> <ul style="list-style-type: none"> <li>Issue a policy affirming person-centered values as the foundation for the entire mental health services system.</li> <li>Conduct training for all staff including administration and direct support on person-centered thinking/philosophy, following by training on person-centered planning.</li> <li>Provide access to mentors to facilitate person-centered planning and implementation of plans.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td>√</td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL	√	√			CY&F	ADULT	OA	ALL				√	<p><b>DMH Divisions of DD and CPS and UMKC Institute for Human Development</b></p>	E	2	High												<p>The Centers for Medicare and Medicaid Services (CMS) awarded a three-year grant to CPS and DD to enhance person-centered planning in Missouri. Neal Adams, MD, is providing consultation and technical assistance to CPS on implementation of a model that is compatible within psychiatric settings.</p>
MI	DD	ADA	ALL																														
√	√																																
CY&F	ADULT	OA	ALL																														
			√																														
2.1	<p><b>Self-Directed Supports and Services:</b></p> <ul style="list-style-type: none"> <li>DD Waivers amended to add options for self-directed and family directed services.</li> <li>Secure a fiscal management service contractor to provide a wide range of fiscal support services to enable more people to self-direct</li> <li>Training to be provided to service coordinators, consumers and families regarding choices, risks and benefits.</li> <li>Explore methods to expand self-directed options to other services</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td>√</td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL		√			CY&F	ADULT	OA	ALL				√	<p><b>DMH Division of DD, Missouri DD Planning Council &amp; UMKC IHD</b></p>	E	9	Medium												<p>New fiscal management contract to improve services for individuals wishing to self direct was awarded and implementation began in July. The contractor will provide workman s compensation and a call-in system for staff; both areas listed as barriers to participation by the SDS Advisory Board. Training for self-advocates, family members, and service coordinators on self-direction has begun.</p>
MI	DD	ADA	ALL																														
	√																																
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions				Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008																	
	MI	DD	ADA	ALL																																		
2.1	<b>Consumer Principles for Practice Workgroup:</b> Charter short-term work group to review The Practice Guidelines for Consumer Directed Services and Supports developed in 2002 by DMH. These will be reviewed by all State agencies that provide human services, with the goal of adoption as appropriate to the population(s) served.  <b>Initial Target Population:</b> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>				MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	TWG	E	N/A	Low														Initial internal DMH workgroup reviewed guidelines and charter has been drafted to present to TWG at future meeting.
MI	DD	ADA	ALL																																			
			√																																			
CY&F	ADULT	OA	ALL																																			
			√																																			
2.1 6.1	<b>Wrap-Around Fidelity:</b> Identify wraparound values/principles that all state child-serving departments can endorse. Certified wraparound facilitators are members of the committee working on this issue. Once values/principles are developed and endorsed, departments will identify system and infrastructure changes necessary to support them. Missouri's ultimate goal is that high fidelity wraparound will be used by all public agencies with ongoing training needs met through the use of in-state certified trainers.  <b>Initial Target Population:</b> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> </table>				MI	DD	ADA	ALL	√				CY&F	ADULT	OA	ALL	√				DMH OCCMH & CSMT	E	2	Medium	√												A subcommittee of the Comprehensive System Management Team has been meeting regularly on the wraparound values/principles and a draft is expected in the fall.	
MI	DD	ADA	ALL																																			
√																																						
CY&F	ADULT	OA	ALL																																			
√																																						

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
2.2	<p><b>Peer Specialists Training and Certification:</b></p> <ul style="list-style-type: none"> <li>Continue training primary consumers to provide direct services within the CPS provider network using training and certification model developed by Larry Frick/ Appalachia.</li> <li>Initiate supervisory training to assist supervisors in effectively working with peer specialists.</li> <li>Continue annual training (Approximately 40 consumers).</li> <li>Review rules, regulations and certification standards and modify or develop new rules as needed.</li> <li>Work on sustainability plan for the training and plan to provide continuing support for the peer specialists.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td>√</td> <td></td> <td></td> </tr> </table>	MI	DD	ADA	ALL	√				CY&F	ADULT	OA	ALL		√			DMH Division of CPS and OOT	C E	2	Medium												<p>Medicaid provider rates set under Community Psychiatric Rehabilitation program option. The first session for training of primary consumers was held at the end of September 2008, where 36 completed the five-day course. A website created to provide ongoing support and networking for peers. Supervisory training will be provided at the end of October so as to assist supervisors in effectively working with peers.</p>
MI	DD	ADA	ALL																														
√																																	
CY&F	ADULT	OA	ALL																														
	√																																
2.2	<p><b>Family Support Training:</b></p> <ul style="list-style-type: none"> <li>The second round of trainings will be completed by December 2008.</li> <li>Quarterly in-service trainings will be scheduled for continuing education.</li> <li>At least one meeting will be scheduled for supervisors in how to support FSPs in their role.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> </table>	MI	DD	ADA	ALL	√				CY&F	ADULT	OA	ALL	√				DMH OCCMH & Division of CPS	C	2	Medium												<p>Curricula finalized and the first training a four-day session was held in May 2008, where 21 people participated: 14 Family Support Providers (FSP) and seven supervisors. The decision was made to hold two two-day sessions instead and four FSPs and four supervisors began the second round of training in September, to be completed by December 2008. This training has been added as a Medicaid-covered service. Training is required for all FSPs who will bill Medicaid.</p>
MI	DD	ADA	ALL																														
√																																	
CY&F	ADULT	OA	ALL																														
√																																	

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008				
2.2	<b>Consumer Operated Service Program (COSP) Quality Improvement Initiative:</b> <ul style="list-style-type: none"> <li>Continue Phase 2 of COSP Quality Improvement Initiative to continue self-assessment of fidelity for COSP services.</li> <li>Reissue RFP in Spring 09, which will include mandatory use of the Fidelity Assessment Common Ingredient Tool (FACIT)</li> <li>Develop plan for peer specialist employment in both COSPs and Psycho-social rehabilitation Programs</li> <li>Modify fidelity tool to use with telephone support lines and initiate baseline reviews.</li> </ul>	DMH Division of CPS, MIMH	A E	8	Medium	^												Initiated phase two of COSP Quality improvement initiative that provides training for self-assessment of fidelity. The drop-in programs have piloted a SAMHSA-funded EBP toolkit. All programs have received a fidelity visit to establish baseline. Phase 2 includes: Made fidelity follow-up visits to two (2) of the five (5) programs. All programs are receiving instructions on how to self-administer the fidelity tool.				
																			Initial Target Population:			
																			MI	DD	ADA	ALL
	√																					
	CY&F	ADULT	OA	ALL																		
		√																				
2.3	<b>Procovery Statewide Expansion:</b> <ul style="list-style-type: none"> <li>Continue statewide implementation of Procovery program.</li> <li>Implement facilitator support to add new Procovery circles.</li> <li>Develop Business plan and complete state and regional infrastructure for sustainability</li> <li>Establish second phase evaluation to include one article submitted /published in peer review journal.</li> </ul>	DMH Division of CPS & OOT	C E	2	Medium	^												Initial state infrastructure established. Four Procovery introductory trainings have been completed with 361 attendees. Three facilitator trainings have been completed with 257 participants. It is anticipated there will be more than 200 licensed facilitators statewide by year end.				
																			Initial Target Population:			
																			MI	DD	ADA	ALL
	√																					
	CY&F	ADULT	OA	ALL																		
				√																		

(See appendix for Legend of Abbreviations.)



Missouri Comprehensive Plan for Mental Health  
Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008						
2.2	<p><b>Peer and Family Mentoring:</b> Expand access to peer and family mentoring through Sharing our Strengths.</p> <p>Initial Target Population:</p> <table border="1"> <tr> <td>MI</td> <td>DD √</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI	DD √	ADA	ALL	CY&F	ADULT	OA	ALL √	DMH- DD & UMKC Institute for Human Development	C	9	Medium	COMPLETE										The enhancement of Sharing Our Strengths, a peer-to-peer mentoring program has been completed. Transition coordinators are informed about SOS and will be assisting to coordinate outreach efforts at the habilitation centers. SOS staff conducted a presentation to Transformation staff on September 23 to evaluate expansion to new target groups.
MI	DD √	ADA	ALL																					
CY&F	ADULT	OA	ALL √																					
2.3 5.1 5.2	<p><b>Positive Behavioral Support Training:</b></p> <ul style="list-style-type: none"> <li>Utilize certified trainers to expand knowledge of the principals and practices of positive behavior supports.</li> <li>Explore expansion of positive behavior supports principals and populations to other target groups and systems of care.</li> </ul> <p>Initial Target Population:</p> <table border="1"> <tr> <td>MI √</td> <td>DD √</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI √	DD √	ADA	ALL	CY&F	ADULT	OA	ALL √	DMH Division of DD	C E	2	Medium	^	^	^	^	^	^	^	^	^	^	Certification process developed. First training of trainers scheduled for end of October 08. Plan is for approximately 20 individuals to be trained as Positive Behavioral Support Trainers by end of September 09. Training will include DD and Mental Health staff. Those 20 certified trainers will train approximately 120 direct care staff in positive behavior supports.
MI √	DD √	ADA	ALL																					
CY&F	ADULT	OA	ALL √																					

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
2.4 5.4	<p><b>Peer and Family Participation in Certification, Monitoring and Quality Service Reviews:</b></p> <ul style="list-style-type: none"> <li>Implement guidelines developed by CPS State Advisory Council to include peers and family members in the monitoring and certification of CPS funded community-based programs.</li> <li>Provide additional family training for participation in Quality Service Reviews (QSR) conducted at local system of care sites for children.</li> <li>Continue implementation of quality of life surveys conducted by self-advocates and families for people transitioning from institutions and receiving community-based services.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td>√</td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL	√	√			CY&F	ADULT	OA	ALL				√	<p>DMH Division of CPS</p> <p>DMH OCCMH &amp; CSMT</p> <p>DMH Division of DD</p>	A E	9	Medium												<p>CPS consumer/ family monitors surveyed three agencies in 2008. Additional consumers and family members will be trained to participate in the certification survey process in 2009.</p> <p>10 family members have been trained to participate in QSR reviews and 4 have participated on a review team.</p> <p>Through the DD, Self-Advocates and Families for Excellence (SAFE) program, 41 individuals and/or family members have completed SAFE volunteer training and four are currently in the process.. To date, 60 visits have been initiated with individuals or their guardians across the state. Of those 60 visits, 38 have been completed; six visits are pending; three are currently scheduled; and 13 declined.</p>
MI	DD	ADA	ALL																														
√	√																																
CY&F	ADULT	OA	ALL																														
			√																														
2.4	<p><b>Consumer, Family and Youth Leadership Training:</b></p> <p>Workshops will be held to engage emerging leaders by taking a journey through the process of telling their stories to becoming leaders who promote systems change. Participants explore the difference between advocacy and leadership and when to use the different approaches. The workshop provides examples of the supports that may be needed for participants to participate on teams and committees.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH OOT	E	2	Low to Medium											<p>Had one youth leadership planning meeting and one youth leadership retreat this year. Twelve young people representing all regions of the state attended a youth leadership retreat in August 2008, along with 10 parents/ guardians, who participated in a separate leadership session. A strategic planning meeting is scheduled.</p>	
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



Missouri Comprehensive Plan for Mental Health  
Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
3.1 3.2 4.3 5.1	<p><b>Capacity Development Analysis:</b> Using information contained in Needs Assessment and Inventory of Resources, conduct system capacity analysis.</p> <ul style="list-style-type: none"> <li>Identify required service array inclusive of peer and family support and education service across continuum based upon prevalence, identified need and review of available evidence.</li> <li>Perform gap analysis of need and resources to include gaps related to culture, geography, and age.</li> <li>Develop appropriate criteria to identify true waitlist for services consistent with model used by DD division.</li> </ul> <p>Project scope will be phased over next two years.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL	√				CY&F	ADULT	OA	ALL				√	DMH OOT	C E	N/A	Medium to High												Draft work plan for Capacity Analysis received from prospective contractor with this expertise. Work plan is being evaluated and negotiated.
MI	DD	ADA	ALL																														
√																																	
CY&F	ADULT	OA	ALL																														
			√																														
3.1 - 4.3	<p><b>Telehealth:</b></p> <ul style="list-style-type: none"> <li>Pilot the delivery of behavior therapy and crisis intervention using telehealth equipment, and evaluate results.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td>√</td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL		√			CY&F	ADULT	OA	ALL				√	DMH Division of DD	C	9	Low	COMPLETE										<p>DD and the Thompson Center have partnered to provide intensive behavior therapy to individuals with Autism spectrum disorders and some participants are receiving services through telehealth. DD has piloted the delivery of behavior therapy and crisis intervention utilizing telehealth technology.</p> <p>Research of the necessity to amend the DD waivers to allow for telehealth found that amendment was not necessary so that action from 2008 has been dropped from the plan.</p>	
MI	DD	ADA	ALL																														
	√																																
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
3.3	<p><b>Employment Workgroup:</b> Continue plan to implement employment strategies. Review current state rules, regulations and financing policies and recommend revisions as appropriate to increase consumer employment and financial independence without losing necessary services and supports.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	TWG	C	N/A	Medium	√											<p>First meeting September 2008 Oriented members to status of employment for persons with disabilities Reviewed final progress report of MIMH grant on the Missouri Mental Health Employment project Reviewed employment data. In-depth discussion of workgroup charter.</p>
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														
3.4	<p><b>Housing Workgroup:</b> Chartered workgroup to identify current resources and gaps in affordable and integrated housing and begin implementing housing strategies. Review current state rules, regulations and financing policies and recommend revisions as appropriate to increase consumer access to an array of housing options for persons with disabilities.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	TWG	A C	N/A	Medium	√											<p>Workgroup initiated. During its first meeting in August, members reviewed the current housing environment and available resources. The group identified three areas for exploration: Identify strong housing programs and national models, determine availability and resources for persons with disabilities, and address bricks and mortar issues.</p>
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														
3.4	<p><b>Housing Registry:</b> Develop a housing resource, which will include a registry of affordable, accessible, integrated housing in Missouri, as well as resources to rent, buy, or modify a home of one's own.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH Division of DD & MPC	C	9	Medium	√										<p>The Missouri Planning Council for Developmental Disabilities is in the process of developing a housing resource which will include a registry of affordable, accessible, integrated housing in Missouri as well as resources to rent, buy or modify a home of one's own.</p>	
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
3.2	<p><b>Deaf Services Capacity Development:</b> Begin implementation of revised plan. Budget request submitted for FY 2010 to support a Tele-Health approach to delivery of services, delivered by ASL competent Mental Health Professionals. Continue evaluation of the state's current plans and services for individuals who are deaf and have mental health needs based on best practices in other states and consistent with culturally distinct needs of the deaf community.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH Office of Director	A C E	9	Medium- High												Meeting held with representatives from DMH and Deaf Services Community to review proposed updates/changes to Plan. New director of Deaf Services hired by DMH.
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														
3.2	<p><b>Language Translation:</b> Develop translation for DMH web content, brochures and other informational materials. Partner with local groups to assist in translating materials. Initial priority is Spanish translation. Phase 2 priorities are ASL and Bosnian translation.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH Office of Director	C	9	Medium												The effort to address issues of language translation of DMH information and resources was delayed due to staff changes in 2008. Staff has stabilized and effort will begin again in FY 09.
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														
4.1	<p><b>Improving Entry Pilot:</b> Continue pilot to implement standardized screening tool across mental health and substance abuse providers in Eastern region. Operationalize plan to increase access to care. Evaluation will guide further refinement and potential for state-wide expansion.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td>√</td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td>√</td> <td>√</td> <td></td> </tr> </table>	MI	DD	ADA	ALL	√		√		CY&F	ADULT	OA	ALL		√	√		SLRHC Behavioral Health Steering Team  DMH OOT & Divisions of CPS and ADA	A E	9	Medium											A standardized, web enabled screening tool has been developed. Information will be given to all providers as to use of the tool. The group is working to operationalize access, to maintain access to the consumer, and to establish a call center.	
MI	DD	ADA	ALL																														
√		√																															
CY&F	ADULT	OA	ALL																														
	√	√																															

(See appendix for Legend of Abbreviations.)



Missouri Comprehensive Plan for Mental Health  
Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions				Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008
	MI	DD	ADA	ALL																	
4.1	<b>Mental Health Coordinator Legislation Change:</b> Propose legislative change to allow private mental health providers to be designated to perform outreach and investigative procedures as a component of the access-crisis intervention functions to facilitate assessments of need for services including need for involuntary commitment.  <b>Initial Target Population:</b>				DMH Division of CPS	A C	1	Medium	COMPLETE											Legislation has been passed to allow private mental health providers to perform outreach and investigative procedures as a component of the access/crisis intervention functions.	
	MI	DD	ADA	ALL																	
	CY&F	ADULT	OA	ALL																	
4.1	<b>Statewide Expansion of Police Crisis Intervention Teams (CIT):</b> Establish contracted statewide coordinator position to staff steering group to develop and implement CIT state-wide in partnership with Chief Justice initiative. Develop rural adaptations to existing model. FY10 budget request to be submitted for \$200,000 one time funding for further expansion.  <b>Initial Target Population:</b>				DMH Division of CPS, Office of State Courts A Chief Justice Initiative	C E	9	Medium-High												This initiative received one-time funding through the Office of the State Courts Administrator to establish a statewide coordinator position to staff a steering group. A \$200,000 budget item was approved in the Division of Comprehensive Psychiatric Services Budget in state FY 09 for one time funding to complete Implementation in Kansas City, St. Louis, and expand to one other metropolitan area of the state. Discussion has begun to identify specific outcomes to support ongoing funding of the initiative.	
	MI	DD	ADA	ALL																	
	CY&F	ADULT	OA	ALL																	

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
4.3 6.2	<p><b>Psychiatric Acute Care Transformation (PACT):</b></p> <ul style="list-style-type: none"> <li>Identify potential regional partnerships with community general hospitals and community providers of psychiatric services to determine if there are options for providing acute inpatient psychiatric care to DMH consumers by non-state operated providers</li> <li>Ensure the continued availability of acute psychiatric inpatient beds on both a statewide and regional basis, while improving access to both inpatient and outpatient services and enhancing the dollars available for operating the entire continuum of psychiatric care.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td>√</td> <td>√</td> <td></td> </tr> </table>	MI	DD	ADA	ALL	√				CY&F	ADULT	OA	ALL		√	√		DMH Division of CPS	C	8	High												One proposal received from prospective partner for one area of Missouri. Public meetings begun to process potential implementation of proposal. Negotiations underway with potential partner. Legal, fiscal, and other issues being researched.
MI	DD	ADA	ALL																														
√																																	
CY&F	ADULT	OA	ALL																														
	√	√																															
1.3 4.1	<p><b>SBIRT:</b> This program will expand the existing continuum of care to include Screening, brief intervention, brief treatment, and referral for individuals with unhealthy levels of alcohol use, overuse of prescription medications, or the use of illegal substances. Implementation will be in general medical settings targeting individuals at risk before they develop significant problems.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td>√</td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td>√</td> <td>√</td> <td></td> </tr> </table>	MI	DD	ADA	ALL			√		CY&F	ADULT	OA	ALL		√	√		DMH Division of ADA	A E	8	Medium to High												SBIRT grant awarded for September 2008. The first six months of the grant are for planning and developments. The first site implementation will be in March 2009.
MI	DD	ADA	ALL																														
		√																															
CY&F	ADULT	OA	ALL																														
	√	√																															
4.3	<p><b>Coordinating Care for High Utilizers Pilot:</b></p> <p>Develop and implement cross-agency coordinated care plans for identified high users of care in Eastern region.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td>√</td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td>√</td> <td>√</td> <td></td> </tr> </table>	MI	DD	ADA	ALL	√		√		CY&F	ADULT	OA	ALL		√	√		<p>SLRHC Behavioral Health Steering Team</p> <p>DMH OOT &amp; Divisions of CPS/ADA</p>	A E	9	Medium												A pilot study with 27 high users is being conducted and measurement system is being refined. The steering team is looking at the current system of crisis, beds, and law enforcement efforts to assess how to better coordinate care.
MI	DD	ADA	ALL																														
√		√																															
CY&F	ADULT	OA	ALL																														
	√	√																															

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
4.3	<p><b>Children s System High User Analysis:</b> The efficacy of services for children with SED will be assessed. Data will be collected to identify high users of services with poor outcomes. Service and system changes will be identified to improve outcomes for children.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> </table>	MI	DD	ADA	ALL	√				CY&F	ADULT	OA	ALL	√				DMH OCCMH	A E	9	Medium	^											Initial work has been directed toward children and youth impacted by significant trauma. The Department has joined with the University of Missouri - ST. Louis, Washington University, and the Children's Division to submit a grant to the SAMHSA to support training and implementation of trauma informed practices. DMH has submitted a budget request for FY2010 to establish a pilot in the St. Louis area to support the implementation of evidence-based practices to treat children impacted by trauma.
MI	DD	ADA	ALL																														
√																																	
CY&F	ADULT	OA	ALL																														
√																																	
4.2	<p><b>Early Childhood Initiative:</b> Work will continue on identifying the infrastructure for a service delivery system that is based on evidence-based practices for the early childhood population through the Coordinating Board for Early Childhood and the Early Childhood Comprehensive System Steering Committee.</p> <p>The second phase of the Early Childhood Mental Health Summit will be convened in 2009 to focus on increasing capacity to quality early childhood mental health services for children at risk or currently exhibiting social and emotional problems.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL	√				DMH OCCMH  HeadStart MOHealthNet DHSS DSS DESE	E	9	Low	^										The first meeting of the Early Childhood Mental Health Summit was held in June. Participants represented policy makers across child-serving agencies, community leaders and early childhood providers. The focus was on identifying components of a state infrastructure to support a universal social and emotional development approach within early childhood. Priorities were identified and three first action steps were pulled out.	
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
√																																	

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions				Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008									
4.2	<p><b>School-based Bullying Prevention:</b></p> <ul style="list-style-type: none"> <li>Develop funding to enable schools to apply to use one of the Olweus trainers at no cost the school will commit to supply the materials and make time for program implementation. Application for three years of funding has been submitted to the Missouri Foundation for Health.</li> <li>Partner trainers with 3-4 schools each to begin program implementation by training a school based bullying prevention committee. Evaluation is built into the implementation process. Anticipated short-term impact: reduction in bullying; improvement in school climate including attendance, grades, and attitudes; reduction in vandalism and discipline referrals.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F √</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> </table>				MI	DD	ADA	ALL √	CY&F √	ADULT	OA	ALL	DMH, DHSS, MO Center for Safe Schools & Individual School Districts	E	9	Medium	√													<p>A partnership has been formed with the Missouri Center for Safe Schools and DHSS to implement the evidence based Olweus Bullying Prevention Program. Each entity has contributed dollars to this initial roll out. Clemson University held their spring Trainer of Trainers in Kansas City and the Missouri partnership selected nine participants for the training to become certified Olweus trainers.</p>
MI	DD	ADA	ALL √																											
CY&F √	ADULT	OA	ALL																											

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions				Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008																	
<b>4.2 School Based Services Expansion:</b> <ul style="list-style-type: none"> <li>Build on initiative to begin expansion of school based mental health services statewide by partnering with local school districts and community mental health centers utilizing matching funds and MO HealthNet (Medicaid) funding.</li> <li>Submit budget request for 2010 to support school based mental health services. If budget item funded, implement in number of school districts allowed by funding. If budget item isn't funded, determine next steps.</li> <li>Implement St. Joseph Circle of Hope Grant targeting integration of physical and behavioral health integration in school settings in 2-3 elementary schools.</li> </ul>					<b>DMH, DESE, Coalition of CMHCs, Individual School Districts</b>	<b>C E</b>	<b>9</b>	<b>High</b>													<p>Medicaid policy changes made to cover approved school-based services programs. Initiated work on a School-based Mental Health Resource Kit for communities to use to develop services.</p> <p>Budget request submitted for 2009 was not approved by legislature. A new request has been prepared for 2010.</p> <p>The Circle of Hope cooperative agreement with SAMHSA, in the second year of its five-year funding, this year worked on developing two components: (1) linkages of physical and mental health services in a school-based model and (2) implementation of that model in a school setting. Staff currently is providing case management and clinical services to students enrolled in the St. Joseph Public Schools. Later funding will support students in Buchanan and Andrew counties.</p>																	
	<b>Initial Target Population:</b>																																					
	MI	DD	ADA	ALL																																		
√																																						
CY&F	ADULT	OA	ALL																																			
√																																						

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008								
4.2	<p><b>Bright Futures Targeted Capacity Building:</b> Secure funding to support three communities to participate in the Missouri Bright Futures effort. Partners in the community will include the school districts, early care and education, Children's Division, Health Departments, Court/DJO and other child serving entities. Communities selected will participate in training and support in mapping the resources and needs of the community, organizing the resources of the community to address system needs, and individualizing resource allocations within the community to improve the outcomes for individual youth.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI √</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>CY&amp;F √</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> </table>	MI √	DD	ADA	ALL	CY&F √	ADULT	OA	ALL	<p><b>DMH, DHSS, DSS, DESE, University of Missouri Center for the Advancement of Mental Health Practices in Schools, Head Start Collaboration, Missouri Student Success Network</b></p>	C E	9	Medium	<											>	<p>Funding was used to support the work of the Bright Futures State Team, an interagency group working on developing the Bright Futures program, and for consultation from Georgetown University to develop a model for expansion. A grant proposal has been submitted to the Missouri Foundation for Health. The grant funds would be used to support the implementation of Bright Futures in three communities in Missouri.</p>
MI √	DD	ADA	ALL																							
CY&F √	ADULT	OA	ALL																							
3.1 4.2 5.2 6.2	<p><b>Autism Treatment Services:</b></p> <ul style="list-style-type: none"> <li>• Provide services to families and individuals impacted by autism spectrum disorders through the Missouri Parent Advisory Councils (PACs).</li> <li>• Contract with academic institutions known as Missouri Autism Centers for Excellence (MO-ACE) to develop and deliver best practices to individuals with autism spectrum disorders.</li> <li>• Partner with the MU Thompson Center to provide intensive behavioral supports to children and young people.</li> <li>• Establish Office of Autism within DD.</li> <li>• Review recommendations from Governor's Blue Ribbon Council to identify those that can be implemented.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD √</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI	DD √	ADA	ALL	CY&F	ADULT	OA	ALL √	<p><b>DMH Division of DD &amp; PACs &amp; MO-ACEs</b></p>	C	9	Medium to High	<b>COMPLETE</b>										<p>All of the actions listed in 2008 have been achieved including SB 768, signed into law in June 2008, which establishes the Office for Autism within the DD, and establishes a 24-member Missouri Commission on Autism and Autism Spectrum Disorders. Commission members have been appointed by the Governor, and the Commission is scheduled to meet in the fall 2008. Commission will guide future actions.</p>		
MI	DD √	ADA	ALL																							
CY&F	ADULT	OA	ALL √																							

(See appendix for Legend of Abbreviations.)



Missouri Comprehensive Plan for Mental Health  
Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
4.3	<p><b>Crisis Intervention:</b> Continue efforts to expand crisis intervention capacity through partnerships with local organization.</p> <p>In reorganization of DD Regional Offices, In-Home Support Teams will be established to provide proactive training on positive behavior supports and functional behavioral assessment to crisis support via phone and direct service when necessary.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td>√</td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL		√			CY&F	ADULT	OA	ALL				√	DMH Division of DD	C	9	Medium	√											In Dec. 07, approximately 220 staff were trained in crisis intervention and more will be trained in Dec. 08. Habilitation Centers have been designated as having specialized areas for crisis intervention. Currently 25 beds have been designated as crisis beds in Habilitation Centers.
MI	DD	ADA	ALL																														
	√																																
CY&F	ADULT	OA	ALL																														
			√																														
5.1	<p><b>Workforce Development Plan:</b> Review Annapolis Coalition Action Plan recommendations and current SAMHSA priorities for workforce development. Develop initial scope and steps for workforce development plan.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH OOT & OOCMH	A E	N/A	Medium	√											Annapolis Plan reviewed and plan for the inclusion of consumers/family members as part of the workforce addressed (see peer and family support action items). 3 universal core competencies have been identified for workforce development: cultural competency, person-centered planning, and trauma-informed care.
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														
5.1	<p><b>E-learning Platform and Core Safety Training Modules:</b> E-learning accounts for direct care staff will be established in all DMH facilities. Core training to be available on the web with safety as an important component. SB 3 requirements will be included in the safety modules being developed. FY 09 budget request submitted includes expansion to community providers, basic certification for direct care staff and supervisory training.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH	C E	9	Medium	√										As of August 2008 172 training programs have been established: 13 department wide programs, seven division-wide programs and 152 facility-specific programs. Of the 152 programs, 71 are classroom-based and 58 are on-line.  There are 22 individual courses currently under development.	
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008							
5.1	<p><b>College of Direct Support:</b></p> <ul style="list-style-type: none"> <li>Pilot College of Direct Support, a web-based training for direct support professionals, with DD service providers.</li> <li>Expand College of Direct Support to additional providers (included in DMH FY09 budget request).</li> <li>Explore expansion of College of Direct Support to other segments of Missouri's long term care system.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD √</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI	DD √	ADA	ALL	CY&F	ADULT	OA	ALL √	DMH Division of DD, MPC, & UMKC IHD MACDDS & MARF & MO-ANCOR	E	9	Medium	^											33 agencies are participating statewide in the CDS project. Over 1,900 individuals are taking MO CDS courses and Nearly 40,000 lessons have been completed. 218 individuals have completed all 13 MO CDS courses and passed the on the job assessment. There is a request for additional funding in the DMH FY 2010 budget proposal.
MI	DD √	ADA	ALL																						
CY&F	ADULT	OA	ALL √																						
5.1 5.2 5.3 5.4 6.1 6.2	<p><b>Evidence Based Practices Workgroup:</b></p> <p>Continue to convene cross-cutting workgroup to:</p> <ul style="list-style-type: none"> <li>Establish and evidence ruler, with input from stakeholders</li> <li>Determine implementation methodology.</li> <li>With information from divisions, compare current fund distributions to the ruler.</li> </ul> <p><b>Note:</b> In DMH CPS, EBP programs are progressing and feedback loop established.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI	DD	ADA	ALL √	CY&F	ADULT	OA	ALL √	TWG EBP Workgroup	A E	N/A	High	^										Two meetings have occurred. Study of work from other states will help to fashion a Missouri system for determining EBPs.  Evidence-based practices identified and currently in use include Assertive Community Treatment, Integrated Dual Diagnosis Treatment, Supported Employment, and Dialectical Behavior Therapy.	
MI	DD	ADA	ALL √																						
CY&F	ADULT	OA	ALL √																						

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008	
2.4 5.4 6.3	<p><b>Quality Service Review (QSR):</b> The quality service review is a tool that measures the quality of interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided. Plans for FY 08 and O9:</p> <ul style="list-style-type: none"> <li>• More families will be trained as reviewers;</li> <li>• Baseline data will be obtained from the 11 system of care sites and follow-up QSR will be conducted for mature sites.</li> <li>• Adult QSR adaptation will be developed.</li> </ul>	DMH OCCMH & Division of CPS & CSMT	A E	4	Medium	√												√	QSR is employed on almost all sanctioned system of care sites (13). Work is being done to evaluate expansion and sustainability. Patterns and trends from QSR data are being analyzed.
Initial Target Population:																			
	MI	DD	ADA	ALL															
	√																		
	CY&F	ADULT	OA	ALL															
				√															

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions				Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008																	
5.1 2.4	<p><b>Trauma Informed Care</b> An organizational assessment of trauma care will be completed. Workforce development and training needs will be identified and prioritized. Technical assistance will be secured and training implemented and evaluated.</p> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>				MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH OOT & OCCMH	E	2															<p>The OOT and OCCMH worked with a subcommittee Missouri's Mental Health Commission to develop a plan for moving to a trauma informed system. A contract with a local mental health organization has been secured to complete and organizational assessment and to develop a training plan with local Children's Advocacy Services. A grant has been submitted to SAMHSA to support Trauma Informed Training within the Child Advocacy Network in Missouri. In addition, a budget request has been approved by the Mental Health Commission for FY2010 to support development of a pilot effort to create a Trauma-Informed Collaborative of Service Providers in St. Louis area.</p>
MI	DD	ADA	ALL																																			
			√																																			
CY&F	ADULT	OA	ALL																																			
			√																																			
5.4	<p><b>Common State Identifier:</b></p> <ul style="list-style-type: none"> <li>Complete assignment of Document Control Numbers (DCNs) to all DSS, DHHS, and DMH consumers who currently don't have one.</li> <li>Continue discussions with the Departments of Corrections and Elementary and Secondary Education to adopt the common identifier or a common methodology to link consumers within their systems to those in the other human service agencies.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>				MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	OOA & State Human Service Departments	A E	9	Medium													<p>The Departments of Social Services (DSS), Health and Senior Services (DHHS), and Mental Health (DMH) have adopted the Document Control Number (DCN) as the common identifier.</p> <ul style="list-style-type: none"> <li>Achieved 95% match of three agencies using common identifier.</li> </ul>	
MI	DD	ADA	ALL																																			
			√																																			
CY&F	ADULT	OA	ALL																																			
			√																																			

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
5.4	<p><b>Data Warehouse:</b></p> <ul style="list-style-type: none"> <li>Identify best solution to developing and housing interagency data warehouse containing data from all state human service agencies to provide more accurate and timely information concerning individuals served across the agencies.</li> <li>Develop the interagency data warehouse.</li> <li>Begin with a children s services data warehouse and then expand across the lifespan.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL	√				OOA & State Human Service Departments	A E	9	High												Multiple discussions held regarding single data warehouse but no solution yet identified. Item to be re-assessed by TWG
MI	DD	ADA	ALL																														
			√																														
CY&F	ADULT	OA	ALL																														
√																																	
5.4	<p><b>Electronic Records:</b></p> <ul style="list-style-type: none"> <li>Based on FY 09 budget item, evaluate, select, and implement a bar coding solution.</li> <li>DMH partnership with MO HealthNet (Medicaid) to coordinate development of an electronic Medical Health Record.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td>√</td> <td></td> <td></td> <td></td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL	√				CY&F	ADULT	OA	ALL				√	DMH Division of CPS	A E	9	High											<p>A bar coding budget item passed in DMH budget in May 08. Evaluations and negotiations are currently underway to select and implement a bar coding solution.</p> <p>Work continues with MO Healthnet to develop an electronic Medical Health Record.</p>	
MI	DD	ADA	ALL																														
√																																	
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008							
6.1 6.2 6.3	<p><b>State-Local Infrastructure Development Plan:</b></p> <ul style="list-style-type: none"> <li>Establish subcommittee to review current state and local cross-departmental initiatives, statutory mandates and department regulations.</li> <li>Establish preliminary criteria for formal partnership agreements with local bodies.</li> <li>Engage local leaders in dialogue to determine state-local infrastructure development. Consider mini-policy academy format or summit.</li> <li>Propose recommendations to full TWG and HSCC for enduring state and local infrastructure to continue transformation efforts beyond grant to include cross-departmental structure for consumer input.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>	MI	DD	ADA	ALL √	CY&F	ADULT	OA	ALL √	TWG	A	N/A	Medium	√											<p>The TWG assigned a subcommittee at July meeting. Background review of current state and local policies and service area structures completed and compiled. First subcommittee meeting will focus on review of this information.</p>
MI	DD	ADA	ALL √																						
CY&F	ADULT	OA	ALL √																						
6.1	<p><b>Older Adult Workgroup:</b></p> <ul style="list-style-type: none"> <li>Complete operational plan and propose the management structure for ongoing monitoring and oversight of the operational plan.</li> <li>Identify key stakeholders to propose the next steps in implementing system of care plan in local communities.</li> <li>Explore the proper use of mental health services and supports for persons with Alzheimer s disease and related dementias, as well as those persons with Alzheimer s type disease and co-occurring mental illnesses.</li> </ul> <p><b>Initial Target Population:</b></p> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA √</td> <td>ALL</td> </tr> </table>	MI	DD	ADA	ALL √	CY&F	ADULT	OA √	ALL	TWG	C	N/A	Medium to High	√										<p>The mental health and aging work group has met three times between June and September 2008. The process to identify projects embodying the principles of a system of care has been initiated and is well underway. A consultant with national expertise in mental health and aging has been contracted and is providing technical assistance to the work group. Initial discussions of the proper use of mental health services and supports for persons with Alzheimer s Disease and related dementias have been undertaken within the contest of the mental health and aging work group.</p>	
MI	DD	ADA	ALL √																						
CY&F	ADULT	OA √	ALL																						

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008															
6.2	<b>Regional Collaboratives:</b> Develop partnerships and incentives to implement regional collaboratives that integrate mental health with overall local community health planning and initiatives. Based on initial successful partnership with SL Regional Health Commission in Eastern region, develop principles and criteria to expand collaboratives that can be adapted to fit local needs in other areas of state and achieve broader transformation goals. Initiate partnership agreements with 2 additional regional areas. Work with local private foundations to support and leverage change efforts.  <b>Initial Target Population:</b> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH OOT TWG	C	9	High												Established criteria for membership and principles for a collaborative. Continued partnership with Eastern Region Health Commission and Missouri Foundation for Health and established initial partnership with Kansas City area collaborative and two local foundations by giving seed grant for needs assessment. Have initiated discussions regarding a potential rural collaborative.
		MI	DD	ADA	ALL																												
					√																												
CY&F	ADULT	OA	ALL																														
			√																														
6.1	<b>Transitional Youth:</b> Develop plan to establish workgroup or committee within current management team/workgroup structure to begin development of system of care to meet needs of transitional youth. Develop youth advisory infrastructure as a first step to guide activities. Recommend structure to TWG.  <b>Initial Target Population:</b> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH OOT & OCCMH		9	Low											A Transitional Youth Advisory Group was initiated to guide decision-making prior to work group starting. Initial meeting and full-day retreat held.	
		MI	DD	ADA	ALL																												
					√																												
CY&F	ADULT	OA	ALL																														
			√																														
6.3	<b>Community of Hope Pilots:</b> Develop criteria and proposal to provide seed funding to local communities to begin process of community assessment and capacity building. Identify state and local partners and linkages with public education actions. Provide recommendations to TWG for implementation.  <b>Initial Target Population:</b> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL</td> </tr> <tr> <td></td> <td></td> <td></td> <td>√</td> </tr> </table>	MI	DD	ADA	ALL				√	CY&F	ADULT	OA	ALL				√	DMH OOT & OCCMH	C	9	Low											Worked with staff from Department of Health and Senior Services with expertise in similar community development projects to identify and develop Community of Hope criteria and projects.	
		MI	DD	ADA	ALL																												
					√																												
CY&F	ADULT	OA	ALL																														
			√																														

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2009 Action Plan Update

Goal/Objectives	2009 Priority Actions				Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	October	November	December	January	February	March	April	May	June	July	August	September	Progress through September 2008									
	MI	DD	ADA	ALL																										
6.1	<b>Emerging Issues:</b> <ul style="list-style-type: none"> <li>Traditionally it is difficult for state entities to respond rapidly to issues that emerge. If an appropriate issue emerges, identify staff for responsibility.</li> <li>Research for outcomes and appropriateness.</li> <li>Develop a potential plan for implementation.</li> <li>Present to TWG.</li> </ul> <b>Initial Target Population:</b> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>				MI	DD	ADA	ALL √	CY&F	ADULT	OA	ALL √	TWG, DMH and others depending on identified issue	A C E	9	Medium													√	Two new action items researched and presented to TWG for inclusion in action plan.
MI	DD	ADA	ALL √																											
CY&F	ADULT	OA	ALL √																											
2.1 2.2 2.3 2.4	<b>Consumer/Family and Youth Leadership Summit</b> Hold Consumer, Family and Youth (CFY) Leadership summit to facilitate CFY leader dialogue, education and information sharing across populations and lifespan that results in: <ol style="list-style-type: none"> <li>Improved understanding of issues related to the different population and age groups and knowledge of existing CYF resources currently available;</li> <li>Identification of mutual goals and sharing strengths across populations and lifespan; and</li> <li>Identification of priorities for common agenda that promotes CFY driven system and next steps that include focus areas/tracks for 2009 Statewide Conference.</li> </ol> <table border="1"> <tr> <td>MI</td> <td>DD</td> <td>ADA</td> <td>ALL √</td> </tr> <tr> <td>CY&amp;F</td> <td>ADULT</td> <td>OA</td> <td>ALL √</td> </tr> </table>				MI	DD	ADA	ALL √	CY&F	ADULT	OA	ALL √	DMH and TWG	A C E	9	Low													√	A planning committee was established comprised of consumer and family members representing three division populations. Planning for summit well underway and is scheduled for November 2008.
MI	DD	ADA	ALL √																											
CY&F	ADULT	OA	ALL √																											

(See appendix for Legend of Abbreviations.)





## Appendix

### Legend of Abbreviations used in Action Plan

**ACE Goals-measures of anticipated long-term impact**

- A-Improved Accountability
- C- Increased Service Capacity
- E-Increased Service Effectiveness

**GPRA Goal-measures of infrastructure changes completed:**

- 1= Policy Changes Completed
- 2= # of Persons in Workforce Trained
- 3= Financing Policy Changes Completed
- 4= Organizational Changes Completed
- 5= # of Organizations that Regularly Obtain and Analyze Data
- 6= # of Members in Consumer and Family Run Networks
- 7= Programs Implementing Practices Consistent with CMHP
- 8= Separate Evaluation Process
- 9= To Be Determined

**Target Populations:**

Persons served across agencies and/or systems that are at risk for or experiencing:

- MI = Mental illness
- ADA = Addictions
- DD = Developmental Disabilities

Note: This also covers the general public and service providers.

Age Group:

- CY&F = Children, Youth and Families
- A = Adults
- OA = Older Adults

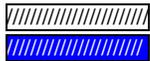
**Complexity of Implementation:**

Low = action will be completed with ease during established timeframes

Medium = major components of action will be realistically achieved over course of plan timeframe/grant period resulting in significant progress to achieving overall objective

High = Action will require multiple years that will likely extend beyond plan timeframe

**Time Frames:**



Start-up Planning

Implementation

< Implementation initiated prior to 2009

> Implementation anticipated to continue beyond 2009

**Acronyms Used:**

AAA - Area Agency on Aging

ADA - Division of Alcohol and Drug Abuse

CPS - Division of Comprehensive Psychiatric Services

CSMT - Comprehensive System Management Team

DESE - Department of Elementary and Secondary Education

DHSS - Department of Health and Senior Services

DMH - Department of Mental Health

DPS - Department of Public Safety

DSS - Department of Social Services

EBP - Evidence Based Practices

MACDDS - Missouri Association of County Developmental Disabilities Services

MARF-Missouri Association of Rehabilitation Facilities

MHFA - Mental Health First Aid

MO-ACEs - Missouri Autism Centers for Excellence

MO-ANCOR - Missouri Chapter of the American Network of Community Options and Resources

MIMH - Missouri Institute of Mental Health

MPC - Missouri Planning Council

DD - Division of Developmental Disabilities

OCCMH - Office of Comprehensive Child Mental Health

OOA - Office of Administration

OOT - Office of Transformation

PACs - Parent Advisory Council

SLRHC - St. Louis Regional Health Commission

TWG - Transformation Working Group

UMKC - University of Missouri - Kansas

UMKC IHD - UMKC Institute for Human Development



Missouri Department of Mental Health  
Office of Transformation  
1706 E. Elm St., P.O. Box 687  
Jefferson City, MO 65102

800-364-9687

[www.dmh.mo.gov/transformation/transformation.htm](http://www.dmh.mo.gov/transformation/transformation.htm)