

Missouri

UNIFORM APPLICATION FY 2007

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 08/26/2004 - Expires 08/31/2007

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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 0930-0080.

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Missouri

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

X **FY2007** **FY 2006-2007** **FY 2005-2007**

STATE NAME: Missouri

DUNS #: 780871430

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Division of Comprehensive Psychiatric Services

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

CITY: Jefferson City

STATE: MO

ZIP: 65102

TELEPHONE: 573-526-5890

FAX: 573-751-7815

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

NAME: Ron Dittmore, 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: 07/01/2006

TO: 06/30/2007

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 2007 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.

The population of Missouri from US Census Bureau (2000) is 5,595,211 individuals. Missouri's population from the 2005 census is estimated at 5,800,310. Missouri continues to be primarily rural with a historically agricultural economic base. 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 an extended overall economic slowdown over several years. A limitation on general revenue growth has caused the DMH to face core budget reductions, withholds and staff layoffs for five consecutive years. The DMH has experienced core net reductions on General Revenue state dollars of \$80.1 million in recent years. The total full-time equivalent positions have been reduced from 10,386 in fiscal year 2002 to 9,122 in fiscal year 2006. This has required the department to focus on protecting current services and programs while attempting to maximize the use of other funding sources.

The DMH, Division of Comprehensive Psychiatric Services (CPS) has met these 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, evidence based practices, 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 2007, 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 Medication Risk Management Project, suicide prevention, and Procovery will accelerate change to a public health model of care that supports recovery. The Block Grant State Plan will provide an overview of the programming, services and initiatives the department and division have developed to serve Missouri's citizens with mental illness and severe emotional disturbances.

Involvement and inclusion of consumers, providers, and advocates in the planning, monitoring, and evaluation of programs continues to be a high priority for the department. Advocates and consumers are involved with a variety of activities 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 has recently been hired and plans are being made to involve consumers in the monitoring process of community agencies.

Throughout the budgetary adversities and challenges, the Missouri Department of Mental Health has continued to pursue its vision – *“Missourian’s shall be free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities, and alcohol and other drug abuse”*. The Division of 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.

The department has developed a Logic Model that demonstrates the Mental Health Transformation vision, core strategic priorities, and results of system change.

Vision: Living Lives Beyond Limitation within Communities of Hope

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DMH Values

- ❖ Prevention
- ❖ Self Determination
- ❖ Access
- ❖ Community Integration
- ❖ Caring, Competent Staff

Federal Influences

- President's New Freedom Commission
- Changes in Block Grant Requirements
- Recovery movement
- Focus on EBP
- Deficit Reduction Act

State Influences

- Mental Health Parity Legislation
- Suicide Prevention Legislation
- Children's Mental Health Reform Act
- MO Medicaid Reform
- Government Review Commission
- Rural Mental Health Access Assessment
- Federal grants: Co-SIG, Supported Employment, Systems of Care, and Strategic Prevention SIG

Mental Health System Transformation

Achieving transformation requires that the system move ...	Core Strategic Priorities and Activities
From a Disability to A Public Health Model	Prevention & Promotion <ul style="list-style-type: none"> •Shared Prevention Position •Strategic Prevention Collaboration <ul style="list-style-type: none"> •Suicide Prevention Plan •Mental Health Disaster Preparedness Plan •Mental Health Literacy & Anti-stigma Campaign •Early Detection
Toward Evidence-based Practice and a Culturally Competent System of Care	Science & Service <ul style="list-style-type: none"> •Research consortium •EBP Steering Committee •Coordinating Centers of Excellence •Workforce Development •Procovery •Trauma Self Assessment
From Fragmentation to Appropriate consultation, Collaboration & Integration	Access & Capacity <ul style="list-style-type: none"> •System Capacity Development •Home & Community-based Services Development •Housing, Employment, & Education •Local Community Infrastructure •Local Mental Health Board Development •Special Populations
Toward Equal Access with Balanced Public-Private Capacity and State-Local Ownership and investment	Consumer-driven System of Care <ul style="list-style-type: none"> •Consumer/family-centered IPC •Procovery •State Planning & Advisory Committees •Consumer/Family Monitoring & Evaluation •Consumer-operated Services
Toward a statewide consumer and family voice that drives decision-making & services at all levels of the system	Technology <ul style="list-style-type: none"> •Data Warehouse •Network of Care •Tele-Services •Technology Transfer Methodologies •Electronic Medical Records

Comprehensive State Plan Quality & Accountability Quality Infrastructure

Results

- Mental Health is recognized as essential to overall health
- Excellent Services Delivered by Competent Staff
- Community Access to Same Quality Service Array Anywhere in the state
- Meaningful choices based on life goals
- Information supports Personal recovery & quality services

Recovery Oriented ↔ Trauma-Informed ↔ Culturally Competent

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2007

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 State¹ will expend the grant only for the purpose of:

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

Section 1912

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

Section 1913:

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

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

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

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

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

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

(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 Stated 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.

Notice: Should the President's FY 2007 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2007 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

~~XXXXXXXX~~
 Ron Dittmore, Ed.D., Department Director

 Date

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

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

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about –
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

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

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

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

3. CERTIFICATION REGARDING LOBBYING

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

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

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any

person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

<p>5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE</p> <p>Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.</p> <p>Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.</p>	<p>By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.</p> <p>The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.</p> <p>The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.</p>	
<p>SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</p>	<p>TITLE</p> <p>Deputy Director of Administration</p>	
<p>APPLICANT ORGANIZATION</p> <p>Missouri Department of Mental Health</p>		<p>DATE SUBMITTED</p>

DISCLOSURE OF LOBBYING ACTIVITIES

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

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ Congressional District, if known: _____	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____	
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10.a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

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Standard Form – LLL -A

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

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

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

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

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

ASSURANCES – NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

Approval Expires: 08/31/2007

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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

Approval Expires: 08/31/2007

Missouri

Public Comments on State Plan

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

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

Public 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 and 2006 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 Citizen read-only username and password were posted on the website during August for review and comment by the general public on the fiscal year 2007 State Plan.

The Mental Health Planning Council for Missouri has instituted a regular review of the Block Grant data at their monthly open meetings. The Planning Council regularly engaged in discussion about evidence-based practices, mental health transformation, and stigma throughout the fiscal year 2006. The Planning Council was emailed copies of the draft State Plan for comment and given access to the web based version with a specific user identification and password. The July and August 2006 meetings provided specific time for discussion of the draft State Plan. All comments have been considered and incorporated where applicable.

While not specific to the State Plan the Department of Mental Health has recently had public hearings throughout the State for the Mental Health Commissions to hear public comment on the services provided. This information was reviewed 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 2005	Estimate/Actual FY 2006
<u>\$14,716,201.00</u>	<u>\$.00</u>	<u>\$20,636,706.00</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 2004	Actual FY 2005	Actual/Estimate FY 2006
<u>\$109,786,978.00</u>	<u>\$111,823,737.00</u>	<u>\$109,628,744.00</u>

MOE Shortfalls

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

(1). Waiver for Extraordinary Economic Conditions

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

(2). Material Compliance

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

TABLE 1.**List of Planning Council Members**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(Optional)
Atwell, MD, Mariann	State Employees	Department of Corrections (Criminal Justice)	2729 Plaza Drive P.O. Box 236 Jefferson City,MO 65102 PH:(573) 526-6523 FAX:	
Basta, Karia	State Employees	Dept. of Mental Health, Housing Director (Housing)	1706 East Elm P.O. Box 687 Jefferson City,MO 65102 PH:(573) 751-8208 FAX:(573) 751-9207	
Brandon, Ruth	Consumers/Survivors/Ex-patients(C/S/X)	NAMI - Columbia	1201 Paquin Street Apt.313 Columbia,MO 65201 PH:(573) 817-3386 FAX:	
Clarke, Linda	Family Members of Children with SED	Federation of Families for Children's Mental Health	8 Akin Court St. Peters,MO 63376 PH:(636) 294-0125 FAX:	
Frazier, Geody	Consumers/Survivors/Ex-patients(C/S/X)		2541 Van Brunt Blvd. Kansas City,MO 64128 PH:(816) 231-5226 FAX:	
Harper, John	State Employees	Dept. of Elementary & Secondary Education, Div. of Voc. Rehab.	3024 DuPont Circle Jefferson City,MO 65101 PH:(573) 526-7040 FAX:	
Jones, Karren	Consumers/Survivors/Ex-patients(C/S/X)	NAMI - Missouri	1210 Linden Drive Apt. 13 Jefferson City,MO 65109 PH:(573) 636-6188 FAX:	
Lay, Donna	Family Members of Children with SED	NAMI - Missouri	7416 State Route W West Plains,MO 65775 PH:(417) 277-5473 FAX:	
Meinershagen, Bobbie	State Employees	North St. Francois County R-1 School District (Education)	1218 Mill Street Leadwood,MO 63653 PH:(573) 431-6700 x6 FAX:	
Minth, Helen	Consumers/Survivors/Ex-patients(C/S/X)	St. Louis Empowerment	3427Gravois St. Louis,MO 63118	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(Optional)
		Center	PH:(314) 865-2112 FAX:	
Munsterman, Janet	Providers	Supported Community Living	2201 N. Elm Suite C Nevada,MO 64772 PH:(417) 448-3463 FAX:	
Ousley, Julie	State Employees	Dept. of Social Services, Div. of Medical Services (Medicaid)	P.O. Box 6500 Jefferson City,MO 65102-6500 PH:(573) 751-9290 FAX:	
Pijut, Susan	Family Members of adults with SMI	NAMI - Missouri	620 Apple Glenn Court Arnold,MO 63010 PH:(636) 461-1928 FAX:	
Qualls, Robert	Consumers/Survivors/Ex-patients(C/S/X)	NAMI - Missouri Southwest Chapter	1701 S. Campbell Ave Springfield,MO 65807 PH:(417) 864-7119 FAX:(417) 864-5011	
Reese, LuAnn	State Employees		5400 Arsenal Dome Building A-121 St. Louis,MO 63139 PH:(314) 877-0139 FAX:(314) 644-8348	
Russell, Vivian	Consumers/Survivors/Ex-patients(C/S/X)		1827 Crader Drive Jefferson City,MO 65109 PH:(573) FAX:	
Stanton, Sarah	Providers	Truman Medical Center	2211 Charlotte Kansas City,MO 64108 PH:(816) 404-5700 FAX:	
Stephens, Erica	Providers	Missouri Protection & Advocacy	925 South Country Club Drive Jefferson City,MO 65109 PH:(573)-893-3333 FAX:	
Taggart, Suzanne	Providers	Pathways Community Behavioral Healthcare	P.O. Box 104146 Jefferson City,MO 65110-4146 PH:(573) 634-2516 FAX:	
Taylor, Betty	Consumers/Survivors/Ex-patients(C/S/X)		494 Munger Lane Apt 19 Hannibal,MO 63401 PH:(573) 321-2199 FAX:	
Wesson, Ethel	Consumers/Survivors/Ex-patients(C/S/X)		5618 Indiana Kansas City,MO 64130 PH:(816) 361-2298 FAX:	

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	21	
Consumers/Survivors/Ex-patients(C/S/X)	8	
Family Members of Children with SED	2	
Family Members of adults with SMI	1	
Vacancies(C/S/X and Family Members)	3	
Others(not state employees or providers)	0	
TOTAL C/S/X, Family Members and Others	11	52.38%
State Employees	6	
Providers	4	
Vacancies	1	
TOTAL State Employees and Providers	10	47.62%

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.

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.

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.

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. The CPS/SAC convenes monthly. The division director routinely reported on the department budget monthly to maintain an informed council and solicit input from council members on the limited dollars available. The letter from the CPS/SAC Chair outlines the review of the plan with recommendations for modifications.

The CPS/SAC serves as an advocate for adults with serious mental illness and children with severe emotional disorders. CPS/SAC advocacy activities include planning Mental Health Awareness Day, participation at 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 the trauma initiative, seclusion and restraint reduction grant, disaster services, suicide prevention, and consumer operated services multi-site research outcomes.

Mental Health Awareness Day 2006: *Transforming the Landscape of Mental Health* at the State Capitol on April 5th was a huge success. Over 600 consumers converged on the State Capitol for educational opportunities. Events included presentations on housing, Procovery, and self-advocacy planned entirely by the council members. Eighteen exhibitors provided information about services and supports throughout the state. Council members staffed the event to assure it ran smoothly.

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 July and August 2006 meetings focused on reviewing 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. A subcommittee of the CPS/SAC was formed and has made recommendations to the Division on issues that need to be worked out in order for consumers to be involved in the contracted community agency certification process. The Council Chair continues to serve on the implementation committee.

The CPS/SAC members are involved in many department workgroups 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.

To ensure Missourians understand that mental health is essential to overall health, a small group of CPS/SAC consumer members, working with other mental health consumers, and DMH staff have worked on an Anti-Stigma Public Education Campaign. The department has contracted with a group to perform a digital random telephone survey of 1000 homes. A series of questions will be asked to gather views regarding mental illness. Specialty questions are included on youth, elderly, medications, and homelessness. Utilizing the results of the survey, the department, SAC members, and consultants will be able to target their message for transformation activities. CPS/SAC has discussed developing 30 second television public service announcements with a “Get the Facts” tag line. Viewers could be directed to access more information on a website.

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), the Statewide Stakeholder’s Task Force on DMH Supported Housing, the Library Grant Workgroup, the Consumer Monitoring Committee, the Missouri Mental Health Employment Project Guiding Coalition, and the Olmstead Stakeholders Group. 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.

To ensure excellent mental health care is delivered and research is accelerated, CPS/SAC has had many discussions on evidenced based practices including Integrated Dual Diagnosis and Supported Employment for adults and Comprehensive System of Care for children. Jean Campbell, a nationally recognized consumer/researcher, has been hired to assist 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.

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.

Additionally, as the department develops a five year comprehensive plan for mental health transformation across the lifespan, the CPS/SAC members will be major participants in the development and implementation of the plan.

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

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

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

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

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.

The vision, mission and values of the Missouri DMH are below:

Vision Lives Beyond Limitations

Missourians shall be free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities, and alcohol and other drug abuse.

Mission

Working side by side with individuals, families, agencies, and diverse communities, the Department of Mental Health establishes philosophy, policies, standards, and quality outcomes for prevention, education, habilitation, rehabilitation, and treatment for Missourians challenged by mental illness, substance abuse/addiction, and developmental disabilities.

Values

Full Community Membership

All people are accepted and included in the educational, employment, housing, and social opportunities and choices of their communities.

Cultural Diversity

All people are valued for and receive services that reflect and respect their race, culture, and ethnicity.

Excellence

All people determine the excellence of their services and supports based on the outcomes they experience.

Access

All people can easily access coordinated and affordable services of their choice in their own communities.

Dignity, Self-worth, and Individual Rights

All people are treated with respect and dignity and their rights are ensured by persons providing them with services and supports.

Valued Workers

All people who provide services and supports are our organizations' most important resources.

Individualized Services and Supports

All people design their own services and supports to enhance their lives and achieve their personal visions.

Prevention and Early Intervention

All people live their lives free of, or are less affected by, mental or physical disabilities as a result of our emphasis on prevention and early intervention.

Competence

All people receive services delivered by staff who are competent in dealing with culture, race, age, lifestyles, gender, sexual orientation, religious practice, and ethnicity.

Missouri

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

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

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

Areas needing Attention

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

- **Financial limitations** continue to cut into the administration of State mental health services. The Missouri DMH needs to prevent or minimize cuts to core funding affecting direct consumer care.
- **Recovery** should be a focus for the Department and Division. Staff and consumers should be provided training to support and enhance recovery-based programs and services.
- **Education efforts** continue through partnership with other Department of Mental Health advisory councils and advocates to continue addressing stigma and negative stereotypes regarding mental illness and to educate new legislators on issues affecting consumers and their quality of life. Anti-Stigma Public Education Campaign efforts continue in the hopes of affecting change across the state. Individuals with mental health issues should be welcomed in their community and be afforded the right to work and live as valued members of the community.

Significant Achievements

DMH has had many significant achievements in 2006:

- **Procovery** – The Procovery movement has taken hold in Missouri. Statewide implementation of trainings and support for consumer facilitated Procovery Circles has taken place. In March 2005, the Missouri Department of Mental Health announced a philosophical change in its psychiatric services delivery system with an enhanced focus on recovery. The Procovery program model of Kathleen Crowley and the Procovery Institute was adopted as the vehicle for doing so, beginning with a first year demonstration project in St. Louis, Southeast Missouri, and Kansas City. Approximately 80 Procovery Circles have been started around the State.
- **Mental Health Transformation** - Missouri applied for the SAMHSA Mental Health Transformation grant and prioritized transformation activities. The DMH has made the decision to implement mental health transformation activities with or without the federal grant. Mental Health Transformation is underway in Missouri to move forward with transformation described in the President's New Freedom Commission Report.
- **Mental Health Awareness Day** - Mental health consumers in Missouri took the lead on Mental Health Awareness Day in 2006: Transformation the Landscape of Mental Health. Partnering with providers and other advocacy agencies across the state they came together to develop presentations for legislators and the general public. Many brought exhibit booths and information to the State Capitol for the day. Constituents invited their legislators to visit their booths and collect information from service providers from across the State.
- **Medication Risk Management (MRM)** - MRM is designed to help the State develop disease management strategies for Medicaid recipients diagnosed with Schizophrenia, who are at highest risk for adverse medical and behavioral outcomes, and whose

combined behavioral and medical care expenditures can be significantly higher than other Medicaid recipients.

- **Organized Health Care Delivery System (OHCDS)** - The Missouri Department of Mental Health began using an OHCDS in 2005. This change in the Department's Medicaid status allowed us to secure additional federal funding to address financial limitations. The OHCDS allows us to continue our Access Crisis Intervention (ACI) Program. The current situation with budget cuts and withholds for the coming fiscal year would have ended ACI.
- **Suicide Prevention** - The Department of Mental Health continues to implement suicide prevention services according to the legislative mandates and grant guidelines. State-wide suicide prevention trainings have taken place. Contracts have been awarded in each region of the state for resource centers to provide prevention services.

Mental Health Transformation in Missouri Initiatives Linked to New Freedom Commission Goals

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

- Developed state-wide Suicide Prevention Plan through enabling state legislation.
- Established partnership with state advocacy organizations to initiate state-wide Anti-Stigma Campaign planning.
- Mental Health Parity legislation successfully passed.

Goal 2: Mental Health Care is Consumer and Family Driven

- Developed Comprehensive Mental Health Plan for Children through enabling state legislation.
- Developing Comprehensive Mental Health Plan across lifespan. The recent Missouri Medicaid Reform and Government Review Commission recommendations specific to mental health will be incorporated into the planning process.
- Initiated Missouri "Procovery" Demonstration to accelerate the development of a recovery focused system of care in partnership with consumers, providers, families and local communities.

Goal 3: Disparities in Mental Health Care are Eliminated

- Rural Mental Health Care Access Assessment recently completed.
- Cultural Competency Plan developed.

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

- Established and implemented a "Custody Diversion Protocol" for children.
- Piloting co-occurring mental health/substance abuse screening for adults.
- Jail diversion programs piloted including Police Crisis Intervention Teams (CIT) in the greater Kansas City and St. Louis areas.
- Trauma Screening for Children training provided to contract agencies across state.

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

- Piloting and evaluating evidence based practices (EBP) including Integrated Dual Diagnosis & Supported Employment for adults and Comprehensive System of Care for children.
- Recently developed partnership with Missouri Institute of Mental Health to accelerate multi-state Consumer Operated Service Programs (COSP) findings into practice.
- Piloted Quality Service Review process for children’s system to systematically evaluate service fidelity and quality. Currently developing process for adults.

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

- Recently contracted for a state-wide “Network of Care” web-based system to facilitate consumer information and access to mental health services.
- Currently developing state cross-departmental data warehouse for children.
- Developed Emergency Medical Service System psychiatric module/screen in partnership with Missouri Hospital Association for real-time tracking of acute psychiatric bed availability.
- Implementing Tele-psychiatry Service Initiative.

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

Missouri Department of Mental Health is committed to following the federal initiative of transforming the mental health system. Based on the President's New Freedom Commission Goals, the department is exploring policies to implement evidence based practices such as Integrated Dual Diagnosis Treatment and Supported Employment.

The current influences on the department are:

Federal Influences

- President's New Freedom Commission
- Changes in Block Grant Requirements
- Recovery Movement
- Focus on Evidence Based Practices
- Deficit Reduction Act

State Influences

- Mental Health Parity Legislation
- Suicide Prevention Legislation
- Children's Mental Health Reform Act
- Missouri Medicaid Reform
- Government Review Commission
- Rural Mental Health Access Assessment
- Federal grants: COSIG, Supported Employment, Systems of Care, and Strategic Prevention SIG

New Developments and Issues

Consumer and Family Driven Services

The DMH is committed to providing services that are consumer and family driven. Several changes have occurred to this end.

- 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, has been hired 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 will help each program to improve the quality of services delivered.
- The department has recently awarded contracts to five agencies for Warm Lines. Warm Lines are peer support services offered by telephone. The listing of Drop-In Centers and Warm Lines are at the end of this section.
- Plans are being made to include consumers in the certification (monitoring) of community agencies. A job description has been written and a budget is being prepared. Discussions have occurred with department staff and the Mental Health Planning Council Chair to implement this inclusion of consumers in the day to day operations.

- Interviews have occurred and a decision will be made soon for the Director of Consumer Affairs position for the department. This position has been vacant since last year and the new staff will infuse renewed energy into the departments consumer driven focus.
- Several years ago a large scale training occurred with consumers to implement a Community Support Assistant program. Eleven of the Community Support Assistants continue to work in the mental health agencies providing services to consumers. The division is currently reviewing the Peer Specialist credentialing organizations with the hopes of implementing a training for additional Peer Specialists in Missouri.

Integrated Dual Diagnosis Treatment

Community Psychiatric Rehabilitation Programs (CPRP), funded through the Medicaid Rehabilitation Option, are being enhanced using the evidence based treatment model of Integrated Dual Diagnosis Treatment (IDDT). CPRP has traditionally followed the case management model in Missouri. The Division of Psychiatric Services is moving to a multi-disciplinary, continuous treatment team approach. Examples of services which may be offered are;

- Substance Abuse Services
- Psychotherapy
- Outreach and Engagement
- Employment Supports

The DMH has completed Phase I of the SAMHSA COSIG grant and is planning for Phase II. This grant allows the department to modify infrastructure to support the delivery of integrated services to persons with co-occurring psychiatric and substance use disorders. A request for proposal is in process to contract with a minimum of two agencies initially to implement IDDT.

Supported Community Living

Previously the DMH Supported Community Living staff acted as the gatekeepers for consumers transitioning from state facilities to community programs. The process of Community Mental Health Centers/Administrative Agents acting as the entry and exit point for individuals referred for admission to and discharge from DMH acute and long term facilities has been completed. This furthers efforts to provide seamless services to consumers entering and exiting the mental health system in Missouri.

Mental and Physical Health Collaboration

The DMH is submitting a New Decision Budget Item for a Community Mental Health Center (CMHC) and Federal Qualified Health Center (FQHC) Collaborative. Physical care is a core component of basic services for persons with serious mental illness. Services should include preventative 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 emergency rooms for care. The strategy for the new budget item is to have seven sites each including a CMHC and a FQHC integrating services through a collaborative process targeting the uninsured population. A Family Practice Nurse would be located a CMHC primary care clinic and a Targeted Case Manager/Community support Worker would be located in the FQHC.

Drop-In Center Services

Ark of Friends

4245 Walnut
Kansas City, MO 64111
Phone: (816) 753-8683
Fax: (816) 753-8683
Contact: Jerry Armstrong or Sybil Noble
Email: arkfriends@kc.rr.com

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: Kevin Kraft or Sherri Redding
Email: kevin.kraft@tmcmcd.org
Website:
[www.trumanmed.org/sections/content.aspx?
SID=28](http://www.trumanmed.org/sections/content.aspx?SID=28)

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 or Mickie
McDowell
Email: eburke@namiswmo.com
Website: www.namiswmo.com

Depressive Manic-Depressive Association of 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

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
Website: www.selfhelpcenter.org

Warm Lines
Peer Phone Support Services

Mental Health Association 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
Website: 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

NAMI of Missouri
Phone: (573) 634-7727
Toll free: 1-800-374-2138
1001 Southwest Blvd, Suite E
Jefferson City, MO 65109
Agency phone: (573) 634-7727
Fax: (573) 761-5636
Email: mocami@aol.com
Website: 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
Website: www.namiswmo.com

Depressive Manic-Depressive Association of 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

Missouri

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

Adult - Legislative Initiatives and Changes

The 2006 legislative session ended May 12, 2006. The final version of the Department of Mental Health budget continues to present challenges to meet the needs of the citizens it serves. Several specific service sites, initially slated for cut backs by the legislature, were either restored to full or partial funding. Mental health advocates from across the state impressed upon their legislators the importance of services provided by both inpatient and community mental health providers.

Transformation/Medicaid Reform

Missouri's Governor and legislature are in the process of Transforming State Government. The Missouri Medicaid Reform Commission derived its charge and legislative authority from 208.014, RSMo. and Senate Concurrent Resolution 15 (2005) which stated that the work of the Commission shall include but not be limited to "clear and concise policy recommendations on reforming, redesigning, and restructuring a new, innovative state Medicaid healthcare delivery system." The Commission report and recommendations were provided to the legislature by January 1, 2006. Missouri has passed legislation that will end the Medicaid program in 2008.

The commission consisted of ten members, five from the House and five from the Senate. Additionally, the directors of the Departments of Social Services, Health and Senior Services, and Mental Health shall served as ex-officio members. The DMH advocated that Medicaid Reform must take place in the context of Transformation and must be coordinated with other funding into a single, unified, accountable and comprehensive public mental health services system.

The Medicaid Reform Commission Report states:

Transformation

The Medicaid Reform Commission finds that the principles of the Mental Health System Transformation initiative in Missouri are consistent with the recommendations of the "New Freedom Commission" for reforming Medicaid mental health coverage. These principles include transforming the public mental health system under the leadership of the Department of Mental Health as the State Mental Health Authority:

From

- A Disability Model to a Public Health Model
- Fragmentation to Consultation, Collaboration, and Integration

Toward

- Balanced public-private system capacity and local-state ownership and investment
- Full implementation of evidence-based practices and a culturally competent and responsive system
- Equal availability and a statewide consumer and family voice that drives decision-making and services
- The advancement of technology to accelerate and sustain transformation

Recommendations

The Medicaid Reform Commission acknowledges that the systems of care for these populations must reflect their unique needs, and therefore the Commission recommends that the state do the following:

1. As the State Mental Health Authority, the Department of Mental Health (DMH) leads the initiative to identify and evaluate the mental health responsibilities and resources scattered across state agencies with the goal of identifying efficiencies and additional federal resources that could be gained through collaboration and/or integration.
2. Continued collaboration between the Department of Social Services (DSS) and DMH in support of Medicaid waivers to assure that an appropriate array of services and supports are available for individuals with (1) developmental disabilities and (2) serious mental illnesses or emotional disorders who are eligible through the PTD category.
3. DMH continues to promote local investment in services and supports by county developmental disabilities mill tax boards.
4. DMH develops provider profiling approaches that give consumers and their families adequate information to make informed decisions in selecting providers.
5. The state departments collaborate to assure that evidenced based practices are readily incorporated in Medicaid behavioral health programs.
6. The state continues to employ care management technologies that promote efficiency and consumer choice without inappropriately restricting availability.
7. Implementation of a pilot coordinated care program by DMH for individuals with serious mental illnesses.
8. Support approaches to strengthening the linkages between federally qualified health centers and community mental health centers.
9. Support a public health approach that emphasizes prevention, early intervention and integration of primary care with basic behavioral health services.
10. Support local investment in mental health services and supports, and to develop mechanisms that reduce fragmentation at the local level and appropriately balance state and local control.
11. Promote the use of new technologies, such as telemedicine and electronic medical records, as appropriate for mental health services.
12. Continue collaboration between the Department of Health and Senior Services DSS, and DMH to assure that the health promotion initiatives of the MC+ plans are coordinated with the state's overall initiative to create a culture of health and that specialty mental health services are readily accessible to MC+ enrollees who require them.
13. Ensure that DMH is responsible for establishing appropriate standards of care.
14. Incentives are developed to promote expansion of employer sponsored benefit plans that include coverage of basic behavioral healthcare.

Other Missouri Government Initiatives

Government Review Commission

In January 2005, Governor Matt Blunt created by Executive Order the Missouri State Government Review Commission. Its twenty members hailed from every region of the state, and possessed a broad range of experience and expertise. Noting that a comprehensive review of state government functions has not occurred in over thirty years, the Governor charged the Commission "...with the task of reviewing every Executive Department within our state

government to identify opportunities to restructure, retool, reduce, consolidate, or eliminate state government functions in accordance with what will result in the best and most cost-effective service for Missouri citizens." November 2005 a report and recommendations were submitted to the Governor.

Suicide Prevention

Legislation passed in 2005 that continues to affect the Department of Mental Health includes:

Missouri Revised Statutes 630.910 creates a Suicide Prevention Advisory Committee based on recommendations of the state suicide prevention plan developed by the DMH and other state and local agencies. The Suicide Prevention Advisory Committee has recently been formed and is moving forward with its charge.

Per legislation, the Suicide Prevention Advisory Committee shall:

- (1) Provide oversight, technical support, and outcome promotion for prevention activities;
- (2) Develop annual goals and objectives for ongoing suicide prevention efforts;
- (3) Make information on prevention and mental health intervention models available to community groups implementing suicide prevention programs;
- (4) Promote the use of outcome methods that will allow comparison and evaluation of the efficacy, effectiveness, cultural competence, and cost- effectiveness of plan-supported interventions, including making specific recording and monitoring instruments available for plan-supported projects;
- (5) Review and recommend changes to existing or proposed statutes, rules, and policies to prevent suicides; and
- (6) Coordinate and issue a biannual report on suicide and suicidal behaviors in the state using information drawn from federal, state, and local sources.

Missouri Revised Statutes 537.037 provides some immunity from civil liability for treatment professionals and others who provide suicide interventions at the scene of a threatened suicide.

“Any mental health professional, as defined in section 632.005, RSMo, or substance abuse counselor, as defined in section 631.005, RSMo, or any practicing medical, osteopathic, or chiropractic physician, or certified nurse practitioner, or physicians' assistant may in good faith render suicide prevention interventions at the scene of a threatened suicide and shall not be liable for any civil damages for acts or omissions other than damages occasioned by gross negligence or by willful or wanton acts or omissions by such person in rendering such suicide prevention interventions.”

“Any other person who has been trained to provide suicide prevention interventions in a standard recognized training program may, without compensation, render suicide prevention interventions to the level for which such person has been trained at the scene of a threatened suicide and shall not be liable for civil damages for acts or omissions other than damages occasioned by gross negligence or by willful or wanton acts or omissions by such person in rendering such suicide prevention interventions.”

Missouri

Adult - Description of Regional Resources

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

Adult – Description of Regional Resources

The DMH Division of CPS operates eleven facilities, providing acute, long term rehabilitation and residential care for youth and adults as well as forensic, sexual predator and corrections services for adults. The number of statewide psychiatric beds is 1,531 as of May 31, 2006.

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.

Eleven (11) counties and the city of St. Louis have passed Mental Health Mil Taxes and have Mil Tax Boards. The Division has recently 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 has expanded its suicide prevention efforts by awarding contracts to seven agencies that will serve as Regional Resource Centers to provide suicide prevention services across the state. The Resource Centers will engage 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.

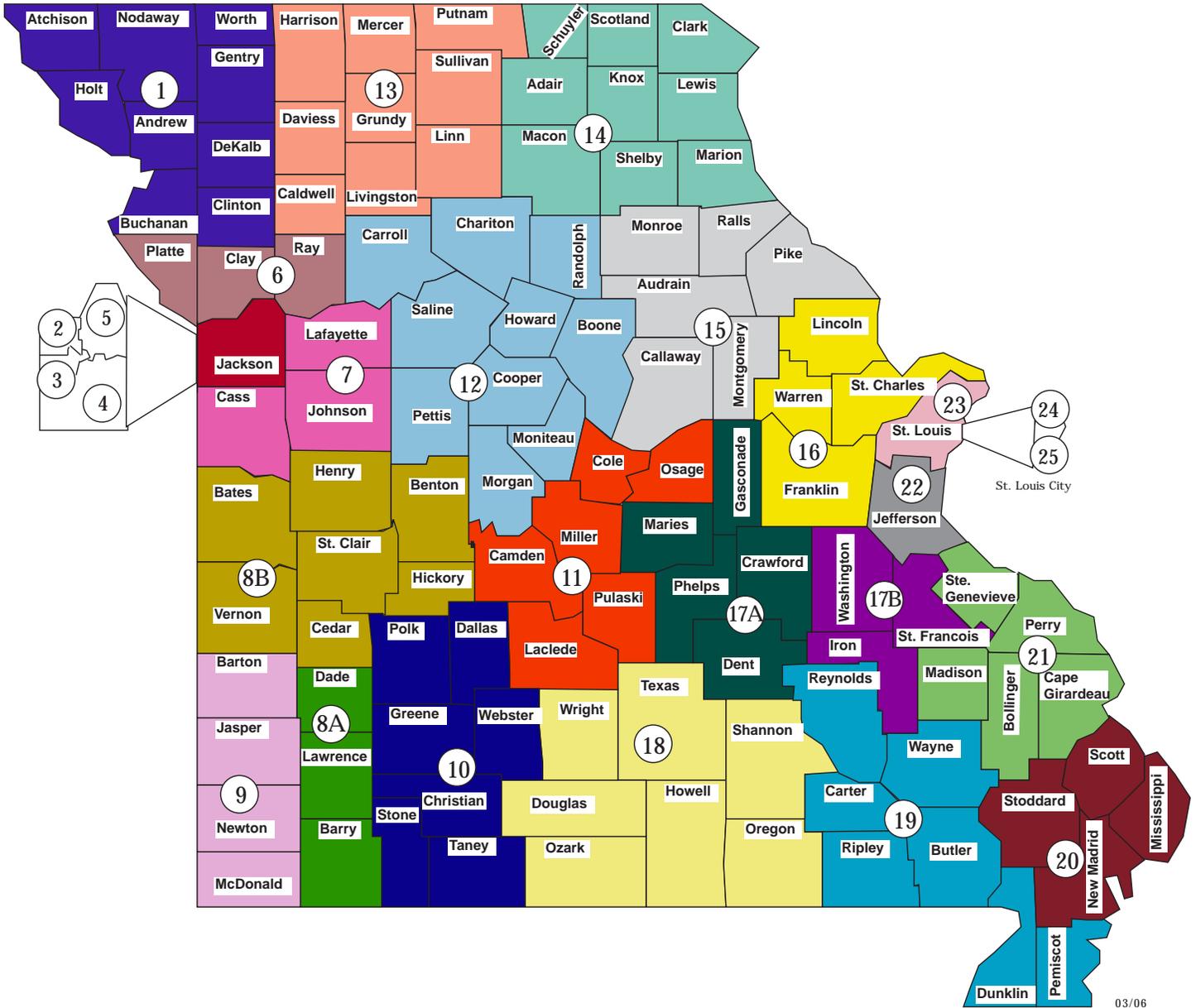
The goals of ACI are:

- 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.

Consumer Operated Drop-In Center contracts have recently been revised and expanded. Five organizations have received contracts to operate Consumer Operated Drop-In Centers according to the evidence based protocol being developed by a national expert consumer/researcher. An additional five contracts have been awarded for peer support phone lines.

Following is a map of Missouri's Service Areas and a listing of all Administrative Agents providing services by area.



Administrative Agents

1

Family Guidance Center

510 Francis Street #200

St. Joseph, MO 64901

816/364-1501

816/364-6735 (FAX #)

Counties Served: Andrew, Atchison, Buchanan, Clinton, Dekalb, Gentry, Holt, Nodaway, Worth

2

Truman Medical Center Behavioral Health

2211 Charlotte

Kansas City, MO 65108

(816)404-5700

(816)404-5731 (FAX #)

County Served: Jackson County

3

Swope Health Services

3801 Blue Parkway

Kansas City, MO 64130

816/922-7645

816/922-7683 (FAX #)

County Served: Jackson County

4

ReDiscover

901 N.E. Independence Ave.

Lee's Summit, MO 64086

816/246-8000

816/246-8207 (FAX #)

County Served: Jackson County

5

Comprehensive Mental Health Services

10901 Winner Road

P.O. Box 520169

Independence, MO 64052

816/254-3652

816/254-9243 (FAX #)

County Served: Jackson County

6

Tri County Mental Health Services

3100 NE 83 rd Street

Kansas City, MO 64119-9998

816/468-0400

816/468-6635 (FAX #)

Counties Served: Clay, Platte, Ray

7

Pathways Community Behavioral Healthcare, Inc.

520C Burkarth Road

Warrensburg, MO 64093

660/747-7127

660/747-1823 (FAX #)

Counties Served: Cass, Johnson, Lafayette

8A

Clark Community Mental Health Center

307 Fourth Street

P.O. Box 285

Monett, MO 65708

417/235-6610

417/235-3629 (FAX #)

Counties Served: Barry, Dade, Lawrence

8B

Pathways Community Behavioral Healthcare, Inc.

1800 Community Drive

Clinton, MO 64735

660/885-8131

660/885-2393 (FAX #)

Counties Served: Bates, Benton, Cedar, Henry, Hickory, St. Clair, Vernon

9

Ozark Center

3006 McClelland

P.O. Box 2526

Joplin, MO 64803

417/781-2410

417/781-4015 (FAX #)

Counties Served: Barton, Jasper, McDonald, Newton

10

Burrell Behavioral Health

1300 Bradford Parkway

Springfield, MO 65804

417/269-5400

417/269-7212 (FAX #)

Counties Served: Christian, Dallas, Greene, Polk, Stone, Taney, Webster

11

Pathways Community Behavioral Healthcare

1905 Stadium Blvd.

P.O. Box 104146

Jefferson City, MO 65110-4146

573/634-3000

573/634-4010 (FAX #)

Counties Served: Camden, Cole, Laclede, Miller, Osage, Pulaski

Affiliated Center (11)

New Horizons Community Support Services

2013 William St.
Jefferson City, MO 65109
573/636-8108
573/635-9892 (FAX #)
County Served: Cole

12

University Behavioral Health Services

601 Business Loop 70 W
Suite 202
Columbia, MO 65201
573/884-1550
573/884-2800 (FAX #)
Counties Served: Boone, Carroll, Chariton, Cooper, Howard, Moniteau, Morgan, Pettis, Randolph, Saline

Affiliated Center (12)

New Horizons Community Support Services

1408 Hathman Place
Columbia, MO 65201-5551
573/443-0405
573/875-2557 (FAX #)
County Served: Boone

13

North Central MO Mental Health Center

1601 East 28th, Box 30
Trenton, MO 64683
660/359-4487
660/359-4129 (FAX #)
Counties Served: Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Putnam, Sullivan

Affiliated Center (#13)

Preferred Family Healthcare, Inc.

900 LaHarpe
Kirksville, MO 63501
660/665-1962
660/665-3989 (FAX#) **Counties Served:** Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Putnam, Sullivan

14

Mark Twain Area Counseling Center

105 Pfeiffer Avenue
Kirksville, MO 63501
660/665-4612
660/665-4635 (FAX #)
Counties Served: Adair, Clark, Knox, Lewis, Macon, Marion, Schuyler, Scotland, Shelby

Affiliated Center (#14)

Preferred Family Healthcare, Inc.

900 LaHarpe
Kirksville, MO 63501
660/665-1962
660/665-3989 (FAX#)

Counties Served: Adair, Clark, Knox, Lewis, Macon, Marion, Schuyler, Scotland, Shelby

15

East Central Missouri Behavior Health Services

321 West Promenade
Mexico, MO 65265
573/582-1234
573/582-1212
573/582-7304 (FAX#)

Counties Served: Audrain, Callaway, Monroe, Montgomery, Pike, Ralls

Affiliated Center (#15)

Comprehensive Health Systems, Inc.

12677 Heavenly Acres Drive
New London, MO 63459
Mailing address - P.O. Box 468
Hannibal, MO 63401
573/248-1372
573/248-1375 (FAX#)

Counties Served: Audrain, Callaway, Monroe, Montgomery, Pike, Ralls

16

Crider Center

1032 Crosswinds Court
Wentzville, MO 63385
636/332-8000
636/332-9950 (FAX #)

Counties Served: Franklin, Lincoln, St. Charles, Warren

17A

Pathways Community Behavioral Healthcare

1441 Forum Drive
P.O. Box 921
Rolla, MO 65401
573/364-7551
573/364-4898 (FAX #)

Counties Served: Crawford, Dent, Gasconade, Maries, Phelps

17B

BJC Behavioral Health Community Services

Southeast Site
1085 Maple Street
Farmington, MO 63640-1955
573/756-5353
573/756-4557 (FAX #)

To Request Services: Call Center (877) 729-4004

Counties Served: Iron, St. Francois, Washington

Affiliated Centers (#17)
Mineral Area CPRC
P.O. Box 510
Farmington, MO 63640
573/756-2899
573/756-4105 (FAX#)
County Served: St. Francois

Southeast Missouri Community Treatment Center

512 East Main Street
P.O. Box 506
Park Hills, Missouri 63601
573/431-0554
573/431-5205 (FAX#)
County Served: St. Francois

18

Ozarks Medical Center

Behavioral Health Center
P.O. Box 1100
West Plains, MO 65775
417/257-6762 or 1-800-492-9439
417/257-5875 (FAX #)
Counties Served: Douglas, Howell, Ozark, Oregon, Shannon, Texas, Wright

19

Family Counseling Center

925 Highway V V
P.O. Box 71
Kennett, MO 63857
573/888-5925
573/888-9365 (FAX #)
Counties Served: Butler, Carter, Dunklin, Pemiscot, Reynolds, Ripley, Wayne

20

Bootheel Counseling Services

760 Plantation Blvd.
P.O. Box 1043
Sikeston, MO 63801
573/471-0800
573/471-0810 (FAX #)
Counties Served: Mississippi, New Madrid, Stoddard, Scott

21

Community Counseling Center

402 S. Silver Springs Road
Cape Girardeau, MO 63701
573/334-1100
573/334-9766 (FAX #)
Counties Served: Bollinger, Cape Girardeau, Madison, Perry, Ste. Genevieve

22

Comtrea Community Treatment

227 Main Street
Festus, MO 63028
636/931-2700
636/931-5304 (FAX #)
County Served: Jefferson County

23

BJC Behavioral Health Community Services

North Site

3165 McKelvey Road, Suite 200
Bridgeton, MO 63044-2550
314/206-3900
314/206-3995 (FAX #)
To Request Services: Call Center (877) 729-4004
County Served: St. Louis County (North)

South Site

343 S. Kirkwood Road, Suite 200
Kirkwood, MO 63122-6915
314/206-3400
314/206-3477 (FAX #)
To Request Services: Call Center (877) 729-4004
County Served: St. Louis County (Central & South)

24

Hopewell Center

1504 S. Grand
St. Louis, MO 63104
314/531-1770
314/531-7361 (FAX #)
County Served: Central & North St. Louis City

25

BJC Behavioral Health Community Services

Central Site

1430 Olive Street, Suite 500
St. Louis, MO 63103-2377
314/206-3700
314/206-3708 (FAX #)
To Request Services: Call Center (877) 729-4004
County Served: Central & South St. Louis City

Affiliated Centers (25)

Places for People, Inc.

4120 Lindell Boulevard
St. Louis, MO 63108
314/535-5600
314/535-6037 (FAX #)
County Served: St. Louis County & St. Louis City

Independence Center

4380 West Pine Boulevard

St. Louis, MO 63108

314/533-4380

314/531-7372 (FAX #)

County Served: St. Louis County & St. Louis City

ADAPT Institute of Missouri

2301 Hampton

St. Louis, MO 63139

314-644-3111

314-781-3295 (FAX #)

County Served: St. Louis City & St. Louis County

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

Mental Health Transformation

To both achieve the promise of “**Lives Beyond Limitations**” 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 and sustain a comprehensive, integrated mental health system that is **consumer and family driven, community based, easily accessible and openly accountable**; where promoting mental health and preventing disabilities of Missourians is common practice in all of our communities, and people are free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities and alcohol and other substance abuse disorders.*

Over the past two years, Missouri has initiated, with bipartisan legislative and chief executive support, several significant initiatives that will serve as building blocks to achieve our transformation vision—including the passage of legislation mandating mental health insurance parity; promoting development of a coordinated statewide approach to suicide prevention; and most significantly, 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 (Reforming Children’s Mental Health, 2004).

Transformation of the state’s mental health system is a high priority for the Governor. He has recently established a Human Services Cabinet Council (the “Council”) 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 will also participate 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 identified the positions to be 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 Chief of Staff has convened two major meetings in preparation for the transformation process, one with Cabinet-level leadership and one inclusive of specific division senior leaders who will be serving on the MHTWG.

The Council will serve as the governing body of the MHTWG and will receive regular reports from the MHTWG, review and approve all recommended plans and policy changes, and assure consistency with and alignment of MHTWG activities with the activities and recommendations of the Government Review Commission and other Governor initiatives. The Council will link 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.

The Governor has identified the principle members of the MHTWG. 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 division of 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 will be 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.

The Missouri Suicide Prevention Plan

In 2004, the legislature passed, and the Governor signed into law, legislation mandating the development of a state suicide plan. The Missouri Suicide Prevention Plan under the direction of a ten-member team has been developed with broad input from public health experts, mental health providers, suicide survivors, and through twelve town hall meetings conducted in communities across Missouri. The plan presents a statewide coordinated approach to suicide prevention across the lifespan. Legislation passed this year ensures ongoing administrative infrastructure to oversee implementation of the plan by mandating a permanent advisory committee.

Other State Agency Leadership Examples

In addition, several collaborative state agency initiatives endorsed by the Governor and senior Cabinet leadership have been advanced, including:

- Expanding access to substance abuse treatment, including non-traditional services and supports and faith-based providers supported by the Access to Recovery Grant
- 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,
- MC + Managed Care,
- Family Investment Trust,
- Interdepartmental Initiative for Children,
- Olmstead Act,
- Mental Health Courts,
- Licensure and Certification, and
- HIPAA compliance issues.

The Division embraces the importance of employment and contribution as critical to recovery of mental health consumers. In addition to ongoing efforts to create work programs and pre-vocational services in inpatient settings, the Department has designated a cross-Divisional work team to address systemic vocational development work in community settings. The team has developed a working plan that establishes priorities and tasks to develop more work opportunities for individuals with mental illness, serious emotional disturbances, and other disabilities. A major initiative with the Division of Vocational Rehabilitation is to promote development of work programs in each administrative agent across the State. Grants have been made available through the Missouri Division of Vocational Rehabilitation to prepare agencies for CARF accreditation in vocational areas and to promote expertise and infrastructure within mental health agencies to support individuals in vocational development, particularly supported employment. Upon completion of the final year in March 2001 of a four-year establishment grant, these efforts have led to the development of 15 specialized supported employment programs. Seven of these are operated by community mental health centers and the rest are administered by Comprehensive Rehabilitation Programs primarily located in rural areas. All programs have made the commitment to provide supported employment services as a vendor for Vocational Rehabilitation upon completion of the grant funding. In addition to systemic development, there has been significant emphasis on improving referral relationships and procedures to assure access by Department of Mental Health consumers. As a result, Vocational Rehabilitation now shows a total of 18,535 DMH consumers receiving their services.

During fiscal year 2004, the Department of Mental Health and the Division of Vocational Rehabilitation Services partnered in sponsoring a workshop on supported employment. The DMH received training and technical assistance through PATH. Through this resource, information on best practices for employment of persons who are homeless and have a mental illness or co-occurring disorder. Training continued in fiscal year 2005 with DMH service providers and VR providers coming together to share information and experience about their goals and working relationships in a two day conference in Columbia, Missouri. DMH provided

VR workers with information about working with SMI individuals and with the agencies that support them. VR provided information about their organization and mission. The DMH and VR partnered again to write a grant application for a Missouri Mental Health Employment Project. The National Institute of Health grant was awarded to Missouri and a Stakeholders group was formed. The Institute for Community Inclusion, Boston, MA is providing 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 informs the Stakeholders group about current best practices and gaps in the system, the experts can now assist the Department of Mental Health in developing new statewide initiatives to address gaps or weaknesses. Missouri will seek additional funding to continue this project to enhance our supported employment programming.

Missouri has both urban and rural Projects for Assistance in Transition from Homelessness (PATH) providers giving the State a variety of challenges. In 2006 PATH technical assistance was sought to assist PATH providers to work collaboratively with DMH housing staff and each other. Ann Denton and Laura Ware will assist Missouri with this effort. Missouri PATH programs meet quarterly to share information and expertise and will participate in ongoing training developed to address their needs. PATH programs are monitored annually by the State's PATH Coordinator.

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

The PIC supports the five year transition plan developed and being implemented by the Division of MR/DD. Initiatives to educate residents and family members about community options and to increase community provider capacity are essential to a successful transition plan. Members of the PIC appreciate Governor Blunt recognizing the importance of transitioning individuals from habilitation centers to the community where they can live as integrated members of their communities. We also support his decision to allow more time to transition individuals out of the Bellefontaine Habilitation Center so that appropriate community supports can be made available.

For the past four years, the Real Choice Systems Change grant supported the PIC by covering the expenses of the Commission meetings. That funding ended in September 2005. The Executive Order calls for the four state agencies participating on the PIC to cover the expenses of the Commission. In a time of tight budgets, it could be a challenge to secure the financial support we need from the state agencies. 2006 will also be an opportunity to strengthen the Commission with the re-appointment and appointment of members who are dedicated to the work of the Commission.

The Department of Mental Health has participated actively in Missouri's planning and implementation efforts related to the Olmstead decision. Department staff and consumers have been actively involved and at the table in the development of Missouri's Olmstead plan. A report from the National Conference of State Legislatures listed the State of Missouri as one of the four leading states that stand out as having comprehensive and effectively working Olmstead Plans. Internal efforts are underway to implement sections of the plan that relate specifically to Department compliance. In 2005 Missouri's Olmstead grant funded a one-day workshop on dual diagnosis (MI/MR) for CPS and MRDD staff. In October, seventy DMH staff attended the Annual conference of the National Association for the Dually Diagnosed in St. Louis. The Department has been awarded financial assistance from CMHS that will be used to support staff participation in cross-disability coalitions related to Olmstead, particularly as they relate to housing development, a critical barrier to community transition for many consumers. This will integrate well with the Department's housing team that has been working actively to promote housing development through development of HUD funding proposals, participation in efforts to shape the State's comprehensive housing plan, and providing technical assistance to local providers in their development efforts.

Finally, in 2006 the DMH received Technical Assistance through Olmstead from Advocates for Human Potential. Amy Long came to the State on two occasions to train on Consumer Choice and "Hearing Voices that are Distressing". Workers from DMH State Hospitals, Administrative Agents and from the Missouri Assisted Living Association attended these workshops as did consumers and family members. The training evaluations were all very positive.

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 - Summary of Areas Previously Identified by State as Needing Attention

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

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

Areas Needing Attention

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

- **Financial limitations** continue to cut into the Administration of State mental health services. The Missouri DMH needs to prevent or minimize cuts to core funding affecting direct consumer care.
- **Continued expansion** of services for children and youth in need of treatment of co-occurring disorders. The importance of educating elementary and secondary schools about the needs of mentally ill children need to be addressed as part of the interagency initiative.
- **Transitioning youth into the adult system of care** continues to need attention. The Missouri DMH needs to address the concerns of the young adult as they age out of the youth system and provide continued support and treatment for youth and their families to the adult system of care.
- **Suicide prevention** activities should continue. The Department of Mental Health is committed to reducing the 700 suicides committed each year in Missouri.

Significant Achievements

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

- **The Office of Comprehensive Child Mental Health** was established within the Department of Mental Health. This office will assure the implementation of the Comprehensive Children's Mental Health Service System and will be advised by the **Comprehensive System Management Team (CSMT)** that provides 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.
- **The Custody Diversion Protocol** was developed through the shared efforts of DMH, Department of Social Services, courts and family members and implemented statewide in January, 2005 following extensive training of Children's Division staff, DMH provider staff and juvenile justice officers. In February of 2005, the Children's Division was able to implement a Voluntary Placement Agreement through an amendment to the state's IV-E plan. This allowed the Children's Division 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.
- To guarantee broad input from Missouri's diverse stakeholders, especially families of children with mental health needs, a **Stakeholders Advisory Group (SAG)** was formed and has held regular meetings.
- A School Based Services Committee has been convened with the Division of Medical Services acting as chair to look at **financing educational activities**. The membership of

the committee is composed of staff from various state agencies, community leaders and school districts throughout the state.

- Piloted **Quality Service Review** process for children's system to systematically evaluate service fidelity and quality.
- DMH is working with its providers to implement a functional assessment instrument that would be consistent across all three Divisions. The **Child and Adolescent Functional Assessment Scale (CAFAS)** is being pursued as this instrument.
- Department of Elementary and Secondary Education (DESE) have identified **Positive Behavior Support (PBS)** as an evidence-based approach to support children succeeding in school. PBS teams have been created in several local school districts through a State Improvement Grant. The CSMT is working with DESE to incorporate the PBS approach into system of care for children and youth with mental health needs. Over one hundred individuals from twelve organizations in the Western Region participated in dual diagnosis training on functional assessments and Positive Behavioral Support Planning. With continued training to conclude in September, five to seven member specialized teams will be trained to use the model in eight Administrative Agents, two MRDD Regional Centers, Western Missouri Mental Health Center and a local children's residential agency.
- Trauma Screening for Children training provided to contract agencies across state. Training on Trauma Focused Cognitive Behavioral Therapy to eight Administrative Agents in Western Region concluding in 19 credentialed therapists.

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

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

In December of 2004 the Department of Mental Health submitted a plan to the General Assembly as called for by SB 1003. SB1003 created the Comprehensive State Management Team and the Stakeholder's Advisory Group. The Comprehensive Children's Mental Health Services System Plan provides a description of how Missouri's publicly funded child serving agencies, working in partnership with families, advocates and providers will improve the delivery of mental health services and supports. This plan describes a public mental health model of service provision and constituted the formation of the Office of Comprehensive Child Mental Health. SB 501 passed in 2005 describes the formation and function of this office and a Clinical Advisory Committee. The major goal/vision of the Plan is *"Every child who needs mental health services and supports from the public mental health system will receive them through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. Missouri's public mental health services system for children shall be easily accessible, culturally competent, and flexible to individual needs, accountable to those it serves and shall result in positive outcomes for children and families."*

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, 160 youth have been referred through the Diversion Protocol and 150 children or ninety-four percent have been diverted from state custody. Of those children diverted from custody 51% received intensive services in their home and community while 49% required a placement outside of their home. In any given month approximately 30-35 children were supported in their out of home placement through the VPA. The continued implementation of the Custody Diversion Protocol will be monitored by the DMH, CD and the Stakeholders' Advisory Group for the Comprehensive Children's Mental Health Service System.

Missouri

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

Child - Legislative Initiatives and Changes

The 2006 legislative session ended May 12, 2006. The final version of the Department of Mental Health budget continues to present challenges to the agency to meet the needs of the citizens it serves. Several specific service sites, initially slated for cut backs by the legislature, were either restored to full or partial funding. Mental health advocates from across the state impressed upon their legislators the importance of services provided by both inpatient and community mental health providers.

Legislation passed in 2005 that affects the Department of Mental Health children's services includes:

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

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

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

Missouri

Child - Description of Regional Resources

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

Child - Description of Regional Resources

In addition to the Adult Description of Regional Resources section, the children's system has several additional resources.

The Department of Mental Health has ten System of Care sites operating in Missouri. In a System of Care (SOC), mental health services (psychiatric, mental retardation/developmental disabilities, alcohol and drug abuse) as well as other services and supports are organized in such a way as to enable children with the most complex needs to remain in their homes, schools and communities. System of Care brings the right people together-at multiple levels-to develop resources and remove barriers for children with complex needs that might otherwise fall through the cracks.

Children with the most challenging mental health issues, particularly those who are involved with multiple agencies have a local coordinated team of individuals that work to meet with the family's needs for as long as is necessary. This team is referred to as the Family Support Team. Many such teams (though perhaps under different names) already exist for children with complex needs. In addition to the Family Support Team, a System of Care brings a Local System of Care Policy Group into plan. The Local SOC Policy Group's functions include reviewing and identifying policy (local and state) that may be creating a barrier to children getting their needs met. It is also responsible for contributing appropriate resources from its member agencies (for example, dollars or in-kind services), to assist in meeting the needs of a child being served in System of Care.

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

In addition to the Mental Health Transformation State Agency Leadership activities identified in the Adult section of the Block Grant, there are several other leadership activities to highlight. The state agencies designated by the Governor to serve on the Workgroup have demonstrated capability and experience working together on inter-departmental planning and program implementation around mental health issues. Several initiatives particularly demonstrate the capability and experience of the participating organizations.

Reforming Children's Mental Health Services

The 2004 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.

Responsibility for oversight for the development of the comprehensive children's mental health services plan and its implementation lies with the Comprehensive State Management Team, which is comprised of representatives of DSS, DHSS, DESE, DMH, families, representatives of state family organizations, and advocates. Each of the departments have contributed senior managers from various divisions to focus on developing and implementing culturally appropriate and competent approaches to promoting mental health, preventing disability and meeting the mental health needs of severely emotionally disabled children and their families.

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

Strategic Prevention Framework State Incentive Grant

In 2003, Missouri was awarded a State Incentive Planning Grant and, in 2004, a Strategic Prevention Framework State Incentive Grant (SPF SIG). The Governor's Prevention Initiative Advisory Committee, established under the Planning SIG, continued under the SPF SIG to provide leadership for the development of a statewide, data-driven system to reduce alcohol and drug abuse across the life span, enhance recovery supports, foster preventive interventions to reduce co-occurring disorders, and prevent alcohol use by children. The Governor appointed the Advisory Committee comprised of senior state agency leadership, community leaders and stakeholders. State agency representatives, inclusive of agencies that will be represented on the MHTWG, have collaborated on the implementation of an inventory of state prevention resources and conducted an initial statewide prevention needs assessment. The resources inventory identified prevention-related funding and programs, including those specific to racial/ethnic groups and geographic regions. The needs assessment also addressed identification of prevention

needs of sub-populations including racial/ethnic minorities and rural and urban residents.

Other Collaborative Initiatives

In addition, several collaborative state agency initiatives endorsed by the Governor and senior Cabinet leadership have been advanced, including:

- Three federally funded local Children's System of Care initiatives
- Cross-departmental initiative to promote the use of best practices in the prescribing of psychiatric medications for Medicaid recipients.

Through experiences gathered by working on statewide initiatives, the state agencies appointed to the Transformation Workgroup have developed the capability to collaborate on the planning and implementation of mental health and other behavioral health projects, including the identification of funding and programming resources. The initiatives cited demonstrate government-wide commitments to creating an effective and culturally competent behavioral health services system; maximizing effective and efficient use of resources; and establishing enduring collaborative and cooperative partnerships to promote mental health, prevent the onset and progression of substance use and other behavioral and psychiatric disorders, and enhance recovery supports.

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

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

Suicide Prevention

Suicide prevention across the lifespan continues to be a priority for the state. The DMH, and partners in the efforts to reduce suicide, developed a state-wide Suicide Prevention Plan through enabling state legislation. The department was awarded a Youth Suicide Prevention and Early Intervention grant from SAMHSA. Working cooperatively with the Missouri Institute of Mental Health, state agencies are moving forward on suicide prevention. The DMH continues to implement suicide prevention services according to the legislative mandates and grant guidelines using braided funding from multiple sources such as the SAMHSA grant and Block Grant dollars. State-wide suicide prevention trainings have taken place and were well attended. Contracts have been awarded in each region of the state for resource centers to provide prevention services. Mini-grants for special projects have been awarded and an 800 number for suicide prevention has been implemented. The Suicide Prevention Advisory Committee established in legislation has been appointed.

Prevention

The DMH has elevated the Office of Prevention to the Director’s Office as part of a Prevention Initiative. The department level staff will work cooperatively with each of the three division staff to coordinate prevention activities. The Division of CPS has hired a Prevention Manager to emphasis mental health prevention activities. The mission of prevention activities is to enhance the health and well being of Missouri’s children and youth, adults, and families through comprehensive approaches to reduce the incidence and prevalence of mental retardation and developmental disabilities; alcohol and drug abuse; and mental illness and serious emotional disturbances. The Department of Mental Health works to accomplish this mission by:

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

A risk and protective factor framework is employed to identify disorders and disabilities and preventive interventions. The initial activities under the Office of Prevention have included development and submittal of a youth violence prevention grant application and development of a proposed concept for preventive interventions with the children of

substance abusing mothers. Suicide prevention activities are associated with both the Division of Comprehensive Psychiatric Services and the Office of Prevention. Prevention programming addressing developmental disabilities and public education addressing stigma are anticipated in the coming year.

Anti-Stigma Public Education Campaign

The DMH has established a partnership with state advocacy organizations to initiate a state-wide Anti-Stigma Public Education Campaign. To ensure Missourians understand that mental health is essential to overall health, a small group of CPS/SAC consumer members, working with other mental health consumers, and DMH staff have worked on an Anti-Stigma Public Education Campaign. The department has contracted with a group to perform a digital random telephone survey of 1000 homes. A series of questions was asked to gather views regarding mental illness. Specialty questions were included on youth, elderly, medications, and homelessness. Utilizing the results of the survey, the department, SAC members, and consultants will be able to target their message for transformation activities. CPS/SAC has discussed developing 30 second television public service announcements with a “Get the Facts” tag line. Viewers could be directed to access more information on a website.

Goal 2: Mental Health Care is Consumer and Family Driven

Procovery

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

The *First Year Missouri Report Procovery Circles* identified these accomplishments:

- Referral Listing of 80 active Procovery Circles all nearing structural fidelity
- 1368 Procovery Circle meetings (for which data was submitted by facilitators— estimate this is 60% of meetings actually held)
- Average attendance 8.6 persons per Circle meeting
- Regions: St Louis, Farmington, Poplar Bluff, Kennett, Cape Girardeau, Sikeston, Kansas City, Springfield, Fulton, Rolla

- Settings: In-patient acute, inpatient forensic, outpatient, RCF, clubhouse, community, faith, NAMI, co-occurring substance abuse, HIV, women's, men's, transitional youth, homeless, run by and for client, family, and staff

Goal 3: Disparities in Mental Health Care are Eliminated

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. It contains an assessment of mental health resources in Missouri. The assessment will also assist the department in targeting resources if new money becomes available.

Cultural Competency Plan

The DMH has developed a Cultural Competency Plan and a Comprehensive Treatment Model for Deaf and Hard of Hearing to assure disparities in mental health care are eliminated.

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

COSIG

The Co-Occurring State Incentive Grant (COSIG) has been the change agent for implementing co-occurring psychiatric and substance abuse treatment in Missouri. The COSIG project has:

- Implemented standardized screening and assessment tools at 14 pilot provider sites
- Completed a feasibility study of the tools
- Provided intensive cross training throughout Years 1 and 2
- Increased level of awareness regarding Co-Occurring Disorders (COD) and need for more appropriate treatment services across the state
- Increased communication between mental health and substance abuse staff and agencies
- Identified rules and regulations that hindered services for clients with COD, led to clarification and several rule changes
- Some agencies have increased capability to appropriately treat clients with COD (e.g., Substance Abuse (SA) sites contracted for medication services and hired Mental Health (MH) staff; MH sites contracted with SA staff and provided SA treatment groups)

Crisis Intervention Teams

Jail diversion programs have been 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.

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.

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

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) and Supported Employment for adults are the focus for enhancement and fidelity to the evidence based models. Aspects of IDDT have been implemented as part of the COSIG. Exploration is underway to expand the services offered with new budget item proposals and system changes. The DMH has worked cooperatively with the Missouri Foundation for Health, a private funding source, to provide additional dollars for IDDT services. The foundation will be awarding 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. Existing Supported Employment services have been surveyed and proposals are moving forward to enhance consumer choice to be employed in the competitive workforce.

Consumer Operated Services

The DMH has recently developed a partnership with Missouri Institute of Mental Health to accelerate multi-state Consumer Operated Service Programs (COSP) findings into practice. The self assessment and technical assistance process has begun of the five recently awarded Consumer Drop-In Centers and five Warm-lines around the state. A nationally recognized consumer/researcher has been contracted with to implement the changes.

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

Network of Care Website

The DMH recently contracted for a state-wide “Network of Care” web-based system to facilitate consumer information and access to mental health services. The Missouri Governor Matt Blunt launched the Network of Care website in June at the State Capitol and it is in operation.

Emergency Medical Service System

The DMH developed an Emergency Medical Service System psychiatric module/screen in partnership with Missouri Hospital Association for real-time tracking of acute psychiatric bed availability.

Tele-Psychiatry Service Initiative

The DMH is implementing a Tele-psychiatry Service Initiative to reach consumers in the rural areas where access to psychiatrists has previously been limited. Working with Clark Community Mental Health Center and the University of Missouri, psychiatric services are becoming more accessible in rural areas of southern Missouri.

Medicaid Pharmacy Partnership

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

Medical Risk Management (MRM)

The DMH and the Division of Medical Services (DMS) are implementing a new program called Medical Risk Management (MRM) for Medicaid Recipients diagnosed with Schizophrenia with co-occurring medical disorders. Schizophrenia, a severe mental illness, affects 1% of the population and is also associated with high rates of medical illness and early death. Persons diagnosed with schizophrenia are twice as likely to have major medical illnesses such as diabetes, hypertension heart disease asthma, digestive, and lung disorders. MRM is patient focused and is designed to keep physicians and case managers informed of medical and psychiatric issues arising in each patient's care. MRM utilizes predictive risk modeling for pinpointing which patients with Schizophrenia are trending toward high-risk/high cost disease states, allowing existing provider systems to proactively focus appropriate clinical interventions. The program utilizes administrative claims data (both medical and behavioral services and pharmacy) to identify targeted patients most in need of intervention.

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.

Evidence based practices are being utilized around the state. For example, two contracted agencies in the Eastern region of the state are implementing the Assertive Community Treatment teams. However, evidence based practices are scattered and level of fidelity can be difficult to monitor. The department has formed an Evidence Based Practice Committee to address the issue.

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

Capacity

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

The Capacity Development committee undertook its work by scanning the other states for methodologies to identify capacity needs for mental health service needs. For children's services, Friedman and Pires¹ have established and promoted models for sizing components of care and the committee utilized their models to project capacity targets for Missouri's children. However, there is no generally accepted standard or model for sizing adult services. Although some states have used computer simulation technology, the cost of such an effort was prohibitive and the committee pursued an expert consensus panel of Missouri providers, consumers and policy-makers to project capacity using a process similar to that devised by Friedman. A review of literature and comparison to other states' experiences regarding need for services was conducted and Ciarlo census-based epidemiological figures were used to project need in the adult system. These projections are being compared to existing capacity to identify gaps in service delivery.

Co-Occurring Psychiatric and Substance Use Disorders Treatment

Minkoff² stated that co-occurring disorders (mental illness and substance use disorders; COD) are so common they "should be expected rather than considered the exception". Epidemiological data suggests that more than 50% of individuals with a mental illness have a co-occurring substance use disorder, and vice versa.³ Research further suggests that individuals with COD

¹ Stroul, BA, Pires, SA, Roebuck, L, Friedman, RM, Barrett, B, Chambers, KL, Kershaw, MA, *Journal of Mental Health Administration*, 1997 Fall;24(4):386-99. State health care reforms: how they affect children and adolescents with emotional disorders and their families. National Technical Assistance Center for Children's Mental Health, Georgetown University, McLean, VA 22101, USA.

² Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services*, 52, 597-599.

³ Kessler, R. C., Crum, R. M., Warner, L. A., Nelson, C. B., Schulenberg, J., & Anthony, J. C. (1997). Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. *Archives of General Psychiatry*, 54, 313-321.

have poorer outcomes in treatment, and are at greater risk for relapse, suicide, homelessness, incarceration, discharge from treatment against medical advice, and infectious diseases including HIV/AIDS.⁴ Studies suggest treatment for COD is often fragmented and ineffective.⁵ However, research and theory suggests that integrated treatment, that combines effective components of mental health and substance abuse treatment in an integrated service system, can be more effective and efficient than fragmented systems.⁶ Several national reports, including the Surgeon General's Report on Mental Health, CSAT, and the American Society of Addiction Medicine also list integrated assessment and treatment as a best or evidence-based practice.

Most publicly-funded substance abuse and mental health services in Missouri are provided by the Department of Mental Health through its divisions of Comprehensive Psychiatric Services (CPS) and Alcohol and Drug Abuse (ADA) which share integrated fiscal and program certification sections. The certification unit uses core rules, adopted in 2001, which apply to both ADA and CPS programs. The DMH conducts an annual Spring Training Institute and in-service workshops for ADA/CPS staffs. CPS is responsible for mental health services. It operates two children's hospitals, five long-term hospitals (four of which have forensic units), and four acute-care hospitals, and it 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.

In a 2002 Practice Survey of Missouri treatment providers, although 60% (97) of sites stated that they provided co-occurring services, less than 10 integrated treatment programs approximating best practices are known to exist. Less than 70% of ADA and CPS sites have treatment planning protocols for COD, and less than 80% have treatment collaboration protocols. Most sites noted transportation and difficulties with medication as barriers to services. Consumers have stated that they often do not receive help negotiating between the two types of services, and often encounter a lack of understanding from staff regarding their special needs.

Supported Employment

⁴ Rosenberg, S. D., Goodman, L. A., Osher, F. C., Swartz, M. S., Essock, S. M., Butterfield, M. I., Constantine, N. T., Wolford, G. L., & Salyers, M. P. (2001). Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. *American Journal of Public Health, 91*, 31-37.

⁵ Watkins, K. E., Burnam, A., Kung, F-Y., & Paddock, S. (2001). A national survey of care for persons with co-occurring mental and substance use disorders. *Psychiatric Services, 52*, 1062-1068.

⁶ Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52*, 469-476.

A review of the DMH data collected on a sample of Community Psychiatric Rehabilitation Program consumers suggests that only 8.4% are engaged in competitive employment. This differs from the Substance Abuse and Mental Health Services Agency (SAMHSA) 16 State Study indicating that only 13% of Missourians with psychiatric disabilities in the Medicaid Rehabilitation Option were employed. Discrepancy is attributed to inadequate resources for extensive data collection as well as inconsistencies in the definition of employment. In fiscal year 2005, the Department of Elementary and Secondary Education, Division of Vocational Rehabilitation reported that 56% of the clients it served also were served by the DMH (Total = 15,776 clients).

Research and best practice indicate that employment is an integral part of the recovery process for many consumers. The DMH is committed to improving those numbers by implementing Supported Employment evidence based practices. The Supported Employment grant from the National Institute of Health has allowed for a survey of the system and identified gaps in services. A telephone survey and a fidelity survey were conducted to assess current practices. A list of gaps in the current system was identified, including such issues as:

- 1) DMH needs to place greater emphasis on employment
- 2) Better integration of employment and mental health services
- 3) A need for better information for job seekers about how work will affect benefits
- 4) Rural communities need better infrastructure
- 5) More funding for job development and job placement.

The supported employment fidelity scale survey found one agency that was approaching full implementation of the supported employment model. Other agencies surveyed had varying degrees of meeting the fidelity scale.

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

Capacity

As budget constraints still exist, the DMH has prioritized capacity expansion. 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 we do 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 would be the development of Transitional Community Programs (TCP's) to fill the gap between state hospital settings and existing community services. Such programs would need to provide higher levels of oversight and supervision than is typically provided currently in community settings and also would meet the special clinical needs of such consumers. These programs could afford opportunities to consumers who do not pose a risk to public safety, but who would not meet the criteria for release to existing community services. These consumers might 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 will develop and implement a Transitional Community Program. While the Department envisions a statewide system, the approach will be piloted in two sites. The plan is that each site can have 15 residential beds. 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 has been issued.

Co-Occurring Psychiatric and Substance Use Disorders Treatment

As the Co-Occurring State Infrastructure Grant (COSIG) moves into Phase II the focus will change to implementing the evidence based practice of Integrated Dual Diagnosis Treatment (IDDT) one of the SAMHSA approved evidence based practices. The DMH wants to better serve existing consumers by offering a full array of services to meet their psychiatric and substance abuse needs.

The COSIG Phase II goals are:

- Sustainable Changes in Infrastructure
 - Program Certification Standards for Co-Occurring programs in CPS and ADA
 - Counselor Credentialing
 - Medicaid Reimbursement for co-occurring services
 - Community Stakeholder Steering Committee
- Establish structure to support change
- Issue a Request For Proposal for a group of agencies interested in developing state-of-the-art programming
- Implement Statewide Standardized Screening and Assessment
- Support the Missouri Foundation for Health Co-Occurring Initiative

Efforts are already underway on all the points listed above. The DMH has worked collaboratively with the Missouri Foundation for Health to reduce traditional barriers between the mental health and substance abuse systems that have too often prevented service providers from working together on behalf of individuals diagnosed with mental health and substance abuse disorders. The Foundation has made a priority area for funding co-occurring disorders services with the DMH Administrative Agent organizations. The competitive grants will focus on bringing stakeholders together to create a system in which both disorders are addressed and the long-standing systemic barriers to appropriate treatment and support services for people with co-occurring disorders are removed. A selective group of Administrative Agents will have additional money to advance progress they have already made in integrating treatment. Grant awards should be announced in September.

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 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. Under consideration are:

- Staff Education: Educate/inform CPRP staff on existing billable Community Support Worker (CSW) services for Supported Employment long term support activities for consumer employment.

- Benefits counseling: CPRP will systematically provide individualized information to all consumers on entitlements and the impact of employment on benefits eligibility by linking consumer to appropriate trained benefits planner. All consumers receive individualized information regarding the impact of employment on their benefits.
 - DMH will provide information to CSWs on contact persons for Benefits Planning
 - Develop agency expertise in benefits planning through collaborative training from RCEP VII.
- Peer support: Job support groups are offered where consumers can talk about their jobs with other consumers. Procovery Circles specific to supporting employment activities are encouraged.
- Information to consumers on employment: CPRP must have a system in place whereby all consumers are methodically exposed to information on employment in multiple ways (i.e. informational meetings, formal presentations, etc.). Specific examples of clinical interventions such as Supported Employment, Club House, vocational training, etc. will be addressed in this curriculum.
- Memorandum of Understanding: CPS and VR will review existing MOU and develop update consistent with EBP's and minimum standards/expectations. Require DMH Administrative Agents and Affiliates to develop MOU's with their local VR district office, Employment Services Provider, utilizing the CPS/VR MOU as the minimum template with locale specific customization such as treatment team meetings, progress staffing, office hours, joint in-service training, to be detailed.
- RCF income restrictions: Income for individuals residing in RCF is restricted based on rule, creating a significant disincentive. Explore income issues/rules related to individuals being served in CPRP's who reside in RCF's and impact employment outcome.

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

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

Leadership Institute for Missouri COSIG Project

Working collaboratively within the COSIG project the Mid-America Technology Transfer Center and DMH has conducted the Leadership Institute for Missouri. Because there have been few educational opportunities to groom successors for leadership positions, the Leadership Institute professional development opportunity has been made available to addiction and mental health professionals in Missouri. The need for leadership development has been recognized by national experts and leaders in behavioral health services.

Middle and upper level management staff were recruited for the Leadership Institute. Twenty mentors and 20 protégées were selected. The goal is to develop emerging leaders to accomplish the following objectives:

1. Develop individual leadership skills
2. Receive individualized attention for leadership development
3. Meet other developing leaders across state
4. Learn more about personal leadership style
5. Gain practical experience that can be taken into real world COD settings

There is a four phase training design consisting of:

- Phase 1: Assessment
- Phase 2: Immersion Training
- Phase 3: Experiential Learning
- Phase 4: Commencement and Recognition Luncheon

The Leadership Institute will allow new leadership to emerge as current leadership retires. A well trained and highly skilled workforce provides better services to consumers.

Missouri Mental Health Medicaid Pharmacy Partnership

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

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

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

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

Supported Employment

The Missouri Department of Mental Health received funding from the National Institute of Mental Health in October 2005 to explore implementation issues in the delivery of evidenced based supported employment services for people with psychiatric disabilities. The project, entitled the Missouri Mental Health Employment Project (MMHEP), is a collaborative effort that includes the DMH, the state vocational rehabilitation agency, supported employment vendors, and community stakeholders. During the one year of funding, the MMHEP has completed the following activities:

- Created an active Guiding Coalition of stakeholders including state agency personnel, supported employment vendors, consumers and advocacy groups;
- Assessed implementation issues in the state of Missouri through a telephone survey and a fidelity assessment;
- Conducted two case studies of vendor agencies (site visits, key informant interviews);
- Presented at a statewide training on the implementation of evidenced based supported employment and planned a statewide training for vendors, state staff and consumers;
- Planned an intervention project to the National Institute on Mental Health that represents the next wave of implementation issues.

Trauma Initiative

The psychological effects of violence and trauma are priority issues for the Missouri Department of Mental Health. Psychological trauma refers to clusters of symptoms, adaptations, and reactions that interfere with the daily functioning of an individual who has experienced suffering, neglect, deprivation, physical abuse and injury, sexual abuse and/ exploitation, threatened sense of safety, or who meets the criteria for Post-Traumatic Stress Disorder (PTSD). Psychological trauma affects men, women, and children. Two key factors that affect an individual's response to trauma are resiliency and vulnerability. The impact of trauma for vulnerable individuals is linked to such difficulties as mental illness, addiction and abuse, personality disorders, physical illness, suicide, self-injury, aggression towards others, and re-victimization. Many people cannot begin healing from the effects of other disorders until the trauma is addressed. Failure to address trauma-related issues may worsen the symptoms of trauma survivors and may exacerbate their experience of disempowerment and victimization.

The DMH has developed a Position Statement on Services and supports for Trauma Survivors, created a listing of staff competencies, added billing codes specific to trauma individual and trauma group education and added contract language specific to trauma to the ADA Primary

Recovery Programs, and provided a trauma track at the Spring Training Institute for five consecutive years.

Fulton State Hospital received a SAMHSA grant to Reduce and Eliminate Seclusion and Restraint. The grant labeled Focus on Safety has made many changes to the hospital system to reduce seclusion and restraint.

Specific Seclusion and Restraint Grant Efforts:

- developing a comfort room on Hearnese 2
- developing a comfort cart for the Biggs Unit
- video vignettes were developed to augment ProACT staff training in verbal de-escalation. In addition, early signs of aggression were incorporated into this SR prevention training for staff
- implementing Personal Safety Plan tool/intervention beyond the 2-month pilot phase to the entire facility
- developing a Staffing to Acuity Work Group to create protocols for increased individual staff support for consumers in acute distress
- creating a new debriefing form and process
- updating the Fulton web-site and Strategic Plan, now dated: 2004-2007, <http://www.dmh.missouri.gov/fulton/strategicplan.htm>
- hiring a half-time peer specialist consumer in October 2005
- consulting with Joel Slack, a noted Consumer Advocate, in October 2005. Mr. Slack conducted focus groups, met with the Consumer Roles group and RESPECT Speakers about ways to expand/enhance Fulton's consumer inclusion and consumer-centered care. More than 700 staff received training from the RESPECT Speakers or Joel Slack.
- holding a Focus on Safety (FOS) Expo on October 27, 2005 to communicate the direction the hospital is moving in as reflected in the FOS strategic plan. More than 500 staff participated.
- creating FOS Bulletin Boards in every ward to help communicate the SR reduction effort and post bi-weekly SR data.
- holding a Peace Rally at the Biggs Unit. This was organized by the BLAST Committee and enrolled 78 members into the Peace Club who took a pledge of non-violence. The Guhleman Unit is now interested in developing their own Peace Club. Ways to "keep the peace" and promote the benefits of the Club and non-violence are also being explored by members and staff.
- analyzing data. Doctoral students have been further reviewing Fulton's SR data, developing a SR database, SR data entry interface /on-line reporting, and a variety of SR reports, and
- Fulton's evaluation partner in the SIG project, the Missouri Institute of Mental Health at the University of Missouri – Columbia, has developed a data plan, begun to collect data, conduct surveys and collect consumer data on community readiness and empowerment.

Spring Training Institute

The Missouri Department of Mental Health provides an annual Spring Training Institute in May for consumers, providers and staff of the Divisions of Alcohol and Drug Abuse, Comprehensive Psychiatric Services, and Mental Retardation and Developmental Disabilities. Additionally the

Institute attracts staff from the Department of Corrections, Department of Social Services (Division of Youth Services, Division of Family Services, Division of Medical Services) Department of Elementary and Secondary Education (Division of Vocational Rehabilitation), Department of Health and Senior Services and other statewide organizations. The Institute provides the opportunity for participants to learn about the latest research in the field regarding medications, evidenced-based treatment, and other issues related to the population that we serve. In 2006, the Institute had over 900 participants.

Mental Health Courts

There are Mental Health Courts in Springfield, Kansas City, St. Louis City, St. Louis City, and St. Charles. The following remarks by A. Kathryn Power, M.Ed., CMHS Director, given in Los Angeles, California, on June 21, 2005, capture DMH's goal for mental health courts. "The concept of community is especially important when we consider populations who are involved in the criminal justice system—they are, after all, from our communities, and almost all of them will someday return there. When they do, it is up to us to see to it that we are there to build resilience to face life's challenges...to facilitate their recovery...and to reduce the chance that they will re-offend and begin the hopeless cycle all over again."

Linkages with Institutes of Higher Learning

The DMH has many current collaborations with universities and institutes of higher learning. Through projects such as COSIG, Prevention State Incentive Grant, Missouri Mental Health Employment Project, Trauma Initiative, System of Care grants, Tele-psychiatry, and consumer operated programs, the following entities are working with the department:

- University of Missouri – Columbia;
- University of Missouri – Kansas City;
- Mid-America Addiction Technology Transfer Center;
- Missouri Institute of Mental Health;
- University of Massachusetts – Boston, Institute for Community Inclusion;
- Washington University, St. Louis; and
- Rehabilitation Continuing Education Program, RCEP7.

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

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

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

The Division of Comprehensive Psychiatric Services is excited about the ongoing implementation of the Procovery movement in Missouri. The expectation is that Procovery Circles will grow across the state and support consumer driven recovery.

The department envisions consistent state-wide implementation of evidence based practices at a high level of fidelity to the SAMHSA toolkits. As Integrated Dual Diagnosis Treatment, Supported Employment, and Assertive Community Treatment 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 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

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

Suicide Prevention

Suicide prevention across the lifespan continues to be a priority for the state. The DMH, and partners in the efforts to reduce suicide, developed a state-wide Suicide Prevention Plan through enabling state legislation. The department was awarded a Youth Suicide Prevention and Early Intervention grant from SAMHSA. Working cooperatively with the Missouri Institute of Mental Health, state agencies are moving forward on suicide prevention. The DMH continues to implement suicide prevention services according to the legislative mandates and grant guidelines using braided funding from multiple sources such as the SAMHSA grant and Block Grant dollars. State-wide suicide prevention trainings have taken place and were well attended. Contracts have been awarded in each region of the state for resource centers to provide prevention services. Mini-grants for special projects have been awarded and an 800 number for suicide prevention has been implemented. The Suicide Prevention Advisory Committee established in legislation has been appointed.

Goal 2: Mental Health Care is Consumer and Family Driven

Established a Comprehensive Children's Mental Health Services System

In 2004, Senate Bill 1003 (SB1003) was enacted into law establishing a Comprehensive Children's Mental Health Services System. The DMH, in partnership with all of the Departments represented on the Children's Services Commission, are charged with developing a comprehensive children's mental health service system. Legislation mandates that families and representatives of family organizations participate on the Comprehensive System Management Team and the Comprehensive Children's Mental Health Services System Stakeholder's Advisory Group (SAG). At least 51% of the SAG must be family representatives.

Families of children with severe emotional disturbances advocated for legislation that would allow them to keep custody of their children and receive the needed mental health services. In response to the family voices, SB1003 continues the work of SB266 by addressing the painful choices limited system capacity forced on families of relinquishing custody to access needed services. The legislation requires the Children's Division (CD) to determine which children are in their custody solely due to mental health needs. Then, in partnership with the family and other agencies, submit for court approval, an individualized service plan delineating agency responsibility and funding. For children in need of only mental health services, custody may return to the family while services are provided under the coordination of the DMH with DMH billing the Department of Social Services (DSS) for services. To avoid custody transfers to the CD, SB1003 also allows for the standard means test for children in need of mental health services to be waived.

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

Established and Implemented a “Custody Diversion Protocol” for Children

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, 160 youth have been referred through the Diversion Protocol and 150 children or ninety-four percent have been diverted from state custody. Of those children diverted from custody 51% received intensive services in their home and community while 49% required a placement outside of their home. In any given month approximately 30-35 children were supported in their out of home placement through the VPA. The continued implementation of the Custody Diversion Protocol will be monitored by the DMH, CD and the Stakeholders’ Advisory Group for the Comprehensive Children’s Mental Health Service System.

CAFAS

The DMH is working with its providers to implement a functional assessment instrument that would be consistent across all three Divisions. The **Child and Adolescent Functional Assessment Scale (CAFAS)** is being pursued as this instrument. The CAFAS will aid the DMH in obtaining the following: a) actively managing services by periodically assessing progress towards specified goals, b) designing treatment plans which link problematic behavior with a target goal and related strengths, and c) assessing outcomes. At least two community mental health centers currently utilize the CAFAS. The DMH met with the developer of the CAFAS, Kay Hodges, regarding its implementation in Missouri in November, 2005. CAFAS training of DMH staff and providers has begun across the State. The DMH and the state Juvenile Justice have a policy task force developing guidelines to support good assessment/screening for youth with mental health needs in the Juvenile Justice system.

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

Training

Five trainings were conducted across the state in 2005 by the KC Metro Child Traumatic Stress Program, a partner in the National Child Traumatic Stress Network, for caseworkers and therapists on Identifying and Responding to Child Traumatic Stress. The day long training focused on assisting direct care staff in recognizing the signs of psychological trauma and responding appropriately with services and referrals.

The eight Northwest Administrative Agents pooled their training dollars to implement the several critical trainings. These two training have been sited as needs and

recommendations within the Jackson County System of Care Quality Service Review. These trainings will make a vast impact for the region in many ways: consumer outcome, client specific training and professional recruitment, program development, and increased professional consultation, communication and coordination between the divisions of Mental Retardation and Development Disabilities and Comprehensive Psychiatric Services.

- **Training One:** In conjunction with the Division of Mental Retardation and Development Disabilities Albany and Kansas City Regional Centers, Western Missouri Mental Health Center and the Gillis Center for Children, the eight Administrative Agent Children Directors brought in Marc Goldman for a two day training on the assessment, treatment planning and implementation of strategies for the dually diagnosed population. Each agency brought in a team of 5-7 staff including Qualified Mental Health Professional (QMHP) and Targeted Case Management/Community Support Work staff. The first round of training taught the Functional Analysis by the QMHP and Mental Retardation Professional, how to develop behavioral strategies from the analysis utilizing Positive Behavioral Supports, how to develop and implement the Person Centered Plan, how the QMHP/QMRP leads the design, structure and implementation of these strategies towards the desired outcome. Each team will then go back and perform the functional analysis, design and develop behavioral strategies through Positive Behavioral Supports and implement the Person Centered Plan. In 30 days, Marc will then return to consult for one day with each of the teams regarding the process, plan, implementation, difficulties and further strategies and resources. Over 100 staff from 12 agencies have received the training.
- **Training Two:** The Evidence Based Practice Model of Trauma Focused Cognitive Behavioral Therapy was presented to the eight Administrative Agents. The Clinical Supervisor and the primary therapist were encouraged to attend. This training was provided by the Children's Place staff Margaret Comford. There was a one day session training on the model and supervision. Then for the next 30 days there was on-line exercises and response as therapists on utilizing the EBP model. There was a second day for consultation and follow up. Lastly, there will then be six months of supervisory oversight with the Clinical Supervisor and primary therapist provided by Margaret Comford and her staff. Nineteen therapists have been credentialed in the eight Administrative Agents to provide Trauma Focused Cognitive Behavioral Therapy.

Comprehensive System of Care for Children

The Department of Mental Health has ten System of Care sites operating in Missouri. Currently two sites are funded through the SAMHSA Comprehensive Children's Mental Health Services grants, one site is a graduate of the federal funding and seven are state system of care sites. 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.

Piloted Quality Service Review

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).

To date the QSR instrument and interview process has been developed and piloted in seven of the local system of care sites under the direction of the CSMT. Results from the initial review shows that between 60% and 70% of the children with the most complex needs are improving in the key areas of safety, staying in school, and improved emotional and behavioral well-being. At the system level, review findings reflect the evolutionary nature of system of care development with the more established sites showing the most creativity and flexibility in how they use existing dollars and work collaboratively to meet the needs of children.

Positive Behavior Support

Department of Elementary and Secondary Education (DESE) has identified Positive Behavior Support (PBS) as an evidence-based approach to support children succeeding in school. PBS teams have been created in several local school districts through a State Improvement Grant. The Comprehensive System Management Team is working with DESE to incorporate the PBS approach into system of care for children and youth with mental health needs.

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

State Cross-Departmental Data Warehouse for Children

Surveillance and assessment of mental health needs is critical to the development of the proposed system. To assist with this assessment, the comprehensive children's plan recommended the creation of a "data warehouse" process to compile needed data across the multiple child serving agencies. DMH in partnership with DSS has begun the initial phase of development of a data warehouse. When completed, the data warehouse would compile data across child-serving agencies in a comprehensive, integrated, and reliable view of all relevant information collected to permit quality decision making. The system would allow access to such information as level of function, service needs, utilization, and financial expenditures. The first phase of this effort, to identify specific subject areas, systems and data attributes to be included in the data warehouse, was completed in November 2005.

Weaknesses

The Quality Service Reviews consistently identified three major cross-site issues: the need for universal screens addressing trauma, “at risk” planning for transition and independence, and improved communication with school personnel.

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 Division of Family Services (now 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. Few resources are directed to prevention and early intervention activities.

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

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.

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. 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.

The plan for a comprehensive mental health system for children builds on years of work to address the mental health needs of Missouri's children. The plan also continues to address a tragic consequence of the current system that sometimes results in families relinquishing custody of their child for the purpose of accessing needed mental health services. This is a decision no family should be forced to make. Senate Bill 923 enacted in 2002 and Senate Bill 266 enacted in 2003 gave rise to policies aimed at stopping this terrible dilemma. As a result of Senate Bill 923, protocols were developed to divert children from having to be placed in state custody for the sole purpose of mental health treatment. These protocols are being established statewide. Senate Bill 266 called on the state to identify those children in state custody for mental health treatment only and return those children to the custody of their family when appropriate. This process currently is being implemented. The system of care mandated by Senate Bill 1003 will further refine and incorporate the work of the previous legislation to ensure that relinquishing custody is never an option to be considered for accessing the children's mental health system in Missouri.

The transformation of children's services uses as its foundation a public health approach to meeting the mental health needs of children. The public health model emphasizes the necessity of health promotion and prevention as a part of the full spectrum of services. 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
- **Service delivery system**, providing services that are evidence-based 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

A data warehouse is in development to compile data across multiple child serving agencies in a comprehensive, integrated, and reliable manner to permit quality decision making. The data include level of functioning, service needs, utilization and financial information across all of the involved agencies. Analysis of the data will help to determine if the correct services are being provided, in the right duration, and in the most cost effective manner. DMH and its partners are

seeking grant or foundation funding to create this data warehouse. Concern will be taken to assure that the data collection procedures meet confidentiality and HIPPA statute and regulations. Activities will be coordinated with the Missouri Juvenile Justice Information System (MOJJIS) that is currently in use to collect data between the juvenile divisions of the circuit court and state agencies to ensure integration of all information within the system.

The 2004 iteration of the Missouri Student Survey (MSS) provides an example of state and local assessment of mental health needs. The 2004 MSS was provided to the state's school districts as a web-based instrument with individual districts being able to access reports on risk and protective factors, incidence and prevalence of alcohol and other drug use, data on violent behaviors, and information about suicidal thoughts. In addition, the complete database is accessible by DMH and its evaluation and data analysis team in order to produce state-level and regional reports. These reports, which will be made publicly available, will assist the state and communities with planning the most appropriate array of services. Information about risks and protection and incidence and prevalence are essential for service planning and development. Under funding from the Substance Abuse and Mental Health Services Administration, DMH will develop a model for collecting, analyzing and reporting state-level needs-related data and for assisting communities with collecting, analyzing and reporting on local needs-related data.

Policy Development

The DMH is partnering with other agencies to jointly establish policy to support the following key system components:

- That the state interagency group convened as a result of SB1003 develop and implement a plan that ensures that children in need of mental health services receive them regardless of the system or environment in which that need is identified;
- That the Department of Mental Health consult with other state departments on the development of protocols for responding to the mental health needs of children;
- That funding follow the child, regardless of which system he or she starts in;
- That all child-caring systems are capable of identifying and assessing, if appropriate, the mental health needs of children (the "no wrong door");
- That relinquishment of custody is not necessary solely to receive needed mental health services; and
- That the children's mental health service system is family-driven, culturally competent and has a cross systems perspective.

The Stakeholder Advisory Group has formed to ensure a consumer driven system of care. The role of the Stakeholder Advisory Group after one year is to provide feedback regarding quality of services, barriers/success of the system, advocacy, public relations for the system, use of data to drive decision-making, and identification of emerging issues. Consumer members on the Stakeholder Advisory Group are also members of the CPS State Advisory Council so that information can be easily shared.

Service Delivery System

The focus for the coming year is on both expanding the service capacity statewide and continuing to create the infrastructure to support the system. Service capacity expansion will focus on priorities targeted in the comprehensive children's plan, workforce enhancement, and

developing a process to ensure services implemented are research-based and support coordinated and individualized care planning. Policy and infrastructure development will center around continuing to formalize the interagency management structures at both the local and state levels, continued identification of more effective ways of funding the system, expanding the data warehouse to support more effective data collection and sharing across agencies and continued evaluation of the system through use of the Quality Service Review statewide.

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

As a first step to address the issue of voluntary custody relinquishment, Missouri's legislators passed SB923 in 2002. SB923 allowed juvenile/family courts to take jurisdiction over a child when a parent could not access or afford the mental health services and supports needed without the family having to be placed on the Child Abuse Registry. In 2003 SB266 was passed which required the Departments of Mental Health (DMH) and Social Services (DSS) to develop a plan to address the needs of children in state custody solely due to their need for mental health services. In response to SB266 the DMH and DSS worked with Alicia Smith and Associates, LLC to study and provide recommendations related to children in state custody to access mental health and development of comprehensive financing strategies for the development of a system of care.

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 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, 160 youth have been referred through the Diversion

Protocol and 150 children or ninety-four percent have been diverted from state custody. Of those children diverted from custody 51% received intensive services in their home and community while 49% required a placement outside of their home. In any given month approximately 30-35 children were supported in their out of home placement through the VPA. The continued implementation of the Custody Diversion Protocol will be monitored by the DMH, CD and the Stakeholders' Advisory Group for the Comprehensive Children's Mental Health Service System.

Although the groundwork for the Custody Diversion Protocol was initiated prior to passage of SB1003 in 2004, this legislation took the additional step of having the DMH and the CD examine the population of youth currently in CD custody solely to access mental health services. SB1003 outlined a process through which this population of youth would be identified and a Family Support Team would review and assess the feasibility of the child being returned to the parent's legal custody while maintaining appropriate treatment services. DMH and the CD convened an interagency group to develop a protocol for implementation of transferring custody from the state to the child's parents as outlined in SB1003. The Children's Division conducted a paper review of the initial list of 600 children that had been identified through the previously cited study. From this list, 104 children were identified that were currently in CD custody and that by review met the criteria of being placed in CD custody solely to access mental health services and for whom no allegation of abuse or neglect had been substantiated and there were no current safety issues. Funding for services for these children after custody is returned to the parents is continued through the CD, thereby having the funding follow the child. Initial data on transfer of custody gathered through June 2005 indicated that of the 104 youth reviewed through a Family Support Team, transfer of custody was recommending to the court for 47 youth. Upon judicial review and disposition 38 youth were returned to their parent's custody.

Based on the findings to date, it is evident that children can be diverted from state custody if effective communication occurs across child-serving agencies and resources exist to be able to respond to families' urgent needs. Likewise, with interagency communication and collaboration children can be returned to their parents' custody while still receiving the mental health services they need. Effective local interagency teams are critical to successful implementation of these initiatives. Due to the lower than expected successful transfers, the CD and DMH continue to monitor the numbers, outcomes and funding for this population of youth. Additionally staff training is a high priority as while this proxy methodology works, without a significant amount of staff training there is a danger of under identifying children for whom custody relinquishment is a concern

Building a Comprehensive Children's Mental Health System

Assess mental health service needs statewide

Surveillance and assessment of mental health needs is critical to the development of the proposed system. To assist with this assessment, the plan recommended the creation of a "data warehouse" process to compile needed data across the multiple child serving agencies. DMH in partnership with DSS has begun the initial phase of development of a data warehouse. When completed, the data warehouse would compile data across child-serving agencies in a comprehensive, integrated, and reliable view of all relevant information collected to permit quality decision making. The system would allow access to such information as level of

function, service needs, utilization, and financial expenditures. The first phase of this effort, to identify specific subject areas, systems and data attributes to be included in the data warehouse, was completed in November 2005.

Policy Development & infrastructure administration

SB1003 calls 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 sponsors and supports the development of local interagency system of care (SOC) teams. Over the last year, three new sites have been developed for a total of ten local SOC sites. During the past several months, the CSMT has sponsored and directed meetings between the Department of Mental Health and juvenile justice system to enhance local collaboration between the two entities and address specific barriers that prevent families from receiving services. In addition the CSMT finalized the Quality Service Review summary report. The CSMT enacted by-laws to formalize its structure and is in the process of creating five standing work groups to address the various tasks outlined in the Comprehensive Plan. The five committees include Finance, Practice, Local Team Liaison, Family and Consumer Issues, and Evaluation and Quality Assurance.

To guarantee broad input from Missouri's diverse stakeholders, especially families of children with mental health needs, SB1003 establishes a Stakeholders Advisory Group (SAG). The role of the SAG is to provide 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. The Director of DMH appointed members to serve on the Stakeholders Advisory Committee based on recommendations from the state child serving agencies. Care was taken to ensure that members represent all geographic areas and ethnic populations with at least 51% of the members representing families and youth. The first meeting was held in November, 2005. As directed in the plan, three standing committees were formed: Public Education; System Development Monitoring; and Enhancing Parent Involvement. The initial focus will be on elections of chairs, establishment of operating guidelines or by-laws, monitoring the implementation of the Custody Diversion Protocol and implementation of the process for transferring children placed in state custody solely to access mental health services back to their parents/guardians.

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.

While the divisions within DMH continue to maintain responsibility for day-to-day operations for their respective populations, each division will appoint one liaison to work with the Office to coordinate program and policy development as well as address clinical and training issues. Although both the divisions and the Office may initiate policies or programs, when it addresses the needs of youth under the age of 22 and their families it must be done in conjunction with the Office and the respective division. Additionally, each division has appointed a representative to the CSMT.

SB501 also establishes within DMH a Comprehensive Child Mental Health Clinical Advisory Council whose members are appointed by the Director of DMH and represent many child clinical disciplines. The focus of the Council is to: share information on state and national trends, evidenced-based practices and research; serve as a liaison with their respective discipline; identify funding and research opportunities; and advise the department. The Clinical Director of Children, Youth and Families serves as staff to the Council with the Director of DMH or designee and the DMH Medical Director serving as ex-officio members.

The Array of Services and Supports within the Service Delivery System

Financing: In response to the directive in SB1003 to describe the mechanisms for financing, the Plan identifies several funding strategies and activities to be undertaken to finance the system. In addition to successfully amending the state's IV-E plan allowing CD to fund a child's out of home placement up to 180 days without having to take custody, the DMH continues to work with DSS to obtain a 1915cWaiver. The Community-based (1915C) Waiver focuses on community service capacity development for youth diverted from an inpatient admission, or to decrease the length of stay.

A School Based Services Committee has been convened with the Division of Medical Services acting as chair to look at financing educational activities. The membership of the committee is composed of staff from various state agencies, community leaders and school districts throughout the state. Three subcommittees were formed to address dental, health services and mental health in schools. The Department of Mental Health chairs the Mental Health sub-committee. The goal of the committee was to determine what mental health services are currently provided in the schools and what future services, if any could be offered. The committee participated in a statewide survey of schools to find out additional information. The results of the survey and recommendations to the Division of Medical Services are expected by the spring of 2006.

Functional Assessment: DMH is working with its providers to implement a functional assessment instrument that would be consistent across all three Divisions. The Child and Adolescent Functional Assessment Scale (CAFAS) is being pursued as this instrument. The CAFAS will aid the DMH in obtaining the following: a) actively managing services by periodically assessing progress towards specified goals, b) designing treatment plans which link problematic behavior with a target goal and related strengths, and c) assessing outcomes. At least two community mental health centers currently utilize the CAFAS. The DMH met with the developer of the CAFAS, Kay Hodges regarding its implementation in Missouri in November, 2005. It is anticipated that CAFAS training of DMH staff and providers will begin in May 2006.

Evidence Based Practice: Department of Elementary and Secondary Education (DESE) has identified Positive Behavior Support (PBS) as an evidence-based approach to support children succeeding in school. PBS teams have been created in several local school districts through a State Improvement Grant. The CSMT is working with DESE to incorporate the PBS approach into system of care for children and youth with mental health needs.

Early Childhood: The Department of Health and Senior Services (DHSS) received a two year \$100,000 planning grant through the Maternal and Child Health Bureau to strengthen collaboration and promote effective utilization of resources through development of an Early Childhood Comprehensive System. To follow up the DHSS has applied and been approved for the implementation grant. Mental Health and Social/ Emotional Development are one focus and DMH staff has served as the co-chair along with Head Start for this group. DMH is also on the Interagency Steering Committee. A partnership with DESE continues in implementation of the First Steps program. Appointments to the Coordinating Board for Early Childhood are being made for state agencies and non-state agency representatives will be appointed in the near future.

Juvenile Justice Activities: Representatives from DMH, DSS, MJJA, the judiciary and parents attended a National Policy Academy on Improving Services for Youth with Mental Health and Co-Occurring Substance Use Disorders Involved in the Juvenile Justice System. The Missouri team agreed the state's goal was to improve access and capacity for a comprehensive and seamless service system to meet the needs of youth involved in the juvenile justice system. One issue to address is how the state can develop a partnership with the 45 county based circuits in the state to all. To achieve this goal a state partnership with the circuit courts will be formed to create mechanisms for insuring outcomes, tracking of fiscal and support/service resources and establishing effective protocols, policies and information management systems. The first task Mental Health/Juvenile Justice Policy Team agreed to address is increasing the court's and child welfare's understanding of the role of mental health assessments and improving the quality of mental health assessments for children involved with juvenile justice. Additionally, through a Challenge Grant from the Office of Juvenile Justice and Delinquency Prevention and the MO Dept. of Public Safety a series of regional videoconferences have been held to explore how mental health and juvenile justice can collaborate more effectively. This has been followed by providing technical assistance to local interagency teams on developing policy collaboratives. The DMH continues to work with OSCA and MJJA in training juvenile officers on children with special needs and mental health service system.

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).

To date the QSR instrument and interview process has been developed and piloted in six of the local system of care sites under the direction of the CSMT. Results from the initial review shows that between 60% and 70% of the children with the most complex needs are improving in the key areas of safety, staying in school, and improved emotional and behavioral well-being. At the system level, review findings reflect the evolutionary nature of system of care development with the more established sites showing the most creativity and flexibility in how they use existing dollars and work collaboratively to meet the needs of children. The reviews consistently identified three major cross-site issues: the need for universal screens addressing trauma and “at risk” planning for transition and independence; and improved communication with school personnel.

Following the reviews, local teams have worked to address any identified child-specific concerns. The CSMT in partnership with the Department of Mental Health (DMH) has focused on capacity building to support expansion of the QSR statewide by developing the ability to train reviewers, conduct reviews and manage the data in-state. Next steps include conducting a baseline QSR in newly developed SOC local sites, continuing to build capacity through expansion of the reviewer pool, and exploring ways to coordinate similar QSR and PDR administrative functions.

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

Missouri’s mental health system wants to shift emphasis from a largely disability focused model to a public mental health approach that addresses the mental health of the entire population across the whole lifespan. Adopting a public mental health approach means that the state and local communities shift from a diagnosis and disability-driven view to one which emphasizes prevention and risk reduction in addition to treatment and recovery supports. Consequently, in order to transform the mental health system in Missouri, two critical needs must be addressed.

- 1) Lack of a comprehensive prevention infrastructure and strategy for reducing stigma. Missouri is working towards a strategy to incorporate the promotion of good mental health and the prevention of mental health problems across the entire lifespan. The anti-stigma campaign is part of this strategy.
- 2) Lack of formal infrastructure for local ownership of, and investment in, mental health. The mental health system is currently very centralized, yet many aspects of promoting and protecting public health have long been recognized, and effectively administered, as shared state and local responsibilities. Although Missouri counties have the option to fund and administer mental health and substance abuse services, only 13 of the 114 counties and City of St. Louis have chosen to do so. Therefore, to elevate the importance of mental health to the same level as health, the development of an infrastructure that balances state authority and local investment in a mental health system is needed.

The promotion of mental health and the prevention of mental illness is a goal of the comprehensive children’s mental health system. Promoting positive mental health and preventing the onset and progression of behavioral disorders can reduce deaths and injuries. The Missouri School-Based Initiative, Missouri SPIRIT, is a pilot program demonstrating the efficacy and effectiveness of implementing evidence-based prevention programs in schools. Information from the first two years of the program strongly suggests that there are not only reductions in alcohol and other drug use, but also improvements in school climate – including, reductions in violent behavior among high school students and reduced numbers of children with 10 or more absences per year. SPIRIT is demonstrating that evidence-based programs, implemented with some fidelity, can, not only reduce behavioral disorders, but also improve school environment. The DMH proposed budget for FY2008 includes a request for funds to expand the SPIRIT project to additional schools.

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

A primary goal of the Comprehensive Children’s Mental Health System is to insure that children who need mental health services and supports receive them earlier, rather than later. Early identification and intervention will allow these children to be helped within the community and before the need for institutional services. Early treatment is only possible when children in need

are identified early in the progression of their illness. The comprehensive system emphasizes early identification through intensive campaigns to teach physicians and providers, school personnel and parents how to identify a child in need of mental health services and how to obtain appropriate services.

Missouri

Adult - Establishment of System of Care

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

Criterion 1: 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.

The State's Revised Statutes of Missouri 2005 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 (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 CPRP is a Medicaid supported program, the federal government pays approximately 60 percent of the costs for clients with Medicaid eligibility.

Expansion of the Community Psychiatric Rehabilitation Program for both adults and children and youth has been a priority. The CPRP program is a client-centered approach that emphasizes individual choices and needs; features flexible community-based services and supports; uses existing community resources and natural support systems; and promotes independence and the pursuit of meaningful living, working, learning, and leisure-time activities in normal community settings. The program provides an array of key services including evaluations, crisis intervention, community support, medication management, and psychosocial rehabilitation.

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

To increase housing options within the past 3 years, the DMH Housing Team has collaborated with community providers to develop semi-independent apartments through the HUD 811 process. This option targets those individuals who need additional supports in order to transition to independent living. During the current funding cycle, several CPS providers are submitting HUD applications to develop Safe Havens, low –demand housing for those with co-occurring mental illness and substance abuse disorders.

Educational Services

PSR services, as described in the CPR handbook, 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

The CPR program is also developing strategies to help adults with substance abuse/addiction. Adults 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.

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).

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 most 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 five years. Four contracts are currently in place for peer phone support services (warm-lines) in various sites throughout the state. Each warm-line is operated by mental health consumers. These services are intended to reduce feelings of social isolation and loneliness. The consumers answering the phone lines do not provide crisis intervention services but are trained to provide support, friendship and assistance over the telephone to other mental health consumers. Additionally, six 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 recently 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 begun of the six recently awarded 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

Missouri received a Co-Occurring Substance Abuse and Mental Health State Infrastructure Grant (COSIG) in the fall of 2003. Provider pairs for the pilot project were identified in both rural and urban areas. The COSIG has been the change agent for implementing co-occurring psychiatric and substance abuse treatment in Missouri. The COSIG project has:

- Implemented standardized screening and assessment tools at 14 pilot provider sites
- Completed a feasibility study of the tools
- Provided intensive cross training throughout Years 1 and 2
- Increased level of awareness regarding Co-Occurring Disorders (COD) and need for more appropriate treatment services across the state
- Increased communication between mental health and substance abuse staff and agencies
- Identified rules and regulations that hindered services for clients with COD, led to clarification and several rule changes
- Some agencies have increased capability to appropriately treat clients with COD (e.g., Substance Abuse (SA) sites contracted for medication services and hired Mental Health (MH) staff; MH sites contracted with SA staff and provided SA treatment groups)

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.

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									
2005 Estimated Census Data and Prevalence Rates									
FY2006 Clients Served By Service Area									
SA	Tot. Est. Popn	Adults	Children	Adlt Prevalence	Child Prevalence	SMI Adults Served	SED Child Served	Rural	Rural
	2005			at 5.7%	at 7%	FY06	FY06	Adult	Child
01	176,898	134,056	42,842	7,641	2,999	1,469	997	1,469	997
02	103,892	76,053	27,839	4,335	1,949	3,612	439		
03	100,451	77,022	23,429	4,390	1,640	929	83		
04	289,268	212,374	76,894	12,105	5,383	761	87		
05	167,622	124,470	43,152	7,095	3,021	1,145	322		
KCsub						4,749	2,253		
KC	661,233	489,919	171,314	27,925	11,992	11,196	3,184		
06	305,091	224,495	80,596	12,796	5,642	3,354	647	3,354	647
07	175,752	127,870	47,882	7,289	3,352	843	477	843	477
08	190,851	143,028	47,823	8,153	3,348	1,810	706	1,810	706
09	200,558	147,424	53,134	8,403	3,719	3,326	943	3,326	943
10	466,292	353,504	112,788	20,150	7,895	4,211	1,667	4,211	1,667
11	230,670	172,591	58,079	9,838	4,066	1,489	507	1,489	507
12	311,932	236,860	75,072	13,501	5,255	2,512	586	2,512	586
13	79,836	59,855	19,981	3,412	1,399	1,158	414	1,158	414
14	106,299	80,686	25,613	4,599	1,793	1,415	474	1,415	474
15	118,119	88,308	29,811	5,034	2,087	1,874	588	1,874	588
16	497,205	352,198	145,007	20,075	10,150	1,704	667	1,704	667
17	199,950	150,033	49,917	8,552	3,494	2,942	862	2,942	862
18	121,898	90,635	31,263	5,166	2,188	1,307	198	1,307	198
19	132,688	98,795	33,893	5,631	2,373	2,350	665	2,350	665
20	104,679	77,333	27,346	4,408	1,914	1,343	569	1,343	569
21	131,002	98,424	32,578	5,610	2,280	1,063	248	1,063	248
22	211,049	151,325	59,724	8,626	4,181	1,611	273	1,611	273
23	1,010,530	755,902	254,628	43,086	17,824	4,462	747	4,462	747
24	124,588	91,584	33,004	5,220	2,310	3,262	626		
25	200,978	152,510	48,468	8,693	3,393	1,934	150		
STLsub						828	65		
STL	325,566	244,094	81,472	13,913	5,703	6,024	841		
Out of State						250	17		
Unknown						500	599		
TOTAL	5,758,098	4,277,335	1,480,763	243,808	103,653	58,213	16,876	40,243	12,235
RURAL (EXCLUDES COUNTIES	4,771,299	3,543,322	1,227,977	201,969	85,958				

095 & 510)									
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Definition of the Population

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

1. Disability: There must be clear evidence of serious impairment in each of the following areas of behavioral functioning.
 - a) Social role functioning – ability to functionally sustain the role of worker, student or homemaker; and
 - b) Daily living skills – ability to engage in personal care (grooming, personal hygiene, etc.) and community living activities (handling personal finances, using community resources, performing household chores, etc.) at an age-appropriate level.

2. Diagnosis: A primary diagnosis of one of the DSM-IV Diagnostic and Statistical Manual of Mental Disorders, (Fourth Edition, Revised in 1994) listed below, but such diagnosis may coexist with other DSM-IV diagnoses in Axis I or other areas.
 - a) Schizophrenic disorder (295.1,2,3,6 or 9)
 - b) Delusional (paranoid) disorder (297.10)
 - c) Schizoaffective disorder (295.7)
 - d) Bipolar disorder (296.4,5,6 or 7)
 - e) Atypical psychosis (298.90)
 - f) Major depression, recurrent (286.3)
 - g) Dementia or Other Organic Condition complicated with Delusional Disorder, Mood Disorder or Severe Personality Disorder (290.20, 290.21, 290.12, 290.13, 290.42, 290.43 or 294.10)
 - h) Obsessive-compulsive disorder (300.30)
 - i) Post-traumatic stress disorder (309.89)
 - j) Borderline personality disorder (309.83)
 - k) Dissociated identity disorder (300.14)
 - l) Generalized anxiety disorder (300.02)
 - m) Severe phobic disorder (300.21,22 or 23)

3. Duration: The individual exhibiting the disability specified in 1 (above) resulting from the DSM IV disorder specified in 2 (above) must meet at least one of the following criteria:
 - a) Has undergone psychiatric treatment more intensive than outpatient care more than once in his/her lifetime (e.g. crisis response services, alternative home care, partial hospitalization or inpatient hospitalization).
 - b) Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
 - c) Has exhibited the disability specified in 1 (above) for a period of no less than a year.

CHARACTERISTICS OF CLIENTS SERVED (Community Programs, including Residential)
UNDULICATED CPS CONSUMERS
 State: MISSOURI
 Fiscal Year: 2006

	Statewide	Eastern	Central	Northwest	Southwest	Southeast	Region Unknown	Out of State
Total People Served	71,763	15,477	8,522	23,294	12,484	10,763	1,047	176
Total Population (Estimated Census 2004)	5,754,618	2,055,504	760,606	1,394,322	854,335	689,851		
Number of People Served per 1000 Population	12.5	7.5	11.2	16.7	14.6	15.6		
Age								
0-03	148	3	7	46	65	19	8	.
04-12	8,456	1,106	973	3,028	1,860	1,120	366	3
13-17	8,087	1,402	1,059	2,606	1,389	1,397	225	9
18-20	2,572	511	324	926	418	356	28	9
21-30	11,243	2,326	1,363	3,934	1,977	1,514	84	45
31-45	21,241	4,879	2,489	6,764	3,693	3,178	178	60
46-64	18,047	4,721	2,073	5,457	2,825	2,781	143	47
65-74	1,450	394	182	379	185	295	14	1
75+	496	133	50	137	71	103	.	2
Not Available	23	2	2	17	1	.	1	.
Gender								
Female	37,160	7,741	4,490	11,798	6,613	5,915	533	70
Male	34,603	7,736	4,032	11,496	5,871	4,848	514	106
<i>Total Male Population</i>	<i>2,810,852</i>	<i>990,855</i>	<i>378,656</i>	<i>682,697</i>	<i>418,902</i>	<i>339,742</i>		
Number of Males Served per 1000 Male Population	12.3	7.8	10.6	16.8	14.0	14.3		
<i>Total Female Population</i>	<i>2,943,766</i>	<i>1,064,649</i>	<i>381,950</i>	<i>711,625</i>	<i>435,433</i>	<i>350,109</i>		
Number of Females Served per 1000 Female Population	12.6	7.3	11.8	16.6	15.2	16.9		
Race/Ethnicity								
Caucasian	53,721	8,296	7,635	15,189	11,751	9,836	877	137
African American	14,973	6,811	625	6,423	207	745	134	28
American Indian	288	29	37	118	70	34	.	.
Asian	188	53	19	85	21	8	1	1
Hispanic	1,071	66	33	868	46	46	4	8
Other	831	163	89	438	49	60	30	2
Not Available	691	59	84	173	340	34	1	.
Number of Caucasians Served per 1000 Caucasian Population	10.9	5.2	10.9	13.0	14.4	15.2		
Number of African Americans Served per 1000 African Am. Population	22.6	17.0	14.9	36.1	19.7	25.0		
Number of American Indians Served per 1000 Am. Indian Population	10.9	6.2	11.3	17.4	8.9	8.7		
Number of Asians Served per 1000 Asian Population	2.5	1.3	2.3	5.2	3.7	2.4		
Number of Hispanics Served per 1000 Hispanic Population	7.2	1.9	2.1	13.5	1.9	5.6		

Diagnoses (DSM IV Codes)								
Alzheimers and Organic Brain (290,293,294,331.0)	375	91	44	86	82	69	.	3
Anxiety (300-300.02,300.3,308.3,309.21,309.81)	4,795	863	528	1617	869	797	112	9
Attention Deficit (314)	4,771	710	694	1533	839	784	207	4
Conduct (312.8,312.9,313.81)	1,768	229	169	668	351	302	48	1
Delusion & Other Psychoses (297,298)	1,227	373	86	460	136	149	11	12
Depressive and Mood Disorders (296,300.4,301.13)	30,997	6,980	4,110	9,088	5,381	4,944	435	59
Mental Retardation, Autism, and Specific Development (299,315 except 315.4,317-319)	126	21	20	30	29	22	3	1
No Diagnosis, Deferred, Not Available	7,335	567	639	3449	1749	890	22	19
Other Childhood Disorders (307.0,307.2-307.23,307.52-307.59,307.6-307.7,313.23,313.89,313.9,315.4,787.6)	187	41	18	38	69	16	5	.
Other MH Diagnoses	6,387	920	693	2,375	1,295	974	106	24
Personality Disorders (301 except 301.13,312.3)	512	97	66	154	86	96	11	2
Schizophrenia (295)	10,722	3,862	1,214	2,735	1,336	1,469	85	21
Substance Abuse (291-292,303-305)	2,561	723	241	1061	262	251	2	21
Major Mental Illness								
Adults with Major Mental Illness (Age 18 & over & DSM 295/296)	36,375	9,879	4,692	9,869	5,885	5,614	363	73
Other Adults	18,697	3,087	1,791	7,745	3,285	2,613	85	91
Children with Major Mental Illness (under age 18 & DSM 295/296/314)	8,510	1,435	1,234	2,813	1,432	1,272	318	6
Other Children	8,181	1,076	805	2,867	1,882	1,264	281	6
Race/Gender Crosstab								
NonWhite Female 0 to 17	1,619	446	103	838	107	97	26	2
NonWhite Female 18 to 59	6,571	2,812	291	2,856	214	330	52	16
NonWhite Female 60 plus	555	303	26	196	7	19	3	1
NonWhite Male 0 to 17	3,005	818	160	1,560	195	215	57	.
NonWhite Male 18 to 59	6,017	2,661	293	2,566	200	249	28	20
NonWhite Male 60 plus	272	141	13	87	10	17	4	.
White Female 0 to 17	4,485	450	693	1,191	1,070	893	182	6
White Female 18 to 59	21,800	3,312	3,078	6,173	4,823	4,117	254	43
White Female 60 plus	2,110	416	298	529	391	459	15	2
White Male 0 to 17	7,575	797	1,083	2,089	1,937	1,331	334	4
White Male 18 to 59	16,707	3,113	2,323	4,952	3,353	2,802	84	80
White Male 60 plus	1,024	206	159	240	176	234	7	2

Missouri

Adult - Quantitative Targets

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

Adult – Quantitative Targets

National Outcome Measures

Decrease the length of stay for individuals in state hospital beds

Decrease rate of readmission to state psychiatric hospitals within 30 days

Decrease the rate of readmission to State psychiatric hospitals within 180 days

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

Increase the number of individuals receiving Evidence Based Practice of Supported Employment

Maintain the percentage of consumers satisfied with services provided

State Indicators

Expenditures per capita will be equal to or greater than previous years

Expenditures per person served will be equal to or greater than previous years

Increase the number of individuals receiving case management/community support services

Maintain or increase the percentage of adults with SMI receiving mental health services

Maintain the percentage of adults with SMI living in rural areas who are receiving CPS funded mental health services

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

The Missouri Association for Social Welfare (MASW) completed a census of homeless shelters in 2001. (The survey conducted was a point-in-time count.) The census data was used by the Missouri Department of Economic Development as part of its Consolidated Plan to the US Department of Housing and Urban Development. That report showed 16,425 people being sheltered per day, an increase of 42% since the 1998 census. The sheltered homeless constitute a minority of homeless people. Numbers for the total homeless population (including people living on the streets and places not designed for human habitation, people living in homeless shelters and people who are doubled-up living arrangements with family and friends because they no longer have their own homes) were derived by applying an annualizing factor developed by Dr. Renee' Jahiel, New School of Social Work, New York, and the relative percentages of sheltered to unsheltered and hidden homeless populations in a national study by Dr. Bruce Link & Associates, Columbia University and Dr. Martha Burt, Urban Institute, Washington D.C. This methodology results in 45,700 homeless persons per day and 87,250 homeless persons per year. Unfortunately, there has not been a new census in Missouri since 2001. MASW is preparing to conduct a new census and is seeking the funding to do so at this writing. According to the 2003 – 2004 Homeless Children and Youth Census Report conducted by the Missouri Department of Elementary and Secondary Education, there are approximately 13,968 school-age children and youth that are homeless.

The MASW homeless census report estimates that 28% of the homeless are those with severe mental illness, 34% are addicted to drugs or alcohol and 10% are both mentally ill and addicted. Thus, we estimate that on any given day in the State of Missouri 12,796 homeless individuals have severe mental illness, 15,538 are addicted to alcohol or drugs and that another 4,570 have a dual diagnosis. Annually there are about 24,430 homeless mentally ill, 29,665 homeless who are substance addicted and 8,725 dually diagnosed homeless individuals in the State.

About 60% of the homeless population in Missouri is concentrated in the metropolitan regions of the State, 25% are located in small cities and 15% in rural areas. A further breakdown of data indicates 39% are located in the Gateway/St. Louis region; 13% in the Lakes/Springfield region; 22% in the Mid-America/Kansas City region; 9% in the Central I-70 Corridor/Columbia region; 11% in the Southeast region/Cape Girardeau, Kennett, Popular Bluff, Sikeston; and 6% in the Northern Tier/Northwest Region.

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

- 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 (MHSH) 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. This provider has doubled their use of PATH funding in two years time and continues to provide excellent service to the area's homeless population. In 2006 Missouri received approval for Technical Assistance for PATH providers across the State. Advocates for Human Potential will provide training and expertise in areas related to housing and employment for individuals with mental illness who are experiencing homelessness.

- **Shelter Plus Care** is a program designed to link rental assistance to supportive services on a long-term basis for homeless persons with disabilities, (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families who are living in places not intended for human habitation (e.g., streets) or in emergency shelters. The program allows for a variety of housing choices, and a range of supportive services funded by DMH, in response to the needs of the hard-to-reach homeless population with disabilities. Currently DMH has twenty-three (23) Shelter Plus Care grants. These grants provide rental assistance for over 1900 individuals and their families throughout fifty different counties expending over 6.5 million a year in rental assistance and 9 million in supportive services.
- The **Access Demonstration Grant** project, a five-year federal grant that recently expired. However, the Division of CPS received General Revenue funds to continue the outreach program initially started through the grant.

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.¹ 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.²

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/resources.php> It contains an assessment of mental health resources in Missouri and makes recommendations for individual actions and community collaborations.

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

² 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 12 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.^{3 4}

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.⁴

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.³ 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.⁴ 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

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

⁴ 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.⁵ 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.⁶ However, primary care providers do not always have the training needed to provide adequate mental health treatment. To meet this gap, some medical clinics are adding behavioral health units. In addition, 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. 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.⁷

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.⁷ Telehealth is being used to a limited degree to provide mental health services in Missouri; the shortage of mental health professionals is one of the barriers to the expansion. In addition, psychiatric services via telehealth are generally not reimbursable by Medicaid.

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

⁵ 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>

⁶ 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

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

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. On the Internet go to 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 Association. 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 Association has affiliates in St. Louis and Kansas City. The Mental Health Association 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 Association 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 - Resources for Providers

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

Adult and Child Plan
Criterion 5: Management Systems
Resources for Providers

Financial Resources

Missouri has experienced the effects of an extended overall economic slowdown over several years. A limitation on general revenue growth has caused the DMH to face core budget reductions, withholds and staff layoffs for five consecutive years. The DMH has experienced core net reductions on General Revenue state dollars of \$80.1 million in recent years. The total full-time equivalent positions have been reduced from 10,386 in fiscal year 2002 to 9,122 in fiscal year 2006. This has required the department to focus on protecting current services and programs while attempting to maximize the use of other funding sources.

Missouri's Governor and legislature are in the process of Transforming State Government. In 2006, Missouri passed legislation that will end the current Medicaid program in 2008. The Missouri Medicaid Reform Commission derived its charge and legislative authority from 208.014, RSMo. and Senate Concurrent Resolution 15 (2005) which stated that the work of the Commission shall include but not be limited to "clear and concise policy recommendations on reforming, redesigning, and restructuring a new, innovative state Medicaid healthcare delivery system." The Commission report and recommendations were provided to the legislature by January 1, 2006.

The DMH has an effective relationship with the State Medicaid Authority (Department of Social Services, Division of Medical Services). 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.

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

The DMH, in collaboration with the Missouri Medicaid Program, is offering the Missouri Mental Health Medicaid Pharmacy Partnership to evaluate the use of mental health medications and to offer education when opportunities exist to improve prescribing practices. The program, which is adjunctive to other efforts in the state, aims to reduce health-care costs to Medicaid patients. Over \$7 million Medicaid dollars has been saved by reducing medication costs.

Recent economic conditions in Missouri have resulted in withholds and reductions that have substantially limited growth. Even through this down turn the Division, with the resources available, is moving toward a participatory seamless integrated system of care more accessible and responsive to the needs of individuals with serious mental illness and children and youth

with serious emotional disturbance. The Mental Health Block Grant, PATH Grant, Olmstead Grant, Mental Health Mil Tax Boards, discretionary grant awards from SAMHSA, Medicaid and other community funding all help fund mental health services in Missouri. Missouri is 9th of the 50 states in receipt of discretionary (competitive grant) funding from SAMHSA for fiscal year 2005/2006.

The total budget for Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services is \$353,683,302 for Fiscal Year 2006. The federal Block Grant portion of the budget is \$6,944,057. Please refer to the *Grant Expenditure Manner* section for detail on Fiscal Year 2006 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.¹ 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.² 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.³ 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 designations even though the cities themselves do not. Ninety-six percent of Missouri’s rural

¹ 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.

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

³ 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.

counties are MHPSA. This compares to 62% of metro counties and 83% of urban/suburban counties.”⁴

Staffing in rural areas of the state continue to challenge service providers. An innovative telepsychiatry program has been implemented at the Administrative Agent Clark Community Mental Health Center. Located in rural southwest Missouri, Clark CMHC has 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 CSR 10-5.1090.

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 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.

⁴ 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>

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)

Clinical / Direct Consumer Care	Mean
Handling Difficult Behavior	3.90
Crisis Intervention/Critical Incidents	3.80
Critical Incident Reporting and Documentation	3.76
Co-Occurring Disorders/Dual Diagnosis	3.74
Clinical Best Practices	3.73
Consumer Treatment Planning (e.g., person-centered)	3.73
Trauma and Abuse Issues	3.66
Special Populations (e.g., geriatric, children, sex offenders)	3.63
Relationships with Consumers	3.60
Assessment Skills	3.57
Counseling/Therapy	3.56
Seclusion/Restraint	3.55
Abuse and Neglect (consumer)	3.54

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. The Division of Mental Retardation and Developmental Disabilities also partners with the other Department of Mental Health Divisions

by holding their annual Autism Conference at the same venue on overlapping dates. In 2006, over 900 professionals, administrators and consumers participated in the training.

CETV

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 is CETV. Providers and staff can access trainings on the internet and receive CEU's for a nominal fee. The web site for CETV is <http://www.mimhcetv.com/welcome/welcome.html>.

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 two full time staff supported through the Department of Health and Senior Services (DHSS) HRSA grant as well as a part-time intermittent administrative assistant. The HRSA Grant supports deliverables to DHSS and DMH staff and providers that includes planning and training activities, participation in exercises, interagency coordination, risk communication message development and crisis management.

In the last year the DMH has:

- Completed the Disaster Communications Guidebook for mental health risk communication messages. This Guidebook is being published through the Department of Health and Senior Services for Public Information Officers and others in DMH and DHSS in leadership roles.
- Coordinated an After Action meeting and written report after the evacuation of one of its facilities in an emergency event.
- Developed DMH Central Office COOP plan.
- Convened and facilitated committees to develop two resource CE's for planning for culturally diverse populations and for planning for children and youth.
- Continued to partner closely with other state level departments:
 - Department of Health and Senior Services:
 - Provided leadership to establish an ongoing mental health subcommittee for planning mental health response in pandemic flu scenarios to be modeled after information contained in the HHS plan.
 - Participated in the Pandemic Flu Summit, leading a discussion group related to mental health needs in a pandemic event.
 - Provision of psychological first aid training to hospital staff and public health care workers.
 - Placement of community mental health centers staff at Strategic National Stockpile exercise pods during the May, 2006 exercise.
 - Department of Public Safety, State Emergency Management Agency
 - Staff worked on committees to develop portions of the Missouri Homeland Security Grant including mass care planning especially for vulnerable populations, volunteers and donations.
 - Mental Health is working with SEMA to plan for a catastrophic event such as an earthquake in the New Madrid Fault line.
 - Participation in a Homeland Security Committee addressing School planning, including crisis counseling.

- Presentation of lessons learned regarding persons with special needs in the aftermath of hurricane Katrina at the annual SEMA conference.
 - Met with SEMA staff for EMAP accreditation for their agency.
 - Special Needs Planning for Region D- Annex X training for Region D Emergency Managers
 - Department of Agriculture
 - Participated in agriculture bird flu exercise with discussion about the mental health effects on farm families/producers that lost flocks of turkeys/chickens as well as discussion of quarantine.
- Developed and lead various trainings using curriculum jointly developed with St. Louis University Heartland Centers Those trainings include:
 - Development and presentation of: *Mental Health and Disasters: A Basic Approach for Pastoral Care*. This training will equip chaplains and clergy with the knowledge of psychological first aid as well as planning for their own congregations and their communities.
 - FEMA Crisis Counseling Program training for the Immediate Services grant and Phase 1 and 2 for Regular Services Grant for Hurricane Katrina.
 - Hurricane Katrina case manager training on psychological first aid
 - School personnel training at the Missouri School Counselors Association and the Missouri Association of Rural Education Conferences and three 6 hour curriculum trainings around the state on *Mental Health and Disasters: A Basic Approach for School Personnel*.
 - Curriculum training: *Mental Health and Disasters: A Basic Approach for Health Care Workers* for the Primary Care Association, a Southeast Missouri Hospital in the Earthquake zone and a 6 hour curriculum offering in Central Missouri; Additionally provided a conference presentation for the Public Health Nurses Conference: *Mental Health Needs and Shelters*.
 - Training for Kansas City area Community Mental Health Centers, 6 hour curriculum.
- Provided hospital plan components for mental health related planning to St. Louis Area Regional Response System (STARRS) St. Louis coordinator to initiate planning efforts, including coordination with hospital partners, designation of mental health representatives in planning efforts and opportunities for training participation.

Disaster Services Continuing Projects:

- Work with DHSS in developing pandemic plans and mental health resources for the general populations as well as resources unique to the special needs populations.
- Continue development of plans with DHSS to address special population needs by function
- Provide ongoing supervision for the FEMA Katrina Crisis Counseling Program and provide Phase 3 close out training.

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
 FY 2007 Block Grant Expenditure Proposal

Provider	Adult	Youth	Total
Adapt of Missouri	\$ 19,802	\$ -	\$ 19,802
East Central MO BH (formerly Arthur Center)	\$ 47,902	\$ 2,146	\$ 50,048
Bootheel Counseling Services	\$ 21,514	\$ 4,994	\$ 26,509
Burrell Center	\$ 733,038	\$ 2,517	\$ 735,555
Clark Community Mental Health	\$ 36,887	\$ 56,510	\$ 93,398
Community Health Plus - Park Hills	\$ 99,431	\$ -	\$ 99,431
Community Health Plus - St. Louis	\$ 651,624	\$ 88,871	\$ 740,495
Community Treatment	\$ 294,203	\$ 36,046	\$ 330,249
Comprehensive Mental Health	\$ 162,507	\$ 63,231	\$ 225,738
Comprehensive Health Systems	\$ 2,334	\$ -	\$ 2,334
Crider Center for Mental Health	\$ 464,712	\$ 117,085	\$ 581,797
Comprehensive Psychiatric Services CO	\$ 280,892	\$ 39,650	\$ 320,542
University Behavioral Health	\$ 159,675	\$ 21,242	\$ 180,917
Family Counseling Center	\$ 310,340	\$ 105,271	\$ 415,611
Family Guidance Center	\$ 32,054	\$ 4,362	\$ 36,416
Hopewell Center	\$ 491,897	\$ 13,622	\$ 505,519
Mark Twain Mental Health	\$ 173,462	\$ 37,619	\$ 211,081
North Central	\$ 276,971	\$ 14	\$ 276,986
Ozark Center	\$ 146,020	\$ -	\$ 146,020
Ozark Medical Center	\$ 31,120	\$ 397	\$ 31,517
Pathways Community Behavioral Health	\$ 391,032	\$ 67,634	\$ 458,667
Places For People	\$ 10,238	\$ -	\$ 10,238
ReDiscover Mental Health	\$ 279,152	\$ 32,696	\$ 311,848
Swope Parkway Mental Health Center	\$ 325,766	\$ 72,606	\$ 398,371
Tri-County Mental Health Services	\$ 193,169	\$ 44,744	\$ 237,912
Truman Behavioral Health	\$ 493,644	\$ 29,174	\$ 522,818
Total	<u>\$ 6,129,385</u>	<u>\$ 840,431</u>	<u>\$ 6,969,816</u>

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

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Access to Services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	7,487	7,218	6,499	N/A
Numerator	0		--	--
Denominator	0		--	--

Table Descriptors:

Goal:	Increase access to services
Target:	Decrease admissions to state hospital beds
Population:	Adults with SMI
Criterion:	2:Mental Health System Data Epidemiology 3:Children's Services
Indicator:	Number of admissions to acute care facilities (state hospitals)
Measure:	No numerator or denominator
Sources of Information:	CTRAC
Special Issues:	Adult SMI admissions are frequently linked to involuntary commitments and forensic issues beyond the control of the Department of Mental Health.
Significance:	An important outcome of the the development of a community based system of care is the reduced utilization of State operated psychiatric hospital beds and reduced average length of stay. The challenge it to increase the number of individuals served in the community. Reduction of State general revenue dollars over the past five years continue to strain the mental health system.
Action Plan:	State hospitals and community service providers will continue collaborative activities to keep individuals out of the hospitals when possible.

ADULT - GOALS TARGETS AND ACTION PLANS

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	6.10	8.70	9.36	9.36
Numerator	798	713	--	--
Denominator	13,072	8,170	--	--

Table Descriptors:

Goal:	Decrease rate of readmission to state psychiatric hospitals within 30 days
Target:	Continue to achieve a level of less than or equal to the baseline of 10.76% for the percentage of adults readmitted to state psychiatric hospitals within 30 days of discharge
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 to state psychiatric hospitals in fiscal year.
Sources of Information:	CTRAC
Special Issues:	Adult SMI admissions are frequently linked to involuntary commitments and forensic issues beyond the control of the department. The decreases in the department fiscal budget over the past five years has led to constraints on services.
Significance:	Community Psychiatric Rehabilitation Programs (CPRP) are Missouri's modified ACT programming. 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 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 when possible.

ADULT - GOALS TARGETS AND ACTION PLANS

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	15.10	14.52	14.85	N/A
Numerator	1,997	1,832	--	--
Denominator	13,249	12,619	--	--

Table Descriptors:

Goal:	Decrease the rate of readmission to State psychiatric hospitals within 180 days
Target:	This is a new data element for Missouri's block grant. In previous block grant applications, the department has reported average length of stay for adults admitted to State-operated acute inpatient hospitalizations. The division is in the process of developing a target for readmission 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 fiscal year.
Sources of Information:	CTRAC
Special Issues:	Adult SMI admissions are frequently linked to involuntary commitments and forensic issues beyond the control of the division.
Significance:	Community Psychiatric Rehabilitation Programs (CPRP) are Missouri's modified ACT programming. 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 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 when possible.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Practices

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	1	1	1	2
Numerator			--	--
Denominator			--	--

Table Descriptors:

Goal:	Increase the number of Evidence Based Practices utilized in the Missouri mental health system
Target:	Increase 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 consistently utilized in the Missouri mental health system
Measure:	Number of Evidence Based Practices consistently utilized in the Missouri mental health system. No numerator or denominator.
Sources of Information:	Department of Mental Health, Division of Comprehensive Psychiatric Services
Special Issues:	The Missouri Mental Health Employment Project grant has allowed for a fidelity assessment of the seven Community Mental Health Centers (CPS vendors) and four additional Vocational Rehabilitation vendors that provide Supported Employment services to consumers with psychiatric illness. All of the Community Mental Health Centers can provide long term clinical supports for employment through community support work and medication management. CPS is striving for integration of employment into clinical practice leading to improved outcomes of employment including the EBP of Supported Employment.
Significance:	CPS has one Evidence Based Practice of Supported Employment implemented in at least seven agencies across the State. The level of fidelity to the EBP toolkit model has been assessed. Through the Co-Occurring State Incentive Grant (COSIG), the DMH plans to implement a minimum of two sites with Integrated Dual Diagnosis Treatment to the fidelity of the EBP toolkit in fiscal year 2007. The possibility exists for additional IDDT sites to be added in future years.
Action Plan:	CPS is working towards integrating employment activities into all consumer individualized treatment plans, when appropriate, in the Community Mental Health Center system beyond these seven programs. CPS is also working to consistently implement Integrated Dual Diagnosis Treatment and Assertive Community Treatment evidence based practices in the mental health system.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Employment

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	236	444	460	480
Numerator			--	--
Denominator			--	--

Table Descriptors:

Goal:	Increase the number of individuals receiving Evidence Based Practice of Supported Employment
Target:	Increase the number 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:	Number 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:	Number of individuals receiving the Evidence Based Practice of Supported Employment through cooperative services between the Community Mental Health Centers and Missouri Division of Vocational Rehabilitation. No numerator or denominator.
Sources of Information:	Missouri Department of Elementary and Secondary Education, Division of Vocational Rehabilitation
Special Issues:	The Division of CPS received a National Institute of Health grant to survey their Supported Employment Services. National experts in the field have consulted with CPS and VR to strength the system for employment opportunities for consumers.
Significance:	The Division of Comprehensive Psychiatric Services and the Division of Vocational Rehabilitation have a strong working relationship. Using the Vocational Rehabilitation federally mandated definition of employment from the U.S. Department of Education, 313 individuals of the 444 CPS/VR clients receiving Supported Employment services were successfully employed. Thus, the success rate for VR clients served by DMH/CPS is 70%. Supported Employment is only a subset of clients employed through this successful collaboration; 1042 total individuals were successfully employed in Fiscal Year 2005 through the CPS/VR partnership utilizing various models of employment; 313 of those were Supported Employment clients leaving 729 CPS/VR clients successfully employed through other models.
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.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Client Perception of Care

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	90	90	90
Numerator	0	2,424	--	--
Denominator	0	2,498	--	--

Table Descriptors:

Goal:	Clients reporting positively about outcomes
Target:	The target is that more than 75% of the respondents to the Consumer Satisfaction Survey will be satisfied or very satisfied with the services received.
Population:	All adults receiving Community Psychiatric Services during a chosen month each year.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Percentage of adults 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 during one month of the year on all consumers receiving services during that month.
Significance:	Consumers were satisfied with services received at a high rate.
Action Plan:	The department will continue to revise the consumer satisfaction survey process to utilize new technologies and improved questions.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Adult Expenditures per capita

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	67.32	68.29	69.65	N/A
Numerator	283,362,507	287,474,527	--	--
Denominator	4,209,334	4,209,334	--	--

Table Descriptors:

Goal:	Maintain expenditures per capita
Target:	Expenditures per capita will be equal to or greater than previous years
Population:	Adults with SMI.
Criterion:	5:Management Systems
Indicator:	CPS expenditures per capita
Measure:	The numerator is the CPS expenditures on adult consumer services. The denominator is the population of Missouri.
Sources of Information:	expenditure report and population data
Special Issues:	Decrease in state general revenue dollars over the past five years has strained the mental health system.
Significance:	Developing and maintaining a system of care and equitable allocation of resources are essential to providing mental health services to the target population.
Action Plan:	To maintain existing community-based services and increase effectiveness through State general revenue and/or other resources.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Adult Expenditures per person served

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	5,040	4,939	5,117	N/A
Numerator	283,362,507	287,474,527	--	--
Denominator	56,219	58,210	--	--

Table Descriptors:

Goal: Maintain expenditures per person served

Target: Expenditures per person served will be equal to or greater than previous years

Population: Adults with SMI

Criterion: 5:Management Systems

Indicator: CPS Average Expenditures per person served

Measure: The numerator is CPS expenditures on adult consumer services. The denominator is number of persons served.

Sources of Information: Expenditures Report

Special Issues: Decrease in state general revenue dollars over the past five years has strained the mental health system

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

Action Plan: To maintain existing community based services and increase effectiveness through State general revenue and/or other resources

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Case Management Services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	33,667	37,068	38,723	38,900
Numerator			--	--
Denominator			--	--

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 constraints have limited enhancing the current mental health services system to a full Assertive Community Treatment model of care. The DMH is exploring financial options for providing a more comprehensive array of services per the Assertive Community Treatment model.
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. The number of individuals participating in the Comprehensive Psychiatric Rehabilitation Programs for fiscal year 2005 was 26,027 and the projected number for fiscal year 2006 is 29,431.
Action Plan:	CPS is requesting general revenue funding to expand the services provided to include the Assertive Community Treatment evidence based practice model within four selective agencies. With additional resources and a team approach more consumers can live health lives in their communities.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Percentage of adults receiving services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	23.40	24	23.87	24
Numerator	56,219	57,754	--	--
Denominator	239,932	239,932	--	--

Table Descriptors:

Goal:	Provide mental health services to the target population of adults with SMI
Target:	Maintain or increase the percentage of adults with SMI receiving mental health services
Population:	Adults diagnosed with SMI.
Criterion:	2:Mental Health System Data Epidemiology
Indicator:	Percentage of adults with SMI who receive CPS funded services versus the estimated prevalence of SMI in Missouri
Measure:	The numerator is the number of adults with SMI served with CPS funds. The denominator is the estimated prevalence of SMI at 5.7% of population.
Sources of Information:	CTRAC; provider billing database; federal census and SMI prevalence table
Special Issues:	Mental health services are underfunded both nationally and in the State of Missouri.
Significance:	Due to fiscal constraints, Missouri is only meeting the mental health needs of 24% of the estimated prevalence.
Action Plan:	The DMH and CPS will continue to explore funding opportunities to meet the mental health needs of Missourians.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Rural adults receiving mental health services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	20.40	20.60	19.93	20
Numerator	40,311	40,695	--	--
Denominator	197,678	197,678	--	--

Table Descriptors:

Goal:	Maintain access and capacity of mental health services to adults with SMI who live in rural areas
Target:	Maintain the percentage of adults with SMI living in rural areas who are receiving CPS funded mental health services
Population:	Adults with SMI
Criterion:	4:Targeted Services to Rural and Homeless Populations
Indicator:	Percentage of adults with SMI in rural areas receiving CPS funded mental health services
Measure:	The numerator is number of adults with SMI served in rural Missouri. The denominator is adult SMI prevalence at 5.7% for rural Missouri.
Sources of Information:	CTRAC; 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 adults with SMI in rural and semi-rural areas of the state.

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.

See Adult - Establishment of System of Care

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 disturbances. These community-based services are designed to maximize independent functioning and promote recovery and self-determination. In addition, they are designed to increase the interagency coordination and collaboration in all aspects of the treatment planning process. Ultimately, the services help to reduce inpatient hospitalizations and out-of-home placements. At intake children and youth are required to have a medical examination. Community Support Workers with the CPR program keep track 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 Community Support services are the heart of CPR programming. The CPR program is also developing strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to 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.

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. Individuals 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.

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 service. Day treatment may include vocational education, rehabilitation services, individual and group therapies and educational service. Youth preparing for jobs are referred to the local Vocational Rehabilitation services through an agreement with Community Psychiatric Services providers and Vocational Rehabilitation.

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 disturbance and/or acute crisis. This service provides parent-to-parent guidance that is directed and authorized by the treatment plan. Some of the activities provided in this service are: problem solving, emotional support, disseminating information, and linking to services.

Treatment Family Homes provides individualized treatment within a community-based family environment with specially trained foster parents. It allows out-of-home services for those children who need them. Children are able to remain in their own community and often in their home school districts. Training for these homes was developed in collaboration with the DOSS and agreements at the local level allow for these homes to be used by both child serving agencies.

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

Substance Abuse Services

The CPR program is also developing strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to **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. 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 more easily accessible in most areas, some individuals living rurally must travel to larger communities to be seen and treated for medical or dental conditions. Many community providers rely on donations to assist with the payment of medical and dental services for their consumers. Providers are finding it difficult to raise more donations to cover consumers who no longer qualify for Medicaid.

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 disturbances, 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 billing code for parent support 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 disturbance. 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.

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; d) dissemination of relevant research, instructional strategies, and adoption of effective practices.

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

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

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

The Center has continued to educate school based personnel through an online graduate degree program with a focus in mental health. Student can progress toward either a Master's degree or a post Master's Educational Specialist degree. To date, there are 47

graduate students, (23 Masters and 24 Educational Specialists) enrolled in the formal degree programs from around the State of Missouri, the United States and overseas.

The Center's online courses are taught by a variety of doctoral level professionals from around the United States, including ESCP faculty. These professionals range from a variety of disciplines including medicine, nursing, law, psychology, psychiatry, special and general education and educational leadership. Sample course titles include: Building Resiliency and Optimism, Wellness Management for School Personnel, Psychiatric Disorders in the Classroom and Youth Violence and Bullying. Courses are also taught at the undergraduate level to increase the mental health knowledge and skills of preservice teachers by applying psychological research for today's educator.

This year, the Center was proud to graduate its first two graduating classes from the online graduate degree program totaling 12 students. Center staff continues to develop a number of specific academic content modules which represent knowledge/competency-based needs designed to directly assist individuals on their job. The Center is currently developing and translating these modules into sanctioned online coursework also available for student continuing education credit.

Center staff delivered a number of scholarly presentations at the Ninth National Advancing School-Based Mental Health conference on activities and issues impacting state, national and global mental health school issues in Dallas, Texas.

Five Center proposals were accepted for representation at the Ninth Annual National Conference on Advancing School-Based Mental Health Programs, scheduled fall 2005 in Cleveland, OH.

Center staff provided in-service trainings on *Creating Mentally Healthy Classrooms* to select teachers in Missouri. Center staff designed and integrated a weekly leadership group with middle school students at risk for exhibiting bullying behaviors. 21 ESCP graduate students have rotated through the Center as paid graduate research assistants. Example duties include program design, curriculum development, providing consultation and other outreach services to agencies, schools and families, teaching, research, etc.

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

Thirteen regional focus groups were conducted to generate the final report. Throughout the focus group discussions, participants were explicitly asked for their recommendations for creating a shared agenda in Missouri, at both the state and local levels. These recommendations were subsequently compiled and offered for review at a final gathering of focus groups participants held at the University. As a result, recommendations for combating the barriers to a shared agenda emerged from several sources: the original focus group discussions, the final meeting of participants, University personnel responsible for conducting and analyzing the focus groups, and government officials from both DMH and DESE. The full report from the Shared Agenda Project is available at:

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

Case Management Services

Intensive Targeted Case Management (ITCM) – Children already admitted to the system are eligible for ITCM. The service supports children and families by linking them to the service system and coordinating the various services they receive. Case managers work with the families, treatment providers and other child-serving agencies to assist the children to remain in or progress toward least-restrictive environments. 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 **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. 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

Senate Bill 1003 was enacted into law in 2004 to reform the current children's mental health delivery system. Senate Bill 1003 requires the development of a comprehensive plan for children's mental health services. The plan was delivered to the Governor and General Assembly in December, 2004. When fully implemented, this plan will ensure that all of Missouri's children 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 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.* Appendix A attached has the detailed plan for Reforming Children's Mental Health Services in Missouri.

Additionally, Missouri has several System of Care grants for children and youth services. 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* and out of the hospitals. 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.

In System of Care, children with the most challenging mental health issues, particularly those who are involved with multiple agencies have a local coordinated team of individuals that work to meet with the family's needs for as long as is necessary. This team is referred to as the Family Support Team. Many such teams (though perhaps under different names) already exist for children with complex needs. In addition to the Family Support Team, a System of Care brings a Local System of Care Policy Group into plan. The Local SOC Policy Group's functions include reviewing and identifying policy (local and state) that may be creating a barrier to children getting their needs met. It is also responsible for contributing appropriate resources from its member agencies (for example, dollars or in-kind services), to assist in meeting the needs of a child being served in System of Care.

Show-Me Kids is an example of a System of Care program in the Southwest region of Missouri. Show Me Kids is primarily funded through a six-year federal cooperative agreement awarded through the Missouri Department of Mental Health. Their fourth fiscal year began October 2005. Local project development is managed through partnerships with community agencies Burrell Behavioral Health and Clark Community Mental Health. Other partners included: the Springfield Regional Center; Missouri Statewide Parent Advisory Network; the Missouri Departments of Elementary & Secondary Education, Children's Division, Juvenile Justice Offices, the Division of Youth Services; local schools; the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, the Center for Mental Health Services; and many more children and family-serving organizations within 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

Missouri Department of Mental Health									
2005 Estimated Census Data and Prevalence Rates									
FY2006 Clients Served By Service Area									
SA	Tot. Est. Popn	Adults	Children	Adlt Prevalence	Child Prevalence	SMI Adults Served	SED Child Served	Rural	Rural
	2005			at 5.7%	at 7%	FY06	FY06	Adult	Child
01	176,898	134,056	42,842	7,641	2,999	1,469	997	1,469	997
02	103,892	76,053	27,839	4,335	1,949	3,612	439		
03	100,451	77,022	23,429	4,390	1,640	929	83		
04	289,268	212,374	76,894	12,105	5,383	761	87		
05	167,622	124,470	43,152	7,095	3,021	1,145	322		
KCsub						4,749	2,253		
KC	661,233	489,919	171,314	27,925	11,992	11,196	3,184		
06	305,091	224,495	80,596	12,796	5,642	3,354	647	3,354	647
07	175,752	127,870	47,882	7,289	3,352	843	477	843	477
08	190,851	143,028	47,823	8,153	3,348	1,810	706	1,810	706
09	200,558	147,424	53,134	8,403	3,719	3,326	943	3,326	943
10	466,292	353,504	112,788	20,150	7,895	4,211	1,667	4,211	1,667
11	230,670	172,591	58,079	9,838	4,066	1,489	507	1,489	507
12	311,932	236,860	75,072	13,501	5,255	2,512	586	2,512	586
13	79,836	59,855	19,981	3,412	1,399	1,158	414	1,158	414
14	106,299	80,686	25,613	4,599	1,793	1,415	474	1,415	474
15	118,119	88,308	29,811	5,034	2,087	1,874	588	1,874	588
16	497,205	352,198	145,007	20,075	10,150	1,704	667	1,704	667
17	199,950	150,033	49,917	8,552	3,494	2,942	862	2,942	862
18	121,898	90,635	31,263	5,166	2,188	1,307	198	1,307	198
19	132,688	98,795	33,893	5,631	2,373	2,350	665	2,350	665
20	104,679	77,333	27,346	4,408	1,914	1,343	569	1,343	569
21	131,002	98,424	32,578	5,610	2,280	1,063	248	1,063	248
22	211,049	151,325	59,724	8,626	4,181	1,611	273	1,611	273
23	1,010,530	755,902	254,628	43,086	17,824	4,462	747	4,462	747
24	124,588	91,584	33,004	5,220	2,310	3,262	626		
25	200,978	152,510	48,468	8,693	3,393	1,934	150		
STLsub						828	65		
STL	325,566	244,094	81,472	13,913	5,703	6,024	841		
Out of State						250	17		
Unknown						500	599		
TOTAL	5,758,098	4,277,335	1,480,763	243,808	103,653	58,213	16,876	40,243	12,235
RURAL (EXCLUDES COUNTIES	4,771,299	3,543,322	1,227,977	201,969	85,958				

095 & 510)									
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Definition of Serious Emotional Disturbance Among Children

Missouri's estimate of prevalence and definition is consistent with federal definition and methodologies. Based upon a 7% prevalence rate, it is estimated that approximately 103,653 Missouri youth experience serious emotional disturbance (SED). However, not all of these youth seek services from the public sector. The number of children and youth who receive CPS-funded services has consistently increased in the past several years. The Division served 16,876 children and youth during FY 2006.

The current definition of a youth with SED is consistent with the Federal Definition of SED. SED is defined in Missouri as:

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

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

CHARACTERISTICS OF CLIENTS SERVED (Community Programs, including Residential)
UNDULICATED CPS CONSUMERS
 State: MISSOURI
 Fiscal Year: 2006

	Statewide	Eastern	Central	Northwest	Southwest	Southeast	Region Unknown	Out of State
Total People Served	71,763	15,477	8,522	23,294	12,484	10,763	1,047	176
Total Population (Estimated Census 2004)	5,754,618	2,055,504	760,606	1,394,322	854,335	689,851		
Number of People Served per 1000 Population	12.5	7.5	11.2	16.7	14.6	15.6		
Age								
0-03	148	3	7	46	65	19	8	.
04-12	8,456	1,106	973	3,028	1,860	1,120	366	3
13-17	8,087	1,402	1,059	2,606	1,389	1,397	225	9
18-20	2,572	511	324	926	418	356	28	9
21-30	11,243	2,326	1,363	3,934	1,977	1,514	84	45
31-45	21,241	4,879	2,489	6,764	3,693	3,178	178	60
46-64	18,047	4,721	2,073	5,457	2,825	2,781	143	47
65-74	1,450	394	182	379	185	295	14	1
75+	496	133	50	137	71	103	.	2
Not Available	23	2	2	17	1	.	1	.
Gender								
Female	37,160	7,741	4,490	11,798	6,613	5,915	533	70
Male	34,603	7,736	4,032	11,496	5,871	4,848	514	106
<i>Total Male Population</i>	<i>2,810,852</i>	<i>990,855</i>	<i>378,656</i>	<i>682,697</i>	<i>418,902</i>	<i>339,742</i>		
Number of Males Served per 1000 Male Population	12.3	7.8	10.6	16.8	14.0	14.3		
<i>Total Female Population</i>	<i>2,943,766</i>	<i>1,064,649</i>	<i>381,950</i>	<i>711,625</i>	<i>435,433</i>	<i>350,109</i>		
Number of Females Served per 1000 Female Population	12.6	7.3	11.8	16.6	15.2	16.9		
Race/Ethnicity								
Caucasian	53,721	8,296	7,635	15,189	11,751	9,836	877	137
African American	14,973	6,811	625	6,423	207	745	134	28
American Indian	288	29	37	118	70	34	.	.
Asian	188	53	19	85	21	8	1	1
Hispanic	1,071	66	33	868	46	46	4	8
Other	831	163	89	438	49	60	30	2
Not Available	691	59	84	173	340	34	1	.
Number of Caucasians Served per 1000 Caucasian Population	10.9	5.2	10.9	13.0	14.4	15.2		
Number of African Americans Served per 1000 African Am. Population	22.6	17.0	14.9	36.1	19.7	25.0		
Number of American Indians Served per 1000 Am. Indian Population	10.9	6.2	11.3	17.4	8.9	8.7		
Number of Asians Served per 1000 Asian Population	2.5	1.3	2.3	5.2	3.7	2.4		
Number of Hispanics Served per 1000 Hispanic Population	7.2	1.9	2.1	13.5	1.9	5.6		

Diagnoses (DSM IV Codes)								
Alzheimers and Organic Brain (290,293,294,331.0)	375	91	44	86	82	69	.	3
Anxiety (300- 300.02,300.3,308.3,309.21,309.81)	4,795	863	528	1617	869	797	112	9
Attention Deficit (314)	4,771	710	694	1533	839	784	207	4
Conduct (312.8,312.9,313.81)	1,768	229	169	668	351	302	48	1
Delusion & Other Psychoses (297,298)	1,227	373	86	460	136	149	11	12
Depressive and Mood Disorders (296,300.4,301.13)	30,997	6,980	4,110	9,088	5,381	4,944	435	59
Mental Retardation, Autism, and Specific Development (299,315 except 315.4,317-319)	126	21	20	30	29	22	3	1
No Diagnosis, Deferred, Not Available	7,335	567	639	3449	1749	890	22	19
Other Childhood Disorders (307.0,307.2- 307.23,307.52-307.59,307.6- 307.7,313.23,313.89,313.9,315.4,787.6)	187	41	18	38	69	16	5	.
Other MH Diagnoses	6,387	920	693	2,375	1,295	974	106	24
Personality Disorders (301 except 301.13,312.3)	512	97	66	154	86	96	11	2
Schizophrenia (295)	10,722	3,862	1,214	2,735	1,336	1,469	85	21
Substance Abuse (291-292,303-305)	2,561	723	241	1061	262	251	2	21
Major Mental Illness								
Adults with Major Mental Illness (Age 18 & over & DSM 295/296)	36,375	9,879	4,692	9,869	5,885	5,614	363	73
Other Adults	18,697	3,087	1,791	7,745	3,285	2,613	85	91
Children with Major Mental Illness (under age 18 & DSM 295/296/314)	8,510	1,435	1,234	2,813	1,432	1,272	318	6
Other Children	8,181	1,076	805	2,867	1,882	1,264	281	6
Race/Gender Crosstab								
NonWhite Female 0 to 17	1,619	446	103	838	107	97	26	2
NonWhite Female 18 to 59	6,571	2,812	291	2,856	214	330	52	16
NonWhite Female 60 plus	555	303	26	196	7	19	3	1
NonWhite Male 0 to 17	3,005	818	160	1,560	195	215	57	.
NonWhite Male 18 to 59	6,017	2,661	293	2,566	200	249	28	20
NonWhite Male 60 plus	272	141	13	87	10	17	4	.
White Female 0 to 17	4,485	450	693	1,191	1,070	893	182	6
White Female 18 to 59	21,800	3,312	3,078	6,173	4,823	4,117	254	43
White Female 60 plus	2,110	416	298	529	391	459	15	2
White Male 0 to 17	7,575	797	1,083	2,089	1,937	1,331	334	4
White Male 18 to 59	16,707	3,113	2,323	4,952	3,353	2,802	84	80
White Male 60 plus	1,024	206	159	240	176	234	7	2

Missouri

Child - Quantitative Targets

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

Child – Quantitative Targets

National Outcome Measure Performance Indicators

Reduce or maintain the average length of stay for children and youth in inpatient hospitalization

Achieve a level of less than the FY2005 rate of 6.5% of children and youth readmitted to State psychiatric inpatient care within 30 days of discharge

Decrease the rate of readmission to State psychiatric hospital beds within 180 days

Provide one Evidence Based Practice of Therapeutic Foster Care Programs to children and youth with SED

Maintain or increase the number of children receiving services in Therapeutic Foster Care

Maintain the 90% level of consumer satisfaction with services provided

State Performance Indicators

Expenditures per capita will be equal to or greater than previous years

Expenditures per person served will be equal to or greater than previous years

Increase the number of Children's System of Care local teams

Increase or maintain the percentage of children and youth with SED who receive CPS-funded services

Maintain or increase the percentage of days children and youth with SED spend in home or homelike settings

Maintain or increase the percentage of children and youth with SED in rural areas receiving CPS funded mental health services

Maintain the low rate of children and youth with SED expelled from school

Maintain or decrease the percentage of children and youth with SED in out-of-home placement

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.

Social Services

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

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

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

- Development of a Comprehensive Children's Mental Health State Management Team whose functions include oversight, coordination, and technical assistance to ensure implementation of a comprehensive children's mental health system. This committee consists of representatives from: **The Department of Social Services: Children's Division, Division of Youth Services and Division of Medical Services; The 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; The Office of State Court Administrators: Juvenile Court; parents; parent advocacy groups; and representatives from each of the geographic local systems of care.** This group meets at least once a month.
- Development and implementation of a quality service review process for assessing the level of success of children living in their communities who are served by the local system of care groups.

The DMH has been awarded two six-year federal grants from the SAMHSA to support system of care development through creation of an integrated interagency community-based system of care for children with severe emotional disturbance and their families. One grant serves six rural southwest counties: Greene, Christian, Taney, Stone, Barry and Lawrence and the other serves the St. Louis area. Local project development for the southwest counties is managed through partnerships with two Department of Mental Health Administrative Agents: Burrell Behavioral Health and the Clark Center and the St. Louis project is managed by BJC Behavioral Health Community Services and Hopewell Center. Lessons learned through these projects have been infused into Missouri's comprehensive children's mental health system.

The Department of Mental Health has ten System of Care sites operating in Missouri. In addition to the two sites federally funded through the SAMHSA Comprehensive Children's Mental Health Services grants, one site is a graduate of the federal funding and seven are state system of care sites. 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.

Educational 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 service. Day treatment may include vocational education, rehabilitation services, individual and group therapies and educational service. Youth preparing for jobs are referred to

the local Vocational Rehabilitation services through an agreement with Community Psychiatric Services providers and Vocational Rehabilitation.

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.

Juvenile Justice Services

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).

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

- **Missouri Juvenile Justice Information System (MOJJIS)** is the response to statute which intends to have the divisions of circuit courts and the departments of social services, mental health elementary and secondary education and health share information regarding individual children who have come into contact with or been provided service by, the courts and cited departments. The Department of Mental Health participates in this effort while maintaining compliance with HIPAA and AOD Confidentiality Laws.
- **Juvenile Justice Advisory Group (JJAG)** provides leadership and education to the people of Missouri in the area of juvenile justice and ensures the safety and well being of all youth, their families and community. JJAG serves as the conduit for federal, state and

local education, treatment and prevention services. This group advises the Governor and the Department of Public Safety, which maintains compliance with the Juvenile Justice and Delinquency Prevention Act of 1974.

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

Substance Abuse Services

The CPR program is also developing strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to 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. 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.

Health and Mental Health Services

The Comprehensive Children's Mental Health System provides the framework to link effectively with other plans that target the health and mental health needs of children and families. The DMH has worked cooperatively with schools and public health to develop training called *Promoting Resiliency in Children, Families and Communities: Connecting Schools, Public Health and Mental Health*. School, public health and mental health experts developed the workshops to look at new ways of collaborating on issues that affect the mental health of Missouri's children. The workshop focuses on enhancing available services to promote resilient children, strong families and healthy communities. The first round of training was completed from November 15 to December 8, 2005. The trainings took place in six locations around the

State for easy access to each region. A second round of trainings is being planned. The workshop features national presenters Ellen Kagen, MSW and Neal Horen, Ph.D. from the National Technical Assistance Center for Children's Mental Health, Georgetown University and Rochelle Mayer, Ed.D., from Bright Futures at Georgetown University. The workshop was for school, public health and mental health professionals.

Goal 1 of the New Freedom Commission Report: Americans Understand that Mental Health is Essential to Overall Health is addressed in Missouri's Suicide Prevention Plan. The State Suicide Prevention Plan, like the Comprehensive Children's Plan, emphasizes the public health approach and the collaboration of multiple agencies. The assessment of the risk and protective factors and the subsequent intervention strategies around suicide prevention are consistent with strategies of the comprehensive mental health plan. Mental disorders and substance abuse are risk factors that can increase the likelihood of suicide. Detailed steps being achieved on the Suicide Prevention Plan are highlighted in the Child – Strengths and Weaknesses section of the Block Grant.

The State Disaster Plan to address mental health needs of children following a disaster also must be linked to the Comprehensive Children's Plan. A disaster can impact the emotional, behavioral, and cognitive status of children. The strategies of the state's disaster plan for children include identifying high-risk children, screening and treatment. These strategies are consistent with the Comprehensive Children's Plan.

Missouri

Child - Geographic Area Definition

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

Missouri

Child - Outreach to Homeless

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

See Adult-Outreach to Homeless

Missouri

Child - Rural Area Services

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

See Adult-Rural Area Services

Missouri

Child - Resources for Providers

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

See Adult Plan, Criterion 5:Management Systems, Resources for Providers

Missouri

Child - Emergency Service Provider Training

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

See Adult Plan section, Criterion 5: Management Systems, 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

Department of Mental Health
Division of Comprehensive Psychiatric Services
FY 2007 Block Grant Expenditure Proposal

Provider	Adult	Youth	Total
Adapt of Missouri	\$ 19,802	\$ -	\$ 19,802
East Central MO BH (formerly Arthur Center)	\$ 47,902	\$ 2,146	\$ 50,048
Bootheel Counseling Services	\$ 21,514	\$ 4,994	\$ 26,509
Burrell Center	\$ 733,038	\$ 2,517	\$ 735,555
Clark Community Mental Health	\$ 36,887	\$ 56,510	\$ 93,398
Community Health Plus - Park Hills	\$ 99,431	\$ -	\$ 99,431
Community Health Plus - St. Louis	\$ 651,624	\$ 88,871	\$ 740,495
Community Treatment	\$ 294,203	\$ 36,046	\$ 330,249
Comprehensive Mental Health	\$ 162,507	\$ 63,231	\$ 225,738
Comprehensive Health Systems	\$ 2,334	\$ -	\$ 2,334
Crider Center for Mental Health	\$ 464,712	\$ 117,085	\$ 581,797
Comprehensive Psychiatric Services CO	\$ 280,892	\$ 39,650	\$ 320,542
University Behavioral Health	\$ 159,675	\$ 21,242	\$ 180,917
Family Counseling Center	\$ 310,340	\$ 105,271	\$ 415,611
Family Guidance Center	\$ 32,054	\$ 4,362	\$ 36,416
Hopewell Center	\$ 491,897	\$ 13,622	\$ 505,519
Mark Twain Mental Health	\$ 173,462	\$ 37,619	\$ 211,081
North Central	\$ 276,971	\$ 14	\$ 276,986
Ozark Center	\$ 146,020	\$ -	\$ 146,020
Ozark Medical Center	\$ 31,120	\$ 397	\$ 31,517
Pathways Community Behavioral Health	\$ 391,032	\$ 67,634	\$ 458,667
Places For People	\$ 10,238	\$ -	\$ 10,238
ReDiscover Mental Health	\$ 279,152	\$ 32,696	\$ 311,848
Swope Parkway Mental Health Center	\$ 325,766	\$ 72,606	\$ 398,371
Tri-County Mental Health Services	\$ 193,169	\$ 44,744	\$ 237,912
Truman Behavioral Health	\$ 493,644	\$ 29,174	\$ 522,818
Total	<u>\$ 6,129,385</u>	<u>\$ 840,431</u>	<u>\$ 6,969,816</u>

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

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Access to Services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	16.90	21.20	18.30	18
Numerator	12,758	14,617	--	--
Denominator	751	687	--	--

Table Descriptors:

Goal:	Increase access to community based acute care services for children and youth by decreasing or maintaining the length of stay to State-operated acute inpatient hospitalization
Target:	Reduce or maintain the average length of stay for children and youth in inpatient hospitalization
Population:	Children and youth with SED
Criterion:	2:Mental Health System Data Epidemiology 3:Children's Services
Indicator:	Average length of stay in days for children and youth in State-operated acute inpatient hospitalization
Measure:	The numerator is the total number of inpatient hospitalization bed days for children and youth. The denominator is the number of children and youth discharged from inpatient hospitalization.
Sources of Information:	CTRAC
Special Issues:	The total number of children and youth that are served by the Division is expected to remain stable or increase as the system of care expands. The hope is that the relative overall utilization and average length of stay in State-operated psychiatric hospitals will decrease as community-based alternatives are developed. Recent funding limitations and changes in funding for Foster Care may have a negative impact on this indicator.
Significance:	A major outcome of the development of a community-based system of care is the reduced re-admission to State-operated psychiatric hospital beds and a reduced average length of stay.
Action Plan:	Develop and support community based resources to help reduce length of hospital stays for children and youth in the Missouri mental health system. The department is pursuing collection of data to form a more accurate picture of length of stay for particular clients.

CHILD - GOALS TARGETS AND ACTION PLANS

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	3.30	6.50	4.55	4.50
Numerator	40	46	--	--
Denominator	1,215	706	--	--

Table Descriptors:

Goal:	Decrease the rate of readmission within 30 days to State psychiatric hospital beds
Target:	Achieve a level of less than the FY2005 rate of 6.5% of children and youth readmitted to State psychiatric inpatient care within 30 days of discharge.
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:	CTRAC
Special Issues:	The total number of children and youth that are served by the Division is expected to remain stable or increase as the system of care expands.
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

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	9.10	12.32	11.62	N/A
Numerator	94	113	--	--
Denominator	1,038	917	--	--

Table Descriptors:

Goal:	Decrease the rate of readmission to State psychiatric hospital beds within 180 days
Target:	This is a new data element for Missouri's block grant. In previous block grant applications, the average length of stay for children and youth admitted to State-operated acute inpatient hospitalizations was reported. The division is in the process of developing a target for readmission 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:	CTRAC
Special Issues:	The total number of children and youth that are served by the Division is expected to remain stable or increase as the system of care expands. The hope is that the relative overall utilization and average length of stay in State-operated psychiatric hospitals will decrease as community-based alternatives are developed. Recent funding limitations and changes in funding for foster care may have a negative impact on this indicator.
Significance:	A major outcome of the development of a community-based system of care is the reduced readmission to State-operated psychiatric hospital beds and a reduced average length of stay.
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. 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

Name of Performance Indicator: Evidence Based - Number of Practices

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	1	1	1	1
Numerator			--	--
Denominator			--	--

Table Descriptors:

Goal:	Provide one Evidence Based Practice of Therapeutic Foster Care Programs to children and youth with SED
Target:	Maintain the number of licensed Therapeutic Foster Care Programs 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

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Therapeutic Foster Care

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	100	108	110	115
Numerator			--	--
Denominator			--	--

Table Descriptors:

Goal:	Increase the number of SED children and youth receiving the Evidence Based Practice of Therapeutic Foster Care
Target:	Maintain or increase the number of children receiving services in Therapeutic Foster Care
Population:	Children and youth with SED
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Number of children and youth with SED receiving Therapeutic Foster Care (No numerator or denominator)
Measure:	Number of children and youth with SED receiving Therapeutic Foster Care
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.
Significance:	The department meets the definition of Therapeutic Foster Care provided in the application instructions.
Action Plan:	Continue to refine the collection of data to accurately measure Therapeutic Foster Care number of clients served

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Client Perception of Care

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	87	92.30	92	92
Numerator	365	350	--	--
Denominator	420	379	--	--

Table Descriptors:

Goal:	Maintain high level of consumer satisfaction
Target:	Maintain the 90% level of consumer satisfaction with services provided
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 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
Special Issues:	The Consumer Satisfaction Survey is conducted during one month of the year on all consumers receiving services during that month.
Significance:	Parents of children with SED were satisfied with services received at a high rate.
Action Plan:	The department will continue to revise the consumer satisfaction survey process to utilize new technologies and improved questions.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Expenditures per capita

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	36.06	38.35	37.36	38.35
Numerator	51,287,001	54,543,690	--	--
Denominator	1,422,210	1,422,210	--	--

Table Descriptors:

Goal:	Maintain expenditures per capita
Target:	Expenditures per capita will be equal to or greater than previous years
Population:	Children with SED
Criterion:	5:Management Systems
Indicator:	Per capita expenditures for SED children receiving CPS funded services
Measure:	The numerator is the CPS expenditures on children consumer services. The denominator is the child and youth population of Missouri.
Sources of Information:	expenditure report and census data
Special Issues:	A decrease in State of Missouri general revenue dollars over the past five years has strained the mental health system. CPS has attempted to maintain spending per capita; however, the decreases have effected the amount available for children's services for FY 2006. Additionally the population of Missouri has increased and general revenue has not increased in kind.
Significance:	The expenditures per capita for FY 2005 Actual have increased from the FY 2004 amounts. The FY 2006 projected numbers are decreased due to the above mentioned state general revenue decreases.
Action Plan:	The Statewide Comprehensive Children's System of Care will continue the collaboration of state and local agencies to ensure dollars are use effectively and efficiently to treat the most numbers of children with the services needed for recovery.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Expenditures per person served

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	3,590.02	3,469.92	3,277.78	N/A
Numerator	51,287,001	54,543,690	--	--
Denominator	14,286	15,719	--	--

Table Descriptors:

Goal:	Maintain expenditures per person served
Target:	Expenditures per person served will be equal to or greater than previous years
Population:	Children with SED
Criterion:	5:Management Systems
Indicator:	CPS Average Expenditures per person served for children and youth with SED
Measure:	The numerator is CPS expenditures on children and youth with SED consumer services. The denominator is number of children and youth with SED served.
Sources of Information:	Expenditures report; census data
Special Issues:	A decrease in state general revenue dollars over the past five years has strained the mental health system.
Significance:	The expenditures per person served may be decreasing due to several factors. The number of children and youth with SED receiving services is increasing from the FY 2005 number of 15,719 to the FY 2006 number of 16,876. A substantially greater number of children are being served compared with the limited increase in dollars spent. The collaborative activities with the State Medicaid Authority, the Missouri Department of Elementary and Secondary Education and the state Juvenile Justice agency may be impacting a shift in dollars spent on each child.
Action Plan:	The Statewide Comprehensive Children's System of Care will continue the collaboration of state and local agencies to ensure dollars are used effectively and efficiently to treat the most numbers of children with the services needed for recovery.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Number of Children with SED receiving CPR

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	4,190	5,168	5,200	5,250
Numerator			--	--
Denominator			--	--

Table Descriptors:

Goal:	Increase the number of children and youth with SED receiving Comprehensive Psychiatric Rehabilitation services
Target:	Increase the number of children and youth with SED receiving Comprehensive Psychiatric Rehabilitation services
Population:	Children and youth with SED
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Number of children and youth with SED receiving Comprehensive Psychiatric Rehabilitation services
Measure:	Number of children and youth with SED receiving Comprehensive Psychiatric Rehabilitation services (No numerator or denominator)
Sources of Information:	Billing database
Special Issues:	
Significance:	Increased participation in the CPR program helps children, youth and their families stay in their communities and maximize their ability to function with a healthy lifestyle.
Action Plan:	Continue to increase the opportunities for children and youth with SED to participate in Comprehensive Psychiatric Rehabilitation programs in their communities

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Number of System of Care Teams

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	7	9	10	11
Numerator			--	--
Denominator			--	--

Table Descriptors:

Goal: Increase the number of Children's System of Care local teams

Target: Increase 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: Number of Children's System of Care local teams in Missouri
(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 ten System of Care sites operating in Missouri in FY2006. Currently two sites are funded through the SAMHSA Comprehensive Children's Mental Health Services grants, one site is a graduate of the federal funding and seven are state system of care sites. 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 Children's System of Care local teams as funding becomes available

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Percentage of children receiving services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	14.30	15.30	16.28	16.28
Numerator	14,286	15,239	--	--
Denominator	99,555	99,555	--	--

Table Descriptors:

Goal:	Increase access to community based services to children and youth with SED
Target:	Increase or maintain the percentage of children and youth with SED who receive CPS-funded services
Population:	Children and youth with SED
Criterion:	2:Mental Health System Data Epidemiology
Indicator:	Percentage of Missouri children and youth with SED who receive CPS-funded services
Measure:	The numerator is the number of children and youth with SED served in CPS-funded programs. The denominator is the total number of children and youth in Missouri with SED based on a 7% estimated prevalence rate.
Sources of Information:	CTRAC and federal census data
Special Issues:	Mental health services are underfunded both nationally and in the State of Missouri.
Significance:	Due to fiscal constraints, Missouri is only meeting the mental health needs of 16% of the estimated prevalence of children and youth with SED. However, the department is increasing the percentage of children with SED served despite these fiscal challenges.
Action Plan:	Continue to build community based services for children and youth with SED based on the reforming children's mental health services in Missouri plan

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Percentage of days SOC children/youth in home/homelike settings

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	82.30	78.60	78.40	78.60
Numerator	2,123	3,916	--	--
Denominator	2,580	4,980	--	--

Table Descriptors:

Goal:	Children and youth with SED will spend an increased number of days in home or homelike settings
Target:	Maintain or increase the percentage of days children and youth with SED spend in home or homelike settings
Population:	Children and youth with SED in System of Care programs
Criterion:	3:Children's Services
Indicator:	Percentage of days children and youth with SED spend in home or homelike settings
Measure:	The numerator is the number of days children and youth with SED in the System of Care programs are in a home or homelike setting. The denominator is the total number of potential days available for children and youth with SED in the System of Care to be in a home or homelike setting.
Sources of Information:	Youth Status Report data on System of Care children collected on a monthly basis
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 goal of a consumer and family driven program is to hear the consumer voice. Parents want to maintain custody of their children and receive the needed 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, 160 youth have been referred through the Diversion Protocol and 150 children or ninety-four percent have been diverted from state custody. Of those children diverted from custody 51% received intensive services in their home and community while 49% required a placement outside of their home. In any given month approximately 30-35 children were supported in their out of home placement through the VPA. The continued implementation of the Custody Diversion Protocol will be monitored by the DMH, CD and the Stakeholders' Advisory Group for the Comprehensive Children's Mental Health Service System.

The percentage may have decreased slightly due to the potential number of days available in a homelike setting increasing.

Action Plan:

The department will continue to place children and youth with SED in a home or homelike setting whenever possible.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Rural children receiving mental health services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	13.90	14.60	14.23	14.23
Numerator	11,354	11,900	--	--
Denominator	81,683	81,683	--	--

Table Descriptors:

Goal:	Maintain or increase the percentage of children and youth with SED in rural areas receiving CPS funded mental health services
Target:	Maintain or increase 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:	CTRAC; 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.

CHILD - GOALS TARGETS AND ACTION PLANS

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	3.10	.01	.01	.01
Numerator	19	1	--	--
Denominator	611	166	--	--

Table Descriptors:

Goal:	Keep children and youth with SED engaged in school
Target:	Maintain the low rate of children and youth with SED expelled from school
Population:	Children and youth with SED served in System of Care programs
Criterion:	3:Children's Services
Indicator:	Percentage of children and youth with SED served in the System of Care programs expelled from school
Measure:	The numerator is number of children and youth with SED in the System of Care programs expelled from school. The denominator is the total number of children and youth with SED served in the System of Care programs with a review/discharge status report for the fiscal year.
Sources of Information:	Youth Status Report
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:	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."
Action Plan:	Missouri's Comprehensive Children's Mental Health System is working if only 1 out of 166 students with SED are expelled from school. Continue to support children and youth with SED in their communities to maintain consistent school attendance

CHILD - GOALS TARGETS AND ACTION PLANS

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	20	26.50	26.80	26
Numerator	0	44	--	--
Denominator	0	166	--	--

Table Descriptors:

Goal:	Decrease the number of children and youth with SED in out-of-home placement
Target:	Maintain or decrease the percentage of children and youth with SED in out-of-home placement
Population:	Children and youth with SED served in the System of Care programs
Criterion:	3:Children's Services
Indicator:	Percentage of children and youth with SED in out-of-home placement
Measure:	The numerator is the number of children and youth with SED in the System of Care programs living in out-of-home placement. The denominator is total number of children and youth with SED in the System of Care programs with a review/discharge status report in the fiscal year.
Sources of Information:	Youth Status Report
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 goal of a consumer and family driven program is to hear the consumer voice. Parents want to maintain custody of their children and receive the needed 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, 160 youth have been referred through the Diversion Protocol and 150 children or ninety-four percent have been diverted from state custody. Of those children diverted from custody 51% received intensive services in their home and community while 49% required a placement outside of their home. In any given month approximately 30-35 children were supported in their out of home placement through the VPA. The continued implementation of the Custody Diversion Protocol will be monitored by the DMH, CD and the Stakeholders' Advisory Group for the Comprehensive Children's Mental Health Service System.
Action Plan:	The percentage is maintaining stability from FY 2005 to FY 2006. The Comprehensive Children's Mental Health System of Care will continue to strive for ways

to keep children and youth with SED in their homes or in a homelike setting. The department and collaborating agencies will work together to keep children out of out-of-home placements.

Missouri

Appendix A (Optional)

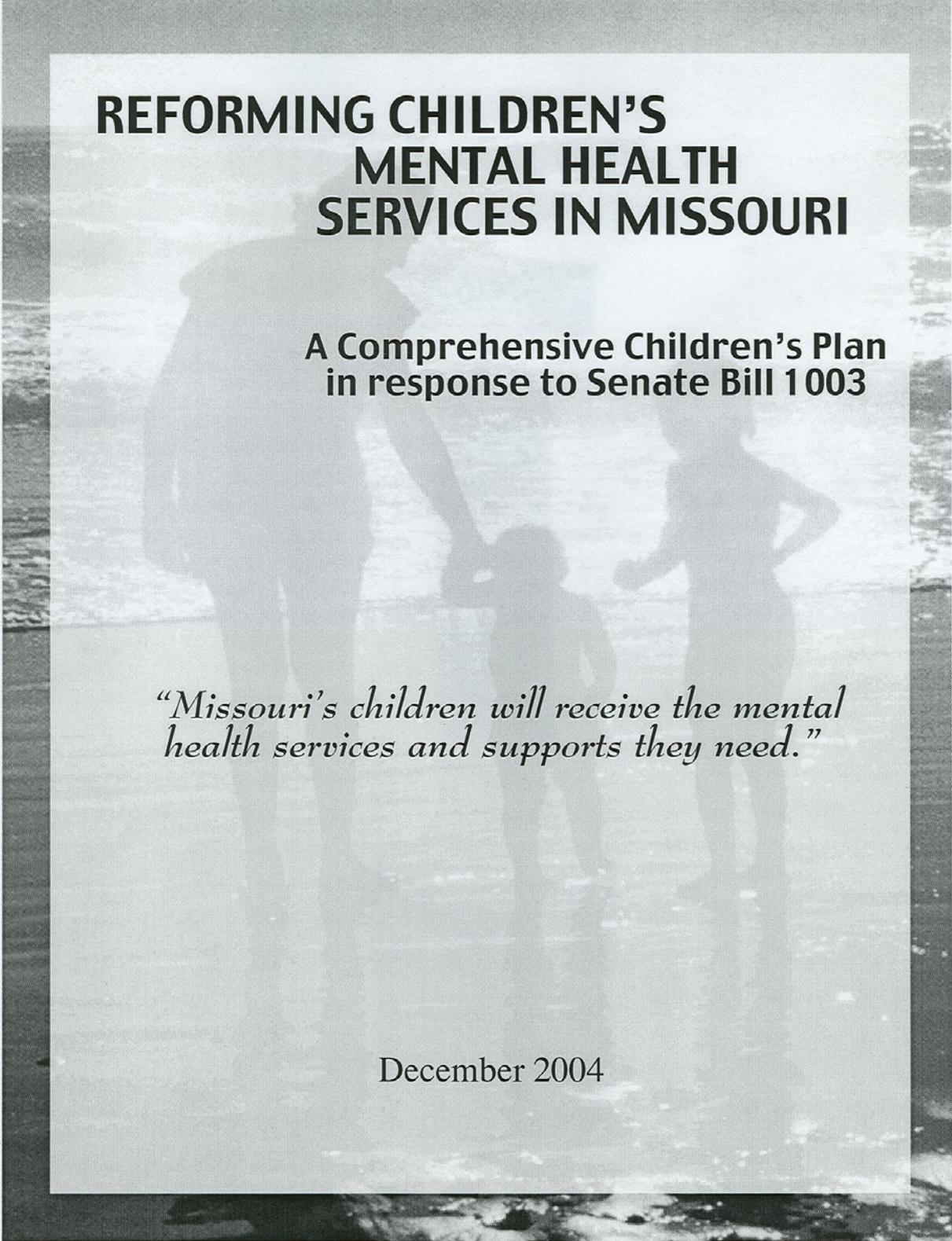
OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.

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Missouri Suicide Prevention Plan: A Collaborative Effort
Year 2005-2010: Bringing a National Dialogue to the State

State of Missouri, Department of Mental Health, Multicultural Competency Plan: A Plan for Achieving Multicultural Competency



REFORMING CHILDREN'S MENTAL HEALTH SERVICES IN MISSOURI

**A Comprehensive Children's Plan
in response to Senate Bill 1003**

*"Missouri's children will receive the mental
health services and supports they need."*

December 2004

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REFORMING CHILDREN'S MENTAL HEALTH SERVICES IN MISSOURI

“Missouri’s children will receive the mental health services and supports they need”

EXECUTIVE SUMMARY

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.

This plan for a comprehensive mental health system for children builds on years of work to address the mental health needs of Missouri’s children. The plan also continues to address a tragic consequence of the current system that sometimes results in families relinquishing custody of their child for the purpose of accessing needed mental health services. This is a decision no family should be forced to make. Senate Bill 923 enacted in 2002 and Senate Bill 266 enacted in 2003 gave rise to policies aimed at stopping this terrible dilemma. As a result of Senate Bill 923, protocols were developed to divert children from having to be placed in state custody for the sole purpose of mental health treatment. These protocols are being established statewide. Senate Bill 266 called on the state to identify those children in state custody for mental health treatment only and return those children to the custody of their family when appropriate. This process currently is being implemented. The system of care mandated by Senate Bill 1003 will further refine and incorporate the work of the previous legislation to ensure that relinquishing custody is never an option to be considered for accessing the children’s mental health system in Missouri. Information on the status of these efforts is provided in the *Status of Reform*, which is under Tab 6.

Under Senate Bill 1003, all the diverse interests in children’s mental health are brought together with a mandate to develop and implement a comprehensive children’s mental health service system. The plan that follows in this report is not a Department of Mental Health plan to address children’s mental illness, but rather it is a state plan for a full spectrum of services and supports needed to provide for the mental health of

Reforming Children’s Mental Health Services in Missouri
A plan submitted to the General Assembly per S.B. 1003.

all children in Missouri. To that end, the plan focuses on prevention, early identification and intervention as well as the community-based treatment and hospitalization services that are needed in a comprehensive system.

Public Health Model:

The comprehensive plan presented in this report will use as its foundation a public health approach to meeting the mental health needs of children. The public health model emphasizes the necessity of health promotion and prevention as a part of the full spectrum of services. This is a departure from the medical model used in Missouri and most other states. The public health model presented in this 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
- **Service delivery system**, providing services that are evidence-based and organized by developmental stages through a matrix of services, health promotion, quality, access to care, and evaluation and monitoring.

Recommendations:

Development of the comprehensive statewide system will include changes in state policies, financing mechanisms, training and other support structures; changes at the state and local level to plan, implement, manage and evaluate the system; and changes at the service delivery level to ensure quality prevention and treatment services and supports.

The recommendations for accomplishing these changes and implementing the comprehensive system using the public health model are included under Tab 4 of this report. A table listing the recommendations and short-term and long-term goals for each recommendation is under Tab 5. Recommendations are summarized around the following areas:

Assess mental health service needs statewide

- Develop capacity to gather and compile data across multiple agencies;
- Assess risk and protective factors at the local level

Policy development

- Partner agencies will establish collaborative policies to support key system components
- Create governance structure across state departments at the Director level
- An interagency Comprehensive System Management Team (CSMT) will operationalize policies
- Establish local management structure
- Ensure family involvement at all levels of administrative structure

- Ensure sufficient and flexible funding to support system

Service Delivery System

- Ensure early screening
- Make education, information and outreach available to families
- Children with identified needs will have an Individualized Plan of Care (IPC)
- A full array of evidence-based services and supports, from prevention, to treatment, to follow-up, will be available in all areas of the state
- Appropriate training on the comprehensive system will be provided at all levels
- A system evaluation and monitoring process will be established

Financing the System:

Developing and implementing the Comprehensive Children’s Mental Health Services System will require the development of resources and the shifting of resources. Proposals to address the priorities of the system are included in the Department of Mental Health budget request for Fiscal Year 2006. Some of the requests focus on DMH programs, but others are not items that are specific to DMH, but represent critical issues in the implementation of the Comprehensive Children’s Mental Health Service System that cut across multiple public child serving agencies. The items include strategies found in the budget requests of other agencies, with DMH supporting the request. In most cases, these items build on past work. These issues addressed in the DMH budget include:

- Early Childhood
- School Based Services
- Prevention
- Relinquishing Custody
- Mentally Ill Juvenile Offenders
- Federal Grants

Implementation Timeline:

The plan will be implemented in three phases over a five-year period:

- Planning and transition (FY 2005 – FY 2006);
- Capacity and infrastructure building (FY 2007 – FY 2008);
- Continue capacity building and system refinement (FY 2009 – 2010).

THE CALL FOR REFORM

“Growing numbers of children are suffering needlessly because their emotional, behavioral, and development needs are not being met by those very institutions which were explicitly created to take care of them.”

—U.S. Surgeon General’s Conference on Children’s Mental Health (2000)

Background

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. Reforming the current children’s mental health system represents a sound investment in the future.

The passage of Senate Bill 1003 in March of 2004 continues to focus attention on this reform. This landmark legislation provides a clear direction for the future, while building on previous and ongoing efforts to improve this critically needed and very complex system of care.

The call for reform began with the parents and families that use the system. Motivated by a desire to ease the personal pain and challenges these families face has brought advocates, services providers and policymakers together to address this complex issue. Foremost among the challenges faced by families under the current system is a lack of access to treatment for their children. A horrible reality of the current system is that sometimes parents relinquish custody of their child for the sole purpose of accessing the needed mental health care. Usually, these families do not qualify for Medicaid and have exhausted all of their private health insurance for their child’s mental health care. Relinquishing custody to the state is their last hope. This terrible dilemma has fueled the drive for reform in Missouri.

Citizens for Missouri’s Children (CMC), a statewide children advocacy and policy organization, brought this situation to light in Missouri with a 2002 report. The CMC report followed up on a national report on the issue by the Bazelon Center for Mental Health Law.

Exposing the issue of relinquishing custody helped initiate the current efforts at reform. Legislation to exclude parents from placement on the abuse and neglect registry when they relinquish custody for mental health care only was passed in 2002. The Children’s Division (CD) and the Department of Mental Health (DMH) established a process to divert children from ever having to be placed in state custody to receive mental health care. The following year legislation was passed to require the state to identify those children already in state custody for mental health care only and to return those children to the custody of their parents when appropriate. Senate Bill

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1003 builds on this progress and brings together the varied programs and policies on children's mental health needs into a seamless, comprehensive system.

The Growing Need

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 Division of Family Services (now 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. Few resources are directed to prevention and early intervention activities

The Current System

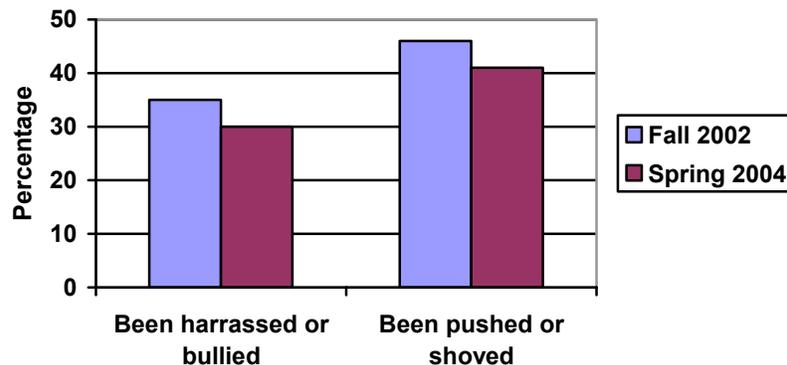
Presently the children's mental health system can point to successful programs such as the partnership between the Department of Mental Health (DMH) and the courts to identify and provide for the mental health needs of youth in the Juvenile Justice system. Through a collaborative agreement between DMH and the Department of

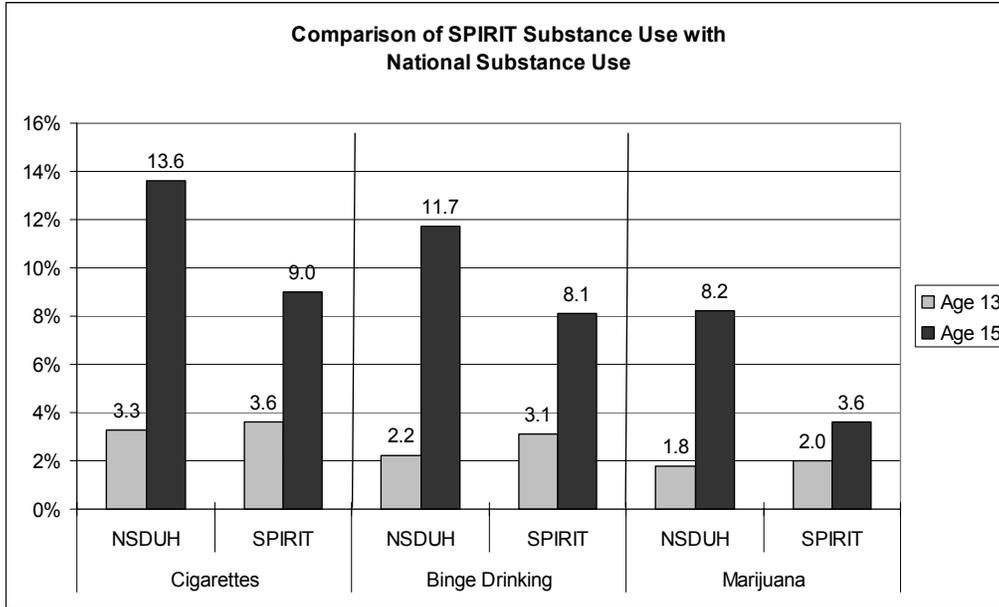
Social Services, efforts are in place in several areas of the state to more effectively meet the needs of children in the custody of the Children’s Division who are placed in highly restrictive levels of residential care.

The Department of Mental Health, in partnership with other child serving entities, has helped develop local community-based services for children with serious mental health needs and their families. Federal grants have helped to establish an integrated, inter-agency, community-based “System of Care” in the following areas: Adair County; St. Louis City and St. Louis County; Jackson County; St. Charles County; St. Francois County; and Butler and Ripley counties. Recently, the state was awarded a six-year federal grant from the Substance Abuse and Mental Health Administration to support system of care development in the southwestern counties of Greene, Christian, Taney, Stone, Barry and Lawrence.

Prevention activities include the implementation of evidence-based practices to reduce the risk of substance abuse in five local Missouri school districts through the Division of Alcohol and Drug Abuse’s S.P.I.R.I.T initiative. The charts below show current SPIRIT outcomes for bullying in middle school and alcohol and other drug use (compared with national sample).

Percentage of middle-school students reporting harassment or bullying behavior





“The current child mental health service system in Missouri involves multiple state departments. Without defined leadership, coordination, and dedicated funding, the system is not as efficient and effective as it can be in achieving successful outcomes for children.”
 —*Children’s Mental Health Advocates (2004)*

Despite the success of these and other initiatives, the current children’s mental health services system in Missouri is fragmented among multiple state departments. This fragmented and inadequate system can inadvertently cause parents to give up custody of their child to the state in order to secure necessary mental health care for their child.

The Bazelon Center for Mental Health Law reports that relinquishing custody to receive mental health care is a national problem. In at least 10 states, almost one in four families considers choosing between getting mental health treatment for their child and retaining legal custody of the child. As noted earlier, an estimated 600 children may be in the custody of the child welfare system solely to receive mental health services. They were not placed due to child abuse, neglect or abandonment. This tragic dilemma, more than any other factor, stirred the effort now underway to reform the children’s mental health system in Missouri.

A consistent underlying theme in describing the current system is one of limited resources and uneven allocation (Smith, 2004; Workgroup 1). While all of Missouri’s child-serving state departments provide some form of mental health services along the prevention, early intervention, and direct service continuum, a lack of resources severely affects both access to the system and the capacity of the system to provide necessary services. Some services are available statewide, however most services are

limited due to issues of capacity, geography, and/or narrow eligibility criteria. Access to mental health services for children is, in part, dependent upon where the need is identified, by the system the identifier is in, and the diagnosis itself. Much of the current system is organized around the provision of high intensity, highly restrictive treatment services even though there is little or no evidence that the current practice is effective at meeting the needs of children and families or the most effective use of limited state and federal resources.

The impact of resource availability and allocation on children's mental health services was one of the areas examined in an in-depth review of the current system. A workgroup studied and reported on the components of the current system. The trends identified by this workgroup are consistent with national findings around five key areas:

- prevention/early intervention
Many state agencies and community providers offer some type of prevention or early intervention services. However, access and capacity across the state varies significantly in almost all programming. This is in part due to funding priorities for many community and state agencies.
- child and family supports
There appears to be an increased recognition of the needs of families to help them access support services with some increase in available supports. However, there is not a consistent philosophy for supporting families across the system, as well as a lack of funding and capacity.
- treatment and rehabilitation
There are examples of successful programs in Missouri, such as Division of Youth Services (DYS) program for juvenile offenders; CSTAR program for substance abuse treatment; therapeutic foster care; and wrap around services. There needs to be better collaboration among the state agencies involved and the state needs to expand its ability to fund these effective programs.
- special populations
Early childhood, youth involved with the juvenile justice system, and youth with co-occurring disorders are some of the populations that require greater levels of interagency collaboration and are in need of more attention. The system, at the same time, is not able to fully meet the needs of the more traditional populations of youth with a serious emotional disturbance and youth with developmental disorders.
- system administration
In the past year there has been a growing level of collaboration across state departments and systems that serve children. One of the major barriers to more effective collaboration is the diversity of departments' organizational

structures. Some are very centrally driven, others rely heavily on provider networks, and others are more locally driven. The ability to collaborate, communicate, influence practice at the local level and set policy is impacted by this structural diversity.

The report of the workgroup shows the strengths and weaknesses of the current system and establishes the baseline for the implementation of the comprehensive system. The findings of the workgroup are available as a separate report under the cover of “Current Mental Health Services.”

Legislation

Energized by the tireless efforts of parents and child advocates, the Governor and Legislature began enacting legislation in 2002 to improve the child mental health system and to specifically address the issue of parents relinquishing custody.

Senate Bill 923, passed and signed into law in 2002, started the current process to correct through legislation the flaws in the system. Under the changes made by the bill:

- A family may now seek assistance from the court to obtain mental health services without being placed on the child abuse and neglect register;
- Juvenile courts now have jurisdiction in cases of children in need of mental health services, whose parent, guardian or custodian is unable to afford or access appropriate mental health treatment or care for the child;
- Juvenile courts may now order that the child receive necessary services in the least restrictive environment, including home and community-based mental health services, treatment and supports. That order must be based on a treatment plan developed by the state agencies responsible for providing and paying for the services.

Senate Bill 266, enacted in 2003, continued the effort of children’s mental health reform. The bill focused on identifying children in state custody for mental health needs only. The bill required the Department of Mental Health and Department of Social Services to jointly prepare a plan to address the need for mental health services and supports for all cases in the custody of the Department of Social Services that involve children in the system due exclusively to a need for mental health services, and where there is no instance of abuse, neglect or abandonment.

This requirement led to the identification of an estimated 600 children who might be in state custody of the child welfare system solely to receive mental health care.

Sweeping reform for children’s mental health took place in 2004 with the passage of **Senate Bill 1003**. The changes called for in this bill evolved from the work of the Children’s Services Commission, an entity created in 1983 by state statute 210.101. The

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Children's Services Commission represents all three branches of government and the private sector. The commission takes a leadership role in identifying and evaluating current programs and makes recommendations to the state.

A special subcommittee of the Children's Services Commission was formed to look at reforming the child mental health service delivery system. The subcommittee's 2003 report recommended statutory language to establish the comprehensive children's mental health service system. Senate Bill 1003 became the legislative vehicle for this language and was the first bill passed by the Legislature and signed by the Governor in the 2004 session.

SB 1003 requires that the state have a Comprehensive Children's Mental Health Services System and that the Department of Mental Health, in partnership with other state agencies, develop a plan for the system. The plan was submitted to the Governor and General Assembly in December, 2004.

Senate Bill 1003 also expands Senate Bill 266 by requiring Children's Division to determine which children are in their custody solely due to mental health needs. Within 60 days of identifying these children, appropriate agencies and the family must develop an individualized services plan for each child, identifying which agencies will provide and pay for services, subject to appropriations. The plan must be submitted to the court for approval.

After the court approves a plan, the court may order the child returned to the custody of their parent, guardian, or custodian. This section of the legislation is intended to get children back into the custody of their families as soon as possible.

Finally, the bill creates a new funding relationship between the Department of Mental Health and the Children's Division. After children return to the custody of their family and are being served by DMH, DMH can bill the Children's Division for the cost of care pursuant to the individualized service plan and the comprehensive financing agreement made by the two agencies.

House Bill 1453 was also enacted in 2004. This bill made major reforms in the state foster care system. The legislation included provisions authorizing the Department of Social Services to enter into "voluntary placement agreements" with parents, legal guardians or custodians for placement and of children who only need mental health services. The parents, legal guardian or custodian would retain legal custody. This is another effort to avoid the relinquishing of custody for mental health care.

Developing the Plan

Developing the plan for the comprehensive system began almost immediately after Senate Bill 1003 was signed into law. Language in the bill called for the formation of a Comprehensive System Management Team to establish the system detailed by the plan. Members of this team can be found in under Tab 7. The bill also required a

Stakeholders Advisory Committee to provide input to the management team and ensure positive outcomes for children are being achieved. Members of this committee can also be found in under Tab 7.

The language in Senate Bill 1003 detailed the agencies and other groups that must be represented in the new system. The language also was very detailed about the components that must be included in the plan. The Stakeholders Advisory Committee, in conjunction with the Department of Mental Health, led the plan development process. Work groups representing all the interested parties in children's mental health issues were formed to develop the plan, based on the requirements set forth in Senate Bill 1003. The work groups are listed below.

- **Current Mental Health Services Workgroup** described the current mental health service system for Missouri's children and their families, including the specialized services for specific segments of the population. The group described the gaps in services, as well as the service needs.
- **Ideal Comprehensive Services Array Workgroup** described the ideal array of services including services such as intensive home-based services, early intervention services, family support services, respite services, and behavioral assistance services. The group looked at ways to finance the implementation of the complete array of services. In addition, the group looked at ways to evaluate the effectiveness of the system and identify the training needed.
- **Ideal Administrative and Services Structure Workgroup** described the ideal structure for the administrative function and service system, based on principles defined in the legislation. The structure should allow for providing services at the local level; involving the family and local schools; coordination of services across child serving agencies and providers; payment methods; and the roles and responsibilities of the state and local agencies that are part of the system.
- **Implementation of Child Welfare/Mental Health Reform Workgroup** is responsible for monitoring the implementation of the reforms and requirements of Senate Bill 923 (2002); Senate Bill 266 (2003); and Senate Bill 1003 (2004). The group's status report on the legislation is included in this report.

The workgroups met throughout the summer and their products were compiled as the core of the Comprehensive Children's Mental Health Services System Plan.

**COMPREHENSIVE CHILDREN’S MENTAL HEALTH SERVICES SYSTEM PLAN:
ASSURING THAT MISSOURI’S CHILDREN AND FAMILIES RECEIVE THE MENTAL HEALTH SERVICES AND
SUPPORTS THEY NEED**

“To improve the system, it will be necessary to look beyond who is already in the system to the greater population and seeing care happen on a broader continuum that begins with health promotion and illness prevention, includes treatment and supports the process of recovery throughout.”

—National Association of State Mental Health Program Directors (2004)

Plan Overview

The Comprehensive Children’s Mental Health Plan provides a description of how Missouri’s publicly funded child serving agencies, working in partnership with families, advocates and providers will improve the delivery of mental health services and supports. While the system proposed in the Plan would be impossible without Missouri’s long history of successful collaborations, the proposed comprehensive system moves beyond fixing any one particular systemic problem. The Plan presented in this document represents a major transformation both in who is served as well as how services are delivered.

Organization of the Plan

The Comprehensive Children’s Mental Health Plan outlines the specific features of a children’s mental health system. It describes the overarching mission, principles and goals of the system as a whole; the rationale underlying reform and components of the system; necessary infrastructure and financing to support the system; and finally outlines a vision for the future. Building on past work, key areas of the system are described; priority components are targeted for immediate implementation while other system components identified will be incorporated into the Plan as they are developed. The Plan provides a guide and organizing framework for reforming how “Missouri’s children will receive the public mental health services and supports they need.”

Vision and Fundamental Principles of the comprehensive system

The **major goal**/vision of the Stakeholders Advisory Group and, therefore, this Plan is that:

“Every child who needs mental health services and supports from the public mental health system will receive them through a comprehensive, seamless system that

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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."

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.

Common goals, values, and set of operating principles are critical if a population-based, as opposed to diagnosis-based, approach is to be effective in accomplishing its objectives. The goals and values must be shared by all stakeholders; including the executive, legislative and judicial branches of government; mental and behavioral health agency staff; parents; children's services providers; and communities. Developing and maintaining goals and values that everyone can agree to have historically been impeded by fragmented systems, differing missions, and perceived differences in perspectives; yet, on the other hand, all systems share the common principle that the welfare of the child is of utmost importance. The above **principles of practice** are not meant to replace any specific system's mission or values; they do provide the organizing philosophy and guidelines that underlie the proposed public mental health service delivery approach.

While the Plan specifically addresses the public mental health system, many children receive mental health services through various private service options. Although the vast private mental health service sector is beyond the scope of the SB1003 legislation, the Department of Mental Health acknowledges the importance of alignment with and fostering integration across the public and private systems.

Therefore the department will work to interface with leaders within the private sector as the system is implemented.

The foundation for improving the system will be moving away from the medical model used in Missouri and most states and adopting a public health approach to the mental health needs of Missouri's children and youth as called for in the President's New Freedom Commission on Mental Health.

Desired System Results

The transformation of the children's mental health system from one heavily 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.

Reforming Children's Mental Health Services in Missouri
A plan submitted to the General Assembly per S.B. 1003.

- 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.

System development phases

Development of the proposed comprehensive statewide system is a multifaceted, multilevel process (Stroul, 2002), which includes:

- Changes in state policies, financing mechanisms, training, and other structures and processes to support the system;
- Changes at both the state and local level to plan, implement, manage, and evaluate the system; and
- Changes at the service delivery level to provide a broad array of effective, evidence-based prevention and treatment services and supports to children and families in an individualized and coordinated manner.

Comprehensive reform of the children’s mental health service system must be a progressive but incremental process. Historically, responsibility for children’s mental health services has not resided in any one state agency: each child- and family-serving agency has had its own policies and procedures. This, in part, led to the enactment of SB 1003. In order to bring these multiple components into a

coordinated and comprehensive system, considerable assessments and discussions will be required. The very fact that families had to relinquish custody in order to get the care that their children required and deserved is reflective of the fragmented growth of Missouri's children's mental health service system. The components of a comprehensive system are interrelated and, therefore, an effective system must be able to harmonize the elements of the system, across existing systems and agencies. Under the best of circumstances, effective system reform takes several years. Reform of a system affecting some of Missouri's most vulnerable populations must be focused and implemented in a progressive and timely manner. Reformation of the children's mental health services system will require significant changes in program development, implementation of new administrative structures and collaborative arrangements, financing strategies, and major workforce development efforts.

The Stakeholder Advisory Committee workgroups established in response to SB 1003 began the work of defining what is needed to transform the system. The Plan that follows represents this work but should also be considered as a living, evolving document that changes over time to meet the needs of the maturing system. To reflect the complexities involved in this level of change and the planned stages of development, the implementation is phased over five years.

1. Planning and transition (FY2005-2006) began with the signing of SB1003 and the meetings of the Stakeholder Advisory Committee and its workgroups throughout the summer in order to conceptualize and plan for the system. Planning activities will continue with broad-based input from stakeholders to address short-term goals and objectives in the Plan. Transition activities include: implementing statewide protocols designed to address the needs of children at risk of entering the custody of the Children's Division solely to access needed mental health services; returning children already placed in Children's Division custody to the custody of their families when possible; changes in identified funding streams including Medicaid and Title IV to support these efforts; and testing of a service quality review practice for statewide implementation. Education of partner agency staff, families and the public on the system is also a priority for this phase (see Part IV: Status of Reform for additional information).
2. Capacity and Infrastructure building (FY2006-2008) will focus on both expanding service capacity and creating the infrastructure to support the system. Service capacity expansion will focus on priorities targeted in the Plan, workforce enhancement, and developing an approach to ensure services implemented are research-based and include the essential elements of care coordination and methods for individual care planning. Areas of focus for infrastructure development include: formalizing interagency management structures at both the local and state levels; continued identification of more

effective ways of combining and maximizing multiple funding sources and mechanisms; implementation of a quality review process statewide; and developing a capacity to collect data on children served across all systems.

3. Continued Capacity building and system refinement (FY2008-2010) will utilize the information received from the quality service review process and integrated data collection regarding the maturing system to make any adjustments necessary. Changes identified to funding streams will be finalized and a mechanism for seeking new funding opportunities established. Service expansion with corresponding workforce development will continue with a mechanism established for ongoing workforce enhancement.

Foundation of the Integrated System: a Public Health Approach

Missouri is not alone in its concern for the mental health needs of its children. At the first ever U. S. Surgeon General's Conference on Children's Mental Health in 2000, the Surgeon General reported "growing numbers of children are suffering needlessly because their emotional, behavioral, and development needs are not being met by those very institutions which were explicitly created to take care of them." The National Advisory Mental Health Councils' Workgroup on Child and Adolescent Mental Health concluded its review by reporting "no other illnesses damage so many children so seriously." In July 2003, the President's New Freedom Commission on Mental Health released its report that both recognized the nation's current mental health system as a "patchwork relic" and recommended a fundamental transformation of the nation's approach to mental health care. Identifying the current situation as a "public health crisis" the report concludes that "the extent, severity, and far-reaching consequences of mental health problems in children and adolescents make it imperative that our nation adopt a comprehensive, systematic, public health approach to improving the mental health status of children."

The New Freedom Commission report advances a vision for children's mental health that promotes the emotional well-being of children and provides access to comprehensive, home and community-based, family-centered services with supports for children with mental health disorders and their families. This vision includes a call for creating conditions that promote positive mental health and emotional well-being and prevent the onset of emotional problems in all children.

The Report from the President's New Freedom Commission on Mental Health as well as the earlier reports helped inform the development of Missouri's Plan.

While there are pockets of excellent mental health services, the stakeholders of this system readily agree that the system as a whole is neither as effective nor as

efficient as it can be. The foundation for improving the system will be moving away from the medical model used in Missouri and most states and adopting a public health approach to the mental health needs of Missouri's children and youth as called for in the President's New Freedom Commission on Mental Health.

The current medical model emphasizes service or treatment based on diagnosis. In order to improve access and availability, and quality and appropriateness, it will be necessary to "look beyond who is already in the system to the greater population and seeing care happen on a broader continuum that begins with health promotion and illness prevention, includes treatment, and supports the process of recovery throughout" (NASMHPD, 2004). With its strong emphasis on prevention, early identification and intervention, the public health model provides the best approach for reforming the system. The public health approach emphasizes collective action and cooperative efforts among diverse agencies and requires individuals, communities, organizations and leaders at all levels to collaborate in promoting mental health in children and youth.

Application of a public health model affords the opportunity to best use a community to establish a comprehensive children's mental health services system. Among the U.S. Surgeon General's major conclusions about children's mental health is the importance of assessing the mental health of children "within a developmental context that takes into account family, community, and cultural expectations about age-appropriate thoughts, emotions, and behaviors." (U.S. Surgeon General's Report, 2001). Mental health in childhood and adolescence is defined as "the achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology." (Hoagwood et al., 1996)

Research over the past 30 years has elucidated a number of the risk factors that predispose children and adults to mental illness. A public health model emphasizes the necessity of incorporating health promotion and prevention practices into the development and delivery of services provided by the public mental health system. Prevention research has demonstrated that prevention can increase positive functioning and resilience, decrease the risk of developing mental illness, and facilitate recovery. Incorporating health promotion and prevention into the comprehensive children's mental health plan recognizes that mental health is essential to overall health and well-being.

Mental health promotion and prevention activities complement treatment and have as their goal the earliest possible detection of mental health problems across the

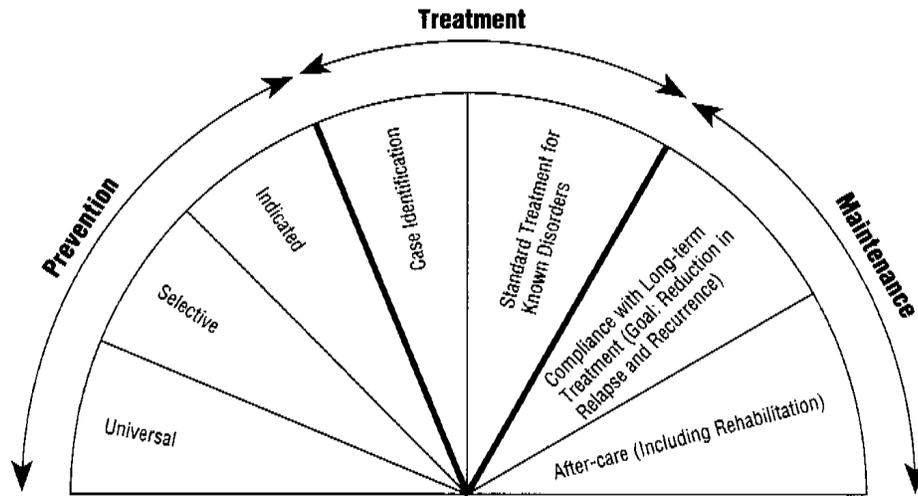
lifespan through routine comprehensive screening and assessment, and coordination of services among a broad range of disciplines.

Prevention research has demonstrated that prevention practices can reduce risk factors and enhance protective factors. Also, these interventions are a cost effective use of resources relative to more expensive, treatment-based approaches. Direct and indirect cost savings associated with prevention have been and can be substantiated.

The model used to organize the system components in the Plan follows the approach of the Institute of Medicine (IOM). In its 1994 publication, *Reducing Risks for Mental Disorders*, the IOM emphasized the need for adopting a preventive approach to mental health in order to reduce known risk factors, enhance protective factors, and reduce the incidences of severe mental illness and suicide. The authors described a spectrum of interventions for mental disabilities ranging from prevention through aftercare/recovery supports. This spectrum, see diagram below, emphasizes the importance of preventive intervention as a necessary component of addressing mental illness. This emphasis on prevention is a marked shift away from an emphasis on high intensity services for the severely emotionally disturbed. The authors and others (e.g., Suicide Prevention Plan, NASMHPD) argue that the individual, family, and societal impact of mental illness can be lessened through health promotion, universal preventive interventions, and preventive interventions with individuals and groups at high risk for developing a behavioral disorder or displaying early symptoms. In the behavioral health field, and in DMH, this approach is most realized in the areas of suicide prevention and prevention of substance use and abuse. Various studies have demonstrated the cost effectiveness of preventive interventions; namely, that benefits and savings from evidence-based preventive interventions in some cases heavily outweighs the cost, and in most circumstances produces more benefits and savings than doing nothing. Also, and most importantly, preventive interventions have the potential of reducing the number of children needing expensive, high intensity services as well as the number of children attempting and completing suicide.

The spectrum of preventive interventions has three major components: prevention (including early intervention); assessment, diagnosis, and treatment; and supports to prevent relapse and compliance with recovery and/or maintenance plans. The approach proposed by the IOM has also been espoused by the World Health Organization and was the subject of a State Medical Directors paper on prevention in the public mental health system. The development of an array of services across the spectrum will necessitate a shift in thinking about the role of the public mental health system. This “paradigm shift” will result in the public mental health system adopting principles from the broader public health field. Families, primary care providers, teachers and other school personnel, and communities will focus on

reducing the incidence of behavioral disorders and interrupting their development at the earliest onset of symptoms, in addition to providing necessary treatments and supports for those with a diagnosable disorder.



The mental health intervention spectrum.

The Ideal Services Array Workgroup proposed adoption of a public health model consisting 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
- **Assurance that prevention, treatment, and support services** are evidence-based and organized by developmental stages through a matrix of services, health promotion, quality, access to care, and evaluation and monitoring.

Role of partner agencies within the public health approach to mental health

Historically in Missouri as in other states, once a child entered any system, that system was responsible for meeting all the needs of that child. This led to each system developing some capacity for providing mental health services for the children they served, thereby creating a very fragmented mental health system. Viewing the mental health needs of children through a public health lens causes the focus of reform to shift from a “particular system” to that of a cross-system, non-categorical approach to improving the mental health outcomes for all children. This change from a medical to a public health approach necessitates that the

Department of Mental Health assumes the role of lead agency for the comprehensive mental health system as established in SB 1003. Working in partnership with the other child-serving agencies, the department will broaden its scope to: provide expertise to primary service delivery systems on responding to mental health service needs; provide oversight and leadership to ensure mental health services are effectively integrated into all systems; and work in collaboration with all state departments funding mental health services to set mental health policy and monitor the quality and effectiveness of mental health services across state departments. This type of “lead agency” role between state agencies already exists. The relationship between the Departments of Corrections and Mental Health concerning the substance abuse treatment needs of incarcerated individuals is one that fits the above description of the role of “lead agency.”

The public child serving agencies identified in SB1003 agree to work together with the Department of Mental Health in the design and implementation of the comprehensive system. Over the next five years, each agency will clarify its role in the comprehensive children’s mental health system within the context of each agency’s primary responsibility: teaching for schools; child safety for Children’s Division; community safety for the Juvenile Justice system; and promoting health for the Department of Health and Senior Services.

Characteristics of the Comprehensive System

To be effective, the comprehensive children’s mental health system encompasses three fundamental characteristics: Meaningful partnerships with families and youth; cultural competence; and a multi-disciplinary perspective. While each of these characteristics is woven throughout the plan, each is of such importance as to merit a more detailed discussion.

Partnerships with Families: Parents and care givers play a critical role in the lives of children; they are key to fostering mental health and early identification of problems; and they are central to the coordination of care for their children and the development of Individual Plans of Care. Family members also contribute integrity to policy group work by providing reality-based, culturally relevant information from a perspective that no one else has. Included among the Surgeon General’s major conclusions is that “families are essential partners in the delivery of mental health services to children.”

Meaningful family involvement doesn’t just happen. For family involvement, support, and development at all levels of the system to work, it must be thoughtfully organized with multiple strategies developed to engage the diversity of families potentially impacted by the system.

Cultural Competence: Cultural competence ensures that services are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values; cultural competence also ensures that services are responsive to the diverse needs of differing cultural traditions, differing socio-economic strata, and the differing social values of communities and regions. Cultural competence in mental health is an approach to delivering services that recognizes, incorporates, practices, and values cultural and social diversity. Our basic objective is to ensure quality services, including prevention, outreach, service location, engagement, assessment, and intervention, for culturally and socially diverse

Cross Agency Perspective: The transformation of Missouri's public mental health system from one providing intense services to severely emotionally disturbed children to one rooted in a public health model, which not only retains its service provision mission but also has the responsibility and expertise to promote mental and emotional health, prevent the onset of behavioral and emotional disorders (including substance use and suicide), and intervene early when risks are elevated and symptoms first occur, will require differing child-serving agencies to share a common framework for understanding the etiology of behavioral disorders in childhood. Also, it will require a common vision that conjoins physical health, academic and social development, and care and protection. Attaining a common framework requires a cross-agency, multi-disciplinary approach to children, their development, and their families.

As mentioned earlier, state agencies that have had responsibility for the care of children, from education to juvenile justice to foster care, have evolved their own, and agency-appropriate, means of responding to the mental health needs of children. Unfortunately, this has resulted in a fragmented system which marginalizes the role of families. This plan, which seeks a coordinated and comprehensive plan for children suffering from behavioral disorders and their families, recognizes the need for a cross-agency perspective. Carrying out the mandates of SB1003, and meeting the needs of Missouri's families and children, demands that child-serving agencies put children and their families first in policy and practice. The development of protocols for responding to the needs of families who have had to give up custody in order for their children to receive needed mental health services and the implementation of the Missouri SPIRIT school-based program indicate that a cross-agency perspective is achievable.

Achieving a cross-agency perspective and, therefore, the success of the implementation of this plan, will require: recognition of the Department of Mental Health as the agency of cognizance for mental, emotional, and behavioral disorders; an understanding that these disorders can occur in the community, schools, and

institutions; and an executive commitment to putting children and their families first. While this approach is emergent in the mental health field, it is long-practiced—that the public health agency is the agency of cognizance for childhood and communicable diseases is recognized by all state agencies; that the mental retardation and developmental disabilities agency is the agency of cognizance for those disorders is also recognized by all state agencies; and, recently, that the substance abuse prevention and treatment agency is the agency of cognizance for those disorders is increasingly recognized. The goal and challenge of this plan is simple: that policy recognizes that the mental health needs of children are recognized and responded to similarly across state child- and family-serving agencies.

This cross-agency, multi-disciplinary approach to the mental health of children is especially critical for **specialized populations of children** who have issues that cross many system boundaries and, due to the complexity of need, are at greatest risk for mental health problems. Children within special populations at greatest risk include children with autism; co-occurring mental health and substance abuse and/or developmental disabilities; sexually aggressive; physical health problems; family history of mental and addictive disorders; and issues related to trauma, caregiver separation or abuse and neglect. Youth aging out of children's services and in need of transition support and planning are another special population that requires a cross-system response. In addition to special populations, specific geographic issues stemming from isolated rural conditions must be responded to from a cross system perspective.

Linkages to other cross-system plans: The Comprehensive Children's Mental Health System provides the framework to link effectively with other plans that target the mental health needs of children and families. The State Suicide Prevention Plan, like the Comprehensive Children's Plan, emphasizes the public health approach and the collaboration of multiple agencies. The assessment of the risk and protective factors and the subsequent intervention strategies around suicide prevention are consistent with strategies of the comprehensive mental health plan. Mental disorders and substance abuse are risk factors that can increase the likelihood of suicide. The State Disaster Plan to address mental health needs of children following a disaster also must be linked to the Comprehensive Children's Plan. A disaster can impact the emotional, behavioral, and cognitive status of children. The strategies of the state's disaster plan for children include identifying high-risk children, screening and treatment. These strategies are consistent with the Comprehensive Children's Plan.

In 2003 the Department of Health and Senior Services, as the Title V agency for the state, received a 2-year, \$100,000 grant to develop a plan for a comprehensive early childhood system that builds on previous initiatives in the state and builds a

framework of collaboration between public and private entities. An Early Childhood Comprehensive System Coalition was formed with an interagency Steering Committee; and six focus areas were identified: Medical Home, Early Care and Education, Parent Education, Family Support, Disparate Outcomes and Mental Health and Social/Emotional Development.

The focus of Mental Health and Social/Emotional Development is on the education and support of primary caregivers (both parents and early education providers) in creating a safe and stimulating environment that supports healthy emotional development. Also, this group is focusing on providing information on identifying risk factors for emotional problems and/or developmental delays including the provision of screening tools and mechanisms available to families, care providers and pediatricians; and providing competent and developmentally appropriate mental health services and supports to the early childhood population as well as providing mental health services and supports to parents so they can meet the needs of their child. The basic premise is that information, services and supports should be available in the natural environments where young children live and learn. A documented goal for this system is to have a formal link to the Comprehensive Children's Mental Health Service System.

In the 2004 Legislative session a Coordinating Board for Early Childhood (a body corporate and politic) was developed that can take this plan forward in implementation.

RECOMMENDATIONS FOR A COMPREHENSIVE CHILDREN'S MENTAL HEALTH SYSTEM

The following service system descriptions and recommendations are organized according to the three public health model components: Assess mental health service needs; policy development; and the assurance of quality services and supports across the spectrum.

Assess mental health service needs statewide

Surveillance and assessment of mental health needs is critical to the development of the proposed system. Outside of data from the Missouri Student Survey (MSS) and studies of suicide, there is scant local or statewide data on the mental health needs of Missouri's children and families. The MSS provides the state with a picture of risk and protective factors associated with the onset of alcohol and other drug use, in addition to incidence and prevalence rates of substance use in Missouri's public school population, grades 6, 8, 10, and 12. Research indicates that there are clusters of risk factors that appear to be predictive of the development of behavioral disorders; yet, there are very few formal assessments of risk factors present in the population or subpopulations. In order to develop an appropriate array of services it is necessary to know the level of need for mental health services. Assisting communities with local needs assessments, gathering and comparing data from health assessments conducted by other state agencies, and implementing a statewide surveillance process are essential public mental health functions.

Recommendations for assessing mental health service needs:

- *The state partners will develop a "data warehouse" process to compile needed data across the multiple child serving agencies of the comprehensive system in an integrated and reliable manner including level of functioning, service needs, utilization and financial information across all of the involved agencies.*

A data warehouse is a process to compile data across multiple child serving agencies in a comprehensive, integrated, and reliable manner to permit quality decision making. The data include level of functioning, service needs, utilization and financial information across all of the involved agencies. Analysis of the data helps determine if the correct services are being provided, in the right duration, and in the most cost effective manner. DMH and its partners will seek grant or foundation funding to create this data warehouse. Concern will be taken to assure that the data collection procedures meet confidentiality and HIPPA statute and regulations. Activities will be coordinated with the Missouri Juvenile Justice Information System (MOJJIS) that is currently in use to collect data between the juvenile divisions of the circuit court and state agencies to ensure integration of all information within the system.

- *The Comprehensive Systems Management Team(CSMT) will develop a process to assist local areas to continually assess the factors contributing to mental health of children, to track emerging issues and to communicate findings to the CSMT.*

State and local assessment of mental health needs is essential to ensuring that services are appropriately located. To ensure the diverse geographic, cultural and full range of needs locally are assessed, the process developed must provide a mechanism for honoring local uniqueness while feeding into a broader policy development process.

The 2004 iteration of the Missouri Student Survey (MSS) provides an example of state and local assessment of mental health needs. The 2004 MSS was provided to the state's school districts as a web-based instrument with individual districts being able to access reports on risk and protective factors, incidence and prevalence of alcohol and other drug use, data on violent behaviors, and information about suicidal thoughts. In addition, the complete database is accessible by DMH and its evaluation and data analysis team in order to produce state-level and regional reports. These reports, which will be made publicly available, will assist the state and communities with planning the most appropriate array of services. Information about risks and protection and incidence and prevalence are essential for service planning and development. Under funding from the Substance Abuse and Mental Health Services Administration, DMH will develop a model for collecting, analyzing and reporting state-level needs-related data and for assisting communities with collecting, analyzing and reporting on local needs-related data.

Policy Development and System Administration

Policy development, including financing, inter-agency collaboration, and policy initiatives are essential public mental health functions. In order to attain the goals of system reform, it is necessary to develop policies that support the objectives and functions of the system. The development of policy proposals for the prevention, treatment, and aftercare of mental illness is a function of the public mental health agency. Public policies for addressing the mental health needs of Missouri's children and families are developed in collaboration with the other state agencies that have been providing mental health services for children, e.g., schools, the Children's Division, the Division of Alcohol and Drug Abuse, and others. Policy development must be directly related to an understanding of the extent of the problem and rooted in evidence-based principles. Public policy determines how the government will allocate its resources; therefore, inter-agency collaboration is essential to effective policy development and implementation. In an integrated system, implementation of policy requires a collaborative administrative structure that provides for both management and governance functions. Management and governance each have a distinct set of key functions that occur at very different levels within the state system.

Recommendations for policy development and system administration:

Policy: *Partner agencies jointly establish policy to support the following key system components:*

- *That the state interagency group convened as a result of SB1003 develop and implement a plan that ensures that children in need of mental health services receive them regardless of the system or environment in which that need is identified;*
- *That the Department of Mental Health consult with other state departments on the development of protocols for responding to the mental health needs of children;*
- *That funding follow the child, regardless of which system he or she starts in;*
- *That all child-caring systems are capable of identifying and assessing, if appropriate, the mental health needs of children (the “no wrong door”);*
- *That relinquishment of custody is not necessary solely to receive needed mental health services; and*
- *That the children’s mental health service system is family-driven, culturally competent and has a cross systems perspective.*

Policy Structure: *Create a formalized structure for policy & decision-making across departments at the Director level.*

This Governance structure will provide overarching leadership and vision for the system. As part of its leadership function, collaborative governance sets policies and decision-making in all areas of the Comprehensive Children’s Mental Health Service System including finance, family involvement, cultural competence, quality improvement, and workforce development.

Administration: *The Comprehensive System Management Team (defined in SB1003) functions as the management structure responsible for implementation of the system.*

The Comprehensive System Management Team (CSMT), as defined in SB1003, will provide a management function with operational oversight based on policy set by the Governance structure. The CSMT will operationalize the policies created by the governance body and function as linkage between state and local management structures

Stakeholder Input: *Create a Stakeholder Advisory Group to the Policy and CSMT level.*

The role of the **Stakeholder Advisory Group** after one year is to provide feedback regarding quality of services, barriers/success of the system, advocacy, public relations for the system, use of data to drive decision-making, and identification of emerging issues. The state interagency committee established in response to SB 1003 (hereafter referred to as the Governance Committee) will nominate two to three candidates that represent the local level covering the areas of prevention, early intervention, and complex treatment needs. The 30 members, representing all areas of the state and ethnic populations, will then be selected by the Governance Committee and appointed by the DMH Director to serve staggered three year terms with at least 51% of the membership representing families and youth.

The committee will elect a chair from among its membership, establish a set of operating guidelines or by-laws and a mechanism to review annually with the Governance Committee the composition of the membership and ensure broad representation consistent with the guidelines. The Stakeholder Advisory Committee will meet quarterly, at a minimum, with additional meetings as needed.

To ensure that members have the support they need for meaningful participation, all new members will receive an orientation to the Committee, the Plan and system development, and any reports and additional information needed to fully inform them. In addition family representatives will be provided opportunities to attend family focused conferences and training as part of their role on the Committee. Members will be reimbursed for the cost associated with participation including travel to and from meetings and meals.

Local Management:

- *Consider an area management structure that assures that the children's mental health services system serves the needs of communities and families and adapts to geographic and cultural differences.*

The Stakeholders Advisory Group strongly urged consideration of an area management structure in order to assure that the children's mental health services system serves the needs of communities and families and is able to adapt to geographic and cultural differences.

In a state as geographically large and diverse as Missouri, with an increasingly diverse population, moving some of the operational decision and planning functions to some kind of collaborative structure encompassing an area is a consideration. In order to assure both a broad platform for including the voice of families, stakeholders and the community as well as provide a reasonable management structure to coordinate and deliver services at the local level, it may be necessary to consider a larger regional

advisory mechanism tied to a smaller, local area management structure comprised of state and local agency staff and family representatives.

Family Driven

- *Increase family involvement at all levels of administrative structure*

If the comprehensive system is to function on behalf of children and families, then it is essential that families are included in the decision making and advisory structures. Parents of children currently or formerly in the children's mental health system and parents who have an interest in children's mental health, but do not have a child in the system, will be recruited to serve on the state and regional advisory groups. Family members will be recruited coalitions, advocacy groups, support groups and other venues. If the short and long term needs of children are to be effectively addressed, genuine family involvement in administrative structures is necessary.

Financing:

- *Ensure sufficient and flexible funding will be available to support an efficient system of prevention activities, services and supports.*
- *Establish an integrated funding mechanism to support required workforce enhancements.*
- *Create policy and fiscal mechanism to support family participation at all levels of system.*

In order for a comprehensive system to function properly, policy initiatives must include identification and allocation of necessary resources; essential resources that will support workforce development and services delivery. Though the Stakeholders Advisory Group did not conduct a formal resources assessment—one is recommended—anecdotal evidence suggests that many of the fiscal resources may be available for implementation of the plan; for example, preliminary results from an inventory of prevention resources being conducted by the Governor's Advisory Committee on Substance Abuse Prevention seem to indicate that there are various, but disparate, funding streams available.

To support the development of the proposed system, several fiscal strategies are proposed, including the restructuring of Title XIX (Medicaid), the redirection, when possible of funds from high cost institutional settings to community-based services, leveraging of state resources through the expanded access to federal Title IV-E reimbursement by DMH for children diverted from the Children's Division for voluntary placement to address mental health needs, and flexible use of existing state and federal block grant resources. Further support for the development of the proposed system, especially the prevention and early intervention components, will require assessing and leveraging, where possible, substance abuse and other prevention dollars from federal block grant and discretionary programs. Even if existing resources can be

leveraged for children's mental health services as described in this plan, new, additional dollars will be necessary to assure service adequacy and quality.

The Array of Services and Supports

Assurance that services are evidence-based, organized by developmental stages, reflect a matrix of services, and include mental health promotion is one function performed by the public mental health system. The public mental health system is also charged with assuring quality, access to care, and evaluating and monitoring service delivery and outcomes. Assuring that prevention, treatment, and support services are evidence-based will require mental health service providers to examine their practices and the competencies needed by the workforce. The Ideal Services Array workgroup initiated a review of evidence-based strategies, practices, and programs; completion of this review will be an early task of the Stakeholders Advisory Group. Two criteria of effectiveness are that services are age- and developmentally appropriate and culturally competent. Ongoing quality service reviews will help to ensure that programs and practices are evidence-based, practiced with fidelity to the model, appropriate for the child's developmental stage, and culturally competent. Ongoing monitoring and evaluation of services will help to ensure that desired outcomes, both system wide and for individual children, are being achieved and that care staffs are receiving the training and information necessary to support attainment of outcomes. In addition, monitoring and evaluation will help to ensure access to care and reduce disparities in the care received. Assurance activities, including workforce development, ensuring use of age and developmentally appropriate and culturally competent evidence-based practices implemented with fidelity, monitoring and evaluation, and ensuring access to quality care, are important functions of the public mental health agency.

Recommendations for array of services and supports:

Service Access

- *Any child can be screened for mental health needs at the first sign or request of a parent or child serving entity.*
- *Make available education, information and outreach to families on promoting mental health, risks and signs of mental illness, where to get help, information about their child's illness and availability of support.*

Families and advocates have long claimed that for the system to be responsive and effective, the system of services should adopt a "no wrong door" approach. The learning from the physical health area is that access to care does not require presenting one's self at a hospital door. Rather, accessing care is available from any door.

Population to be served

The Stakeholders Advisory Group recognizes that even if all potential sources of support for the reformed system are leveraged, there will not be sufficient resources

available. Therefore, some prioritization of system effort may be required in order to make most effective use of available resources.

Plan of Care

- *An Individualized Plan of Care and Care Coordination is available to all children, as needed.*
- *All children and families have access to the right level and mix of personally selected individuals, community and professional staff who join together to support the family and develop a cohesive, supportive IPC.*

The Individual Plan of Care (IPC) is a process for making decisions about which services and supports are provided to individual children and their families and flows out of the screening, assessment, and evaluation process. Not all children involved in the system will need a IPC. The needs of children involved in prevention activities and early intervention services and supports will be addressed by the program. The IPC process is an individualized, comprehensive, and coordinated planning process across child-serving systems. Missouri's individualized planning model(s) will ensure that the planning process gives the family and youth choice and decision making, is culturally relevant, and the services and supports identified match the level of need, and supports a community-based approach. An Individual Plan of Care is central to assuring each child and family served in the system has control over their services and that direct service planning and coordination occurs.

Key to assuring children receive the services and supports they need in a timely fashion is **care coordination**. To serve the broad range of children's needs, the system needs to incorporate a care coordination approach. The approach may vary based on level and complexity of need and may be provided by more than one system.

Bringing a team of individuals together to partner with a child and family to create an IPC builds on current Missouri resources as well as federal and state mandates by utilizing existing service planning entities within each system. Although current practice is not consistent across agencies and across the state, each system has access to or is required to develop an individualized planning team as a vehicle to address the unique needs of any child. These teams may already be involved with the child and reflect a group of individuals who know the child best in all areas of functioning and that are willing to meet on a regular basis to assist the child and family in identifying needs, supports, and services. Many children will never need a team but for children with severe and complex needs involved in more than one system a team provides an important cross-system perspective.

Service Array:

- *Make available in all areas of the state an array of services addressing prevention, treatment and ensuring a smooth transition to adult services when necessary.*

Evidence-based practices and quality assurance:

Reforming Children's Mental Health Services in Missouri
A plan submitted to the General Assembly per S.B. 1003.

- *When possible, services and supports are based on effective and evidence-based programs and practices.*

Use of evidence-based practices is not uniform across the children's mental health services system. Implementation of evidence-based practices will require an assessment of risk factors and needs, training of the workforce, and identification of age- and developmentally appropriate practices and programs. Research over the past 20 years has concluded that there are practices and programs that are proven to be effective in addressing the mental health needs of children and their families; and many of these practices and programs are, additionally, cost-effective (see Washington State study). The bulk of the research has been in the specialties of substance abuse and delinquency prevention and they have clearly demonstrated that effective programs and practices, administered with fidelity, are likely to reduce substance use and delinquency. In fact, Mary Ann Pentz, Ph.D, has stated that declines in child and adolescent use of marijuana and other illicit drugs and, to a lesser extent, alcohol can be traced to the adoption of evidence-based prevention curricula in schools and by communities (Pentz, 2004). Preventive intervention programs such as Multi-systemic Therapy are proven to interrupt progression to adult criminality and addiction and alcoholism and to result in increased socially appropriate behavior and strengthened families; Family Strengthening programs reduce inter-generational transmission of behavioral disorders and enhance chances of social success. Locally, early results from Missouri SPIRIT seem to indicate that evidence-based programs implemented with fidelity effectively address risk factors for development of behavioral disorders; absenteeism rates are lowered, school disciplinary incidences are lowered, and alcohol and other drug use among high school students is markedly reduced. Evidence-based programs can reduce, over time, the cost of untreated or ill-treated behavioral disorders. Yet, it is necessary for even the most highly effective program or practice-set to be implemented with fidelity.

Quality monitoring and assessment is a necessary component of an effective system. Routine and ongoing quality monitoring and assessment helps to assure that the care needs of children are being met in the most effective manner; and that family involvement, a crucial element of effective care, is maximized. Quality Service Reviews, which are being implemented in Missouri System of Care sites, are an example of a methodology to ensure that the services provided are effective and appropriate; this quality assurance methodology will be extended throughout the state as resources allow.

Workforce Development:

- *Consistent training on emotional risk factors for all partner agency staff, local school and court personnel and physical health practitioners.*
- *Competency-based training in identified evidence-based practices*
- *Systematic orientation to the comprehensive system across all systems with a focus creating strengths-based partnerships with families.*

Implementation of the Comprehensive Children’s Mental Health Services System will require a commitment from all partners to workforce development and the overall education of stakeholders regarding the mental health needs of children. The education must be inclusive of all stakeholders and include a description of the structure and process of the system. There is also a need for a systematic approach to staff orientation and skill building to ensure competence in identification, assessment, and treatment, including clinical expertise, of mental health needs. Finally, a comprehensive funding strategy to support ongoing training activities across all systems is a critical component.

While the training requirements are massive and critical to the overall success of the Plan, training is not the only issue relevant to the development of a competent workforce. The Current Mental Health Services Workgroup identified additional workforce issues including staff turnover and retention, the need for competitive pay ranges for qualified staff and the severe shortage of qualified mental health staff in most of Missouri’s rural areas. The Missouri Foundation for Health reported that three-fourths of Missouri’s counties are considered mental health professional shortage areas (Missouri Foundation for Health, 2002). Lack of qualified staff creates service access difficulties related to all types of mental health services.

Evaluation and Monitoring for Quality Service:

- *Incorporate a quality improvement process including mechanisms for shared data collection and the Quality Service Review process to assure that data is used to monitor both system performance and child and family outcomes and monitoring results are used to improve the system.*
- *Develop and conduct an evaluation of implementing evidence-based prevention and early intervention programs, including measuring fidelity.*
- *Assure meaningful roles for youth and family members in the monitoring and evaluation.*

The Comprehensive Children’s Mental Health Initiative will provide the full array of mental health services, from prevention to inpatient care, involving multiple state as well as private agencies and providers. Collecting and analyzing data will be critical to the success of the system. We know that the various components of the existing system do not “talk” with one another very well when it comes to data and information. A top priority must be the establishment of a useable data system across all the agencies involved in the Comprehensive Children’s Mental Health Initiative.

The purposes of the data collection system are: to maximize the effectiveness of services and assist with decision making; and to evaluate the service system and its components to ensure accountability, efficiency and progress in achieving successful outcomes for children and their families.

There are both data collection and evaluation processes being used for specific components of the existing system. These processes include the **Missouri Juvenile**

Justice Information System (MOJJIS) and the Quality Service Review. MOJJIS is currently in use to collect data between the juvenile divisions of the circuit court and state agencies. The QSR process is being used to measure the quality and improvement of system in local system of care sites. Expanding and adjusting these processes along with the development of the proposed **Data Warehouse** and then applying them across the components of the system as it develops will provide the needed data collection, analysis, and accountability measurement. In addition, an evaluation of the implementation of evidence-based programs at selected sites will be undertaken.

Quality Service Review (QSR), which was designed by Dr. Ivor Groves of Human Systems and Outcomes, Inc., a nationally recognized expert on measuring system effectiveness, measures the quality of interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided. Under the QSR concept, each child served is a unique “test” of the service system. It is based on the logic that each child and family reviewed through the QSR becomes a unique and valid descriptor in assessing the system’s performance. The QSR highlights the strengths of the system, as well as the areas that need improvement.

The technique has a strong background in Missouri as it has been used extensively by the Department of Social Services (DSS) for Practice Development Review. It was also used with the Children’s System of Care Project established by the State System of Care Team, now known as the Comprehensive Service Management Team. The agencies and child advocates realized that in order to evaluate the effectiveness of the System of Care project and its components, the measurement process had to move beyond just reporting data about families served, to a measurement tool devised to track progress, measure quality, and make adjustments. The project builds on the previous use of the technique by DSS.

Ongoing Public Input

Reform of the children’s mental health system in Missouri is an ongoing process. The development and implementation of the plan for a comprehensive system is based on uniting the multiple state agencies and broad array of stakeholders in a commitment to better serve children and their families. Input has been a key component of the reform effort up to this point. Input from all stakeholders will be perhaps the most critical piece to assure continued success of this effort.

The stakeholder advisory group will continue to be the sounding board for ideas and the compass for direction as the state move the plan forward. Beyond this group, however, public input will be an ongoing part of the process.

Strategies will be implemented to obtain input from child mental health providers, the juvenile justice community, judges, educators, legislators, child and family advocates, and parents. A tremendous amount of input has been received to date from these stakeholder groups, and the process will continue to focus on these key interests.

Strategies include: holding public meetings throughout the state; participating in local, regional and statewide meetings, conferences and trainings; and soliciting comments on the plan through the worldwide web.

This input must not only come from the broadest array of stakeholders possible, it must also come from all levels of the system. - From individual parents, and families, and local providers and judges, to regional and statewide agencies, advocates and policymakers.

Summary of Recommendations and Goals

Developing a unified, comprehensive children's mental health system that provides a full array of services across developmental stages will require significant changes in financing; new program development; the implementation of new administrative structures and collaborative arrangements; and major workforce development efforts. To reflect the complexities involved in a change of this magnitude, the Plan reflects a five year transition plan for the creation of the necessary service capacity, infrastructure and management mechanisms. Effective management of a complex change process requires careful attention to sequencing and a mechanism for making mid-course corrections. The process will necessarily be incremental, as resources are shifted and capacity develops. The following is a summary of the recommendations along with a guide to both short and long term implementation goals planned for the next five years.

Recommendations & Goals of the Comprehensive Children's Mental Health Services System

Recommendation	Short-Term Goals	Long-Term Goals
Assess Mental Health Needs		
Develop a “data warehouse” process to compile needed data across the multiple child serving agencies of the comprehensive system in an integrated and reliable manner including level of functioning, service needs, utilization and financial information across all of the involved agencies.	<ul style="list-style-type: none"> Explore grant or private foundation funding to develop data warehouse. 	<ul style="list-style-type: none"> Develop data warehouse process
Develop a process to assist local areas to continually assess the factors contributing to mental health of children, to track emerging issues and to communicate findings to the CSMT	<ul style="list-style-type: none"> Review current and proposed statewide and local assessments of behavioral health needs as the basis for conducting assessments of mental health needs. 	<ul style="list-style-type: none"> Phase in statewide community assessment process to determine risk and protective factors, incidence and prevalence; risk levels among populations; available resources; and community readiness to act.
Policy and Administration		
Jointly establish policy to support key system components	<ul style="list-style-type: none"> Create a formalized structure for policy & decision-making across departments at the cabinet level. 	
The Comprehensive System Management Team (defined in SB1003) to function as the management structure responsible for implementation of the comprehensive system. Provides coordination and	<ul style="list-style-type: none"> Finalize CSMT structure, protocols, and membership Provide orientation to all members regarding comprehensive system, 	<ul style="list-style-type: none"> Include team membership responsibilities into job descriptions for CSMT

Recommendation	Short-Term Goals	Long-Term Goals
oversight to local system.	role and function of respective groups. <ul style="list-style-type: none"> • Develop a process and structure for communication regarding system implementation and reporting mechanisms 	representatives.
Create a Stakeholder Advisory Group to the Policy and Administrative interagency structures.	<ul style="list-style-type: none"> • Develop charge to Stakeholder Advisory Group • Identify & orient membership • Create workgroups, as identified by group to include <ul style="list-style-type: none"> ○ Public Education ○ System Development Monitoring ○ Enhancing Parent Involvement 	<ul style="list-style-type: none"> • Develop ongoing mechanism for communication with system structures.
Consideration of an area management structure to assure the children’s mental health system serves the needs of communities and families and is adaptable to geographic and cultural differences.	<ul style="list-style-type: none"> • Explore composition and structure of local area interagency/stakeholder teams • Increase family and youth membership on existing local/area interagency teams representing a broad perspective of needs and systems. • Establish reimbursements/supports to facilitate family involvement. • Create mechanism to support parents working in each child serving agency to function as resource guides to assist 	<ul style="list-style-type: none"> • Develop evaluation data and community needs assessments to inform resource allocation across systems. • Ensure local mechanisms for a clinical quality/utilization review process, barrier identification and technical support is available to individual

Recommendation	Short-Term Goals	Long-Term Goals
	<p>families in accessing information about the systems and to serve as a feedback mechanism for the Stakeholder Advisory Group.</p>	<p>child and family teams.</p> <ul style="list-style-type: none"> • Identify how the system will interface with service providers. • Include team role and responsibilities in job descriptions, performance appraisals across all systems.
<p>Increase family participation at all levels of administrative structure.</p>	<ul style="list-style-type: none"> • Actively increase family involvement at all levels, including families representing various systems. • Expand family supports to facilitate involvement including transportation, childcare, and any special needs to participate (interpretation). 	<ul style="list-style-type: none"> • Provide capacity-building support that gives families the information, skills, and confidence to partner, including training, peer and non peer mentoring.
<p>Financing:</p> <ul style="list-style-type: none"> • Ensure sufficient & flexible funding will be available to support an efficient system of activities, services and supports across the service spectrum. • Establish an integrated funding mechanism to support required workforce enhancements • Create a policy and fiscal mechanism to support family participation at all levels. 	<ul style="list-style-type: none"> • Conduct a formal assessment of resources currently available for children’s mental health services across federal and state agencies. • Submit FY05 budget request to support priority services. • Implement the voluntary placement option under Title IVE of the Social Security Act. • Expand home and community based mental health services available 	<ul style="list-style-type: none"> • Create incentives to expedite eligibility and support home and community-based services, when appropriate • Develop strategies for blending or braiding funding to assure non categorical service capacity.

Recommendation	Short-Term Goals	Long-Term Goals
	<p>through changes to the Medicaid Community Psychiatric Services Rehab Option for children.</p> <ul style="list-style-type: none"> • Seek federal approval for a home and community based waiver program [1915(c)] for children with SED, including children returning to the community from placement under SB266 	<ul style="list-style-type: none"> • Explore options for a research and demonstration waiver to blend federal funding streams (1115C) to support a comprehensive system. • Identify a payment structure/methodology for the system.
The Array of Services and Supports		
<p>Service Access:</p> <ul style="list-style-type: none"> • Any child can be screened for mental health needs at the first sign or request of a parent or child serving entity. • Make available education information and outreach to families on promoting mental health, risks and signs of mental illness, where to get help, information about their child's illness and availability of support. 	<ul style="list-style-type: none"> • Develop a plan and establish responsibility for educating professionals and others about mental illness and to detect early warning signs. • Pilot 3-4 indicators in each age bracket on emotional/mental health risk factors within current Medicaid health screen for children (EPSDT) • Develop materials to educate families and disseminate. 	<ul style="list-style-type: none"> • Based on pilot, explore development of a partial mental health screen under Medicaid EPSDT • Material will be disseminated across the state to professionals, schools, and medical staff. • A public education campaign will be developed for media and community use. • All new parents will receive this information at birth or

Recommendation	Short-Term Goals	Long-Term Goals
		following adoption.
<p>Plan of Care:</p> <ul style="list-style-type: none"> • An Individualized Plan of Care is available to all children, as needed • Care Coordination is available to all children, as needed. 	<ul style="list-style-type: none"> • Create a workgroup to conduct assessment of the care plans currently used by the various agencies and staff and identify essential requirements. • Test a nationally recognized IPC model in the two federally funded system of care sites and conduct a fidelity study. • Based on assessment of current practice and findings from test sites, the CSMT will explore feasibility of adopting a comprehensive care plan with a universal format. • Develop mechanisms to ensure safeguards for family voice when they don't agree with their care coordinator, team, or provider agency. 	<ul style="list-style-type: none"> • Field test the universal care plan format • Develop a curriculum to train staff in ICP development • Conduct a review to determine the feasibility of utilizing the IPC as the method for authorizing funding at the individual child level and how funding would flow in support of the IPC.

Recommendation	Short-Term Goals	Long-Term Goals
	<ul style="list-style-type: none"> Care coordination mechanisms to be explored as part of ICP workgroup activities. 	
<p>All children and families have access to the right level and mix of personally chosen representatives, community and professional staff who join together to support the family and develop a cohesive, supportive service plan.</p>	<ul style="list-style-type: none"> Create an interagency task force to assess status of current practice, identify commonality of tools and practice across systems and identify best practice. Develop tool kit and training curriculum to ensure consistency of practice statewide Pilot in federally funded system of care sites 	<ul style="list-style-type: none"> Train across all systems statewide Ensure fidelity through incorporation into Quality Service Review Support practice by incorporating practice expectations into job descriptions, performance appraisals, and supervisory functions.
<p>Service Array:</p> <ul style="list-style-type: none"> The system will have available in all areas of the state an array of services addressing prevention, treatment and ensuring a smooth transition to adult services when necessary. Evidence-based practices established whenever possible based on effective and evidence-based programs and practices. 	<ul style="list-style-type: none"> Hold a state level summit on school-based mental health services. DESE and DMH to identify EBP within school-based mental health and highlight successful programs Conduct national scan for appropriate evidence-based practices Expand SPIRIT activities 	<ul style="list-style-type: none"> Expansion of service capacity based on capacity study. Select and implement evidence-based practices Monitor and evaluate programs through QSR
<p>Workforce Development</p> <ul style="list-style-type: none"> Consistent training for all partner agency staff, school personnel, and physicians on emotional risk factors. Ensure competency-based training statewide in 	<ul style="list-style-type: none"> Develop a workgroup to assess training needs, available resources, identify workforce issues and develop a comprehensive training plan. Promote a strength-based, family 	<ul style="list-style-type: none"> Develop cross system funding mechanism to support orientation and identified training on system.

Recommendation	Short-Term Goals	Long-Term Goals
<p>evidence based practices.</p> <ul style="list-style-type: none"> All training includes a family strengths-based and cultural competency approach. 	<p>partnership model in all service development and staff training across all agencies.</p>	<ul style="list-style-type: none"> Establish mechanism for ongoing workforce development to ensure evidence-based practice across front-line staff.
<p>Evaluation and Monitoring for Quality Service</p> <ul style="list-style-type: none"> Incorporate a quality improvement process including mechanisms for shared data collection and quality services review to assure that data is used to monitor both system performance and child and family outcomes and monitoring results are used to improve the system Develop and conduct an evaluation of implementing evidence-based prevention and early intervention programs, including measuring fidelity. Youth and family members will have meaningful roles in the monitoring and evaluation. 	<ul style="list-style-type: none"> Seek grant or foundation funding to support development of a Data Warehouse Complete QSR pilot in local system of care sites and develop report. Develop mechanisms to ensure random selection of child & families for QSR process and safeguards protecting families from reprisal as a result of their participation in an evaluation of their child's services. 	<p>Phase in QSR process throughout the system.</p>

STATUS OF REFORM

Background

For 15 years, the Missouri Department of Mental Health (DMH), advocates, family advocates, and providers have worked together with other state child-serving agencies to improve outcomes for children with mental health needs and their families. In 1989 Missouri received a five-year grant from the National Institute of Mental Health and initiated the Child and Adolescent Service System Project (CASSP); and local interagency teams were developed in key sites. In 1992-93, in response to House Bill 503, DMH piloted the 503 Project, an interagency System of Care (SOC) demonstration for children and youth with severe emotional disturbances (SED), in St. Louis County. In 1998, the Interdepartmental Initiative for Children with Severe Needs and Their Families began. This ambitious effort among the state's child-serving agencies, while not realizing all of its goals, did further the development of community-based services and provider networks. The Missouri System of Care (SOC) initiative was launched in 2002 with the creation of a state level SOC interagency team, which included families, advocates and representatives from all state child-serving agencies. In 2002 local projects were implemented in six counties across the state.

In addition to the above efforts, the state also implemented Missouri's Caring Communities initiative, which linked the services of schools, neighborhoods, and public agencies in 21 communities and across eight (8) State agencies. Both Caring Communities and SOC have been primary vehicles through which various public service agencies and families have come together to develop public policy regarding children, youth and families.

Senate Bill 1003 (SB 1003) is the culmination of these early efforts in addition to being a consolidated response to previous legislation addressing some parents' being required to relinquish custody in order to obtain necessary mental health services. The recommendations in the Comprehensive Children's Mental Health Plan build on existing resources, draw from research on preventing and treating mental disorders, and incorporate past experiences as the starting point for creating a truly comprehensive, responsive, and evidence-based system of mental health services for Missouri's children and their families.

Current Status of System Change

The challenge during any system development is to launch and sustain a necessary three-part strategy that : 1) addresses the immediate press of relinquishment of custody created by the unmet needs in the current system; 2) broadens and expands the collaborative state and community resource pool; and 3) creates a system improvement process to ensure that the most effective resources are available with the most efficient pathways to access these resources. DMH and its partners have already made great strides in addressing issues identified in the legislation as

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needing an immediate response. Work has also begun to identify ways to enhance and broaden needed resources and to create mechanisms for system improvement. Other relevant initiatives have also been consolidated under the comprehensive system planning process to streamline efforts and enhance the final system. The following is a status report of efforts to date.

1. Immediate Response Activities

Relinquishing Custody

As noted previously in this report, the inability of the current system to meet the mental health needs of children and their families can sometimes cause families to relinquish custody of their child to the state for the sole purpose of accessing mental health care. This usually involves children with the most severe needs. Legislation passed in each of the past three legislative sessions – Senate Bill 923, Senate Bill 266, and Senate Bill 1003 – has taken steps to address this horrible situation for families.

Diversion Protocols

One step has been the development of a protocol to divert families from the facing the situation of considering relinquishing custody when their only need is mental health services. The protocol is specific steps that child serving agencies must follow in those cases involving parents who are considering voluntarily relinquishing custody of their child for the sole purpose of accessing mental health care. The protocol has been implemented in the 12th Judicial Circuit, which includes Audrain, Montgomery, and Warren counties, and the 21st Judicial Circuit which includes St. Louis County. All judicial circuits have been trained in the use of the protocol, making implementation possible throughout the state.

The protocol is predicated on the belief that no parent should voluntarily have to relinquish custody of their child to access mental health services, if clinically appropriate services and supports, either within or outside the home setting, can be provided to the youth and family. So far, in the communities using this protocol, 20 children have been diverted from state custody, and 75 percent of those children were supported in their community while remaining with their families.

Returning Children to Custody of their Parents

Another step has been the identification of children already in state custody solely for mental health services, and returning custody of those children to their families. Senate Bill 266 called for the identification of those children and Senate Bill 1003 established a framework to return those children to the custody of their parents, when appropriate.

The Department of Mental Health and Department of Social Services hired Alicia Smith & Associates to conduct the evaluation called for by Senate Bill 266. The report identified 296 children ages 3 – 17 that likely entered foster care during a

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one-year timeframe between January 1, 2002, and December 31, 2002, solely to access mental health services; the report also estimated that there were approximately 300 children already in the foster care system during that period who appeared to meet the criteria. The criteria for identifying these youth were:

1. The circumstances for removal were identified as: child's behavior problem; child's disability; child's alcohol abuse; child's drug abuse; abandonment or relinquishment; and
2. The child was placed in an institutional setting within 90 days of being placed in state custody for any of the above reasons except abandonment.
3. When the circumstance was abandonment, the child was placed in an institutional setting on the date they were placed in state custody.)

Identified Children with any of the following were then screened out of the final report:

1. Those with a substantiated report of child abuse or neglect within the year prior to state custody.
2. Those with a moderate or severe mental retardation disability.
3. Those who did not access mental health services within six months of being placed in state custody.

In 2004, the Children's Division (CD) initiated a case review process using the proxy method developed by Smith. This review identified approximately 550 children who met the criteria. The CD, upon further review of these 550 children, identified 112 in state custody who possibly meet SB 1003 criteria of as having been placed for need of mental health care only. Children's Division staff is in the process of convening Family Support Teams for the children identified to determine future custody status. The CD is also in the process of conducting a more detailed review of the remaining 438 children in order to assure that all efforts to identify and return to the custody of families are implemented. As families come forward and self identify as having given up custody to obtain mental health services for their child, these children will also be reviewed through the Family Support Team process. A separate report has been developed jointly by the Departments of Mental Health and Social Services detailing efforts and status of children identified through procedures established under SB 266 and SB1003.

2. Activities to Enhance and Broaden Resources

Workforce Development and Training

A critical component of a successful child mental health system is the cooperation of the juvenile justice and mental health system. A concerted effort to further this cooperation is underway. Training has been conducted with the juvenile justice system on the implementation of SB 1003 and the development of a comprehensive children's mental health services system. At the Missouri Juvenile Justice Association conference in October, 2004, training was provided on the Plan for the

children's mental health system, as well as on the issues of custody diversion, custody transfer and Quality Service Review.

In addition a specific effort was made to improve collaboration between the juvenile justice and mental health systems. The first of four scheduled regional trainings were held with juvenile justice and mental health providers attending as local, interagency teams. At this training, the teams heard a national and state perspective on mental health and juvenile justice issues. Teams also met for facilitated discussion of the roles and responsibilities of the members of the team. The teams were encouraged to develop local solutions and identify what needs to be done at the state level to enhance cooperation between the juvenile justice and mental health systems.

Also critical is the working relationship between the local school systems and mental health systems. The Missouri school counselors, at their annual conference in November, 2004, identified some of the issues that need to be addressed in order to enhance collaboration with mental health service providers. These issues included: language barriers between mental health providers and school personnel; the need for funding for programs and services in schools; lack of local access to mental health services; accountability for mental health providers; the need to be included as part of a team with mental health providers; and the lack of mental health professionals and services in some areas of the state. A plan to address these and other issues with local schools is being developed and will be incorporated into the Comprehensive Children's Mental Health Services System Plan.

A review of the health professional shortage areas in Missouri for both mental health professionals and psychiatrists indicates a critical need for these services. Families and providers have consistently reported lack of local access to child psychiatrists and psychologists as fundamental problems in accessing services. To address this problem, the Department of Mental Health and Department of Health and Senior Services are working to encourage mental health care professionals with child expertise to provide services in shortage areas. Some of the efforts include a waiver program from the U.S. Department of State that waives the requirement for students in the mental health professions to return to their native country in exchange for three years of service in a health professional shortage area; and a program which repays outstanding educational loans in exchange for providing services in areas of need in Missouri. Participants must accept Medicaid consumers. The Department of Elementary and Secondary Education (DESE) and Department of Higher Education (DHE) are engaged in mental health training activities. DESE's Division of Special Education has implemented a system of personnel development that is coordinated with each school district's Professional Development Plan. Under this initiative, local schools assess and identify their needs regarding: (1) the number of qualified personnel available to serve all students with disabilities; (2) the appropriate in service training that staff need; (3) required training for paraprofessionals; and (4) dissemination of relevant research, instructional strategies, and adoption of effective practices.

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For the past four years, the Department of Mental Health and the Curators of the University of Missouri – Columbia have had a contract for the Center of the Advancement of Mental Health Practice in Schools. The Center is 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 trained 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 Center has received recognition for its efforts in promoting awareness of school-based mental health issues, including: national recognition from the National Center for School Mental Health Assistance for one of its mental health modules and one of its online courses. There are 21 graduate students enrolled in Center programs.

Financing

Senate Bill 266 passed in 2003 mandated that the state evaluate the number of children who had likely been placed in the custody of the state solely to gain access to mental health services, and to make recommendations for financing those services. The Department of Mental Health hired Alicia Smith & Associates to conduct the evaluation, which was noted above under “relinquishing custody.”

The Alicia Smith report estimated the cost to treat these children at approximately \$3,600 per child per month, or about \$43,000 per year in state and federal funds. The report recommended two options for the state to pursue to address both the children identified in the report, and the development and implementation of the comprehensive children’s mental health service system. The recommendations are: Voluntary Placement option under title IV-E of the Social Security Act; and Section 1915 (c) home and community based waiver under the Medicaid Rehab Option.

Voluntary Placement under Title IV-E

Voluntary placement allows a family to relinquish physical custody but retain legal custody of their children. These children become eligible for mental health services reimbursed by Medicaid and residential services funded with Title IV-E funds. The voluntary placement is for 180 days and is meant to be a respite for parents. This option does not solve the problem of long-term residential care, but the state is exploring this as an option for a small subset of children. The Voluntary Placement

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Option will operate in conjunction with the Diversion Protocol mentioned previously. The Voluntary Placement will be available statewide as of January, 2005.

1915 (c) Home and Community Based Waiver

The 1915 (c) waiver allows the state to receive federal matching funds to offer an array of community based services to children who would otherwise receive institutional placement. Initially, the waiver would cover those children identified by Senate Bill 266 who would be returned to the custody of their families. It is possible to expand this program to additional children as state funds become available. The waiver could also be used to help finance the comprehensive children's mental health service system.

The state has set up a financing workgroup to plan for this waiver. The Department of Mental Health and Children's Division are working to apply for the waiver in 2005. Depending on the response from the federal government, implementation could begin in mid to late 2005.

Services

Prevention

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

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

Early Identification and Intervention

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

The Department of Health and Senior Services received a two-year planning grant to strengthen collaboration and promote effective utilization of resources through development of an Early Childhood Comprehensive System. The Department of Mental Health is on the Interagency Steering Committee. The Early Childhood Comprehensive System Planning Coalition is made up of representatives from the Children's Services Commission Subcommittee on Early Childhood, as well as families and other groups with strong early childhood interests. Additionally, subcommittees have been formed to address the five mandated focus areas: Access to Medical Homes; Mental Health and Social-Emotional Development; Early Care and Education/ Child Care Services; Parent Education Services and Family Support Services; and Reduction in Minority Health Disparities.

HB1453 established a Coordinating Board for Early Childhood with representation from the departments of health and senior services, mental health, social services and elementary and secondary education; governor's office; the judiciary; the Family and Community Trust Board; Head Start; and nine members appointed by the governor representing groups such as business, philanthropy, civic groups, faith-based organizations, parent groups, advocacy group, early childhood providers and other stakeholders. The Coordinating Board will develop a comprehensive long-range plan for a cohesive early childhood system, promote and improve the development of children from birth to age five, identify legislative recommendations to improve services for this population, promote coordination of existing services and programs, promote research-based approaches to services and ongoing program evaluation, and identify service gaps. A Coordinating Board for Early Childhood Fund was also established which can accept private and public moneys to carry out its duties.

School-based services

Efforts are underway between the education community and mental health to explore how education and mental health can work together to better utilize resources and provide services for school-age children. The Department of Elementary and Secondary Education, the Children's Division, Medicaid, Missouri School Board Association and Department of Mental Health are reviewing the current practices in Missouri related to school-based mental health services. The review includes an analysis of the mental health services currently provided in the

schools, the payer of these services (e.g. Medicaid, IDEA), identifying the gaps in mental health services in the schools, exploring how these services can be funded through Medicaid, and finally establishing standards of care for the services. As a means of beginning this work, focus groups were held this fall with local school personnel to provide their perspective on mental health needs of children in school. In a jointly DMH and DESE sponsored focus group held with the support of the Missouri School Board Association, participants recommended that treatment and services for children with mental health issues needs to be in the context of the school environment. A presentation on SB1003 was made to School Counselors who identified barriers that will need to be addressed as school-based services are developed.

Juvenile Justice

The Missouri Alliance for Youth is a partnership between the Department of Mental Health and juvenile justice system. The partnership is committed to improving services for youth with mental health needs involved in the juvenile justice system. For example The Alliance supported the MO MAYSII Project which screened youth in detention, Division of Youth Services and referred from the community to the juvenile office for mental health needs and issues. Results were reported separately and as a comparison across these 3 groups. Thirty-six percent of the youth screened has a history of mental health services. Approximately 74% of the youth screened positive on at least one scale. Full reports on this data are available through the DMH. In FY004 the Alliance Steering Committee provided support for a budget item for the DMH to support partnerships between community mental health centers and juvenile offices to better serve youth at risk of or currently in the juvenile justice system. The Alliance also currently supports implementation of a Challenge Grant through the Department of Public Safety with a focus on training for mental health and juvenile justice professionals to work more collaboratively.

3. System Improvement Process Activities

Federal Grants

The Department of Mental Health in partnership with other child serving entities has helped develop local interagency teams to oversee coordinated community-based services for children with complex mental health needs requiring services from more than one system and their families. Currently local teams are working in Adair County; St. Louis City and St. Louis County; Jackson County; St. Charles County; St. Francois County; and Butler and Ripley counties. Federal grants have helped to support this effort by providing funding for an integrated, inter-agency, community-based "System of Care" in three areas of the state. The Partnership with Families in St. Charles County just completed a six year federally funded initiative that helped to create an integrated system of care. In 2001, the state was awarded a six-year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to support system of care development in the southwest counties of Greene, Christian, Taney, Stone, Barry and Lawrence. Local project development for this system of care is managed through partnerships with two

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Department of Mental Health Administrative Agents – Burrell Behavioral Health and the Clark Center. The DMH also received SAMHSA funding in 2003 to support the system of care efforts through the Transitions project in St. Louis City and St. Louis County. These federally funded sites provide a rich environment to learn what is needed to support true service integration at the community level. In 2005 both sites will pilot a nationally recognized model for developing individualized care plans. Their efforts will help inform the CSMT workgroup as it develops guidelines for implementing evidence-based practice statewide.

Quality Management

Quality Service Review

Missouri's child-serving agencies selected Quality Service Review (QSR) as the process to measure quality and evaluate the effectiveness of services for the children's mental health system of care projects developed around the state under the System of Care Grant (SOC).

QSR is a tool to measure the quality of interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided. QSR is critical to the project's ability to track progress and make adjustments. . Approximately 60 individuals from the various child serving agencies including Department of Mental Health, Department of Social Services, Department of Health and Senior Services, Department of Elementary and Secondary Education, as well as parents of children receiving services from these departments have been trained as qualified reviewers for the QSR. To date, six of the local SOC sites have completed their initial QSR process. These reviews involved approximately 47 children at the six sites. An aggregate report based on the six sites that have been reviewed will be completed by end of January 2005.

Missouri Juvenile Justice Information System (MOJJIS)

The Missouri Juvenile Justice Information System (MOJJIS) was created to bring the juvenile divisions of the circuit courts and various state agencies into compliance with the Juvenile Crime Bill. The juvenile divisions of the circuit courts and the departments of social services, mental health, elementary and secondary education and health and senior services share information regarding individual children who have come into contact with, or been provided services by the courts and departments. MOJJIS was formalized through a memorandum of understanding between the courts and state agencies.

Next Steps

Developing a unified, comprehensive children's mental health system that provides a full array of services across developmental stages will require significant changes: in policies and state infrastructure; changes in the way the system is managed; and changes at the service delivery level. Effective management of a complex change

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process requires careful attention to sequencing and a mechanism for making mid-course corrections. The process will necessarily be incremental, as resources are shifted or expanded and capacity develops. To reflect the complexities involved in a change of this magnitude, the Plan reflects a five year transition plan for the creation of the necessary service capacity, infrastructure and management mechanisms. As described in the Plan (page 13), the period from FY2005 through FY2006 focuses primarily on planning and transition activities necessary to support long term system change in four major areas:

Policy and state infrastructure

Identify legislative and budget issues: Over the next year legislative and budget items needed to support system reform efforts will be identified within each of the work groups created by either the CSMT or the Stakeholder Advisory Group and reported to the Department Directors.

System Management and Improvement

Comprehensive System Management Team: The existing CSMT membership has been expanded to meet the requirements of the legislation. During 2005, four workgroups will be created under the direction of the CSMT to continue addressing the recommendations generated in the planning workgroups. Workgroups include: financing; workforce development; evaluation and quality assurance; and evidence-based practices including the individualized care plan process.

Stakeholder Advisory Committee: The Stakeholder Advisory Committee will be established as described in the Plan (page 24). The first task of this group will be to develop by-laws and operating procedures. Four standing committees will then be created to ensure the following critical functions are addressed:

- Public Education of Missouri citizens, especially families on the importance of mental health, issues of mental and emotional disorders and how to access the system, if needed.
- Monitoring both the activities initiated in response to the various legislation concerned with custody relinquishment and activities related to development of a comprehensive children's mental health system. As a first step, this committee will review the recommendations developed by the Implementation of Child Welfare/Mental Health Reform Workgroup.
- Family Participation. The Plan calls for family participation at all levels of the system. Effective family participation requires a range of support activities and resources. A committee comprised of family members and other stakeholders will develop recommendations on what is needed to ensure this critical component of the system.

- Cultural competency: Missouri is a diverse state and values the unique differences of its people. Ensuring that the system develops in ways that best honor and work within this diversity is vital and complex work that can not be an afterthought. Therefore a standing committee will be created responsible for providing oversight and guidance regarding cultural competency.

Changes at the Service Delivery Level

Communication Plan:

- Providing information and education to the citizens of Missouri, including families and local service providers is a core component of the Plan. A plan detailing communication efforts regarding Senate Bill 1003 and planning activities has been developed. An initial step to creating change at the service delivery level is to increase awareness. A basic presentation package will be developed on SB1003 and the Plan to be used by staff and Stakeholder Advisory Group members to increase awareness within communities. A video showing department leadership working in partnership will be included to stress the point that this is not just a mental health initiative but a jointly shared plan.
- As schools are a door for many children in need of mental health services, it is essential to create a mechanism for communication and training between the local school systems and the state interagency partnership which includes DESE. To begin this dialogue a state summit will be held during FY006 focused on the mental health needs of children in school.

Relinquishing Custody: work will continue on addressing the immediate issues identified in SB 266, HB923 and SB1003 regarding relinquishing custody.

- Diversion Protocols: statewide implementation of the protocols will continue and be monitored.
- Returning Children to Custody of their Parents: Family Support Teams will continue to be convened as children are identified.

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Missouri Suicide Prevention Plan

A Collaborative Effort



Year 2005-2010

Bringing a National Dialogue to the State

The Personal and Public Tragedy of Suicide

The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.

Kay Redfield Jamison

Suicide is the eleventh leading cause of death for adults and the third leading cause for kids.

There are many more suicides in Missouri than homicides

Every day 2 people die by suicide in Missouri

INTRODUCTION

Purpose of the Suicide Prevention Plan

“Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives.”¹ “Compounding the tragedy of loss of life, suicide evokes complicated and uncomfortable reactions in most of us. Too often, we blame the victim and stigmatize the surviving family members and friends. These reactions add to the survivors’ burden of hurt, intensify their isolation, and shroud suicide in secrecy.”²

In response to national recognition of suicide as a worldwide public health problem, collaborative planning efforts began in Missouri that resulted in the passage of legislation in 2003 that mandates the development of this statewide suicide prevention plan. The Missouri Suicide Prevention Plan has been developed with broad input from public health experts, mental health providers, suicide survivors and twelve town hall meetings conducted in communities across Missouri (Appendix 1). The recommendations have been developed using reviews of research, experience of other states in suicide prevention and experience gained in suicide prevention efforts in Missouri. Broad community input was sought to tailor the scientific knowledge and national experience to address the specific needs of Missouri communities and organizations.

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

Suicide Prevention Principles for Missouri

A ten person working group comprised of community representatives, consumers and state agency representatives was convened to draft the plan. In developing the plan, the group envisioned the development of community based plans and programs that:

¹ National Strategy for Suicide Prevention, p. 17

² Surgeon General’s Call to Action

- Enhance or strengthen protective factors and reduce the impact of risk factors.
- Promote and address help-seeking behaviors as the norm.
- Are targeted to the level and type of risk of the specific population in Missouri.
- Are developmentally appropriate and culturally sensitive.
- Are focused and adapted to the specific needs of a local area's population.
- Are sustainable with repeated positive messages, prevention strategies and evaluation.

Definitions and clarifiers are included in the Appendix

SUICIDE PREVENTION AND THE PUBLIC HEALTH APPROACH

Suicide is a preventable public health problem.

There is a growing body of evidence indicating that suicide is preventable. A large number of researchers have undertaken the task of understanding the roots of suicide and preventing its occurrence. Suicide can be prevented and its impact reduced in much the same way as public health efforts have prevented and reduced other health problems, such as infectious diseases, pregnancy complications, and injuries.

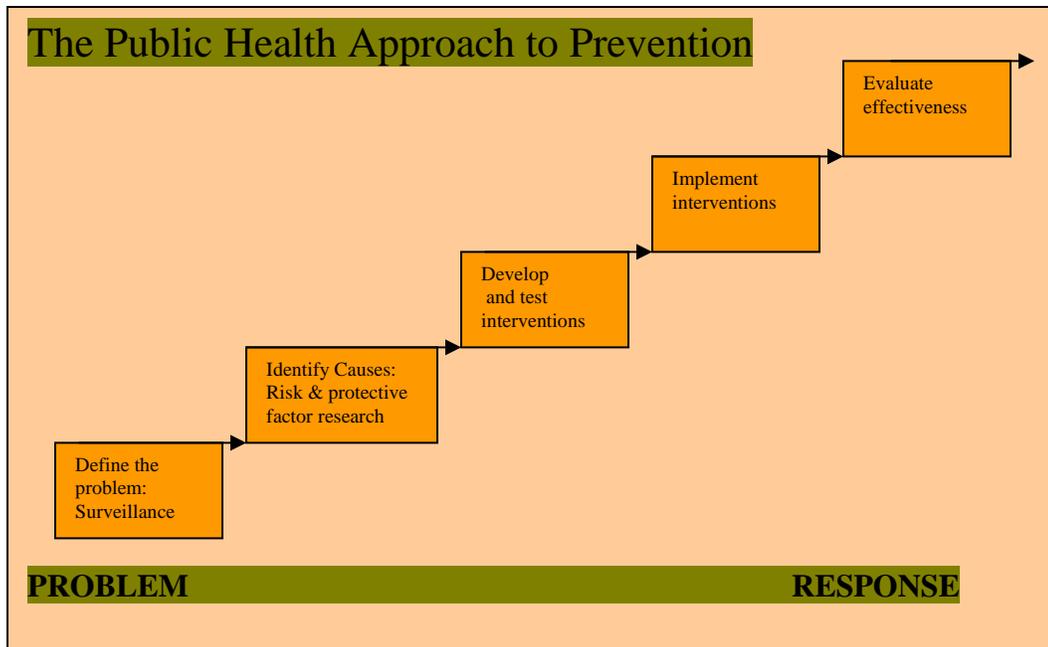
Many people find it difficult to identify suicide as a public health issue. Suicide is a major health problem because of the large number of people impacted and the enormous health care costs associated with it.

What can a Public Health Approach Contribute to Suicide Prevention?

The public health approach is a rational and systematic way to marshal prevention efforts and to assure that those efforts are effective. There are several characteristics of the public health approach that makes it the ideal way to address suicide prevention.

The public health approach to any problem is interdisciplinary and draws upon the knowledge of many disciplines. This broad knowledge base allows the field of public health to be innovative and responsive to the many different underlying issues thought to be associated with suicide and suicidal behavior. The public health approach emphasizes collective action and cooperative efforts among diverse agencies such as health, mental health, social services, education, law enforcement and corrections. The public health approach requires individuals, communities, organizations and leaders at all levels to collaborate in promoting suicide prevention.

In concert with the clinical medical approach, which explores the history and health conditions that could lead to suicide in a single individual, the public health approach focuses on identifying patterns of suicide and suicidal behavior throughout a group of population. The public health approach is based on the rigorous requirements of the scientific method, moving from problem to solution. It starts by defining the problem, and then identifies the risk factors, protective factors and causes of the problem. Utilizing that information, interventions are developed, implemented and evaluated for effectiveness.



Although the diagram above suggests a linear progression from the first step to the last, in reality the steps often overlap and depend upon each other. The next three sections of this report will address the specific steps of the public health model.

DEFINING THE PROBLEM OF SUICIDE

Suicide exacts an enormous toll from the American people.

- ▲ Suicide claims more than 29,500 American lives each year³
- ▲ Ranked 11th cause of death in the U.S
- ▲ The rate of suicide⁴ is 10.8 per 100,000 equaling 1.3% of all deaths
- ▲ Average 1 person every 17.2 minutes kills themselves
- ▲ For each completed suicide, as many as 25 people will make a non-lethal attempt

Suicide affects everyone, but some populations have higher numbers.

- ▲ Suicide is the 3rd leading cause of death for youth age 15 – 24
 - 19% of students have ‘seriously considered’ attempting suicide⁵
 - 8% have made a suicide attempt
- ▲ Elderly account for 18.1% of completed suicides
 - Over the age of 65, there is 1 suicide for every 4 attempts
 - 75% have seen a primary care physician within a month of their suicide

The economic burden of suicide is significant.

- ▲ Average medical cost per completed suicide exceeds \$2,000⁶
 - Average work-lost cost per case exceeds \$800,000
- ▲ Each day, as many as 10 suicide attempters are hospitalized
 - The medical cost per attempt averages \$7,500
 - The work-lost cost per case can be as high as \$10,000
 - The hospitalized rate for suicide attempts is 64.2 per 100,000

More Missourians die by suicide than by DWI, homicide, or AIDS.

- ▲ Missouri’s rate of suicide (*12.9 / 100,000*) is the highest in Region VII (*Kansas, Iowa, Nebraska and Missouri*)
- ▲ Suicide is the 11th leading cause of death in Missouri⁷
- ▲ Average 707 Missourians die by suicide annually⁸
- ▲ Leading methods of suicide: firearms, suffocation, and poisoning
- ▲ Men account for 78% of completed suicides; women 22%
- ▲ 93% White non-Hispanics; 6% Black/African-American of completed suicides

³ American Association of Suicidology, average 1999, 2000, 2001 Official Data Pages. www.suicidology.org

⁴ Suicide Rate = (number of suicides by group ÷ population of group) X 100,000

⁵ Youth Risk Behavior Survey, 2001. Centers for Disease Control. www.cdc.org

⁶ Suicide Prevention Resource Center, Missouri Suicide Prevention Fact Sheet; www.sprc.org

⁷ Missouri Department of Health & Senior Services, Vital Statistics; Table 19 2002, 2001, 2000
www.dhss.mo.gov/VitalStatistics/

⁸ MDHSS, Death MICA Statistics. 2002, 2001, 2000 averages. www.dhss.mo.gov/MICA/

RISK FACTORS AND PROTECTIVE FACTORS

The public health approach to suicide prevention often is based on decreasing risk factors associated with suicidal behavior and enhancing the protective factors. Understanding the interactive relationship between risk and protective factors in suicidal behavior continues to be studied and drives the development of interventions.

Risk Factors

Risk factors are a combination of stressful events, situations, and/or conditions that may increase the likelihood of suicide, especially when several coincide at any given time.

Risk factors for suicide include but are not limited to⁹:

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse (bullying, violence and assault)
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss (divorce, incarceration, legal problems)
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Sociocultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to suicidal behavior of others, including through media coverage and influence of others who have died by suicide

Protective Factors

Protective factors make it less likely that individuals will develop suicidal ideations; and may encompass biological, psychological or social factors in the individual, family and environment. Protective factors include:¹⁰

- Effective clinical care for mental, physical, and substance use disorders

⁹ National Suicide Prevention Strategy

¹⁰ National Suicide Prevention Strategy

- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation.

INTERVENTIONS: DEVELOPMENT, IMPLEMENTATION AND EVALUATION

The first two steps of the public health model provide important information about populations impacted by suicide. Developing that knowledge into effective interventions is a central goal of public health. Researchers in the field of suicide prevention are focusing efforts on specific groups. Interventions are grouped as follows:

Universal Interventions aimed at the general population without regard to individual risk.

Selected interventions aimed at those considered at heightened risk for suicide (having one or more risk factors).

Indicated Interventions aimed at specific individuals that have a risk factor or condition that puts them at extreme high risk.

Many suicide interventions have been developed and are being implemented; most continue to be evaluated to determine their effectiveness. Some of the more common interventions include clinical treatment, behavioral and relationship approaches, community-based efforts such as suicide and crisis prevention centers, school-based interventions, restricting access to means, gatekeeper training, improved access to care, awareness campaigns, media reporting and interventions with survivors.

The development, implementation and evaluation of effective interventions in Missouri is a major goal of this plan. The plan is intended to provide broad guidelines from which communities can base local planning and implementation efforts.

Recommendation

The overall goal of a state plan for suicide prevention is to reduce suicide and suicidal behaviors in all populations. Missouri has followed the AIM framework (Awareness, Intervention, Methodology) as stated in the Surgeon General's Call to Action with recommendations for initiatives in each of the three areas, awareness, interventions, and methodology.

Suicide is a huge, complex problem and Missouri's communities are too diverse in their members and needs for a single intervention to be adequate. Thus, a diverse array of interventions will be required to meet the particular local needs of the many unique communities in Missouri. Collaboration is essential if the activities outlined in this section are to be effective. The following are key to the success of this plan:

- Suicide prevention is everybody's responsibility. Every Missourian should effectively promote prevention efforts, whether at the individual, community or agency level.
- Additional federal, state and local funding should be pursued to increase access to mental health and substance abuse treatment and suicide prevention efforts.
- Communities should use this plan as a guide to develop and implement their own local plan.
- An overarching prerequisite recommendation calls for the immediate establishment of an Advisory Committee to monitor and oversee the effective implementation of the goals and activities set forth in this plan. The role of the Advisory Committee is to assure that focus and direction is not lost during the ongoing work of the many entities that will be required to implement the activities of this plan. (covered in more detail under "Focus 3: Methodology")

Focus 1 - Awareness

In Missouri, the suicide prevention messages should be consistent among all those engaged with awareness efforts. That message should include information regarding:

- Risk and protective factors,
- Reduce stigma by increasing the acceptability of asking for help around mental health issues,
- The importance of screening and early interventions,
- That effective treatments are available for mental illness and substance abuse disorders,
- Where to go for help.

Action 1: Develop a statewide public awareness initiative designed to change attitudes toward

accessing care, the acceptability of seeking help and the availability of treatment.

- Develop public service announcements, brochures, resource guides; billboards, videos, Internet Web sites, and a speaker's bureau.
- Identify Community partnerships and collaborations to distribute information.
- Identify funds and resources to assist in local implementation of awareness efforts.
- Promote the use of national and state suicide prevention hotline numbers.
- Develop strategies to target specific groups to receive information from the public awareness initiative. These groups will include but not be limited to the following:
 - Journalists, including print and broadcast media
 - School boards, administrators, staff, and students.
 - Social services, health, mental health and criminal justice professionals.
 - Public officials, libraries, clergy
 - Consumers, Survivors and families
 - Employer associations, unions and safety councils.
- Promote inclusion of suicide prevention as part of conferences and training that pertain to high risk populations.

Action 2: Promote activities to further investigate and implement ways to influence positive attitudes and behaviors (to seek help and to access appropriate treatment.)

Action 3: Develop training and education opportunities for providers of services to high-risk populations; including but not limited to:

- Education professionals
- Case managers
- Criminal justice professionals
- Seniors program providers
- Child and adolescent program providers
- Social services, health and mental health professionals
- Employee assistance programs
- Suicide prevention training experience should be included in
- Basic professional development courses
- Continuing education courses and workshops
- Conferences and training sessions

- Existing community based forums attended by the above groups.

Action 4: Ensure that the suicide prevention message is consistent across agencies and that the prevention strategies and information about the risk and protective factors are integrated into suicide-related materials of all groups and agencies.

- Monitor the development of suicide prevention messages and assure that they are guided by the state plan.
- Develop an advisory committee on suicide prevention that will keep the message consistent and complete through an identified staff to shepherd this effort in DMH.

Focus 2 - Interventions

Improve access and availability of services that encourage early detection, promote intervention and eliminate stigma associated with suicidal ideation/behavior

Action 5: Endorse, recommend and/or develop appropriate screening tools

- Assessment of coping and problem solving skills and help seeking behaviors
- Promote informal mental health screenings (anxiety, depression, stress, etc)
- Encourage inclusion of formal mental health screenings to the medical community
- Assure use of age appropriate tools for early identification of suicidal ideation across the lifespan

Action 6: Promote the development of prevention and intervention training within communities for all citizens

- Develop community education opportunities
- Recommend gatekeeper training curricula
- Include suicide prevention and intervention training for those working in elementary and secondary education and institutions of higher learning
- Identify key members of the community, both professional and lay persons
- Target providers of services to high-risk populations; including but not limited to
 - Education
 - Case Managers
 - Criminal justice professionals
 - Seniors program providers
 - Child & adolescent program providers
 - Social services, health and mental health professionals
 - Employee assistance programs
- Suicide prevention training component(s) should be included in
 - Professional curricula development
 - Continuing education and refresher opportunities
 - Conferences and related enrichment
 - Community based forums

Action 7: Publicize community, state and national crisis telephone hotlines

- Develop community rosters of available telephone services
- Assist providers of telephone services in marketing of services

Action 8: Develop community based interventions/action plans that support participation of minority and non-traditional populations (caregivers, 1st responders, etc.)

- Support the development of community based forums to address suicide
- Involve local communities and support local efforts to prevent suicide by assessing and acting on local risk or protective factors.
- Provide or assist in obtaining funding for prevention initiatives sponsored by local efforts.
- Facilitate formation of new suicide survivor support groups.

Action 9: Promote and encourage the use of existing local prevention and intervention resources including but not limited to:

- Mental health service providers
- Community service providers
- Opportunities to facilitate community networking; and
- Development of a community resource guide; provided via access to a data base or website

Action 10: Encourage collaboration among law enforcement, mental health and other service providers

- Implement crisis intervention teams
- Cross train staff for greater understanding of situation management and end result

Action 11: Improve capacity for primary care providers to refer patients for appropriate care

- Strive for mental health and substance abuse treatment insurance parity
- Identify and reduce barriers to adequate care (transportation, provider availability, facility location, financial, work-related, etc.)

Action 12: Promote the use of follow-up protocols and supports

- Identify and provide protective services after suicide risk has been identified (support groups, skill building/educational programs, self-enhancement activities);
- Eliminate barriers in public and private insurance programs for provision of mental health treatments; and
- Develop and implement effective training and support programs for family members of those at risk
- Identify protocols for aftercare for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings.

Focus 3 - Methodology

Action 13: Establish an advisory committee to monitor and oversee the effective implementation of the goals and activities set forth in this plan. Membership should include:

- Six members from each of the following Executive Departments: Health and Senior Services, Mental Health, Social Services, Elementary and Secondary Education, Corrections and Higher Education.
- Ten members drawn from citizens representing survivors, criminal justice system, business community, clergy, schools, youth, mental health professionals, health care providers, not-for-profit organizations, and a researcher.
- A member of the House and Senate.
- The Committee should be staffed by at least a coordinator and clerical staff person.

Action 14: The advisory committee will provide oversight, technical support and outcome promotion for prevention activities

- Develop annual goals and objectives for ongoing suicide prevention efforts.
- Make information on prevention and mental health intervention models available to community groups implementing suicide prevention programs
- Promote the use of outcome methods that can allow the comparison and evaluation of the efficacy (does an intervention work), effectiveness (does an intervention work in different settings), cultural competence and cost-effectiveness of plan-supported interventions, including making specific recording and monitoring instruments available for plan-supported projects
- Review and recommend changes to existing or proposed statutes, regulations and policies to prevent suicides.

Action 15: Develop methods to assess the occurrence of suicide attempts and suicide completions in Missouri

- The advisory committee will coordinate and issue a biannual report on suicide and suicidal behaviors in the state using information drawn from federal, state and local sources.
- Improve reporting and the accurate surveillance of suicide and suicidal behaviors

Action 16: Promote the development of scientific knowledge in suicide prevention activities within the state and the establishment of research partnerships

- Review state suicide prevention projects for their potential to add to evidence-based prevention knowledge and their effectiveness in diverse settings and among different age, gender and ethnic subgroups.
- Foster partnerships to conduct scientific research and secure external funding

Action 17: Assess the cultural, gender and age attitudes toward getting help for depression and suicide, the barriers (stigma) related to refusing help and the attitudes of Missourians about clinical interventions for mood disorders (psychotropic medication and psychotherapy)

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APPENDIXES

1. TOWN HALL MEETING
2. HISTORY OF THE MISSOURI PLANNING PROCESS
3. EVIDENCE BASE FOR SUICIDE PREVENTION
4. RESOURCES
5. GLOSSARY

APPENDIX I

Report

on the

Town Hall Meetings

for the

Missouri Suicide Prevention Plan

A Collaborative Effort

Go to the people

Work with them

Learn from them

Respect them

Start with what they know

Build with what they have

And when the work is done

The task accomplished

The people will say,

“we have done this ourselves”

-Lao Tsu, China 700 BC

Introduction

Town Hall Meetings were held through out the state during July, August and September of 2004 to receive public input on the draft suicide prevention plan in preparation for submission to the state legislature by December 31, 2004 as mandated by legislation passed in 2003. The plan is titled “Missouri Suicide Prevention Plan: A Collaborative Effort”. This report is divided into two sections, one that describes the process used and the other describes the input received.

Process

A “Call to Host” was sent to mental health, health, corrections, education, and community-based organizations in April and May. Approximately twenty-three agencies and organizations responded to the call to host the town hall meetings. Many of who resided in the same cities or in close proximity to each other, thus some agencies agreed to share the responsibility of hosting town hall meetings. Host agency responsibilities included:

- Providing adequate space to hold a three to four hour meeting that is accessible to the community.
- Assisting in the general advertisement and promotion of the town hall meeting and to notify and involve key community leaders.
- Providing light refreshments (coffee or water) – optional.

The Town Hall Meetings were held in fourteen communities and generally lasted for approximately 2 hours. Approximately 535 individuals were in attendance. Participants included consumers, survivors and community representatives from health, mental health, alcohol and drug abuse, corrections, police, funeral directors, and educational agencies. The plan was made available prior to the meetings and attendees were encouraged to read the plan prior to the meeting.

The meetings consisted of a Power Point presentation describing the development and contents of the plan, an open mike session, and breakout groups. Participants were asked to respond to the plan by answering the following questions:

1. What did you like about the plan and why?
2. What did you like least about the plan and why?
3. What has not been included, but should be?
4. What can be done to make it more likely that people will act on recommendations and become involved in suicide prevention activities?

Participants were given three methods to provide general feedback and to respond to these four questions:

1. Attendees were given an opportunity to provide verbal feedback during the meeting during the open mike session and during the group breakout sessions.
2. Feedback cards that listed the four questions were distributed to each attendee. They were asked to provide written feedback and to submit the cards at the end of the meeting.
3. Attendees were given a dedicated e-mail to send additional comments after the meeting.

Input

Surveys of the attendees during the meetings revealed that 80 to 90% of the attendees had not read the plan prior to the meeting. A summary of responses from the fourteen meetings to each of the four questions are listed below.

1. What did you like about the plan and why?

All attendees recognized the importance of suicide prevention and expressed the need for collaborative action. Attendees favorably responded to the use of the National Suicide Prevention Strategies, the Surgeon General's Call to Action and the Public Health Approach as models for the state plan.

Other components of the plan that received recurring positive comments included: use of local community resources, awareness and prevention education, early identification of risk factors, evidence based practices, stigma reducing strategies, and attention to survivors' issues. Comments reflected the plan was comprehensive, broad based, well organized and easy to read.

2. What did you like least about the plan and why?

In summarizing the written comments received for this question, it became more evident that many of the attendees were not familiar with the plan and that the questions were misinterpreted. For example many comments listed were more accurately in response to question number 3.

Many of the comments under this question reflect a desire for more information and education on specific risk factors and at risk groups (for example violence and abuse and specific age categories). The items participants liked least about the plan is that it did not include how the plan was to be funded.

3. What has not been included but should be?

Funding was the major point identified as missing from the plan; how to access money, sustain programming and fund efforts seemed to be the primary roadblock. Interventions for specific populations (G/L/B/T, Hispanic, rural, youth/elderly, etc.) identification of and access to resources (telephone hotline numbers, crisis services, and counseling services), improved skill building programs (coping, awareness, teacher education, etc.) identification of reference materials, websites, and training curricula were frequently cited. The lack of psychiatric

inpatient beds and after hours crisis options were frequently mentioned.

4. What can be done to make it more likely that people will act on recommendations and become involved in suicide prevention activities?

Creating media advertising and community based awareness campaigns were identified as the leading way to get people involved. Enhancing public education, creating greater awareness and making training opportunities more readily available were recommended. Identifying ‘systems of care’ within communities, options and availability for help, and how to become a ‘helper’ were recommendations as well. Collaborative efforts that advance advocacy, reduce stigma and encourage greater community involvement were also suggested.

Conclusion

The Town Hall meeting process allowed for considerable input from consumers, survivors and providers at the local level. The plan was generally well received and community input was productive. Town Hall audiences were supportive of the plan and expressed hope that it would be implemented. Many criticisms of the plan resulted from not having read the draft prior to the meeting: other critiques were useful to the writing team and they worked to finalize the draft plan.

**This document can be found in its entirety on DHSS website: www.dhss.mo.gov and the DMH website: www.dmh.mo.gov.

APPENDIX II

ACTING ON SUICIDE PREVENTION

MISSOURI'S ROLE IN A NATIONAL MOVEMENT

A. Call to Action

In 1998 the U.S. Surgeon General, David Satcher, identified suicide as a major public health problem. He convened more than 450 leading public health officials, mental health professionals and consumer advocates from all over the country to begin the process of addressing suicide as a significant health problem. This resulted in *The Surgeon General's Call to Action to Prevent Suicide (1999)* where Dr. Satcher established the promise that

“We must promote public awareness that suicides are preventable. We must enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment. And we must reduce the stigma associated with mental illness that keeps many people from seeking help that could save their lives.”

The Surgeon General's Call to Action to Prevent Suicide presented the nation with an initial blueprint for addressing suicide AIM

- Awareness,
- Intervention
- Methodology

AIM provided both the framework for immediate implementation of suicide prevention initiatives and also served as the foundation for development of the more comprehensive *National Strategy for Suicide Prevention*.

B. National Strategy for Suicide Prevention

In 2001 the U.S. Department of Health and Human Services, through the Surgeon General's Office issued the *National Strategy for Suicide Prevention*. The strategy identifies suicides high cost to the American nation noting that as the eighth leading cause of death in Americans, suicide kills 50% more people than homicide and twice as many people as HIV/Aids. The goal of the strategy is to provide national guidance to prevent suicide and reduce the rates of suicidal behaviors, reduce the traumatic after effects that suicide has on family and friends and to enhance the resiliency and interconnectedness of individuals and their communities. The national goals are:

1. Promote awareness that suicide is a public health problem that is preventable.
2. Develop broad-based support for suicide prevention
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services

4. Develop and implement suicide prevention programs
5. Promote efforts to reduce access to lethal means and methods of self-harm
6. Implement training for recognition of at-risk behavior and delivery of effective treatment
7. Develop and promote effective clinical and professional practices
8. Improve access to and community linkages with mental health and substance abuse services.
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media
10. Promote and support research on suicide and suicide prevention
11. Improve and expand surveillance systems

C. The Missouri Suicide Prevention Plan 2001-2003.

The initial *Missouri Suicide Prevention Plan 2001-2003* was developed in a collaborative process headed by then Missouri Department of Health and Missouri Department of Mental Health using a series of regional and statewide planning meetings that also included Department of Elementary and Secondary Education, Department of Corrections, community self-help groups and survivors. This plan using the AIM format led to actions including:

1. Public awareness campaigns using radio, TV and billboards.
2. Suicide prevention training for professional caregivers including public health nurses, school counselors, gambling counselors, substance abuse counselors, probation and parole officers and others
3. Training of hundreds of Suicide Prevention Gatekeepers (gatekeepers are anyone who by virtue of their daily activity come into contact with individuals who may be at risk for suicide and can recognize and refer for help).
4. Community based efforts.

D. The Missouri Legislature takes Action

In Fall of 2003 the 92nd General Assembly passed the bipartisan House Bill #'s 59 and 269 directing the Director of the Department of Mental Health in partnership with the Department of Health and Senior Services in collaboration with other agencies and community organizations to develop a new state suicide prevention plan including but not limited to workplaces, schools and public and community health settings. The new plan shall be submitted to the general assembly by December 31, 2004 with recommendations for implementation.

Appendix III Evidence Base for Suicide Prevention

Strategy	Rationale	Limitations	Effect
School-based Suicide Awareness Curriculum	Some research available on teenager's attitudes on help seeking behavior	<ul style="list-style-type: none"> ▪ Some shifts in desirable attitudes ▪ some evidence of increase in maladaptive coping ▪ Possibility of contagion. 	Minor increase in knowledge and attitude shifts.
Screening	Extensive research on risk factors available from psychological autopsy studies and studies of attempters	<ul style="list-style-type: none"> ▪ Many false positives identified ▪ Assistance in referrals to adequate treatment necessary. 	If targets of screening depression, substance abuse and suicide attempts are treated the potential impact on reducing suicides is considerable.
Gatekeeper Training	Similar to CPR Trains members of general public to identify persons at risk, briefly intervene then refer person to professional	Repetition of training program appears necessary	Evidence of knowledge gain and reduction of gender specific suicidal rates
Crisis Centers and Hotlines	Psychological autopsy studies indicate that suicide is often associated with a stress event	Widely available but less apt to be used by boys	Decrease of over 1/3 in suicide rate for young white females
Restriction of lethal means	Several studies indicate availability of firearms in homes significantly increases risk of completed suicide	Second Amendment rights limit acceptability within segments of public	23% reduction in firearm suicides reported. Method substitution appears to be minimal.
Media Education	Numerous studies indicate existence of suicide contagion	Media might be reluctant to participate. Turn over of editorial staff and journalists would require repetition of education programs.	7% reduction in suicides reported in first year and 20% over 4 years post guidelines.
Postvention/crisis intervention	Several studies have examined	High risk persons are not necessarily identified without systematic screening	Not yet known.

Appendix IV

RESOURCES

I Federal Policy and Plans

National Strategy for Suicide Prevention

www.mentalhealth.org/suicideprevention

Suicide Prevention Advocacy Network

www.SPANUSA.org

Surgeon General's Call to Action

www.surgeongeneral.gov/library/calltoaction/calltoaction.htm

II State and National Resources

American Association of Suicidology

www.SUICIDOLOGY.org

Missouri Department of Health and Senior Services

www.dhss.mo.gov

Missouri Department of Mental Health

www.dmh.mo.gov/cps/issues/suicide.htm

National Institute of Mental Health Suicide Research Consortium

www.nimh.nih.gov/research/suicide.htm

Suicide Prevention Resource Center

www.SPRC.org

III Missouri Data on Deaths, Hospitalization and ER Visits

Missouri Information for Community Assessment (MICA)

www.dhss.mo.gov/MICA/

Appendix V

Glossary for Missouri State Suicide Prevention Plan

attempter: *an individual who makes a nonfatal suicide attempt. An attempter carries out a suicide plan but does not die as a result of their action(s)*

awareness: *broaden the public's recognition, knowledge and understanding*

best practice: *an activity or program based on the best available evidence regarding what is effective*

biopsychosocial: *biological, psychological and social elements that may influence behavior(s) (mental disorder, substance use/abuse, history, etc.)*

cause: *contributing factor or condition*

completer: *a person who intentionally caused their own death*

comprehensive suicide prevention plans: *plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting , biological, psychological and social factors*

connectedness: *closeness to an individual, group or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others*

contagion: *a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.*

culturally appropriate: *a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles,*

depression: *a collection of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure*

environmental: *physical or social elements that influence behaviors (financial, home, relationships, etc.)*

gatekeeper: *those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as needed*

goal: *a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work*

intervention: *a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition*

lethality: *the potential for death*

means: *the instrument or object whereby a self-destructive act is carried out*

means restriction: *techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm*

methodology: *advance the scientific research, evaluation, and monitoring systems for the prevention of suicide and suicidal behaviors*

method: *action or technique which results in an individual inflicting self-harm*

non-lethal: *non-fatal, injury may occur*

objective: *a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often*

outcome: *a measurable change in the health of an individual or group of people that is attributable to an intervention*

postvention: *a strategy or approach that is implemented after a crisis or traumatic event has occurred (this can also be a form of prevention for future attempts).*

prevention: *a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors*

protective factors: *factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment*

risk factors: *those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment*

screening tools: *those instruments and techniques used to evaluate individuals for increased risk of certain health problems; examples, questionnaires, check lists, self-assessment forms, etc.*

sociocultural: *consideration of the influences of societal &/or cultural norms, beliefs and attitudes*

stakeholders: *entities, including organizations, groups and individuals, that are affected by and contribute to decisions, consultations, and policies*

stigma: *an object, idea, or label associated with shame, disgrace, dishonor or reproach*

suicidal behavior: *a variety of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide*

suicide: *death where there is evidence that a self-inflicted act led to the person's death*

surveillance: *the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings*

survivor: *family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide*

State of Missouri

Department of Mental Health



**A Plan for Achieving
Multicultural Competency**

Introduction

In October, 1998, Roy C. Wilson, M.D., Director of the Department of Mental Health (DMH), convened a statewide committee to draft a cultural competency plan for DMH. The minority groups identified in the original plan were determined through the use of census data and demographic information about Department service usage patterns. Based on this information, four ethnic minority groups were identified. Also, since spoken English is not the primary means of communication for a significant portion of the individuals in some of these ethnic minority groups, the committee decided to include linguistic competency as a issue to be addressed in the plan. Through the analysis of service usage patterns; the Deaf and Hard of Hearing population emerged as a significant culture presenting similar communication and linguistic competency issues. Based on this information the five minority groups addressed in the original plan included: African Americans, Asian/Pacific Islanders, Deaf and Hard of Hearing, Latinos, and Native Americans. As a result of discussions about other groups, the committee reached consensus that this plan would be developed as a model that could easily be applied to any cultural group.

In preparing a draft plan, the statewide committee analyzed DMH operational data, surveyed DMH provider agencies, conducted focus groups with individuals from the five minority populations, and reviewed professional literature regarding multicultural competence. A draft plan was submitted to the Department Director in February, 2000.

In 2001, David Satcher, M.D., Surgeon General of the United States, issued a report entitled Mental Health: Culture, Race, and Ethnicity. This report served as a supplement to the landmark Surgeon General's Report on Mental Health published in 1999 which detailed the best scientific evidence on the nature of mental illness and the most effective treatment approaches. The report on Mental Health: Culture, Race, and Ethnicity documents the nature and extent of disparities in mental health care for racial and ethnic minorities and the promising directions for elimination of these disparities. This report provides the best information available regarding the mental health status and access to quality mental health care for four of the five minority groups addressed in the draft plan prepared by the cultural competency committee convened by Dr. Wilson: African Americans, Hispanic Americans, Native Americans, and Asian Americans and Pacific Islanders.

In October, 2002, Dorn Schuffman, Director of the Department of Mental Health, convened a task force to update and revise the draft plan submitted to Dr. Wilson, based on the findings of the Surgeon General's report on Mental Health: Culture, Race, and Ethnicity. The task force consisted of Department staff, many of whom had participated in the committee originally established by Dr. Wilson. This document is the result of the work of that task force. Because the task force only involved DMH staff, this document is only a draft. It requires review and, perhaps, revision by DMH consumers, customers, and providers, and especially by individuals and organizations that represent the minority populations it is intended to address, before it is adopted as the Cultural Competence Plan of the Department of Mental Health.

This document follows the Surgeon General's report on Mental Health: Culture, Race, and Ethnicity in defining the following key terms:

Race: The Report notes that “race” is not a biological category: “No consistent racial groupings emerge when people are sorted by physical and biological characteristics.” (pg. 7) Instead, “race” is better understood as a social category: “The concept of race is especially potent when certain groups are separated, treated as inferior or superior, and given differential access to power and other valued resources.” (pg. 9)

Ethnicity: “Ethnicity refers to a common heritage shared by a particular group,” where ‘common heritage’ includes shared or similar “history, language, rituals, and preferences for music and foods.” (pg. 9)

Culture: The Report also references the concept of ‘common heritage’ in defining ‘culture’ as a “common heritage or set of beliefs, norms, and values,” but notes that individuals who identify themselves as part of the same racial or ethnic groups may “identify with other social groups to which they feel a stronger cultural tie such as being Catholic, Texan, teenaged, or gay.”

Minority: The term ‘minority’ is used in the Report to signify a group’s “limited political power and social resources, as well as [its] unequal access to opportunities, social rewards, and social status. The term is not meant to connote inferiority or to indicate small demographic size.” (pg. 5)

In general, the term “minority group” or “minority population” will be used in this document to refer to any racial, ethnic, or cultural group that has “limited political power and social resources, as well as unequal access to opportunities, social rewards, and social status”, regardless of demographic size.

Vision, Values, Principals and Goals

The Department of Mental Health vision and values provide the context for all of the work of the Department, including efforts to fulfill our responsibility to meet the specialized needs of minority populations. Three of the nine DMH values are particularly relevant to these efforts:

Cultural Diversity: “All people are valued for, and receive services that reflect and respect, their race, culture, and ethnicity.”

Competence: “All people receive services delivered by staff who are competent in dealing with cultural, race, age, lifestyles, gender, sexual orientation Religious practice, and ethnicity.

Valued Workers: “All people who provide services and supports are our organizations’ most important resource.”

Within the context of the DMH vision and values, the Department has established the following vision, values, principles, and goals that are specific to fulfilling our responsibility to minority populations.

Vision of the Department of Mental Health for Multicultural Competency:

- The Department of Mental Health will help consumers maximize their human potential by valuing, promoting, offering services, and using natural supports that are culturally and linguistically competent.

Values of the Department of Mental Health regarding Multicultural Competency:

- An integrated approach in which Multicultural Competency is inextricably embedded in all levels of the system.
- The celebration of consumer individuality is seen as enriching the entire system.
- Maximizing consumer potential by providing services that recognize, understand, and respond to the consumers’ cultural, linguistic and spiritual needs.
- A system that embraces the concepts of recovery and MRDD support processes.
- Consumers will have an environment where universal acceptance, respect and learning are fundamental and indispensable.

Guiding Principles of the Department of Mental Health regarding Multicultural Competency:

- The following five principles formed the basis for guiding the work of the Multicultural Competency Committee

Principle I Multicultural competence shall be integrated throughout the entire DMH service system in whatever form the system assumes.

Principle II The Multicultural Competency Plan including action Steps will be consumer focused and driven; therefore, consumer input is essential throughout the process.

Principle III Individual differences and abilities are considered and valued across a person's life span (from infancy to elderly).

Principle IV Consumers are able to maximize their human potential when their:

- culture is understood and recognized;
- treatment is culturally and linguistically responsive;
- spirituality and beliefs are considered;
- hope is encouraged, enhanced, and/or maintained; and
- individuality is promoted through recovery and MRDD support processes.

Principle V Multicultural competence should foster an environment that:

- values acceptance;
- encourages learning;
- expects respect;
- accepts language differences; and
- promotes education.

Goals of the Department of Mental Health regarding Multicultural Competency:

- Promotion of cultural awareness and development of cultural competency
- Identification and reduction of mental health care disparities among cultural and ethnic minority population
- Mitigation of risk factors and promotion of protective factors for consumers and the various ethnic and cultural groups they represent
- Improvement of ethnic and cultural diversity within the Department's workforce

Missouri Demographics

During the decade from 1990 – 2000, Missouri’s population became more diverse. There were large percentage increases in the Hispanic/Latino and Asian/Pacific Islander populations, and the African-American and American Indian/Aleut populations increased by larger percentages than the overall state population. Though the numbers of Hispanic/Latinos, Asian/Pacific Islanders, and American Indian/Aleuts are relatively small, the rates of increase suggest that encounters between the DMH service systems and these populations will increase. An examination and understanding of these increases will assist DMH with planning and deployment of culturally appropriate services and staff.

Chart 1

Changes in State Populations, 1990 – 2000

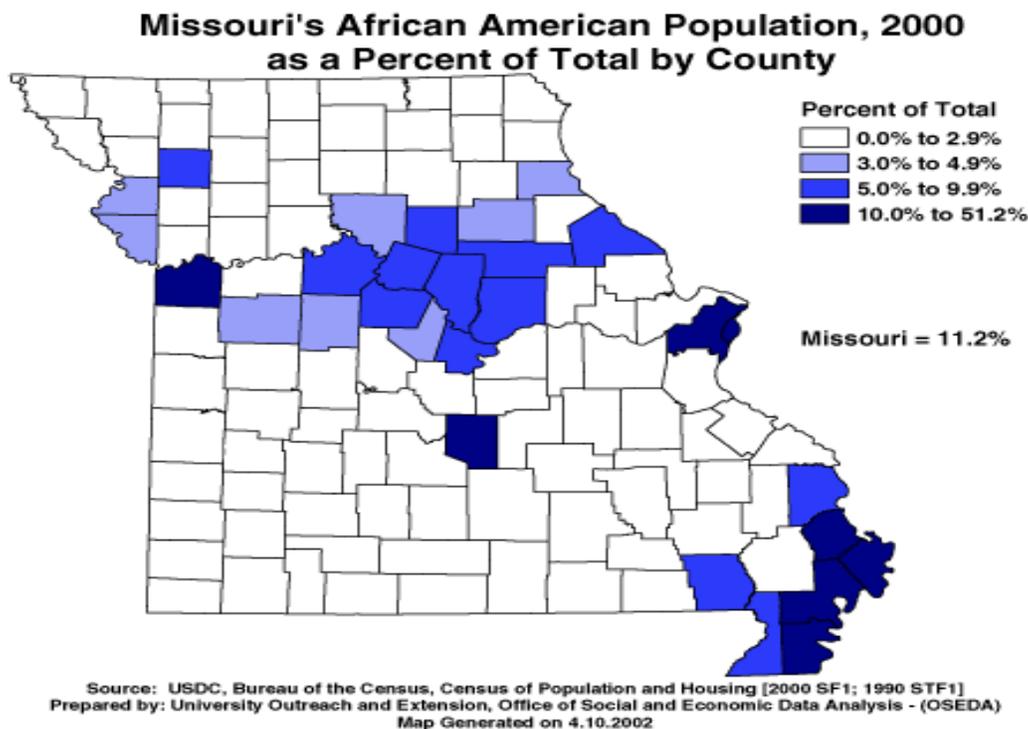
Group	1990 Census	2000 Census	Difference	Percent +/-
African American	548,208	629,391	81,183	+ 14.8%
Hispanic/Latino	61,702	118,592	56,890	+92.2%
Asian/Pacific Island	41,277	64,773	23,496	+56.9%
American Indian/ Aleut	19,835	25,076	5,241	+26.4%
Missouri	5,117,073	5,595,211	478,138	+9.3%

African Americans

African Americans remain Missouri’s dominant minority group. Between the 1990 and 2000 census, the African-American population increased by 14.8 percent—from 548,208 to 629,391. This rate of increase, while the lowest of all minority groups, was significantly greater than the 9.3 percent overall increase of Missouri’s population. African Americans comprise 11.2 percent of the state’s population; an increase from 10.7 percent in 1990.

Missouri’s African-American population is clustered in 32 counties, which are home to 98 percent of African Americans. Of those counties, there are 8 in which African Americans comprise more than 10 percent of the population: Jackson, Mississippi, New Madrid, Pemiscot, Pulaski, St. Louis City, St. Louis County, and Scott. Essentially, African Americans are heavily clustered in the Kansas City and St. Louis metropolitan areas and the Bootheel. (Pulaski County, in the south central region of the state, is home to a military base, Fort Leonard Wood.) 21 of the remaining 24 counties stretch across the middle of the state, roughly following the course of the Missouri River. Counties in this area include Pike, Audrain, Boone, Callaway, Cole, Howard, and Cooper. (Though largely thought of as an urban population, African Americans are present in significant numbers in some mainly rural and semi-rural counties — e.g., Howard, Cooper, Pike, Randolph, Pemiscot, and New Madrid.) Map 1 displays the density of the African-American population by county.

Map 1



St. Louis City continues to have the most African Americans even though the numbers of African Americans decreased from 188,408 to 178,266. As part of the continuing overall trend of population moving from St. Louis City to St. Louis County, the African-American population of St. Louis County experienced the largest increase of African Americans: 53,988 (38.8 percent). Also, as part of the continuing overall trend of population increases in Kansas City/Jackson County, the African-American population grew from 135,649 in 1990 to 152,391 in 2000. Eighty-seven (87) percent of the increase in Missouri's African-American population occurred in Jackson and St. Louis Counties; their increases totaled 70,730.

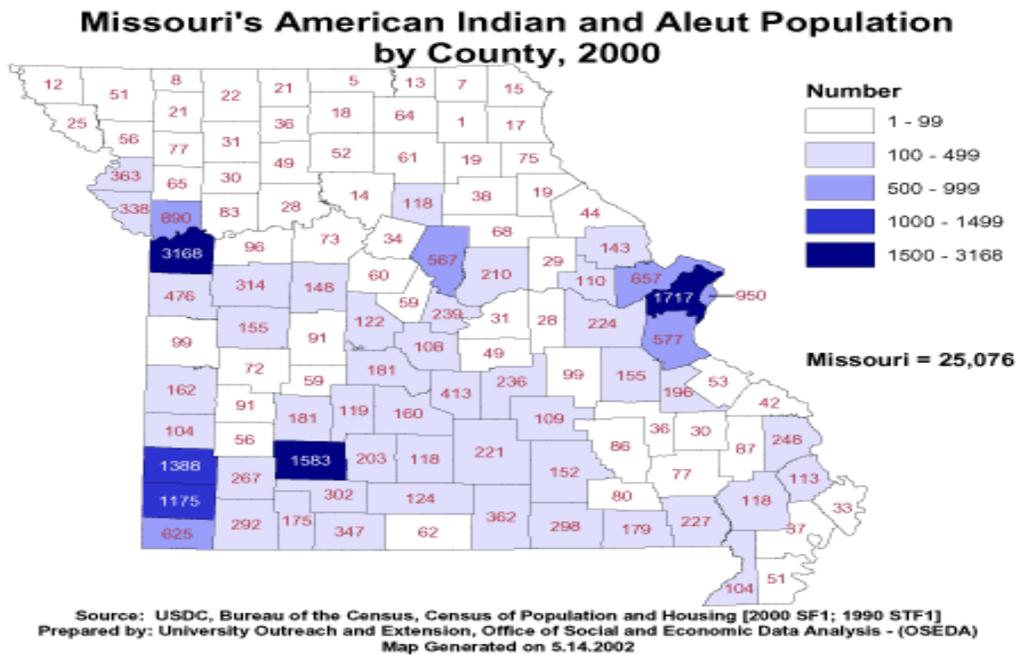
Native Americans

American Indians constitute the smallest group discussed in this section; their population, though, experienced significant growth — from 19,835 to 25,076 (a 26.4 percent increase). American Indians account for 0.4 percent of Missouri's population.

As displayed on Map 2 the American Indian population is dispersed throughout Missouri (all 115 counties have some Indian population), though are large concentrations (population of at least 500) in and around the counties with the state's largest cities: Jefferson, St. Louis City, St. Louis County, St. Charles, Jackson, Clay, Greene, and Boone. Newton, Jasper, and McDonald are the other counties with American Indian populations of at least 500. Jackson County continues to have the largest number of American Indians, 3,168 but their percentage increase, 4.5 percent, was significantly less than the population's overall increase, 26.4 percent, statewide.

Most of the counties having an Indian population of greater than 100, but less than 500 are throughout the Ozarks in southern and southwestern Missouri.

Map 2

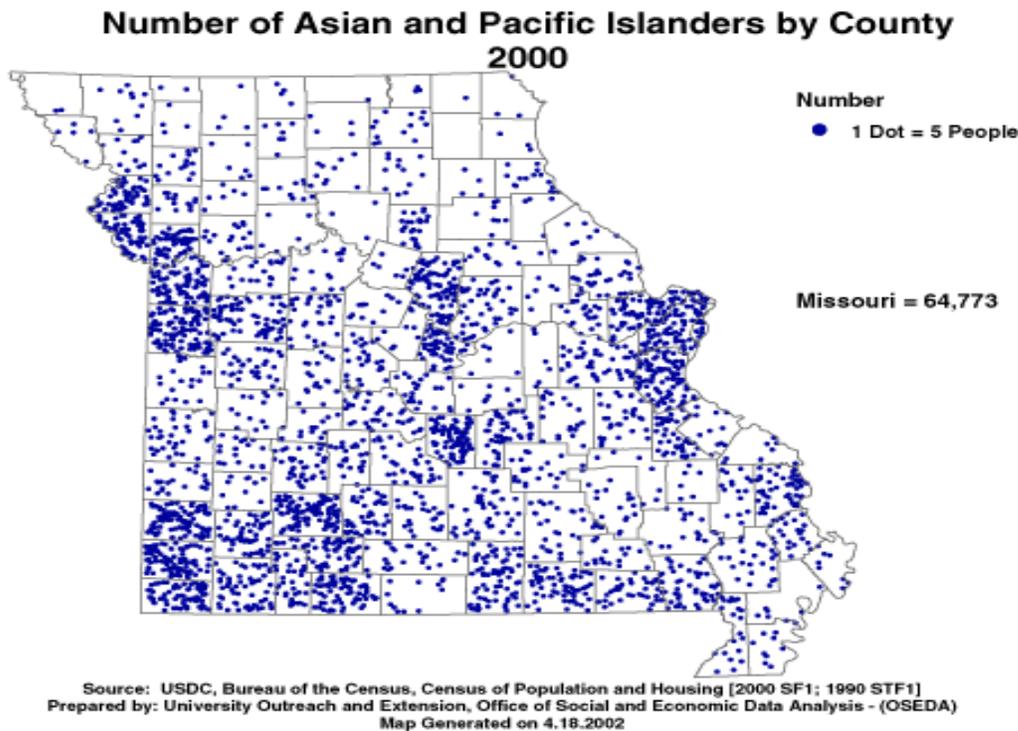


Asian Americans and Pacific Islanders

Missouri's Asian/Pacific Islander population increased 56.9 percent (from 41,277 to 64,773) from 1990 to 2000; 3,071 individuals in this population are Native Hawaiian and other Pacific Islander. The percentage growth of Asian/Pacific Islanders was the second-largest of all populations discussed in this section. Asian/Pacific Islanders now comprise 1.2 percent of Missouri's population—up from 0.8 in 1990.

There is an Asian/Pacific Islander population in all of the state's 115 counties. St. Louis and Jackson Counties have the largest Asian/Pacific Islander populations, 22,857 and 9,580, respectively (see Map 3). Overall, the Asian/Pacific Islander population increased in 99 counties between 1990 and 2000.

Map 3



Though approximately 50 percent of Missouri’s Asian/Pacific Islander population lives outside of Jackson and St. Louis Counties, it is a highly urbanized population. The overwhelming majority of the other 50 percent live in the Kansas City, St. Louis, and Columbia SMA—there is also a significant Asian/Pacific Islander population in Pulaski County (Fort Leonard Wood).

The Asian/Pacific Islander population grew fastest in the nine counties with 1,000 or more Asian/Pacific Islander residents. The increase of Asian/Pacific Islander population in these jurisdictions was 64.1 percent from 1990 to 2000. In comparison, the Asian/Pacific Islander population grew by 29.3 percent in the remaining counties of the state.

Hispanic Americans

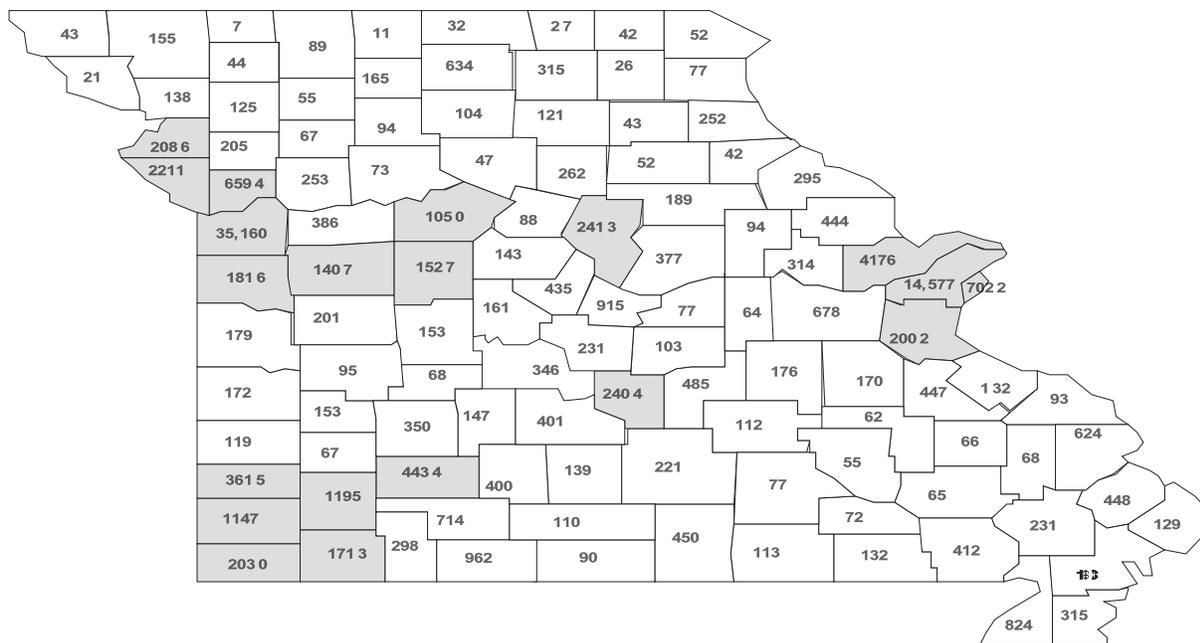
Hispanic Americans are Missouri’s fastest growing racial/ethnic population with an increase of 92.2 percent in the past decade. Hispanic Americans are Missouri’s second-largest racial/ethnic group, population 118,592, following African Americans. Even so, they account for a relatively small percentage of the state’s population—2.2 percent.

Hispanic Americans are found in all of Missouri’s counties (see Map 4); and in some counties, e.g., Osage, out-number African Americans. In contrast to the African-American and Asian/Pacific Islander populations, the “clusters” of Hispanic American

population are more widely dispersed across the state. Counties with more than 1,000 Hispanic American residents are found in the eastern part of the state (metropolitan St. Louis), metropolitan Kansas City, along a narrow belt running south of the Missouri River from Boone to the Kansas border, and in the southwestern part of the state. There are relatively few Hispanic Americans in south central Missouri and across the northern tier

Map 4

**Missouri's Hispanic Population, by County
2000**



Source: USDC, Bureau of Census, Census of Population and Housing (2000 SF1; 1990 STF1)
Prepared by: University and Extension, Office of Social and Economic Data Analysis (OSED)
Map Generated on 3.4.2002

The metro Hispanic American population increased by 80.1 percent (from 50,399 to 90,785) during the 1990s while the non-metro Hispanic American population increased by 146 percent (from 11,303 in 1990 to 27,807 in 2000 - an increase of 16,504).

There were 20 counties having a 2000 Hispanic population of at least 1,000. Of those 20 counties, 13 are located in one of the metropolitan areas. By far the largest Hispanic American population is in Jackson County, which increased from 18,890 in 1990 to 35,160 - an increase of 86.1 percent. Following Jackson County the next greatest Hispanic populations in 2000 were St. Louis County, 14,577; St. Louis City 7,022; Clay County 6,594; Greene County, 4,434; and St. Charles County, 4,176.

There are ten counties in which the Hispanic American population more than quadrupled (increase of more than 300 percent). These 10 are all counties in which there was a dramatic increase in demand for workers during the 1990s. Taney County (Branson) was one of those counties and illustrates the effect of dramatic employment growth. Employment in Taney County doubled during the 1990s and demand for

workers far exceeded local supply. Hispanics were among workers moving to the county to fill jobs. As a result, the Taney County Hispanic population increased from 194 in 1990 to 962 in 2000 - an increase of almost 400 percent.

In the remaining nine counties, large scale production of poultry or swine was associated with establishment of major meat processing facilities, creating a large demand for packing house workers. Hispanic American workers were recruited both from within and outside the U.S. to meet local demands. Consequently, there were dramatic increases in Hispanic population in those counties, especially during the last half of the 1990s. Five of those counties are in Missouri's Southwest corner and are focused on poultry production and processing. Illustrative of the impact, the Hispanic population increased from 1990 to 2000 in those counties as follows: Barry County, from 152 to 1,713; McDonald County, from 121 to 2,030; Lawrence County, from 211 to 1,195; Newton County, from 353 to 1,147; and Jasper County, from 797 to 3,615. Similar industrial, and therefore demographic, changes occurred in Dunklin County in the Bootheel (Hispanic population growth from 169 in 1990 to 824 in 2000) and in Pettis and Moniteau Counties in central Missouri. The Hispanic American population increased from 268 to 1,527 in Pettis County and from 46 to 435 in Moniteau County.

Two additional counties, Saline and Sullivan, experienced similar additions of major meat processing plants and subsequent Hispanic American immigration to meet demand for labor. In Saline County the Hispanic American population increased from 208 to 1,050 and in Sullivan County, the Hispanic American population increased from 28 to 634.

In aggregate the 10 counties in which the Hispanic American population more than quadrupled during the 1990s had a Hispanic population of 2,279 in 1990 and 13,605 in 2000. These 10 counties accounted for 3.7 percent of Missouri's Hispanic population in 1990 but 11.5 percent in 2000.

Deaf and Hard of Hearing

There is a recognized culture of deaf and hard of hearing persons that cuts across other variables such as race, ethnicity, and socioeconomic status. It is not highly visible to the general public but exists nonetheless. Rather than taking a pathological view of this population, the Department adheres to the cultural view, which defines the deaf and hard of hearing community as a group of people that shares a common means of communication (sign language) that provides the basis for group cohesion and identity, and whose primary means of relating to the world is visual.

On a national level, there is evidence of clinical biases toward deaf and hard of hearing people that result in longer inpatient admission stays with less treatment provided than would be expected in the hearing population (Dickert, 1988). In addition, deaf and hard of hearing consumers often report limitations in receiving services, such as inaccessibility to service and poor quality of service (Pollard, 1994).

Using data compiled by the 2000 Census, we can estimate that Missouri has nearly a half million citizens that are deaf or hard of hearing. Public testimony and focus groups resulted in the deaf community expressing negative feelings toward both the lack of services as well as their adequacy for the deaf and hard of hearing population.

Although the Department currently collects little reliable information about deaf and hard of hearing consumers, the situation that is being resolved by the addition of several required items to its case register system. The Committee recognized that the collection of data on deafness and hearing loss is crucial and must be accomplished throughout the public mental health system.

Summary

Though Missouri's non-African-American minority populations are small, census data indicate that significant growth is occurring. Significantly, this growth is not confined to the major metropolitan areas of the state. These data suggest that the department consider cultural issues and needs across all facilities (state-operated or contracted) in all areas of the state. Similarly, as noted in the introduction to this document, as Missouri's population continues to change, there may be other minority groups that require specialized attention either locally, or on a statewide basis. The Department of Mental Health has an obligation to monitor population changes, and to expand and update its cultural competence initiatives in order to best advocate for and meet the mental health needs of Missourians.

Cultural Competence

Competence is defined as having sufficient knowledge, judgment, or skill to perform a service or function. In the provision of mental health services, a distinction can be made between general and specific or specialized competence.

General competence can be defined as having the:

- Awareness of, and sensitivity to, specialized needs
- Knowledge and skill to identify the presence of specialized needs, and
- Knowledge and relationships necessary to make appropriate referrals for specialized services.

Specific or specialized competence can be defined as having the:

- Knowledge and skill to conduct a comprehensive assessment of specialized needs, and
- Knowledge and skill to serve individuals with specialized needs.

Applying this distinction to meeting the needs of cultural minorities, the Department of Mental Health is committed to:

Goal #1: Cultural Competence

Assure that DMH facilities and providers exhibit **general competence** in serving individuals regardless of race, ethnicity, or culture; and that DMH facilities and providers that are responsible for serving a significant percentage of minority individuals exhibit **specific competence** to meet the specialized needs of those individuals.

In order to achieve this goal, the DMH Cultural Competence Committee will supervise the development and implementation of standards for documenting and/or certifying the general competence of DMH facilities and programs for serving individuals regardless of race, ethnicity, or culture. These standards are likely to include requirements that DMH facilities and programs

- assess their awareness of, and sensitivity to, the specialized needs of minorities;
- provide training to staff regarding specialized cultural needs, based on the assessment;
- use screening methods and tools that assure the identification of specialized needs; and
- maintain referral relationships to assure access to specialized services when appropriate.

The Cultural Competence Committee will also establish expectations regarding DMH facilities and programs that should develop specialized competence to serve specific minority populations, as well as develop guidelines to assist those facilities and providers in developing the necessary specialized competence.

It must be acknowledged that acquiring and maintaining general competence in serving individuals regardless of race, ethnicity, or culture is an ongoing developmental process in which there is always room for growth and improvement. This is true because of continuing changes in the demographics of the populations served, the programs and staff providing services, and our understanding of cultures and how best to meet diverse needs.

Finally, it must also be acknowledge that we face an even greater challenge in achieving the goal of assuring that appropriate facilities and programs exhibit specialized competence in meeting these needs of specific minority populations. This is true, not only because of the changes in demographics, programs and staffing, and our understanding of cultures noted above, but because the depth of our knowledge regarding what “works best” in meeting the specialized needs of specific cultures remains extremely limited. The need for certain types of specialized expertise, such as the ability to speak the same language, is obvious. However, a great deal remains to be learned about how best to engage and appropriately support individuals in a way that both respects and affirms their cultural heritage and takes advantage of cultural strengths, while avoiding approaches or techniques that frustrate, or even create barriers to effective services and supports.

Prevention

A comprehensive approach to multi-cultural competency for the Department of Mental Health (DMH) involves more than addressing the skills and abilities necessary to provide culturally competent services. It should also address culturally specific risk and protective factors aimed at the prevention of disorder development.

Approach

The Department of Mental Health's strategic approach to prevention is based on a model developed by the Institute of Medicine [*reference*]. This model defines three prevention strategies based on population: universal, selective, indicated.

Universal strategies are those that address a population without regard to risk for or presence of a disorder. Examples include public education about the dangers of drinking and driving. These activities are directed to the universe of a population, including, in this example, non-drinkers and those who don't drive.

Selective strategies are those that address a population that may be at elevated risk for disorder development. Continuing with the drinking and driving example, selective prevention activities would be directed toward the population of people who drink and who drive—this being the population at elevated risk for driving after drinking.

Indicated strategies are those that address the population that has begun to exhibit aspect of the problem. In the case of our example, prevention activities would be directed toward the population of people who have driven after drinking, including those who have not experienced arrest.

This approach allows for tailoring prevention and intervention activities differently for each segment of the population.

Risk and Protective Factors

In the area of physical health, the concept of risk factors is well established—e.g., with smoking and lung cancer. Within mental health, the concept of risk factors has become established over the past 20 years largely through the work of Hawkins and Catalano [*reference*] and others [*reference*]. Their research has firmly established the existence of factors in the individual-peer, community/environment, family, and school domains that place individuals at elevated risk for development of behavioral disorders.

Risk Factors are those aspects of the individual, family, school, and community/environment that place individuals and groups, at elevated risk for disorder development (for example, teenagers who drink are at greater risk for attempting suicide than teens who don't drink). It is important to note that risk factors are associated with disorder development but are not predictive.

Protective Factors are those aspects of the individual, family, school, and community/environment that protect individuals from disorder development (for example, success in school is associated with lower risk of delinquency). Protective factors, like risk factors, are not predictive.

The 2001 Surgeon General's report, Mental Health: Culture, Race, and Ethnicity, included extensive discussion of the role culture may play in the etiology of mental disorders and in individual and group responses to those disorders once developed. The report states that "culture and social contexts, while not the only determinants, shape the mental health of minorities and alter the types of mental health services they use." Therefore, DMH prevention efforts must involve efforts to mitigate and respond to risk and protective factors that appear related to culture, race, and ethnicity. (It should be noted that mitigation of some of the risk factors cited in the Surgeon General's will

require a multi-faceted approach, involving a broad range of state departments, and a broad, coordinated array of policy approaches.)

There are a number of environmental risk factors that disproportionately effect minority populations, including poverty, homelessness, incarceration, foster care, and exposure to violence or trauma. What are the implications of these risk factors for the provision of culturally competent prevention, intervention, and treatment?

Research findings indicate that, for example, among the major mental illnesses, there is wider variation in the prevalence of major depression than for schizophrenia and bipolar disorder. The research also indicates a stronger association between environmental factors and major depression than appears to exist between environmental factors and schizophrenia and bipolar disorder. Specifically, poverty and exposure to violence appear to be risk factors for major depression. Therefore, multi-cultural competence would seem to require the development of skills and resources to address the role violence and poverty play in disorder development.

Though the department cannot, on its own, mitigate the risks posed by poverty and violence, it can mitigate the impact these risk factors have on individuals and groups. Through a focus on protective factors in, especially, the individual-peer, school, family, and community/environment domains, the department can mitigate the risks posed by poverty and violence. For example, supportive families and good sibling relationships can protect against the onset of mental illness. Therefore, by identifying individual, family, school, and community/environment protective factors, the department can work toward mitigating those risk factors that may influence disorder development and care seeking by minority groups.

“Migration, a stressful life event, can influence mental health. Often called acculturative stress, it occurs during the process of adapting to a new culture.”

Missouri has experienced significant growth in the number of immigrants over the past decade. From 1990 to 2000 Asian/Pacific Islander population increased by 57 percent and the Latino/Hispanic population increased by nearly 100 percent. Though both populations are a small percentage of the state’s population, 1.2 and 2.2 percent, respectively, their growth suggest that the department consider the role that immigration plays in the development of mental disorders. While immigration *per se* is not a risk factor for disorder development, the stresses attendant to migration and the fact that many immigrants have experienced trauma from war, civil unrest, or forced relocation prior to migration suggest that these populations may experience problems requiring response from the department.

Due to the timing of Asian/Pacific Islander migration to Missouri, this population is a generation removed from the traumas of the conflicts in Southeast Asia (the Vietnam War and the genocide in Cambodia) and the Cultural Revolution in China. They, as a group, though, maintain a family structure that is both risk and protective. Protective in that they maintain large, relatively cohesive and organized family structures, and risk in that mental health problems are highly stigmatized within the family group. Culturally competent mental health services would, therefore, seek to address the risk factor of stigma, which presents a barrier to seeking services.

Latino/Hispanic populations are, on average, of low socio-economic status and have relatively low educational status. They are, therefore, subject to some of the risk resulting from these factors. Research indicates that Mexican Americans born in the

United States have higher rates of depression and phobias than those born in Mexico. Other studies have concluded that Latino/Hispanic children experience a significant number of mental health problems, “and in most cases, more problems than whites.”

For Asian/Pacific Islander and Latino/Hispanic populations (as with all other cultures) it will be necessary and important to discern patterns of care seeking and to better understand symptom formation. Also, especially for Latino/Hispanic populations, it will be important to ensure the availability of Spanish-speakers throughout the treatment process.

Given this diversity of cultural risk and protective factors, the Department of Mental Health is committed to:

Goal #2: Prevention

Promote culturally specific protective factors that foster good mental health, and reduce culturally specific risk factors that increase the likelihood of the development of mental health problems.

In order to achieve this goal, the Department will need to take action on two fronts.

First, the Department will assure that DMH universal, selective, and indicated prevention activities include initiatives targeted to each of the minority populations identified in this plan, based on what is known about the risk and protective factors specific to those minority groups.

Second, as the state mental health authority, DMH will work with other social service agencies and advocates to educate policy makers and the public regarding the disproportionate correlation between minority populations and high risk factors such as poverty, homelessness, incarceration, foster care, and exposure to violence or trauma.

Minorities and Mental Health Care Disparities

The Surgeon General’s report on Mental Health: Culture, Race, and Ethnicity demonstrates that minority groups have disparate access to, and utilization of, mental health services and supports, as well as disparate mental health outcomes. To a large extent this is because minority populations are over-represented among people living in poverty, as well as among other high risk groups, including individuals who are homeless, incarcerated, in foster care, and exposed to violence or trauma.

As the public mental health authority, the Department of Mental Health serves as the safety net for mental health care, serving individuals regardless of the ability to pay. Consequently, individuals who are poor are more likely to access DMH services than those with an ability to pay. As a result, largely because minority groups are over-represented in among people living in poverty, minority groups are also over-

represented among the individuals receiving services from the Department of Mental Health.

In FY 2002, the Department provided services to 176,899 individuals, of whom 45,248 were from minority groups as defined in this plan. Therefore, although minority groups account for only about 14% of Missouri's population, more than is 25%, or one in four, of the consumers served by the Department in FY 2002 were from a minority group.

DIVISION	WHITE	BLACK	OTHER
ADA	71.3%	25.4%	3.3%
CPS	76.9%	19.9%	3.1%
MRDD	73.6%	18.4%	7.9%

Nevertheless, access to care remains problematic for certain minorities, and in specific geographic areas. In general, Hispanic American individuals are under-represented, and in urban areas, where African Americans account for a larger percentage of the population (St. Louis: 51%; Jackson County: 23%), African Americans may be under-represented.

The Surgeon General's report also suggests that many persons from minority groups receive services in the primary care setting or from the faith community. This is an area that requires further study by the Department in order to effectively impact the quality of care and outcomes of persons receiving treatment in these settings.

There are also disparities in the utilization of DMH services and supports by minorities. Preliminary analysis suggests that minority groups receive services, supports and treatments in more restrictive settings, and are more like to use emergency services, terminate services more quickly, and be forced into treatment through the criminal justice system or civil commitment.

The Department of Mental Health has annually surveyed consumers and family members regarding satisfaction with DMH services and supports since 1998. The survey is an important measure of consumer and family perception of the process and quality of service provision. (The Department does not consider the satisfaction survey to be a measure of service outcomes.)¹ Differences in satisfaction among various consumer demographic groups are analyzed for statistical significance. Analysis of the 2001 Satisfaction Survey shows:²

- All groups were generally satisfied with services provided by the Department. There are, however, differences between demographic groups.
 - Females were more satisfied with services than males.
 - Whites and Native Americans had the highest satisfaction with services of any racial/ethnic group.

¹ The survey asks people to rate their level of satisfaction with a variety of aspects of services. Satisfaction Reports are posted on the DMH web site at <http://www.modmh.state.mo.us/pm2001/index.htm>

² The survey uses a 5 point Likert scale: 1 = not at all satisfied, 5 = very satisfied.

- Although the ratings of both African Americans and Hispanics were in the satisfied range, their ratings tended to be lower than those of Whites.
- The youngest consumers (up to 18 years old) were the least satisfied with services.
- All groups gave a satisfied rating to staff for respect for culture, with exception of the Pacific Islander group.³

Appendix B provides a table of survey questions that had statistically significant differences between groups of different racial and ethnic backgrounds.

In addition to disparities in access, utilization, and consumer satisfaction, additional analysis of outcome data is needed to determine whether there are also disparities among minority populations in terms of consumer outcomes in Missouri.

The Department of Mental Health is committed to:

Goal #3: Minority Mental Health Care Disparities

Reduce mental health care disparities among minority populations.

In order to achieve this goal, the DMH Cultural Competence Committee will develop and monitor minority specific data regarding disparities in access to, utilization of, satisfaction with, and outcomes of mental health services and supports. The specific data to be developed and monitored will, at least, include information regarding:

- Percent of clients served by Division
- Hospitalization
 - Percent of admissions
 - Inpatient days
 - Length of Stay
 - Percent of readmissions within 30 days
 - Percent on new atypical medications
 - Percent of restraints
 - Percent of seclusions
- Commitments
 - Percent of Civil Involuntary Commitments
 - Percent of Forensic Commitments
- Percent enrolled in specific programs by service area
 - CPRC
 - Targeted Case Management
 - CSTAR
 - Family Directed Services
 - ICF-MR Waiver
- Percent of consumers showing improvement in outcomes
- Consumer Satisfaction

³ Only eight respondents identified themselves as Pacific Islanders—a sample too small to support any far-reaching conclusions.

Based on a review of this data, the DMH Cultural Competence Committee will identify factors that may be contributing to any apparent disparities, and recommend strategies for reducing mitigating the factors and reducing the disparities.

Cultural Diversity in the Workplace

The Department of Mental Health strives to maintain a workforce that is highly qualified and competent, while reflecting the diversity of the citizens we serve. A diverse workforce strengthens the Department's ability to provide culturally sensitive services to individuals of all races, ethnic heritage and cultures, regardless of gender. To that end, the Department has developed an Affirmative Action Plan. Affirmative Action is the adoption of culturally conscious hiring practices to achieve a work force that reflects the population of the communities we serve. The goals set forth in the Department's Affirmative Action Plan are designed to promote continued improvement in the development and maintenance of a well qualified, competent, and appropriately diverse work force.

Three major challenges face the Department of Mental Health in assessing the extent to which the Department's workforce appropriately reflects the diversity of the general workforce in Missouri.

First, workforce data from the 2000 Census has not yet been released by the federal government. Therefore, despite significant changes in Missouri's workforce in recent years, we are forced to rely on data from the 1990 Census. Once data is available from the 2000 Census, we will update our analyses and plans accordingly. In the meantime, we can only note major trends in workforce that are likely to be reflected in the 2000 Census data. Two trends are of

- A significant reduction in the population of St. Louis City and a significant growth in southwest Missouri.
- A significant growth in the number of individuals of Hispanic background in certain parts of Missouri.

The reduction in the population of St. Louis and growth of the population in southwest Missouri also illustrates the second challenge that faces the Department in analyzing workforce data: the importance of looking at data on a regional basis. The Missouri Office of Administration divides the state into a number of Labor Manpower Areas (LMA(s)) for the purposes of analyzing workforce data. This is extremely important for the Department of Mental Health because the majority of its workforce is located in facilities around the state that primarily recruit staff from their adjacent communities. Consequently, assessing the Department's success in reflecting the diversity of Missouri's workforce is dependent upon assessing the diversity of the available workforce in the appropriate LMA(s). We know, for example, that although African Americans account for 11.2% of the Missouri population, some areas of the state where DMH facilities are located have a much higher percentage of African Americans, notably St. Louis City (51.2%) and Jackson County (23.3%). It would not be

appropriate to measure the diversity of the facilities located in these areas against statewide data.

The growth in Missouri's Hispanic population illustrates the third challenge that faces the Department in analyzing workforce data: All minorities, except African Americans, are grouped together and reported as "other minorities" in the available workforce data. Therefore, although we know that some parts of the state now have a significant Hispanic population (e.g. Jackson County at 5.4%), we have no way to determine the actual size of the available Hispanic workforce, or any other minority group, except African Americans, by EEO category or Merit System classification.

Taken together, these challenges suggest caution in drawing broad conclusions from the available data. An accurate understanding of the Department's progress in assuring appropriate diversity of its workforce is dependent on careful analysis at the LMA level, and will require significant reassessment once data is available from the 2000 Census.

Because the majority of the Department's employees are located in its facilities, it is critical that each facility have an effective Affirmative Action Plan and Affirmative Action processes that accurately analyze the current status of the facility workforce compared to the available workforce in the appropriate LMA(s), set forth realistic goals and strategies for improvement, and establish mechanisms and responsible parties for implementing the strategies and measuring progress.

Because the majority of the individuals served by the Department receive their services through contract providers, the Department also has a responsibility to promote the development of a culturally diverse workforce among our contract providers.

The Department of Mental Health of Mental Health is committed to:

Goal #4: Cultural Diversity

Improve the diversity of the DMH workforce as outlined in the DMH Affirmative Action Plan.

The DMH Affirmative Action Plan outlines the Department's specific objectives and strategies for achieving this goal.

Action Plan

As noted in the introduction, this document is a draft plan that requires review by DMH consumers, customers, and providers, and especially by individuals and organizations representing the minority populations on which it focuses. In order to initiate the review process, and to create a mechanism that can consider comments, make appropriate revisions, and then oversee implementation of the plan, the Department is establishing a DMH Cultural Competence Committee. The DMH staff that developed this draft document will serve on the Committee along with consumer and provider representatives from each of the three divisions of the Department, and representatives from the CPS and MR/DD facilities. Derrick Willis, Coordinator of the Office for Multi-Cultural Affairs will chair the Committee. The Committee will provide

quarterly progress reports to the DMH Executive Committee, and will revise and update the action plan annually. The Department Director will report progress to the Mental Health Commission quarterly.

Goal #1: Cultural Competence

Assure that DMH facilities and providers exhibit **general competence** in serving individuals regardless of race, ethnicity, or culture; and that facilities and providers that are likely to have a significant percentage of minority individuals with specialized needs exhibit **specialized competence** to meet those needs.

General Competence

Objective #1

Document each DMH facility's general competence to serve individuals regardless of race, ethnicity, or culture by July, 2005.

Objective #2

Certify each DMH provider's general competence to serve individuals regardless of race, ethnicity, or culture by July, 2006.

Specialized Competence

Objective #3

Determine which DMH facilities and providers should be expected to develop specialized competence for specific minority populations by January, 2004.

Objective #4

Establish processes for the development of guidelines to assist DMH facilities and providers in developing specialized competence for specific minority populations by March, 2004.

Goal #2: Prevention

Promote culturally specific protective factors that foster good mental health, and reduce culturally specific risk factors that increase the development of mental health problems.

Objective #1

Assure that DMH prevention activities include initiatives targeted to each of the minority populations identified in this plan by July, 2004.

Objective #2

Work with other social service agencies and advocates on an ongoing basis to educate policy makers and the public regarding the disproportionate correlation between minority populations and the following high risk factors: poverty, homelessness, incarceration, foster care, and exposure to violence or trauma.

Goal #3: Minority Mental Health Care Disparities

Reduce mental health care disparities among minority populations.

Objective #1

Develop and monitor minority specific data regarding disparities in access to, and utilization of, DMH services, including, at least, any disparities in program enrollments and facility admissions; lengths of stay; commitments; restraints and seclusion; abuse and neglect; consumer satisfaction; and outcomes by March, 2004 and on an ongoing basis.

Objective #2

Identify factors that may be contributing to disparities in access and utilization, and develop strategies for reducing the disparities by October, 2004.

Goal #4: Cultural Diversity

Improve the diversity of the DMH workforce in accordance with the Affirmative Action Plan.

Objective #1

Develop an Affirmative Action Plan for Central Office by April 15, 2003.

Objective #2

Develop an Affirmative Action Plan at each DMH facility by July, 2003.

Objective #3

Promote the development of a culturally diverse workforce among DMH contract provider.

APPENDIX A

FIGURE 1: FISCAL YEAR 1998 DMH UNDUPLICATED ADMISSIONS

Unique count of clients admitted to DMH facilities or providers, by division, in FY1998. In the last column, a client counts once, even if served by multiple divisions

Race	ADA	CPS	MRDD	Total Clients
Alaskan-Native (Eskimo-Indian)	7	11	2	20
American Indian	284	197	44	280
Asian/Pacific Islander	49	47	57	145
Bi-Racial	95	148	115	328
Black/Non-Hispanic	23,223	13,823	6,082	39,790
Oriental	81	131	78	280
Spanish American	332	337	120	738
White/Non-Hispanic	40,216	54,560	23,770	111,454
Other	221	271	253	700
Unknown	94	548	598	1,157
TOTAL	64,602	70,073	31,119	155,092

Division of ADA

Black	35.9%
White	62.3%
Other	1.8%

Division of CPS

Black	19.7%
White	77.9%
Other	2.4%

Division of MRDD

Black	19.5%
White	76.3%
Other	4.2%

All DMH

Black	25.7%
White	71.9%
Other	2.4%

FIGURE 1: FISCAL YEAR 2002 DMH UNDUPLICATED ADMISSIONS

Unique count of clients admitted to DMH facilities or providers, by division, in FY2002. In the last column, a client counts once, even if served by multiple divisions

Race	ADA	CPS	MRDD	Total Clients
Alaskan-Native (Eskimo-Indian)	11	16	4	30
American Indian	338	297	73	631
Asian/Pacific Islander	112	70	99	269
Bi-Racial	159	296	257	649
Black/Non-Hispanic	18,399	15,461	7,591	37,754
Oriental	112	164	135	391
Spanish American	608	592	168	1,281
White/Non-Hispanic	51,528	59,626	30,287	131,165
Other	446	368	428	1,178
Unknown	568	637	2,103	3,065
TOTAL	72,281	77,527	41,145	176,899

Division of ADA

Black	25.4%
White	71.3%
Other	3.3%

Division of CPS

Black	19.9%
White	76.9%
Other	3.1%

Division of MRDD

Black	18.4%
White	73.6%
Other	7.9%

All DMH

Black	21.3%
White	74.4%
Other	4.2%

DMH employees by Division by Race (2002)

	AFRICAN AMERICAN	%	WHITE	%	OTHER DIVERSE GROUPS	%	TOTAL
CPS Facilities	1,427	28%	3,562	69%	160	3%	5,149
MR/DD Facilities	1,622	35%	2,974	64%	86	2%	4,682
Central Office	40	9%	391	89%	6	1%	437
Total DMH	3,089	30%	6,927	67%	252	2%	10,268

APPENDIX B

2001 Comparison of Race/Ethnic Background in ADA, CPS, and MRDD Residential and Non-Residential Settings Combined

The analysis compared the responses of consumers by different racial and ethnic backgrounds on the satisfaction survey items. On the average, Caucasians and Hispanics were more satisfied with services than consumers of other racial and ethnic backgrounds. Caucasians were more satisfied with where they lived and how safe they felt in the neighborhood. African Americans were more satisfied with their opportunities to make friends and what they did in their free time.

How satisfied are you...	White	Black	Hispanic	Native American	Pacific Islander	Other	Significance
Services							
With the staff who serve you? (a,b,c)	4.34 (5462)	4.18 (1141)	3.99 (78)	4.28 (107)	4.13 (8)	4.04 (202)	F(5,6992)=11.957, p<.001
With how much your staff know how to get things done? (a)	4.22 (5404)	4.10 (1138)	3.95 (76)	4.22 (106)	4.05 (199)	4.05 (199)	F(5,6925)=6.376, p<.001
With how staff keep things about you and your life confidential? (a,c,d)	4.37 (5363)	4.19 (1134)	4.12 (76)	4.42 (105)	4.00 (8)	4.03 (197)	F(5,6877)=12.021, p<.001
That the treatment plan has what you want in it? (a)	4.19 (5339)	4.07 (1124)	3.83 (76)	4.13 (107)	3.88 (8)	4.02 (197)	F(5,6845)=5.814, p<.001
That the treatment plan is being followed by those who assist you? (a,b,c)	4.24 (5338)	4.11 (1125)	3.88 (78)	4.20 (106)	3.88 (8)	3.98 (196)	F(5,6845)=8.582, p<.001
That the staff respect your cultural background? (a,b,c)	4.39 (5124)	4.22 (1132)	4.00 (73)	4.29 (104)	3.88 (8)	4.15 (193)	F(5,6628)=12.547, p<.001
With the services you receive? (a,c)	4.32 (5389)	4.19 (1132)	4.05 (75)	4.17 (107)	4.13 (8)	4.01 (202)	F(5,6907)=9.458, p<.001
That services are provided in a timely manner? (a,c)	4.22 (5409)	4.04 (1127)	3.92 (76)	4.07 (107)	3.75 (8)	3.94 (197)	F(5,6918)=11.063, p<.001
Quality of Life							
With how you spend your day? (a)	3.53 (5397)	3.69 (1136)	3.61 (77)	3.44 (106)	3.88 (8)	3.46 (191)	F(5,6909)=4.863, p<.001
With where you live?	3.70 (5362)	3.64 (1130)	3.58 (74)	3.42 (107)	3.25 (8)	3.57 (192)	F(5,6867)=2.353, p=.039
With the amount of choices you have? (a,e)	3.46 (5371)	3.64 (1131)	3.59 (76)	3.35 (108)	3.75 (8)	3.31 (192)	F(5,6880)=5.634, p<.001
With the opportunities you have to make friends? (a,e)	3.57 (5342)	3.78 (1127)	3.62 (78)	3.58 (107)	3.63 (8)	3.47 (189)	F(5,6845)=6.761, p<.001
With what you do in your free time?	3.59 (5371)	3.70 (1135)	3.62 (76)	3.32 (106)	4.25 (8)	3.60 (190)	F(5,6880)=3.560, p=.003
With how safe you feel in your neighborhood? (a)	3.91 (5180)	3.75 (1101)	3.89 (70)	3.78 (100)	3.88 (8)	3.67 (181)	F(5,6634)=5.294, p<.001
<p>The first number represents a mean rating. <i>How satisfied are you?</i> Scale: 1=Not at all satisfied . . . 5=Very satisfied. <i>How safe do you feel?</i> Scale: 1=Not at all safe . . . 5=Very safe. The number in parentheses represents the number responding to this item.</p> <p>Scheffe Post-Hoc significance at .05 or less</p> <p>(a) Interaction between White and Black. (b) Interaction between White and Hispanic. (c) Interaction between White and Other. (d) Native American and Other. (e) Black and Other.</p>							