

**DBH State Advisory Councils on
Alcohol and Drug Abuse and
Comprehensive Psychiatric Services
Joint Meeting Minutes
June 23, 2016**

Members Present: (ADA) Sean Adams, Kathi Grose, Jean Harris-Sokora, Sandra Jackson, Nancy Johnson, Richard Kenney, Christine McDonald, Liz Page, Randall Robb, Mark Smith, David Stoecker, Stephanie Washington, Janet Worthy, and Malva Yocco
(CPS) Amanda Dumey, Liz Hagar-Mace, John Harper, Mary Horn, Toni Jordan, Mickie McDowell, Denise Mills, Scott O’Kelley, Carrie Rigdon, Barb Scheidegger, Susan Scott, Amy Stevens, and Mindy Ulstad

Members Absent: John Czuba, Karen Leydens-Martin, Rosanna Metcalf, Gloria Nepote, Angela Reynolds, Hugh Scott, Karah Waddle, Daniel Cayou, Bruce Charles, Sarah Earll, Jesse Gilkey, Stacey Gilkey, Eric Martin, Linda Myers, and Shawn Sando

Division Staff: Lexy Thompson, Vicki Schollmeyer, Vanessa Nozinor, Lori Baysinger, Amanda Baker, Tish Thomas, Susan Blume, Kathy Huber, Vickie Epple, Angie Stuckenschneider, Rosie Anderson-Harper, Amy Kessel, Brooke Dawson, LuAnn Reese, Stacey Williams, Kate Wieberg, Tim Rudder, Jon Sabala, and Nora Bock

Guests: Dr. Christine Patterson, Melissa Daughtery, Michelle Horvath, Missy McGaw, Claire Beck, Tish Thomas, and Susan Depue

Call To Order	ADA SAC Acting Chairperson, Sandra Jackson, called the meeting to order with CPS SAC Chairperson, Mickie McDowell, present. Self-introductions were made.	ACTION/PENDING
Division Director Update	<p>Rosie Anderson-Harper, Director of Recovery Services, for Dr. Rick Gowdy, Division Director</p> <p>Dr. Gowdy sends his regrets that he is unable to be here today. He is with Governor Nixon, celebrating a milestone at Fulton State Hospital, the completion of the Energy Control Center, the first building of the new hospital to be completed. The construction of the hospital proper will now begin with anticipated completion in the winter of 2018. It does remain on time and on budget.</p> <p>The governor signed Missouri House Bill 1568, which allows licensed pharmacists to sell and dispense Narcan/naloxone, the emergency opioid antagonist that blocks the effects of opioid overdose. This will allow individuals to purchase naloxone from their local pharmacy. That bill will go into effect on August 28.</p> <p>In regard to the State Advisory Councils, Dr. Gowdy hopes to understand more what the groups are considering in terms of their structure. He does want to hear your thoughts and advice about where we need to go and will need your input before any action is taken.</p>	

	Discussion/Recommendation	Action/Pending
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<p>Mental Health Crisis Prevention Project (MHCPP) Update</p>	<p>The Mental Health Crisis Prevention Project (MHCPP), also known as the 1115 Waiver, application has been submitted and is being reviewed by Centers for Medicare and Medicaid Services (CMS). We are in the negotiation mode with CMS and now are trying to determine the best way to manage the number of individuals involved in the waiver against the amount of money we have. If we were to have to stop the waiver before the five-year period, meaning stop new admissions, we want to insure that individuals on the waiver do not have their services cut off abruptly or before clinically appropriate. Our new implementation date goal is August 1. We continue with trainings and trained the CMHL and ERE groups last week. We are training other provider groups this week and DBH staff in the next few weeks. As the waiver rolls out there will be additional trainings that are specific to CIMOR, first episodes psychosis, and some other principles associated with the goals of the waiver.</p>	
<p>“Be Under Your Own Influence” Campaign</p>	<p>Finally, Angie Stuckenschneider, Director of Prevention and Mental Health Promotion, asked me to mention to you that we have fact sheets available in the back, which are part of the “Be Under Your Own Influence” campaign, an anti-substance abuse campaign. The website, http://EndRXMisuse.org provides information regarding prescription drug misuse with links for additional resources.</p>	
<p>Community Mental Health Liaison (CMHL) Program Update</p>	<p>Dr. Christine Patterson, Community Integration Manager, Missouri Coalition for Community Behavioral Healthcare</p> <p>There are 31 CMHLs that work across the state. They work exclusively with law enforcement and the courts. We provide statewide coverage with a CMHL in every county. The goal of this project is to form better community partnerships with crisis systems, law enforcement, community mental health, and the courts. One of the things this project demonstrates is that we can always do a better job of working together. For law enforcement and the courts, liaisons have become their point person. The behavioral health system is complicated and is hard to navigate so to have one person they can call to ask questions, refer people to, or obtain information from about how things work has really been helpful for law enforcement. The design of the project is to improve communication across systems in order to save money and produce better outcomes for the people that come into contact with law enforcement and the courts. It is intended to divert people early on so they do not get deeper into the criminal justice system.</p> <p>The liaisons do a variety of things such as answer basic questions from law enforcement, connect people to services, find psychiatric beds, and facilitate access to behavioral health services. They also work to resolve structural barriers and issues in the community, and they facilitate training. They do not do case management. Two big projects they are working on are helping connect people with services and supports and expanding Crisis Intervention Teams (CIT). The liaisons are required to follow-up for a minimum of 30 days to see where people are. This project is two and a half years old at this point. There have been over 32,000 contacts between law enforcement and the courts and almost 20,000 referrals.</p>	<p>Handouts provided</p>

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	<p>The project has demonstrated that there is quite a need. We have found that the majority of people being referred do not have behavioral health services at the time. They tend to be referred to community providers and also tend to need behavioral health services. Most of the referrals are coming from law enforcement (about 76 percent at this point). We are trying to get courts more involved.</p> <p>One of the things that CMHL data showed early on is that there are a lot of people, age 19 to 35 that really need treatment but are without it. Forty percent of the referrals that CMHLs receive are in that 19 to 35 age group, and 57 percent of these do not have insurance. For this reason, the 1115 Waiver is going to be a great thing. Twenty-five percent of referrals to CMHLs are currently suicidal so training with the CMHLs involves understanding and talking about suicide prevention.</p> <p>We have designed six trainings that are exclusively designed for law enforcement at this point. We have done 425 trainings on behavioral health issues with law enforcement and have trained over 5000 officers to give them some basic knowledge of behavioral health issues (what to look for/some of the warning signs). There are an additional four trainings that will be rolled out in the next few months. We are working with the Missouri CIT council to expand CIT across the state. The CMHLs have been instrumental in that.</p> <p>In a pilot project, the Youth Behavioral Health Liaison (YBHL), instead of working exclusively with law enforcement and the courts, works primarily with schools but also juvenile court and children's division. The goal is much like the CMHL, to connect people early to services. The YBHL currently works in four counties and we are hoping eventually it will be expanded statewide.</p> <p>CMHLs have become involved with the Missouri State Highway Patrol most recently. That has been a great project. They have been part of critical incident stress debriefing (CISD) so whenever there is a law enforcement-involved shooting or accident, the CMHLs are part of that peer-led team to debrief the situation. This has been a great partnership that has started in the last several months. We have assigned CMHLs across the state that will be working exclusively with the highway patrol to debrief those situations and be an ongoing resource for law enforcement.</p> <p>Melissa Daugherty, Community Mental Health Liaison, Burrell Behavioral Health</p> <p>Educating and enlightening law enforcement officers to mental illness is a huge step so that the stigma can be reduced and they can recognize symptoms. For individuals needing substance use treatment, I will make a call to our Burrell Detox and often the law enforcement officer and I will escort the person to detox. From that point on, they will refer for longer term care if it is appropriate and if the client wants that. I have also made referrals to a 30-day program. For longer term treatment there is usually a wait list, but I'm learning more and more the resources that are available and will use those. Some counties have many more resources than others.</p>	
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<p>Team Building Activity</p> <p>Approval of Minutes</p> <p>Individual Placement and Support (IPS)/Supported Employment Update</p>	<p>We also assist in providing officers with peer support when they experience trauma due to their job. We have seen the other side – officers who are struggling themselves. They need to take care of themselves as well as the people they serve.</p> <p>Michelle Horvath, Community Mental Health Liaison, Compass Health-Crider Each day as a CMHL is different. It may involve receiving a call regarding an individual struggling with psychosis and working with the guardian to develop a plan in the event of worsened symptoms, offering treatment resources for individuals who had overdosed on heroin, referring an individual who had experienced a traumatic event to a trauma specialist, arranging continued treatment for an individual who had attempted suicide, assisting a homeless person, or seeking treatment for someone who had been making homicidal statements and making sure that he and others around him were safe.</p> <p>Educating law enforcement regarding the symptoms to look for in a person suffering from mental illness has had a very positive effect. I have received calls from officers who have recognized symptoms in individuals and felt empathy toward them. For the individual suffering from mental health issues, witnessing firsthand this concern from an officer toward them can and has made a significant impact in their treatment.</p> <p>Sandra Jackson, acting ADA SAC Chair and Mickie McDowell, CPS SAC Chair Council members took part in a team building activity to learn a little more about each other. This involved answering questions written on a ball.</p> <p>After a correction was made to the minutes from the CPS SAC meeting of April 28, 2016, Toni Jordan made a motion to approve the minutes. The motion was seconded and the minutes were approved. After two corrections were made to the minutes from the ADA SAC meeting of April 6, 2016, a motion was made to approve the minutes. The motion was seconded and the minutes were approved.</p> <p>Tish Thomas, State Trainer; Missy McGaw, State Trainer; and Claire Beck, State Trainer, IPS Supported Employment A slide presentation about evidence-based supported employment, also known as individual placement and support, was given. Work is a Mental Health Intervention. Listening to the success stories of the community mental health liaisons earlier, I thought “Ok, the next step would be a job.” We formerly brought IPS on in 2006, laying the groundwork with transformation grants. Prior to that we attempted to do some employment activities, but it just didn’t line up. This is a partnership between the Missouri Department of Mental Health, Division of Behavioral Health and the Missouri Department of Elementary and Secondary Education (DESE), Office of Vocational Rehabilitation (VR).</p>	<p>Handouts provided</p>

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	<p>We are funded by these two agencies. In order for an agency to provide IPS services they need to have an agreement to become a Community Rehabilitation Provider (CRP).</p> <p>Research has long stated that 60 to 70 percent of people with serious persistent mental illness do want to work, but in actuality the national and state average of those that have competitive jobs is only 7 to 11 percent. In Missouri, our IPS sites range anywhere from 26 to 71 percent of the employment rate. The Missouri average mean is 40 percent (as of the 4th Quarter of 2015) compared to 7 to 11 percent, so we know it works and have many success stories.</p> <p>Per a report from the Dartmouth College Learning Cooperative, which we are part of, in 2009 there were 423 people actively served in this program compared to 826 people served in 2015. People working in Missouri totaled 38 percent. We have gone from six IPS Fidelity sites in 2009 to 13 in 2015. We have many individuals on the IPS team who do Fidelity reviews for any agency that provides the service. We are now applying this to Comprehensive Substance Treatment and Rehabilitation (CSTAR) standalone programs. It is not just community health centers anymore. We have two official IPS sites that are CSTAR Programs and they are some of our best.</p> <p>IPS is only provided to individuals with serious and persistent mental illnesses who are coded MSD (Most Significantly Disabled) by VR and who qualify to receive either Community Psychiatric Rehabilitation (CPR) or CSTAR services. It is only for individuals receiving services from community mental health providers with CRP agreements to provide IPS. Additional funding is provided by Medicaid & DMH with specific documentation. We are training mental health centers how to bill employment-related activities and bill Medicaid because it is a medically necessary intervention.</p> <p>Research shows that employment makes such a difference. It is a mental health intervention just like anything else. It is a substance use intervention just like anything else. IPS is a dynamic partnership between the two agencies. The missions of each agency focus on helping people recover from any kind of disabling condition they have, and for some that means helping people get jobs. IPS is shown to increase employment outcomes. The one thing that we tell everybody is that people surprise you. People that you think will never be able to hold a job because of their mental illness or their substance use disorder will surprise you when given the right motivation and the right supports.</p> <p>An overview of the eight Individual Placement and Support Principles, the first of which is considered to be the most important principle, was given. Every person who wants to work is eligible - Zero exclusion.</p>	
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<p>SAC Integration Steering Committee Update</p>	<p>What this means is that if you want to get a job and are receiving services from a CRP with a contract with VR and you have an integrated team supporting you, there is an employment specialist who will help you get and keep a job. What we are also trying to do is promote employment for all mental health centers as a mental health intervention; that if a person, whether they are receiving services from an IPS site or not, wants to get a job, it should be on their treatment plan and they should receive help to get a job. We are trying to make sure everyone knows how important employment is in the recovery process. Work has not been considered a mental health intervention for the longest time. Now it is. It is everything. It is our identity. It is our reason to get up in the morning. It is our bread and butter. It is who we are. And with the right supports and the right match, everyone is employable.</p> <p>The Division of Behavioral Health has placed employment service information resources on both the ADA and CPS pages on the DMH website. VR is also a source of information as well as the Dartmouth website.</p> <p>http://dmh.mo.gov/mentalillness/adacpsemploymentservices.html http://dese.mo.gov/adult-learning-rehabilitation-services/vocational-rehabilitation/supported-employment http://sites.dartmouth.edu/ips/</p> <p>Lexy Thompson, Staff Training and Development Coordinator</p> <p>Expressed how great it is to work with the Integration Steering Committee. The people who are volunteering their time and talent to work on this committee have approached it with openness, honesty, and respect for one another and I am honored to continue working with them. We have discussed as both large and small groups the concerns surrounding integration. We have also highlighted the benefits that could come from our two councils integrating into one single council. There are financial advantages to having fewer meetings, which could mean more resources are available to the council for initiatives, advocacy, and education, should the council choose that as part of its mission. There is great opportunity to provide education to one another and reduce stigma and misinformation among members and groups. The council as one body can begin to address lack of parity in funding that exists for some services in our state. As our state has moved forward with integration in other areas and will continue to shift to providing services in an integrated way, an integrated council may be in a better position to evaluate the effectiveness of those services and make recommendations to the Division.</p> <p>The bulk of the work this committee has done so far has focused on discussing concerns surrounding integration along with the benefits, as I mentioned before. We have also had discussions regarding the specific requests the council has for this committee. Trying to land on the exact task and expectation of this committee has been a stumbling block for us.</p>	
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	Discussion/Recommendation	Action/Pending
Adjourn	<p>We are currently working under the assumption that the mission of the Integration Steering Committee is to develop a strategic plan for integration of the ADA and CPS SAC into one single unified advisory council in order to present that strategic plan to both councils for consideration on whether or not to move forward with that strategic plan. At this time I would like the council members to provide feedback and confirmation or correction of this mission as I have stated it.</p> <p>A conversation took place among Integration Steering Committee members and SAC members. Concerns were discussed as well as potential advantages and disadvantages of integration. The purpose of the steering committee, to develop a strategic plan as to what integration would look like then present it to ADA and CPS council members for a vote, was reiterated.</p> <p>Bruce Emery and John Hudgens, our Substance Abuse and Mental Health Services Administration (SAMHSA) consultants, are actively working with the steering committee to provide the councils with preliminary proposals. They will then come in and speak to the council members as a whole.</p> <p>Motion to adjourn was made by Toni Jordan. Motion was seconded.</p>	<p>Integration Steering Committee members will continue to meet. They will present a plan for councils to review. We will meet again in December as a joint group and hope to have additional information to continue the discussion about integration.</p>