Missouri

UNIFORM APPLICATION
FY 2009 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

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

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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.

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DUNS #: 780871430

I. AGENCY TO RECEIVE GRANT
AGENCY: Department of Mental Health  
ORGANIZATIONAL UNIT: Division of Comprehensive Psychiatric Services  
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STATE: MO  
ZIP: 65102  
TELEPHONE: 573-526-5890  
FAX: 573-751-7815

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT
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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: 07/01/2008  TO: 06/30/2009

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION
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ORGANIZATIONAL UNIT: Division of Comprehensive Psychiatric Services  
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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 2009-2011 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.

With strong support from Governor Matt Blunt and legislative leaders, DMH experienced an increase in funds for the FY 2009 budget. Missouri had experienced the effects of an extended overall economic slowdown over five consecutive years. A limitation on general revenue growth had caused the DMH to face core budget reductions, withholds and staff layoffs. The DMH had experienced core net reductions on General Revenue state dollars of more than $80 million. The total full-time equivalent positions have been reduced from 10,386 in fiscal year 2002 to 8,826 in fiscal year 2007. This has required the department to focus on protecting current services and programs while attempting to maximize the use of other funding sources. While the increase in funds for the current fiscal year is a positive development, DMH had lost ground and continues to make up for the lean years. Missouri relies heavily on Medicaid to reimburse for services. This reliance puts the State at significant risk if the Federal government initiates Medicaid reform as has been proposed. The State has sought funding through various sources and has thoroughly investigated Federal grant sources.

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

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

CPS is beginning to adopt a public health approach. Coupled with a strong and effective linkage with the MO HealthNet program, CPS has moved toward greater integration of mental health services with other healthcare, vocational, and housing services. Other significant achievements for the Division are its suicide prevention efforts and the focus on evidence based practices (EBP).

The DMH CPS has met challenges by cooperating with other state agencies to enhance services and programs and develop new and innovative ways to serve consumers. Initiatives within the department have been developed to look at quality assurance, EBPs, recovery and prevention of illness and disability. Legislation passed in 2004 formalized a children’s comprehensive mental health plan offering families access to mental health care without relinquishing custody of their child. The next step is to assure treatment for youth with co-occurring disorders and address the transition from youth to adult services. As the DMH moves into FY 2009-2011, efforts to provide quality services to adults with serious mental illness will take shape through Mental Health Transformation activities. The use of programs and projects like the Medicaid Pharmacy Partnership, suicide prevention, and Peer Specialist Certification has begun the change to a public health model of care that supports recovery. The Block Grant State Plan provides an overview of the programming, services and initiatives the department and division have developed to serve Missouri’s citizens with mental illness and severe emotional disturbances.

Involvement and inclusion of consumers, providers, and advocates in the planning, monitoring, and evaluation of programs continues to be a high priority for the department. Advocates and consumers are involved with a variety of activities that will be described in more detail in the planning council section of the Block Grant. Consumers and advocates serve on a variety of committees and workgroups, lending experience and advice to the department in prioritizing needs and developing responsive policies and programs. A Director of Consumer Affairs is working to assure safety of consumers. The Mental Health Block Grant Planning Council is engaged and energized, working to improve consumer involvement. In conjunction with the Planning Council, CPS is providing education and advocacy training and is incorporating consumers and family members in its monitoring of the service system.

Missouri DMH CPS has made great strides in State Fiscal Year 2008 on implementing EBPs.

- CPS is measuring fidelity to Integrated Dual Disorders Treatment (IDDT) and sixteen community mental health centers are working towards full fidelity.
- Assertive Community Treatment (ACT) is being implemented in six agencies across the state. ACT pilot sites have developed their teams and are enrolling consumers. ACT teams are using the Comprehensive Outcome Measure system.
- CPS has recently been awarded a Johnson & Johnson grant to continue the progress on expanding Supported Employment opportunities for individuals with mental illness.
Additionally, progress is being made on easy access to physical and mental health services in the same location through our community mental health center and federally qualified health center initiative.

The CPS is attempting to improve its data management to support system transformation. A client information system continues to be developed to provide an improved ability to track services, outcomes, and costs of services. The DMH also has a Data Infrastructure Grant (DIG) targeted toward improving data quality and conducting outcomes studies.

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

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

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

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

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

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

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

**Hope * Opportunity * Community Inclusion**

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

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

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

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

Section 1911:
Subject to Section 1916, the State 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 2008, 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.

________________________       ____________________
Governor       Date

Keith Schafer, Ed.D, Department Director
CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;

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

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

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

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central
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 undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</th>
<th>TITLE</th>
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<tbody>
<tr>
<td></td>
<td>Deputy Director of Administration</td>
</tr>
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<table>
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<tr>
<th>APPLICANT ORGANIZATION</th>
<th>DATE SUBMITTED</th>
</tr>
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<tbody>
<tr>
<td>Missouri Department of Mental Health</td>
<td></td>
</tr>
<tr>
<td>1. Type of Federal Action:</td>
<td>2. Status of Federal Action</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>a. contract</td>
<td>a. bid/offer/application</td>
</tr>
<tr>
<td>b. grant</td>
<td>b. initial award</td>
</tr>
<tr>
<td>c. cooperative agreement</td>
<td></td>
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<td>d. loan</td>
<td></td>
</tr>
<tr>
<td>e. loan guarantee</td>
<td></td>
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<tr>
<td>f. loan insurance</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Status of Federal Action</td>
<td></td>
</tr>
<tr>
<td>a. bid/offer/application</td>
<td></td>
</tr>
<tr>
<td>b. initial award</td>
<td></td>
</tr>
<tr>
<td>c. post-award</td>
<td></td>
</tr>
<tr>
<td>3. Report Type:</td>
<td></td>
</tr>
<tr>
<td>a. initial filing</td>
<td></td>
</tr>
<tr>
<td>b. material change</td>
<td></td>
</tr>
</tbody>
</table>

For Material Change Only:

Year ______ Quarter ______

date of last report ______

<table>
<thead>
<tr>
<th>4. Name and Address of Reporting Entity:</th>
<th>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime</td>
<td>Sub awardee</td>
</tr>
<tr>
<td>Tier _____ , if known:</td>
<td></td>
</tr>
<tr>
<td>Congressional District, if known:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Federal Department/Agency:</th>
<th>7. Federal Program Name/Description:</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>8. Federal Action Number, if known:</th>
<th>9. Award Amount, if known:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. a. Name and Address of Lobbying Entity</th>
<th>b. Individuals Performing Services (including address if different from No. 10a.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(if individual, last name, first name, MI):</td>
<td>(last name, first name, MI):</td>
</tr>
</tbody>
</table>

| 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 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. | | |
|                                                                              |                                                                                   |
|                                                                              |                                                                                   |

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)
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.
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 VII 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.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


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.

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<thead>
<tr>
<th>SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</th>
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<tbody>
<tr>
<td>Missouri Department of Mental Health</td>
<td></td>
</tr>
</tbody>
</table>
Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

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

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

The Mental Health Planning Council for Missouri has instituted a regular review of the Block Grant at their monthly open meetings. Meeting agendas are posted to the DMH website at least 24 hours before the open meetings. Block Grant Discussion is clearly labeled on the agendas, thus giving the general public opportunity to attend the meeting and make comment. The Planning Council regularly engaged in discussion about evidence-based practices, mental health transformation, and budget throughout the fiscal year 2008. The Planning Council has direct access to the Department and Division Directors, at meetings and by phone/email/DMH blog, to offer opinions and comments on the adequacy of mental health services within the State.

The Planning Council was emailed copies of the draft State Plan for comment and given access to the web based version with a specific user identification and password. The June, July and August 2008 meetings provided specific time for discussion of the draft State Plan. All comments have been considered and incorporated where applicable.
II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

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

Data Reported by:

State FY    X    Federal FY ______

State Expenditures for Mental Health Services

<table>
<thead>
<tr>
<th>Calculated FY 1994</th>
<th>Actual FY 2007</th>
<th>Estimate/Actual FY 2008</th>
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<tbody>
<tr>
<td>$14,716,201</td>
<td>$22,357,716</td>
<td>$27,076,216</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>State FY</th>
<th>Federal FY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual FY 2006</td>
<td>Actual FY 2007</td>
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<tr>
<td>$109,628,744</td>
<td>$117,728,866</td>
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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>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone and Fax</th>
<th>Email (If available)</th>
</tr>
</thead>
</table>
| Bussabarger, Mary Louise | Family Members of adults with SMI | 1914 Princeton Dr. Columbia, MO 65203  
PH: (573) 445-4147  
FAX:                                      |                                      | lindaclarke@charter.net          |
| Clarke, Linda      | Family Members of Children with SED | 8 Akin Court St. Peters, MO 63376  
PH: (636) 294-0125  
FAX:                                      |                                      | liz.hagar-mace@dmh.mo.gov        |
| Hagar-Mace, Liz    | State Employees                  | 1706 East Elm P.O. Box 687 Jefferson City, MO 65102  
PH: (573) 522-6519  
FAX: (573) 526-7797                             |                                      | Shami226165@aol.com             |
| Hamilton, Sandra J | Family Members of Children with SED | 12333 Bristol Avenue Grandview, MO 64030  
PH: (816) 767-8393  
FAX:                                      |                                      | john.harper@vr.dese.mo.gov       |
| Harper, John       | State Employees                  | 3024 DuPont Circle Jefferson City, MO 65101  
PH: (573) 526-7040  
FAX: (573) 751-1441                     |                                      | TPFPROGRAM-CPSSAC@yahoo.com      |
| Henning, Al        | Consumers/Survivors/Ex-patients(C/S/X) | 1824 Newton Avenue Kansas City, MO 64126-2762  
PH: (816) 255-2567  
FAX:                                      |                                      |                              |
<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone and Fax</th>
<th>Email (If available)</th>
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</thead>
<tbody>
<tr>
<td>Johnson, Jessica</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>1118 London Drive Columbia, MO 65203 PH:(417) 343-1634 FAX:</td>
<td><a href="mailto:ladyhawc77@yahoo.com">ladyhawc77@yahoo.com</a></td>
</tr>
<tr>
<td>Johnson, Kimberly</td>
<td>State Employees</td>
<td>Medicaid</td>
<td>P.O. Box 6500 Jefferson City, MO 65102-6500 PH:(573) 751-3277 FAX:</td>
<td>Also Represents Department of Social Services</td>
</tr>
<tr>
<td>Jones, Karren</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>NAMI of Missouri</td>
<td>1210 Linden Drive Apt. 13 Jefferson City, MO 65109 PH:(573) 636-6188 FAX:</td>
<td><a href="mailto:mocamiksj@yahoo.com">mocamiksj@yahoo.com</a></td>
</tr>
<tr>
<td>Lay, Donna</td>
<td>Family Members of Children with SED</td>
<td></td>
<td>7416 State Route W West Plains, MO 65775 PH:(417) 277-5473 FAX:</td>
<td><a href="mailto:jd3031@socket.net">jd3031@socket.net</a></td>
</tr>
<tr>
<td>Markway, Ph.D.,</td>
<td>State Employees</td>
<td>Criminal Justice</td>
<td>2729 Plaza Drive P.O. Box 236 Jefferson City, MO 65102 PH:(573) 526-6523 FAX:(573) 526-8156</td>
<td><a href="mailto:greg.markway@doc.mo.gov">greg.markway@doc.mo.gov</a></td>
</tr>
<tr>
<td>Meachum-Cain, Glenda</td>
<td>State Employees</td>
<td>Other</td>
<td>Department of Health and Senior Services 930 Wildwood Jefferson City, MO 65102 PH:(573) 751-6064 FAX:</td>
<td><a href="mailto:glenda.meachum-cain@dhss.mo.gov">glenda.meachum-cain@dhss.mo.gov</a></td>
</tr>
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<td>Name</td>
<td>Type of Membership</td>
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<td>-----------------</td>
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<td>---------------------------------------------------------</td>
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<td>----------------------------------------------</td>
</tr>
<tr>
<td>Minth, Helen</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>St. Louis Empowerment Center</td>
<td>3024 Locust St. Louis, MO 63118 PH:(314) 652-6100 FAX:(314) 652-6103</td>
<td><a href="mailto:hminth@sbcglobal.net">hminth@sbcglobal.net</a></td>
</tr>
<tr>
<td>O’Toole, Mark</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>27614 Indian Drive Rocky Mount, MO 65072 PH:(573) 392-7631 FAX:</td>
<td><a href="mailto:otoolem@earthlink.net">otoolem@earthlink.net</a></td>
</tr>
<tr>
<td>Qualls, Robert</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>2145 W. Brower Springfield, MO 65802 PH:(417) 831-2985 FAX:</td>
<td><a href="mailto:robert-qualls@sbcglobal.net">robert-qualls@sbcglobal.net</a></td>
</tr>
<tr>
<td>Robbins, John</td>
<td>State Employees</td>
<td>Education</td>
<td>Department of Elementary and Secondary Education 205 Jefferson City, MO 65102 PH:(573) 522-1488 FAX:(573) 526-4261</td>
<td><a href="mailto:john.robbins@dese.mo.gov">john.robbins@dese.mo.gov</a></td>
</tr>
<tr>
<td>Stanton, Sarah</td>
<td>Providers</td>
<td>Truman Medical Center</td>
<td>2211 Charlotte Kansas City, MO 64108 PH:(816) 404-5730 FAX:</td>
<td><a href="mailto:sarah.stanton@tmcmed.org">sarah.stanton@tmcmed.org</a></td>
</tr>
<tr>
<td>Stephens, Erica</td>
<td>Providers</td>
<td>Missouri Protection &amp; Advocacy</td>
<td>925 South Country Club Drive Jefferson City, MO 65109 PH:(573)-893-3333 FAX:(573) 659-0677</td>
<td><a href="mailto:erica.stephens@mo-pa.org">erica.stephens@mo-pa.org</a></td>
</tr>
<tr>
<td>Name</td>
<td>Type of Membership</td>
<td>Agency or Organization Represented</td>
<td>Address, Phone and Fax</td>
<td>Email (If available)</td>
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<td>-----------------</td>
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<tr>
<td>Taggart, Suzanne</td>
<td>Providers</td>
<td>Pathways Community Behavioral Healthcare</td>
<td>P.O. Box 104146 Jefferson City, MO 65110-4146 PH:(573) 634-2516 FAX:</td>
<td><a href="mailto:staggart@pbhc.org">staggart@pbhc.org</a></td>
</tr>
<tr>
<td>Wesson, Ethel</td>
<td>Family Members of adults with SMI</td>
<td></td>
<td>5618 Indiana Kansas City, MO 64130 PH:(816) 361-2298 FAX:</td>
<td></td>
</tr>
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TABLE 2. Planning Council Composition by Type of Member

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
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</thead>
<tbody>
<tr>
<td>TOTAL MEMBERSHIP</td>
<td>20</td>
<td></td>
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<tr>
<td>Consumers/Survivors/Ex-patients (C/S/X)</td>
<td>6</td>
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<tr>
<td>Family Members of Children with SED</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Family Members of adults with SMI</td>
<td>2</td>
<td></td>
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<tr>
<td>Vacancies (C/S/X and Family Members)</td>
<td>0</td>
<td></td>
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<tr>
<td>Others (not state employees or providers)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL C/S/X, Family Members and Others</strong></td>
<td>11</td>
<td><strong>55.00%</strong></td>
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<tr>
<td>State Employees</td>
<td>6</td>
<td></td>
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<tr>
<td>Providers</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL State Employees and Providers</strong></td>
<td>9</td>
<td><strong>45.00%</strong></td>
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</tbody>
</table>

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

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council’s efforts and related duties as mandated by law:

- reviewing plans and submitting to the State any recommendations for modification
- serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
- monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
- the role of the Planning Council in improving mental health services within the State.

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

The role of the Missouri Mental Health Planning Council is to improve mental health services within the State. The mission of the planning council known as the Division of Comprehensive Psychiatric Services State Advisory Council (CPS/SAC) is to advise the division in the development and coordination of a statewide inter-agency and inter-departmental system of care for children and youth with serious emotional disorders and adults with mental illness and their families. Council members are primary consumers, family members, providers and State agency representatives. The CPS/SAC serves as the block grant planning council for Missouri and was first established in 1977 by a Governor's Executive Order. Missouri Revised Statues, Chapter 632 Comprehensive Psychiatric Services, Section 632.020 currently stipulates the requirements for the advisory council.

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

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

Advocacy
The CPS/SAC serves as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems. CPS/SAC advocacy activities include promoting the Peer Specialist training and certification; planning and implementing Mental Health Awareness Day; participation in the Department of Mental Health’s Annual Spring Training Institute, Anti-Stigma Public Education Campaign, Mental Health Transformation activities, and Procovery to name a few. Presentations were provided at monthly meetings on topics such as Mental Health Block Grant, Budget Priorities, Performance/Outcome Data, Tobacco Cessation, Suicide Prevention, Prevention, Mental Health Elderly Issues, Consumer Involvement in Monitoring Community Agencies, Mental Health Transformation, Consumer Operated Drop-In Centers, Wellness Recovery Action Planning, Peer Specialist Certification, Olmstead and PATH grants, Protection and Advocacy, Mental and Physical Health Connection including the Morbidity and Mortality Study, Person Centered Planning, Housing, and Employment.
Mental Health Awareness Day 2008: Transformation: From Hope to Health at the State Capitol on April 10th was a huge success. Over 300 consumers converged on the State Capitol for educational opportunities and advocacy. Events, planned entirely by the council members, included the Consumer Conference presentations on RESPECT, Advocacy Workshop, BRIDGES, Crisis Intervention Teams, Mental Health Transformation, and Peer Run Programs. The First and Third Floor Rotunda of the Missouri State Capitol hosted twenty-two mental health related exhibits. The Capitol speakers included key State Representatives and Senators. Media Awards were presented to three individuals for public education reducing the stigma of mental illness. Music provided by a consumer singer/guitar player and free ice cream for participants and legislative staff rounded out the celebratory event. Many individuals with mental illness and their families made appointments with their legislators to share their stories. Individuals participated with intensity and passion to help those suffering from mental illness. Council members staffed the event to assure it ran smoothly.

**Monitoring, Reviewing and Evaluating**

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

1. CPS/SAC members review the Block Grant and on a continuous basis review the data gathered by the DMH. The June, July and August 2008 meetings focused on discussion and review of the Block Grant proposal.

2. CPS/SAC meetings often include presentations on the budget, current programming, grants, and initiatives for the purpose of allowing input and feedback on the adequacy of mental health services within the State.

3. CPS/SAC meetings include monthly conversations with the Department and Division Directors allowing feedback and ideas to be presented directly to decision makers.

4. New in 2008, CPS/SAC members are full team members for certification surveys of the community mental health centers. These reviews evaluate the quality of care from a consumer/family perspective.

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

**Mental Health Transformation**

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

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

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

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

A statewide Transformation Leadership Working Group has been formed. Two consumer members and two State agency members of CPS/SAC were included. Six Transformation Work Groups were formed; one for each New Freedom Commission goal. CPS/SAC members were on multiple work groups. The CPS/SAC sponsored thirteen Public Meetings around the State to obtain public feedback on the draft plan. A CPS/SAC member co-hosted the meeting in their area of the State. The Office of Transformation Director continues to attend CPS/SAC meetings to provide updates on the plan implementation and obtain input from members. CPS/SAC members are currently co-hosting the thirteen statewide RESPECT Seminars to reduce stigma and assist individuals in telling their recovery story. One CPS/SAC member has been trained in Mental Health First Aid as part of the Mental Health Transformation Show Me Series. CPS/SAC members are on several of the next step working groups to develop the transformation implementation details.

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

The DMH provides services to about 170,000 Missourians each year, many of whom are making major progress in overcoming the challenges of mental illnesses, substance abuse, and developmental disabilities. Unfortunately, few of their personal stories are known. To address this, the department recognized the accomplishments of three of these individuals with the first-ever Mental Health Champions recognition. Three persons were selected from statewide nominations as Mental Health Champions. A member of CPS/SAC was nominated and another
member was on the selection committee. The nominees were representative of individuals with mental illnesses, developmental disabilities, and persons in recovery from substance or gambling addictions. They were persons who have overcome their personal challenges to make life better for others and for their communities. The first Mental Health Champions Banquet was held April 16, 2008, at the Capitol Plaza Hotel in Jefferson City. Videos of the Mental Health Champion awardees can be viewed at http://www.dmh.mo.gov/news/MHChampions.htm

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

To ensure mental health care is consumer and family driven, consumer members have been selected for membership on such groups as the Comprehensive System Management Team (CSMT), Comprehensive Children’s Mental Health Services System Stakeholder’s Advisory Group (SAG) among others. Both the CSMT and the SAG have consumer parent representatives from the CPS/SAC to ensure a connection and sharing of information between the groups. Procovery has been implemented across the State including specific training for consumers, including CPS/SAC members, on starting and maintaining Procovery Circles. These committees are in addition to the Transformation Work Groups mentioned above. Several of the CPS/SAC members are also members of the National Alliance for the Mentally Ill (NAMI). There have been several collaborative activities with NAMI Missouri regarding reducing stigma. An attorney from the Missouri Protection and Advocacy organization is a member of CPS/SAC.

A staff person with the Centers for Medicare and Medicaid Services Person Centered Planning grant has been added as an Ad hoc member of the SAC. She keeps the SAC updated on progress and requests their feedback at every meeting.

To ensure early mental health screening, assessment and referral are common practice, two members of the CPS/SAC have actively participated in the Crisis Intervention Team training for law enforcement. This training teaches law enforcement appropriate interventions for individuals with mental illness they meet on the streets.

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 Disorders Treatment, Assertive Community Treatment and Supported Employment for adults and Comprehensive System of Care for children. Jean Campbell, a nationally recognized consumer/researcher, is assisting the department in the transformation process. She offers a consumer voice in transformation. She has provided a presentation to CPS/SAC on ways to accelerate the multi-state Consumer Operated Service Programs (COSP) findings into practice. One of the Consumer Operated Drop-In Center Executive Directors actively participates on CPS/SAC. Additionally, one of the CPS/SAC members is working on the Juvenile Justice Grant for the Children’s Initiative in promoting the evidence based practice of Trauma Focused Cognitive Behavioral Therapy.
To ensure technology is used to access mental health care and information, the CPS/SAC members have tested and given feedback on the state-wide “Network of Care” web-based system to facilitate consumer information and access to mental health services. The Network of Care website has been approved as meeting SAMHSA’s mental health transformation goals. Council members have promoted use of the Network of Care site and the My Folder component. My Folder includes recorded messages from Mary Ellen Copeland on the use of the Wellness Recovery Action Plan. Consumers are currently being trained on the resources available in Network of Care and how to train their peers on using the resources.

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

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

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

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

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

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

Advocacy/Awareness, Reduce Stigma and Increase Education
CPS/SAC will continue to plan and implement the Mental Health Awareness Day activities in efforts to reduce stigma and raise awareness of the general public and legislators. The department has paid the expenses of all CPS/SAC members to participate in the annual Spring Training Institute for the past several years and will continue to do so. The goal is to promote leadership and knowledge of evidenced based practice for consumer leaders. Council members presented at Spring Training Institute 2008 on Peer Specialist Certification.
DMH is developing a new Public Service Announcement (PSA) called “You Know Me.” The CPS/SAC Chair has recorded the first PSA.

Several members of the CPS/SAC are involved in planning a statewide consumer/family/youth conference with the Office of Consumer Affairs. Additionally, a Missouri Youth Advisory Council is being formed with input from CPS/SAC.

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

**Consumer Provided Services**

CPS/SAC members researched and chose a Peer Specialist training and certification model. Based on the CPS/SAC recommendations CPS has adopted the Appalachian Consulting Group “Georgia Model” for Peer Specialist training. Missouri’s mental health system predominantly relies on a provider-driven model of service delivery that uses *traditional* planning and service delivery methods based on the theory professionals have the expertise to make health care decisions. It is the intent of the Division to move the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. One primary strategy in transforming the system is to recognize the power of consumer as providers. Recognizing consumers as providers is a relatively new concept within some parts of the mental health system. The traditional provider-driven model has unfortunately established strong boundaries between the provider and the service participant. However, emerging evidence strongly supports the need for peer support services as a cost-effective and complementary adjunct to professional mental health services and supports. Peer support services can move the system to focus less on illness and disability and more on wellness. To accomplish this goal, Missouri will provide equal weight to expertise gained through the “lived experience” as is done with any other credential or knowledge base. Peer support services are those services with a focus on recovery. A Peer Specialist can share lived experiences of recovery, share and support the use of recovery tools and model successful recovery behaviors. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. Additionally, Peer Specialists can help consumers connect with other consumers and with their community at large. Several of the CPS/SAC members will be receiving the training and the plan is for the CPS/SAC Chair to become a Missouri Peer Specialist trainer.

The CPS/SAC members are individually and collectively committed to improving the outcomes of individuals served in the mental health system. It is characteristic of membership to be involved locally in their communities as well as on the State level.
BYLAWS OF THE STATE ADVISORY COUNCIL FOR COMPREHENSIVE
PSYCHIATRIC SERVICES

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

Article II – Responsibilities
In order to accomplish this mission the SAC shall:

A. Advise CPS in the development of models of services and long range planning and
   budgeting priorities.

B. Identify statewide needs, gaps in services, and movement toward filling gaps.

C. Provide education and information about mental health issues.

D. Monitor, evaluate, and review the allocation and adequacy of mental health services
   within the state.

Article III – Organization

A. The Director of the Division of Comprehensive Psychiatric Services shall appoint up
to 25 members to the State Advisory Council for Comprehensive Psychiatric
   Services.

B. The terms of office for members shall be overlapping terms of a full three (3) years.
   A member of the State Advisory Council for Comprehensive Psychiatric Services
   may serve an additional three-year term if properly nominated and approved by the
   State Advisory Council and the Division Director.

C. Members shall have a professional, research, or personal interest in the prevention,
   recovery, evaluation, treatment, rehabilitation, and system of care for children/youth
   with serious emotional disturbance and persons affected by mental disorders and
   mental illness and their families. The Council shall include representatives from the
   following:

   1. Non-government organizations or groups and state agencies concerned with the
      planning, operation or use of comprehensive psychiatric services.
2. Representatives of primary and secondary consumers and providers of comprehensive psychiatric services, who are familiar with the need for such services.

D. The membership composition of the State Advisory Council shall follow the guidelines set forth in P.L. 102-321 as follows:

1. At least 13 of the members of SAC shall be self-identified consumers defined as follows:
   a. Primary Consumer: A person who is an active or former recipient of mental health, substance abuse and/or developmental disabilities services, regardless of source of payment. Parents, family members, and/or legal custodians/guardians of children and youth are primary consumers if they are actively engaged in the treatment planning and/or delivering services and supports for the child or youth.
   b. With respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council.
   c. With respect to the membership of the Council, the ratio of individuals with Serious Mental Illness to other members of the Council is sufficient to provide adequate representation of such individuals in the deliberations of the council.

2. At least 12 of the members of SAC shall be providers defined as follows:
   a. System Customer: An entity/service delivery system, which uses, purchases and/or coordinates with mental health, substance abuse and developmental disabilities services provided by the Department of Mental Health. Representatives of the following state agencies are mandated: mental health, education, vocational rehabilitation, criminal justice, housing, social services, and Medicaid. The remainder could be representatives of mil tax boards, community agencies, faith sector, family members, and advocates.

E. The Council shall be representative of the state’s population, taking into consideration their employment, age, sex, race, and place of residence and other demographic characteristics of the state, determined essential by the Council and Director.

Article IV – Membership Nominations

A. Nominations for vacant council positions shall be accepted from any individual or organization.

B. Vacancies, when they occur, shall be announced and publicized.
Article V – Officers

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

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

Article VI – Committees

A. Project Committees:

1. Project Committees shall be formed as they are needed. These Committees shall address block grant planning and special issues identified by the State Advisory Council or the Division as topics relevant to the Mental Health Service Delivery System.

2. Project Committee members will report to the full council at each council meeting.

3. A Committee will disband when work is done on its particular issue.

B. Executive Committee:

1. The membership of the Executive Committee shall consist of the chairperson of the Council, the vice-chairperson of the Council, immediate past chairperson, and chairpersons of any project committees.

2. The Executive Committee shall meet at the call of the chairperson, upon request of three or more of the committee members, or a call of the Division Director. A quorum shall consist of a majority of Executive Committee members.

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

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

Article VII – Meetings

A. The Council shall meet at least every ninety days at the call of the Division Director or the Council chairperson.
B. A quorum requires the attendance of at least 50% of the members of the Council.

C. When necessary, a telephone poll may be conducted to complete the quorum necessary for action and to conduct other Council matters in a timely manner, and such action shall be included in the minutes of the next regularly scheduled meeting.

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

Article VIII – Meeting Attendance

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

Article IX - Miscellaneous

A. Compensation: Each member shall be reimbursed for reasonable and necessary expenses including travel expenses pursuant to the travel regulations for employees of the Department, actually incurred in the performance of his/her official duties.

B. Amendments: Any Council member may present amendments for consideration at any meeting. Such amendment will be voted on at the next regular meeting and requires a 2/3 majority to amend the bylaws. In circumstances where amendments to the bylaws are time sensitive, a vote may be taken by telephonic or electronic means.

C. The Division Director shall:

1. Serve as the primary Departmental consultant to the State Advisory Council.
2. Provide the Council and committees with Division staff for technical assistance and secretarial support.

Approved 10/21/04
Missouri

Adult - Overview of State's Mental Health System

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

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

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

State Capital: Jefferson City
Governor: Matt Blunt
Area: 68,886 sq miles
Counties: 141 + 1
Cities > 100K: (2005)
445K Kansas City
344K St Louis City
159K Springfield
110K Independence
Counties > 250K: (2006)
1,001K St Louis County
664K Jackson County
339K St Charles
255K Greene County
The Bureau of Economic Analysis estimates that Missouri's total state product in 2003 was $195 billion. Per capita personal income in 2003 was $29,464, 27th in the nation. Major industries include aerospace, transportation equipment, food processing, chemicals, printing/publishing, electrical equipment, light manufacturing, and beer. Tourism, services, and wholesale/retail trade follow manufacturing in importance.

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

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

The Department Director appoints the Director of the Division of CPS. There are four regional hospital systems comprised of eleven (11) CPS inpatient facilities. Each hospital system has a single Regional Executive Officer (REO) and each facility within a hospital system has its own chief operating officer (COO). For the provision of community based services, Missouri’s 114 counties and the City of St. Louis are subdivided into 25 mental health service areas, each with an Administrative Agent (AA). AA’s are community mental health centers responsible for the assessment and provision of services to persons in their designated area and for providing follow-up services to persons released from State-operated inpatient services. The Office of Comprehensive Child Mental Health (OCCMH) was established within DMH. This office will assure the implementation of a Comprehensive Children’s Mental Health Service System and will be advised by the Comprehensive Child Mental Health Clinical Advisory Council.

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

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

Comprehensive Psychiatric Services
- 11 state operated facilities
  - 9 State psychiatric hospitals for adults with SMI
  - 2 Child psychiatric hospitals for children with SED
- 74,000 unduplicated consumers served in FY07
Mission

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

Vision

Hope ▼ Opportunity ▼ Community Inclusion
Missourians receiving mental health services will have the opportunity to pursue their dreams and live their lives as valued members of their communities.

Values

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

Accessible, Safe, Affordable, and Integrated Services
Missourians with mental health needs easily access safe, affordable, and integrated medical and behavioral services.

Partners in Personal Service Design
Missourians participating in mental health services are active partners in designing their services and supports.

Effectiveness Measured by Participant Outcomes
The effectiveness of Missouri’s mental health services is measured by meaningful outcomes experienced by the people receiving them.

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

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

Respected Unique Participant Characteristics
Missourians participating in mental health services are valued for their uniqueness and diversity and respected without regard to age, ethnicity, gender, race, religion, sexual orientation, or socio-economic condition.
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 in 2008 was 1,558.

CPS is responsible for statewide 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. The certification standards of care contain core rules, adopted in 2001, which apply to both ADA and CPS programs. Collaborative annual reviews of joint contracted community organizations are conducted by CPS and ADA staff.

Missouri’s 114 counties and the City of St. Louis form 25 mental health service areas each with an administrative agent. These administrative agents are responsible for the assessment and services to persons in their assigned area and to provide follow-up services for persons released from State operated inpatient facilities. Children and youth are provided services in the same way through contracts with administrative agents and State operated children’s facilities. A map of the service areas and listing of corresponding community service provider follows the narrative in this section.

Supported community living programs provide services for persons who do not have a place to live or need more structured services while in the community. These programs range from nursing homes to apartments and other living accommodations in the community. Persons in these programs are provided support through case management and community psychiatric rehabilitation programs.

Twelve (12) counties and the city of St. Louis have passed Mental Health Mil Taxes and have Mil Tax Boards. Four (4) counties have passed a Children’s Services Tax. Four counties are actively planning for a mil tax and have formed task forces. The Division hired a Community Development Manager to work closely with the local Mil Tax Boards and local organizations to increase the number of counties with mil tax monies for mental health services. The Division maintains regulatory and quality control of services purchased by local boards through enforcement of certification standards for those services.

The department has expanded its suicide prevention efforts by awarding contracts to seven agencies that serve as Regional Resource Centers to provide suicide prevention services across the state. The Resource Centers have engaged community partners to develop and implement local strategies, provide public education and training, offer support for survivors, and promote proven practices to help with preventing suicide within their designated service areas.
The department’s Access Crisis Intervention (ACI) line is staffed by mental health professionals who can respond to your crisis 24 hours per day and 7 days per week. They will talk with consumers about their crisis and help determine what further help is needed, for example, a telephone conversation to provide understanding and support, a face-to-face intervention, an appointment the next day with a mental health professional, or perhaps an alternative service that best meets your needs. They provide resources or services within the community to provide ongoing care following a crisis. All calls are strictly confidential.

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

The department funds five Drop-In Centers for persons with mental illness. Jean Campbell, Ph.D., principal investigator of the COSP Multi-site Research Initiative, 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 are helping each program to improve the quality of services delivered. An additional five contracts have been awarded for peer support phone lines.

**Drop-In Center Services**

**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: Sherri Redding
Email: sherri.redding@tmcmed.org
Website: 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: 1-877-555-4357
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
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<td>9</td>
<td>Ozark Center</td>
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**Family Guidance Center**
- 510 Francis Street #200
- St. Joseph, MO 64501-1706
- Garry Hammond, Executive Director
- 816-364-1501
- Fax: 816-364-6735
- Email: ghammond@familyguidance.org

**Community Recreation and Resocialization, Inc.**
- 525 S. 10th Street
- St. Joseph, MO 64501
- Martha Goodding, Executive Director
- 816-233-0430
- Fax: 816-233-3795
- Email: crr@stjoewireless.net

**Truman Medical Ctr Behavioral Health**
- 2211 Charlotte
- Kansas City, MO 64111
- Marsha Morgan, Executive Director
- 816-404-5700
- Fax: 816-404-5731
- Email: marsha.morgan@tmcmed.org

**Swope Health Services**
- 3801 Blue Parkway
- Kansas City, MO 64130
- Gloria Joseph, Executive Director
- 816-922-7645
- Fax: 816-922-7683
- Email: gjoseph@swopecommunity.org

**ReDiscover**
- 901 NE Independence Avenue
- Lees Summit, MO 64086
- Alan Flory, President
- 816-246-8000
- Fax: 816-246-8207
- Email: aflory@rediscovermh.org

**Comprehensive Mental Health Services**
- 10901 Winner Road,
- PO Box 520169
- Independence, MO 64052
- William H. Kyles, Executive Director
- 816-254-3652
- Fax: 816-254-9243
- Email: jking@thecmhs.com

**Tri County Mental Health Services**
- 3100 NE 83rd Street
- Kansas City, MO 64119-9998
- Thomas H. Cranshaw, Executive Director
- 816-468-0400
- Fax: 816-468-6635
- Email: tomc@tri-countymhs.org

**Pathways Community Behavioral Healthcare, Inc.**
- 520C Burkarth Road
- Warrensburg, MO 64093
- 660-747-1605
- Fax: 660-747-1638
- Mel Fetter, President/CEO
- 660-890-8054
- Email: MelF@pbhc.org

**Clark Community Mental Health Center**
- 307 Fourth St
- PO Box 285
- Monett, MO 65708
- Frank Compton, Executive Director
- 417-235-4120
- Fax: 417-236-0058
- Email: ccmhc@sofnet.com

**Pathways Community Behavioral Healthcare, Inc.**
- 1800 Community Drive
- Clinton, MO 64735
- Mel Fetter, President/CEO
- 660-890-8054
- Fax: 816-318-3117
- Email: MelF@pbhc.org

**Ozark Center**
- 3006 McClelland, PO Box 2526
- Joplin, MO 64803
- Paula Baker, MS, Chief Executive Officer
- 417-781-2410
- Fax: 417-781-4015
- Email: pfbaker@freemanhealth.com
**Service Area**

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

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

*Affiliated Center (#11)*

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

12  **Burrell Behavioral Health Central Region**  
    601 Business Loop 70 West, Suite 202  
    Columbia, MO  65201  
    Bruce Horwitz, PhD, Director  
    Todd Schaible, Ph.D., President/CEO  
    573-777-7550  
    Fax:  573-777-7587  
    Email: bruce.horwitz@coxhealth.com

*Affiliated Center (#12)*

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

13  **North Central MO Mental Health Center**  
    1601 East 28th, Box 30  
    Trenton, MO 64683  
    Lori Irvine, Executive Director  
    660-359-4487  
    Fax:  660-359-4129  
    Email: lori@ncmmh.org

14  **Mark Twain Area Counseling Center**  
    917 Broadway  
    Hannibal, MO  63401  
    Mike Cantrell, Executive Director  
    573-221-2120  
    Fax:  573-221-4380  
    Email: mcantrell@mtacc.org

*Affiliated Center (#14)*

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

*Affiliated Center (#14)*

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

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

Affiliated Center (#15)

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

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

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

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

Affiliated Center (#17)

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

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

Mountain Grove Medical Complex
1604 N. Main
Mountain Grove, MO 65711
573-926-6563

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

20 Bootheel Counseling Services
760 Plantation Blvd.
PO Box 1043
Sikeston, MO 63801
Cheryl Jones, Executive Director
573-471-0800
Fax: 573-471-0810
Email: cjones@bootheelcounseling.com

21 Community Counseling Center
402 S. Silver Springs Road
Cape Girardeau, MO 63703
John A. Hudak, Executive Director
573-334-1100
Fax: 573-651-4345
Email: sfoster@cccntr.com
Service Area

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

Service Area

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

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

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

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

Affiliated Centers (#25)

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

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

ADAPT of Missouri
   2301 Hampton
   St. Louis, MO 63139
   Bill Leritz, MSW, Executive Director
   314-657-3200
   Fax: 314-781-3295
   Email:  billleritz@adapt.us
Community Contacts for Incidents Involving Administrative Agents and Affiliates

Brooke Dawson
1706 E. Elm
Jefferson City, MO  65102
brooke.dawson@dmh.mo.gov
Phone: 573-751-8122
Fax: 573-751-7815

(Central Area)

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

(Eastern Region)

Connie Kirbey
2201 N. Elm St.
Nevada, MO   64772
connie.kirbey@dmh.mo.gov
Phone:417-448-3400
Fax: 417-667-6526

(Western Region)

Revised: May 24, 2007
Division of Comprehensive Psychiatric Services

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Fax: 417-667-6526

Central Area Director
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Department of Mental Health
1706 E. Elm St.
Jefferson City, MO 65101
573-751-8122
Fax: 573-751-7815

Eastern Area Director
Scott Giovanetti
St. Louis Psychiatric Rehabilitation Center
5400 Arsenal St.
St. Louis, MO 63139
314-877-0372
Fax: 314-877-0392
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.
Missouri

Adult - New Developments and Issues

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

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

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

Also on the Internet is the Needs Assessment and Resource Inventory for Mental Health at http://www.dmh.mo.gov/transformation/FinalNARI04-18-08_001.pdf and in Appendix A of this document.

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

- Creating Communities of Hope begins with RESPECT. Joel Slack, founder of Respect International, LLC, developed the RESPECT Seminar to promote the powerful impact that respect (and disrespect) has on a person recovering from a psychiatric disability. Joel presents personal experiences and shows that RESPECT impacts all of us in our daily lives. His message is relevant to anyone interested in gaining a consumer’s perspective regarding mental health and the relationship between service provider and patient. Free public seminars are scheduled throughout Missouri in summer 2008. In addition, Joel will be offering training later this year through the RESPECT Institute, a five-day training program designed to teach consumers how to share their own personal stories to educate others.

- Most Missourians understand first aid and what to do if someone is choking, not breathing or exhibiting signs of another health emergency. However, few people know basic interventions if they encounter a person experiencing a mental health emergency even though they are likely to encounter such situations as well. In Australia, Betty Kitchener and Anthony Jorm developed Mental Health First Aid (MHFA) to teach basic first aid interventions for common mental health problems such as anxiety, bipolar disorder, depression, substance use disorder, or a crisis situation such as suicidal behavior, post trauma distress, drug overdose, panic attack, and the like. Participants in a MHFA course demonstrated improved confidence in providing initial help, increased help given, and reduced stigma regarding mental health disorders resulting in international adoption and adaptation. Missouri is working collaboratively with a team
from Maryland and the National Council of Community Behavioral Healthcare to launch the American version of Mental Health First Aid.

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

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

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

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

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

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

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

The DMH wants to assure physical healthcare to persons with serious mental illness as a core component of their basic services with access to preventive healthcare and ongoing integration and management of medical care. Among this population are individuals released from DOC who are uninsured. Integration of mental health/substance abuse services with management of chronic health conditions has been shown to improve self management and patient healthcare outcomes. (Source: 2006-Reynolds-NCCBH-Behavioral Health and Primary Care)
Seven sites (each site includes one CMHC and one FQHC in collaboration) were selected to implement this new budget item funded through State General Revenue. The Department is working with the Community Health Centers on integrated services through a collaborative process to target the uninsured population. Family Practice Nurses are located at the CMHC for primary care clinics for the uninsured. Targeted Case Manager/Community Support Workers are located in FQHC for behavioral health referral/linking/support.

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

**Integrated Dual Disorders Treatment (IDDT) (NFC Goal 5)**
At least 50% of adults with serious mental illness (SMI) also have a co-occurring substance abuse (SA) disorder. Persons with co-occurring SMI/SA disorders have poor outcomes when served in traditional treatment programs where each disorder is treated by a separate team of providers. The evidence based treatment model of care for persons with co-occurring SMI/SA disorders that is recommended by SAMSHA is Integrated Dual Disorders Treatment (IDDT). In the IDDT model persons receive coordinated, integrated treatment by a single multidisciplinary team including trained specialists in co-occurring disorders.

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

**Assertive Community Treatment (ACT) (NFC Goal 5)**
The Missouri General Assembly approved funding the EBP of ACT for SFY 2008. Planning meetings occurred with treatment providers to work out implementation issues. Six agencies are currently contracted to provide ACT. The agencies have developed their teams and are enrolling consumers. DMH has worked with agency staff to identify the high end users of crisis services. Over the next three years, DMH will work on implementing and expanding the number of teams using the ACT model. A Missouri variation of the Comprehensive Outcome Measure Program is being used to measure client outcomes on a quarterly basis. Experts from the field such as Michelle P. Salyers, Ph.D., from the ACT Center of Indiana, have made numerous technical
assistance visits to Missouri. Additionally, members from each ACT team and CPS employees have shadowed ACT teams in Minnesota to observe how ACT is implemented.

**Department of Corrections Collaboration (NFC Goal 3)**
CPS has a joint project with Department of Corrections for SFY09 to provide services to mentally ill persons recently released from correctional facilities through the CMHCs. The Department of Mental Health has added a service code for “Intake Screening-Corrections” to allow for the pre-release planning and intake screening of persons with serious mental illness being discharged from correctional facilities in the DMH/DOC Mental Health 4 project.

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

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

**Peer Specialist Certification (NFC Goal 2)**
CPS has adopted the Appalachian Consulting Group “Georgia Model” for Peer Specialist training and certification. It is the intent of the Division to move the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. Certified Peer Specialists are a part of this process. CPS has contracted with Larry Fricks to provide the first training in Missouri. Ike Powell and Beth Filson of his staff will conduct the first training on September 29 through October 3, 2008. CPS plans to have several individuals trained to become the Missouri trainers. Two more trainings are being planned for this fiscal year along with training for supervisors of peer specialists. Additionally, CPS has contracted with Wichita State University to provide the web site support for the training and certification process. The web site is [www.peerspecialist.org](http://www.peerspecialist.org).

CPS hopes to train approximately 35 individuals with the first training. Further trainings will be smaller groups and may occur on a more regional basis. The Medicaid reimbursement rate was increase recently to incentivize the hiring of Peer Specialists in the CMHCs. The rate is comparable to the community support worker rate.
Missouri

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.
Adult - Legislative Initiatives and Changes

Budget

SFY 2009
HB 2010 was **Truly Agreed to and Finally Passed**. Highlights of the DMH budget include GR and FED funding for:

### Approved Appropriations Item

<table>
<thead>
<tr>
<th>Amount: Total Funds and (GR)</th>
</tr>
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<tbody>
<tr>
<td>3% State Employee COLA $8.5 million ($7.8 million GR)</td>
</tr>
<tr>
<td>3% Community Provider Inflationary Increase $22 million ($10 million GR)</td>
</tr>
<tr>
<td>Serving families of returning Veterans with MH problems; and, $2.2 million ($950,000 GR)</td>
</tr>
<tr>
<td>Transition Services for Homeless Veterans in St. Louis</td>
</tr>
<tr>
<td>Personnel Advisory Board approved repositioning for critical $1.7 million ($845,920 GR)</td>
</tr>
<tr>
<td>DMH clinical and direct care positions including psychiatrists</td>
</tr>
<tr>
<td>Increased Medication Costs-Community and DMH Facilities $1.6 million GR</td>
</tr>
<tr>
<td>Police Crisis Intervention Training (single year funding) $200,000 GR</td>
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<tr>
<td>DMH CPS inpatient Electronic Medication Administration $3.8 million Healthcare Technology Fund-GR equivalent</td>
</tr>
<tr>
<td>System (pharmacy barcode distribution system-single year funding)</td>
</tr>
<tr>
<td>MO HealthNet/Mental Health Technology Partnership $500,000 GR</td>
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<tr>
<td>Community Mental Health Center/FQHC Cost-to-Continue $750,000 GR</td>
</tr>
<tr>
<td>Non-Emergency Medical Transportation Cost-to-Continue $1,000,000 ($370,000 GR)</td>
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<tr>
<td>Caseload Growth $528,631 ($195,593 GR)</td>
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</tbody>
</table>

**Disappointments in the SFY 2009 Budget Cycle:** Failure of the Legislature to fund Governor-recommended School Based Mental Health Services and funding expansion for Assertive Community Treatment Teams (ACT), a high DMH priority, also failed to receive legislative support.

SFY 2010 and 2011
Emphasis will continue to be placed on funding evidence based practices and continuing gains made in improving client outcomes.

**New Legislation**

HB 1890 -- Comprehensive Psychiatric Services
This bill changes the laws regarding comprehensive psychiatric services. In its main provisions, the bill:

(1) Includes suicide prevention intervention rendered in good faith by a qualified counselor or any other person to the list of care or services rendered in an emergency situation that are immune from civil liability;
(2) Requires facilities or programs operated, funded, or licensed by the Department of Mental Health to disclose medical record information to a patient's guardian or legal custodian as allowed by the federal Health Insurance Portability and Accountability Act;

(3) Allows the use of security escort devices to maintain safety and security and to prevent escape when a patient is being transported outside a mental health facility;

(4) Specifies that measures used to ensure the safety and security of patients by the head of a mental health facility during a natural or man-made disaster will not be considered restraint, isolation, or seclusion;

(5) Revises the definition of "mental health coordinator" to any mental health professional authorized by the department director to serve a designated area or mental health facility; and

(6) Adds investigations regarding mental health admission, detention for evaluation, and treatment by health care professionals, public officials, and certain peace officers to the list of actions that are immune from civil liability.
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.
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 “Hope*Opportunity*Community Inclusion” and promote movement toward achieving positive mental health in “Communities of Hope” for all Missourians, our vision of a transformed system is:

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

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

Missouri has initiated, with bipartisan legislative and chief executive support, several significant initiatives that serve as building blocks to achieve our transformation vision—including the passage of legislation mandating mental health insurance parity; implementation of a coordinated statewide approach to suicide prevention (See Appendix A: Missouri Suicide Prevention Plan); 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 (See Appendix A: Reforming Children’s Mental Health).

Transformation of the state’s mental health system is a high priority for the Governor. He 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 also participates on the Council to support the work of the grant. The purpose of the Council is to review cross-department policy and operations related to human services; the Governor’s Chief of Staff chairs the Council. In addition to the Council, the Governor has appointed to the Mental Health Transformation Working Group (MHTWG) and, in partnership with the Council, to develop and implement a comprehensive state mental health plan.

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

The Governor 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 CPS—the division that administers the Community Mental Health Services Block Grant—have also been appointed to the Workgroup. Other appointees to the Workgroup include youth and adult consumers and family members and senior representatives from the Office of State Courts Administrator (OSCA) and the state Housing Commission. The MHTWG members are representative of the racial/ethnic diversity of Missouri.

The initial charge of the MHTWG was to:

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

The MHTWG has accomplished the initial goals. A plan was been developed and approved by SAMHSA in June 2008.

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

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

Developed under the leadership of the DMH, Missouri's state-wide Suicide Prevention Plan continues to be implemented. DMH staff continues to support the Suicide Prevention Advisory Committee which meets on a regular basis.

Prevention Initiative

DMH has a presence at the Missouri State Fair which is attended by over 379,000 annually. For 2008, the focus is on “connecting the dots” and demonstrating the supportive relationship between prevention and treatment in the continuum of mental health. “Stress balls” were distributed as an acknowledgement of the correlation between stress and the beginning pathway to mental health disorders. Maintaining balance and perspective is the foundation for good mental health.

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

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

Missouri has both urban and rural Projects for Assistance in Transition from Homelessness (PATH). In 2008 technical assistance for the implementation of SSI/SSDI Outreach, Access and Recovery (SOAR) began for PATH providers in 4 areas of the State targeted as pilot sites for the SOAR initiative. Eight PATH Program staff from across the State have attended the SOAR Train the Trainer events and will be training with assistance from Policy Research Associates in the pilot areas. Data collected from PATH agencies and others dealing with Missouri’s homeless will be added to the national database. Missouri PATH programs meet quarterly to share information and expertise and participate in ongoing training developed to address their needs. PATH programs are monitored annually by the State’s PATH Coordinator.

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

Late in 2007 the discharge planner for Fulton State Hospital, a State Mental Health Institution, requested assistance for some consumers who need some additional support to be able to leave the hospital and function in the community. A small amount was pledged from the Olmstead Grant Funding to assist these individuals. To date we have helped with transportation allowing consumers and their support staff to attend trainings and provided funding for a consumer who can work now that she is out of the State Hospital but needs orthopedic shoes to do so. This program is working well and will be expanded to discharge planners at Missouri’s other hospitals housing consumers who have been in the hospital setting long term and who are returning to their home community.
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.
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.
Children’s System of Care legislation has created opportunities to serve Missouri’s children within their own communities and supported by the Comprehensive System Management Team (CSMT). There have been four SAMSHA cooperative agreements within Missouri since this federal initiative was started. Each cooperative agreement was for a six year period. The first was awarded to the St. Charles County community through Crider Center for Mental Health in 1997. The remaining three were awarded to the DMH to implement in the selected community (Show-Me Kids, 2002; Transitions, 2003; and Circle of Hope, 2006). This latest site focuses on integration of schools, physical health and mental health.

The Custody Diversion Protocol was developed through the shared efforts of DMH, DSS, courts and family members and implemented statewide in January, 2005 following extensive training of Children’s Division (CD) staff, DMH provider staff and juvenile justice officers. In February of 2005, the CD was able to implement a Voluntary Placement Agreement (VPA) through an amendment to the state’s IV-E plan. This allowed the CD to enter into a contract with parents to fund a child’s out of home placement for a maximum of 180 days if deemed appropriate through a DMH level of care assessment without having to take custody. This VPA is only available in conjunction with the Custody Diversion Protocol. This initiative continues to be successful with 93% of the youth referred being diverted from state custody, and of those diverted 40% have been able to be maintained in the home as opposed to placed outside of their community.

Representatives of the DMH and Children’s Division presented on the development of the protocol and its results at the 2008 Georgetown Training Institutes. In 2007 CPS in conjunction with its provider network provided an alternative eligibility criteria for Community Psychosocial Rehabilitation based on the youth’s functioning using the Child and Adolescent Functional Assessment Scale (CAFAS®). Youth who have a SED diagnosis and have a total score of 100 on the CAFAS, reflecting impaired functioning in multiple domains, are eligible for the intensive community-based service packet. CPS has purchased the computer version to allow statewide access to its provider network. The CAFAS will be used not only in eligibility determination but as a tool in guiding service plan development and as a quality assurance tool.

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

Policies, protocols and training curriculum are or will be developed for each of these services to ensure and support quality.

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

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

In 2005 the Departments of Health and Senior Services and Mental Health partnered on what was identified as the Bright Futures: Promoting Resiliency in Children through Partnerships. This was originally designed to provide a series of regional trainings based on the Bright Futures mental health curriculum and tools to enhance collaboration between local public health nurses, school nurses and counselors and community providers of mental health services. Through consultation and work with Georgetown’s Center for Child and Human Development Child Maternal and Child Health three different trainings were provided across the state building on the public health model, family engagement and collaboration. This grassroots effort grew to the development of a multi-agency state strategic team to devise a plan to assist communities in support of schools to address the social and emotional development of children. An initial proposal was accepted for further review through the Missouri Health Foundation for funding. If approved current Community Based Child Abuse Prevention sites will receive an invitation to participate in a Community Academy and receive targeted technical assistance in surveillance methodologies, addressing identified needs through policy, provision of training for identified needs, and development of a local system for ongoing surveillance and monitoring.
Missouri

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.
There were no significant legislative initiatives in SFY 2008 related to children's mental health services.
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 - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.
Child – Role of the State Mental Health Agency

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.

**Transforming 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.

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. A total of thirteen local SOC sites exist. The CSMT enacted by-laws to formalize its structure and has created 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. The CSMT this last year created an additional group that focuses on Prevention. During this last year, the CSMT identified strategic goals that the committee would work on for the next 1 to 2 years. Their source document was the Children’s Comprehensive Mental Health Plan. (See attachment entitled OCCMH Goals). The CSMT meets on a monthly basis. They submit an annual report to the Governor and General Assembly related to progress.

To guarantee broad input from Missouri’s diverse stakeholders, especially families of children with mental health needs, SB1003 established a Stakeholders Advisory Group (SAG). The SAG is charged with providing feedback to the CSMT regarding the quality of services, barriers/successes of the system, advocacy, public relations for the system, use of data to drive decision-making, and identification of emerging issues. 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. As directed in the Plan, three standing committees were formed: Public Education; System Development Monitoring; and Enhancing Parent Involvement. These sub-committees meet monthly.

In November 2007, the SAG held a two day retreat for its members facilitated by a national consultant. The focus of the retreat was to clarify and reiterate roles and responsibilities of the SAG, identify strengths and weakness, discuss recruitment and orientation of new members, and
identify goals for the next 1 to 2 years. One outcome of this retreat was for the SAG to have full membership meetings every other month as opposed to quarterly. This change enhanced the SAG’s ability to help plan and provide feedback regarding the changes occurring in the comprehensive children’s mental health system. The SAG subcommittees were reorganized to focus on communication, membership, and monitoring and feedback to the system. Goals for each committee were identified. SAG members identified liaisons to the CSMT to aid in planning and communication.

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. Three full-time staff members are currently positioned in the Office, including a Coordinator of the Office, Coordinator of System of Care Programs, and Family Integration Specialist. 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 the Office identifies future system needs and initiatives, creating the base structure for child-serving agencies/divisions to then operationalize into respective policies and practices.

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 including pediatric medicine, child psychiatry, child psychology, social work, research and financing. 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 DMH received notice in October, 2006 that Missouri had been awarded a Mental Health Transformation State Incentive Grant: Creating Communities of Hope. This grant will allow the State to further the infrastructure development on data collection, finance, community development and overall development of a comprehensive approach for mental health service delivery for children in Missouri.

**Strategic Prevention Framework State Incentive Grant**

The Missouri Strategic Prevention Framework State Incentive Grant funded by the U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention has identified a state priority of reducing the percentage of people ages 12-25 that report engaging in risky drinking (binge or underage) in the past 30 days. Twenty coalitions receive funding to implement evidence based programs and practices to address the overarching goals of the grant: prevent the onset and reduce the progression of substance abuse and underage drinking, reduce substance-related problems in communities, build prevention capacities and infrastructure at the State and
community levels, and implement a process of infusing data across all Strategic Prevention Framework (SPF) steps for improved decision-making. Cultural competency and sustainability are overarching principles of the SPF that are to be integrated into every step of the process. The SPF works to bring together multiple funding streams from multiple sources to create a community-based approach to substance abuse prevention and mental health promotion that cuts across existing programs.

**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.
- Coordinating Board for Early Childhood which is charged with developing a comprehensive statewide long-range strategic plan for a cohesive early childhood system; identify legislative recommendations to improve services for children from birth through age five; promote coordination of existing services and programs across public and private entities; promote research-based approaches to services and ongoing program evaluation; and to identify service gaps and advise public and private entities on methods to close such gaps.
### Goal 1. Develop the OCCMH workforce.

Build a competent and skilled interagency children’s work force that will effectively provide mental/behavioral health services to those with, or impacted by, mental/behavioral health challenges.

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<thead>
<tr>
<th>CSMT VISION THEME(S)</th>
<th>Strong Local DMH Service Systems</th>
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<tbody>
<tr>
<td>STRATEGIES</td>
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<tr>
<td>1) Create a statewide committee comprised of key stakeholders including parents and families as a Workforce Steering Committee.</td>
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<tr>
<td>2) Survey workforce for level of education, license and experience.</td>
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<tr>
<td>3) Identify needed strength-based culturally relevant core competencies (basic, intermediate and advanced).</td>
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<td>4) Develop a comprehensive interagency workforce development and training plan.</td>
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<td>5) Modify certification standards and contracts to incorporate core competencies.</td>
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<td>6) Provide cross departmental, community stakeholder training.</td>
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<td>7) Begin dialogue with state universities, community colleges and other professional training institutions regarding core competencies.</td>
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<thead>
<tr>
<th>PERFORMANCE MEASURES</th>
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<tbody>
<tr>
<td>1) List of basic, intermediate and advanced strength-based culturally relevant core competencies</td>
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<tr>
<td>2) Number and percent of staff trained in basic, intermediate and advanced strength-based culturally relevant core competencies</td>
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<tr>
<td>3) List of partners in universities, community colleges and other professional training institutions</td>
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### CSMT VISION THEME(S)
- Strong Consumer/Family Voice

### STRATEGIES
1. Develop, in conjunction with the Stakeholders Advisory Group and Comprehensive System Management Team (CSMT), a knowledge base and skill sets for parents to participate on state and local policy administrative teams.
2. Develop a “leadership” curriculum based on the knowledge base and skill sets for training parents to participate on local and state policy teams.
3. Identify, through the CSMT, funding streams that can support a network of key parent leaders in the state that can act as trainers/coaches/mentors to agencies and parents in regards to policy team participation.
4. Develop a list of parents that have been trained and have demonstrated leadership competencies for agencies/stakeholders to access.
5. Begin discussions regarding the development of a Leadership Institute.
6. Gather and explore existing leadership trainings.
7. Develop a Tip Sheet for professionals that list ways to support families and youth on committees and teams.
8. Use the tip sheet to develop a training for professionals to better understand how to support families and youth on committees and teams.

### PERFORMANCE MEASURES
1. List of parent core competencies for participation on policy administrative teams.
2. Number of key family representatives from state child-serving agencies serving on the CSMT.
3. Number of trained family representatives on the CSMT.
4. Number of representatives actively participating at local system-of-care sites.

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**Goal 2. Increase family participation.**

Increase family participation at all levels of the administrative/policy structure across state child-serving departments.
Goal 3. Create a coordinated children’s network of support.
Create a coordinated children’s system of care to meet the multiple and changing needs of children and their families.

<table>
<thead>
<tr>
<th>CSMT VISION THEME(S)</th>
<th>Strong Local DMH Service Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGIES</td>
<td>1) To formalize the structure of mature, local children’s interagency collaborative teams.</td>
</tr>
<tr>
<td></td>
<td>2) To develop a communication, monitoring and technical assistance plan for local sites.</td>
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<tr>
<td>PERFORMANCE MEASURES</td>
<td>1) A formal measurement of local team infrastructure will be developed.</td>
</tr>
<tr>
<td></td>
<td>2) All local, interagency teams will be mapped and kept current.</td>
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<td></td>
<td>3) A communication plan between the CSMT and local sites will be designed.</td>
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<td></td>
<td>4) A plan to monitor local sites will be established.</td>
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<td></td>
<td>5) A technical assistance plan for local sites will be developed.</td>
</tr>
</tbody>
</table>
Goal 4. Support the healthy social-emotional development, learning and academic achievement of all children.

Support the healthy social-emotional development, learning and academic achievement of all children by identifying models for statewide implementation and mental health consultation via schools, early childhood programs, other community agencies and families.

<table>
<thead>
<tr>
<th>CSMT VISION THEME(S)</th>
<th>● A Stronger Missouri Child Mental Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGIES</td>
<td>1) Identify current models or strategies used in schools and early childhood settings to promote healthy social-emotional development.</td>
</tr>
<tr>
<td></td>
<td>2) Identify current models or strategies used in schools and early childhood settings for mental health consultation to school and early childhood staff and families to support the child’s healthy social-emotional development.</td>
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<td></td>
<td>3) Identify current mental health services and service delivery mechanisms provided in schools and early childhood settings.</td>
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<td>4) Identify sufficient and flexible funding streams to strategies 1-3.</td>
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<td>5) Review evidence-based literature relevant to promotion, mental health consultation and mental health service delivery for all children.</td>
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<tr>
<td></td>
<td>6) Identify or develop potential funding sources or mechanisms for promotion, mental health consultation and mental health service delivery for all children.</td>
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<td></td>
<td>7) Develop comprehensive written plan encompassing above strategies and lessons learned.</td>
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<tr>
<td></td>
<td>8) Submit plan to State Leadership to include the Comprehensive System Management Team, the Mental Health Commission, the Office of State Courts Administration, the Department of Health and Senior Services and the Department of Elementary and Secondary Education.</td>
</tr>
<tr>
<td>PERFORMANCE MEASURE</td>
<td>1) A report to State Leadership in FY 2008 recommending promotion, mental health consultation and mental health service delivery funding options based on evidence and agreed upon by a variety of statewide partners.</td>
</tr>
</tbody>
</table>
**Goal 5. Create a practice model for children’s mental health services.**

Create a practice model for children’s mental health services utilized by the state child-serving departments.

<table>
<thead>
<tr>
<th>CSMT VISION THEME(S)</th>
<th>A Stronger Missouri Child Mental Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGIES</td>
<td></td>
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<tr>
<td>1) Use Quality Service Review as the basis for developing the practice model.</td>
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<tr>
<td>2) Review, with the CSMT, practice models that other states have developed based on their Quality Service Review mechanism.</td>
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<tr>
<td>3) Develop a Missouri children’s mental health practice model that can be endorsed by the state child-serving departments on the CSMT.</td>
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<tr>
<td>4) Develop an ongoing training mechanism for this model across state child-serving departments.</td>
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<tr>
<td>PERFORMANCE MEASURES</td>
<td></td>
</tr>
<tr>
<td>1) A list of practice models that other states have developed based on their Quality Service Review mechanism</td>
<td></td>
</tr>
<tr>
<td>2) A formalized practice model utilized by state child-serving departments</td>
<td></td>
</tr>
</tbody>
</table>
Missouri

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.
Adult – Service System’s Strengths and Weaknesses

Strengths

Strengths identified by the Mental Health Planning Council were as follows: adult crisis stabilization, consumer operated services of warm-line peer support and drop-in centers, inpatient facility care, peer specialist initiative, Mental Health First Aid, RESPECT Seminars, Procovery, collaboration with other state agencies, emphasis on wellness, disaster training and preparedness, new initiatives on veterans issues, rural focus, Network of Care website, advocacy, person centered planning grant, mental health champions award and banquet, and anti-stigma public education efforts. (See also sections on New Developments and Issues; Planning Council Charge, Role and Activities; and Description of State Agency Leadership.)

Suicide Prevention

Since the federal declaration that suicide is a serious public health concern and the accompanying call to action for individual states, Missouri DMH has accepted the responsibility to provide both leadership and technical assistance on mental health promotion within Missouri communities, and has recognized suicide as a leading public health concern. The Missouri delegation to the national suicide prevention conference in Reno, Nevada, completed a state-wide plan of suicide prevention strategies. Implementation has included passing legislation relative to suicide prevention and establishing a Governor-appointed Suicide Prevention Advisor Committee. A subsequent award of a three-year federal grant to prevent suicide in youth up to age 25 has enabled this high risk group to receive targeted services. DMH utilizes this SAMSHA funding in conjunction with block grant funding to provide state-wide suicide prevention services tailored to local needs and supplemented with local support. Strategies include gatekeeper training, policy change, a focused initiative on college campuses, regional Resource Centers, survivor support groups, promotion of the National Suicide Prevention Lifeline, incentive awards geared to meet local needs, incorporating suicide prevention information in distance learning courses, raising public awareness through print and electronic media, and conferences.

During FY 2007 our regional resource centers conducted nearly 500 educational presentations/gatekeeper trainings reaching more than 10,000 individuals. Our second annual Missouri Suicide Prevention Conference was held in September 2007, during Suicide Prevention Week. The two-day conference included thirty speakers, providing presentations on such topics as depression, substance abuse, domestic violence, gambling, stigma, school-related issues, suicide among the elderly, survivor support groups, and prevention efforts in the military.:

Prevention

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

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

- Developing policies directed at changing community norms, attitudes, and laws
- Researching and deploying evidence-based preventive interventions to prevent the onset of disorders and disabilities
- Implementing continuous quality improvement strategies and outcome evaluations to ensure that interventions are timely, relevant, and effective
- Conducting staff development and training programs for agency and provider personnel on best practices and prevention strategies
- Coordinating with prevention initiatives within other state departments.

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

Prevention staff has been active in the development of a state-wide plan to prevent child abuse and neglect. A partnership was established with the Missouri Center for Safe Schools and the Missouri Department of Health and Senior Services to begin a three plan to develop a cadre of individuals certified in the Olweus Bullying Prevention Program throughout the state. With the first training held in Kansas City in April 2008, each new trainers was then available to up to three school buildings that were willing to implement the Olweus syllabus, a SAMHSA model program with demonstrated short term and long term results.

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

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

Prevention staff was active in a stigma initiative for the Department. This involved establishing an entity called the Missouri Mental Health Foundation as an alternative funding source for private donations, a banquet to celebrate the accomplishments of those individuals who have made significant contributions to their communities, and selecting three individual “Champions” who exemplify accomplishments among us in their daily life and work within communities.
Another focus within Transformation is facilitating a public health approach to mental health. This represents a shift from a focus on the individual to a tactic that is primarily interested in the health of the population as a whole and the links between health and the physical and psychosocial environment. And the public health approach is broader than prevention; strategies encompass Surveillance, Health promotion, Prevention, Evaluation of Services, Risk & Protective Factors.

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

**Mental Health Transformation**

The Office of Transformation in the Missouri Department of Mental Health was established to address concerns regarding the state's mental health service delivery system. President George Bush's New Freedom Commission on Mental Health final report, issued in July 2003, identified weaknesses at the state and federal levels in mental health care, reporting on a system that is “broken and fragmented.”

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

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

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

- Consumer and Family Driven Services
- Disparities are Eliminated
• Easy, Early Access
• Evidenced-based practices
• Mental Health is Essential to Overall Health
• Technology

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

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

Since approval of the plan, five cross-departmental implementation work groups chartered by the Transformation Work Group (TWG) have begun their work to lead implementation of some of the Transformation priorities. The groups will focus on Employment, Evidence-Based Practices, Housing, Mental Health and Aging, and Mental Health Promotion and Education. Information about these work groups, their charters, and membership is available on the Office of Transformation web site. The Office of Transformation web site (www.dmh.mo.gov/transformation/transformation.htm) has been reorganized to include a calendar of events and highlights the Show-Me series.

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

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

The first Mental Health First Aid instructor training in Missouri is scheduled for September 28-October 3 in Jefferson City. Because there are more qualified applicants than training slots (22) available, a second instructor training is being planned for the end of the year. Betty Kitchener, founder of Mental Health First Aid in Australia, will assist with Missouri’s first training.

A consumer, family, and youth leadership summit, with the theme “Real Voices/Real Choices,” is in the planning stages for this fall. The aim of the summit is to bring together individuals and families from within and outside the mental health system to formally launch the Real Voices/Real Choices initiative and serve as a springboard for a statewide conference in 2009.
Procovery
Missouri Department of Mental Health is administering statewide implementation of recovery services through the Procovery™ program, following the completion of a successful demonstration pilot and extensive statewide foundational planning. The Procovery™ program, developed by Kathleen Crowley, author and Executive Director of Procovery Institute, emphasizes a hope-centered, forward-focused, and skills-based partnership of the client, the family, the service provider, and the community. It includes eight principles for resilience in healing, 12 strategies for action, and a highly structured system, known as the Procovery Circle, for group training and support.

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

Evaluation of the demonstration pilot by the Missouri Institute of Mental Health concluded that the Missouri Procovery Demonstration Program was a promising catalyst of system transformation. The success of Procovery Circles to instill hope and a forward focus among mental health consumer members means that statewide implementation of this program could facilitate progress towards an integrated system response to growing demands from consumers for recovery-based services and supports to secure jobs, housing, and training.

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

More information on the Procovery™ program in Missouri is available at www.procovery.com.

Office of Consumer Affairs
The Missouri Department of Mental Health has a Director of Consumer Affairs. The individual is a former consumer of mental health services and is already bringing a consumer driven services focus to the position.
Crisis Intervention Teams
Jail diversion programs were piloted including Police Crisis Intervention Teams (CIT) in the greater Kansas City and St. Louis areas. The DMH was the recipient of a SAMHSA Targeted Capacity Expansion (TCE) Jail Diversion grant that provided the foundation of a pre and post booking jail diversion program in St. Louis County. Kansas City has also been awarded a SAMHSA TCE Jail Diversion grant and coordinates the program with the local community mental health center. CIT training in Kansas City, Lee Summit and St. Louis City and County, has resulted in hundreds of law enforcement officers being certified as CIT officers.

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

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

Evidence Based Practices
The DMH understands the importance of implementing evidence based practices to assure excellent care is delivered in Missouri. Integrated Dual Diagnosis Treatment (IDDT), Assertive Community Treatment (ACT) and Supported Employment (SE) for adults are the focus for enhancement and fidelity to the evidence based models. Aspects of IDDT have been implemented as part of the COSIG. The DMH has worked cooperatively with the Missouri Foundation for Health, a private funding source, to provide additional dollars for IDDT services. The foundation has awarded grants to DMH-only providers, both mental health and substance abuse, for co-occurring services in the amount of 4 million dollars per year for 3 years. ACT programs have been funded for six sites in Missouri. 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 developed a partnership with Missouri Institute of Mental Health to accelerate multi-state Consumer Operated Service Programs (COSP) findings into practice. The assessment and technical assistance process has begun of the five organizations 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. Quarterly meetings of the five Drop-In Centers have enhanced the cohesiveness of the centers and consistency of implementing the COSP fidelity model.
**Network of Care Website**
The DMH contracted for a state-wide “Network of Care” web-based system to facilitate consumer information and access to mental health services. The Missouri Governor Matt Blunt launched the Network of Care website in 2006 at the State Capitol and it continues to be enhanced and promoted.

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

The DMH and MO HealthNet Division Partnership initiative to improve the prescribing of psychiatric medications for all MO HealthNet-eligible individuals saves Missourians $36 million per year off trend. The project promotes evidence-based prescribing practices to outlier physicians and has significantly reduced pharmacy costs and hospitalizations without resorting to mandatory restriction on medications. A 2005 study revealed that inpatient admissions and hospitalization stays dropped by nearly 50 percent after prescribers received intervention messages.

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

**Services to Families of Veterans**
In SFY 2009, the legislature approved dollars for the DMH to provide counseling services to families of Veterans. The initiative is in the beginning stages of planning and implementation. Training is planned for September 2008 for the staff identified in specific CMHCs to familiar them with issues facing Veterans and their families. BATTLEMIND curriculum has been chosen for implementation.

**Weaknesses**

The DMH recognizes that collecting and using meaningful data is a challenge. The DMH is developing the Customer Information Management, Outcomes, and Reporting (CIMOR) management information system. The CIMOR system should allow for easier collection of consumer specific data and usable reports.
Some of the weaknesses mentioned by the Mental Health Planning Council were as follows: lack of adequate mental health professionals (i.e. psychiatrists, nurses, etc.) in rural areas, lack of public transportation in rural areas, lack of child psychiatrists, and disappointment in legislature not funding the budget item to enhance school based mental health.
Missouri

Adult - Unmet Service Needs

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

Financial limitations continue to cut into the administration of State mental health services. The Missouri DMH needs to prevent or minimize cuts to core funding affecting direct consumer care. Missouri’s current economic condition may prove problematic in the coming fiscal year. High gasoline and heating oil costs, a deflated housing market and resulting problems in the banking industry, as well as depressed consumer confidence, may result in a lower projected annual state revenue growth in SFY 2009. The Legislature reduced the overall SFY 2009 state operating budget $150 million below the Governor’s Office recommendations to help offset constricted revenue growth and avoid additional withholdings or core cuts beyond usual reserves. Given the above, DMH and its advocates should not expect SFY 2010 DMH budget growth to be comparable to SFYs ’08 and ’09. With the limited funding, maintaining adequate coverage for psychiatric care has been an issue, especially in rural areas.

The Mental Health Transformation Initiative and DMH Executive Team strategic planning processes have identified key themes for Missouri Mental Health Transformation in coming years. They are:

- access to mental health services, both community based and state operated;
- critical direct care and clinical staff vacancy rates and limited training resources for both DMH facilities and community providers; and
- increase focus on prevention and disease management, including better risk prediction, early intervention and better integration of behavioral and medical healthcare.
Missouri

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.
See State of Missouri Comprehensive Plan for Mental Health for a statement of the State's priorities and plans to address unmet needs (Appendix A)

See also sections on New Developments and Issues and Service System's Strengths and Weaknesses for current projects to address unmet needs
Adult - Recent Significant Achievements

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

DMH has had many significant achievements in 2008:

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

Evidenced Based Practices – DMH has focused on implementing multiple EBPs statewide with a focus on measuring fidelity to the models.

Suicide Prevention - The DMH continues to implement suicide prevention services according to the legislative mandates and grant guidelines. The Suicide Prevention Advisory Committee has met regularly and is prepared to take action as issues emerge. The group has supported efforts on college campuses as well as directing the Department to work collaboratively with federal initiatives to prevent suicides among veterans.

Integration of Behavioral and Medical Healthcare – DMH has focused on the physical health as well as the mental health of consumers. Collaboration is occurring in seven locations statewide to co-locate medical and behavioral health staff.

Trauma-Informed Care – CPS hired a staff person to focus on implementation of the evidence based practice of Dialectical Behavior Therapy (DBT). She has accomplished:
  ● Over 36 presentations to large audiences throughout the state,
  ● Over 75 agency consultations on DBT and specific consumer planning and
  ● Multiple staff supervision activities.
Missouri

Adult - State's Vision for the Future

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

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

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

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

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

CAFAS
The Child and Adolescent Functional Assessment Scale (CAFAS) is designed to measure impairment in the day-to-day functioning in children and adolescents in kindergarten through the 12th grade who have, or are at risk for emotional, behavioral or psychological problems. There are 8 subscales on the CAFAS measuring functioning at home, school/work, community, behavior towards others, moods/emotions, self-harm, thinking and substance use. The CAFAS takes about 10 minutes to complete and is based on a quality, comprehensive assessment of the child/adolescent. In addition to the scales noted above, the CAFAS includes two Caregiver subscales that assess how the child’s material needs are met and the family’s psychosocial resources relative to the child’s needs. With the use of the CAFAS strengths and goals can also be identified that culminate in the creation of a treatment plan tied to the child’s specific needs and strengths. CPS plans to have the CAFAS computerized and used by all CMHC’s in 2009.

The CAFAS can be used in many ways which include assessing progress in treatment, classifying cases to guide specific treatment protocols, creation of a treatment plan, to aid in determination of service need or level of care and as an outcome measure. Agencies can also use this for continuous quality improvement to insure effective and meaningful services for children/adolescents are provided.

The Division of Comprehensive Psychiatric Services will be utilizing the CAFAS to achieve multiple purposes.
1. Alternate eligibility determination for Community Psychosocial Rehabilitation (CPR) for children and youth. This expands eligibility to children and youth who may not have a CPR qualifying diagnosis, but due to the severity of impact on the youth’s functioning require a more coordinated and comprehensive service package;
2. Treatment planning tool to guide selection of treatment interventions and priorities based on the CAFAS profile;
3. Outcome measure to address the impact of the services delivered;
4. Quality assurance tool in examining needs of population served, matching populations needs to effective service provision, and helping programs to improve outcomes for children and families.

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

This service was added to our Community Psychiatric Rehabilitation Program in January 2008.

Objectives for this service include:

1. Certify at least two train-the-trainers by July 2009 to provide family support training.
3. Provide at least two DMH sponsored trainings per year to train family support providers and their supervisors.
4. Provide in-service training to trained Family Support providers at least twice a year.
5. Monitor quality and fidelity to Family Support competencies through the CPR certification process.

**Treatment Family Home**

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

In order to provide a more consistent, cohesive Treatment Family Home service across the state, CPS is redesigning its model to maximize therapeutic effectiveness while minimizing restrictiveness. Accomplishment of this task will involve the following steps:

1. Develop a Missouri “Toolkit for Treatment Family Home Care”
2. Revise and update contracts consistent with the toolkit.
3. Certify Treatment Family Home train–the-trainers.
4. Provide training to providers on the “Toolkit”.
5. Monitor provider implementation of “Toolkit” through CPS annual compliance review.

**Suicide Prevention**

Suicide prevention for youth continues to be a priority for Missouri and for the Department of Mental Health. Implementing a SAMSHA youth suicide prevention grant has enabled the state to respond to local needs. Activities have focused on gatekeeper training within schools and youth serving organizations, training parents, teachers and caregivers on the risk and protective factors associated with youth suicide. No one is sure why teens choose to take their lives. Clearly, psychiatric diseases, especially depression, mood and conduct disorders and substance abuse contribute to the risk of teen suicide. Often teenagers who complete suicide are impulsive with little or no planning.

Plans for the coming year include an expansion in the number of regional resource centers and an increase in the number of certified suicide prevention trainers throughout the state. A new education and awareness campaign will be prepared, as well as sample suicide prevention procedures and guidelines for schools. Gatekeeper training, raising public awareness, a hot line
for GLBT youth, an educational newsletter, mini grants to accommodate local need and regular meeting of the Suicide Prevention Advisory Committee will continue.

Weaknesses

CPS will continue to work towards accurate collection of outcome data to further the utilization of data-driven decision making.
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.


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

- **Surveillance and assessment of mental health needs**, including risk factors, demographics, access in care, and rates of disease;
- **Policy development**, including financing, inter-agency collaboration, and policy initiatives; and
- **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**

The Department of Mental Health continues to work with other child-serving agencies and departments to create data systems that can capture meaningful data, enhance the sharing and matching of data across systems and increase the use of data analytics to inform both policy and clinical decision-making. One example is the work the DMH has done with MOHealthNet (Medicaid) in their development of the CyberAccess system. This system allows for real-time monitoring of all services provided and allows for enhanced health monitoring and shaping towards best practices.

Additionally, the use of the CAFAS as a required outcome measure for services will allow CPS and its network of providers to track the major needs of children, youth and families, develop evidence based services and programs directed towards those needs, and assess the impact of those interventions. The goal is to enhance access to this data through inclusion into our CIMOR data system and/or work with the developer on achieving web-based access for CPS and its providers.

The 2006 iteration of the Missouri Student Survey (MSS) provides an example of state and local assessment of mental health needs. The 2006 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 are made publicly available, 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 Comprehensive System Management Team (CSMT) has been tasked with the operational oversight of the comprehensive children’s mental health service system (630.097 RSMo) and to act as a linkage between the state and local management structures. Membership is comprised of state child-serving agencies, families, advocacy organizations and local system representatives. The CSMT and its sub-committees have made progress on at least three key areas. They are as follows:

- CSMT members have made site visits to a variety of implementation sites throughout the state of Missouri to gather data regarding tiered models of intervention, focusing on the healthy social-emotional development and the prevention of serious social-emotional problems. One example identified was Positive Behavioral Interventions and Supports (PBIS). DMH partnered with DESE to sponsor a state-wide PBIS conference through funding the luncheon speaker and providing a panel composed of CMHC personnel who presented at the conference about school partnering.

- The CSMT has sponsored a Leadership Training for parents of children with a mental illness. Approximately 14 parents have participated in this training thus far. Many of these parents are involved in system of care sites around the state as well as have involvement in the CSMT and its subcommittees. These parents are now drafting policy and participate as trainers for the Family Support service.

- CSMT developed language for incorporating system of care values and principles into state child serving contracts and Request for Proposals.

- CSMT revised and updated policy for communication between CSMT and local system of care sites.

Under the Director of DMH and as incorporated into statute through 630.100 RSMo, the Office of Comprehensive Child Mental Health (OCCMH) is to provide leadership in implementing the Comprehensive Children’s Mental Health Service plan. The OCCMH took a leadership role in drafting and submitting a school mental health budget item in FY09. While this budget item was not funded in ‘09, the OCCMH is drafting language for a 2010 budget item for school mental health. In addition, the OCCMH is taking a leadership role in drafting language for a trauma informed budget item.

While the divisions within DMH continue to maintain responsibility for day-to-day operations for their respective populations, each division has appointed 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 18 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. OCCMH is responsible for the convening and management of the Clinical Advisory Council.

**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, creating a trauma-informed system, increasing access to Evidence Based Practices 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

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. Since its inception 93% of the youth referred have been diverted from state custody. Of those diverted, 40% have been maintained in their homes and communities through the provision of intensive community based services as opposed to being placed out of their homes. This has been considered a very successful initiative and the process the state partners went through to develop and implement the protocol was presented at the 2008 Georgetown Training Institute in Nashville.

Building Infrastructure to Support a System Of Care

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. Although initial steps were taken to create such a data warehouse, a shift in budget parameters and a change in the political environment have diverted the interest to creating data systems that track individuals to enhance the quality of care coordination. In partnership with Missouri HealthNet (Medicaid) DMH has fed data into and has access to data through the CyberAccess system to enhance the coordination of services delivered on consumers. Through this same data system that tracks delivery of Medicaid billed services, other quality assurance projects have been initiated related to prescribing practices. Additionally, this data base has allowed for DMH to work with Children’s Division (child welfare) to track services for youth in state custody in residential care, to guide policies and practices for this population. Efforts continue to look at data systems that can support data driven policy decision making.

Additionally, through the Show Me Bright Futures initiative the state strategic team is partnering with the Community Based Child Abuse Prevention communities to bring to these sites, the public health model in creating local surveillance and assessment tools and procedures to guide their needs assessment for supporting the social and emotional development of their children. This project was presented at the 2008 Georgetown Training Institute in Nashville.

Policy Development & 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 and its committees continue to meet monthly. The recent focus has been in the area of developing a cross-system practice model; examining data collected from local system of care sites to assess impact and trends; and reviewing the current screening practices and tools for social and emotional functioning of the 0-5 age population across the state. Each of these tasks is with the intent to bring forward needed changes in policies and practice. For example as part of the Early Childhood Comprehensive System plan’s goal on Social and Emotional Development, the CSMT took on the task of surveying current practice to identify gaps not only in screening/identification but to map where connections need to be made regarding universal and targeted interventions.

Another area currently the focus of efforts is in creating a model for a trauma informed system for children and youth. CPS is submitting a budget item to implement this model across child–serving systems that will assess organizational sensitivity and readiness for needed change, providing training on trauma sensitivity and awareness, when and how to make a referral for trauma-focused services and increasing capacity of evidence-based practices appropriate for the population. As an initial step, CPS is working with child welfare’s management team to review the National Child Traumatic Stress Network’s Trauma Toolkit for Child Welfare to identify policy and practice changes and integration needed to create a trauma informed system.

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

CPS was also able to expand the array of services available through Community Psychosocial Rehabilitation Program that are eligible for MOHealthNet funding. These services include Family Support, Family Assistance, Day Treatment and Psychosocial Rehabilitation. Although no additional general revenue dollars were provided, it is hoped that through creating a mechanism the limited resources can be used through its maximum potential to support access and capacity to these services.

Array of Services and Supports

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

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

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

Prevention
The Show Me Bright Futures initiative has continued work through the state strategic team to identify mechanisms and funding to assist local communities in application of a public health
approach to the social and emotional well-being of children. Through cross-agency funding, partnership with Community Based Child Abuse Prevention initiative and an application to the Missouri Health Foundation the plan is to work with three to four communities in creating the community will, knowledge and skills in assessment and surveillance of children’s needs, communities supporting schools in reaching children and families and implementation of evidenced based practices that meet the identified needs of that community. Additionally, DMH has provided training for school personnel on the Olweus Bullying Prevention Program. As noted above, one community mental health center has been working with schools in implementation of the Too Good for Drugs curriculum. The CSMT has a Prevention committee that is currently surveying the state for current screening tools and practices in the area of early childhood social and emotional development.

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

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

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

Juvenile Justice Activities
As noted above, CPS and the Office of State Courts Administrator applied and received a field demonstration grant through the Office of Juvenile Justice and Delinquency Prevention. The focus was to develop and provide training on guidelines for mental health assessments for the juvenile/family courts, implementation of an evidence based practice, continued support and enhancement of local policy teams and creating a mechanism to mentor other communities and policy teams. The guidelines’ training was completed and training on EBP’s selected will be completed in September of 2008. An evaluation of the impact of the local policy teams, guidelines training and EBP’s will follow.
School Based Activities
DMH has on contract a Childhood Education Specialist to continue work on enhancing collaborations with the Department of Elementary Education and local schools with community mental health providers. Although a budget item was presented, it was not approved to begin implementation of school mental health services. Efforts continue to find mechanisms and models to support school mental health services across the continuum.

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

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

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

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

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

Efforts continue both at the policy and service level to engage families in the process and empower their voice and impact on the system. Family Leadership Training has been provided by the State Coordinator for Family Support to increase the number of family members who have the skills, knowledge and desire to work in shaping state and local policies. As noted previously, Family Support service has been included in the Community Psychosocial Rehabilitation array of services. A training curriculum has been approved based on the work of John Vandenberg. With this training CPS hopes to insure the quality and increase access to this service. The first Youth Summit is being planned to similarly increase the impact that youth have on system and policy development. Additionally, through the Transformation Grant a Consumer, Family and Youth Summit will be held to begin plans for a statewide annual conference presented by and for consumers.
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.
See Child Plan – Role of the State Mental Health Agency
Especially Office of Comprehensive Child Mental Health (OCCMH) Goals
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 States Revised Statutes of Missouri 2006 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.
Adult - Available Services

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

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.
Adult Plan
Criterion 1: Comprehensive Community-Based Mental Health Services System
Available Resources

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

Health, Mental Health, and Rehabilitation Services

Community Psychiatric Rehabilitation Program (CPR)
The CPR program is a consumer and family driven approach that emphasizes individual choices and needs; features flexible community-based services and supports; uses existing community resources and natural support systems; and promotes independence and the pursuit of meaningful living, working, learning, and leisure-time activities in normal community settings. The program provides an array of key services to persons with severe, disabling mental illnesses. Services include evaluations, crisis intervention, community support, medication management, and psychosocial rehabilitation. Because CPR is a Medicaid supported program, the federal government pays approximately 60 percent of the costs for clients with Medicaid eligibility.

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

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

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

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

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

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

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

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

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

**Employment Services**
Employment services are accomplished through referral of individuals to Division of Vocational Rehabilitation (DVR) services and long term supports by community support workers (CSW). Administrative Agents are encouraged to work collaboratively with the local DVR office to address the employment needs of consumers. Seven Administrative Agents/Affiliates provide supported employment services funded by vocational rehabilitation. All Administrative Agents are allowed to bill CSW services to provide clinical integration of employment into the individualized treatment plan.
Housing Services
Residential services provide a variety of housing alternatives to meet the diverse needs of clients. Funds are used to support the cost of such housing services as nursing facilities, residential care facilities, group homes, and supported housing. Contractual arrangements are made to obtain these residential services in the community. As individuals move into more independent housing alternatives, they require intensive and flexible services and supports in order to maintain that housing. Provisions of these services and supports will enable these individuals to successfully live and work in their communities.

To increase housing options within the past five years, the DMH Housing Team has collaborated with community providers to develop semi-independent apartments through the HUD 811 process. This option targets those individuals who need additional supports in order to transition to independent living. Several CPS providers have submitted HUD applications to develop Safe Havens, low –demand housing for those with co-occurring mental illness and substance abuse disorders. See also the section on Outreach to Homeless for more details on housing options.

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

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

Some agencies in the contemplative stages of organizational change or who have individuals needing intensive substance abuse services refer adults identified as having a co-occurring disorder to Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs in their community or service area. CSTAR programs use research based treatment modalities to address problems with substance abuse and addiction. CPR and CSTAR programs cooperate to develop a treatment plan to meet each individual’s needs. The goal is that all agencies will
provide integrated treatment for individuals identified with psychiatric and substance use disorders.

**Medical and Dental Services**

Medical and Dental Care for individuals receiving Mental Health services in the state of Missouri are provided through community providers unless an individual is hospitalized and in need of services (in which case the hospital provides services). Federally Qualified Health Centers, local health departments and free health clinics provide medical services around the state. With the new cooperative FQHC/CMHC initiative, physical and mental health care is more coordinated for individuals with psychiatric disorders. Individuals can receive their medical services in the same location as their behavioral health services.

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

**Support Services**

The Division of CPS continues to move forward with a recovery-based care model and has funded contracts for the development of consumer-run services ranging from warm-lines to drop-in centers for the past six years. Five contracts are currently in place for peer phone support services (warm-lines) in various sites throughout the state. Each warm-line is operated by mental health consumers. These services are intended to reduce feelings of social isolation and loneliness. The consumers answering the phone lines do not provide crisis intervention services but are trained to provide support, friendship and assistance over the telephone to other mental health consumers.

Additionally, five contracts are in place for consumer-run drop-in centers in a variety of settings statewide. These drop-in centers offer services such as, self-care education, support groups, peer-support, community integration activities, socialization skills education and recreational opportunities. The centers operate at a minimum of three days per week. Center staff members are primary mental health consumers who complete training sessions that pertain to the programs and initiatives of that particular center. The DMH has developed a partnership with Missouri Institute of Mental Health to accelerate multi-state Consumer Operated Service Programs (COSP) findings into practice. The self assessment process has been completed of the five Consumer Drop-In Centers around the state.

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

Services provided by local school systems under the Individuals with Disabilities Education Act are detailed in the Child Plan, Criterion 1: Comprehensive Community-Based Mental Health Services, Available Services section of the Block Grant Application.
Case Management Services
Targeted Case Management includes the following services: arrangement, coordination, and assessment of the individual’s need for psychiatric treatment and rehabilitation, as well as other medical, social, and educational services and supports; coordination and monitoring of services and support activities; and documentation of all aspects of case management services, including case openings, assessments, plans, referrals, progress notes, contacts, rights and grievance procedures, discharge planning, and case closure.

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

Other Activities Leading to Reduction of Hospitalization
Emergency services for consumers are provided through Access Crisis Intervention (ACI). Service providers are trained by the Administrative Agents to respond to crisis calls. To ensure quality services that are delivered on a consistent basis the Division developed an administrative rule that governs the ACI program. ACI programs are certified to provide crisis services.

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

#### FY2008 Clients Served By Service Area

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**Total (2007 Estimates)**

| RURAL (EXCLUDES COUNTIES 095 & 510) | 4,771,299 | 3,543,322 | 1,227,977 | 191,339 | 85,958 |

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I:\CMHS Block Grant\FY2009-2011 Block Grant\Census Prevalence FY08_popest05.xlsx

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Missouri

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1
See Goals, Targets and Action Plans section
Missouri

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless
Adult and Child Plan
Criterion 4: Targeted Services to Rural and Homeless Populations

Outreach to Homeless

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

PATH Grant
Missouri has both urban and rural Projects for Assistance in Transition from Homelessness (PATH). The PATH Grant is a federal entitlement grant available to all states and territories to provide outreach and case management services to homeless individuals who are mentally ill and who may also have co-occurring substance abuse problems. PATH funds are used to continue services provided by the agencies originally funded through the Mental Health Services for the Homeless (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 2008 technical assistance for the implementation of SSI/SSDI Outreach, Access and Recovery (SOAR) began for PATH providers in 4 areas of the State targeted as pilot sites for the SOAR initiative. Eight PATH Program staff from across the State have attended the SOAR Train the Trainer events and will be training with assistance from Policy Research Associates in the pilot areas. Data collected from PATH agencies and others dealing with Missouri’s homeless will be added to the national database. Missouri PATH programs meet quarterly to share information and expertise and participate in ongoing training developed to address their needs. PATH programs are monitored annually by the State’s PATH Coordinator.

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

Shelter Plus Care
Shelter Plus Care is a program designed to link rental assistance to supportive services on a long-term basis for homeless persons with disabilities, (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families who are living in places not intended for human habitation (e.g., streets) or in emergency shelters. The program allows for a variety of housing choices, and a range of supportive services funded by DMH, in response to the needs of the hard-to-reach homeless population with disabilities. Currently, Missouri has 26 Shelter Plus Care grants.
On December 21, 2007, both the U.S. Department of Housing and Urban Development (HUD) and the Missouri Housing Development Commission (MHDC) announced the results of their annual competitions for housing and homeless assistance funds—HUD through the Continuum of Care (CoC) process and MHDC through the Missouri Housing Trust Fund process.

Missouri’s nine CoC’s received a total of just under $22.5 million out of a nationwide total of $1.326 billion in HUD funds awarded, or about 1.7% of the total. The Department of Mental Health’s Shelter Plus Care grants accounted for over $9.4 million in renewals of existing grants and two new grants, or almost 42% of the total federal funding statewide.

DMH applied for and received funds for two new Shelter Plus Care programs, one in the City of St. Louis and one in Kansas City, both to house chronically homeless persons. DMH also applied for new Shelter Plus Care funding to house homeless disabled persons in Cole, Boone and St. Charles Counties but HUD declined to fund those requests.

The amounts awarded to individual Missouri Continuums by HUD consist of the following:
St. Louis City $10,198,965
Kansas City 7,531,869
Missouri Balance of State 2,054,128
MHDC Housing Trust Fund Awards
On December 21, 2007, the Commissioners of the Missouri Housing Development Commission announced a total of $5,142,241 in awards from the Missouri Housing Trust Fund. Seventy-six separate awards were made in the areas of homeless prevention, construction and rehabilitation, rental assistance, home repair, and operating matching funds. The awards break down by MHDC Region as follows: St. Louis Metro $1,830,762; Kansas City Metro $1,056,712; Central Region $812,185; South Region $807,483; and North Region $635,099; for a total of $5,142,241.

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

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

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

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

The DMH Housing Unit webpage has additional information on services and resources available in Missouri at http://www.dmh.mo.gov/ada/housing/housingindex.htm
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<td>This page has links to agencies and resources that may be able to help you with finding a place to live, paying your rent or energy bill, fixing your home, buying a home, or finding emergency shelter. <strong>Updated 8/6/08</strong></td>
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<tr>
<td><img src="image" alt="Shelter Plus Care" /></td>
<td>Here DMH service providers may download the DMH Application for Shelter Plus Care rental assistance for mental health consumers who are homeless and disabled. The page explains the scope of the program and how DMH operates its 23 Shelter Plus Care grants. <strong>Updated 4/4/08</strong></td>
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<td><img src="image" alt="Newsletter" /></td>
<td>&quot;Housing News&quot; is a quarterly newsletter with articles for renters, homeowners, people with disabilities, housing providers, people who want to develop affordable housing for people with and without disabilities, and for anyone interested in housing issues generally. <strong>Updated 7/30/08</strong></td>
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<tr>
<td><img src="image" alt="Contact Us" /></td>
<td>Here you'll find full contact information for each member of the DMH Housing Team and information about each person's area of expertise. <strong>Updated 8/6/08</strong></td>
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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.


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.  

**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.

**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. 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. 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

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

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. 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. 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.

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. 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


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


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

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 - Older Adults

Adult - Describes how community-based services are provided to older adults
Adult Plan
Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Community-based Services Provided to Older Adults

Currently, the Department of Mental Health (DMH) has no programs geared specifically to the unique mental health needs of older adults. Older adults are served in so far as they have come into the service system at a younger age and have aged. A few may come in as a result of a crisis/emergency needs or a diagnosis of a Serious and Persistent Mental Illness made as an older adult. However, older adults suffering from late onset depression or anxiety disorders, or late onset problems with alcohol or prescription medications, are normally not served by the state mental health system. At least one community mental health center has a specialized Older Adult Program funded by resources other than DMH.

Effective October 2006, the state of Missouri was awarded a five-year Mental Health Transformation Grant by the Substance Abuse and Mental Health Services Administration (SAMHSA). As a result of this grant, a plan, *The State of Missouri Comprehensive Plan for Mental Health: Creating Communities of Hope, January 2008-January 2013*, has been written and approved by SAMHSA. This plan, adopting a lifespan perspective, covers the mental health needs of children, adolescents, adults, and the elderly. While each age group is not cited in every example, the plan is sufficiently broad that it covers all ages.

Further, *The State of Missouri Needs Assessment and Resource Inventory for Mental Health: Creating Communities of Hope January 2008-January 2013*, written as part of the Transformation process by the Missouri Institute of Mental Health (MIMH), has been submitted to and approved by SAMHSA. This needs assessment has sections which focus on the needs of the elderly. Focus groups were conducted and a literature review was made to ascertain the needs of older adults in Missouri. Recommendations from these data were set forth in the report.

The Transformation Working Group (TWG) determined that more specific action items relating to older Missourians were needed for the next update of the *Comprehensive Plan*. To achieve this, a Mental Health and Aging Implementation Team was chartered and is meeting. This interdepartmental working group, also guided by consumers, is to identify and prioritize problems facing older adults, and propose specific action plans to ameliorate these problems. A target date of January 2009 was established for recommendations from this group.

DMH continues to work closely with the Missouri Department of Health and Senior Services (DHSS), especially their Division of Senior and Disability Services (DSDS). This agency is the State Unit on Aging. DSDS maintains a 24-hour elder abuse/neglect hotline and has staff to investigate reported abuse and neglect and provide protective services to Missouri seniors. It also provides case management, in-home services, and coordinates services through the Area Agencies on Aging (AAAs). Through liaison and bridge-building activities, an MIMH elderly coordinator is assisting DMH to build and maintain a closer, better coordinated working relationship.

As the “baby boomers” age and the proportion of seniors in the Missouri population increases, DMH has recognized that seniors are a population with a growing need of mental health and
substance abuse services and supports. The Mental Health Commission, MH Transformation Groups and the DMH Leadership Team have identified Missouri elders as an underserved population with significant unmet mental health needs. Mental health problems such as depression, dementia, and substance abuse, which often are exacerbated by age, personal loss and complicated medical conditions, are conditions that a range of state and local, public and private agencies will need to address with a coordinated effort over the upcoming years.
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

With strong support from Governor Matt Blunt and legislative leaders, DMH experienced an increase in funds for the FY 2009 budget. Missouri had experienced the effects of an extended overall economic slowdown over five consecutive years. A limitation on general revenue growth had caused the DMH to face core budget reductions, withholds and staff layoffs. The DMH had experienced core net reductions on General Revenue state dollars of more than $80 million. The total full-time equivalent positions have been reduced from 10,386 in fiscal year 2002 to 8,676 in SFY 2009. This has required the department to focus on protecting current services and programs while attempting to maximize the use of other funding sources. While the increase in funds for the current fiscal year is a positive development, DMH had lost ground and continues to make up for the lean years. Missouri relies heavily on Medicaid to reimburse for services. This reliance puts the State at significant risk if the Federal government initiates Medicaid reform as has been proposed.

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

For the SFY 2009 the community providers received a 3% Cost of Living Adjustment increase from the Legislative budget process. Provider rates were adjusted with the 3% increase to help offset the increased costs of doing business. The provider COLA will be requested again in the SFY 2010 budget process.

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 changes with the State Medicaid Authority have allowed maximization of revenue. The Missouri Department of Mental Health began using an Organized Health Care Delivery System (OHCDS) in 2005 to allow billing for administrative services provided for Medicaid. This change in the Department’s Medicaid status allowed additional federal funding to be secured to address financial limitations. The OHCDS allows continuation of the Access Crisis Intervention (ACI) Program.

The Mental Health Block Grant, PATH Grant, Olmstead Grant, Mental Health Mil Tax Boards, discretionary grant awards from SAMHSA, Medicaid, general state revenue and other community funding all help fund mental health services in Missouri.
The total budget for Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services is $423,432,213 for State Fiscal Year 2009. The federal Block Grant portion of the budget is $6,751,507. Please refer to the Grant Expenditure Manner section for detail on Fiscal Year 2009-2011 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.”

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. Nurses with special psychiatric training made up a smaller portion of the mental health workforce. 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. 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 counties are MHPSA. This compares to 62% of metro counties and 83% of urban/suburban counties.”

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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 tow (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.

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)

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

The department has provided technical assistance and training on many evidence based practices to the community treatment providers. Treatment providers have received extensive training on Integrated Dual Disorders Treatment, Assertive Community Treatment, Supported Employment, Motivational Interviewing Skills, Dialectal Behavior Therapy and Trauma Informed Care. This addresses many of the areas identified in the needs assessment noted above. The children’s service providers have received extensive training on Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Twenty-four therapists have recently become certified in TF-CBT in the Central region of the state. This is in addition to the nineteen therapists trained last year in the Western region.

The Missouri Foundation for Health has also funded significant training and technical assistance for treatment providers on co-occurring psychiatric and substance abuse disorders.
Spring Training Institute
One of the premiere training events in the state of Missouri is the annual Spring Training Institute. The Division of Alcohol and Drug Abuse and the Division of Comprehensive Psychiatric Services provide a three day event each May that allows direct care staff members an opportunity to receive information and training about the most up-to-date treatment methodologies for a low conference cost. In 2008, over 1180 professionals, administrators and consumers participated in the training.

Missouri Institute of Mental Health
Service Providers across the State also have access to trainings at low cost through the Missouri Institute of Mental Health. Among the array of trainings and services operated by this Department of the University of Missouri Medical School are web-based and on-line trainings in addition to the face-to-face regional trainings.
Missouri

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;
Adult and Child Plan
Criterion 5: Management Systems
Emergency Service Provider Training

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

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

In the last year the DMH has:

- Developed DMH Facilities All-Hazards Planning Guide and corresponding DMH provider training to assist with implementation of this National Incident Management compliant planning process.
- Responded to the 2008 spring and summer 2008 flooding events. Participated in the Governor’s Faith-based and Community Partnership symposia regional conferences to encourage engagement of the faith community in disaster preparedness and community response.
- Continued to partner closely with other state level departments:
  o Department of Health and Senior Services: ODR has continued to be an active participant of the Special Needs committee to complete Annex X which has now identified the Missouri recommendations for the successful operation of Emergency Special Needs shelters.
  o Department of Public Safety. State Emergency Management Agency
    ▪ Completed a table top anthrax bio-terrorism exercise with active involvement of two eastern region DMH facilities in coordination with DMH Central Office staff.
    ▪ Continued participation in a Homeland Security Committee addressing School planning, including crisis counseling. Assisted in promotion of utilization of the Emergency Response Information Program (ERIP), a computer based tool for public and private school to assist with prediction of violence in the school system.
    ▪ Exhibition of Mental Health TIPS for coping in emergency and disaster situation and other Mental Health resource materials was offered to the annual SEMA conference with an attendance of 500+ attendees.
- Developed and led various trainings using curriculum jointly developed with St. Louis University Heartland Centers that included:
  o Disasters and Mental Health: A Basic Approach for Healthcare
Disasters and Mental Health: A Basic Approach for School Personnel
Disasters and Mental Health: A Basic Approach for Pastoral Care.

- The Pastoral Care training will equip chaplains and clergy with the knowledge of psychological first aid as well as planning for their own congregations and their communities.

- Development and provision of Psychological First Aid Train-the-Trainer course for hospital staff, public health care workers and mental health workers was developed through the sponsorship of the St. Louis Area Regional Response System (STARRS) in January, 2008. This training was provided to St. Louis Health Care, Long Term Health Care Providers, and Federal Region 7 Medical Reserve Corps staff in Kansas City and Columbia in March 08.

- Train-the-Trainer programs in Peer Directed Disaster Preparedness were provided to the NAMI-MO and the People First members of central Missouri in an effort to reach these consumers who have experienced mental illness or developmental disabilities, and their caregivers.

- School personnel training: Mental Health and Disasters: A Basic Approach for School Personnel, trainings in Webb City and Cape Girardeau.

- Just-in-Time Psychological First Aid was provided to 52 DMH employees and Red Cross workers responding to the May 10 tornadoes in Jasper and Newton Counties.

- Crisis Counseling Training for the FEMA Immediate Services Grant, for crisis counselors, grants administrators and hotline personnel from the Northeast region.

- Coordination and provision of the Emergency Planning for Special Needs Populations; Course provided through the State Emergency Management Agency;

- Missouri Alliance for Home Care: Preparation, Response, Recovery: Mitigating a Disasters’ Emotional Impact on your Clients and Yourselves;

- Pandemic Flu: Continuity of Operations was provided at the DMH Spring Institute Conference May 2008

- Display table at Missouri National Association of Social Workers State Conference, the DMH Spring Institute, the 2008 Statewide Healthcare Disaster Planning Meeting, the Annual Missouri Emergency Management Conference, the 4th Annual Public Health Volunteer Symposium, and the 11 regional Governor’s Faith-based Partnership symposia.

- Participated in Missouri Hospital Association planning meeting for hospitals and long term care providers and participated in discussions regarding mental health components in regional and hospital plans.

Disaster Services Continuing Projects: Future Plans
The Office of Disaster Readiness will continue to provide the Disasters and Mental Health courses to healthcare providers, school staff and pastoral care. Efforts will continue to provide specialized presentations to targeted groups to respond to the needs of hospital and health care staff to assist in provision of responsive mental health services and to plan for meeting the needs of their staff in times of disaster or terrorism events. The Office of Disaster Readiness is currently planning to write a curriculum for higher educational institutions to assist them with their behavioral health planning. Additionally, we will be providing direct training and technical
assistance to the 29 DMH state-operated facilities and all contracted DMH service providers to assist them in their disaster emergency planning process.
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
<table>
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<tr>
<th>Provider</th>
<th>Adult</th>
<th>Youth</th>
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<td>East Central MO BH (formerly Arthur Center)</td>
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<td>Bootheel Counseling Services</td>
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<td>Burrell Center</td>
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</table>

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<table>
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<tr>
<th>Provider</th>
<th>Adult</th>
<th>Youth</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapt of Missouri</td>
<td>$18,257</td>
<td>-</td>
<td>$18,257</td>
</tr>
<tr>
<td>East Central MO BH (formerly Arthur Center)</td>
<td>$20,210</td>
<td>$12,860</td>
<td>$33,071</td>
</tr>
<tr>
<td>Bootheel Counseling Services</td>
<td>$55,880</td>
<td>-</td>
<td>$55,880</td>
</tr>
<tr>
<td>Burrell Center</td>
<td>$335,513</td>
<td>$2,921</td>
<td>$338,434</td>
</tr>
<tr>
<td>Clark Community Mental Health</td>
<td>$56,418</td>
<td>$428</td>
<td>$56,847</td>
</tr>
<tr>
<td>Community Health Plus - St. Louis</td>
<td>$357,545</td>
<td>$105,703</td>
<td>$463,248</td>
</tr>
<tr>
<td>Community Network for Behavior</td>
<td>$8,607</td>
<td>$1,237</td>
<td>$9,844</td>
</tr>
<tr>
<td>Community Treatment</td>
<td>$265,145</td>
<td>$13,686</td>
<td>$278,830</td>
</tr>
<tr>
<td>Comprehensive Mental Health</td>
<td>$155,008</td>
<td>$11,552</td>
<td>$166,560</td>
</tr>
<tr>
<td>County of Nodaway Committee</td>
<td>$7,658</td>
<td>$1,101</td>
<td>$8,759</td>
</tr>
<tr>
<td>Crider Center for Mental Health</td>
<td>$618,273</td>
<td>$193,669</td>
<td>$811,941</td>
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<tr>
<td>Comprehensive Psychiatric Services CO</td>
<td>$231,827</td>
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<tr>
<td>Dexter Community Regional</td>
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<tr>
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<td>$108,230</td>
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<td>$316,417</td>
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<td>$322,514</td>
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<tr>
<td>Hopewell Center</td>
<td>$735,967</td>
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<tr>
<td>Kids Under Twenty One</td>
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<td>$18,553</td>
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<tr>
<td>Mark Twain Mental Health</td>
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<td>$221,125</td>
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<tr>
<td>North Central</td>
<td>$172,551</td>
<td>$1,944</td>
<td>$174,494</td>
</tr>
<tr>
<td>Ozark Center</td>
<td>$641,287</td>
<td>$125,722</td>
<td>$767,008</td>
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<tr>
<td>Ozark Medical Center</td>
<td>$89,874</td>
<td>$27,574</td>
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<tr>
<td>Pathways Community Behavioral Health</td>
<td>$442,418</td>
<td>$15,122</td>
<td>$457,539</td>
</tr>
<tr>
<td>ReDiscover Mental Health</td>
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</tr>
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<tr>
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<td>$138,683</td>
<td>-</td>
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</tr>
<tr>
<td>Tri-County Mental Health Services</td>
<td>$149,752</td>
<td>$10,193</td>
<td>$159,945</td>
</tr>
<tr>
<td>Truman Behavioral Health</td>
<td>$299,433</td>
<td>$11,148</td>
<td>$310,581</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,910,416</strong></td>
<td><strong>$841,091</strong></td>
<td><strong>$6,751,507</strong></td>
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Table C. MHBG Funding for Transformation Activities
State: Missouri

<table>
<thead>
<tr>
<th>GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health</th>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is MHBG funding used to support this goal? If yes, please check</td>
<td>☒</td>
<td>Actual: N/A, Estimated: 150,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOAL 2: Mental Health Care is Consumer and Family Driven</th>
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</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>GOAL 3: Disparities in Mental Health Services are Eliminated</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Is MHBG funding used to support this goal? If yes, please check</td>
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<td>Estimated: 916,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is MHBG funding used to support this goal? If yes, please check</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Is MHBG funding used to support this goal? If yes, please check</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOAL 6: Technology Is Used to Access Mental Health Care and Information</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is MHBG funding used to support this goal? If yes, please check</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

| Total MHBG Funds | N/A | 1,066,000 |

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

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State’s transformation activities are described elsewhere in this application, you may simply refer to that section(s).
Goal 1: Americans Understand that Mental Health is Essential to Overall Health $150,000 is for Suicide Prevention.

Goal 3: Disparities in Mental Health Services are Eliminated $916,000 is for New Medications.
Name of Performance Indicator: Increased Access to Services (Number)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2006 Actual</td>
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<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>FY 2007 Actual</td>
<td>24.50</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>FY 2008 Projected</td>
<td>24.59</td>
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<td>--</td>
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<td>FY 2009 Target</td>
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<td>--</td>
</tr>
<tr>
<td>FY 2010 Target</td>
<td>24</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>FY 2011 Target</td>
<td>24</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table Descriptors:
- **Goal:** Increase access to services
- **Target:** Maintain the percentage of adults with SMI receiving mental health services above FY2006 level
- **Population:** Adults with SMI
- **Criterion:**
  - 2: Mental Health System Data Epidemiology
  - 3: Children’s Services
- **Indicator:** Percentage of adults with SMI who receive CPS funded services divided by the estimated prevalence of individuals with 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 5.4% of the population.
- **Sources of Information:** CIMOR, federal census, SMI prevalence table
- **Special Issues:** Mental health services are underfunded both nationally and in the State of Missouri.
- **Significance:** Due to fiscal contraints, Missouri CPS is only meeting 24% of the estimated prevalence of SMI.
- **Action Plan:** The DMH and CPS will continue to explore funding opportunities to meet the mental health needs of Missourians.
Transformation Activities:

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

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
<th>(7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>FY 2006 Actual</td>
<td>FY 2007 Actual</td>
<td>FY 2008 Projected</td>
<td>FY 2009 Target</td>
<td>FY 2010 Target</td>
<td>FY 2011 Target</td>
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<td>Performance Indicator</td>
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<td>6.81</td>
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<td>576</td>
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<td>8,963</td>
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</tbody>
</table>

**Table Descriptors:**

**Goal:** Decrease rate of readmission to state psychiatric hospitals within 30 days

**Target:** Lower rate of readmission than national benchmark rate of 9%

**Population:** Adults with SMI

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

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

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

**Sources of Information:** CIMOR

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

**Significance:** 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 medication and psychiatric services in the community. The program provides case management activities and community support, linking individuals with appropriate programs and services within their community, providing experiential training in social and professional settings, and helping individuals access treatment and follow a treatment regimen.

**Action Plan:** State hospitals and community service providers will continue collaborative activities to keep individuals out of the state hospitals when possible.
Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Actual FA2006</th>
<th>Actual FA2007</th>
<th>Projected FA2008</th>
<th>Target FA2009</th>
<th>Target FA2010</th>
<th>Target FA2011</th>
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</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>11.87</td>
<td>11.76</td>
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<td>Denominator</td>
<td>11,607</td>
<td>12,548</td>
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</tr>
</tbody>
</table>

Table Descriptors:
- **Goal:** Decrease the rate of readmission for adults to State psychiatric hospitals within 180 days
- **Target:** Lower rate of readmission than national benchmark rate of 20%
- **Population:** Adults with SMI
- **Criterion:**
  1: Comprehensive Community-Based Mental Health Service Systems
  3: Children's Services
- **Indicator:** Percentage of adults readmitted to State psychiatric hospitals within 180 days of discharge
- **Measure:**
  The numerator is number of clients readmitted to State psychiatric hospitals within 180 days of discharge.
  The denominator is total discharges from State psychiatric hospitals in year.
- **Sources of Information:** CIMOR
- **Special Issues:** Adult SMI admissions are frequently linked to involuntary commitments and forensic issues beyond the control of the division.
- **Significance:** CPRP serve adults with Severe Mental Illness within their community with the goal of reducing admissions and readmissions into State psychiatric hospital beds. The program provides medications and psychiatric services in the community. The program provides case management activities and community support, linking individuals with appropriate programs and services within their community, providing experiential training in social and professional settings, and helping individuals access treatment and follow a treatment regimen.
- **Action Plan:** State hospitals and community service providers will continue collaborative activities to keep individuals out of the state hospitals when possible.
### ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

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

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
<th>(5) FY 2009 Target</th>
<th>(6) FY 2010 Target</th>
<th>(7) FY 2011 Target</th>
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<tbody>
<tr>
<td>Performance Indicator</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Numerator</td>
<td>N/A</td>
<td>N/A</td>
<td>--</td>
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<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
<td>N/A</td>
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</table>

**Table Descriptors:**

**Goal:**

**Target:**

**Population:**

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

3: Children’s Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**
### ADULT - GOALS TARGETS AND ACTION PLANS

#### Transformation Activities:

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

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
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<th>(7) FY 2011 Target</th>
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</thead>
<tbody>
<tr>
<td><strong>Performance Indicator</strong></td>
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<td>1,078</td>
<td>1,266</td>
<td>1,275</td>
<td>1,285</td>
<td>1,300</td>
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<td><strong>Numerator</strong></td>
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<td>N/A</td>
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<tr>
<td><strong>Denominator</strong></td>
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<td>N/A</td>
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**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 Johnson & Johnson grant to provide Supported Employment training and technical assistance.

**Significance:** The Division of Comprehensive Psychiatric Services and the Division of Vocational Rehabilitation have a strong working relationship. Using the Vocational Rehabilitation federally mandated definition of employment from the U.S. Department of Education, there is a 70% success rate for VR clients served by DMH/CPS.

**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: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
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<tr>
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Table Descriptors:
Goal:
Target:
Population:
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
Indicator:
Measure:
Sources of Information:
Special Issues:
Significance:
Action Plan:
**Transformation Activities:**

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

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**Table Descriptors:**

**Goal:**

**Target:**

**Population:**

**Criterion:**

1: Comprehensive Community-Based Mental Health Service Systems

3: Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

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

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**Table Descriptors:**

**Goal:**

**Target:**

**Population:**

**Criterion:**

1: Comprehensive Community-Based Mental Health Service Systems

3: Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**
**Transformation Activities:**

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

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**Table Descriptors:**

**Goal:**

**Target:**

**Population:**

**Criterion:**

1: Comprehensive Community-Based Mental Health Service Systems
2: Children’s Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

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

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**Table Descriptors:**

**Goal:**

**Target:**

**Population:**

**Criterion:**

1: Comprehensive Community-Based Mental Health Service Systems

3: Children’s Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

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

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<td>91.77</td>
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<td>1,163</td>
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<td>2,698</td>
<td>1,286</td>
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Table Descriptors:
Goal: Clients reporting positively about perception of care
Target: The target is that Missouri will exceed the national benchmark rate of 87% of the respondents to the Consumer Satisfaction Survey will be satisfied or very satisfied with the services received.
Population: Adults receiving Community Psychiatric Services funded by CPS
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
Indicator: Percentage of adults satisfied or very satisfied with services
Measure: The numerator is the number of clients reporting being "satisfied" or "very satisfied" with the services provided. The denominator is the total number of clients surveyed.
Sources of Information: Consumer Satisfaction Survey
Special Issues: The Consumer Satisfaction Survey is conducted on a continuous basis using a revised form of the MHSIP.
Significance: Consumers were generally satisfied with services.
Action Plan: The department will continue to use the revised MHSIP to gather consumer satisfaction data. The data will be analyzed and used to measure consumer outcomes.
Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

<table>
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<tr>
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<td></td>
<td>3,598</td>
<td>2,979</td>
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Table Descriptors:
Goal: Increase or maintain the percentage of consumers employed
Target: Increase or maintain the percentage of consumers employed
Population: Adults with SMI
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
Indicator: Percentage of adults with SMI working
Measure: The numerator is the number of adults with SMI working.
The denominator is the total number of adults working and not working in sample.
Sources of Information:
Adult Status Reports
Special Issues: An Adult Status Report sample is used to obtain this percentage. The low sample size (less than 3300) can lead to fluctuations in percentages based on small actual number changes. As CPS refines the new CIMOR database, the hope is that data will be more accurate and easily collected. Data will be obtained and analysed on every consumer rather than a sample.
Significance: Nationally and in Missouri the numbers of adults with severe mental illness who are competitively employed is fairly low.
Action Plan: DMH will continue to implement EBP of Supported Employment with the goal of increasing the number of individuals with psychiatric illness who are competitively employed.
ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

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<thead>
<tr>
<th>(1)</th>
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Table Descriptors:

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

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

Population: Adults with SMI

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

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

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

Sources of Information: Consumer Satisfaction Survey

Special Issues: CPS has recently started using a modified MHSIP for the Consumer Satisfaction Survey. This is new data for the Division. CPS will wait to set targets until trend data is established after several years.

Significance: A low number of adults with SMI have been arrested in the past 12 months.

Action Plan: CPS will continue to support mental health courts to encourage consumers to live healthy lifestyles free of criminal activity. CPS will continue to support the Crisis Intervention Team collaboration with police departments to appropriately handle mental illness behaviors in the community.
### Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

<table>
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<tr>
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<th>Denominator</th>
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<td>77.03</td>
<td>2,988</td>
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<td>FY 2007 Actual</td>
<td>77.34</td>
<td>2,495</td>
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<td>76.40</td>
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<td>FY 2010 Target</td>
<td>76.60</td>
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<td>76.70</td>
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**Table Descriptors:**
- **Goal:** Increase stability in housing
- **Target:** Increase the percentage of consumers living in home or home-like settings
- **Population:** Adults with SMI
- **Criterion:**
  - 1: Comprehensive Community-Based Mental Health Service Systems
  - 3: Children's Services
- **Indicator:** Percentage of adults with SMI living in their own home or home-like settings
- **Measure:** The numerator is the number of adults with SMI sampled living in home or home-like settings. The denominator is the total number of adults with SMI sampled living in all settings.
- **Sources of Information:** Adult Status Reports
- **Special Issues:** An Adult Status Report sample is used to obtain this percentage. As CPS refines the new CIMOR database, the hope is that data will be more accurate and easily collected. Data will be obtained and analyzed on every consumer rather than a sample.
- **Significance:** Currently DMH has twenty-four Shelter Plus Care grants. These grants provide rental assistance for over 1900 individuals and their families members throughout fifty different counties expending over $6.5 million a year in rental assistance and $9 million in supportive services. The program allows for a variety of housing choices, and a range of supportive services funded by DMH, in response to the needs of the hard-to-reach homeless population with disabilities.
- **Action Plan:** DMH will continue to support housing options that offer independent housing in the consumers community of choice.
**Name of Performance Indicator:** Adult - Increased Social Supports/Social Connectedness (Percentage)

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<th>Fiscal Year</th>
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<td>FY 2011 Target</td>
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**Goal:** Increase or maintain the social supports/social connectedness reported by consumers of CPS services

**Target:** Increase or maintain the social supports/social connectedness reported by consumers of CPS services

**Population:** Adults with SMI

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

**Indicator:** Percentage of consumers reporting social connectedness on the Consumer Satisfaction Survey

**Measure:** The numerator is the number of consumers reporting social connectedness on the Consumer Satisfaction Survey.
The denominator is the number of consumers completing the Consumer Satisfaction Survey.

**Sources of Information:** Consumer Satisfaction Survey

**Special Issues:** CPS has recently started using a modified MHSIP for the Consumer Satisfaction Survey. This is new data for the Division. CPS will wait to set targets until trend data is established after several years.

**Significance:** 68.65% of consumer report being socially connected

**Action Plan:** Additional Consumer Satisfaction Surveys will be collected over time.
**Name of Performance Indicator:** Adult - Improved Level of Functioning (Percentage)

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**Table Descriptors:**

- **Goal:** Improve level of functioning
- **Target:** Improve consumer reported level of functioning
- **Population:** Adults with SMI
- **Criterion:**
  1: Comprehensive Community-Based Mental Health Service Systems
  3: Children’s Services
  4: Targeted Services to Rural and Homeless Populations
- **Indicator:** Percentage of consumers reporting improved level of functioning on Consumer Satisfaction Survey
- **Measure:**
  The numerator is the number of consumers reporting improved level of functioning on the Consumer Satisfaction Survey.
  The denominator is the total number of consumers responding to the Consumer Satisfaction Survey.
- **Sources of Information:** Consumer Satisfaction Survey
- **Special Issues:** CPS has recently started using a modified MHSIP for the Consumer Satisfaction Survey. This is new data for the Division. CPS will wait to set targets until trend data is established after several years.
- **Significance:**
- **Action Plan:** Additional Consumer Satisfaction Surveys will be collected over time.
**Name of Performance Indicator:** Case Management Services

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<th>Fiscal Year</th>
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<th>FY 2007 Actual</th>
<th>FY 2008 Projected</th>
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**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 has been identified for the Assertive Community Treatment model of care. CPS will slowly be ramping up ACT programming with outreach to underserved populations.

**Significance:** Case management/community support work along with medication management have been shown to reduce the rate of hospitalization. The DMH provides case management to eligible adults with SMI within the CPS system to reduce hospitalizations and allow individuals to live productive lives in their communities. The majority of the individuals receiving case management/community support are participating in the Comprehensive Psychiatric Rehabilitation Programs.

**Action Plan:** CPS received general revenue funding to expand the services provided to include the Assertive Community Treatment evidence based practice model within selective agencies. With additional resources and a team approach more consumers can live healthy lives in their communities.
Name of Performance Indicator: EBP Integrated Dual Disorders Treatment

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Table Descriptors:

**Goal:** Increase the number of community agencies working towards fidelity to the EBP Co-Occurring Disorders: Integrated Dual Disorders Treatment model

**Target:** Increase the number of community agencies working towards fidelity to the EBP Co-Occurring Disorders: Integrated Dual Disorders Treatment model

**Population:** Adults with SMI

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

**Indicator:** Number of community agencies working towards fidelity to the EBP Co-Occurring Disorders: Integrated Dual Disorders Treatment model

**Measure:** No numerator or denominator

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

**Special Issues:** The Co-Occurring State Incentive Grant (COSIG) has allowed CPS to provide intensive technical assistance and training to community agencies to implement the IDDT EBP. CPS is collaborating with the Mid-America Addiction Technology Transfer Center for the TA and the Missouri Institute of Mental Health for evaluation. Fidelity measurement is being conducted on a regular basis to assure fidelity to the IDDT model. Funding is also provided to the agencies for co-occurring disorders treatment from the Missouri Foundation for Health.

**Significance:** CPS is cautiously adding agencies to the list of IDDT providers as assurance that fidelity is being strived for and action plans are in place.

**Action Plan:** CPS will continue to provide technical assistance, training and evaluation to community agencies to increase the number providing IDDT to fidelity.
**Name of Performance Indicator:** Rural adults receiving mental health services

<table>
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<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
<th>(5) FY 2009 Target</th>
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<tr>
<td>Denominator</td>
<td>191,339</td>
<td>191,339</td>
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**Table Descriptors:**

**Goal:** Maintain access and capacity of mental health services to adults 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 5.4% for rural Missouri.

**Sources of Information:** CIMOR; 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.
Child Plan
Criterion 1: Comprehensive Community-Based Mental Health Services System
Establishment of System of Care

Department of Mental Health State Statute

The State’s Revised Statutes of Missouri 2006 RSMo 630.020 set the Departmental goals and duties. It states:

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

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

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

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

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

Comprehensive Children’s Mental Health Service System State Statute

The State’s Revised Statutes of Missouri 2006 RSMo 630.097 and 630.1000 outline the Departmental Comprehensive Children’s Mental Health Service System:

“Comprehensive children's mental health service system to be developed--team established, members, duties--plan to be developed, content--evaluations to be conducted, when.

630.097. 1. The department of mental health shall develop, in partnership with all departments represented on the children's services commission, a unified accountable comprehensive children's mental health service system. The department of mental health shall establish a state interagency comprehensive children's mental health service system team comprised of representation from:

(1) Family-run organizations and family members;

(2) Child advocate organizations;

(3) The department of health and senior services;
(4) The department of social services' children's division, division of youth services, and the
division of medical services;

(5) The department of elementary and secondary education;

(6) The department of mental health's division of alcohol and drug abuse, division of mental
retardation and developmental disabilities, and the division of comprehensive psychiatric
services;

(7) The department of public safety;

(8) The office of state courts administrator;

(9) The juvenile justice system; and

(10) Local representatives of the member organizations of the state team to serve children with
emotional and behavioral disturbance problems, developmental disabilities, and substance abuse
problems.

The team shall be called "The Comprehensive System Management Team". There shall be a
stakeholder advisory committee to provide input to the comprehensive system management team
to assist the departments in developing strategies and to ensure positive outcomes for children
are being achieved. The department of mental health shall obtain input from appropriate
counteragent and family advocates when selecting family members for the comprehensive system
management team, in consultation with the departments that serve on the children's services
commission. The implementation of a comprehensive system shall include all state agencies and
system partner organizations involved in the lives of the children served. These system partners
may include private and not-for-profit organizations and representatives from local system of
care teams and these partners may serve on the stakeholder advisory committee. The department
of mental health shall promulgate rules for the implementation of this section in consultation
with all of the departments represented on the children's services commission.

2. The department of mental health shall, in partnership with the departments serving on the
children's services commission and the stakeholder advisory committee, develop a state
comprehensive children's mental health service system plan. This plan shall be developed and
submitted to the governor, the general assembly, and children's services commission by
December, 2004. There shall be subsequent annual reports that include progress toward
outcomes, monitoring, changes in populations and services, and emerging issues. The plan shall:

(1) Describe the mental health service and support needs of Missouri's children and their
families, including the specialized needs of specific segments of the population;

(2) Define the comprehensive array of services including services such as intensive home-based
services, early intervention services, family support services, respite services, and behavioral
assistance services;
(3) Establish short- and long-term goals, objectives, and outcomes;

(4) Describe and define the parameters for local implementation of comprehensive children's mental health system teams;

(5) Describe and emphasize the importance of family involvement in all levels of the system;

(6) Describe the mechanisms for financing, and the cost of implementing the comprehensive array of services;

(7) Describe the coordination of services across child-serving agencies and at critical transition points, with emphasis on the involvement of local schools;

(8) Describe methods for service, program, and system evaluation;

(9) Describe the need for, and approaches to, training and technical assistance; and

(10) Describe the roles and responsibilities of the state and local child-serving agencies in implementing the comprehensive children's mental health care system.

3. The comprehensive system management team shall collaborate to develop uniform language to be used in intake and throughout the provision of services.

4. The comprehensive children's mental health services system shall:

(1) Be child centered, family focused, strength based, and family driven, with the needs of the child and family dictating the types and mix of services provided, and shall include the families as full participants in all aspects of the planning and delivery of services;

(2) Provide community-based mental health services to children and their families in the context in which the children live and attend school;

(3) Respond in a culturally competent and responsive manner;

(4) Emphasize prevention, early identification, and intervention;

(5) Assure access to a continuum of services that:

(a) Educate the community about the mental health needs of children;

(b) Address the unique physical, behavioral, emotional, social, developmental, and educational needs of children;

(c) Are coordinated with the range of social and human services provided to children and their families by local school districts, social services, health and senior services, public safety, juvenile offices, and the juvenile and family courts;
(d) Provide a comprehensive array of services through an integrated service plan;

(e) Provide services in the least restrictive most appropriate environment that meets the needs of the child; and

(f) Are appropriate to the developmental needs of children;

(6) Include early screening and prompt intervention to:

(a) Identify and treat the mental health needs of children in the least restrictive environment appropriate to their needs; and

(b) Prevent further deterioration;

(7) Address the unique problems of paying for mental health services for children, including:

(a) Access to private insurance coverage;

(b) Public funding, including:

a. Assuring that funding follows children across departments; and

b. Maximizing federal financial participation;

(c) Private funding and services;

(8) Assure a smooth transition from child to adult mental health services when needed;

(9) Coordinate a service delivery system inclusive of services, providers, and schools that serve children and youth with emotional and behavioral disturbance problems, and their families through state agencies that serve on the state comprehensive children's management team; and

(10) Be outcome based.

5. By August 28, 2007, and periodically thereafter, the children's services commission shall conduct and distribute to the general assembly an evaluation of the implementation and effectiveness of the comprehensive children's mental health care system, including an assessment of family satisfaction and the progress of achieving outcomes.”

Missouri State Statute 630.1000
“Office of comprehensive child mental health established, duties--staff authorized.

630.1000. 1. There is hereby established in the department of mental health an "Office of Comprehensive Child Mental Health". The office of comprehensive child mental health, under the supervision of the director of the department of mental health, shall provide leadership in
developing and implementing the comprehensive child mental health service system plan established under section 630.097. The office shall:

(1) Assure oversight and monitoring of the implementation of the comprehensive child mental health service system plan;

(2) Provide support, technical assistance and training to all departments participating in the development and implementation of the comprehensive child mental health service system established under section 630.097;

(3) Develop and coordinate service system, financing and quality assurance policy for all children's mental health services within the department of mental health;

(4) Provide leadership in program development for children's mental health services within the department of mental health, to include developing program standards and providing technical assistance in developing program capacity;

(5) Provide clinical consultation, technical assistance and clinical leadership for all child mental health within the department and to other child-serving agencies participating in the comprehensive child mental health system;

(6) Participate in the work of the coordinating board for early childhood;

(7) Participate in interagency child mental health initiatives as directed; and

(8) Provide staff support and leadership to the state comprehensive system management team established under section 630.097.

2. The departments participating in the comprehensive child mental health service system established under section 630.097 shall designate staff to represent their respective department on the state comprehensive system management team.”
Missouri

Child - Available Services

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

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

Criterion 1: Comprehensive Community-Based Mental Health Services

Available Services

State statute allows the DMH to provide for the establishment and implementation of rules for community-based programming and an integrated system of care for individuals with mental illness. Services are available to children, youth and families in Missouri as categorized below.

Health, Mental Health, and Rehabilitation Services

Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health service to children and youth with serious emotional disorders. These community-based services are designed to maximize functioning and promote recovery and self-determination. In addition, they are designed to increase the interagency coordination and collaboration in all aspects of the treatment planning process. Ultimately, the services help to reduce inpatient hospitalizations and out-of-home placements. At intake children and youth are required to have a medical examination. Community Support Workers with the CPR program keep track of medical conditions and record changes as they occur. Individuals access medical and dental care along with other critical services with the assistance of their community support worker. The CPR program has developed strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs in their community or service area. CSTAR programs use research based treatment modalities to address problems with substance abuse and addiction. CPR and CSTAR programs cooperate to develop a treatment plan to meet each individual’s needs. The Community Support Worker is often the person coordinating services and finding resources needed to pay for critical medical, dental or other related services. In January 2002, The Division of Comprehensive Psychiatric Services added an “intensive” level of care to the Community Psychiatric Rehabilitation (CPR) program and implemented a Provisional Admission category in CPR. These two changes allow expanded services under the CPR program service umbrella. Children and youth are able stay in the community when they experience an acute psychiatric condition and need time limited intensive services through the CPR program. The Provisional Admission allows 90 days for providers to enroll a child or youth who meets the disability, but not the diagnostic requirements so that a comprehensive evaluation may be completed. If the agency determines that an eligible diagnosis cannot be verified, then there is time to transition the individual to appropriate programs and services. In March of 2003, CPR eligibility codes for children and youth were expanded with three new diagnoses. They are: Major depressive disorder, single episode; Bipolar disorder, not otherwise specified; Reactive attachment disorder of infancy or early childhood. In 2007 the Division of CPS agreed to expand CPR eligibility for children through using a functional assessment in combination with a diagnosis of a serious emotional disorder. The Child Adolescent Functional Assessment Scale was selected as the functional tool. Children who have any serious emotional disorder and a CAFAS score of 100 or higher will now qualify for CPR services. The CAFAS will also be used to identify the priority for treatment along with the impact of services provided.

Community Support Services within the CPR program provide a range of support to consumers in the community. Support begins with discharge planning at the institutional level or with
admission and intake in the community. Families and youth plan and direct the supportive services that they receive and are assisted with community integration so that they are able to draw on natural and family supports within their community. In FY08 the Division worked with MOHealthNet (Missouri’s division that manages Medicaid) to add 4 additional services to CPR. These services include Family Support, Family Assistance, Day Treatment and Psychosocial Rehabilitation for children.

**Educational services and Employment services**

**Day Treatment** offers an alternative form of care to children with SED who require a level of care greater than can be provided by the school or family, but not as intensive as full-time inpatient services. Day treatment includes, rehabilitation services, individual and group therapies and, as needed, vocational education, and occupational therapy.

**Housing Services**

**Residential Treatment** services consist of highly structured care and treatment to youth on a time-limited basis, until they can be stabilized and receive care in a less-restrictive environment or at home.

**Family Support** is a treatment plan driven service that is designed to develop a support system for parents of children with a serious emotional disorder. This service provides parent-to-parent guidance. Some of the activities provided in this service are: problem solving, emotional support, disseminating information, and linking to services.

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

**Substance Abuse Services**

The CPR program has developed strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to CSTAR programs in their community or service area. CSTAR programs use research based treatment modalities to address problems with substance abuse and addiction. CPR and CSTAR programs cooperate to develop a treatment plan to meet each individual’s needs. CSTAR Adolescent Treatment Programs are specialized for youth needs. Early intervention, comprehensive treatment, academic education, and levels of care are important in averting chronic substance abuse and resulting problems that might otherwise follow a young person for a lifetime. The specially trained staff of adolescent CSTAR programs utilize individual, group and family interventions.
Medical and Dental Services

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

Support Services

Several of the System of Care federal grant programs, Show-Me Kids and Transitions, have parent support programs. Their purpose is:

- to support families of children/youth with serious emotional disorders, by providing information, training, and networking opportunities;
- to provide family voice at all levels of the System of Care;
- to partner with other organizations, agencies, and key stakeholders; and
- to promote change that leads to positive outcomes for children/youth and their families.

The Division of Comprehensive Psychiatric Services (CPS) has a service that is designed to provide support to parents called Family Support. This service may involve a variety of related activities to the development or enhancement of the service delivery system. Activities are designed to develop a support system for parents of children who have a serious emotional disorder. Activities must be directed and authorized by the treatment plan. Activities may include, but are not limited to, problem solving skills, emotional support, disseminating information, linking to services and parent-to-parent guidance. An eligible provider is an individual that meets the requirements specified in the CPS Family Support Model and has successfully completed the required Family Support training as approved and provided by the Department of Mental Health, Division of Comprehensive Psychiatric Services.

Additionally, CPS has a contract with National Alliance for the Mentally Ill (NAMI) of Missouri for parent support programming. NAMI of Missouri offers support, information and technical assistance to families served by the department. NAMI of Missouri provides an 800 number HELPline service accessible to urban, rural and impoverished parents. NAMI has resource libraries for families of children with SED. NAMI’s contract requires them to provide support groups. NAMI trains support group facilitators for peer support groups for families of children and adolescents with SED. They have used the Family-to-Family model of peer support facilitator training to train support volunteers. Family-to-Family has been identified by the Substance Abuse and Mental Health Administration as an evidence based exemplary practice. Research indicates that families’ participation in multiple family groups reduces the families “subject burden” and incidence of relapse and hospitalization.
In 2007, NAMI was awarded a Statewide Family Network Grant through SAMHSA. This grant helps to provide parents, families and youth with a unified aggregate platform from which to engage decision makers. It enable NAMI and other family organizations within Missouri to identify, recruit, train and support parents and youth in their quest for a comprehensive system of care with families needs at the center. NAMI’s support groups for parents, foster parents and custodial grandparents of children and adolescents with SED are active in St. Louis, Kansas City, Springfield, Rolla, and Jefferson City. Family members of children currently participate in general family support groups in other areas of the State.

**Services Provided by Local School Systems Under the Individuals with Disabilities Education Act**

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

The Missouri Department of Mental Health (DMH), Division of Comprehensive Psychiatric Services (CPS) and the Curators of the University of Missouri – Columbia (University) has collaborated on the Center for the Advancement of Mental Health Practice in Schools (the Center). The Center was established through a partnership between the DMH and the University Department of Educational, School and Counseling Psychology (ESCP) to respond to the needs and to the shift in the priorities of federal and state agencies pertaining to policy, practice and research concerning child and adolescent mental health. The center was initiated, in part, as a response to the shift in the priorities of federal and state agencies pertaining to policy, practice, and research concerning child and adolescent mental health. This shift recognizes prevention as a fundamental element in supporting our nation's youth in facing developmental challenges, psycho-social issues, and environmental stressors within the school system and community.

The Center is a partnership between the College of Education of the University and the DMH intended to:

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

The first online program of its kind nationally is the result of this unique partnership. ESCP has two graduate programs accredited by the American Psychological Association; the master’s program includes 24 hours of required course work and nine hours of electives, for a total of 33 hours. The educational specialist requires a total of 30 credit hours. Each course emphasizes the prevention of mental health problems—with schools, families and communities—and the promotion of positive mental well-being for all children and adolescents, to make you a better, more effective educator, administrator or health services professional.

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

For more information go to: http://schoolmentalhealth.missouri.edu/about.htm

Case Management Services

Intensive Targeted Case Management (ITCM) – The service supports children and families by linking them to the service system and coordinating the various services they receive. Case managers work with the families, treatment providers and other child-serving agencies to assist the children to remain in or progress toward least-restrictive environments. CPR programming also provides case management through the treatment team approach. Each member of the team contributes to treatment planning.

Services for Persons with Co-Occurring (Substance Abuse/Mental Health) Disorders

Youth identified as having a co-occurring disorder are referred to CSTAR programs in their community or service area. CSTAR programs use research based treatment modalities to address problems with substance abuse and addiction. CPR and CSTAR programs cooperate to develop a treatment plan to meet each individual’s needs. CSTAR Adolescent Treatment Programs are specialized for youth needs. Early intervention, comprehensive treatment, academic education, and levels of care are important in averting chronic substance abuse and resulting problems that might otherwise follow a young person for a lifetime. The specially trained staff of adolescent CSTAR programs utilize individual, group and family interventions.
Other Activities Leading to Reduction of Hospitalization

Implementation of the Comprehensive Children’s Mental Health Plan is moving Missouri towards children receiving the mental health services they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. The vision is that Missouri’s mental health services system for children will be easily accessible, culturally competent, flexible to individual needs, and result in positive outcomes for the children and families it serves. *By providing comprehensive community services, the department can reduce hospitalizations for Missouri’s children and youth with SED.*

Additionally, Missouri has thirteen state-approved System of Care (SOC) sites for children and youth services. In a SOC, all local child-serving agencies bring needed expertise and resources to the planning process to meet a child and family’s individual needs. The child service delivery system is supported by a local policy/administrative team that address barriers to accessing needed services and monitor trends to aid in policy and service development.

Missouri has three SAMHSA funded system of care cooperative agreements within the state. The overarching goals for these sites are to:
- expand the capacity for community based services and supports,
- create an infrastructure for cross agency individualized care planning,
- incorporate culturally and linguistically competent practices for serving children, and
- promote full participation of families and youth in service planning and in development of services and supports.

For each of the sites, local project development is managed through partnerships with community agencies including local family organizations, the community mental health center, the MR/DD Regional Office, the local office of the Children's Division, local juvenile office, the Division of Youth Services, local schools, local county health offices, as well as individual youth and families in the community.
Missouri

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children
See Adult – Estimate of Prevalence section for Child – Estimate of Prevalence
Missouri

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1
See Goals, Targets and Action Plans section
Missouri

Child - System of Integrated Services

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

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

Health and mental health services.
Child Plan
Criterion 3: Children’s Services
System of Integrated Services

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

Social Services

See also Child Plan sections on New Developments & Issues and Recent Significant Achievements

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 Custody Diversion Protocol was developed through the shared efforts of DMH, DSS, courts and family members and implemented statewide in January, 2005 following extensive training of Children’s Division (CD) staff, DMH provider staff and juvenile justice officers. In February of 2005, the CD was able to implement a Voluntary Placement Agreement (VPA) through an amendment to the state’s IV-E plan. This allowed the CD to enter into a contract with parents to fund a child’s out of home placement for a maximum of 180 days if deemed appropriate through a DMH level of care assessment without having to take custody. This VPA is only available in conjunction with the Custody Diversion Protocol. This initiative continues to be successful with 93% of the youth referred being diverted from state custody, and of those diverted 40% have been able to be maintained in the home as opposed to placed outside of their community. Representatives of the DMH and Children’s Division presented on the development of the protocol and its results at the 2008 Georgetown Training Institutes.

The Comprehensive Children’s Mental Health State Management Team continues to function as oversight, coordination, and technical assistance to ensure implementation of a comprehensive children’s mental health system. This committee consists of representatives from: The Department of Social Services: Children’s Division, Division of Youth Services and Division of Medical Services; The Department of Elementary and Secondary Education: Division of Vocational Rehabilitation and Division of Special Education; The Department of Public Safety; The Department of Mental Health: Divisions of Alcohol and Drug Abuse, Comprehensive Psychiatric Services, and Mental Retardation and Developmental Disabilities; The Department
of Health and Senior Services; 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.

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 services. Day treatment includes, rehabilitation services, individual and group therapies and, as needed, vocational education, and occupational therapy.

Services provided under the Individuals with Disabilities Education Act

The Department of Elementary and Secondary Education (DESE) and its Division of Special Education is the State’s lead agency on the Individuals with Disabilities Education Act (IDEA). The Division of Special Education is funded primarily through the Federal Government and implements programs that support IDEA. A comprehensive system of personnel development has been developed and implemented which is coordinated, as appropriate, with each district’s Professional Development Committee and Comprehensive School Improvement Plan and includes a needs assessment and description of the activities established to meet the identified needs in the areas of: a) number of qualified personnel available to serve all students with disabilities; b) appropriate in-service training of staff; c) required training for paraprofessionals; d) dissemination of relevant research, instructional strategies, and adoption of effective practices. See Child Plan Criterion 1: Comprehensive Community-Based Mental Health Services Available Resources for more detail.

Juvenile Justice Services

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. Issues to be addressed include how the state can develop a partnership with the 45 county based circuits in the state 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, following a series of regional videoconferences to explore how mental health and juvenile justice can collaborate more effectively, ongoing technical assistance has been provided to approximately 14 local interagency teams on developing policy collaboratives. In August, 2006, eight of the local teams attended a two-day Summit in St. Louis to share successes and challenges experienced, provide feedback to the CSMT and develop plans for continued development. These activities were supported through a Challenge Grant from the Office of Juvenile Justice and Delinquency Prevention and the MO Dept. of Public Safety. The DMH continues to work with Office of State
Courts Administrator (OSCA) and MJJA in training juvenile officers on children with special needs and mental health service system. In continuing this effort, OSCA and DMH applied for and received a field demonstration grant through the Office of Juvenile Justice and Delinquency Prevention to promote use of quality assessment guidelines and implementation of evidence-based practices for the juvenile justice population with mental health needs. Five local sites were selected to be trained in the assessment guidelines and an evidence based practice that meets their local population’s needs as well as sustaining a local policy infrastructure to support these practices. In 2008, 24 therapists have been trained and certified on Trauma-Focused Cognitive Behavioral Therapy with these grant dollars.

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.

**Substance Abuse Services**

The CPR program has developed strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to CSTAR programs in their community or service area. CSTAR programs use research based treatment modalities to address problems with substance abuse and addiction. CPR and CSTAR programs cooperate to develop a treatment plan to meet each individual’s needs. CSTAR Adolescent Treatment Programs are specialized for youth needs. Early intervention, comprehensive treatment, academic education, and levels of care are important in averting chronic substance abuse and resulting problems that might otherwise follow a young person for a lifetime. The specially trained staff of adolescent CSTAR programs utilizes individual, group and family interventions.

**Health and Mental Health Services**

Community Support Workers assigned to children and youth receiving services assure that consumers receive physical healthcare. CSWs will make medical appointments for children and youth and assist families in gaining transportation to appointments if this is a barrier.
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 addresses the mental health needs of children following a disaster. 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 DEPARTMENT OF MENTAL HEALTH
Division of Comprehensive Psychiatric Services

CHILDREN’S SERVICE AREAS

CENTRAL
Beth Ewers-Strope
Area Director
1706 East Elm
Jefferson City, MO 65101
Phone: 573-751-7622
Fax: 573-751-7815
beth.strope@dmh.mo.gov

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Dome Building
5400 Arsenal
St. Louis, MO 63139
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SOUTHERN
Betty Turner
Area Director
1903 Northwood Drive
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Poplar Bluff, MO 63901
Phone: 573-840-9275
Fax: 573-840-9191
betty.turner@dmh.mo.gov

WESTERN
Bonnie Neal
Area Director
821 E. Admiral
Kansas City, MO 64141
Phone: 816-889-3458
Fax: 816-889-3325
bonnie.neal@dmh.mo.gov
Missouri

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless
See Adult Plan section on Outreach to Homeless
Missouri

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas
See Adult Plan section on Rural Area Services
Missouri

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;
See Adult Plan Criterion 5: Management Systems Resources for Providers
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
See Adult Plan section Grant Expediture Manner
**Name of Performance Indicator:** Increased Access to Services (Number)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
<th>(5) FY 2009 Target</th>
<th>(6) FY 2010 Target</th>
<th>(7) FY 2011 Target</th>
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</table>

**Table Descriptors:**

**Goal:** Increase access to mental health services for children/youth

**Target:** Increase the number of children/youth receiving CPS funded services

**Population:** Children and youth with SED

**Criterion:**
1: Mental Health System Data
2: Epidemiology
3: Children's Services

**Indicator:** Total number of children/youth receiving CPS funded services

**Measure:** No numerator or denominator

**Sources of Information:** CIMOR

**Special Issues:** Mental health services for children/youth are underfunded both nationally and in the State of Missouri.

**Significance:** Due to fiscal contraints, Missouri is only meeting the mental health needs of 16% of the estimated prevalence of children/youth with severe emotional disorders.

**Action Plan:** Continue to build community based services for children and youth with SED based on Missouri's Comprehensive Children's Mental Health Plan.
Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
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<td>FY 2008 Projected</td>
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<td>FY 2009 Target</td>
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<td>FY 2011 Target</td>
<td>6.70</td>
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</table>

Table Descriptors:

Goal: Decrease the rate of readmission within 30 days to State psychiatric hospital beds
Target: Lower than the national benchmark rate of 6.70%
Population: Children and youth with SED
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
Indicator: Percentage of children and youth readmitted to State psychiatric inpatient care within 30 days of discharge
Measure: The numerator is number of children and youth readmitted to State psychiatric hospitals within 30 days of discharge. The denominator is total discharges for children and youth from State psychiatric hospitals.
Sources of Information: CIMOR

Special Issues: The total number of children and youth that are served by the Division is expected to remain stable.
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.
**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

<table>
<thead>
<tr>
<th>(1)</th>
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**Table Descriptors:**

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

**Target:** Lower than the national benchmark rate of 15.3%

**Population:** Children and youth with SED

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

**Indicator:** Percentage of children and youth with SED readmitted to State psychiatric hospitals within 180 days of discharge

**Measure:** The numerator is number of children and youth readmitted to State psychiatric hospitals within 180 days of discharge.  
The denominator is total discharges for children and youth from State psychiatric hospitals.

**Sources of Information:** CIMOR

**Special Issues:**

**Significance:** A major outcome of the development of a community-based system of care is the reduced readmission to State-operated psychiatric hospital beds and a reduced average length of stay.

**Action Plan:** CPS will develop and support community based resources to help reduce readmission rates for children and youth in the Missouri mental health system of care. Through the Comprehensive Children’s System of Care collaborations, the department will efficiently use resources and enhance services to children and families.
CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
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<th>(2)</th>
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</tbody>
</table>

Table Descriptors:

Goal: Maintain the number of children and youth with SED receiving the Evidence Based Practice of Therapeutic Foster Care.

Target: Maintain the number of children and youth with SED receiving the Evidence Based Practice of Therapeutic Foster Care.

Population: Children and youth with SED.

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

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

Measure: No numerator or denominator.

Sources of Information: Supported Community Living Regional Offices and Children's Area Directors.

Special Issues:
The department is refining the measurement to a centralized Statewide manner for Therapeutic Foster Care to assure accuracy and consistency of numbers served.

The explanation for the decrease in usage is for two fiscal years the Treatment Family Home program had developed more capacity for the program than the funding could support. CPS had to bring the capacity in line with the allocation. CPS developed a standard based on traditional funding patterns and told each of the four Eastern region CMHC that they were funded for a population based number of slots. Usage beyond that funding would have to come out of their Children’s budgets. It has impacted the usage of TFH and has brought the service within funding limits.

Significance: The department meets the definition of Therapeutic Foster Care provided in the application instructions with the Treatment Family Homes.

Action Plan: Treatment Family Home Action Plan:

In order to provide a more consistent, cohesive Treatment Family Home service across the state, CPS is redesigning its model to maximize therapeutic effectiveness while minimizing restrictiveness. Accomplishment of this task will involve the following steps:

1. Develop a Missouri “Toolkit for Treatment Family Home Care”
2. Revise and update contracts consistent with the toolkit.
3. Certify Treatment Family Home train-the-trainers.
4. Provide training to providers on the “Toolkit”.

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5. Monitor provider implementation of “Toolkit” through CPS annual compliance review.
**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

<table>
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</table>

**Table Descriptors:**

**Goal:**

**Target:**

**Population:**

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

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**
**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

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**Table Descriptors:**

**Goal:**

**Target:**

**Population:**

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

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

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

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<th>(3) FY 2007 Actual</th>
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<th>(5) FY 2009 Target</th>
<th>(6) FY 2010 Target</th>
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Table descriptors:
- **Goal:** Maintain high level of consumer satisfaction
- **Target:** Higher than or equal to the national benchmark rate of 84%
- **Population:** Children and youth with SED
- **Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
  3: Children’s Services
- **Indicator:** Percentage of parents of children with SED satisfied or very satisfied with services received
- **Measure:** The numerator is number of parents of children and youth with SED receiving services who are satisfied or very satisfied with those services. The denominator is total number of parents of children and youth with SED receiving services who responded to the consumer satisfaction survey.
- **Sources of Information:** Consumer Satisfaction Survey (Youth Services Survey for Families)
- **Special Issues:** The data is very preliminary. CPS has recently implemented the Youth Services Survey for Family (YSS-F) recommended by SAMHSA.
- **Significance:** Parents of children with SED were satisfied with services received at a high rate.
- **Action Plan:** CPS will continue to receive the YSS-F survey implemented on a continuous basis.
Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

<table>
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<th></th>
<th>(1)</th>
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Table Descriptors:
- **Goal:** Children and youth will return to or stay in school
- **Target:** Equal to the national benchmark rate of 94%
- **Population:** Children and youth with SED
- **Criterion:**
  1: Comprehensive Community-Based Mental Health Service Systems
  3: Children's Services
- **Indicator:** Percentage of children and youth returning to or staying in school
- **Measure:**
  - The numerator is the number of children/youth attending school at time assessment was completed.
  - The denominator is the total number of children/youth in sample.
- **Sources of Information:** Child/Youth Status Report
- **Special Issues:**
  - The Child/Youth Status Report is a sample of the total number served. With the new management information system (CIMOR), CPS eventually plans to collect data on all consumers served by the division.
- **Significance:**
  - According to the President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America, "the mission of public schools is to educate all students. However, children with serious emotional disturbances have the highest rates of school failure. Fifty percent of these students drop out of high school, compared to 30% of all students with disabilities. Schools are where children spend most of each day. While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success, schools must be partners in the mental health care of our children."
  - Missouri's Comprehensive Children's Mental Health System is working if over 94% of children and youth with SED are returning to or staying in school.
- **Action Plan:**
  - CPS will continue to revise the new management information system to improve collection of data on all consumers served. CPS will continue to support children and youth with SED in their communities to maintain consistent school attendance.
**Name of Performance Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

<table>
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<th>(1) Fiscal Year</th>
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<th>(3) FY 2007 Actual</th>
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</table>

**Table Descriptors:**

- **Goal:** Decrease the number of children and youth with SED involved in the Juvenile Justice system
- **Target:** Decrease the number of children and youth with SED involved in the Juvenile Justice system
- **Population:** Children and Youth with SED
- **Criterion:**
  1: Comprehensive Community-Based Mental Health Service Systems
  3: Children's Services
- **Indicator:** Percentage of children and youth with SED involved with Juvenile Justice
- **Measure:** The numerator is the number of children and youth involved with Juvenile Justice. The denominator is the total number of children and youth in sample.
- **Sources of Information:** Child/Youth Status Report
- **Special Issues:** The Child/Youth Status Report is a sample of the total number served. With the new management information system (CIMOR), CPS eventually plans to collect data on all consumers served by the division.
- **Significance:** 80% of the children and youth with SED are not involved with the Juvenile Justice system.
- **Action Plan:** CPS will continue to revise the new management information system to improve collection of data on all consumers served.
Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

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<th>Fiscal Year</th>
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<th>(4)</th>
<th>(5)</th>
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Table Descriptors:
- **Goal:** Increase stability in housing for children/youth
- **Target:** Increase stability in housing for children/youth
- **Population:** Children and youth with SED
- **Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
  3: Children's Services
- **Indicator:** Percentage of children and youth with SED living in home or home-like setting
- **Measure:** The numerator is the number of children and youth with SED living in home or home-like setting.
  The denominator is the total number of children and youth with SED in the sample.
- **Sources of Information:** Child/Youth Status Report
- **Special Issues:** The data is taken from a small sample of total consumers served. This can lead to fluctuations in the outcomes based on small number size.
- **Significance:** State policymakers, families, and practitioners are increasingly concerned about the mental health needs of children in Missouri. Providing appropriate and effective services to meet their needs is a high priority. Senate Bill 1003 was enacted into law in 2004 to require the development of a unified, comprehensive plan for children’s mental health services. When fully implemented, this plan will ensure that all of Missouri’s children receive the mental health services and supports they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. Missouri’s mental health services system for children will be accessible, culturally competent, and flexible enough to meet individual and family needs; and family-centered and focused on attaining positive outcomes for all children.
- **Action Plan:** The department will continue to place children and youth with SED in a home or home-like setting whenever possible.
Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

<table>
<thead>
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<th>Fiscal Year</th>
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<th>Actual</th>
<th>Projected</th>
<th>Target</th>
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Table Descriptors:
Goal: Increase percentage of families reporting Social Supports/Social Connectedness
Target: Increase or maintain percentage of families reporting Social Supports/Social Connectedness
Population: Children and youth with SED
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children’s Services
Indicator: Percentage of families reporting Social Supports/Social Connectedness
Measure: The numerator is number of families reporting social connectedness on the YSS-F consumer satisfaction survey.
The denominator is the total number of responses to the YSS-F consumer satisfaction survey.
Sources of Information: Consumer Satisfaction Survey (YSS-F)
Special Issues: The data is very preliminary. CPS has recently implemented the Youth Services Survey for Family (YSS-F) recommended by SAMHSA. As additional data is gathered and analyzed, targets can be set.
Significance: 83.43% of families of children/youth reported feeling social support/social connectedness
Action Plan: CPS will continue to receive the YSS-F survey recently implemented on a continuous basis. Targets will be set after additional surveys are received
Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
<th>(5) FY 2009 Target</th>
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<th>(7) FY 2011 Target</th>
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Table Descriptors:
Goal: Improve children/youth level of functioning
Target: Increase percentage of children/youth with improved level of functioning
Population: Children and Youth with SED
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
4: Targeted Services to Rural and Homeless Populations
Indicator: Percentage of children/youth with improved level of functioning
Measure: The numerator is the number of reported child/youth with improved level of functioning. The denominator is the total number of responses on the consumer satisfaction survey.
Sources of Information: Consumer Satisfaction Survey (YSS-F)
Special Issues: The data is very preliminary. CPS has recently implemented the Youth Services Survey for Family (YSS-F) recommended by SAMHSA. As additional data is gathered and analyzed, targets can be set.
Significance: Preliminary data
Action Plan: CPS will continue to receive the YSS-F survey recently implemented on a continuous basis. Targets will be set after additional surveys are received.
**Name of Performance Indicator:** Number of System of Care Teams

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2006 Actual</th>
<th>(2) FY 2007 Actual</th>
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</table>

**Table Descriptors:**

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

**Target:** Increase or maintain the number of Children's System of Care local teams

**Population:** Children and youth with SED

**Criterion:** 3: Children's Services

**Indicator:** Number of Children's System of Care local teams

**Measure:** No numerator or denominator

**Sources of Information:** Missouri's Comprehensive Children's Mental Health System of Care staff

**Special Issues:** State policymakers, families, and practitioners are increasingly concerned about the mental health needs of children in Missouri. Providing appropriate and effective services to meet their needs is a high priority. Senate Bill 1003 was enacted into law in 2004 to require the development of a unified, comprehensive plan for children’s mental health services. When fully implemented, this plan will ensure that all of Missouri’s children receive the mental health services and supports they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. Missouri’s mental health services system for children will be accessible, culturally competent, and flexible enough to meet individual and family needs; and family-centered and focused on attaining positive outcomes for all children.

**Significance:** The Department of Mental Health has thirteen System of Care sites operating in Missouri in FY2008. In a System of Care (SOC), mental health services (psychiatric, mental retardation/developmental disabilities, alcohol and drug abuse) as well as other services and supports are organized in such a way as to enable children with the most complex needs to remain in their homes, schools and communities. System of Care brings the right people together at multiple levels to develop resources and remove barriers for children with complex needs that might otherwise fall through the cracks.

**Action Plan:** Continue to add Children's System of Care local teams as funding becomes available.
**Name of Performance Indicator**: Percentage of children receiving services

<table>
<thead>
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<th>Fiscal Year</th>
<th>Performance Indicator</th>
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<tr>
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<td>FY 2007 Actual</td>
<td>16.53</td>
<td>16,716</td>
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**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**: CIMOR 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.

**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.
Name of Performance Indicator: Rural children receiving mental health services

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<th>Fiscal Year</th>
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<td>14.20</td>
<td>12,206</td>
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<td>(3) FY 2008 Projected</td>
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<td>(4) FY 2009 Target</td>
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<td>(5) FY 2010 Target</td>
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<tr>
<td>(6) FY 2011 Target</td>
<td>14.59</td>
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</tbody>
</table>

Table Descriptors:

Goal: Increase or maintain the percentage of children and youth with SED in rural areas receiving CPS funded mental health services

Target: Increase or maintain the percentage of children and youth with SED in rural areas receiving CPS funded mental health services

Population: Children and youth with SED

Criterion: 4: Targeted Services to Rural and Homeless Populations

Indicator: Percentage of children and youth with SED in rural areas receiving CPS funded mental health services

Measure: The numerator is the number of children and youth with SED in rural areas served by CPS. The denominator is the prevalence at 7% of children and youth with SED in rural areas.

Sources of Information: CIMOR; billing database; federal census and prevalence table

Special Issues: Of the 25 service areas in Missouri, 16 are designated rural or semi-rural according to definitions based on boundaries of Metropolitan Statistical Areas adopted by DMH/CPS. Approximately 15% of the state’s population live in rural areas, and 25% are concentrated in small towns and cities.

Significance: Mental illness and its complications and lack of access to care have been identified as major rural health concerns at the national and state level. The Division of CPS is committed to providing mental health services to rural Missourians.

Action Plan: CPS will maintain mental health services to children and youth with SED in rural and semi-rural areas of the state.
August 25, 2008

Barbara Orlando  
Grants Management Specialist  
Substance Abuse and Mental Health Services Administration  
Division of Grants Management, OPS  
1 Choke Cherry Road, Room 7-1091  
Rockville, MD 20857

Dear Ms. Orlando:

The State Advisory Council for the Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services, has reviewed the State Plan for the FY 2009-2011 Community Mental Health Services Block Grant Application. The State Advisory Council is committed to Mental Health Transformation and assuring that the system is consumer and family driven. We approve of the state plan written under our guidance.

The State Advisory Council has been very involved in transforming the mental health system in Missouri to be more consumer and family driven. I, along with multiple other consumers, am on the Leadership Transformation Working Group. Council members have promoted and achieved the inclusion of consumers and family members in surveying the quality of care during certification visits of the community mental health centers in order to offer a consumer/family perspective. We are involved in the Peer Specialist training and certification process being implemented statewide. We support the continued services of consumer operated Drop-In Centers and Warm Lines. We are involved in a Consumer/Family/Youth Committee planning a statewide summit which will lead to annual conferences gathering consumers of all three divisions. We are excited by changes in the system that we have endorsed.

We will continue to work with Comprehensive Psychiatric Services staff in monitoring the implementation of the State Plan and the Mental Health Transformation process. We appreciate our involvement in the Block Grant process and would like to express appreciation to SAMSHA and the Center for Mental Health Services for making these funds available.

Sincerely,

[Signature]

Robert Qualls, Chair  
CPS State Advisory Council

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, national origin, disability or age of applicants or employees.
OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.
State of Missouri

Comprehensive Plan for Mental Health

Creating Communities of Hope

January 2008 - January 2013
Cover design
Special thanks to Rhonda Miller, the graphic artist who created the cover and Transformation logo.

Missouri’s Mental Health Transformation Initiative and this publication are supported by grant number 6 U79 SM57474-01-1 from the Substance Abuse and Mental Health Services Administrations (SAMHSA) Mental Health Transformation State Incentive Grant (MHT SIG) program. The contents are solely the responsibility of the authors and do not necessarily represent the official views of SAMHSA. When referencing this document, please use:


To ensure 24/7 availability and widest distribution, the Comprehensive Plan for Mental Health is available electronically at: http://www.dmh.mo.gov/transformation/transformation.htm
Dedication

Missouri's efforts honor Geody Frazier, a consumer leader from Kansas City appointed to the Transformation Working Group, who passed away in May 2007. Geody designed the color scheme to symbolize:

- **Green**: Transformation, Resiliency, Self-determination & Growth
- **Blue**: Hope & Overcoming Stigma
- **Combined Colors**: Awareness & Pride in our Collective Power.

Acknowledgements

Numerous volunteers, experts and citizens contributed to this plan. The Transformation Working Group gratefully acknowledges the valuable input of everyone who participated in the workgroups, public meetings or otherwise provided comments and feedback. Special appreciation to: 1) the Substance Abuse Mental Health Services Administration (SAMHSA) for funding Missouri's Mental Health Transformation State Incentive Grant (MHT SIG) program; 2) the Center for Medicaid and Medicare Services (CMS) for funding for Missouri's Division of Mental Retardation and Developmental Disabilities (MRDD) Transformation Initiative; 3) the Missouri Foundation for Health and the Milbank Memorial Fund for their support of the planning efforts, and 4) The Change Innovation Agency for facilitating the workgroups and guiding the process.
March 31, 2008

Dear Missouri Citizen:

This is a momentous day for Missouri. Through a bipartisan, cross-agency, public-private effort funded by the federal Substance Abuse Mental Health Services Administration (SAMHSA), Missouri has created its first Comprehensive Plan for Mental Health to address the mental health needs of Missourians across the lifespan.

In October, 2006 Governor Matt Blunt accepted a five-year grant award from SAMHSA's Mental Health Transformation State Incentive Grant program to develop and implement a comprehensive plan to transform the mental health system in Missouri. His executive orders 06-39 and 07-15 established the Mental Health Transformation Working Group (TWG) to carry out this charge.

Over the past year, hundreds of Missourians participated in the development of this plan. Six workgroups, comprising nearly 240 content experts, were chartered and 14 public hearings were held across the state. The voices of consumers and families were prominent in shaping the states mental health priorities. Although the diverse stakeholders involved in this planning effort have not historically spoken with one voice, as the planning progressed it became clear that there are more commonalities than differences regarding mental health issues and that the people across these diverse populations and sectors have much to learn from each other and much to be gained by working together on a common agenda. We sincerely appreciate the enthusiasm and commitment of everyone involved in shaping this plan.

The Comprehensive Plan will move Missourian’s mental health system toward a public health approach. Such an approach is driven by the needs of Missouri citizens, grounded in best practices, and designed to improve the overall health and well-being of Missouri's communities. The plan addresses mental health services and access across systems, age groups, cultures and regions. The shared vision and practical blueprint in this plan will guide the collective action needed to create Communities of Hope throughout Missouri that support a system of care where promoting mental health and preventing disabilities is common practice and everyone has access to treatment and supports essential for living, learning, working and participating fully in the community.
On behalf of the Mental Health Transformation Working Group, we encourage you to join us in creating Communities of Hope throughout Missouri!

Diane McFarland, Chair
Mental Health Transformation Working Group

Benton Goon, Co-Chair
Mental Health Transformation Working Group

Mental Health Transformation Working Group (TWG) Members

Heidi Atkins  Mariann Atwell  Tim Decker  Benton Goon
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Missouri’s Vision

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

Except for world peace, I can't think of a more important project.

Workgroup member

Introduction and Overview

This is a momentous time in Missouri. Through a bipartisan, cross-agency, public-private effort spearheaded by the Governor-appointed Transformation Working Group (TWG) (Appendix A) and funded by the federal Substance Abuse Mental Health Services Administration (SAMHSA), Missouri has created its first Comprehensive Plan for Mental Health to address the mental health needs of Missourians across the lifespan. The President’s New Freedom Commission (NFC) on Mental Health provided the foundation for this transformation when issuing their final report in July 2003 (http://www.mentalhealthcommission.gov/reports/reports.htm). Established through Executive Orders 06-39 and 07-15, the TWG is comprised of consumer and family leaders and public leaders from the executive and judicial branches (Appendix A). The TWG Co-Chairs and principle staff are based in the Directors Office of the Department of Mental Health (DMH) to lead and staff the planning process in partnership with other state agencies involved with mental health services.

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

Scope of Plan

Transforming an entire system is a tremendous undertaking. Compiling, creating and conveying a transformation action plan in the most simplistic terms is exceptionally challenging. Every attempt has been made to be inclusive and comprehensive of all persons, groups, systems and stakeholders and their unique opinions and views while being concise and precise in writing the plan. In Missouri, DMH is the public mental health authority. However multiple federal, state, local and private entities either provide or fund mental health services in Missouri. Therefore, this plan sets forth a shared vision and strategic direction that transcends traditional state, local, public and private boundaries. It provides a roadmap for all mental health stakeholders, incorporating existing initiatives and expanding into content areas as needed to achieve a transformed system.

> From a population perspective, the plan addresses mental health issues important to all Missourians. Specifically it addresses the needs of persons either at risk of developing, or having mental illnesses, substance use and addictive disorders and mental retardation/developmental disabilities. In fact, Missouri is the only state to incorporate these three target populations into an overall Mental Health Transformation Initiative.
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- A life-span perspective was adopted. Every effort has been made to consider the needs of children, adolescents, adults, and the elderly. While these age groups may not be specifically cited in each example, the intent to cover the full lifespan is implied throughout the document.

- Planning was also organized to incorporate issues specific to culture and geography. Missouri is a culturally and geographically rich state. There is no such thing as a one size fits all mental health system to address the diversity of the citizens and regions. Therefore, designing local infrastructure to meet the specific mental health needs of area populations is critical. Cultural and ethnic groups reside throughout the state and include but are not limited to persons who are African American, Hispanic, Deaf and Hearing Impaired, Bosnian, Russian, Asian, refugees and immigrants from war-torn countries, etc. Bordered by eight states and the Mississippi River, Missouri has the urban centers of St. Louis and Kansas City on her east and west borders, respectively; mid-sized cities, small towns and rural outposts throughout the state; thousands of acres of farmland, the rambling Ozark Mountains, and the extensive Mark Twain National Forest. To address this geographic spectrum, the Transformation Initiative has identified four geographic categories: Rural-rural which are the most remote and isolated locations, rural, suburban, and urban.

The Need to Transform

A Serious Public Health Crisis

Of the approximate 5.8 million people who live in Missouri, it is estimated that 10.5% have a serious mental illness, 11% are alcohol dependent, 3% are drug dependent and 1.5% experience mental retardation or a significant developmental disability. (NARI, 2008) Given this prevalence, it is not surprising that there is an enormous emotional and financial burden on individuals, their families and Missouri as a whole. Unfortunately, the impact of these problems on health and productivity is substantial and has long been underestimated. The landmark Global Burden of Disease study (World Health Organization (WHO) 1990) and project (WHO 2000) found that the impact of mental and behavioral disorders on the health and productivity in the United States is vast. This data revealed that mental illness alone, including suicide, accounts for over 15% of the burden of disease in established market economies such as the United States - more than the disease burden caused by all cancers.

This new knowledge brings urgency to the issue of mental health. Historically, mental health problems have not received the level of attention of other diseases and disabilities with a similar public health impact. In addition, his 1999 report on Mental Health, the Surgeon General found that despite the numerous scientific advances and treatment options that exist nearly half of all Americans who have a mental disorder do not seek treatment. Many barriers exist. Foremost among these is the pervasive stigma associated with these problems.

The health of Missouri citizens and the economy depend on the ability to focus efforts to reduce the burden of disease associated with mental health conditions. In the absence of concerted efforts to prevent, diagnose, and better manage and treat these conditions, Missouri will needlessly bear higher socioeconomic costs over time. Many of these costs can be avoided through prevention, early intervention and effective treatment and supportive services.

A Complex and Fragmented System

"Every system is perfectly designed to achieve exactly the results it gets"

Berwick, 2003

Even when people do seek care, there are significant barriers to accessing the care that is needed. The traditional segregation of the mental health system from the overall health system contributes greatly to the public health crisis. In its interim report to the President, the New Freedom Commission declared the
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mental health service delivery system is fragmented and in disarray leading to unnecessary and costly disability, homelessness, school failure and incarceration. Even the private sector is not immune to this problem. Despite important progress, the National Business Group on Health identified that within the private employer market, standardized and integrated programs addressing the delivery of mental healthcare services remain rare and benefits are fragmented, uncoordinated, duplicative, and uneven in terms of access and quality. ("Employer's Guide to Behavioral Health Services" December 2005)

The system complexity in Missouri is illustrated by the number of providers, key stakeholders, and special issues. Grasping the full scope of Missouri's mental health system begins with an understanding of the Department of Mental Health. DMH is Missouri's public mental health authority and served approximately 158,000 people statewide last year in its three divisions. (Note: the preceding number is a duplicated count because individuals may be served by one or more divisions.)

- 53,000 Division of Alcohol and Drug Abuse (ADA)
- 75,000 Division of Comprehensive Psychiatric Services (CPS)
- 30,000 Division of Mental Retardation and Developmental Disabilities (MRDD)

Despite these large numbers, state prevalence estimates indicate that DMH meets the needs of only 8% of Missourians population with substance abuse disorders (based on adding alcohol and drug dependency prevalence rates together), 12% of persons with mental illness, and 35% of persons with mental retardation/developmental disabilities. (NARI 2008) Accurately assessing unmet (or under met) need is extremely difficult given the complex and fragmented system of care.

There are seven organizations at the Federal level that fund mental health services including the departments of: 1) Health and Human Services; 2) Education; 3) Labor; 4) Agriculture 5) Veterans Affairs 6) Justice and 7) Housing and Urban Development. Seven State agencies are involved including the departments of 1) Mental Health (DMH); 2) Corrections (DOC); 3) Elementary and Secondary (DESE); 4) Social Services (DSS); 5) Health and Senior Services (DHSS); 6) Public Safety (DPS) ; and 7) the Office of State Court Administrators (OSCA).

At the local level, there are public entities (County mental health boards, courts, etc.) and private entities (employers, private foundations, United Way, etc). There are thousands of providers with a vast and wide array of educational backgrounds and expertise. Services are provided across 114 counties and 541 school districts. Organizations have separate and overlapping service areas, different criteria and standards for care and conflicting policy and reimbursement mechanisms. There are varied and often competing interests across stakeholders, and the scarcity of resources challenges stakeholders with a particular passion or interest to adopt a broad view of the issues. As a result, care is organizationally fragmented, creating significant and unnecessary barriers to access.

Toward a Public Health Approach

Moving Missouri toward a public health approach is the overarching theme of the Transformation Initiative. Given the sheer magnitude; multiple causes; widespread stigma and discrimination; and the significant treatment gaps that exist around the world, the World Health Organization (WHO), recommended a public health approach as the most appropriate response to reduce the global burden of disease and disability associated with mental and behavioral disorders (GBD WHO 2000). Echoed in the 1999 United States Surgeon Generals Report on Mental Health and encom passed by Missouri's Comprehensive Mental Health Plan for Children, this approach serves as a solid foundation for creating Missouri's first Comprehensive Mental Health Plan to meet the mental health needs of Missourians across the lifespan.

The public health model provides a continuum of services focusing on an entire population rather than individuals or their separate illnesses and disabilities. The continuum offers services from prevention to treatment and supports. It starts with an assessment of mental health needs, continues through population-
Executive Summary

based research on addressing those needs, and identifies policies and practices that promote wellness. Collective action and cooperative efforts among diverse agencies is required. Individuals, communities, organizations and leaders must collaborate to promote mental health. Mental health must be integrated with the overall health system and considered essential to the overall well-being of Missourians. Missouri emphatically agrees with the NFC that mental health is essential to overall health.

Missouri Transformation—“Creating Communities of Hope”

When the world says, “Give up,”
Hope whispers, "Try it one more time."
~Author Unknown

While there remains much to be learned, the emerging scientific evidence is clear: the knowledge and power exist to significantly improve mental health and reduce the burden of disease and disability throughout the nation and in Missouri. This knowledge serves as grounds for a message of hope. Therefore, Missouri's vision begins with Hope. Hope provides the essential and motivating message of a better future that people can and do overcome the barriers and obstacles that confront them. Although hope is personal and internalized, it can be greatly enhanced by interpersonal relationships with family, friends, neighbors, providers, teachers, employers and others in the community. Thus, Missouri's vision also embraces the Community which provides fuel for hope. A community approach is essential to the public health model. Only the collective will of communities can promote mental health and provide the opportunities and supports necessary for everyone to live, learn, work and participate fully in them. Therefore, transforming Missouri mental health system equates quite simply to Creating Communities of Hope.

From the beginning of Missouri's Transformation planning process, the public has shared their personal vision of a Community of Hope. The range of answers is enlightening and powerful:

- People are viewed as part of the community and not as an outcast or someone who is not capable of living a productive life if given or provided needed services.
- People are recognized as individuals with strengths and abilities first. Professionals listen (really listen) and stop trying to fit people with needs into boxes.
- Government supports treatment that works.

From complex to simple, urban to rural, across mental health population groups and state agencies, these personal Community of Hope visions provide an important foundation for Missouri's transformed mental health system. Missouri's vision serves as a Call to Action to reduce the burden of disability for the estimated 1.3 million Missourians with mental illnesses, addiction disorders and developmental disabilities and those at risk of developing them across the state.

A Thousand Voices—All Walks of Life

“Never tell people how to do things. Tell them what to do and they will surprise you with their ingenuity.” - General George Smith Patton, Jr.

To address the conversion of an entire system takes buy-in from consumers, providers, employees, educators, citizens and leaders from across the system. The process is as important as the product. As one of nine states funded to do so, Missouri built upon the NFC guidance and brought together key leaders and stakeholders from across the state to create a shared vision and framework to truly transform the mental health system. The TWG sought input from all sides of the mental health system so they recruited leaders and experts from all sectors to provide their views and concerns in shaping this effort.

- The TWG chartered six workgroups around the goals of the New Freedom Commission report. More than 240 citizens with specialized expertise from diverse backgrounds volunteered their time and expertise to participate in these workgroups. (Appendix B)
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- The Missouri Institute of Mental Health (MIMH) conducted a Needs Assessment and Inventory of Resources (NARI). MIMH researchers gathered information from a variety of individuals and organizations involved in Missouri's mental health care system including consumers, provider agencies, state agency personnel, other professionals and the general population. Numerous focus groups, key informant interviews and surveys were conducted as part of the needs assessment. A special effort was made to engage persons whose voices were underrepresented through focus group and key informant interviews. The NARI serves as a companion document to this plan. MIMH will distribute this document and it is also posted on the Transformation website. [http://www.dmh.mo.gov/transformation/transformation.htm](http://www.dmh.mo.gov/transformation/transformation.htm)

- Hundreds of Missourians attended 14 public meetings held across the state to discuss the initial recommendations.

Representation and input was gathered from key stakeholders throughout the planning stages. Although every attempt was made to be inclusive of all views, it is acknowledged that there may be perceived gaps in addressing specific interests.

Consumers and Families Lead the Way

Consumer and family input and leadership is at the forefront of this initiative. Consumers and families are the bridge between the mental health system as it exists now and the system as it should be. It is their life and hope for the future at stake. Therefore, their needs, wants, and goals should guide the decision-making process at all system levels. Creating a system that meets their needs fully is the reason for undertaking the difficult and necessary work ahead.

TWG members, mental health advisory councils and advocacy groups, elected officials and mental health system representatives nominated consumer and family members to serve on workgroups. Specific consumer expertise is ensured through contracted staff to provide family and peer leadership and support in planning, implementation and evaluation activities. In addition, there is dedicated staff leadership support from the DMH Office of Consumer Safety. A Consumer and Family Leadership Training was held prior to the commencement of the Transformation content workgroups. [http://www.dmh.mo.gov/transformation/FINALCFYLeadershiptrainingNov2007.pdf](http://www.dmh.mo.gov/transformation/FINALCFYLeadershiptrainingNov2007.pdf) Consumer and family leaders were actively involved in all content workgroups and met following the meetings to discuss workgroup actions, their impact or concerns with the process and related issues. Issues were then communicated back to workgroups to address. Support was available between meetings as needed and requested. MIMH surveyed these leaders as part of the overall Transformation evaluation.

Addressing Complexity

“The problem is that most people will only focus on doing more of the same thing or just try to do the same thing better. They won’t think of a new way to do it.” Consumer Leader

Development of a new and better comprehensive statewide mental health system requires 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. A major challenge facing the TWG involved how to ensure work group participants obtained and used a global perspective to assess Missouri's existing mental health system and use this systems view to guide the Mental Health Transformation efforts. Although participants in each workgroup were familiar with some aspect of mental health, most had only a limited view of the whole system. This was seen as both a consequence of system fragmentation and a barrier to change. Additionally, the TWG wanted to distinguish this planning effort from earlier efforts to re-engineer or change mental health care. They also wanted a way to evaluate recommendations and identify priorities from the perspective of a broad population-based viewpoint. They took several steps to address this:
Executive Summary

- A logic model was developed (Appendix E) to serve as a broad outline and guide. In the model, various inputs (resources, technical assistance, and levers of change) were identified along with actions that influence and support the desired objectives and strategic goals.

- Not only did the Missouri Institute of Mental Health (MIMH) staff conduct the needs assessment and inventory of resources as a companion piece to the Comprehensive Plan, but they also participated in the workgroups from day one. They observed the meeting process as part of their evaluation plus gathered findings and data that emerged during the assessment process. MIMH developed a toolkit to provide relevant data to workgroup members as they developed and analyzed various strategies and actions.

- All workgroup meetings were facilitated by skilled and objective facilitators through the Change and Innovation Agency using a variety of methods to ensure that the various aspects of the system were addressed, common themes and potential overlap across workgroups identified and discussed, and diverse perspectives incorporated.

- A consultant with expertise in systems modeling assisted the workgroups during their initial meetings with a group model building (causal mapping) process based on principles of system dynamics (Appendix C). This model was then integrated across groups and updated as objectives, strategies and actions were identified during the planning process. The model was used to help the TWG and workgroup participants see the larger whole, identify potential leverage points for change, identify potential threats to the implementation and sustainability of recommendations and prioritize actions.

A Common Agenda

“Alone we can do so little; together we can do so much.” -Helen Keller

The diverse stakeholders involved in this planning effort have not historically spoken with one voice. As recommendations emerged there often was disagreement among and between consumers, families, providers, educators, policy makers and others. But as the discussions progressed and differences in language, assumptions and intent were explored and made transparent, it became clear that there are more commonalities than differences regarding mental health issues across the various interest groups. It also became abundantly clear that the people across these diverse populations and sectors have much to learn from each other and much to be gained by working together on a common agenda.

Missouri Transformation- Six Strategic Themes

The common agenda that emerged to achieve the shared vision and move Missouri toward a public health approach resulted in six strategic themes. The Strategic Themes are outlined in Table 1 on the following page. Symbols represent these themes which emerged from the planning and public input process. The strategic themes are explained in Part 1 of the plan according to 1) What is the issue; 2) Where do we need to go in Missouri and 3) How will we know we are successful?

Goals and Objectives

Table 2 summarizes the Missouris Transformation Goals and Objectives. These goals and objectives, like the Strategic Themes, are shared across stakeholders. All are based upon the New Freedom Commission findings and refined for Missouri via the planning and public input process. The Strategic Theme symbols are used in Table 1 to illustrate the relationship and alignment between those themes and the Transformation Goals and Objectives. See Part 2 of the plan for full details.
### TABLE 1: MISSOURI MENTAL HEALTH TRANSFORMATION STRATEGIC THEMES

Creating Communities of Hope

Moving Missouri Toward a Public Health Approach

<table>
<thead>
<tr>
<th>MOVE FROM:</th>
<th>MOVE TO:</th>
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<tbody>
<tr>
<td>CULTURE OF CRISIS/RISK OF HARM</td>
<td>CULTURE OF HOPE/FIRST DO NO HARM</td>
</tr>
<tr>
<td>NO WHERE TO GO</td>
<td>EASY, EARLY AND EQUAL ACCESS</td>
</tr>
<tr>
<td>DISABILITY FOCUS</td>
<td>WELLNESS FOCUS WITH PREVENTION AND EARLY INTERVENTION</td>
</tr>
<tr>
<td>BUREAUCRACY/ PROVIDER DRIVEN CARE</td>
<td>CONSUMER DIRECTION AND EMPOWERMENT</td>
</tr>
<tr>
<td>POCKETS OF EXCELLENCE</td>
<td>UNIVERSAL BEST PRACTICES</td>
</tr>
<tr>
<td>FRAGMENTED &amp; CENTRALIZED SYSTEM</td>
<td>SHARED OWNERSHIP &amp; INVESTMENT (STATE-LOCAL, PUBLIC-PRIVATE)</td>
</tr>
</tbody>
</table>
### TABLE 2: MISSOURI COMPREHENSIVE MENTAL HEALTH PLAN GOALS AND OBJECTIVES

<table>
<thead>
<tr>
<th>GOAL 1: MISSOURIANS UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH</th>
<th>OBJECTIVE 1.1:</th>
<th>INCREASE PUBLIC UNDERSTANDING AND REDUCE STIGMA OF MENTAL ILLNESS, SUBSTANCE ADDICTIONS AND DEVELOPMENTAL DISABILITIES.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL 2: MISSOURI'S MENTAL HEALTH CARE IS CONSUMER AND FAMILY DRIVEN</td>
<td>OBJECTIVE 2.1:</td>
<td>INCREASE CONSUMER DECISION-MAKING AND SELF-DIRECTION OF INDIVIDUALIZED PLANS OF CARE.</td>
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<tr>
<td></td>
<td>OBJECTIVE 2.2:</td>
<td>EXPAND AND INTEGRATE PEER AND FAMILY SUPPORT SERVICES INTO THE SYSTEM OF CARE.</td>
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<td>OBJECTIVE 2.3:</td>
<td>CREATE A CULTURE OF RESPECT, DIGNITY &amp; WELLNESS AS THE MILIEU IN WHICH ALL MENTAL HEALTH SERVICES ARE PROVIDED.</td>
</tr>
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<td></td>
<td>OBJECTIVE 2.4:</td>
<td>INCREASE THE NUMBER OF CONSUMERS FULLY PARTICIPATING IN THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF THE SYSTEM.</td>
</tr>
<tr>
<td>GOAL 3: MENTAL HEALTH DISPARITIES ARE ELIMINATED IN MISSOURI</td>
<td>OBJECTIVE 3.1:</td>
<td>IMPROVE ACCESS TO QUALITY CARE IN RURAL AND GEOGRAPHICALLY REMOTE AREAS.</td>
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<td></td>
<td>OBJECTIVE 3.2:</td>
<td>IMPROVE ACCESS TO CULTURALLY COMPETENT CARE</td>
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<td></td>
<td>OBJECTIVE 3.3:</td>
<td>INCREASE CONSUMER ACCESS TO PROGRESSIVE EMPLOYMENT OPPORTUNITIES IN INTEGRATED COMMUNITY SETTINGS.</td>
</tr>
<tr>
<td></td>
<td>OBJECTIVE 3.4:</td>
<td>INCREASE CONSUMER ACCESS TO SAFE AND AFFORDABLE HOUSING IN INTEGRATED COMMUNITY SETTINGS.</td>
</tr>
<tr>
<td>GOAL 4: EARLY MENTAL HEALTH SCREENING, ASSESSMENT AND REFERRAL TO SERVICES ARE COMMON PRACTICE IN MISSOURI</td>
<td>OBJECTIVE 4.1:</td>
<td>PROVIDE TIMELY OUTREACH, SCREENING AND REFERRAL TO CARE THAT IS AGE AND CULTURALLY APPROPRIATE.</td>
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<td></td>
<td>OBJECTIVE 4.2:</td>
<td>PROVIDE MENTAL HEALTH CONSULTATION AND SERVICES IN EARLY CHILDHOOD AND SCHOOL SETTINGS.</td>
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<td></td>
<td>OBJECTIVE 4.3:</td>
<td>EXPAND COMMUNITY CAPACITY TO REDUCE AVOIDABLE USE OF EMERGENCY ROOMS, HOSPITALS AND OTHER INSTITUTIONAL CARE.</td>
</tr>
<tr>
<td>GOAL 5: EXCELLENT MENTAL HEALTH CARE IS DELIVERED AND RESEARCH IS ACCELERATED</td>
<td>OBJECTIVE 5.1:</td>
<td>DEVELOP THE MENTAL HEALTH WORKFORCE</td>
</tr>
<tr>
<td></td>
<td>OBJECTIVE 5.2:</td>
<td>EXPAND EVIDENCE-BASED PRACTICES (EBPs) ACROSS THE STATE.</td>
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<tr>
<td></td>
<td>OBJECTIVE 5.3:</td>
<td>APPLY RESEARCH EVIDENCE MORE QUICKLY AND INVEST IN RESEARCH FOR NEW AND PROMISING PRACTICES.</td>
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<td></td>
<td>OBJECTIVE 5.4:</td>
<td>DEVELOP A COMPREHENSIVE QUALITY MANAGEMENT SYSTEM.</td>
</tr>
<tr>
<td>GOAL 6: MISSOURI COMMUNITIES ARE PROFICIENT IN MEETING LOCAL MENTAL HEALTH NEEDS</td>
<td>OBJECTIVE 6.1:</td>
<td>CREATE CONSISTENT &amp; FLEXIBLE POLICY/PRACTICES ACROSS STATE AGENCIES THAT ARE INFORMED BY CONSUMERS &amp; LOCAL NEEDS.</td>
</tr>
<tr>
<td></td>
<td>OBJECTIVE 6.2:</td>
<td>CREATE AND/OR EXPAND LOCAL PUBLIC-PRIVATE COLLABORATIVES TO IMPROVE SERVICE ACCESS, CAPACITY AND INTEGRATION.</td>
</tr>
<tr>
<td></td>
<td>OBJECTIVE 6.3:</td>
<td>EXPAND THE ROLE AND CAPACITY OF COMMUNITIES TO IDENTIFY THEIR NEEDS, PROMOTE MENTAL HEALTH &amp; CREATE OPPORTUNITIES FOR CONSUMER INCLUSION.</td>
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</tbody>
</table>
Executive Summary

Priority Actions

The TWG priorities were shaped throughout the planning and public input process. Part 3 of this plan provides a detailed review of the 2008 priority actions. Although numerous actions have been identified to address the multiple goals and objectives, the TWG prioritized actions to accomplish the following:

**Build the Foundation for Hope**
- Reduce stigma and increase public understanding
- Promote wellness and integrate mental health and public/primary health practices to address the holistic needs of Missourians.
- Establish a system-wide individual planning process that emphasizes the consumers and families as decision-makers.
- Expand and integrate peer and family support services into the mental health system.
- Increase the voice of consumers and families in mental health policy decisions and actively develop and support new leaders.

**Balanced Capacity Building**
- Identify the true level of unmet need in the state and build local capacity for easy, early and equal access to care. This includes the provision of equitable mental health benefits and equal access to culturally appropriate services.
- Implement a balanced portfolio approach to incrementally expand evidence-based prevention, treatment and support services, apply research evidence more quickly and invest in research for new and promising practices.
- Increase the capacity of local communities to assess and meet local needs and support full community inclusion. This includes coordinating and integrating local services and expanding educational, employment and housing opportunities in integrated settings.
- Establish an enduring structure to integrate & coordinate mental health policy and administrative practices across state departments/agencies to meet the needs of Missourians.

**Sustaining Momentum and Change**

*Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.*

Margaret Mead

True transformation requires changing the underlying infrastructure and the culture of the mental health system. Responsibility for mental health treatment service will never be the sole domain of a single entity. Public mental health must form partnerships with local government, communities, the private sector and ultimately secure ownership by Missourians statewide. This plan provides the initial roadmap for such action.
Key Concepts

Every effort has been made to ensure this plan reflects the input of hundreds of Missourians who volunteered to create this comprehensive vision of Missouri’s mental health future. It is challenging to capture the passion and commitment of these leaders and key stakeholders involved in transforming Missouri’s mental health system within a document designed as a roadmap for action. Since this document is compiled from several sources and edited into one voice, it may not be perfect, but it is certainly heartfelt. While attempting to be 100% current in the content provided, it is acknowledged that once published, this document will be outdated due to the inevitable changes in the state and federal economy, advances in science and technology, political climate, and other realities that impact Missouri’s mental health system. What is provided is the snapshot of Missouri as of March 2008. Key sections such as Part 4, Action Plan will be updated annually and posted online to reflect current priorities. As the reader explores the content, please keep the following in mind:

- It is a challenge to be broad and inclusive while being concise and precise in summarizing hours of research and discussion into a Comprehensive Plan. Missouri is a complex and diverse community of people who identify with one or more special populations or interests. Throughout the planning process, the goal has been to be inclusive, not exclusive and to identify and address gaps.

- Terminology is a challenge so a glossary of terms and acronyms is provided as Appendix D. The glossary has terms and acronyms from this Comprehensive Plan and the Needs Assessment and Resource Inventory (NARI), a companion piece that is a separate publication. Not all terms are defined so only the acronym is provided. Where applicable, the source of the definition is provided. There continues to remain a lack of consensus on terms that are broadly applicable and acceptable to all persons in the field. The plan uses people first language as a rule of thumb. However, it is recognized that many of the terms used within this document are imprecise and imperfect. Two terminology examples worth noting include:
  - The plan uses the terms mental disorders or mental and behavioral disorders interchangeably to refer to developmental disabilities, mental illnesses, emotional disorders and substance and other addiction disorders.
  - The term consumer in this document refers to persons of all ages and population groups as well as families/guardians. In addition, it is inclusive to persons accessing services of any of the three Department of Mental Health (DMH) divisions [Alcohol and Drug Abuse (ADA), Comprehensive Psychiatric Services (CPS) and Mental Retardation and Developmental Disabilities (MRDD)] as well as individuals receiving mental health care from other state agencies or service providers.

In addition, there is a link to the Glossary at the beginning of each section of the electronic version of the plan. For those reading a hard copy of this document, the Glossary appears at the end of the publication.

- Symbols are used to simplify the relationship between the six Strategic Themes that emerged from the planning and public input process and their alignment with the Transformation Goals and Objectives. The Strategic Themes are outlined in Table 1 and the Goals and Objectives can be found in Table 2 in the executive Summary.

- Missouri’s vision to create Communities of Hope is at the forefront of the Missouri Transformation Initiative. Therefore, Community of Hope quotes are used in Part 3: Goals & Objectives of the plan to illustrate how the Goals and Objectives can make a difference.
Plan Organization and Format

Missouri’s plan is organized into the following sections. As relevant, sections will be updated throughout implementation to ensure timely information is captured and shared.

- **Executive Summary.** This section provides highlights of the overall plan.
- **How to Read this Document.** Tips to guide the reader through the comprehensive plan which attempts to cover a complex topic in a direct and concrete format.
- **Part 1: Vision & Strategic Direction.** Provides an overview of the public health approach and exploration of each of the six strategic themes. The strategic themes are addressed according to 1) What is the issue; 2) Where do we need to go in Missouri and 3) How will we know we are successful?
- **Part 2: Goals & Objectives.** Missouri’s Six Goals are aligned with the President’s New Freedom Commission findings and have one or more objectives. Each objective provides Core Strategies. The goals, objectives and strategies are compiled from the recommendations and input of the content workgroups, TWG and public meetings.
- **Part 3: Action Plan.** Presents the 2008 priority actions and the Transformation objectives addressed by each action; the responsible party; Accountability, Capacity, and Effectiveness or ACE GOALS the Government Performance Act of 1993 or GPRA measures (both are mandated by SAMHSA as part of the evaluation of this project); complexity of implementation; timeline, and the target populations and age groups addressed by the action.
- **Part 4: Governance.** Identifies key leadership entities, provides a table of the Transformation Governance Structure and addresses sustainability.
- **References and Links.** Research cited within the plan is listed here. Links are provided to relevant reports, presentations and websites.
- **Appendices.** Additional material mentioned within the plan as follows:
  - Appendix A: Transformation Working Group Membership Roster
  - Appendix B: Transformation Workgroups and Membership
  - Appendix C: Causal Mapping
  - Appendix D: Glossary of Terms and Acronyms
  - Appendix E: Logic Model

**Needs Assessment and Resource Inventory**

As part of the implementation of the Comprehensive Plan, the Missouri Institute of Mental Health (MIMH) created the NARI to be used as a companion document. MIMH researchers gathered information from a variety of individuals and organizations to identify the greatest mental health care needs and what changes could be made to the mental health care system to better meet those needs. In addition to the needs assessment, MIMH compiled an inventory of current state-level mental health care available to meet the needs of Missourians with mental illness. The NARI identifies resources from state departments involved in the provision of mental health care. MIMH will distribute this document and it is also posted on the Transformation website. [http://www.dmh.mo.gov/transformation/transformation.htm](http://www.dmh.mo.gov/transformation/transformation.htm) In subsequent years, a NARI supplemental report with a more in-depth review of mental health needs and existing resources will be provided.
Part 1: Vision and Strategic Direction

Introduction: The Impact of Mental Health Problems on Society

Of the approximate 5.8 million people who live in Missouri, it is estimated that **10.5% suffer from either serious psychological or emotional distress**, **11% are alcohol dependent**, **3% are drug dependent** and **1.5% experience mental retardation or a developmental disability** (NARI 2008). Given this prevalence, it is not surprising that there is an enormous emotional and financial burden on individuals, their families and society as a whole. The economic impact of these problems affect personal income - the ability of ill persons, and often their caregivers - to work, productivity in the workplace, and contributions to the national economy. Unfortunately, the impact of these problems on health and productivity is substantial and has long been underestimated. In the landmark *Global Burden of Disease* study and project, the World Health Organization (WHO GBD 1990; 2000) developed a single measure called Disability Adjusted Life Years (DALYs) to allow for a comparison of the burden of disease across many different health conditions. DALYs measure lost years of healthy life regardless of whether the years were lost to premature death or disability. The study found that the impact of mental disorders on health and productivity in the United States is vast. This data revealed that mental illness, including suicide, accounts for over 15% of the burden of disease in established market economies such as the United States. This is more than the disease burden caused by all cancers. For society, the cost of untreated mental illness is more than 100 billion dollars each year in the United States alone. Moreover, there is strong evidence that mental disorders impose a range of consequences on the course and outcome of co-morbid chronic conditions, such as cancer, heart disease, diabetes and HIV/AIDS. [http://www.who.int/mental_health/policy/en/Country%20activities%20table%20of%20contents.pdf](http://www.who.int/mental_health/policy/en/Country%20activities%20table%20of%20contents.pdf)

*Alcohol use accounts for 4.7% and drug use 1.5% of the burden of disease.* While estimates are not available for the full range of developmental disabilities or their risk factors, attempts have been made to estimate the burden associated with specific causes. For example, it is estimated that nearly 1% percent of the global burden of disease is due to a relatively minor form of Learning and Developmental Disabilities, namely, mild mental retardation (MR) caused by lead ingestion from environmental sources (Fewtrell and others 2004). Since only a small fraction probably much less than 10% of learning and developmental disabilities worldwide can be attributed to lead-induced mild MR, this estimate suggests that learning and developmental disabilities as a whole must account for a large proportion, perhaps more than 10% of the global burden of disease. (Disease Control Priorities Related to Mental, Neurological, Developmental and Substance Abuse Disorders, WHO 2006)

Reducing the avoidable personal and economic costs associated with these conditions is central to meeting the twin challenges of promoting affordable health care and fostering continued economic growth. The health of Missouri citizens and the economy depend on the ability to focus efforts to reduce the burden of disease. In the absence of concerted efforts to prevent, diagnose, and better manage and treat chronic disease, the state will needlessly bear higher socioeconomic costs over time. Many of these costs can be avoided through prevention, early intervention and effective treatment and supportive services. For example, although the average annual costs, including medical, pharmaceutical and disability costs, for employees with depression may be 4.2 times higher than those incurred by a typical beneficiary, the cost of treatment is often completely offset by a reduction in the number of days of absenteeism and productivity lost while at work. [http://www.who.int/mental_health/media/investing_mnh.pdf](http://www.who.int/mental_health/media/investing_mnh.pdf)
Missouri’s Vision of a Transformed Mental Health System

Missouri’s vision of a transformed mental health system is a Call to Action to reduce the burden of disability for the estimated 1.3 million Missourians with mental illnesses, addiction disorders and developmental disabilities and those at risk of developing them across the state. It is first and foremost about Hope. Hope provides the essential and motivating message of a better future that people can and do overcome the barriers and obstacles that confront them. It is now known that biological, psychological and social factors intertwine to impact the development and progression of mental and behavioral disorders. While there remains much to be learned, the emerging scientific evidence is clear: the knowledge and power exist to significantly improve mental health and reduce the burden of disease and disability associated with these disorders throughout the state. This knowledge serves as grounds for a message of hope. Hope is the catalyst for both personal and system transformation. Although hope is personal and internalized, it can be greatly enhanced by interpersonal relationships with family, friends, neighbors, providers, teachers, employers and others in the community. Thus, Missouri’s vision also embraces the community, which provides fuel for hope. Only the collective will of communities can promote mental health and provide the opportunities and supports necessary for everyone to live, learn, work and participate fully in them. Therefore, transforming Missouri’s mental health system equates quite simply to Creating Communities of Hope.

From the beginning of Missouri’s Transformation planning process, the public has shared their personal visions of a Community of Hope. To date, hundreds of comments have been submitted, reviewed, and used to inform the planning and implementation strategies. The range of answers is enlightening and powerful:

- People are viewed as part of the community and not as an outcast or someone who is not capable of living a productive life if given or provided needed services.
- People are recognized as individuals with strengths and abilities first. Professionals listen (really listen) and stop trying to fit people with needs into boxes.
- The public is educated about mental illness and there is no stigma. People see me as having a purpose in life, intelligent enough to work, capable of responsibility.
- Government supports treatment that works.

From complex to simple, urban to rural, across mental health population groups and state agencies, these personal Community of Hope visions provide an important foundation for Missouri’s transformed mental health system.

Toward a Public Health Approach

Given the sheer magnitude; multiple causes; widespread stigma and discrimination; and the significant treatment gaps that exist around the world, the World Health Organization (WHO), recommends a public health approach as the most appropriate response to reduce the global burden of disease and disability associated with mental and behavioral disorders. Echoed in the United States Surgeon General’s Report on Mental Health and encompassed by Missouri’s Comprehensive Mental Health Plan for...
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Children, this approach serves as a solid foundation for creating Missouri's first Comprehensive Mental Health Plan to meet the mental health needs of Missourians across the lifespan.

The public health model provides a continuum of services focusing on an entire population rather than individuals or their separate illnesses and disabilities. The continuum offers services from prevention to treatment and supports. It starts with an assessment of mental health needs, continues through population-based research on addressing those needs, and identifies policies and practices that promote wellness. Collective action and cooperative efforts among diverse agencies is required. Individuals, communities, organizations and leaders must collaborate to promote mental health. The public health model uses the community to establish a comprehensive mental health services system. Mental health is integrated with the overall health system and considered essential to the overall well-being of Missourians.

According to the Centers for Disease Control (CDC), there are 10 Essential Public Health Services to be included at the local, state and governance level. (http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm) Table 3 adapts these to Missouri's mental health system and outlines the essential services.

From a public health perspective, the WHO found that there is much to be accomplished in reducing the burden of mental disorders:

- Formulating policies designed to improve the mental health of populations;
- Assuring universal access to appropriate and cost-effective services, including mental health promotion and prevention services;
- Ensuring adequate care and protection of human rights for institutionalized persons with most severe mental disorders;
- Assessment and monitoring of the mental health of communities, including vulnerable populations such as children, women and the elderly;
- Promoting healthy lifestyles and reducing risk factors for mental and behavioral disorders, such as unstable family environments, abuse and civil unrest;
- Supporting stable family life, social cohesion and human development;
- Enhancing research into the causes of mental and behavioral disorders, the development of effective treatments, and the monitoring and evaluation of mental health systems.

Using a public health approach can also overcome the divisions between mental health and other health care where professionals fail to consider the areas of health outside their narrowly focused

| Essential Service #1: Monitor Health Status to Identify Community Mental Health Problems |
| Essential Service #2: Diagnose and Investigate Mental Health Problems and Mental Health Hazards in the Community |
| Essential Service #3: Inform, Educate and Empower People about Mental Health Issues |
| Essential Service #4: Mobilize Community Partnerships to Identify and Solve Mental Health Problems |
| Essential Service #5: Develop Policies and Plans that Support Individual and Community Mental Health Efforts |
| Essential Service #6: Enforce Laws and Regulations that Protect Mental Health and Ensure Safety |
| Essential Service #7: Link People to Needed Personal Mental Health Services and Assure the Provision of Mental Health Care when Otherwise Unavailable |
| Essential Service #8: Assure a Competent Public and Personal Mental Health Care Workforce |
| Essential Service #9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Mental Health Services |
| Essential Service #10: Research for New Insights and Innovative Solutions to Mental Health Problems |
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responsibility. SAMHSA administrator Terry Cline, Ph.D. endorses this public health approach. "If you have a relationship with a person and are already providing care, it’s a great opportunity to expand care elsewhere," Cline said about the comprehensive approach he advocates. "We’ve seen it work for other illness categories, and we know it works with mental illness." (Psychiatric News July 20, 2007 Volume 42, Number 14, page 14)

To create Communities of Hope and move the state toward a public health approach, Missouri must fundamentally transform the way the entire system thinks and operates today. Table 1 depicts the overarching strategic themes that emerged through the planning and public input process to transform the mental health system in Missouri. The following pages explore each theme.

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TRANSFORMING FROM A CULTURE OF CRISIS TO A CULTURE OF HOPE

What is the Issue?

Missouri’s mental health system should instill hope in those seeking care. Inspiration comes from the medical field where the care philosophy often credited to Hypocrates has been passed down for centuries to physicians: “As to diseases, make a habit of two things -- to help, or at least, to do no harm. Unfortunately, many Missourians have had painful experiences with the mental health system. Such experiences often cause harm, hardship, and the erosion of trust and hope. The Needs Assessment and Resource Inventory (NARI) identified key safety issues (Table 4).

For example, although many medical errors are preventable, the Institute of Medicine report, “To Err is Human, Building a Safer Health System” identified that deaths attributed to preventable medical errors in hospitals exceed those attributable to threats from motor-vehicle wrecks, breast cancer, and AIDS. One of the report’s main conclusions is that the majority of medical errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them. Thus mistakes can best be prevented by designing the health system at all levels to make it safer, to make it harder for people to do something wrong, and easier for them to do it right.

Additionally, people with disabilities, particularly those with intellectual disabilities, remain disproportionately at high risk for violent victimization, abuse and neglect. People who provide care and support to individuals with disabilities, such as relatives and other caregivers, at times do not have access to the training, tools or resources available to carry out their duties effectively. Sadly, the stress created by the situation too often results in these same caregivers victimizing those for whom they care. Missouri’s media have highlighted this issue recently in DMH facilities.

Trauma research reveals that many individuals with mental health, substance abuse and developmental disabilities may have already experienced a traumatic event (i.e. child abuse, sexual assault, military combat, domestic violence) prior to seeking help which compounds the above issues. The NARI summarizes that nationally, the majority of adults in psychiatric hospitals diagnosed with major mental illnesses have experienced physical and/or sexual abuse in their lives. Most of these individuals experienced the abuse as children. In Missouri, of the clients seeking residential and outpatient substance abuse treatment, 64% of women and 16% of men reported being physically or sexually abused. As indicated earlier, persons with intellectual disabilities are at disproportionately higher risk for abuse and neglect. The scope of psychological trauma is pervasive. When psychological trauma is not recognized or addressed, people may be unintentionally re-traumatized by the agencies and providers serving them. Consider the use of seclusion and restraint in mental health inpatient and residential settings. It creates significant risks for adults and children — risks that not only include serious injury or death, but also re-traumatization.
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(NASMHPD NTAC 2005; Smith et al 2005; Jonikas et al 2005). Frequently, the mental health workforce fails to recognize or address the serious psychological impacts of unresolved trauma in the lives of the consumers in the mental health system. These issues can be exacerbated for people receiving care in non-mental health settings such as nursing homes, prison wards, etc. where staff may not only lack knowledge about trauma but about mental health as well.

Not only are systems of care frequently unsafe for consumers, but also they may be unsafe for the staff. U.S. Bureau of Labor Statistics data show that in 2000, 48% of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services. After law enforcement, persons employed in mental health settings have the highest rates of all occupations of being injured while on duty. Physical safety is not the only concern. In “Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation,” Sandra Bloom, M.D., states that “our helping systems are chronically stressed.” Dr. Bloom explains that the national mental health system has experienced what she calls collective systemic trauma. This is due to the numerous changes over the last 20 years as institutions downsized and community mental health systems decreased their scope of service. She suggests that these changes resulted in a significantly heightened level of individual and organizational psychological stress for the programs struggling to respond to their clients needs.

Where do we need to go in Missouri?

First do no harm is the starting point in transforming the mental health system to ultimately create a culture of hope for those in care and their caregivers. From the public health perspective, the essential services most relevant to this include:

- Enforce laws and regulations that protect health and ensure safety.
- Ensure a competent public and personal mental health care workforce.
- Evaluate effectiveness, accessibility, and quality of personal and population-based mental health services.

Recently, Missouri made great strides in addressing safety issues (identified within the NARI and illustrated in Table 5) and continues to build upon these transformative successes. For example, serious safety issues were identified within DMH in 2006. Gov. Blunt swiftly established a Mental Health Task Force (MHTF) to investigate and identify recommendations for a safer mental health system. Senate Bill 3 was introduced to improve safety measures and ensure appropriate, consistent penalties for violators. The MHTF and state legislatures efforts included multiple stakeholder perspectives and solution-oriented discussions. This resulted in sound actions for implementation and also launched the psychological healing process necessary for the people who had been impacted by the systems flaws. The development and endorsement of a safer mental health system moves Missouri closer to a culture of hope.

To create Communities of Hope, Missouri must begin by inspiring hope in the settings where care is delivered. Among the challenges faced by mental health providers is the lack of adequate mental health services and training for staff. To address this, Missouri has made significant progress in addressing safety problems. This progress is documented in the DMH Safety Report.

Table 5: Highlights—Missouri Successes and Strategic Developments

- In 2006, Governor Blunt appointed the Mental Health Task Force (MHTF) to investigate safety concerns. The MHTF issued a final report in November 2006 and incorporated recommendations from Missouri’s Mental Health Commission developed earlier that same year.
- Senate Bill 3, the Mental Health Reform Bill, incorporated many of the key recommendations offered by the MHTF that required legislative changes. Missouri has made significant progress in addressing safety problems. This progress is documented in the DMH Safety Report.
- The DMH has a Trauma Position Statement and has also identified necessary staff core and specialty competency requirements.
- To address preventable medication errors, the Governor's recommended FY09 budget includes proposed funding for electronic applications including bar-coding to improve medication administration-accuracy in DMH hospitals.
- The Fulton State Hospital implemented an organization wide initiative Focus on Safety: Building a Culture of Partnership & Recovery through a three-year SAMHSA grant on seclusion and restraint.
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health and other caregivers is to maintain compassion and respect for, and inspire hope in, every person to whom they provide services. Thus, Missouri must accelerate efforts to promote caring employees who feel supported in their jobs, who possess the skills and tools necessary to work with consumers, who are fairly compensated, and who have a passion for their work. Additionally, the mental health system must monitor and manage the risks associated with the care it delivers. Full use of available technology should support workers in providing safe and effective care. A disciplined approach to monitoring, analyzing data and responding to crises must occur. Underlying causes must be examined and appropriate information shared to engage workers in proactive systemic transformation.

To support such efforts, Missouri must promote a trauma-informed system across all human service agencies. Given the prevalence of trauma among consumers, and the history of abuse and neglect, Missouri's treatment systems should assume that all clients may be trauma survivors and treat them accordingly. A trauma informed system provides services that accommodate the vulnerabilities of trauma survivors. Services are delivered in a way that avoids inadvertently re-traumatizing individuals and facilitates consumer participation in care. It also requires, to the extent possible, close collaborative relationships between public sector service systems serving these clients and the local network of private practitioners with specialized clinical expertise in the treatment of trauma. Administrators must also be trauma sensitive regarding how past and present experiences impact individual attitudes, leadership styles, and group performance within organizations. A system cannot be truly trauma-informed unless the system can create and sustain a process of understanding itself. Missouri must continue to engage in broad-based solution-oriented dialogue that incorporates the perspectives of multiple stakeholders to address these complex issues.

How will we know we are successful?

In a transformed system consumers and families feel safe in seeking the help they need and their first encounter with the service system instills hope. Care is provided in safe, secure and therapeutic environments. Caregivers maintain compassion and respect for, and inspire hope in, every person to whom they provide services. Staff possess the skills and resources to perform their jobs safely, reducing the risk of both physical and psychological harm to themselves and those entrusted to their care. Workers are supported by caring, competent supervisors and managers who establish effective policies and systems to monitor, manage and reduce risk. Quality improvement promotes organizational and individual learning and systemic solutions to address the root causes of problems. Staff and consumers are actively engaged in activities that promote healing and hope.
What is the Issue?

Although Missouri's safety priority for those receiving mental health services is paramount as indicated in the first theme, a concordant mantra across Missouri is that “there is no where to go.” Currently, there is an unhealthy tension between demand and supply of mental health services. Providers often say no to those in need to maintain a safety and quality balance for those already in care. Key issues related to accessing care are detailed in the NARI and depicted in Table 6. Sadly, the quality vs. quantity dilemma has resulted in a system of care where a person literally needs to hit rock bottom before getting help. This is evidenced by the long waiting lists and the increasing demand placed on emergency rooms and institutional care settings, including those not designed for mental health services such as jails and prisons. Missouri's lack of service capacity perpetuates a culture of crisis with broad implications not just for the safety of people in care but also for those who are seeking it. Further, consumers in the system are afraid to leave it for fear of being unable to get back in if they need to return.

Geographic and cultural disparities compound the crisis for many citizens. The NARI documents the rural nature of the state and the multitude of cultural and age groups residing here. Not surprisingly, 89% of Missouri's 114 counties are considered mental health professional shortage areas. Although mental health needs are relatively similar across cultures and geography, problems of accessibility, acceptability and availability cause many consumers to enter into treatment at later stages of their illness.

Unfortunately, research shows that any delay in accessing care has damaging results. The National Co-morbidity Survey Replication (NCS-R, NIMH2005) study documents that the pervasive delays in getting services tend to occur for nearly all mental disorders. Unlike most disabling physical diseases, mental disorders often begin very early in life. Half of all lifetime cases begin by age 14; three quarters have begun by age 24. While approximately 80% of persons with a mental disorder in the United States eventually seek treatment, there are public health implications from long treatment delays. Early-onset, untreated mental disorders are associated with school failure, teenage childbearing, unstable employment, early marriage, marital instability and violence. Untreated psychiatric and substance use disorders at any age can lead to more frequent and severe episodes, and are more likely to become resistant to treatment. These statistics have far-reaching implications as they suggest that people may end up requiring a higher level of public supports and services across human service agencies and more intensive mental health services than would be needed had they received appropriate intervention early. A lack of affordable services and a fragmented financing system were cited in the NARI as key issues related to insufficient service capacity. A lack of specialty mental health service providers was also cited as a key issue. Also, though primary care was found to be a major setting for the potential recognition of mental
health needs especially for children, adolescents and the elderly; trained staff, adequate reimbursement and options for referral to specialty care are limited.

Along with accessing care, consumers and families face multiple barriers to accessing services and supports needed to successfully live, learn, work and participate fully in the community. A good education has long been recognized as one of the most significant predictors of success in later life. However, the Centers for Disease Control (CDC) estimate that 5% of children have mental health issues significant enough to interfere with learning. (Missouri Comprehensive Children’s Mental Health Plan, December 2004) Most schools have neither the expertise nor resources to address these needs. This not only impacts potential educational success for those needing mental health supports, but also detracts from educational resources for other students.

Additionally, the New Freedom Commission found that undetected, untreated, and poorly treated mental disorders interrupt careers, leading many into lives of disability, poverty, and long-term dependence. Although people want to work and can work with modest assistance, people with mental disabilities (mental illness and developmental disabilities) have the worse level of employment of any group of people with disabilities. Understandably, they also have the highest rate of poverty than any other disability group (Houtenville 2006 Disability Status Report) making it extremely difficult to afford services. Transportation, employer perceptions, lack of employment supports, and fear of losing public medical benefits and access to public housing contribute to employment difficulties.

Affordable housing and residential treatment alternatives are also quite limited and poorly distributed across the state. Persons with mental disorders are disproportionately represented in the homeless population in Missouri. Stable, safe, quality and affordable permanent housing is a key to successful community living. However people typically cannot afford to buy or rent housing, even with financial help from existing government housing assistance, given the gap between the level of income support received and the prevailing housing market rates.

**Where do we need to go in Missouri?**

Transforming the mental health system to one that promotes easy, early and equal access is a daunting task given the large number of people uninsured and underinsured. Due to resource constraints, many agencies screen out all but those in the most serious need. From a public health perspective the essential services most relevant to this issue include:

- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Mental Health Services
- Diagnose and Investigate Mental Health Problems and Mental Health Hazards in the Community
- Link People to Needed Personal Mental Health Services and Assure the Provision of Mental Health Care when Otherwise Unavailable

### Table 7: Highlights—Missouri Successes and Strategic Developments

- **SB1003/Custody Diversion Protocol** eliminates the need for Missouri families to give up legal custody of their children just to access mental health care.
- In September 2007, Governor Matt Blunt proposed the **Insure Missouri** health care plan to help nearly 200,000 of Missouri’s lower income, uninsured workers buy health insurance.
- **Missouri** has had 23 Shelter Plus Care Grants awarded to the State.
- **Blue Ribbon Panel on Autism** issued a comprehensive set of recommendations to improve services for persons impacted by autism.
- **Chief Justice initiative on Mental Illness** is leading the state to create effective diversion and reentry strategies from the legal system for persons with mental illnesses.
- **The Money Follows the Person Rebalancing Demonstration** will enable individuals living in facilities to transition to communities with supports and services from the Divisions of Senior and Disability Services (DSS) and MRDD (DMH).
- **FYO8 budget increased funding to MRDD to reduce the Divisions waiting list.**
- With support from the Department of Elementary and Secondary Education, many local Missouri schools have implemented the **Positive Behaviors Supports (PBS) model.**
- **ADA Access to Recovery Initiative**—SAMHSA awarded second 3-year funding to DMH ADA to engage faith-based and non-traditional community providers in delivering, ensuring client free choice of, and improving client access to substances abuse treatment and recovery support services.
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Missouri’s progress and recent accomplishments are highlighted in Table 7. For example, the ground-breaking passage of Senate Bill 1003 eliminated the need for Missouri families to give up legal custody of their children just to access mental health care. Missouri’s Blue Ribbon Panel on Autism recently issued recommendations to create a comprehensive system of care for persons and their families impacted by autism and the Governors FY09 budget proposal includes funding to increase autism treatment services. Currently, the Governor is promoting *Insure Missouri* to extend health and mental health care coverage for up to 200,000 of Missouri’s uninsured workers.

These and other initiatives begin to move the system to one where easy, early and equal access to care is the norm rather than the exception. Diversion actions similar to the SB 1003 custody diversion provisions need to be expanded to other systems and populations. Specific examples include the juvenile and adult justice systems that, although mandated to provide care, are often ill-equipped to offer effective mental health services. Service capacity must be increased and a broader array of effective community-based services offered to promote early intervention and reduce the need for potentially unnecessary and expensive institutional care. Strategies to improve the effectiveness and efficiency of the system must be implemented in conjunction with new funding for services that will have the most significant impact. Missouri must build upon the current NARI to identify and address gaps in care including those directly tied to culture and geography.

For young persons, the early childhood and school settings offer an excellent opportunity to intervene. Although mental health services are offered in some schools, Missouri needs to establish a comprehensive, consistent statewide program. Other access points need to be considered as well. As the primary care physician is often the first point of contact, training and collaborative partnerships need to be established to provide needed mental health care or referral. Also, community service and support options must be developed including employment, housing and transportation opportunities that enable people to become more self-sufficient. Finally, procedures and processes must be developed to allow consumers to quickly re-enter the system and access the broader array of services when needed.

How will we know we are successful?

In a transformed system, the early detection of mental health needs is common practice and mental health screenings are accepted, routine components of physical exams. Early intervention occurs in low-stigma settings such as schools and primary care offices as well as high-risk settings such as the justice and child welfare systems. No individual has to enter the justice or protective services system just to access the care they need. Missourians can enter the system with ease and exit the system without fear of losing needed services and supports. All Missourians share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location. A qualified workforce is available to meet the needs of consumers statewide. Children thrive in schools, adults thrive at work and persons of all ages have access to the opportunities to live, learn, work, and participate fully in their community.
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TRANSFORMING FROM A DISABILITY FOCUS TO A FOCUS ON WELLNESS WITH PREVENTION AND EARLY INTERVENTION

What is the Issue?

The current unhealthy tension that exists between quality vs. quantity discussed in the first two strategic themes apply to people actively seeking or already in care. However, little focus has been given to mental health promotion and illness prevention, cornerstones of the public health model, which can help to alleviate this systemic stress. Michael Hogan, Ph.D., Chair of the New Freedom Commission, stated in a July 23, 2003 interview in the Washington Post that, *We have an 'unintended conspiracy' to keep people disabled.* Unfortunately, this unintended conspiracy has broader implications. Although the barriers to accessing care once people want it are daunting, people nationwide avoid accessing care until symptoms are debilitating and disabling. Thus, the system is designed to not just keep people disabled but often promotes them to become disabled prior to ever seeking help. The system focus downstream vs. upstream actually places more demand on the system than would otherwise be necessary. Key issues identified in the NARI are outlined in Table 8.

Missouri currently dedicates few resources specific to mental health promotion and prevention. For example, state eligibility criteria typically require a particular diagnosis to receive services coupled with criteria that requires a person to demonstrate an inability to carry out daily life functions in one or more areas. **Sadly, the mental health system stands in stark contrast to the public health system that focuses on health education, promotion and regular wellness check-ups.** The current approach is costly, in terms of both human and financial capital.

Unfortunately, the lack of public health literacy related to mental health impedes promotion and prevention. The literature suggests that laypeople have a poor understanding of mental disorders as well as the effectiveness and availability of various treatments and supports. The 2004 U.S. Institute of Medicine (IOM) report titled *“Health Literacy-A Prescription to End Confusion”* indicates that people with limited health literacy tend to have poorer health, are less likely to use preventative services, have less knowledge of health promoting behaviors, and are less able to manage disease. The prevalence of mental disorders means that most Missourians eventually have contact with someone with a mental health problem, but often lack the knowledge to accurately recognize the problem and provide helpful resources. The inability to recognize a disorder in oneself or others could result in delays seeking appropriate treatment, utilization of inappropriate remedies, or difficulties communicating with health professionals.

Stigma and discrimination pose even greater barriers. **Stigma has been identified as the most formidable obstacle to future progress in the arena of mental health.** The 1999 Surgeon Generals Report described the impact as follows: *“Stigma erodes confidence that mental disorders are valid, treatable health conditions. It leads people to avoid socializing, employing or working with, or renting to..."*

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“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)

Table 8: Key Issues identified in NARI:

- Lack of Prevention
- Poor Mental Health Literacy
- Stigma & Discrimination
- Lack of Integration between Mental Health and Physical Health Care
or living near persons who have a mental disorder. Further, stigma deters the public from wanting to pay for care and, thus, reduces consumers’ access to resources and opportunities for treatment and social service. Stigma tragically deprives people of their dignity and interferes with their full participation in society.” The NARI found stigma to be one of the most significant and pervasive issues identified across all stakeholder groups involved in the assessment. The stigmatization of people with mental disorders has persisted throughout history and research indicates that knowledge alone does not defuse it. (Lauber C, Nordt C, Falcato L, et al 2004) Thus stigma can persist even with education. The media also bear responsibility for perpetuating stigma. Although the relationship between the media and public perceptions is complex, the media exert influence, and negative media images are of concern because they increase psychological distress and fear of persons with mental disorders. (Levin 2001)

The historical segregation of mental health and physical health has contributed to and continues to compound the above issues. The inter-relationship between physical and mental health is well documented—mental health problems often contribute to poor health outcomes and vice-versa. Yet in practice, neither prevention nor treatment is often coordinated. This not only results in poor health outcomes but also contributes to the lack of understanding and stigma in the general public.

**Where do we need to go in Missouri?**

Adopting a public health approach in Missouri requires a broader view of mental health, one that integrates health promotion and prevention within the full spectrum of mental health services. **This broader view is based on evidence that when more prevention is undertaken, less people will reach a point where they need increased and more expensive care.** Prevention activities are generally directed against risk factors and are implemented at specific periods before the onset of a problem or disorder. Once a problem or disorder has developed, however, preventive interventions are still useful to reduce the severity, course, duration, and disability associated with the problem. The essential public health services most relevant to this goal include:

- Inform, Educate and Empower People about **Mental Health Issues**
- Mobilize Community Partnerships to Identify and Solve **Mental Health Problems**
- Develop Policies and Plans that Support Individual and Community **Mental Health Efforts**
- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based **Mental Health Services**

Missouri has made much progress as highlighted in Table 9. For example, the adoption of the positive behavioral support model by some Missouri schools promotes cost-effective, proactive systems of behavior support at the school level. Also, the development of a state-wide Suicide Prevention Plan has

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**Table 9: Highlights—Missouri Successes and Strategic Developments**

- Missouri’s **Strategic Prevention Framework State Incentive Grant (SPF SIG)** is helping Missouri coordinate prevention initiatives across state agencies & to promote evidence-based strategies to prevent substance abuse.
- Missouri’s development of a **Statewide Suicide Prevention Plan** to address the high suicide rate in Missouri (12.9/100,000) has brought about positive changes at the local level.
- The **Coordinating Board for Early Childhood (CBEC)** was established to serve as the public/private entity for coordinating a system of early childhood programs for Missouri children from birth through age five.
- Missouri’s **First Steps Program** offers coordinated services to children birth to three with delayed development or conditions that are associated with developmental disabilities.
- Missouri **Substance Abuse Prevention, Intervention and Resources Initiative (Spirit)** supports development/implementation of a continuum of evidenced-based SA prevention services in K-12 public schools.
- Several Missouri schools have adopted the **Positive Behavioral Support Model** to support healthy emotional development and foster resilience in children.
- **FQHC/CMHC Collaboration:** In FY 2008 the legislature appropriated funding to pilot community mental health centers (CMHcs) and federally qualified health centers (FQHCs) collaborative care in seven pilot sites.
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resulted in over 15,000 citizens being trained to recognize the signs and symptoms of suicide across the lifespan and assist them to get the help they may need. **Missouri is now at a critical point with a real opportunity to fundamentally rethink mental health and health care.** Missouri must build upon its recent initiatives to develop a common frame of reference that emphasizes wellness, including mental wellness as a goal important to all Missourians. As the development of mental health problems often occur early in life; social, emotional, and behavioral well-being must be promoted as an integral part of a child’s healthy development. Early identification of mental health needs should be facilitated in existing preschool, childcare, education, health, welfare, juvenile justice, and substance abuse treatment systems. Prevention must not only be applied in childhood but across the lifespan, including the prevention of late-onset depression and suicide, excess disability, and premature institutionalization. Missouri must also invest in evidence-based prevention methods that emphasize the importance of access and supports in community settings that contribute to wellness and begin integrating health promotion into mental health care settings. Because multiple problem behaviors that relate to mental health at some level have been found to have common causes, a shared prevention framework should be developed emphasizing interventions that can impact multiple behaviors.

Missouri must also actively engage and invest in improving mental health literacy in the overall population. **The public needs and deserves to know what to do when encountering a potential mental health problem personally or in others.** Conversely, Missouri should take the necessary steps to assure general health literacy efforts incorporate the needs of persons with mental illnesses, developmental disabilities and addiction disorders. As stigma was found to be one of the most significant and pervasive issues, and key barriers to transformation, the need to incorporate anti-stigma promotion into the overall mental health prevention and promotion framework is critical. Efforts to eliminate it must be multi-dimensional and address the attitudes held by mental health and health professionals as well as the general public. Finally, because mental health is intrinsically related to all health aspects, it is imperative to approach mental health within the context of overall health by integrating public health, primary care and mental health practices.

**How will we know we are successful?**

In a **transformed system** mental health is pursued with the same urgency as physical health and Missourians view mental health as essential to their overall health and well-being. The public is educated about mental illness, addiction disorders and developmental disabilities and stigma does not exist. Educated and caring citizens are actively engaged in promoting mental health and wellness, and in supporting recovery and self-determination. Missourians know how to identify mental health issues and how to respond to their own or others mental health needs. The mental health needs of Missourians are treated as an overall component of their physical health and people know when one component may be affecting the other. People are eager to seek the care they need and the public is willing to absorb the cost.
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TRANSFORMING FROM A BUREAUCRACY/PROVIDER DRIVEN SYSTEM TO CONSUMER DIRECTION AND EMPOWERMENT

What is the Issue?

There is a Chinese proverb that **no one knows better how the shoe fits than the person who wears it.** Yet in Missouri, as elsewhere, consumers are neither in charge of defining the care they need nor in exercising informed choices in the care they receive. **As Missouri moves to promote wellness and create a culture of hope within the mental health service system, consumers must be provided with the tools and supports to manage their own mental health.** Professionals must move from a more paternal role to a teaching and coaching role.

Key issues are identified in the NARI and highlighted in **Table 10**. For example, consumers often lack decision-making power to direct their care. The mental health system predominantly relies on a provider-driven model of service delivery that uses *traditional* planning methods where mental health care decisions are prescribed by professionals. In addition, a professional or expert often determines the plan(s) of care. This practice can unintentionally perpetuate dependence rather than self-direction and wellness. A wellness model empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports.

Programs that promote real self-direction are rare in the mental health system because 1) the workforce often lacks the knowledge and skills needed to conduct them, and 2) institutions, at the provider, organizational, and government levels, lack the culture and processes needed to promote them. **Many in the workforce lack familiarity with wellness-oriented practices** to engage children, youth, and adults, and their families, in collaborative relationships that involve shared decision-making about treatment options. This unfortunately can lead to policies and practices that lack respect and individualization, and negatively impact a consumers ability to take charge of his/her treatment and life. Such practice can also perpetuate internalized stigma, by reinforcing a sense of negative self-worth in individuals due to the perceived unequal balance of power between professionals and consumers. The NARI referenced this in findings from the Voice of the Consumer survey conducted by DMH where some consumers voiced concerns and provided examples regarding poor staff attitudes and practices. In some situations, consumers felt that staff treated them more like “criminalsnot clients” with little respect. Some persons in in-patient care settings said they had house rules that did not apply to the staff regarding cursing, smoking, etc. A general consensus exists that the staff have a direct and profound impact on a persons satisfaction level.

The lack of consumer input is not only a problem at the service delivery level. Missouri’s mental health system does not fully incorporate the consumer and family voice in the policy-making process as well. Although several formal structures exist for policy and planning input *(e.g. State Mental Health Commission, State Planning and Advisory Councils, Children’s Stakeholder Advisory Group, Consumer...*)
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Affairs Offices and private advocacy and self-help organizations), consumers and families lack a structure for ongoing, meaningful consumer and family-directed policy and program development beyond DMH. Consumers and families feel they have little to no voice in the policy-making and budget processes of other state departments that provide mental health care.

From the perspective of workforce planning and development, the amount of services provided by mental health professionals and other health and human services providers pales in comparison to the level of self-care, peer support, and family care giving that occurs. Individuals with mental health problems, along with their families, are a human resource that too often has been overlooked or underutilized. (Annapolis Coalition-An Action Plan for Behavioral Health Workforce Development, 2007) Recognizing consumers as providers is a relatively new concept within some parts of the mental health system. The traditional provider-driven model has often established strong boundaries between the provider and the service participant. However, emerging evidence strongly supports the need for peer and family support services as a cost-effective and complementary adjunct to professional mental health services and supports.

Where do we need to go in Missouri?

Placing the consumer in charge requires a fundamental shift in the culture of Missouri's mental health system. Consumers are the bridge between the mental health system as it exists now and the system as it should be. It is their life and hope for the future at stake. Therefore, their needs, wants, and goals should guide the decision-making process at all system levels. Creating a system that meets their needs fully is not only a critical part of Transformation, but also the reason for undertaking the difficult and necessary work ahead. Missouri must provide equal weight to expertise gained through the lived experience as is done with any other credential or knowledge base.

From a public health perspective, the essential services related to this strategic theme include:

- Inform, Educate and Empower People about Mental Health Issues
- Develop Policies and Plans that Support Individual and Community Mental Health Efforts

Before consumers participate in decision-making, they must be empowered. The first step is obtaining information about their choices and access to training and supports to follow through on their decisions. Mental health providers, from agency directors to line staff, must have the tools needed to successfully accomplish this system change. A fundamental shift in organizational culture needs to occur: from one currently focused more on treatment compliance and risk avoidance toward one of informed choice and effective risk management. Promising and evidence-based practices in illness self-management, such as those promoted by SAMHSA must be incorporated in daily care and treatment. In reviewing practices used within the public health field, other promising models could be applied to mental health as well. For example, the Center for Disease Control is promoting the adoption of Wagner's Chronic Care Model by the healthcare system as an approach to empowering and preparing consumers to manage their health and health care. Another indispensable tool to moving the system to one that is

Table 11: Highlights—Missouri Successes and Strategic Developments

- The division of MRDD has established a variety of mechanisms for consumers to successfully self-direct services and supports.
- A CMS grant awarded in 2007 will enhance the use of person-centered planning practices for persons with developmental disabilities or mental illness, integrating the philosophy through the system.
- The Comprehensive System for Children has successfully developed a Stakeholder Advisory Group comprised of more than 50% family and youth involvement as well as a Youth Involvement Cooperative.
- DMH is participating in the development of best-practice and fidelity standards for consumer-operated services to assure their ultimate credibility and success.
- Missouri has successfully piloted the Procovery Program developed by Kathleen Crowley and has recently developed the infrastructure necessary to take the program state-wide as part of the system transformation effort.
consumer-driven is person-centered (or family centered/youth guided) planning. Person-centered planning is a process-oriented approach to empowering people that has been adopted in the developmental disabilities field. The person-centered approach relies much less on the service system by organizing truly individualized, natural, and creative supports to achieve meaningful goals based on the individual’s strengths and preferences. For families and their children who have serious emotional disturbances, wrap-around planning employs a similar approach. In adopting this new focus, Missouri must also begin to develop policies and technological supports to create individualized care plans that are integrated across agencies involved in a persons care and treatment and developing mechanisms whereby consumers can have integrated personal budgets to effectively choose and manage their support services across agency funding streams.

As Missouri's mental health system moves to a public health approach, consumers and families should inform and guide policy developers. Their insights are based on system experiences and provide a richer, more complete understanding of the issues. Additionally, consumer participation and feedback can 1) counteract the fear and distrust that might surface from limited contact between consumers and government officials, and 2) enhance surveillance and evaluation components to policy or program development. Such feedback can improve program quality, enhance professional development, impact program design, and improve the provision of services and supports.

Additionally, Missouri's concept and definition of workforce must be expanded to include consumers and family members. They are pivotal members of the workforce due to their critical roles in caring for themselves and each other. Peer and family support services can move the system to focus less on illness and disability and more on wellness. They aim to maximize the opportunities to create a lifetime of wellness personally and for family, neighbors, and community.

**How will we know we are successful?**

In a transformed system, savvy and knowledgeable consumers and families know what care and support they need, how to get it and how to evaluate it. They are empowered through education and support to move forward with their lives and to manage their own plan of care. Providers, administrators and policy-makers hold a deep and enduring respect for the persons they are privileged to serve.

Consumers, in partnership with their caregivers set in motion a person-centered planning approach owned by consumers, embraced by providers and defined in a single plan of care. There is a system-wide focus on wellness with consumers and families involved in leadership, support and service provider roles throughout the state. Consumers and families have an active voice in designing and developing the systems of care in which they are involved. Mutual respect guides the process of shared decision-making at all levels of the system.
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TRANSFORMING FROM POCKETS OF EXCELLENCE TO UNIVERSAL BEST PRACTICES

What is the issue?

Not only do people need easy, early and equal access to care, but they also need access to new treatments and the successful, evidence-based treatments already developed through research. A national array of evidence based and promising practices allows for successful treatment and supports for the majority of people with mental health needs. Such advances support people in living full and productive lives in the community. However, most Missourians are not benefiting from these scientific advances for complex and varied reasons. Key issues are identified in the NARI (Table 12). First and foremost, serious workforce problems exist. Not only is there a shortage of mental health professionals, but also the available providers often lack training in evidenced based and other promising practices. Changes in health care have outpaced changes in the educational programs offered to the mental health workforce. The result is a training gap that often leaves graduate students and direct care providers inadequately prepared for practice in the current health care environment. The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported.

The IOM report Crossing the Quality Chasm identified several barriers to delivering excellent care, i.e. current shortage and maldistribution of workers; work environments that do not support excellent service delivery; a lack of diversity and cultural expertise; outdated educational/training content and methods; variation in the scope of practice and assurance of competencies; and concerns about legal liabilities. The varied backgrounds of professional and non-professional mental health staff along with their wide array of practice settings significantly compound the problem. There is no agreed-upon level of competency within any profession, much less across professions with respect to providing mental health care. The numerous education institutions providing training are often inadequately grounded in the scientific evidence-base for treatment. One workgroup member stated its just not right. We have to completely retrain people once they graduate just to implement an evidence based practice. A primary concern about professional staff education and training is the absence of clearly specified competencies that must be developed and a process for assessing whether these competencies are achieved. The financing of continuing education is a critical issue. Missouri providers have significantly scaled-back training due to budgetary constraints. Often public and private policy and reimbursement methods compound this problem. Specifically, reimbursement complexities and limitations cause the quality of mental health services to vary greatly (IOM).

The NARI identified that Missouri has a number of facilities and community provider agencies using components of evidenced based practices (EBP) to improve service outcomes; however, the availability of these services varies greatly statewide. Variability also exists in the practices delivered as no infrastructure exists in the state to provide technical assistance, support fidelity reviews, and measure outcomes distinct to EBP implementation. Missouri has yet to achieve consensus on the definition,

"When you pit a bad system against a good performer, the system almost always wins"

(Rummler, 2004)

Table 12: Key Issues identified in NARI

- The Mental Health Workforce Crisis
- Evidence-based Practices-the Science to Service Gap
- Lack of Comprehensive Quality Management Structure
utility and approach to EBPs, although much progress was made to address this in the Transformation planning process by the EBP workgroup and the TWG.

Compounding this issue is the lack of a state-wide research and evaluation infrastructure in Missouri to build an adequate science base that supports innovative promising practices. Also, there is no comprehensive quality management structure. In recent years, significant time and attention has been devoted to reduce variations and improve the effective delivery of care in the overall healthcare industry. This has not received equivalent attention in mental health. Fewer measures of safety, quality and timeliness exist, partly due to the historic separation of mental health from the general healthcare field.

When looking at population-based measurement systems essential to a public mental health approach, the picture is even bleaker: measures and data sets are virtually non-existent.

Where do we need to go in Missouri?

Implementing best practices statewide that are universally available takes the safety issue to the next level—services are not only safe but also highly effective. The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported.

Universal application of proven techniques to produce consumer-desired outcomes should increase the efficiency, access to and capacity of the mental health service system. An investment in research and evaluation of new and promising practices along with a comprehensive quality management infrastructure will accelerate best practices. The essential public health services most relevant to this issue:

- Assure a Competent Public and Personal Mental Health Care Workforce
- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Mental Health Services
- Research for New Insights and Innovative Solutions to Mental Health Problems
- Develop Policies and Plans that Support Individual and Community Mental Health Efforts

Missouri has successfully launched several initiatives to achieve this as highlighted in Table 13 and must build upon these successes. First and foremost, achieving the promise of a transformed mental health system requires a workforce that is sufficient in size, with the necessary competencies, and fully supported by the work environment to provide care consistent with these competencies. A. Kathryn Power, director of the Center for Mental Health Services (CMHS) at SAMHSA, described the need to develop and change competencies at three levels to effect a transformational system change: the individual level, which includes both providers and educators; the organizational level which includes

<table>
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<tr>
<th>Table 13: Highlights—Missouri Successes and Strategic Developments</th>
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<td>Missouri’s DMH/MO HealthNet Pharmacy Improvement Partnership promotes evidence-based prescribing practices and has significantly reduced pharmacy costs and hospitalizations without resorting to mandatory restriction on medications. Missouri won the American Psychiatric Association’s Bronze Achievement Award in 2007.</td>
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<tr>
<td>Missouri is implementing several Evidence based practices including Assertive Community Treatment (ACT), Integrated Dual Diagnosis Treatment (IDDT): Dialectical Behavioral Therapy (DBT) and Supported Employment Services (SE)</td>
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<td>Office of Juvenile Justice and Delinquency Program (OJJDP) Grant—DMH and OSCA joint field demonstration in 5 sites to strengthen community interagency collaborations, implement EBPs to address youth with mental health issues in child welfare or juvenile justice systems; improve quality of mental health assessments to courts and child welfare.</td>
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<td>MRDD is increasing skills of direct support professionals through the College of Direct Support, a web-based training program with nationally recognized curricula. The division is also participating in The National Core Indicators project, a multi-state collaborative to create performance monitoring systems, identify common performance indicators, work out comparable data collection strategies and share results.</td>
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<tr>
<td>The Children’s System of Care Cooperative Agreement Sites funded through SAMHSA have formalized training and program evaluation standards to assess fidelity of implementation of wrap-around services for children and families.</td>
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the organizations that deliver services and the academic institutions that deliver training and the governmental level, which consists of federal and state agencies, as well as accrediting bodies, health care insurers, and professional organizations. (Power, K 2005)

Missouri must take other steps to accelerate the adoption of EBPs. This includes developing a shared definition and a consistent and balanced approach across agencies. An infrastructure for effective research dissemination and technical assistance must be established. As promising new findings are disseminated to front-line providers, policies and financing must provide incentives to support their adoption and use. The successful and sustainable implementation of evidence based practices will require organizational and systems change to support practice changes. Direct service providers as well as supervisors and program managers, will need to increase their knowledge and learn new skills related to the new practice. Formal and informal organizational structures and cultures are needed to bring about and support the changes in service provider practices. Changes in policies, management, and relationships with external partners are also needed to support the implementation of new practice. An investment into research and evaluation along with a comprehensive quality management infrastructure that evaluates consumer desired outcomes is needed to accelerate best practices across the state.

How will we know we are successful?

In a transformed system Missourians regardless of age, culture or place of residence, receive excellent prevention, treatment and support services consistent with scientific understanding. An adequate, well-trained and highly competent workforce work with consumers and their families to create and maintain individualized plans of care. The care they offer focuses on the full range of supports people need to live a full life in their communities. Science informs the provision of services, and the experience of consumers and service providers guides future research. Data-driven quality improvement is the norm across the system and research is used to develop new evidence based practices to prevent and treat illnesses. These discoveries are immediately put into practice. People with, or at risk of developing mental illnesses, developmental disabilities and substance abuse disorders fully benefit from the enormous increases in the scientific knowledge base and the development of many effective treatments.
Part 1: Vision and Strategic Direction

TRANSFORMING FROM A FRAGMENTED AND CENTRALIZED SYSTEM TO SHARED OWNERSHIP AND INVESTMENT

What is the issue?

*no single goal or recommendation alone can achieve the needed changes. No level of government, no element of the private or public sector can accomplish the needed changes on its own. To transform mental health care as proposed, collaboration between the private and public sectors and among levels of government is crucial.*”  --NFC Report

Integrating mental health policy, services and financing is a daunting but necessary challenge for Missouri's mental health and related human service agencies. Consumers cannot take charge of their mental health services and lives if they can't understand, access or navigate the vast and fragmented system. Missourians will not recognize and embrace mental health as being an essential component of overall health if the health and mental health systems continue to remain separate. The gap between scientific advances and community practice will continue if Missouris education and research institutions provide training in discipline-specific silos. Inconsistent priorities and approaches to best practices across educators, policy-makers, benefits administrators and providers, and within communities must be addressed to move the system forward.

The existing mental health delivery system has unclear lines of authority, multiple public and private sector payers and providers, diverse stakeholders, and different types of evidence, standards of care, quality review methodologies and reimbursement policies. The mental health service system is complex and connects many sectors (public/private, specialty/general health, health/social welfare, housing, criminal justice, and education). As a result, care is organizationally fragmented, creating barriers to access. The system is also financed from many funding streams with often competing incentives between funding sources. Currently mental health services in Missouri are provided or financed by over seven distinct state agencies (the Departments of Mental Health; Corrections; Elementary and Secondary; Social Services; Health and Senior Services; Public Safety and the Office of State Court Administrators), seven federal departments (the Departments Health and Human Services, Education, Labor, Agriculture, Veterans Affairs, Justice and Housing and Urban Development), local branches of government, employer-sponsored benefit plans and a multitude of charitable organizations. Even within the private health sector, mental health services are fragmented. Despite important progress, the National Business Group on Health identified that within the private employer market, standardized and integrated programs addressing the delivery of behavioral healthcare services remain rare. In their Employers Guide to Behavioral Health Services the group conc luded that it is not customary for employers to integrate behavioral healthcare benefits offered through the health plan with benefits offered through disability management, employee assistance, or health promotion programs. The result is that employer-sponsored benefits for mental health care are fragmented, uncoordinated, duplicative, and uneven in terms of access and quality.

Table 14: Key Issues identified in NARI:

- Fragmented and lack of coordination between state and local level.
- Lack of shared state and local authority and investment in mental health system.
- Need to improve financing system.
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Unfortunately, there is neither a consensus nor shared agenda for what the mental health system should be. Education and research is often conducted in discipline-specific silos with no commonly agreed-upon standards. The mental health and health care system is not only complex but disjointed. Quality management standards and measures are wide and varied across public agencies and between public and private payers. The ability to integrate and analyze data is limited due to the lack of common measures and a shared data infrastructure across agencies. When attempting to capture population-based data essential to adopting a public health approach, measures and data sets are virtually non-existent.

The historical reliance on the state to provide and fund mental health services has the most profound implications. A large amount of federal funding is dedicated to provide primary care services to the uninsured through federally qualified health centers, rural health clinics and other health facilities. However, with the exception of very limited block grant funding through SAMHSA for substance abuse and mental health services, no equivalent federal funding is dedicated to mental health care for the uninsured. This places a significant undue burden on the state, especially in light of the extreme poverty rates that exist for the people in need of care. These historical policy decisions have contributed to decisions made to limit mental health coverage in the private sector as well, adding to the overall state burden. Not only are federal and private mental health benefits limited, but local funding for mental health services is not on par with funding for healthcare. Currently, most counties in Missouri have dedicated taxes for health services. However, local funding for mental health services is variable; while 83 counties and the City of St. Louis have taxes dedicated to meeting the needs of persons with developmental disabilities, only 14 of Missouri's 114 counties have dedicated funding to meet the needs of people with mental illness and substance abuse problems.

Where do we need to go in Missouri?

Mental health will never be viewed as essential to overall health unless responsibility is shared amongst all levels of government and between the public and private sectors. Collaborative efforts are imperative to move policies, practices, and financing from bureaucratic constraints to human need and a consumer-driven system. The following essential services of the public health approach are most relevant to creating a system of shared ownership and investment:

- Monitor Health Status to Identify Community Mental Health Problems
- Mobilize Community Partnerships to Identify and Solve Mental Health Problems
- Develop Policies and Plans that Support Individual and Community Mental Health Efforts
- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Mental Health Services

Table 15: Highlights— Missouri Successes and Strategic Developments

- Senate Bill 1003 was enacted in 2003. It required the development of a Comprehensive Children’s Mental Health Service Delivery Plan and the establishment of the Comprehensive System Management Team (CSMT) that transcends state departments and other child-serving agencies.
- The Department of Corrections (DOC) and DMH-ADA have collaborated on an Offender Re-entry Program, showing gains in reducing the recidivism of addicted inmates released from DOC. More than 11,300 program participants did not return to the correctional system during the first 12 months of the program.
- Missouri has sanctioned 11 Local System of Care Sites and the Children’s Comprehensive State Management Team is developing systems to support the expansion of such networks in counties throughout the state.
- The Regional Health Commission in St. Louis launched a regional behavioral health transformation initiative that has resulted in broad-based community action to improve access to care.
- FQHC/CMHC Collaboration: In FY 2008 the legislature appropriated funding to pilot community mental health centers (CMHCs) and federally qualified health centers (FQHCs) collaborative care in seven pilot sites.
- The Departments of Mental Health and Corrections have partnered with the Missouri Coalition of Community Mental Health Centers to pilot a project which will assist seriously mentally ill offenders in obtaining mental health treatment services within the community upon release from prison.
Missouri has demonstrated an ability to collaborate for change through multiple initiatives, a few which are highlighted in Table 15. The establishment of Missouri’s Comprehensive System for Children is an excellent example and serves as a solid foundation for current transformation efforts to meet the needs of people across the lifespan. An enduring cross-agency structure must be established to ensure that a comprehensive state plan for mental health guides mental health policy far into the future.

Missouri must now fully engage in a community approach, the cornerstone of the public health model. Central to all transformation initiatives is mobilizing community support for changes at the local level. Missouri must view the community as an essential extension of its mental health workforce. This will require and challenge the state to work with individuals beyond the current service scope. Primary health care, schools, early childhood programs, senior programs and services, daycare across the lifespan, business, criminal justice and all of the other organizations that come into contact with persons at risk of needing mental health services must be involved. Prevention and early access to services and supports should be a top priority for all agencies, not just the state mental health system. Services must be coordinated and integrated across health, mental health and social service agencies.

State agencies must collaborate with local communities to 1) support community interagency efforts to assess systems, resources and needs necessary to form functional partnerships, and 2) ensure communities map their assets to develop new resources and leverage existing resources available from one another to better meet community needs. They must also work together to eliminate inconsistent policies, practices and financing that currently serve a major barriers to receiving excellent care at the local level. This will also require effective partnerships with the Federal government agencies that finance mental health services. Additionally, it will require partnerships with and among educational and research institutions to develop a common framework for education, a research dissemination infrastructure and agreed-upon core competencies for providers. State agencies must collectively establish a set of priority population and individual mental health measures. Such measures should be developed in partnership with private payers. To guide the collective action needed across all stakeholders, Missouri must invest in the technological and data analytics infrastructure needed to effectively collect, analyze and report these measures.

How will we know we are successful?

In a transformed system the burden of coordinating care rests with the system, not on the families or consumers who are already struggling due to the complexities of their illnesses or disabilities. There is no wrong door for persons to access services. Cooperation occurs at and among all levels of the system—federal, state and local; public and private. There is flexibility in the criteria for and financing of services, allowing services and supports to be individualized and seamless in meeting consumer and family. Consumers are included in their community’s social fabric through meaningful and relevant work with adequate income and benefits; educational opportunities; personal relationships; recreational opportunities; recognition and respect from others, and a political voice. Everyone assumes responsibility and everyone is held accountable.
Part 2: Goals & Objectives

GOAL 1: MISSOURIANS UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH

OBJECTIVE 1.1:
INCREASE PUBLIC UNDERSTANDING AND REDUCE STIGMA OF MENTAL ILLNESS, SUBSTANCE ABUSE AND DEVELOPMENTAL DISABILITIES

Core Strategies:
Strategy 1.1a: Develop and conduct a social marketing/public information campaign to dispel myths regarding mental illness, substance abuse and developmental disabilities.

Strategy 1.1b: Develop and incorporate mental health education into health literacy programs and initiatives.

Strategy 1.1c: Develop a 7-12 grade curriculum of mental health competencies to be incorporated into state health curriculum.

Strategy 1.1d: Implement a widely accessible, e-based human services information sharing system for use by all levels of community agencies, providers, families, and consumers.

Strategy 1.1e: Build awareness and accountability for desired transformation outcomes.

OBJECTIVE 1.2:
DEVELOP AND IMPLEMENT A STATEWIDE PREVENTION FRAMEWORK THAT ADDRESSES COMMON RISK AND PROTECTIVE FACTORS.

Core Strategies:
Strategy 1.2a: Create a statewide prevention framework to address common risk and protective factors and develop a coordinated service system, approach, funding strategy and measurement system to be implemented locally.

Strategy 1.2b: Develop/implement pre-service and in-service training modules on predictive factors and prevention strategies for health, social service, school, etc. providers to implement.

Strategy 1.2c: Incorporate 5 Protective Factors model to build parental resilience into philosophy and delivery systems of child-serving agencies.

Strategy 1.2d: Implement State Suicide Prevention Plan and expand services to older adults.

In a Community of Hope:

“The public is educated about mental illness and there is no stigma. People see me as having a purpose in life, intelligent enough to work, capable of responsibility”
Camdenton, MO

“I would know more about mental health and how to get my health back together. I would have opportunities to go back to work and do more things.”
Kennett, MO

“Mental health care would not be a dirty word or kept secret from others. The community would look at it as if receiving care for a physical illness.”
Mexico, MO

“Mental health services will shift from a symptom-reduction model to a holistic, prevention-based model.”
Northeast Missouri

“Somebody would notice the onset of my mental illness. (Mine occurred in college while living in a dorm and nobody noticed.)”
Anonymous
Strategy 1.2e: Adopt CDC guidelines for using tobacco settlement funds for tobacco cessation and other prevention services.

**OBJECTIVE 1.3:**
INTEGRATE PUBLIC, PRIMARY AND MENTAL HEALTH CARE PRACTICES

**Core Strategies:**

**Strategy 1.3a:** Fully develop healthcare home concept and utilize healthcare home coordinator across primary and mental health service agencies.

**Strategy 1.3b:** Implement collaborative care practice model across primary care and mental health settings throughout the state.

**Strategy 1.3c:** Incorporate mental health risk indicators into health risk screenings across the lifespan.

**Strategy 1.3d:** Link mental health professional expertise with local health/public health offices to implement integrated public health promotion.

**Strategy 1.3e:** Integrate health promotion into community environments of people with developmental disabilities.

**Strategy 1.3f:** Implement collaborative planning, technical assistance, training and resources for disaster preparedness and emotional readiness for citizens and communities.

**Strategy 1.3g:** Cross-train health care providers in the care of adults, children and older adults with mental health needs including effective cross-talk between disciplines.

**Strategy 1.3h:** Utilize technologies to support integration of public, primary and mental health care practices.

"My mental health and physical health needs are being treated together and I know when one may be affecting the other. People understand that medication is only part of the solution."
Anonymous

"There would be help to get my teeth fixed so I have a healthy smile and strong jaws every day."
West Plains, MO

"My case documentation follows me to whatever state agency I contact. In other words, my medical and mental health care are well integrated. Agencies know who I am and what progress is made."
Anonymous
GOAL 2: MISSOURI MENTAL HEALTH CARE IS CONSUMER AND FAMILY DRIVEN

OBJECTIVE 2.1: INCREASE CONSUMER DECISION-MAKING AND SELF-DIRECTION OF AN INDIVIDUALIZED PLAN OF CARE.

Core Strategies:

Strategy 2.1a: Develop and implement consistent principles, processes, and framework for an individualized person-centered (or family-focused, youth-guided) plan of care across agencies and levels of care.

Strategy 2.1b: Implement children's wrap-around service practice to fidelity and develop equivalent philosophy and practice for adults and older adults.

Strategy 2.1c: Provide information, education and support to individuals in care and their families to enable them to fully participate in or direct their care and to assist and support each other.

Strategy 2.1d: Provide training to develop shared decision-making skills among individuals receiving care and their service providers.

Strategy 2.1e: Develop individual budgets for designated supportive services specified in individualized plans of care so that the total dollar value of the services is under the control and direction of the program participant.

Strategy 2.1f: Develop financial management service alternatives (e.g. support brokers, fiscal intermediaries) for consumers to assist with finances.

OBJECTIVE 2.2: EXPAND AND INTEGRATE PEER AND FAMILY SUPPORT SERVICES INTO THE SYSTEM OF CARE.

Core Strategies:

Strategy 2.2a: Implement Peer Specialist training/certification program.

Strategy 2.2b: Implement training to support expansion of family support services.

Strategy 2.2c: Increase employment of peer and family support specialists in provider organizations.

Strategy 2.2d: Continue to build the evidence base for Consumer Operated Service Programs (COSPs) and other peer support services.

In a Community of Hope:

"Clinicians start with where people are and people have a say in their goals."
Southeast Missouri

"People receive the services they need, are in charge of what those services are and do not get turned away just because they don't have Medicaid."
Jefferson City, MO

"People (with mental illnesses) are able to pursue goals and dreams without being treated as if goals and dreams are for others."
Anonymous

"There would be places to make friends and support each other and learn how to support yourself and others...safe places to talk about your situation without fear of others judging you."
Anonymous
Part 2: Goals & Objectives

Strategy 2.2e: Expand peer and family education and support services in all provider and community settings, and adapt these programs to meet the needs of diverse communities.

Strategy 2.2f: Utilize a widely accessible web-based system for dissemination of training technologies.

OBJECTIVE 2.3: CREATE A CULTURE OF RESPECT, DIGNITY & WELLNESS AS THE MILEAU IN WHICH ALL MENTAL HEALTH SERVICES ARE PROVIDED.

Core Strategies:

Strategy 2.3a: Incorporate consumers and family members in education and training programs to provide the perspective of the lived experience of mental health conditions and care.

Strategy 2.3b: Expand the Procovery demonstration pilot statewide.

Strategy 2.3c: Incorporate trauma-informed practice across all organizations including practices to reduce the use of restraints and seclusion in all levels of service.

Strategy 2.3d: Increase consumer knowledge and use of Psychiatric Advance Directives (PAD).

Strategy 2.3e: Develop a widely accessible web-based system for dissemination of training technologies usable by consumers, families and providers and further use of teleconferencing for providing training across provider networks.

OBJECTIVE 2.4: INCREASE THE NUMBER OF CONSUMERS AND FAMILIES THAT FULLY PARTICIPATE IN THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF THE SYSTEM

Core Strategies:

Strategy 2.4a: Provide training and develop peer and non-peer mentoring and other supports for consumers and families to effectively participate in policy development across the system.

Strategy 2.4b: Incorporate consumer and families across the lifespan into certification, monitoring and evaluation activities.

Strategy 2.4c: Create consistent policy and fiscal mechanisms to support consumer and family participation at all levels of the system.

"I have dignity and purpose. I will not fear the possibility of failure. State agencies support and empower us and we welcome agencies into our lives without reluctance."
Anonymous

"Labels do not represent the person."
Central Missouri

"Services would be very individualized and given because the person needed them. They would not be forced on them."
Southeast Missouri

"There would be Procovery circles!"
Southwest Missouri

"People get what they need with the expectation of recovery, self-sufficiency and contributing to the overall community and the next person who may need help."
Anonymous
Part 2: Goals & Objectives

GOAL 3: MENTAL HEALTH DISPARITIES ARE ELIMINATED IN MISSOURI

OBJECTIVE 3.1: IMPROVE ACCESS TO QUALITY CARE IN RURAL AND GEOGRAPHICALLY REMOTE AREAS.

Core Strategies:

Strategy 3.1a: Establish geographic access standards and outcome measures and develop service, support and transportation alternatives in areas of state that do not meet standards.

Strategy 3.1b: Establish an equitable need-based method for allocating public sector mental health resources across the state.

Strategy 3.1c: Develop local system protocols to facilitate access to mental health services across geographic boundaries to meet needs when necessary.

Strategy 3.1d: Expand use of Missouri Telehealth Network to include more mental health locations and other healthcare locations to support service delivery, video conferencing, and educational/training sessions.

OBJECTIVE 3.2: IMPROVE ACCESS TO CULTURALLY COMPETENT CARE

Core Strategies:

Strategy 3.2a: Develop, implement and evaluate a statewide plan for cultural and linguistic competency linking existing plans and initiatives.

Strategy 3.2b: Provide training and disseminate standards and tools for culturally competent practice.

Strategy 3.2c: Create workplace environments that are conducive to a diverse workforce.

Strategy 3.2d: Provide educational and performance incentives for professionals proficient in American Sign and non-English languages.

Strategy 3.2e: Expand Missouri Tele-health and other technologies to reduce access disparities.

In a Community of Hope:

"I would be able to get quality services, close to where I live, when I need them...not when I qualify for them. I wouldn't have to drive 100 miles to find a provider."

Trenton, MO

"Everyone has access to appropriate, individualized services regardless of where they live, what they look like or how much money or insurance they have."

Anonymous

"There would be an array of culturally and linguistically appropriate services and community supports available with better insurance and Medicaid coverage for professionals fluent in sign language, etc."

St. Joseph, MO

"All clients would be served without bias. Also, they would not have to quit their job to qualify for Medicaid."

Kirksville, MO
Part 2: Goals & Objectives

OBJECTIVE 3.3: INCREASE CONSUMER ACCESS TO PROGRESSIVE EMPLOYMENT OPPORTUNITIES IN INTEGRATED COMMUNITY SETTINGS.

Core Strategies:

Strategy 3.3a: Issue a policy directive that employment and economic engagement is a Missouri priority as one step out of poverty.

Strategy 3.3b: Provide evidence-based supported employment services with relevant benchmarks for increasing employment.

Strategy 3.3c: Provide benefits counseling to Missourians receiving mental health services as they pursue employment. Highlight mechanisms for continued mental health services and related supports as these persons obtain employment.

Strategy 3.3d: Develop partnerships with employers, agencies and other stakeholders to promote employment and self-sufficiency.

Strategy 3.3e: Promote and develop consumer involvement as mentors, role models and professionals in behavioral health services.

Strategy 3.3f: Use web-based technology to provide training.

OBJECTIVE 3.4: INCREASE CONSUMER ACCESS TO SAFE AND AFFORDABLE HOUSING IN INTEGRATED COMMUNITY SETTINGS.

Core Strategies:

Strategy 3.4a: Develop or enhance local housing collaboratives to increase the development of safe, affordable housing for people with mental health needs/disabilities in their communities.

Strategy 3.4b: Provide ongoing technical assistance and expertise to developers and community partners to plan projects and identify/obtain funding sources, maximizing all federal dollars available.

Strategy 3.4c: Expand supported housing service options to support people with mental health needs in independent or semi-independent housing.

Strategy 3.4d: Utilize web-based technology to disseminate training and affordable housing information.

“Employment is rewarded instead of being a negative consequence for persons seeking it.”

Kansas City, MO

“Recovery is not a penalty in private insurance.”

St. Louis, MO

“I would have support in building a life, finding a home and finding a job—not just working but finding work that I am capable of and enjoy.”

Anonymous

“I would have opportunities for an income and housing. I would no longer be homeless.”

Hayti, MO

“Residential (facilities) inspire hope. There are areas for interaction. There is daily living without stigma. There is one main Center of Support to help with problems/needs.”

Malden, MO
Part 2: Goals & Objectives

GOAL 4: EARLY SCREENING, ASSESSMENT AND REFERRAL TO CARE IS COMMON PRACTICE IN MISSOURI

OBJECTIVE 4.1: PROVIDE TIMELY OUTREACH, SCREENING AND REFERRAL TO CARE THAT IS AGE AND CULTURALLY APPROPRIATE.

Core Strategies:

Strategy 4.1a: Establish a one door philosophy and practice using standardized screening tools and seamless referral protocols across local providers.

Strategy 4.1b: Develop common eligibility standards and means testing across state agencies and a shared information system.

Strategy 4.1c: Train and utilize non-mental health professionals and natural helpers to provide mental health outreach/screening to targeted populations.

Strategy 4.1d: Provide professional outreach and investigation services to engage and assist people in accessing appropriate care.

Strategy 4.1e: Expand Police Crisis Intervention Teams (CITs) and Mental Health Courts for screening/jail diversion statewide. Work in partnership with Chief Justice initiative.

Strategy 4.1f: Identify and remove barriers to voluntary admission and/or outpatient commitment as alternatives to inpatient commitment when appropriate.

Strategy 4.1g: Expand current mobile crisis capacity to allow for non-emergency screening and assessment to targeted groups when indicated.

Strategy 4.1h: Establish functional/behavioral criteria to access services versus diagnosis where appropriate.

Strategy 4.1i: Establish a single identifier and virtual (web-based) single point of entry for all agencies/providers.

Strategy 4.1j: Develop screening and assessment protocols specific to late onset mental illnesses in older adults.

OBJECTIVE 4.2: PROVIDE MENTAL HEALTH CONSULTATION AND SERVICES IN EARLY CHILDHOOD AND SCHOOL SETTINGS.

Core Strategies:

Strategy 4.2a: Support and develop Missouri school-based mental health model to bring to scale.

In a Community of Hope:

"There are no barriers to getting treatment. There is one-stop access to services."
St. Louis, MO

"The door for HELP is always open and only the 'can do' attitude is ever considered. Dreams and hard work are turned into reality."
Farmington, MO

"I would be able to get services before I try to commit suicide and need to be hospitalized. I would not have to wait for months before I 'qualify' for services. People would be able to get help before they lose 'everything'."
Camdenton, MO

"Uninsured college students studying in Missouri could receive medical help and psychiatric care when needed."
Springfield, MO

"My child receives education with care and knowledge for her to stay in school."
St. Joseph, MO

"Children in rural schools who are at risk receive mental health counseling through the schools."
Louisiana, MO
Part 2: Goals & Objectives

**Strategy 4.2b:** Support the Bright Futures interagency effort to enhance community capacity to map assets and needs and increase interagency support for improved child outcomes.

**Strategy 4.2c:** Develop guidelines for the formation/expansion of community response teams linked with local school districts.

**Strategy 4.2d:** Coordinate system development efforts for improved mental health services in early childhood with the Coordinating Board for Early Childhood Services.

**Strategy 4.2e:** Develop and support strategies to increase community and provider knowledge related to infant/toddler/child mental health.

**OBJECTIVE 4.3:**
EXPAND COMMUNITY CAPACITY TO REDUCE AVOIDABLE USE OF EMERGENCY ROOMS, HOSPITALS AND OTHER INSTITUTIONAL CARE.

**Core Strategies:**

- **Strategy 4.3a:** Build capacity for early intervention and access to community-based care.

- **Strategy 4.3c:** Develop Continuing Care options linked with peer supports and integrated health/mental health services.

- **Strategy 4.3d:** Expand evidence-based services that are designed to support people in community settings including integrated dual diagnosis treatment services (IDDT) across state.

- **Strategy 43e:** Develop system to identify high-users of services with poor outcomes and develop/implement and evaluate cross-agency practice model to improve outcomes.

- **Strategy 4.3f:** Assess efficacy of services for children with SED and identify service and system needs to improve outcomes for children.

- **Strategy 4.3g:** Create incentives to expedite eligibility and support home and community-based services, when appropriate.

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“There would be mental health support for my son when he is in school, I am at work, and he is having a bad day or trouble with complying.”

Anonymous

“People would be able to move quickly through the continuum of care.”

Fulton, MO

“Everyone will be able to live with dignity and be free of the fear that they could lose everything because of a crisis.”

St. Louis, MO

“There is no fear of improving just enough to lose my services and then needing them again.”

Camdenton, MO

“The way out of the system is always visible.”

Anonymous
Part 2: Goals & Objectives

GOAL 5: EXCELLENT MENTAL HEALTH CARE IS DELIVERED AND RESEARCH IS ACCELERATED

OBJECTIVE 5.1: DEVELOP THE MENTAL HEALTH WORKFORCE

Core Strategies:

Strategy 5.1a: Assess mental health workforce needs in Missouri and develop comprehensive workforce development plan.

Strategy 5.1b: Identify core and focused competencies for the mental health workforce and implement competency-based curriculum.

Strategy 5.1c: Incorporate person-centered, culturally competent and trauma-informed principles into all curriculums for older adults, adults, youth and children.

Strategy 5.1d: Develop and implement systematic recruitment and retention strategies inclusive of wages and benefits commensurate with capabilities.

Strategy 5.1e: Enhance the infrastructure available to support and coordinate workforce development efforts by establishing integrated funding mechanisms to support workforce enhancements across systems.

Strategy 5.1f: Develop e-learning platform to provide training.

OBJECTIVE 5.2: EXPAND EVIDENCE-BASED PRACTICES (EBPS) ACROSS THE STATE.

Core Strategies:

Strategy 5.2a: Adopt a common definition of EBPs and a balanced portfolio approach to selecting EBPs and targeting resources.

Strategy 5.2b: Implement an incremental needs-driven approach to add evidence-based prevention, early intervention and treatment services on a regular basis that includes fidelity assessment.

Strategy 5.2c: Develop provider financing incentives to support EBP development and practice to include new funding, pay for performance incentives, and funding for training, development, and evaluation.

Strategy 5.2d: Develop a system allowing consumer choice of providers certified in an EBP by DMH, without regard to geographic/service area to insure universal availability.

Strategy 5.2e: Develop policy statement that ensures broad-based consumer and family input into EBP selection and funding.

In a Community of Hope:

"We value substantive training that makes a professional good but also invest resources that make them great."
Anonymous

"Agencies are given the necessary tools to assist people in pursuing their dreams."
Anonymous

"There are incentives for people to pursue career opportunities in mental health such as scholarship opportunities for psychiatry degrees, good pay for staff and employee assistance for mental health professionals to prevent burnout and career change."
Anonymous

"Government resources are used to support treatment that works. The resources are balanced to support known evidence based practice, promising practices and support the people who do the work."
Anonymous

"People with both
OBJECTIVE 5.3: APPLY RESEARCH EVIDENCE MORE QUICKLY AND INVEST IN RESEARCH FOR NEW AND PROMISING PRACTICES.

Core Strategies:

Strategy 5.3a: Incorporate EBP into university formal education curriculum and training/internship opportunities.

Strategy 5.3b: Create a collaborative technical assistance infrastructure (i.e. Coordinating Centers of Excellence) to provide technical assistance, conduct evaluation and research, and disseminate new research findings.

Strategy 5.3c: Create a training curricula and implementation process for EBP core competency development using multiple modalities for education and mentoring.

Strategy 5.3d: Develop education and licensure incentives for continuing education in evidence-based practices adopted by Missouri.

Strategy 5.3e: Educate consumers and families about EBPs that promote resiliency, recovery and self-determination and involve them in the development and implementation of on-going education activities.

OBJECTIVE 5.4: DEVELOP A COMPREHENSIVE QUALITY MANAGEMENT SYSTEM

Core Strategies:

Strategy 5.4a: Adopt common/unique identifier and/or effective crosswalk for consumers across state agencies.

Strategy 5.4b: Develop a statewide data warehouse and information system to track services and support a dynamic system of outcomes across agencies/organizations.

Strategy 5.4c: Develop key population, system and individual outcome measures and performance indicators.

Strategy 5.4d: Phase in the cross-agency quality service review process throughout the children’s system of care and review for adaptation to adult and older adult system.

Strategy 5.4e: Develop an accessible information system for providing quality information about services and providers.
GOAL 6: MISSOURI COMMUNITIES ARE PROFICIENT IN MEETING LOCAL MENTAL HEALTH NEEDS

OBJECTIVE 6.1: CREATE CONSISTENT & FLEXIBLE POLICY/PRACTICES ACROSS STATE AGENCIES THAT ARE INFORMED BY CONSUMERS & LOCAL NEEDS.

Core Strategies:

Strategy 6.1a: Establish enduring state cross-departmental structure at the operations level to maximize funding, set policy, and coordinate activities. Enhance DMH leadership role to ensure consistent mental health policy and practice across agencies.

Strategy 6.1b: Establish leadership structure for consumer/family input to state mental health policy and budget decisions across state departments.

Strategy 6.1c: Develop and adopt a shared service philosophy and common practice model across systems for transitional youth, adults and older adults building on children's comprehensive system model.

Strategy 6.1d: Create more consistent regions/service areas across public agencies.


Strategy 6.1f: Develop flexible funding alternatives (e.g. blending or braiding funding) to assure non categorical service capacity.

OBJECTIVE 6.2: CREATE AND/OR EXPAND LOCAL PUBLIC-PRIVATE COLLABORATIVES TO IMPROVE SERVICE ACCESS, CAPACITY & INTEGRATION.

Core Strategies:

Strategy 6.2a: Establish regional health and mental health planning partnerships that work with local systems and communities to prioritize and formulate solutions to meet local needs and eliminate fragmentation across local agencies.

Strategy 6.2b: Expand local systems of care for children implementing an area management structure to meet the needs of communities and families that are adaptable to geographic and cultural differences.

Strategy 6.2c: Develop incentives and partnerships to increase local investment in mental health including local county funding initiatives.

Strategy 6.2d: Develop/expand consumer, family and provider access to a comprehensive information system(s) that provide information about services received across providers.

In a Community of Hope:

"State agencies are on the same page in support of the client. People do not fall through the cracks."

Steeleville, MO

"The focus is on trying to take care of the problem, not trying to decide on which department or division should fund the service."

Anonymous

"There is ongoing communication between the state facilities and community providers to better serve consumers."

St. Louis, MO

"The system would be simplified with a common language when a client goes from one level of care or location to another so that it doesn't feel like you are traveling to another country."

Anonymous

"Agencies forgo artificial turfs and unselfishly put clients first."

Southeast Missouri
OBJECTIVE 6.3:
EXPAND THE ROLE AND CAPACITY OF COMMUNITIES TO IDENTIFY THEIR NEEDS, PROMOTE MENTAL HEALTH AND CREATE OPPORTUNITIES FOR CONSUMER INCLUSION.

Core Strategies:

Strategy 6.3a: Support communities in their development of the core competencies of assessment, capacity building, planning, implementation, and evaluation.

Strategy 6.3b: Strengthen existing connections between mental health organizations and their local communities.

Strategy 6.3c: Phase in statewide community assessment process to determine risk and protective factors, incidence and prevalence; risk levels among populations; available resources; and community readiness for change.

“Schools, mental health agencies, community organizations, justice system, etc. would all work together with clients/families.”
Springfield, MO

“Providers communicate with each other as well as with the client or family to meet their needs.”
St. Joseph, MO

“Treatment and prevention succeed because the community is vested in the success of the customer.”
St. Louis, MO

“People come together wanting to learn more about mental health and helping others. There is more information available.”
Hannibal MO
Part 3: Initial Action Plan

Overview

Priority actions for 2008 were identified to address the goals, objectives and core strategies in Part 3 of this plan. A separate chapter was developed for three reasons:

- Several actions address multiple objectives and strategies.
- Due to the dynamic nature of the transformation Initiative, the Action Plan will be updated regularly to reflect the current priorities and efforts. This will allow the TWG to capture new opportunities, add or modify actions as more detailed implementation plans are developed and “course correct” as necessary to meet broader goals.
- Annual updates can readily be addressed through a separate plan “Supplement” document without changing the entire plan. The supplement can serve as an annual report that outlines progress, significant updates and an updated Action Plan for the following year.

The Action Plan outlined on the following pages begins with a legend explaining the plan detail. Actions are descriptive and purposefully broad. Timelines reflect the estimated start date of the entire project. As the actions plan will be evaluated using prescribed measures from SAMHSA, preliminary measures have been listed for applicable goals. The evaluation team will develop more detailed measures as implementation begins. Given the scope of the plan, a decision was made to include significant actions that are directly linked with core strategies even if they are funded and evaluated through alternative grants or contracts. Therefore, SAMHSA measures will not be applied to all actions. At the same time, the actions described in this section are by no means inclusive. For example, the implementation of several different evidence-based practices are underway, yet not listed at this time. The TWG recognizes and appreciates the multiple initiatives under way across the state in support of this plan.
Part 3: Initial Action Plan

Legend of Abbreviations used in Action Plan

ACE Goals - measures of anticipated long-term impact
A - Improved Accountability
C - Increased Service Capacity
E - Increased Service Effectiveness

GPRA Goal - measures of infrastructure changes completed:
1 = Policy Changes Completed
2 = # of Persons in Workforce Trained
3 = Financing Policy Changes Completed
4 = Organizational Changes Completed
5 = # of Organizations that Regularly Obtain and Analyze Data
6 = # of Members in Consumer and Family Run Networks
7 = Programs Implementing Practices Consistent with CMHP
8 = Separate Evaluation Process
9 = To Be Determined

Target Populations:
Persons served across agencies and/or systems who are at risk for or experiencing:
- MI = Mental illness
- ADA = Addictions
- DD = Developmental Disabilities

Note: This also covers the general public and service providers.

Age Group:
- CY&F = Children, Youth and Families
- A = Adults
- OA = Older Adults

Complexity of Implementation:
Low = action will be completed with ease during established timeframes
Medium = major components of action will be realistically achieved over course of plan timeframe/grant period resulting in significant progress to achieving overall objective
High = Action will require multiple years that will likely extend beyond plan timeframe

Time Frames:

Start-up Planning
Implementation

Implementation initiated prior to 2008
Implementation anticipated to continue beyond 2008

Acronyms Used:
AAA - Area Agency on Aging
ADA - Division of Alcohol and Drug Abuse
CPS - Division of Comprehensive Psychiatric Services
CSMT - Comprehensive System Management Team
DESE - Department of Elementary and Secondary Education
DHSS - Department of Health and Senior Services
DMH - Department of Mental Health
DPS - Department of Public Safety
DSS - Department of Social Services
EBP - Evidence Based Practices
MACDDS – Missouri Association of County Developmental Disabilities Services
MARF-Missouri Association of Rehabilitation Facilities
MHFA - Mental Health First Aid
MO-ACEs - Missouri Autism Centers for Excellence
MO-ANCOR—Missouri Chapter of the American Network of Community Options and Resources
MPC - Missouri Planning Council
MRDD - Division of Mental Retardation and Developmental Disabilities
OCCMH - Office of Comprehensive Child Mental Health
OOA - Office of Administration
OOT - Office of Transformation
PACs - Parent Advisory Council
SLRHC - St. Louis Regional Health Commission
TWG - Transformation Working Group
UMKC—University of Missouri—Kansas City
UMKC IHD—UMKC Institute for Human Development

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### Part 3: Initial Action Plan

#### 2008 Priority Actions

<table>
<thead>
<tr>
<th>Goal/Objectives</th>
<th>Lead Agency/Group and partners</th>
<th>ACE Goal</th>
<th>Level of Complexity</th>
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<td>Charter cross-departmental workgroup to guide the development and implementation of anti-stigma/public information campaign. Establish subcommittees to advise and direct on key actions and initiatives. Establish small workgroup to meet with existing groups, i.e. Missouri Prevention Partners and other groups, at state level to identify related prevention actions and explore potential for partnerships.</td>
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<td>• Provide statewide training and organizational consultation to build culture of respect. • Initiate training of consumers and families through two 4 day Respect Institutes. • Begin development of Peer Speakers Bureau in Missouri as component of public information campaign in partnership with advocacy organizations. • Link with public education/anti-stigma activities.</td>
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### Part 3: Initial Action Plan

#### 2008 Priority Actions

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<td>1.1 1.3 5.3</td>
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<td>• Implement evidence-based 12-hour mental health literacy training program as part of public education campaign.</td>
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<td>• Work with state of Maryland and SAMHSA to convert training curricula and certification standards for use in United States. Train initial cohort of trainers.</td>
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<td>• Identify populations and begin training.</td>
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<td>• Identify and apply for match funding to expand training.</td>
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<td>• Develop business plan for long term sustainability.</td>
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<td>1.1 2.3 3.2 5.1</td>
<td>Reducing Stigma and Increasing Cultural Competency Pilot:</td>
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<td>• Conduct pilot training program in eastern region to change current culture of health care system by addressing barriers to quality care related to stigma and cultural competency. Initial 1½ day cross-agency training targeted for April with 3 planned follow-ups. Respect Seminars will be combined with Cultural competency curricula.</td>
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<td>• Evaluation will guide state-wide expansion in year 2 in partnership with MO Coalition of CMHC’s.</td>
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<td>Note: Agencies involved serve persons of all ages.</td>
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### Part 3: Initial Action Plan

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<td>• Develop public-private partnership to establish permanent Missouri Mental Health Foundation that supports public education, stigma reduction and consumer empowerment initiatives.</td>
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<td>• Identify potential fundraisers and contributors to foundation and implement for long term success and sustainability of fund projects.</td>
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<td>1.1 Network of Care:</td>
<td>DMH – Director’s Office, Divisions of CPS &amp; MRDD</td>
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<td>• Designate an internal contact and project lead in the Divisions of Comprehensive Services and Mental Retardation/ Developmental Disabilities.</td>
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<td>• Establish work plan and measurable outcomes in terms of NoC usage, updated resource information, expanded transparency and safety promotion.</td>
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<td>• Share all NoC information with Missouri 211 system for inclusion in information and referral services of that system.</td>
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<td>1.1 Transformation Communications and Accountability Plan:</td>
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<td>• Design enhanced Mental Health Transformation website.</td>
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<td>• Produce regular briefings on key issues, successes and progress through prepared media releases, newsletters and other communications</td>
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<td>• Produce annual report.</td>
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<td>1.2 Suicide Prevention E-Learning:</td>
<td>DMH, DHSS &amp; University of Missouri</td>
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<td>● Finalize the content/design of a graduate level course in suicide prevention; make available online for academic credit.</td>
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<td>● Identify 5 content areas for one-hour modules of suicide prevention. Information including: Risk &amp; Protective Factors; Warning Signs &amp; Action Steps; Suicide Statistics for Missouri; Stigma &amp; Suicide; Suicide &amp; Attempted Suicide in Adolescents. Make these modules available on line for ease of access.</td>
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| 1.2 Suicide Prevention Elderly Pilot: | DMH, DHSS & Northwest AAA | C E 7 | Medium | | | | | | | | | | | | | | |
| ● Identify a geographical area for the pilot program with a Suicide Prevention Resource Center and an AAA willing to work together and a CMHC with capacity to meet referral needs. | | | | | | | | | | | | | | | | |
| ● The Suicide Prevention Resource Center will offer suicide prevention training to individuals designated by the AAA to include drivers for Meals on Wheels, home health aides, companions, AAA staff, families and friends and spouses, interested community members. | | | | | | | | | | | | | | | | |
| ● Referrals and results will be documented by those trained to inform the evaluation, identify lessons learned, and ensure help is activated in response to need. | | | | | | | | | | | | | | | | |
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| CY&F ADULT OA ALL | | | | | | | | | | | | | | | | |

| 1.2 NO BUTTS About It: | DMH & DHSS | C 7 | Medium/Low | | | | | | | | | | | | | | |
| ● Assess tobacco usage by consumers of mental health services. | | | | | | | | | | | | | | | | |
| ● Develop a plan to prevent tobacco use by consumers of mental health services | | | | | | | | | | | | | | | | |
| ● Seek implementation funding. | | | | | | | | | | | | | | | | |
| Initial Target Population: | | | | | | | | | | | | | | | | |
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| CY&F ADULT OA ALL | | | | | | | | | | | | | | | | |

| MI DD ADA ALL | | | | | | | | | | | | | | | | |
| CY&F ADULT OA ALL | | | | | | | | | | | | | | | | |
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**Goal/Objectives**

**Lead Agency/Group and partners**

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<td>1.2</td>
<td>Foster collaborative relationships on college campuses across the state to implement recommendations to involve mental health expertise in emergency planning for campuses; Education/training on how to access 24/7 mental health services by campus authorities and students, either CMHCs and/or on campus expertise; Education/training on linkages for activating civil commitment if needed. Investigate applicability of MHFA training for campus personnel and students</td>
<td>Homeland Security Taskforce, Department of Higher Education and Public Safety Subcommittee</td>
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<td>1.3 Disaster Services and Special Needs Shelters:</td>
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<td>4.3</td>
<td>• DMH disaster services staff will participate in bi-monthly meetings. • Provide input and updates regarding special needs shelters for State Emergency Operations Plan Annex X and Annex X Appendix. • Create template for local public health authorities and emergency operations centers to request mental health assistance for activated special needs shelters.</td>
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<td>1.3 CMHC-FQHC Collaborative Care Pilot:</td>
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<td>6.2</td>
<td>Pilot 7 collaborative care pilots between federally qualified health centers (FQHC’s) and community mental health centers (CMHC’s). Evaluation will guide needed policy changes and additional expansion.</td>
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### 2008 Priority Actions

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<td>1.3 Integration of Mental Health to Health Care Home Model (DMH NET):</td>
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<td>• Establish guidelines for Community Mental Health Centers to serve as health care homes for individuals with serious mental illness under the MO HealthNet Plan;</td>
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<td>• Provide disease management services for Medicaid-eligible individuals with mental illness and co-occurring physical health conditions; and</td>
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<td>• Provide data analysis and educational materials to health care providers regarding good psychiatric prescribing practices.</td>
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<td>2.1 Person-Centered Planning:</td>
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<td>2.3 Enhance Person Centered Planning within the Division of MRDD and implement Person Centered Planning principles and process within the CPS provider system.</td>
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<td>• Issue a policy affirming person centered values as the foundation for the entire mental health services system.</td>
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<td>• Conduct training for all staff including administration and direct support on person centered thinking/philosophy, following by training on person centered planning.</td>
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<td>• Provide access to mentors to facilitate person centered planning and implementation of plans.</td>
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| 2.1 Self-Directed Supports and Services: | - MRDD Waivers amended to add options for self-directed and family directed services.  
- Secure a fiscal management service contractor to provide a wide range of fiscal support services to enable more people to self-direct.  
- Training to be provided to service coordinators, consumers and families regarding choices, risks and benefits.  
- Explore methods to expand self-directed options to other services. | DMH Division of MRDD, Missouri DD Planning Council & UMKC IHD | E | 3 | Medium | ▼ | | ▲ | | | | | | |
| Initial Target Population: | MI DD ADA ALL | CY&F ADULT OA ALL | |
| 2.1 Consumer Principles for Practice Workgroup: Charter short-term work group to review The “Practice Guidelines for Consumer Directed Services and Supports” developed in 2002 by DMH. These will be reviewed by all State agencies that provide human services, with the goal of adoption as appropriate to the population(s) served. | TWG | E | 9 | Low | ☑ | ☑ | ☑ | ☑ | ☑ | ☑ | ☑ | |
| Initial Target Population: | MI DD ADA ALL | CY&F ADULT OA ALL | |
| 2.1 Wrap-Around Fidelity: The CSMT is working to identify wraparound values/principles that all state child serving departments can endorse. Certified wraparound facilitators are members of the committee working on this issue. Once values/principles are developed and endorsed, departments will identify system and infrastructure changes necessary to support them. Missouri’s ultimate goal is that high fidelity wraparound will be used by all public agencies with ongoing training needs met through the use of in-state certified trainers. | DMH OCCMH & CSMT | E | 2 | Medium | ☑ | | | ☑ | | ☑ | ☑ | |
| Initial Target Population: | MI DD ADA ALL | CY&F ADULT OA ALL | |
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<td><strong>2.2</strong> Peer Specialists Training and Certification:</td>
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<td>Train primary consumers to provide direct services within the CPS provider network. using training and certification model developed by Larry Frick/ Appalachia Consulting for the State of Georgia. Train 40 consumers this fiscal year. Develop two (2) Missouri trainers to continue annual training. Review rules, regulations and certification standards and modify or develop new rules as needed.</td>
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<td><strong>2.2</strong> Family Support Training:</td>
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<td>Finalize curriculum and initiate state wide training to provide participants including parents of children with mental illness the core competencies and skills sets to become a Family Support Provider within the comprehensive children’s mental health system. Participants will be required to complete a competency test prior to billing for services. Identify policy or financing changes required to support employment of trainees.</td>
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### Part 3: Initial Action Plan

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<td>2.2 Consumer Operated Service Program (COSP) Quality Improvement Initiative:</td>
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<td>Initiate phase two of COSP Quality improvement initiative that provides training for self-assessment of fidelity. The “drop-in” programs are piloting a SAMHSA-funded EBP toolkit. All programs have received a fidelity visit to establish baseline. Phase 2 includes: Fidelity follow-up visits will be made to two (2) of the five (5) programs. All programs are receiving instructions on how to self-administer the fidelity tool. Modify fidelity tool to use with telephone support lines and initiate baseline reviews.</td>
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<td>2.2 Procovery State-wide Expansion:</td>
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<td>Begin state-wide implementation of Procovery program. Infrastructure put in place over past year to prepare for state-wide expansion included organizational and individual licensure process, data management structure and staff support. In 2008: Conduct 4 general trainings and follow-up facilitator trainings beginning April. Implement facilitator support to add new Procovery circles. Establish second phase evaluation to include one article submitted/published in peer review journal.</td>
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<td>Expand access to peer and family mentoring through Sharing our Strengths.</td>
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<td>• Develop a certification process for trainers of PBS to increase expertise and capacity at the local level.</td>
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<td>• Utilize certified trainers to expand knowledge of the principals and practices of positive behavior supports.</td>
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<td>• Explore expansion of positive behavior supports principals and populations to other target groups and systems of care.</td>
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| **2.4 5.4** | Peer and Family Participation in Certification, Monitoring and Quality Service Reviews: | DMH Division of CPS | A E | 4 | Medium |
|             | • Implement guidelines developed by CPS State Advisory Council to include peers and family members in the monitoring and certification of CPS funded community-based programs. | | | | |
|             | • Provide additional family training for participation in Quality Service Reviews (QSR) conducted at local system of care sites for children. | | | | |
|             | • Continue implementation of quality of life surveys conducted by self-advocates and families for people transitioning from institutions and receiving community-based services. | | | | |
| **Initial Target Population:** | | | | | |
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## Part 3: Initial Action Plan

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<td>2.4 Consumer, Family and Youth Leadership Training:</td>
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<td>Workshops will be held to engage emerging leaders by taking a journey through the process of telling their stories to becoming leaders who promote systems change. Participants explore the difference between advocacy and leadership and when to use the different approaches. The workshop provides examples of the supports that may be needed for participants to participate on teams and committees.</td>
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<td>3.1 Capacity Development Analysis:</td>
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<td>Using information contained in Needs Assessment and Inventory of resources, conduct system capacity analysis.</td>
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<td>Identify required service array inclusive of peer and family support and education service across continuum based upon prevalence, identified need and review of available evidence.</td>
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<td>Perform gap analysis of need and resources to include gaps related to culture, geography and age.</td>
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<td>Develop appropriate criteria to identify true waitlist for services consistent with model used by MRDD division. Project scope will be phased over next two years.</td>
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### Part 3: Initial Action Plan

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| • Pilot the delivery of behavior therapy and crisis intervention using telehealth equipment, and evaluate results.  
• Amend MRDD waivers to include telehealth as a venue for service delivery. | | | | | | | | | | | | | | | |
<p>| <strong>3.3 Employment Workgroup:</strong> | TWG | C | 9 | Medium | | | | | | | | | | | |
| Charter workgroup to begin implementation of employment strategies. Review current state rules, regulations and financing policies and recommend revisions as appropriate to increase consumer employment and financial independence without losing necessary services and supports. | | | | | | | | | | | | | | | |
| <strong>3.4 Housing Workgroup:</strong> | TWG | A | 9 | Medium | | | | | | | | | | | |
| Charter workgroup to identify current resources and gaps in affordable and integrated housing and begin implementing housing strategies. Review current state rules, regulations and financing policies and recommend revisions as appropriate to increase consumer access to an array of housing options for persons with disabilities. | | | | | | | | | | | | | | | |
| <strong>3.4 Housing Registry:</strong> | DMH Division of MRDD &amp; MPC | C | 9 | Medium | | | | | | | | | | | |</p>
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<td>3.2 Deaf Services Capacity Development:</td>
<td>Re-evaluate the state’s current plans and services for individuals who are deaf and have mental health needs based on best practices in other states and consistent with culturally distinct needs of the deaf community. Principles and strategies to be explored include use of technology to create a virtual statewide highly-specialized and cross-discipline technical assistance team, service navigators as a support for deaf consumers, categorical eligibility to support early intervention service to deaf individuals and their families, cross-departmental integration of services and data analytics to improve the system’s ability to identify interventions with the greatest benefit to the most individuals.</td>
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<td>3.2 Language Translation: Develop translation for DMH web content, brochures and other informational materials. Partner with local groups to assist in translating materials. Initial priority is Spanish translation. Phase 2 priorities are ASL and Bosnian translation.</td>
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<td>4.1 Improving Entry Pilot: Develop and pilot a standardized screening tool and referral protocols across mental health and substance abuse providers in Eastern region. Evaluation will guide further refinement and potential for state-wide expansion.</td>
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<tr>
<td><strong>4.1 Mental Health Coordinator Legislation Change:</strong> Propose legislative change to allow private mental health providers to be designated to perform outreach and investigative procedures as a component of the access-crisis intervention functions to facilitate assessments of need for services including need for involuntary commitment.</td>
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<td><strong>4.1 State-wide Expansion of Police Crisis Intervention Teams (CIT):</strong> Establish contracted state-wide coordinator position to staff steering group to develop and implement CIT state-wide in partnership with Chief Justice initiative. Develop rural adaptations to existing model.</td>
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<td><strong>4.3 Psychiatric Acute Care Transformation (PACT):</strong></td>
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<td>• Identify potential regional partnerships with community general hospitals and community providers of psychiatric services to determine if there are options for providing acute inpatient psychiatric care to DMH consumers by non-state operated providers</td>
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<td>• Ensure the continued availability of acute psychiatric inpatient beds on both a state-wide and regional basis, while improving access to both inpatient and outpatient services and enhancing the dollars available for operating the entire continuum of psychiatric care.</td>
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### Part 3: Initial Action Plan

#### 2008 Priority Actions

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<tr>
<td>1.3 4.1 SBIRT: To identify individuals in the early stages of substance abuse, ADA will implement Screening, Brief Intervention and Referral to Treatment for individuals presenting at emergency rooms in Springfield and St. Joseph. (Note: Pending funding mechanisms w/Medicaid).</td>
<td>DMH Division of ADA</td>
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<td>4.3 Coordinating Care for High Utilizers Pilot: Develop and implement cross-agency “coordinated care plans” for identified high users of care in Eastern region.</td>
<td>SLRHC Behavioral Health Steering Team</td>
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<td>4.3 Children’s System High User Analysis: The efficacy of services for children with SED will be assessed. Data will be collected to identify high users of services with poor outcomes. Service and system changes will be identified to improve outcomes for children.</td>
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<td>4.2 Early Childhood Initiative: An interagency group will be convened to develop an early childhood consultation model as well as identifying the infrastructure for a service delivery system that is based on evidence based practices for the early childhood population.</td>
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<td><strong>4.2 School-based Bullying Prevention:</strong></td>
<td>DMH, DHSS, MO Center for Safe Schools &amp; Individual School Districts</td>
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<td>• Identify community professionals for scholarships to attend certified training and learn to implement school-wide bullying prevention with fidelity.</td>
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<td>• Partner trainers with 3-4 schools each to begin program implementation by training a school based bullying prevention committee. Evaluation is built into the implementation process. Anticipated short term impact: reduction in bullying; improvement in school climate including attendance, grades, and attitudes; reduction in vandalism and discipline referrals.</td>
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<td><strong>4.2 School Based Services Expansion:</strong></td>
<td>DMH, DESE, Coalition of CMHCs, Individual School Districts</td>
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<td>• Implement FY08 Budget Item to fund school based mental health services in on Missouri School District. Build on FY08 initiative to begin expansion of school based mental health services state-wide.</td>
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<td>• FY09 budget request to expand School-based Mental Health Services by partnering with local school districts and community mental health centers utilizing matching funds and MO HealthNet (Medicaid) funding.</td>
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<td>• If budget item funded, implement in number of school districts allowed by funding. If budget item isn’t funded, determine next steps.</td>
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<td>• Implement St. Joseph Circle of Hope Grant targeting integration of physical and behavioral health integration in school settings in 2 – 3 elementary schools.</td>
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<tr>
<td>4.2 Bright Futures Targeted Capacity Building</td>
<td>DMH, DHSS, DSS, DESE, University of Missouri Center for the Advancement of Mental Health Practices in Schools, Head Start Collaboration, Missouri Student Success Network</td>
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**4.2 Autism Treatment Services:**

- Provide services to families and individuals impacted by autism spectrum disorders through the Missouri Parent Advisory Councils (PACs).
- Contract with academic institutions known as Missouri Autism Centers for Excellence (MO-ACE) to develop and deliver best practices to individuals with autism spectrum disorders.
- Partner with the MU Thompson Center to provide intensive behavioral supports to children and young people.
- Establish Office of Autism within the DMRDD.
- Review recommendations from Governor’s Blue Ribbon Council to identify those that can be implemented.

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<td><strong>4.3 Crisis Intervention:</strong> Expand crisis intervention capacity through partnerships with local organization.</td>
<td>DMH Division of MRDD</td>
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| **5.1 Workforce Development Plan:** Review Annapolis Coalition Action Plan recommendations and current SAMHSA priorities for workforce development. Develop initial scope and steps for workforce development plan. | DMH OOT & OOCCMH | A | E | Low | | | | | | |
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| **5.1 E-learning Platform and Core Safety Training Modules:** E-learning accounts for direct care staff will be established in all DMH facilities. Core training to be available on the web with safety as an important component. SB 3 requirements will be included in the safety modules being developed. FY 09 budget request submitted includes expansion to community providers, basic certification for direct care staff and supervisory training. | DMH | C | E | Medium | | | | | | |
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| **5.1 College of Direct Support:** | DMH Division of MRDD, MPC, MACDDS & MARF & MO-ANCOR | E | 2 | Medium | | | | | | |
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<tr>
<td><strong>5.1</strong> Evidence Based Practices Workgroup:</td>
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<td><strong>5.2</strong> Convene cross-cutting workgroup to:</td>
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<td><strong>5.3</strong> Begin with DMH system and determine level of EBP emphasis per division</td>
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<td><strong>5.4</strong> Determine policy around what amount/level of evidence is needed to use public funds. Address how to handle service to science advances. <strong>Note:</strong> In DMH CPS, EBP programs are progressing and feedback loop established.</td>
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<td><strong>2.4</strong> Quality Service Review (QSR): The quality service review is a tool that measures the quality of interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided. Plans for FY 08 and 09:</td>
<td>DMH OCCMH &amp; Division of CPS &amp; CSMT</td>
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<td>• More families will be trained as reviewers;</td>
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<td>• Baseline data will be obtained from the 11 system of care sites and follow-up QSR will be conducted for mature sites.</td>
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<td>• Adult QSR adaptation will be developed.</td>
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<td><strong>5.1</strong> Trauma Informed Care</td>
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### 2008 Priority Actions

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<td>5.4 Common State Identifier:</td>
<td>OOA &amp; State Human Service Departments</td>
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<td>The Departments of Social Services (DSS), Health and Senior Services (DHHS), and Mental Health (DMH) have adapted the Document Control Number (DCN) as the common identifier. Complete assignment of DCNs to all DSS, DHHS, and DMH consumers who currently don’t have one. Continue discussions with the Departments of Corrections and Elementary and Secondary Education to adopt the common identifier or a common methodology to link consumers within their systems to those in the other human service agencies.</td>
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<td>5.4 Data Warehouse:</td>
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<td>Identify best solution to developing and housing interagency data warehouse containing data from all state human service agencies to provide more accurate and timely information concerning individuals served across the agencies. Develop the interagency data warehouse. Begin with a children’s services data warehouse and then expand across the lifespan.</td>
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<tr>
<td><strong>5.4 Electronic Records:</strong></td>
<td>DMH Division of CPS</td>
<td>A</td>
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<td>High</td>
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<td>• MO FY09 proposed budget item provide bar coding and medication dispensing software and hardware to reduce medication errors within state-operated psychiatric inpatient facilities as the first step toward identifying and implementing an electronic medical record.</td>
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<td>• If budget item funded, implement. If not, determine next steps.</td>
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<td>• DMH partnership with MO HealthNet (Medicaid) to coordinate development of an electronic Medical Health Record.</td>
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| **6.1 State-Local Infrastructure Development Plan:** | TWG | A | 9 | Medium |
| **6.2** | | | | |
| **6.3** | | | | |
| • Establish subcommittee to review current state and local cross-departmental initiatives, statutory mandates and department regulations. | | | | |
| • Establish preliminary criteria for formal partnership agreements with local bodies. | | | | |
| • Engage local leaders in dialogue to determine state-local infrastructure development. Consider mini-policy academy format or summit. | | | | |
| • Propose recommendations to full TWG and HSCC for enduring state and local infrastructure to continue transformation efforts beyond grant to include cross-departmental structure for consumer input. | | | | |
| **Initial Target Population:** | | | | |
| MI | DD | ADA | ALL | |
| √ | | | | |
| CY&F | ADULT | OA | ALL | |
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| **6.1 Older Adult Workgroup:**  
- Charter workgroup to identify the components to be included in an operational plan for older adults that articulates the components of the Mental Health Transformation Plan. This plan will aim toward the development of a system of care for older adults.  
- Secure consultant contract with national expertise in mental health and aging issues and identify to provide technical assistance to workgroup.  
- Propose the management structure for ongoing monitoring and oversight of the operational plan.  
- Identify key stakeholders to propose the next steps in implementing the system of care plan in local communities.  
- Implement the plan embodying a comprehensive and coordinated system of care for older adults in selected local communities.  
- Explore the proper use of mental health services and supports for persons with Alzheimer’s disease and related dementias, as well as those persons with Alzheimer’s type disease and co-occurring mental illnesses. | TWG C 9 Medium to High | | | | | | | | | | | | | |
| Initial Target Population: | | | | | | | | | | | | | | |
| MI DD ADA ALL | | | | | | | | | | | | | | |
| CY&F ADULT OA ALL | | | | | | | | | | | | | | |
| **6.2 Regional Collaboratives:**  
Develop partnerships and incentives to implement regional collaboratives that integrate mental health with overall local community health planning and initiatives. Based on initial successful partnership with SL Regional Health Commission in Eastern region, develop principles and criteria to expand collaboratives that can be adapted to fit local needs in other areas of state and achieve broader transformation goals. Initiate partnership agreements with 2 additional regional areas. Work with local private foundations to support and leverage change efforts. | DMH OOT TWG C 9 High | | | | | | | | | | | | | | |
## Part 3: Initial Action Plan

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| **6.1 Transitional Youth:**  
Develop plan to establish workgroup or committee within current management team/workgroup structure to begin development of system of care to meet needs of transitional youth. Recommend structure to TWG.  
Initial Target Population: | DMH OOT & OCCMH | Low | | |
| MI DD ADA ALL | CY&F ADULT OA ALL | |
| **6.3 Community of Hope Pilots:**  
Develop criteria and proposal to provide seed funding to local communities to begin process of community assessment and capacity building. Identify state and local partners and linkages with public education actions. Provide recommendations to TWG for implementation.  
Initial Target Population: | DMH OOT & OCCMH | C 9 | Low | |
| MI DD ADA ALL | CY&F ADULT OA ALL | |
| **6.1 Emerging Issues:**  
- Traditionally it is difficult for state entities to respond rapidly to issues that emerge. If an appropriate issue emerges, identify staff for responsibility.  
- Research for outcomes and appropriateness.  
- Develop a potential plan for implementation.  
- Present to TWG.  
Initial Target Population: | TWG, DMH and others depending on identified issue | A C E 9 | Medium | |
| MI DD ADA ALL | CY&F ADULT OA ALL | | | |
Part 4: Governance

Overview

The Governor established two principle bodies to lead Missouri's mental health system transformation: the Human Services Cabinet Council (HSCC) and the Transformation Working Group (TWG) (Appendix A). Both have a primary membership of the senior leaders from designated state departments. The TWG Co-Chairs and principle staff are based in the Directors Office of the Department of Mental Health (DMH) to lead and staff the planning process in partnership with other state mental health services agencies. This includes leadership and staffing from the DMH Office of Comprehensive Child Mental Health.

In addition, workgroups, management teams and committees are chartered by the TWG as appropriate to develop and implement the plan. The following groups are incorporated into the structure as well: Comprehensive State Management Team (CSMT) and the Stakeholder Advisory Group (SAG) for children; the CPS State Advisory Council links the Block Grant planning requirements as required by SAMHSA; and the MRDD Transformation Steering Committee.

The TWG coordinates efforts with other state and local governing and advisory bodies that address issues relevant to mental health. At the state level, coordination occurs with groups such as the Governors Strategic Prevention Advisory Committee and Early Childhood Coordinating Board among others. At the local level, coordination occurs with existing regional collaboratives, local system of care teams and other community boards and groups. The community focus of this plan will require a greater degree of collaboration between the state and local level as this plan is implemented. Table 16 on the following page provides a visual outline of the governance structure and its relationship with other bodies. A description of the purpose and roles of each group is provided as well.

Human Services Cabinet Council (HSCC)

A Cabinet subgroup serves as the governing body of the Transformation Working Group and steers the mental health transformation process. The HSCC is chaired by the Governors Chief of Staff. Members include the Directors of the Departments of Mental Health (DMH), Social Services (DSS), Health and Senior Services (DHSS), Elementary and Secondary Education (DESE), Corrections (DOC) and Public Safety (DPS). The principle role of the HSCC is to:

- Establish the strategic direction of the process across departments;
- Facilitate alignment and coordination with other Governor and departmental priorities, and with other branches of government; and
- Serve as the final approval body of the Comprehensive State Mental Health Plan.

Transformation Working Group (TWG)

The TWG is a Governor-appointed board established through Executive Orders 06-39 and 07-15. Members include key Governors Office and departmental senior leaders, consumer and family experts, and other public leaders. The chairpersons and principle staff are based in the DMH Directors Office to lead the planning process in partnership with other mental health services agencies. The principle responsibility of the TWG is to 1) create a Comprehensive Mental Health Plan for Missouri that transcends state department boundaries and fully integrates the current Comprehensive Childrens Mental Health Plan and 2) lead the implementation of the plan once developed. In order to achieve this task, the roles of the TWG will evolve across the course of this process to include:
TABLE 16:
Missouri Mental Health Transformation Governance Structure

- Governor
  - Human Services Cabinet Council
    - Mental Health Transformation
      - Management Teams:
        - Children Comprehensive System Management Team & Stakeholder Advisory Group
        - Older Adult Management Team (Proposed)
      - TWG Committees:
        - MRDD Transformation Steering Committee
        - Other as designated
      - Cross-Cutting Workgroups:
        - Cross-agency content specific Workgroups will be chartered per plan
    - Office of Comprehensive Child Mental Health
    - Office of Transformation
  - Other State Executive, Legislative, Judicial Governing or Advisory Boards/Bodies
  - Regional Collaborative Partnerships
    - Local System of Care Teams
    - Community Collaboratives
    - Other Local Boards/Bodies
- DMH Director
  - DMH Deputy Director
    - Division of CPS
    - Division of ADA
    - Division of MRDD
    - Advisory Councils/Planning Board
    - Office of Comprehensive Child Mental Health
    - Office of Transformation

Project Staff Support
Coordinating Relationships
Transformation Working Group (TWG) (con.)

- Coordinate and/or integrate the activities of the TWG with other Governor, state department, legislative and judiciary initiatives;
- Initiate dialogue, seek input and engages stakeholders;
- Serve as the chartering authority for specific workgroups and deploy staff, as appropriate, to work on key TWG committees;
- Propose and recommend changes to the current mental health system, develop priorities and coordinate implementation;
- Build support for the changes proposed through communication, education and organizational support and commitment;
- Mobilize and coordinate resources for achieving the plan; and
- Ensure evaluation of efforts and promote sustainability.

Children's Comprehensive System Management Team (CSMT)

Senate Bill 1003 mandated that DMH, in partnership with all child-serving departments, develop a unified, comprehensive children's mental health system. This legislation required a Comprehensive System Management Team responsible for developing and implementing a comprehensive mental health plan for children. An initial goal of the current children's comprehensive plan is "to create a formalized structure for policy and decision-making across departments at the cabinet level." Missouri's Mental Health Transformation Initiative provides that structure and moves the responsibility for system wide mental health plan and policy development to the TWG and HSCC. The CSMT now receives principle policy direction from the TWG yet remains responsible for implementing the children's components of the comprehensive plan. The CMST receives principle leadership and staff support from the DMH Office of Comprehensive Child Mental Health. The roles of the CSMT include:

- Develop and implement cross-departmental work plans for identified goals and strategies;
- Assist in the development of local system of care infrastructures and provide technical assistance and policy direction to local system of care policy teams;
- Coordinate activities across departments at the state and local levels;
- Build support for the changes proposed through communication, education and organizational support and commitment.

Children's Stakeholder Advisory Group (SAG)

SB 1003 also required DMH to establish a stakeholder advisory committee to provide input to the CSMT and to assist in developing strategies to ensure positive outcomes for children. The SAG membership requires a majority of family and youth representation. By incorporating childrens policy and planning to the TWG, the SAG serves a principle advisory role to both the TWG and CSMT. The SAG roles include:

- Provide constructive input and feedback to the CSMT and TWG regarding Transformation activities relating to children and families;
- Provide direct input to initial ideas and draft plans of the workgroups and TWG;
- Provide recommendations for final plan approval prior to submission to HSCC; and
- Disseminating information to key childrens system stakeholders in the broader community.
CPS State Advisory Council (SAC)

The State Advisory Council (SAC) is comprised of 25 members who advise the DMH Division of Comprehensive Psychiatric Services and make recommendations to improve the system of care in mental health. Council membership is required by federal law to have a majority of mental health consumers, including parents of children receiving services and family members. As SAMHSA mental health block grant planning is required to be explicitly linked to this plan, the SAC serves a principle advisory role to the TWG plus the SAC chair serves on the TWG. The Council roles include:

- Provide constructive input and feedback to the TWG regarding Transformation activities;
- Provide direct input to initial ideas and draft plans of the workgroups and TWG;
- Align mental health block grant planning with Comprehensive State Plan
- Disseminate information to key system stakeholders; Establish input process for adult and older adult stakeholder groups and DMH cross-divisional advisory bodies.
- Host regional town hall meetings and other local input opportunities.
- Provide recommendations for final plan approval prior to submission to HSCC.

MRDD Transformation Steering Committee

The MRDD Transformation Steering Committee was established upon award of a five-year transformation grant from the Center for Medicaid and Medicare Services (CMS) specific to the MRDD population. The grant application was submitted by the Division of MRDD at the same time the application for the SAMHSA Transformation grant was submitted. Both applications proposed the same governance structure. As the CMS grant was awarded prior to the establishment of the HSCC and TWG, a steering committee was established to guide the initial plan development. Once the SAMHSA grant award was made and the TWG appointed, this steering committee was incorporated into the overall governance structure. The MRDD Steering Committee guides the implementation of strategies and actions in this plan that are specific to persons with developmental disabilities.

Chartered Workgroups, Management Teams and Committees

Given the complex analysis and planning required to develop and implement a comprehensive plan, the TWG will charter workgroups, cross-departmental management teams and committees as appropriate. The TWG initially chartered workgroups (Appendix B) around the six goals of the New Freedom Commission report. Each workgroup was responsible for conducting the primary analyses and creating recommended goals/strategies specific to their focus area. Workgroup membership included representation from relevant state departments and other public offices, consumer and family members, provider and advocacy organizations and other stakeholders with special expertise or interest. Workgroup efforts were coordinated across workgroups and with other relevant taskforces and committees. As the TWG moves to the phase of plan implementation, workgroups and committees will be established where needed to guide and implement priority actions.

Linkage with other State Bodies

The complexity of the system requires a major effort to coordinate activities with other state-level bodies whose role is critical to successful plan development and implementation. Particularly, the General Assembly receives updates on the planning process and works with the Governor, the DMH Director
Part 4: Governance

and the other Cabinet Council members to establish legislative and budget priorities and actions. Also, the Missouri Mental Health Commission, a seven-member body appointed by the Governor to provide policy advice and direction to the DMH Director, receives regular updates from the TWG and advises the department on policy priorities. In addition to the these bodies, the TWG strives to coordinate its work with other groups including the Governors Strategic Prevention Advisory Committee, the Early Childhood Coordinating Board, and the Chief Justice Initiative on Mental Health among many others.

Collaboration with Local Groups

An array of local planning groups and formal boards exist throughout the state. The emphasis placed in this plan to create shared state-local and public-private ownership and investment requires coordination with exiting and emerging local efforts to successfully meet the goals of this plan. Currently, the Comprehensive System Management Team assists in the development of local system of care teams and provides technical assistance and policy direction to these teams. Recently, the TWG partnered with the St. Louis Regional Health Commission to link local mental health transformation activities with the state initiative. The development of local capacity and the state-wide expansion of these structures are key strategies contained within this plan. Numerous other bodies exist that are linked with various state efforts such as the regional support centers established as a result of Missouri's suicide prevention plan. The TWG is committed to developing effective partnerships with local groups to achieve the goals this plan.

Sustainability

The TWG recognizes the inherent barriers to change and has attempted to identify and maximize the key levers of change throughout the initial planning process.

- To address the conversion of an entire system takes buy-in from consumers, providers, employees, educators, citizens, policy makers and others from across the system. Every attempt was made to be inclusive and transparent throughout the planning process. The planning process encompassed the viewpoints of a large and diverse constituency. The TWG sought input from all sides of the mental health system so they recruited leaders and experts from all sectors to provide their views and concerns in shaping this effort. All workgroup meetings were open to the public and proceedings posted to the website.
- A logic model (Appendix E) was developed to serve as a broad outline and guide to the planning process. In the model, various inputs (resources, technical assistance, and levers of change) were identified along with actions that influence and support the desired objectives and strategic goals.
- All workgroup meetings were facilitated by skilled and objective facilitators through the Change and Innovation Agency using a variety of methods to ensure that the various aspects of the system were addressed, common themes and potential overlap across workgroups identified and discussed, and diverse perspectives incorporated.
- A consultant with expertise in systems modeling assisted the workgroups during their initial meetings with a group model building (causal mapping) process based on principles of system dynamics. This model was then integrated across groups and updated as objectives, strategies and actions were identified during the planning process. The model was used to help the TWG and workgroup participants see the larger whole, identify potential leverage points for change, identify potential threats to the implementation and sustainability of recommendations and prioritize actions. Appendix C provides a summary of the causal mapping and qualitative model developed in 2007 as part of the planning process.
Part 4: Governance

The TWG is committed to the sustainability of this initiative far beyond the time frame of the SAMHSA grant that is currently supporting it. The group will continue to employ the strategies listed above as it moves into plan implementation. Also, many objectives and core strategies are directly linked with sustainability. These include, but are not limited to, the establishment of a permanent mental health foundation to support public education and consumer participation at the state level, policy and financing changes to support and sustain changes in practice and the establishment of an enduring infrastructure for state and local planning beyond the life of the transformation initiative. Additionally, the TWG has incorporated the development of a sustainable business plan as a key action step into some priority actions (e.g. Mental Health First Aid Training.) Much work remains and the fate of this plan will certainly be influenced by a complicated set of political and economic forces. However, the shared vision and practical blueprint outlined in this plan will be used to guide collective action needed to create sustainable Communities of Hope through the state.
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World Health Organization
http://www.who.int/en/
Appendices

Appendix A: Transformation Working Group Membership Roster
Appendix B: Transformation Workgroups and Membership
Appendix C: Causal Mapping
Appendix D: Glossary of Terms and Acronyms
Appendix E: Logic Model
<table>
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| Jeanne Loyd  
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| Heidi Atkins Lieberman  
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### Consumer and Family Workgroup
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| Cathy Bruns                      | Jim Casey                                   |
| Client Advocate/Rights Monitor   | Executive Director                          |
| Fulton State Hospital            | Cole County Residential Services            |
| Fulton                           | Jefferson City                              |

| Carolyn Chambers                 | Tec Chapman                                 |
| Consumer Directed Services Auditor/Supervisor | Deputy Director                          |
| Rural Advocate for Independent Living | Division of Mental Retardation and Developmental Disabilities |
| Kirkville                        | Department of Mental Health                 |
|                                  | Jefferson City                              |

| Dora Cole                        | Mary Comer                                  |
| Director of Consumer Service Operations | Consumer/Family Leader                 |
| Division of Comprehensive Psychiatric Services | Jefferson City                              |
| Department of Mental Health      |                                             |
| Jefferson City                   |                                             |

| Tom Cranshaw                     | Edward Duff                                 |
| Chief Executive Officer          | Member of Governors Council on Disabilities |
| Tri-County Mental Health Center  | Joplin                                      |
| Kansas City                      |                                             |

<p>| Becky Ehlers                     | Bill Fleming                                 |
| Substance Abuse Unit Supervisor  | Consumer/Family Leader                      |
| Department of Corrections        | Verona                                      |
| Jefferson City                   |                                             |</p>
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## Disparities Are Eliminated Workgroup
### Membership Roster

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| Thomas Adams              | Tom Breedlove             |
| Program Officer           | Deputy Director           |
| Missouri Foundation for Health | Division of Youth Services |
| St. Louis                 | Department of Social Services |
|                           | Jefferson City            |

| Lawson Calhoun            | Marian Carr               |
| Chief Executive Officer   | Program Manager           |
| ECHO Childrens Home       | Swope Health Services     |
| St. Louis                 | Kansas City               |

| Barry Critchfield         | Kara Daumuelle-Morell     |
| Director                 | Director of Clubhouse     |
| Office of Deaf Services   | Independence Center-Midland House |
| Department of Mental Health | St. Louis                |
| Jefferson City            |                           |

| Kathryn DeForest          | Mel Fetter                |
| Senior Program Officer    | Chief Executive Officer   |
| Missouri Foundation for Health | Pathways Community Behavioral Health Center |
| St. Louis                 | Clinton                   |

| Judy Finnegan             | Barbara Garrison          |
| Childrens Services Coordinator | Superintendent        |
| Department of Mental Health | MO School for the Deaf |
| Jefferson City            | Fulton                    |

<p>| Liz Hagar-Mace            | John Harper               |
| Housing Director          | Supervisor of Mental Health Services |
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| Jefferson City            | Department of Elementary and Secondary Education |
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### Easy, Early Access Workgroup
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## Evidence Based Practice Workgroup

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<td>Patsy Carter, PhD</td>
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| Thomas Adams             | Allyson Ashley           |
| Program Officer          | Vice President of Operations |
| MO Foundation for Health | Burrell Behavioral Health |
| St. Louis                | Springfield              |

| Kate Blair               | Julie Blanco             |
| Associate Director       | Program Director         |
| Independence Center      | Community Alternatives   |
| St. Louis                | St. Louis                |

| Nora Bock                | Jean Campbell, PhD      |
| Mental Health Manager    | Director                |
| Division of Alcohol and Drug Abuse | Program in Consumer Studies and Training |
| Department of Mental Health | Missouri Institute of Mental Health |
| Jefferson City           | St. Louis                |

| Lisa Clements, PhD       | Avera Daniels            |
| Clinical Director/Psychology Program | Research Analyst II |
| Division of Medical Services | Department of Corrections |
| Department of Social Services | Jefferson City          |
| Jefferson City           | St. Louis                |

| Kathryn DeForest         | Stephen Gaioni, PhD     |
| Senior Program Officer   | Associate Chief of Staff|
| MO Foundation for Health | Mental Health Services   |
| St. Louis                | Veterans Administration Medical Center |

<p>| Dennis Gragg             | Steve Grow              |
| Assistant Deputy Director| Consumer/Family Leader  |
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# Mental Health Is Essential To Overall Health

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# Technology Workgroup Membership Roster

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Appendix C Causal Mapping*

Peter S. Hovmand, Ph.D.
Washington University in St. Louis

Introduction

Transformation in Missouri involves changing a system that is inherently complex, dynamic, and spanning multiple sectors of care. Seeing the whole is challenging as each stakeholder sees only a facet of the overall system. Methods that can help people visualize the interconnections between different sectors of care can aid in the planning and evaluation of transformation efforts.

System dynamics (Levin & Roberts, 1976; Sterman, 2000) is one way to understand systems and how they change. The goal of system dynamics is to improve the mental models that stakeholders use to understand and change a system. This can happen through qualitative system dynamics modeling using techniques such group model building (Andersen & Richardson, 1997; Vennix, 1996, 1999), or more formally by developing quantitative models that can be studied through computer simulations and empirical research.

System dynamics approaches understanding systems and change by focusing on the role of reinforcing and balancing feedback loops in a system, identifying stocks and flows, and recognizing the importance of delays on system behavior. Feedback loops are causal chains where the consequences of actions “feed back” to influence the causes. Reinforcing feedback loops accelerate change. Balancing loops slow down or counteract the direction of change.

Also important to system dynamics is the distinction between stocks and flows. Stocks represent the states of a system; for example, the number of people waiting for services or the number of people not seeking but needing services. Flows represent transitions between the stocks; for example, referring people to services or people dropping out of services.

Lastly, delays play an important role in understanding system behavior. Delays make it difficult to see the long term effects of actions. Delays can involve the time it takes for people to access appropriate services, but also the time it takes to accurately perceive the outcomes of actions. Evaluation of services, for example, involves delays as the full benefits of treatment or support might not be known for many years.

System dynamics was used to support the Missouri Mental Health Transformation project. This appendix provides summary of the causal mapping and qualitative model developed in 2007 as part of the planning process. The qualitative system dynamics model represents a collective view of mental health transformation in Missouri, which includes services and supports for persons with mental illness, addictions, and developmental disabilities. The purpose of the Mental Health Transformation (MHT) model was to help participants see the larger whole, identify potential leverage points for change, and identify potential threats to the implementation and sustainability of recommendations.

* This work was supported through a subcontract with Missouri Department of Mental Health, funded by the Substance Abuse Mental Health Services Administration Mental Health Transformation State Incentive Grant (SM57474-01); and, the Center for Mental Health Services Research, George Warren Brown School of Social Work, Washington University through an award from the National Institute of Mental Health (P30 MH068579).
The model was based on an exercise conducted during the initial workgroup planning meetings, subsequent input from the core working group, the leadership meeting in July 2007. Over 240 people participated in the model building process, including consumers and family members, providers, administrators, academics, and policy makers.

The Mental Health Transformation (MHT) model contains nearly 300 variables with 38 stock variables and tens of thousands of feedback loops. While obviously complex, it still represents a significant simplification of reality. This appendix provides an overview of the basic population model, description of the main reinforcing and balancing feedback loops discussed during the planning process, and analysis of the potential short-term and long-term threats to implementation and sustainability of transformation initiatives. The overriding theme from this analysis is the need to focus on eliminating barriers to accessing appropriate care and support and building system capacity for increasing sustainability of transformation efforts.

**Population Model**

The basic population model of transformation is shown in Figure 1. It represents the state of all persons within a given community, including those that are well, those that need services, and those that are receiving some type of services or support. Boxes represent the stocks or the number of people in various states. For example, the box labeled “Personal Wellbeing” represents the number of people in a community who are well, living independently, and achieved resiliency. The double lines with arrows represent flows or transitions of people between the stocks. How many or how fast people transition from one stock to another stock is regulated by a rate variable depicted as a symbol of a valve. People can begin in any state, transition at different rates over their lifespan, and cycle in and out of services and supports. The sum of all the people in the stocks represents the total or base population for a community.

It is important to note that system dynamics adopts a continuous perspective as opposed to a discrete perspective of change. This means that instead of viewing people as either in one stock or another stock where people “jump” from one stock to another, people can be partly in one stock and partly in another stock, and transitioning from one stock to another is a gradual and continuous process. For example, a person might still be receiving some appropriate services and supports while also having some independence and experiencing personal wellbeing.

**Main Stock Variables**

In the population model, people can be in any of nine states. People in a state of *Personal Wellbeing* are fully functioning, not receiving or needing services, resilient, living independently, and not at risk. People are *At Risk* when they are fully functioning, living independently, and at risk for conditions that would need services or supports. People are *Needing Services* when they have a condition that has not been screened and assessed and could benefit from services or supports, but are not yet seeking services and receiving appropriate care and support. People are *Seeking Services* when they decide to access services or supports in response to needs. People can also be *Needing and Not Seeking Services*, either because they decide not to seek them in the first place or because they discontinue seeking services and supports.

People enter the service system through screening and assessments. The service system is represented by the light gray box in Figure 1. No screening and assessment procedure is error free, and all screening and assessment tools generate contribute to persons with incorrect assessments. Thus people who have been screened or assessed for mental illness, substance abuse, or development disabilities are either *Waiting for Services with Accurate Assessments* or *Waiting for Services with Assessment Errors*. 

Appendix C
In transformation, one is concerned with not just the delivery traditional services, but also supports from community, employers, neighbors, families and friends. Both services and support need to be appropriately matched to individual needs. When this happens, people are in the stock of Receiving Appropriate Care and Support. Services can be inappropriate if either the care or support is inappropriate. For example, one might being receiving appropriate counseling, but inappropriate support because one cannot access needed ancillary services. Similarly, housing supports could be excellent, but one is unable to access culturally appropriate evidence-based practices. Both would place the person in the stock or state of Receiving Inappropriate Care or Support.

**Figure 1** Population Model

![Population Model Diagram](image)

**Main Flow or Transition Variables**

There are fifteen flows or transitions between these nine stocks. People who in a state of are in a state of Personal Wellbeing move to At Risk with Increasing Risk of mental illness, substance abuse, or developmental disability. For example, someone experiencing a job transition might be at risk for an adjustment disorder. Similarly, people can move from being At Risk to Personal Wellbeing with Decreasing Risk. This might happen with the aid of natural supports or more formally through primary prevention services. Some people At Risk will move to Needing Services with the Onset of Illness such as substance abuse, mental illness, or disability. Some people Needing Services will Decide to Seek Services and be actively Seeking Services. Of these, some will decide to Discontinue Seeking Services and transition to Needing and Not Seeking Services. For example, they might not be able to access information about available
services in their community or they may encounter stigma from their employer about mental illness, substance abuse, or developmental disability and decide not to seek services despite having needs. There are also others who do not seek services in the first place, although this might not be a decision; for example, a person with depression who does not know that effective treatments are available would move people from Needing Services to Needing and Not Seeking Services via Deciding not to Seek Services. It is important to note that in this version of a generic population structure, there are no outflows out of needing and Not Seeking Services. This places the emphasis on identifying existing mechanisms or developing new interventions that move people from this stock into the services.

Some people Seeking Services will transition into the service system through initial screening and assessments. Since not all screenings and assessments are accurate, some transition to waiting for services via Initial Screen and Assessments while others transition to waiting for services through Initial Screen and Assessments with Errors. Moreover, the longer people wait for services, the more likely their condition has changed from the initial screening and assessment. This does not affect those who are already Waiting for Services with Assessment Errors, but it does have implications for those Waiting for Services with Accurate Assessments. The longer the wait for services, the more likely people are to have assessments that are out-of-date and inaccurate. This transition is represented by the rate Declining Health from Waiting for Services.

People move from waiting for services to receiving care through referral, intake, and care planning. Individualized Care Planning will match appropriate services to individual needs, regardless of whether the initial screening and assessment was accurate. This is represented by the flow Individualized Care Planning from Waiting for Services with Accurate Assessments and Waiting for Services with Assessment Errors. Similarly, non-individualized care planning can lead to care or support that is inappropriate even if one has an accurate screening and assessment. Hence, there is a flow Non-individualized Care Planning from Waiting for Services with Accurate Assessment and Waiting for Services with Assessment Errors to Receiving Inappropriate Care or Support.

People can also move from Receiving Appropriate Care to Receiving Inappropriate Care, which might happen with the limited availability of appropriate programs and services, the loss of other factors related to maintaining quality of care, or a change in clients’ conditions leading to inappropriate care. This is represented by the flow Losing Appropriate Care. When someone is Receiving Inappropriate Care they may develop new needs or decide to discontinue ineffective services. When this happens, people leave the service system with unmet needs and return to the state of Needing Services. The transition is represented by Onset of Co-occurring Conditions and Dropout. This flow really represents two different types of transitions, the onset of co-occurring conditions and the discontinuation of ineffective treatment. Since receiving inappropriate treatment or supports has an opportunity cost of increasing the risk of conditions worsening and the development of co-occurring conditions, the two types of have been simplified into one flow.

Recovery and gaining independence is represented in Figure 1 as both an outcome and process. As an outcome, recovery and independence are represented as a transition from Receiving Appropriate Care to no longer needing services and entering either 1) Personal Wellbeing via Recovery, Resiliency, and Independence, or 2) At Risk via Recovery and Independence. The main difference between the two is whether an individual develops resiliency in addition to recovery and independence. Since persons who do not develop resiliency are still at risk, they return to the At Risk stock after discontinuing with services.
As a process, recovery and gaining independence are represented as the movement or paths through various states toward the states of being Personal Well or At Risk. These paths can be of any length, include cycles, and often specific to the individual. There are an infinite number of possible paths of recovery and gaining independence. For example, one person might cycle between Personal Wellbeing and At Risk and occasionally need services and receive some type of services and return to Personal Wellbeing and At Risk, while another person’s recovery and gaining independence might involve moving from Needing Services to Receiving Appropriate Care.

Feedback Loops

Central to all transformation initiatives is developing local community support for changes at the local level, which depends on two key variables in the model: public awareness and stigma. The analysis that follows begins with considering the potential feedback loops driving public awareness and stigma. Potential feedback loops are identified by looking at the delays or length of the feedback loops. Feedback loops with fewer links and shorter delays respond faster to change and have a larger effect over the short term.

Two influential stocks that have drive perceptions in the model are people Receiving Appropriate Care and Support and People Needing and Not Seeking Services. The three main rates affecting people receiving appropriate care and support are: 1) referrals through Individualized Care Planning, 2) Recovery, Resiliency, and Independence, and 3) Losing Appropriate Care and Support. Of these, addressing factors that lead to Losing Appropriate Care or Support is probably the fastest to respond to change.

The stock of people Needing and Not Seeking Services is influenced by 1) people Deciding to Not Seek Services in the first place, and 2) people Discontinuing to Seek Services. Increasing the number of people who decide to seek services will lead to an increase in the number of people waiting for services and the number of people deciding to discontinue seeking services. To avoid this, one needs to first slow the rate that people decide to discontinue seeking services.

Main Reinforcing Loops

The five main feedback loops are shown in Figures 2 to 4. Each feedback loop is shown in relationship to the basic population model from Figure 1. Plus signs indicate influence of one variable on the other in the same direction with everything else being equal, while minus signs indicate the influence of one variable on another variable in the opposite direction. The half circles with labels (e.g., R1, R2) designate feedback loops with the ‘R’ prefix indicating reinforcing feedback loops.

Peer to Peer Services (R1). More Peer to Peer Services means that Populations Losing Appropriate Services will slow down or decrease, reducing disparities and increasing the number of people Receiving Appropriate Care and Support. This can improve Outcomes According to Families and Consumers, improve Quality of Life, increase Consumer Empowerment and the number of Consumers and Families in Leadership, which feeds back to increase Peer to Peer Services forming the reinforcing loop R1 in Figure 2.
**Figure 2** Peer to Peer Services (R1) and Consumer Empowerment (R2)

![Diagram of Peer to Peer Services and Consumer Empowerment]

**Figure 3** Community Preparation (R3) and Stigma (R4)

![Diagram of Community Preparation and Stigma]

Appendix C
**Consumer Empowerment (R2).** Consumer Empowerment increases with more Consumers and Families in Leadership. This leads to more opportunities and empowerment, forming the reinforcing loop R2 in Figure 2.

**Community Preparation (R3).** Community preparation involves working with communities to support changes that increase natural supports and local investment in services and supports. Increasing natural supports helps prevent populations from losing appropriate services and slows the rate that people lose appropriate care and support. This leads to an improvement in outcomes, quality of life, and consumers and families in leadership. The results feed back to further prepare communities, creating the reinforcing feedback mechanism R3 in Figure 2.

**Stigma (R4).** Lowering stigma increases natural supports, which helps prevent populations from losing appropriate services and reduces the number of people who lose appropriate care or support. This increases outcomes and quality of life, which increases consumer empowerment, consumers and families in leadership, and public awareness. This leads to a further reduction in stigma and creates the reinforcing feedback mechanism R4 in Figure 3.

**Law Enforcement Involvement (R5).** The greater the involvement of law enforcement, injuries, and court system handling, the less compassionate the public is toward persons with mental illness, addictions, or developmental disabilities. Hence, efforts to reducing law enforcement involvement, injuries, and court system handling provide an opportunity for public awareness of to increase, which lowers stigma, and slows the rate that people decide to discontinue seeking services. This begins to lower the number of people needing and not seeking services and creates the reinforcing feedback mechanism R5 in Figure 4.

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**Figure 4** Law Enforcement Involvement (R5)
These five reinforcing feedback mechanisms represent the most immediate drivers of people losing appropriate care or support and discontinuing to seek services in the model. There is considerable overlap between feedback loops. Thus efforts to influence one loop are likely to also affect other loops as well. The strength of these loops and whether they lead to overall improvements will depend on a variety of factors, including the length of the delays and influence of balancing loops that limit transformation.

**Main Balancing Loops**

Balancing loops in the model represent limits that can threaten the long-term sustainability of transformation efforts. Figure 5 through 7 depict some of the main balancing loops identified in the model. Balancing loops are labeled with a ‘B’ prefix. These feedback loops counteract the direction of change or slow the rate of change. Thus an increase in any variable from some intervention will be resisted by the balancing feedback loops.

*Shortage of Mentors (B1).* Slowing or decreasing the number of *Mental Health Workers using EBP* introduces additional constraints. Specifically, it limits the number of *Mentors for Implementing EBP*, which constrains *Training of Professionals, Support Staff, and Supervisors*. This lowers *Fidelity of implementation* and feeds back to lower the number of persons *Receiving Appropriate Care and Support*. This forms the balancing feedback loop reflecting the shortage of mentors B1 in Figure 5.

**Figure 5** Shortage of Mentors (B1), Losing Fidelity (B2), and Slowing Adoption and Implementation of EBP (B3)
Losing of Fidelity (B2). Increasing Caseload also increases the rate that providers Discontinue EBP, which increases the rate that people are Losing Appropriate Care and Support, which lowers the number of people Receiving Appropriate Care and Support, forming balancing feedback loop B2 in Figure 5.

Slowing Adoption and Implementation of EBP (B3). The most immediate effect of increasing persons Receiving Appropriate Care and Support is on increasing Caseload. Increasing Caseload slows the rate that workers are Adopting and Implementing EBP, which lowers the number of Mental Health Workers Using EBP relative to where it would have been. This slows the increase in Individualized Care Planning and slows the growth of persons Receiving Appropriate Care and Support. This forms the balancing feedback loop B1 in Figure 5.

Limiting Peer to Peer Services (B4, B5). Increasing the number of people Receiving Appropriate Care and Support increases Caseloads, which can slow the rate of Adopting and Implementing EBP as well as increase the rate of Discontinuing EBP, which limits the number of Mental Health Workers Using EBP, Mentors for Implementing EBP, and Training of Professionals, Support Staff, and Supervisors. This limits Consumer and Family Driven Services, which limits improvements in Outcomes According to Families and Consumers. This could limit the involvement of Consumers and Family Members in Leadership, limit improvements in Peer to Peer Services, and increase the rate that people are Losing Appropriate Care or Support. This could lower the number of people receiving Appropriate Care and Support, forming two feedback loops, B4 and B5, as shown in Figure 6.
It is important to note here that the model treats training of professionals, support staff and supervisors as separate from leadership or peer to peer service training. In particular, training of consumers and family members for leadership positions or as peer to peer service providers does not depend on the availability of trained professionals. It does depend, however, on consumers and family members being in leadership positions to advocate for peer to peer services and leadership trainings, and this depends on how well professionals, support staff, and supervisors work with consumers and family members.

Limiting Community Preparation (B6, B7). Similar to B4 and B5, increasing the number of people Receiving Appropriate Care and Support increases Caseloads, which can slow the rate of Adopting and Implementing EBP as well as increase the rate of Discontinuing EBP. This limits the number of Mental Health Workers Using EBP, Mentors for Implementing EBP, Training of Professionals, Support Staff, and Supervisors and Consumer and Family Driven Services. The effect would be lower Outcomes According to Families and Consumers, slowing or decreasing Quality of Life, less Consumer Empowerment, and fewer Consumers and Families in Leadership. As a consequence, Community Preparation would slow down or decline, with fewer Natural Supports, and a corresponding increasing in Populations Losing Appropriate Services. That is, an increase in disparities, which would lead to more people Losing Appropriate Care or Support and forming two feedback loops, B6 and B7, as shown in Figure 7.

Figure 7 Limiting Community Preparation (B6, B7)
Discussion

This qualitative model provides a starting place for visualizing the interconnections involved in transformation for Missouri. The focus in this analysis has been on identifying the reinforcing and balancing feedback loops that could play important roles within the first two years of implementing recommendations. There are several observations to be made about the model.

First, training of professionals, support staff, and supervisors plays a central role in the constraints on transformation. More specifically, the main constraint from a feedback perspective is helping professionals gain experience and become mentors for training other professionals, particularly in the use of EBP and consumer and family driven services.

Second, many of the themes from the Leadership Meeting in July 2007 overlap with the implications from the model. For example, participants at the planning meeting discussed the importance of developing consumers and families in leadership positions and peer to peer services as development or growth mechanisms, and how these mechanisms could be used to develop local community support. These mechanisms are represented in model, which offers a more explicit conceptualization of which recommendations would generate change and how.

Third, it is important to remember that the model is a qualitative model and represents a collective understanding of services, supports, and transformation. The utility of such a model is in being able to synthesize diverse participants’ views of services, supports, and transformation, and being able to logically trace the connections between variables. In this sense, it is similar to a logic model and could be used as a basis for theory based evaluations. The benefit of theory based evaluation is that it gives one a better understanding of why changes occurred and insights into the system. Like the scientific method, we learn the most when we make our hypotheses about change explicit and compare them against empirical data. Developing a quantitative system dynamics model that can be simulated would help make hypotheses even more explicit as well as generate insights into the relationships between populations, services, communities, and the dynamics of transformation.

Lastly, it will be helpful to remember that the most immediate threats to implementing recommendations come from the existing state of the system or stocks. Many of the recommendations in the plan focus on initiating change by affecting these stocks. Once some of these stocks are changing, reinforcing loops will accelerate change, followed by a set of constraints or balancing feedback loops that will slow down and potentially threaten both the sustainability of the initial benefits and the implementation of longer term policies.

Conclusion

Statewide transformation is inherently complex, involving many communities, stakeholders, and local, state, and federal agencies. The diversity of needs and level of cooperation required to successfully implement any single set of reforms requires high levels of communication, insight, leadership, and understanding for the system as a whole. Causal mapping of transformation goals and the development of a qualitative system dynamics model provide a new tool for decision makers to discuss, understand, and design changes that consider both the short-term and long term effects. Future work based on these efforts should focus on continuing to support the planning process, theory based evaluation efforts, and the development of a system dynamics simulation model that can be used for evaluation and learning.
References


Appendix D—Glossary of Terms and Acronyms

ACE Goals: From the Strategic Plan of the Substance Abuse Mental Health Services Administration (SAMHSA), the ACE goals are Accountability, Capacity, and Effectiveness. Missouri’s Transformation Initiative is funded by SAMHSA and the priority actions are measured for anticipated long-term impact using the ACE goals as designated below:

A-Improved Accountability
C-Increased Service Capacity
E-Increased Service Effectiveness

Alcohol and Drug Abuse (ADA) Division: one of the three divisions of the Missouri Department of Mental Health. ADA provides funding for prevention, outpatient, residential, and detoxification services to community-based programs that work with communities to develop and implement comprehensive coordinated plans. The Division provides technical assistance to these agencies and operates a certification program that sets standards for treatment programs, qualified professionals, and alcohol and drug related educational programs.

Bright Futures: Bright Futures is a cross agency effort supported by the Missouri Departments of Elementary and Secondary Education, Health, Mental Health, Social Services; Head Start; The Childrens Trust; and the University of Missouri Center for Mental Health Practices in Schools. Bright Futures mission is to help communities develop a professional, systematic, evidence based and sustainable team approach to address prevention, promotion and early intervention related to social emotional health of children

Burden of Disease: A measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability. (Also see Global Burden of Disease study and DALY) According to the World Health Organization, the proportion of the global burden of disease attributable to mental, neurological and substance use disorders is expected to rise from 12.3% in 2000 to 16.4% by 2020. More than 150 million persons suffer from depression at any point in time and nearly one million commit suicide every year. Moreover, there is strong evidence that mental disorders impose a range of consequences on the course and outcome of comorbid chronic conditions, such as cancer, heart disease, diabetes and HIV/AIDS.


Causal Mapping: A method of developing causal loop diagrams that captures how variables in a system are related by cause and effect linkages.

Centers for Disease Control and Prevention (CDC): An agency located in the federal Department of Health and Human Services (DHHS), CDC seeks to promote health and the quality of life by preventing and controlling disease, injury, and disability. Principle functions include: monitoring health, detecting and investigating health problems, conducting research to enhance prevention, developing and advocating for sound public health policies, implementing prevention strategies, promoting healthy behaviors, fostering safe and healthful environments, and providing leadership and training.


Center for Mental Health Services (CMHS): CMHS is the part of the federal Substance Abuse Mental Health Services Administration under the Department of Health and Human Services. CMHS is responsible for mental health treatment and administers the CPS block grant as well as the Transformation grant

Center for Substance Abuse Prevention (CSAP): CSAP is the part of the federal Substance Abuse Mental Health Services Administration under the Department of Health and Human Services. CSAP is responsible for substance abuse prevention.
Center for Substance Abuse Treatment (CSAT): CSAT is the part of the federal Substance Abuse Mental Health Services Administration under the Department of Health and Human Services. CSAT is responsible for alcohol and drug abuse treatment. It is part of SAMHSA and administers the ADA block grant.

Children's Comprehensive System Management Team (CSMT): State legislation (SB 1003) mandated that DMH, in partnership with all child-serving departments, develop a unified, comprehensive children's mental health system. This legislation required a cross-departmental Comprehensive System Management Team responsible for developing and implementing a comprehensive mental health plan for children. The CSMT guides implementation of the children's components of this comprehensive plan.

Commission on Accreditation of Rehabilitation Facilities (CARF): A private, not-for-profit accrediting organization which establishes standards of quality for various service organizations to use as guidelines in developing and offering their programs or services to consumers. Service organizations voluntarily apply for certification and open themselves to survey and inspection. CARF is required by Vocational Rehabilitation for their providers.

Community Mental Health Center (CMHC): An entity designated by the MoDMH to serve as an organization providing services described in section 1916 (c)(4) of the Public Health Service Act that meets applicable licensing or certification requirements for community mental health centers in the state in which it is located. CMHCs provide outpatient services, including specialized services for children, the elderly, and persons with serious mental illness; 24-hour emergency care services; day treatment or other partial hospitalization services or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

Comprehensive Psychiatric Services (CPS) Division: one of the three divisions of the Missouri Department of Mental Health. CPS is charged with the delivery of services to persons with mental illness throughout the State of Missouri. The division is committed to serving four target populations: persons with serious and persistent mental illness (SMI); persons suffering from acute psychiatric conditions; children and youth with serious emotional disturbances (SED) and forensic clients.

Consumer: Missouri is using and enhancing the term as defined in the President's New Freedom Commission Report. Consumer generally identifies people of all ages who use or have used mental health services and includes persons with mental illness, addiction disorders and mental retardation/developmental disabilities. In addition, the term extends to families/guardians who participate in services when they are not explicitly identified. The terms consumer, client and service participant are often used interchangeably with the same meaning.

Consumer Operated Service Programs (COSP): Services and supports directed by and employing consumers who have mental illness. For example, the CPS division contracts with these organizations for the provision of drop-in centers and warm lines.

Co-Occurring Disorders (COD): refers to co-occurring substance-related and other mental disorders. Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders. This term is also used to refer to co-occurring mental retardation or developmental disorders and one or more mental illnesses. The term COD is also used to refer to the specialized services provided to individuals with co-occurring disorders as in COD services or COD program.

Co-Occurring State Incentive Grant (COSIG): SAMHSA-funded State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders. Missouri received funding for five years through September 2008.

Crisis Intervention Teams (CITs): Local law enforcement teams who receive targeted training in how to respond and refer consumers needing mental health services in an effort to avoid inappropriate incarceration.
Department of Corrections (DOC): State department in Missouri that operates correctional facilities and monitors offenders on probation and parole.

Department of Mental Health (DMH): Missouri's public mental health authority. DMH has three divisions: Alcohol and Drug Abuse (ADA), Comprehensive Psychiatric Services (CPS) and Mental Retardation/Developmental Disabilities (MRDD).

Department of Health and Senior Services (DHSS): State agency in Missouri that works to improve the health and quality of life for persons of all ages by providing information and education, regulation and oversight, and quality services and surveillance of diseases and health conditions. Major divisions include: Community and Public Health, Regulation and Licensure, and Senior and Disability Services.

Department of Public Safety (DPS): The Missouri state agency which coordinates federal and state funds and programs for juvenile justice, victims' assistance, law enforcement, emergency management and narcotics control as well as support services and resources to assist local law enforcement agencies and to promote crime prevention. Major divisions include the State Emergency Management Agency, Homeland Security, Veterans Commission, Highway Patrol, Water Patrol, Gaming Commission, Alcohol & Tobacco Control, Fire Safety and Capitol Police.

Department of Social Services (DSS): State agency in Missouri responsible for coordinating programs to provide public assistance to children and their parents, access to health care, child support enforcement, and provide specialized assistance to troubled youth. Major divisions include: Children's Division, Family Support Division, MO HealthNet Division, and Division of Youth Services.

Departmental Client Number (DCN): Unique state identification number assigned by certain state departments. It is also referred to as Document Control Number.

Department of Elementary and Secondary Education (DESE): State department in Missouri that works with educators, legislators, government agencies, and citizens to maintain a strong public education system through statewide school improvement initiatives and regulatory functions. Major divisions of DESE include: Career Education, School Improvement, Special Education, Teacher Quality and Urban Education, and Vocational Rehabilitation.

Dialectical Behavioral Therapy (DBT) is a psychosocial treatment developed by Marsha M. Linehan specifically to treat individuals with borderline personality disorder (BPD), [1] though it is used for persons with other diagnoses as well. The treatment itself is based largely in behaviorist theory with some cognitive therapy elements as well. Unlike cognitive therapy it incorporates mindfulness practice as a central component of the therapy.

Disability Adjusted Life Years (DALY): The Disability Adjusted Life Year or DALY is a health gap measure that extends the concept of potential years of life lost due to premature death (PYLL) to include equivalent years of healthy life lost by virtue of being in states of poor health or disability (1). The DALY combines in one measure the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of healthy life and the burden of disease as a measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability. http://www.who.int/healthinfo/boddaly/en/

Early Periodic Screening Diagnosis and Treatment (EPSDT): Program funded by Mo Healthnet (formerly Missouri Medicaid) also referred to as Healthy Children and Youth. Services include screening for physical development, vision, dental, and hearing; occupational therapy; physical therapy; psychological counseling; case management; immunizations; and other medically necessary services.

Electronic Medical Records (EMR): A medical record in digital format. Additional terms related to EMR include
• Bar-coded Point of Care Technology (BPOC)
• Computerized Physician Order Entry (CPOE)

Evidenced-Based Practices (EBPs): Standardized treatments studied in controlled research designs that are shown to improve important outcomes by objective measures, in research conducted by different investigator teams.

Federally Qualified Health Center (FQHC): A community based health care organization providing comprehensive primary preventive, health, dental, and mental health/substance abuse services to persons in all stages of the life cycle.

Fidelity: Fidelity is the extent to which an evidence-based practice actually implemented corresponds to the practice as designed. Following the design with high fidelity is expected to result in greater success in achieving desired client outcomes than deviating from the design (i.e., having low fidelity).

Global Burden of Disease (GBD) Project: World Health Organization (WHO) 2000 http://www.who.int/healthinfo/bodabout/en/index.html A response to the need for comprehensive, consistent and comparable information on diseases and injuries at global, regional and national levels. The WHO Global Burden of Disease (GBD) project updated the original Global Burden of Disease Study carried out by Murray and Lopez for the year 1990. The WHO GBD project draws on a wide range of data sources to develop internally consistent estimates of incidence, health state prevalence, severity and duration, and mortality for over 130 major causes, for WHO Member States and for sub-regions of the world, for the years 2000 and beyond. WHO program participation in the development and finalization of these estimates ensures that estimates reflect all information and knowledge available to WHO.

Government Performance Results Act of 1993 (GPRA). The Act provides for the establishment of strategic planning and performance measurement in the Federal Government. GPRA measures identified by SAMHSA for the purposes of evaluating the Transformation State Incentive Grant include the following measures of infrastructure changes:
1 = Policy Changes Completed
2 = # of Persons in Workforce Trained
3 = Financing Policy Changes Completed
4 = Organizational Changes Completed
5 = # of Organizations that Regularly Obtain and Analyze Data
6 = # of Members in Consumer and Family Run Networks
7 = Programs Implementing Practices Consistent with CMHP

Health literacy is the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions. But health literacy goes beyond the individual. It also depends upon the skills, preferences, and expectations of those health information providers: our doctors, nurses, administrators, home health workers, the media, and many others. Health literacy arises from a convergence of education, health services, and social and cultural factors, and brings together research and practice from diverse fields.

Hippocrates: Greek physician who is credited with establishing the foundations of scientific medicine. He and his followers worked to distinguish medicine from superstition and magic beliefs by basing their treatment of illness on close observation and rational deduction.

Human Services Cabinet Council (HSCC): A Cabinet subgroup serving as the governing body of the Transformation Working Group and steering the mental health transformation process. The HSCC is chaired by the Governors Chief of Staff. Members include the Directors of the Departments of Mental Health (DMH), Social Services (DSS), Health and Senior Services (DHSS), Elementary and Secondary Education (DESE), Corrections (DOC) and Public Safety (DPS).
Joint Commission (JC): formerly known as JCAHO, Joint Commission on Accreditation of Healthcare Organizations): An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 15,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organizations commitment to meeting certain performance standards.

Lived experience: Is a sociology term referring to the way a person experiences and understands his or her world as real and meaningful. Lived experiences describe those aspects of a situation as experienced by the person.

Mental Disorders: As defined by the World Health Organization (WHO), mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behavior and relationships with others. The term is used interchangeably with mental and behavioral disorders. The WHO definition is used as it includes mental health problems encountered by the majority of the populations addressed in this plan. The broad categories of mental and behavioral disorders covered in International Classification of Diseases manual (ICD-10) include:

- Organic, including symptomatic, mental disorders - e.g., dementia in Alzheimer's disease, delirium.
- Mental and behavioral disorders due to psychoactive substance use - e.g., harmful use of alcohol, opioid dependence syndrome.
- Schizophrenia, schizotypal and delusional disorders - e.g., paranoid schizophrenia, delusional disorders, acute and transient psychotic disorders.
- Mood [affective] disorders - e.g., bipolar affective disorder, depressive episode.
- Neurotic, stress-related and somatoform disorders - e.g., generalized anxiety disorders, obsessive-compulsive disorders.
- Behavioral syndromes associated with physiological disturbances and physical factors - e.g., eating disorders, non-organic sleep disorders.
- Disorders of adult personality and behavior - e.g., paranoid personality disorder
- Mental retardation - e.g., mild mental retardation.
- Disorders of psychological development - e.g., specific reading disorders, childhood autism.
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence - e.g., hyperkinetic disorders, conduct disorders, tic disorders.
- Unspecified mental disorder.

Mental Health Commission: The Mental Health Commission, composed of seven members, appoints the director of the Department of Mental Health with confirmation by the state Senate. Commissioners are appointed to four-year terms by the Governor, again with the confirmation of the Senate. The commissioners serve as principle policy advisors to the department director. The Commission by law must include an advocate of community mental health services, a physician who is expert in the treatment of mental illness, a physician concerned with developmental disabilities, a member with business expertise, an advocate of substance abuse treatment, a citizen who represents the interest of consumer developmental disability services.

Mental Health Literacy: Mental health literacy refers to the knowledge and beliefs about mental health problems which aid their recognition, management or prevention. Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatm ents, and of professional help available; and attitudes that promote recognition and appropriate help-seeking. (See Health Literacy)

Mental Illness (MI): As defined by SAMHSA, a diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual’s cognitive, emotional or social abilities; often used interchangeably with
Mental Retardation/Developmental Disabilities (MRDD): One of the three divisions of the Missouri Department of Mental Health. MRDD, established in 1974, serves a population that has developmental disabilities such as mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22, with the expectation that they will continue. To be eligible for services from the Division, persons with these disabilities must be substantially limited in their ability to function independently.

MSNT: Midwest Special Needs Trust http://www.midwestspecialneedstrust.org/
Midwest Special Needs Trust (MSNT) provides trust services for persons with disabilities. The organization was established as a result of advocacy by parents and professionals who realized that many obstacles hinder planning for the financial future of individuals with disabilities.

Missouri Primary Care Association (MPCA): http://www.mo-pca.org/
The MPCA is a non-profit corporation founded in November 1984 as an alliance of community health centers. The Association functions as an advocacy voice for the medically underserved and explores and implements activities aimed at providing and promoting high quality, accessible, and personalized healthcare services to urban and rural populations - regardless of ability to pay - in the state of Missouri. MPCA’s mission is to be Missouri’s leader in shaping policies and programs that improve access to high-quality, community-based, and affordable primary health services.

MO-ANCOR: http://www.moancor.org/
The American Network of Community Options and Resources - Missouri Chapter is an organization that assists providers in empowering people who experience developmental disabilities to: (1) exercise maximum control over their lives; and (2) experience full inclusion in their communities through a choice of various supports and services. The mission of MO-ANCOR is the promotion of and assistance to private or county providers who offer services and supports to people with disabilities and their families through advocacy, information and education.

Missouri Association of Rehabilitation Facilities (MARF): http://www.marf.cc
MARF is the trade association for organizations serving people with disabilities and others who need community support. The mission of MARF is to provide leadership and a statewide coalition to enhance the lives of Missourians who need community supports through legislative initiatives, partnerships with state agencies, and professional development.

Missouri Association of County Developmental Services (MACDDS): http://www.macdds.org
The Missouri Association of County Developmental Disabilities Services (MACDDS) is a leader in local initiatives for people with developmental disabilities. The organization is comprised of 45 county boards with total expenditures exceeding $117.6 million a year, providing local services for more than 46,000 people with developmental disabilities. Members also invest over $8 million in partnership with the state Department of Mental Health - Division of MR/DD in the Medicaid Waiver. MACDDS is dedicated to ensuring that quality community supports are available for people with developmental disabilities.

The Missouri Autism Centers of Excellence (MO-ACE) consists of three University-based providers of autism services that have been selected to enhance the states efforts to accelerate the pace of early diagnosis and treatment for individuals with autism spectrum disorders (ASD) and their families.

Missouri Autism Response and Research Agenda (MARRA): A collaborative of multiple stakeholders and partnership with University of Missouri Thompson Center on Autism and neuro-developmental disabilities.
Missouri Coalition of Community Mental Health Centers (MOCCMHC):  The Missouri Coalition of Community Mental Health Centers, founded in 1979, represents Missouri’s not-for-profit community mental health centers (CMHCs), as well as alcohol and drug abuse treatment agencies. The MOCHMC represents twenty-eight member agencies that provide mental health treatment and support services across the state.

Missouri Housing Development Commission (MHDC):  MHDC is the state’s housing finance agency. The Commission is dedicated to strengthening communities and the lives of Missourians through the financing, development and preservation of affordable housing.

Missouri Institute of Mental Health (MIMH): A policy, research and training center at the University of Missouri-Columbia, the MIMH is dedicated to providing research, evaluation, policy and training expertise to the Missouri Department of Mental Health, other state agencies, service provider agencies, and other organizations and individuals seeking information related to mental health and other related policy areas. Specific areas of interests include substance abuse prevention and treatment, mental health promotion and treatment, mental health and substance abuse recovery, suicide prevention, violence prevention, behavioral health, behavioral informatics, epidemiology, and health literacy. Areas of expertise include quantitative and qualitative research methods, information technology, web site design and applications, process and outcome evaluation, and program and curriculum development.

Missouri Mental Health Task Force: A one-time group charged with developing long-term solutions to prevent abuse and neglect, assure thorough investigation of abuse and neglect allegations, and recommend actions to increase the safe delivery of mental health services for Missourians with disabilities. This task force was formed at the direction of Governor Matt Blunt to oversee a cross-agency effort to address incidents of abuse and neglect and client deaths at Department of Mental Health facilities and community-based agencies. The task force was made up of the Departments of Mental Health (DMH), Public Safety (DPS), Health and Senior Services (DHSS), and Social Services (DSS). Lt. Governor Peter Kinder and Ron Dittmore, interim director for DMH, served as co-chairs. See Findings and Recommendations of this task force at: http://www.dmh.missouri.gov/mmhtaskforce/.

Missouri Planning Council for Developmental Disabilities (MPCDD): A federally funded, 23-member council, appointed by the Governor. Its mission is to assist the community to include all people with developmental disabilities in every aspect of life. By law, 60 percent of the council’s membership consists of individuals with developmental disabilities and family members. The remaining 40 percent is made up of key representatives from state agencies that provide services and supports to people with developmental disabilities.

Missouri Substance Abuse Prevention, Intervention and Resources Initiative (Spirit) Program: supports development/implementation of a continuum of evidenced-based substance abuse prevention services in K-12 public schools.

Mo Blue Ribbon Panel on Autism: http://www.senate.mo.gov/autism/autism2007.pdf The Blue Ribbon Panel consisted of sixteen members and was established to assist policymakers in providing a better system for individuals and their families affected by Autism Spectrum Disorders. The Blue Ribbon Panel was charged with identifying issues of children, youth, and adults with autism and with making appropriate recommendations to address those identified needs. The Blue Ribbon Panel heard over 60 hours of testimony in 5 cities (Jefferson City, Cape Girardeau, Springfield, St. Louis, and Kansas City) from numerous experts, families, and individuals with ASD.

Needs Assessment & Resource Inventory (NARI): A comprehensive statewide mental health needs assessment and resource inventory conducted by the Missouri Institute of Mental Health (MIMH) for the purpose of assisting in the development of the Comprehensive Mental Health Plan. MIMH researchers gathered information from a variety of individuals and organizations involved in Missouri’s mental health care system including consumers, provider agencies, state agency personnel, other professionals and the general population. Numerous focus groups, key informant interviews and surveys were conducted as
part of the needs assessment. A special effort was made to engage persons whose voices were
underrepresented through focus groups and key informant interviews. The NARI serves as a companion
document to this plan. MIMH will distribute this document and it is also posted on the Transformation

Network of Care (NOC):  http://missouri.networkofcare.org/home_state.cfm?stateid=30
Network of Care is a highly interactive, single information place where consumers, community-based
organizations and municipal government workers all can go to easily access a wide variety of important
information. The resources in this “virtual community” include a fast, comprehensive service directory;
links to pertinent Web sites from across the nation; a comprehensive, easy-to-use Library; a political
advocacy tool; community message boards; and many others.

Office of Administration (OOA):  http://www.oa.mo.gov/
The Office of Administration provides guidance and assistance to state government entities through the
implementation of executive office initiatives, the establishment of uniform procedures and rules as well
as providing services to them in a cost-effective manner.

Office of Juvenile Justice and Delinquency Prevention (OJJDP):  Part of the U.S. Department of
Justice, this agency provides national leadership, coordination, and resources to prevent and respond to
juvenile delinquency and victimization. OJJDP supports states and communities in their efforts to develop
and implement effective and coordinated prevention and intervention programs, and to improve the
juvenile justice system so that it protects public safety, holds offenders accountable, and provides
treatment and rehabilitative services tailored to the needs of juveniles and their families.

Office of State Court Administrators (OSCA): A state courts administrator functions under direction of
the Supreme Court to help develop and implement administrative policies and services for the judicial
branch. The Missouri state courts administrators office ensures court operations and judicial
administrative needs are identified, evaluated and incorporated into appropriate long- and short-range
plans; establishes priorities and secures resources to accomplish those priorities; addresses financial and
operational problems and budgeting issues; and manages use of technology within the judicial branch.
(http://www.courts.mo.gov/page.asp?id=631)

Outcomes: Specific, measurable results used to judge the effectiveness of an intervention.

Positive Behavioral Support (PBS): A set of research-based strategies to enhance the capacity of
schools, families, and communities to design effective teaching and learning environments. It is a
collaborative, assessment-based process to develop effective, individualized interventions for individuals
with challenging behavior. Support plans focus on proactive and educative approaches. In school
settings, it focuses on creating and sustaining school-wide (primary), classroom (secondary), and
individual (tertiary) supports that improve lifestyle results for all students by making problem behavior less
effective, efficient, and relevant, and desired behavior more functional. Use of PBS decreases the need
for interventions such as punishment or suspension.

Prevention: Beginning with public health, prevention is generally categorized as primary prevention,
directed at averting a potential health problem; secondary prevention, directed at early detection and, as
appropriate, intervention to delay onset or mitigate a health problem; or tertiary prevention, directed at
minimizing disability and avoiding relapse. In practice, prevention technologies take three general forms
in clinical practice: (1) prevention strategies that are usually delivered on a one-to-one basis within the
context of traditional medical care; (2) behavioral prevention strategies, sometimes referred to as health
promotion, that focus on adopting lifestyles conducive to health; and (3) environmental prevention
strategies that are undertaken by a community to safeguard the well-being of all citizens (Teutsch, 1992).
In its 1994 report, *Reducing Risks for Mental Disorders: Frontiers for Prevention Intervention Research*, the Institute of Medicine (IOM) proposed a more targeted set of definitions related to behavioral health, correlated with levels of health risk in target populations (Mrazek & Haggerty, 1994). These definitions are based upon a classification proposed more than a decade earlier (Gordon, 1983). The "continuum of care" spectrum that encompasses these three classifications within the IOM Model of Prevention are:

- **Universal** interventions, offered to an entire population because their benefits outweigh their cost and risk;
- **Selective** interventions, targeted only to groups at greater risk than the rest of the population, incurring a moderate cost justified by the increased risk of illness; and
- **Indicated** interventions, provided only to high-risk individuals and to those persons who are experiencing early symptoms of a disorder either to prevent future development of a health problem or to reduce the duration or severity of a health problem.

http://mentalhealth.samhsa.gov/publications/allpubs/SMA00-3437/SMA00-3437ch3.asp

**Procovery**<sup>TM</sup>: [www.procovery.com](http://www.procovery.com) Developed by Kathleen Crowley, Procovery is a process whereby individuals with serious and/or chronic mental or physical illnesses and injuries can build healthier and more fulfilling lives, notwithstanding the possible continuing presence or worsening of symptoms. It is based on the ability to move forward by taking small, ordinary, individual actions toward a holistic integration of ones illness or disability into life. It is both a means and an end that refocuses ones attention, away from illness and loss, and on faith in the future potential of ones life. The practical application of Procovery in Missouri includes a structured small group process (Procovery Circles) that can include consumers, families, professionals and community members as part of the group.

**ACT Assertive Community Treatment (ACT)**: A model of delivering services and supports to adults with serious mental illness. Multidisciplinary teams including physicians, nurses, substance abuse specialists, vocational specialists, and case managers deliver all necessary services.

**Provider**: A recognized and appropriately credentialed individual or organization that delivers mental health services and supports.

**Psychiatric Advance Directives (PAD)**: A legal document created by a competent person that allows the person to give instructions for future mental health treatment or appoint an agent to make future decisions about mental health treatment.

**Respect Seminars and Institutes**: RESPECT Seminars are designed to train professionals, family members and peers in the fundamentals of caring for persons with mental health challenges. The week-long RESPECT Institute is designed to provide 12 consumers the skills and coaching necessary to transform their mental illness, treatment, and recovery experiences into educational and inspirational presentations.

**Quality Service Review (QSR)**: A broad term for a set of processes and tools designed to review human service systems. It is based on an in-depth case review method involving multiple stakeholders, and uses a performance appraisal process to assess how service recipients benefit from services and how well service systems address their needs.

**Recovery**: As defined in the Presidents New Freedom Commission on Mental Health (NFCMH), recovery is the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms (NFCMH, 2003, p. 5).

**Substance Abuse and Mental Health Services Administration (SAMHSA)**: SAMHSA is the section of the federal Department of Health and Human Services that is responsible for alcohol, drug abuse and mental health services. It has three centers including the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP).
Serious Emotional Disturbance (SED): Term used to describe children and youth who have serious disturbances in psychological growth. In Missouri the definition includes children and youth under the age of 18, with substantial impairments in their ability to function at developmentally appropriate levels, have a serious Axis I psychiatric disorder as defined in the DSM-IV, at risk of out of home placement, who require two or more agencies/services to address the disorder.

St. Louis Regional Health Commission (SLRHC): http://www.strhc.org/
The RHC is a collaborative effort of St. Louis City, St. Louis County, the state of Missouri, health providers, and community members to improve the health of uninsured and underinsured citizens in the greater St. Louis area. The Commission has spearheaded a behavioral health transformation initiative in the eastern region of Missouri in collaboration with Missouri’s mental health transformation project.

Stakeholder Advisory Group (Children) (SAG): State legislation (SB 1003) required DMH to establish a stakeholder advisory committee to provide input to the CSMT and to assist in developing strategies to ensure positive outcomes for children. The SAG membership requires a majority of family and youth representation. By incorporating children’s policy and planning to the TWG, the SAG serves a principle advisory role to both the TWG and CSMT.

State Advisory Council (SAC) for Comprehensive Psychiatric Services (CPS): The SAC is comprised of 25 members who advise the Division of CPS in the development and coordination of a statewide interagency and inter-departmental system of care for persons with mental illness, their families, and children and youth with Serious Emotional disturbances (SED). The Council membership is required by federal law to have a majority of mental health consumers, including parents of children receiving services and family members. In addition, representation is required from the following state agencies: Social Services, MO HealthNet, Corrections, Vocational Rehabilitation, Education, Housing and Mental Health. The remainder of the council is made up of private and state-contracted providers, Missouri Protection and Advocacy, and other advocacy groups.

Stigma: Stigma refers to unfavorable attitudes and beliefs directed toward someone or something. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. The word is often applied to personal attributes that are considered shameful or discrediting. The 1999 Report on Mental Health by the Surgeon General of the United States was regarded as a landmark document because of its straightforward identification of the stigma associated with mental disorders as the chief obstacle to effective treatment. The report states that stigma leads others to avoid living, socializing or working with, renting to, or employing people. It reduces peoples access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society.

Transformation Working Group (TWG): The TWG is a Governor-appointed board established through Executive Orders 06-39 and 07-15. Members include key Governors Office and departmental senior leaders, consumer and family experts, and other public leaders. The chairpersons and principle staff are based in the DMH Directors Office to lead the planning process in partnership with other mental health services agencies. The principle responsibility of the TWG is to 1) create a Comprehensive Mental Health Plan for Missouri that transcends state department boundaries and fully integrates the current Comprehensive Childrens Mental Health Plan, and 2) lead the implementation of the plan once developed.

Trauma Informed Care: Trauma-inducing experiences, including physical and sexual abuse, often leads to mental health and other types of co-occurring disorders such as health problems, substance abuse
problems, eating disorders, HIV/AIDS issues, and contact with the criminal justice system. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts peoples lives. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

**Warm lines.** A phone service designed to solve relatively minor problems or to prevent those problems from becoming serious.  
http://www.wordspy.com/words/warmline.asp

**Wrap-around planning:** Typically applied in childrens service settings, the wraparound process is a way to improve the lives of consumers who have complex needs. It is not a program or a type of service. The process is used to help communities develop individualized plans of care. The actual individualized plan is developed by a Wraparound Team, the four to ten people who know the consumer best. The plan is needs-driven rather than service-driven, although a plan may incorporate existing categorical services if appropriate to the needs of the consumer. Planning, services, and supports cut across traditional agency boundaries through multi-agency involvement and funding. Governments at the provincial, state, district, regional and local levels work together to improve services. Outcome measures are identified and individual wraparound plans are frequently evaluated.
Appendix E: Missouri Mental Health Transformation Logic Model

Strategic Themes

Creating Communities of Hope; Moving Missouri Toward a Public Health Approach

From Culture of Crisis/ Risk of Harm to Culture of Hope/First: Do No Harm
From No Where to Go to Easy, Early and Equal Access
From Disability Focus to Wellness Focus with Prevention and Early Intervention
From Bureaucracy/Provider-Driven Care to Consumer Direction & Empowerment
From “Pockets” of Excellence to Universal Best Practices
From Fragmented & Centralized System to Shared Ownership and Investment

Missouris Vision of a Transformed System

Communities of Hope Throughout Missouri

Levers of Change Planning Process Goals Objectives and Strategies Outcomes

International
WHO MH report

National

State

Structure
Governors Office Human Services Cabinet Council

TWG
Office of Transformation

6 Content Work Groups

Resources & TA

Stakeholders
Individuals Families Communities Providers Professional & Trade Associations Educational & Research Institutions Foundations Payers

Advocacy Organizations Oversight Organizations Federal, State and Local Government

Public Education Stigma Reduction
Promotion/Prevention Consumer & Families as Decision-makers Peer Support Services
Evidence-based Practices Innovation & Research
State Collaboration Local Collaboration Integrated Care

Infrastructure Changes
Policy & Financing Service/ program Development Workforce Training & Development Organizational Structure & Culture

System Outcomes
Safe & Effective Care Culture of Respect & Wellness Adequate & Competent Workforce Consumers Involved in Policy, Care & Evaluation Collaboration & Shared Decision-Making Increased Access & Capacity

Individual:
Resiliency & Wellness Self-determination Community Tenure Improved Health Status School Success Employment Success Stability in living Conditions Social supports & connectedness

Community
Reduced Stigma Decreased Disability Improved Mental Well-being Improved Mortality Rates Increased Real Investment in Mental Health

Cross-cutting Strategies
Technology Workforce Development

Evaluation

Infrastructure Changes
Policy & Financing Service/ program Development Workforce Training & Development Organizational Structure & Culture

System Outcomes
Safe & Effective Care Culture of Respect & Wellness Adequate & Competent Workforce Consumers Involved in Policy, Care & Evaluation Collaboration & Shared Decision-Making Increased Access & Capacity

Individual:
Resiliency & Wellness Self-determination Community Tenure Improved Health Status School Success Employment Success Stability in living Conditions Social supports & connectedness

Community
Reduced Stigma Decreased Disability Improved Mental Well-being Improved Mortality Rates Increased Real Investment in Mental Health

Cross-cutting Strategies
Technology Workforce Development

Evaluation
ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Introduction

Of the approximately 5.8 million people who live in Missouri, it is estimated that 10.5%, or approximately 609,000 individuals, suffer from either serious psychological or emotional distress. Furthermore, 11% are alcohol dependent, 3% are drug dependent, and around 1.5% have mental retardation or a developmental disability.¹ The prevalence of these mental health issues is high and demands significant resources to fully meet the needs of all those with mental health issues.

In October 2006, in response to the 2003 President’s New Freedom Commission report, the federal government awarded the Missouri Governor’s Office a Mental Health Transformation State Incentive Grant (MHT-SIG) to transform mental health care statewide and better meet the needs of persons with mental illness. As a first step toward implementation, a needs assessment and resource inventory (NARI) was conducted by the Missouri Institute of Mental Health (MIMH); the NARI was also designed to assist in the development of the Missouri Comprehensive Mental Health Plan. This report reflects information gathered during Year One. Future updates will expand the scope of the NARI to the needs and resources of regional, local and private providers of mental health care services.

Procedure

MIMH researchers collected information from over 500 individuals through a variety of means including (1) 15 focus groups with 191 consumers; (2) in-person and telephone interviews with 23 local mental health agency staff; (3) on-line surveys of 184 mental health, substance abuse and mental retardation/developmental disabilities agencies; (4) 14 on-line surveys of Transformation Working Group (TWG) members; and (5) on-line surveys of 108 Transformation Work Group members. Additionally, dozens of secondary sources were consulted, including the “Voice of the Consumer” report (Change Innovation Agency, 2003) which documents the needs of Missouri consumers in in-patient facilities as well as specialized populations, such as the deaf and hearing impaired. The Lieutenant Governor’s Report on Safety (Missouri Mental Health Task Force, 2006) was also a valuable resource. Other resources included information from 421 individuals who participated in 14 public hearings designed and conducted by the Transformation Planning Team, as well as findings from focus groups and written surveys conducted for the Missouri Planning Council for Developmental Disabilities Statewide Needs Assessment.

¹ Serious Psychological Distress data is for adults (18+) and Serious Emotional Distress data is for children. Data from the National Survey on Drug Use and Health, Prevalence rate estimates were applied to the Missouri population estimates from the 2005 U.S. Census to get the estimated number of Missourians with serious mental illness.
² Participants included rural, African-American, Hispanic, homeless, and elderly individuals, probationers and parolees, foster care transitional youth, families with children, and immigrants/refugees.
MIMH researchers identified over twenty themes that emerged from the review of existing literature and analysis of primary data sources. These themes are clustered into six domains: (1) Safety; (2) Access to Care; (3) Mental Health Wellness; (4) Consumer-driven Care and Support; (5) Quality Mental Health Care; and (6) Mental Health System Fragmentation. The following table presents these themes with the data sources that provided support for these themes. Large checkmarks indicate that the need was very strong; smaller checkmarks indicate that the need was mentioned frequently but was not felt to be one of the most pressing needs.
### Cross-cutting Mental Health Themes by Stakeholder Group³

<table>
<thead>
<tr>
<th>Strategic Themes</th>
<th>Secondary Sources</th>
<th>Focus Groups and Interviews⁴</th>
<th>Mental Health/Substance Abuse Agencies⁵</th>
<th>MR/DD Agencies⁶</th>
<th>Transformation Working Group⁷</th>
<th>Transformation Work Groups</th>
<th>&quot;Voice of the Consumer&quot;</th>
<th>Public Hearings</th>
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</tbody>
</table>

³ Bold checkmarks indicate that the theme was ranked as one of the most important needs of the relevant stakeholders; smaller checkmarks indicate that the theme was mentioned frequently but did not emerge as one of the highest needs.

⁴ Primary needs of the focus group participants derived from systematic review of all focus group transcripts.

⁵ Structured, closed-ended survey.

⁶ Structured, closed-ended survey.

⁷ Primary needs of the TWG were derived from a needs assessment survey conducted by MIMH.
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<tr>
<td>Improved financing</td>
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8 Primary needs of the focus group participants derived from systematic review of all focus group transcripts.
9 Structured, closed-ended survey.
10 Structured, closed-ended survey.
11 Primary needs of the TWG were derived from a needs assessment survey conducted by MIMH.
Cross-cutting Themes

Safety

From key secondary sources supported by focus group and public hearing participants, four primary issues emerged related to safety: (1) abuse and neglect; (2) trauma-informed care; (3) preventable medical errors; and (4) occupational safety. In large part, these concerns are currently being addressed by state agencies. The Lieutenant Governor’s Report on Abuse and Neglect (2006) outlines 25 action steps for improving consumer safety, including (1) recruiting and retaining staff by offering more competitive pay; (2) staff training; (3) centralized data collection and analysis capabilities; (4) leadership stability; and (5) abuse and neglect reporting. That report also recommended that the Missouri Department of Mental Health (DMH) pursue implementation of the Mental Health Commission (MHC) recommendations made in their 8/06 report titled “Building a Safer Mental Health System.” These priorities come from the feedback of 217 individuals attending public hearings held in 2006 to address issues related to abuse and neglect in state facilities. Additional needs suggested by stakeholders included further efforts to expand trauma-informed care and widespread implementation of alternatives to restraint and seclusion and other methods of improving staff and client safety.

Access to Services and Supports

The NARI explored barriers to receiving both treatment and recovery supports. Easier, faster access to services, affordable services, transportation, additional providers, housing and employment emerged as the most significant barriers to receiving care.

➢ Easier, Faster Access to Services

Most stakeholder groups agreed that easier, faster access to services is a major need in the current system. The Transformation Working Group ranked easier access as a high need, and both MIMH and “Consumer Voice” focus groups mentioned difficulty receiving services due to endless waiting lists, bureaucracy, and inadequate crisis services. A need for easier access and a need for “no wrong door” also came out of the focus groups.

➢ Affordable Services

Across the board, affordability of services was a predominant theme among Missouri stakeholder groups. Mental health and substance abuse agencies ranked “services to the uninsured” as the number two priority. Ten of the 13 public hearings conducted by the DMH for the Transformation Initiative identified affordability as a major issue, pointing to MO HealthNet (Medicaid) restrictions as a significant impediment to obtaining care. Eight of the 10 focus groups had similar concerns. These groups included the elderly, African-Americans, rural residents, homeless persons, transitional youth, refugees and immigrants, and probation and parolees. Transitional youth often age out of eligibility for children’s services with no financial means or steady employment to provide them with health insurance; and parolees and probationers transitioning to society find many barriers to reinstating insurance upon reentry.
Transportation was consistently identified as a top need according to providers and consumers who were consulted. It was a high or critical need among almost 90% of mental health care and substance abuse agencies. Among Division of Mental Retardation/Developmental Disabilities (MR/DD) providers, transportation emerged as the fourth most needed service. Transportation was a major problem for individuals in five of the ten focus groups, and six out of thirteen public hearing sites, particularly those held in rural areas. Elderly individuals who cannot drive are in need of mobile services and youth in rural areas reported needing transportation to drive to the closest service providers, which are often in metropolitan areas. Transportation is also a major issue for the homeless, who have difficulty getting services and gaining employment without reliable transportation. Hispanics also reported that lack of transportation makes it less likely that they will seek services. Telehealth and, in-home services were suggested ways to provide services in rural areas while alleviating the demand for transport; provision of services in communities would be ideal.

Additional Providers

More providers, especially those trained to provide specialized services, was repeatedly cited as a strong need. More specifically, geriatric and child psychiatrists, and providers specialized in treating co-occurring disorders are in very high need. Participants at public hearings also reported that psychiatrists are a very strong need; seven of thirteen sites mentioned a need for more psychiatrists or prescribing doctors. Other provider needs included interpreters and professionals trained to work with deaf, international, African-American and Hispanic consumers, according to focus groups conducted by both MIMH and “Consumer Voice,” and people at public hearings. Several MIMH focus groups and participants at public hearings felt that “natural” community caretakers, including members of the faith community and nursing home personnel could be trained in mental health care to provide more information to the community, reduce stigma and encourage accessing mental health services. More in-patient and residential care (especially for co-occurring disorders) was also an expressed need of several stakeholder groups, including mental health and substance abuse agencies, public hearings, and focus groups conducted by MIMH and “Consumer Voice”.

Mental Health Wellness

Prevention/Early Intervention

Prevention and early intervention are major needs according to the MIMH focus groups, the “Consumer Voice” report, the public hearings, and mental health and substance abuse agencies. Specifically, prevention for at-risk youth was particularly important to the focus groups, while mental health and substance abuse agencies emphasized school-based mental health services. A number of recommendations resulted from the work groups, including coordinating existing prevention plans, training providers on prevention strategies, and linking mental health professionals with local public health offices. Eight of thirteen public hearing sites felt prevention was a high priority, and participants from several sites suggested linking mental health with schools and increasing suicide prevention efforts.

Stigma and Discrimination

Reducing stigma and discrimination was a very high priority need for the TWG, focus group members and public hearing participants. Stigma reduction was mentioned by all MIMH focus
groups. The TWG ranked “improving the public perceptions of persons with mental health needs” as the third most important need in the state. Focus group members from the “Consumer Voice” report believed that stigma from the community and mental health staff is an impediment to recovery. Public hearings indicated support for an anti-stigma campaign.

- **Public Mental Health Literacy**

Focus group consumers and public hearing participants felt strongly that the public needed more and better information about mental health wellness and how to obtain treatment. Members from several focus groups said that they were unaware of any mental health literature in their community and believed that additional information would both help de-stigmatize mental illness and increase the number of persons seeking treatment. Transitional youth, families with children and public hearing participants felt that mental health curricula should be placed in high schools, possibly as part of regular health classes. Hispanic and immigrant/refugee focus group members felt that all mental health information should be translated into the appropriate language, so that minorities can be educated about mental illness.

- **Integration of Physical/Mental Health**

The integration of mental and physical health was a need expressed by three of the groups; the MIMH focus groups, five out of thirteen public hearing sites, and mental health and substance abuse agencies providers. Among the focus groups, integration placed 8th in their needs; providers ranked it as 10th. This need was particularly strong for the elderly, where a very high proportion of seniors with mental health needs also have chronic physical illnesses that link them to the health care system. The same is also true for rural Missourians, who often have little access to mental health specialists and therefore often visit family physicians for mental health issues. In addition, families with children pointed out that children with mental illness often have physical illnesses as well, and that both should be considered in an integrated system of care.

**Consumer–driven Care and Recovery Services**

- **Consumer-driven Care**

Consumer-driven care was a high priority need expressed by all groups, whether they were consumers, agency staff, workgroup members, or public hearing participants. TWG members felt that consumer-driven care was a critical need and should be one of the first priorities taken in the transformation effort. Several MIMH and “Consumer Voice” focus group members, as well as public hearing participants, felt that they were not being heard in the current system and that they should be better involved in the treatment decision-making process. Consumer-driven care was the third most important need for which MR/DD agencies would advocate if allowed to choose only one issue.

- **Consumer-driven Recovery Services**

Improved consumer recovery and support services were a strong need among mental health and substance abuse providers, MIMH and “Consumer Voice” focus group members, and public hearing participants. In particular, more consumer-driven support services (peer supports, consumer-operated service providers, etc.) are desired, particularly by public hearing participants (peer supports were mentioned at six of thirteen sites). Provider agencies listed this as their second most important need. Focus group consumers, including transitional youth and rural consumers
expressed frustration with the quality and accessibility of existing support services. Persons on probation or parole expressed concern that, after their release from correctional facilities, many support services are no longer available to them, including medication for mental health disorders identified prior to their incarceration or while in the correctional facility. Transformation Work Group members made several recommendations, including the expansion of evidence-based peer and family-run programs to help strengthen existing recovery and support services.

**Quality Mental Health Care**

- **Workforce Development and Training**
  Workforce development, particularly in the area of co-occurring disorders, was a strong need among providers, focus groups, Transformation Work Groups, and public hearing participants. A total of 82% of mental health and substance abuse providers indicated that training in co-occurring disorders is a high or critical need. Co-occurring disorders training and treatment ranked as the #1 need for which these agencies would advocate if they could choose only one issue. Co-occurring disorder training was the fourth greatest need for MR/DD providers. The need for more co-occurring services is also a theme among focus group consumers. In addition, several MIMH and “Consumer Voice” focus groups felt that their counselors did not have adequate skills to provide quality counseling services.

- **Use of Evidence-based Practices (EBP)**
  Needs related to evidence-based practices stemmed primarily from the Evidence-based Practice Transformation Work Group, focus group participants, and providers. Almost three-fourths of providers felt that training in evidence-based practices was either a high or critical need. The Work Group saw the need to develop: (1) policies, regulations and financing strategies that support Evidence Based Practices (EBP); (2) a policy statement that ensures broad-based input into EBP funding; (3) provider financing incentives to support EBP development and practice; (5) consumer choice of providers certified in an EBP by DMH; (6) “Coordinating Centers of Excellence” to identify and promote the use of EBPs; (7) a training curriculum for EBP core competency development; (8) education and licensure incentives for continuing education in evidence-based practices; and (9) partnerships with colleges and universities to incorporate EBP into course curricula and provide training opportunities in practice and implementation. Assessment of program fidelity and on-going monitoring of new EBPs was also recommended as a priority. The need for EBPs was reflected in consumers’ stated needs for better quality services, particularly in the area of counseling.

- **Quality Management and Use of Technology**
  While the mental health system of care has considerable procedures and technological resources to assure quality management, the Transformation Work Groups identified several steps necessary to further improve the current system. They include: (1) the development of a unique consumer identifier, for use across departments, to improve treatment coordination for individual consumers; (2) Advanced Information Technology systems that fully integrate quality management databases; (3) systematic and comprehensive evaluation of department quality management procedures and programming; (4) an Electronic Health Record (EHR) system that is owned by the consumer and shared with providers; (5) Electronic Medical Records system (EMR); (6) systematic data analysis. (7) outcome analysis; (8) e-based information sharing system; (9) e-based system for training; and (10) expanded teleconferencing to improve program monitoring and communication.
Mental Health System Fragmentation

Collaboration and co-ordination were predominant themes for the TWG, agency providers, “Consumer Voice” focus groups, and public hearing participants. DMH provider agencies surveyed felt strongly that further collaboration between DMH divisions, across departments in state government, and with public/private agencies is critical—about 75% of providers reported either a high or critical need for collaboration in these three areas. Individual consumers and public hearing members voiced concerns about fragmentation as well, expressing the need for better coordination between schools and mental health care providers, substance abuse and mental health care services, and primary care and mental health care professionals. Comments from the public hearings also emphasized the need for an interdepartmental leadership structure, consistent service areas, integrated funding, and a shared service philosophy. MIMH focus groups reported the need to have mental health services better incorporated into their communities, as opposed to a more centralized system. All groups mentioned the need to improve the current financial system, with several stakeholder groups arguing for more effective funding strategies.

Key Needs Identified from NARI Data Sources

The cross-cutting themes described above evolved from an analysis of data collected specifically for the NARI and from secondary sources directly related to mental health needs. While more completely described in the full report, major needs included: (1) access to care (including a single point of entry into the mental health care system); (2) improved financing; (3) agency collaboration/coordination; (4) stigma reduction/public literacy; (5) transportation; (6) housing; (7) recovery/support services; (8) co-occurring disorder training; (9) expanded school-based mental health; (10) more specialized providers and training; (11) affordable services; and (12) prevention/early intervention. The table on the following page lists these priorities in detail.
## Stakeholder Priority Needs*

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<th>Stakeholder Group</th>
<th>Priority Needs</th>
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<td><strong>Transformation Working Group members</strong></td>
<td><strong>Most Pressing Needs</strong></td>
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<td></td>
<td>2. Increased access to mental health care</td>
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<td>4. Public mental health literacy/stigma reduction</td>
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<td>5. Consumer supports</td>
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</tr>
<tr>
<td></td>
<td>2. Community involvement/outreach</td>
</tr>
<tr>
<td></td>
<td>2. Affordable Services</td>
</tr>
<tr>
<td></td>
<td>4. Specialized Providers (esp. psychiatrists)</td>
</tr>
<tr>
<td></td>
<td>5. Transportation</td>
</tr>
<tr>
<td></td>
<td>5. Increased access to mental health care</td>
</tr>
<tr>
<td></td>
<td>5. Prevention/Early Intervention</td>
</tr>
<tr>
<td><strong>Mental health and substance abuse providers</strong></td>
<td><strong>Most Pressing Needs</strong></td>
</tr>
<tr>
<td></td>
<td>1. Co-occurring disorders training/treatment</td>
</tr>
<tr>
<td></td>
<td>2. Affordable services</td>
</tr>
<tr>
<td></td>
<td>3. Better co-ordination of services</td>
</tr>
<tr>
<td></td>
<td>4. Community support services</td>
</tr>
<tr>
<td></td>
<td>5. Greater consumer choice</td>
</tr>
<tr>
<td><strong>MR/DD providers</strong></td>
<td><strong>Needs for System Change</strong></td>
</tr>
<tr>
<td></td>
<td>1. Improved financing</td>
</tr>
<tr>
<td></td>
<td>2. Better coordination/consistency of services</td>
</tr>
<tr>
<td></td>
<td>3. Consumer-driven care</td>
</tr>
<tr>
<td></td>
<td>4. Better pay for providers and staff</td>
</tr>
<tr>
<td></td>
<td>5. Ongoing recovery/support services</td>
</tr>
<tr>
<td>Stakeholder Group</td>
<td>Priority Needs</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Public Hearing Participants| 1. Ongoing recovery/support services  
|                           | 1. Agency collaboration                                                
|                           | 1. Workforce development                                               
|                           | 4. Housing                                                             
|                           | 4. Revised Medicaid coverage/eligibility requirements                 
|                           | 4. Specialized providers (esp. psychiatrists)                          
|                           | 7. Transportation                                                      
|                           | 8. Improved financing                                                  
|                           | 8. Expand school-based mental health services                         
|                           | 8. Co-occurring disorder services                                     |

*Duplicate numbers reflect ties.

**State Resources**

For the NARI, the MIMH team gathered information on the amount spent on mental health care across state departments, the number of persons served by the DMH, state-level mental health services, consumer-operated mental health organizations, and available technological resources. In FY 2006, it was estimated that over two billion dollars was spent on mental health service expenditures in Missouri. Around 55% of those expenditures were for DMH services and around 39% were MO HealthNet (Medicaid) dollars (non-DMH), with the remaining expenditures spread across the Departments of Elementary and Secondary Education, Health and Senior Services, Corrections, and Social Services. As some expenditures were still being calculated at the time of this writing, total expenditures are predicted to be slightly higher.

In FY 2006, DMH served 144,644 consumers. Forty-three percent received psychiatric services, 30% received substance abuse services, 18% received mental retardation and developmental disability services and 9% received services for co-occurring disorders. These numbers represent consumers with services paid for through the DMH; the Division of Alcohol and Drug Abuse Substance Abuse (ADA) traffic program services another 19,095 consumers that self-pay for services.

**Structure of the Report**

This chapter has summarized the major themes that emerged from the needs assessment and resource inventory. The full report contains an expanded discussion of each of the key findings/cross-cutting themes, comprehensive information regarding each of the data sources, and a preliminary inventory of mental health resources at the state level to be enhanced this coming year. Chapters are as follows:

- **Introduction:** *A Snapshot of Missouri.* Describes the general demographic characteristics of Missourians.
- **Chapter One:** *Mental Health in Missouri across the Life Span: Estimates of Prevalence, Financial Resources and Consumer Profiles.* Estimates prevalence rates for mental illness, substance abuse and mental retardation/developmental disabilities. Provides financial resources designed to meet those needs and descriptions of mental health consumers.
- **Chapter Two:** *NARI Key Themes.* Documents the major themes that emerged from the analysis of data sources described in subsequent chapters.

Chapter Four: Summary of Needs from Department of Mental Health-related Sources. Summarizes the findings from pre-existing Department of Mental Health-related sources, including focus groups comprised of consumers in in-patient care, special populations, providers and advocacy groups.

Chapter Five: Needs According to Mental Health Consumer Interviews and Focus Groups. Presents key findings and background information from all focus groups and interviews conducted for the NARI.

Chapter Six: Substance Abuse and Mental Health Provider Agency Survey: Needs and Resources. Describes the characteristics, needs and resources available to substance abuse and mental health providers obtained from on-line surveys provider surveys.

Chapter Seven: MR/DD Provider Agency Survey: Needs and Resources. Describes the characteristics, needs and resources available to providers of mental retardation and developmental disabilities services obtained from on-line provider surveys.

Chapter Eight: Missouri Mental Health Services and Resources. Presents mental health, substance abuse, and MR/DD programs and services provided by all state agencies. Describes consumer-driven recovery and support services and technological mental health resources available to state agencies.
**Introduction:**

**A Snapshot of Missouri**

Geographically, Missouri is the 21st largest state in the United States with 69,704 square miles. It ranks 17th in population, with approximately 5.8 million people. It is often referred to as “The Gateway to the West.” The state of Missouri was named for the local Sioux Indian tribe, whose name translates to “the wooden canoe people.”

**Population**

- 73% of Missouri residents live in metropolitan areas, half of which are in the two largest metropolitan areas: St. Louis on the eastern border and Kansas City on the western border.
- The age distribution is roughly equivalent to the national average, with 6.5% of the Missouri population under 5 years old, 24.1% under 18 years old, and 13.3% 65 and over. Two percent are 85 years of age or older. The percentage of persons 85 and older increased by 21.4% during the 1990s.
- Missouri has many fewer (2.7%) foreign-born residents compared with the national average (11.1%). Missouri also has fewer bilingual households (5.1%) than the national average (17.9%).

**Ethnicity**

- The majority (85.4%) of Missouri’s population is White. 11.5% of Missourians identify themselves as Black/African-American, 2.6% Hispanic/Latino, 1.3% Asian, and 0.5% Native American.
- Although still small in size, the Hispanic population more than doubled in 56 Missouri counties from 1990 to 2000.
- African-Americans constitute 15.8% of the urban population in Missouri, but only 1% of the rural population.

**Income**

- The estimated median household income in 2006 was $42,841, ranking it 37th among all states.
- 13% of Missourians were living below the poverty level in 2005.
- 19% of Missouri children under age 18 were living in poverty in 2005, and 8% were living in extreme poverty, defined as at or below 50 percent of the federal poverty level.
- The largest concentration of poverty is in the rural areas of the state, particularly southeastern Missouri. Of the 16 Missouri counties identified as “persistent poverty counties” by the Economic Research Service (ERS), 14 were located in Southeastern Missouri. ERS defines a persistent poverty county as a county where 20% or more of residents were poor as measured by the last four censuses (1970, 1980, 1990, and 2000).

(Estimates from U.S. Census Bureau, 2007).
CHAPTER ONE

MENTAL HEALTH ACROSS THE LIFE SPAN:
PREVALENCE ESTIMATES, FINANCIAL RESOURCES
AND CONSUMER PROFILES

Background

This chapter presents the best available data on the prevalence of mental health difficulties among Missourians across the lifespan. Also presented are data on the number of consumers served by the Missouri Department of Mental Health (DMH) and MO HealthNet (Medicaid), and related expenditures, as well as preliminary data from other state departments involved in the delivery of mental health care in Missouri. Finally, estimates of the needs met through the state departments are explored.

Prevalence across the Life Span

The prevalence data in this chapter focuses primarily on the prevalence of mental illness, substance dependence and abuse, and mental retardation and developmental disabilities (MR/DD) in the Missouri population. Also included are co-occurring substance use and mental disorders. Future reports will further explore co-occurring disorders, provide updated estimates for mental illness among poor Missourians, as well as improved estimates of unmet need and the prevalence of mental illness among vulnerable individuals in state-run institutional facilities, such as in corrections, mental health facilities, nursing and senior facilities, and the child welfare system. In addition, data regarding mental health expenditures within state departments other than DMH and MO HealthNet will be provided.

Of the approximately 5.8 million people who live in Missouri, an estimated 10.5%, or over 609,000 individuals, suffer from either serious psychological or emotional distress. Further, around 11% are alcohol dependent, 3% are drug dependent, and around 1.5% have been diagnosed with mental retardation or a developmental disability. The highest rates of mental illness and substance abuse are among transitional youth ages...
18-25. They also have the highest rates of co-occurring disorders, with almost half of transitional youth with mental illness also experiencing substance abuse issues. For individuals aged 18 and older, the highest rate of serious psychological distress is in the southeast portion of the state. The table below includes prevalence rates across the lifespan for Missourians with mental illness, alcohol and drug dependence and abuse, and mental retardation/developmental disabilities issues. Total prevalence for Missouri is based on the total estimated 2005 population of 5.8 million (5,800,310) (U.S. Census, 2005). Specific definitions and data sources for the population and prevalence estimates provided in the table are also listed below.

**Estimated Percent (Number) of Missouri Population with Mental Health Difficulties in Past Year, by Age Group, 2005**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Mental Illness</th>
<th>Alcohol Dependence or Abuse</th>
<th>Drug Dependence or Abuse</th>
<th>Mental Retardation/Developmental Disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp;/or Adolescents (4-17)</td>
<td>8.7%</td>
<td>7.0%&lt;sup&gt;12&lt;/sup&gt;</td>
<td>5.7%&lt;sup&gt;12&lt;/sup&gt;</td>
<td>3.4%</td>
</tr>
<tr>
<td>Transitional Youth (18-25)</td>
<td>15.5%</td>
<td>21.0%</td>
<td>9.6%</td>
<td>.79%</td>
</tr>
<tr>
<td>Adults (26-64)</td>
<td>12.8%</td>
<td>7.0%</td>
<td>1.5%</td>
<td>.9%</td>
</tr>
<tr>
<td>Elderly (65 and older)</td>
<td>4.6%</td>
<td>1.6%</td>
<td>0.1%</td>
<td>.4%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>10.5%</td>
<td>10.9%</td>
<td>2.6%</td>
<td>1.49%</td>
</tr>
</tbody>
</table>

| | (609,032) | (486,494) | (178,864) | (86,424) |

**Definitions**

Definitions of what constitute mental illness, mental retardation/developmental disabilities, and substance use and dependence can vary widely across professional organizations, government entities, mental health providers, and even consumers themselves. Terms used in this document are defined as follows:

**Mental Illness.** Mental illness is defined differently for children and adults. In this report, an adult is considered to have “mental illness” if he/she has experienced Serious Psychological Distress (SPD) in the past year. For children, mental illness is defined as the experience of moderate or severe Serious Emotional Disturbance (SED) in the past year. See below for the definitions of both terms.

**Serious Psychological Distress (SPD).** Estimates of serious psychological distress come from the National Survey on Drug Use and Health (NSDUH). The NSDUH is a national telephone survey conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA). To measure (SPD), the NSDUH utilizes the K6 scale, a screening instrument for non-specific psychological distress. The scale was originally designed to measure Serious Mental Illness (SMI)

<sup>12</sup> Number is based on estimates for the 12-17 age range. Substance abuse and dependence estimates for children younger than 12 were not available.
until a few years ago, in which the name was changed to Serious Psychological Distress. The NSDUH measures psychological distress for all participants aged 18 and older.

**Serious Emotional Disturbance (SED).** In the state of Missouri, youth under the age of 18 who exhibit “substantial impairment in their ability to function at a developmentally appropriate level due to the presence of a serious psychiatric disorder” are deemed to have a (SED). For the NARI, the prevalence estimate of SED from the National Survey of Children’s Health (NSCH, 2003) was used, which included moderate and severe SED.

**Mental Retardation/Developmental Disabilities.** Prevalence estimates of mental retardation/developmental disabilities come from the 1994 and 1995 National Health Interview Survey’s Disability Supplement (NHIS-D). The American Association on Mental Retardation (AAMR) defines mental retardation as the co-occurrence of “significantly sub average intellectual functioning . . . with related limitations in two or more adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work,” with such limitations manifested “before age 18” (Luckasson, et al., 1992, p. 1). Developmental disability is defined by the Developmental Disabilities Act as a “severe, chronic disability” attributable to “mental” and/or “physical” impairments that are “likely to continue indefinitely”; resulting in substantial functional limitations in three or more “major life activity areas”: self-care, receptive or expressive language, learning, self-direction, capacity for independent living and economic self-sufficiency; manifested by age 22 and requiring care, treatment or other services of lifelong or extended duration” (The Developmental Disabilities Assistance and Bill of Rights Act, 2000).

**Alcohol/Drug Dependence or Abuse.** Estimates of alcohol dependence and abuse, as well as estimates of drug dependence and abuse, came from the 2004 and 2005 NSDUH (Wright, Sathe, and Spagnola, 2007). To diagnose alcohol and drug dependence and abuse, the NSDUH uses criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).
Detailed Prevalence Estimates

While a previous table supplies the general prevalence estimates by age group, the following sections examine the methodology for estimating Missouri prevalence rates in more detail. The sections are divided by age group, and discussed in the following order:

- Children (ages 4-17)
- Transitional Youth (ages 18-25)
- Adults (ages 26-64)
- Elderly (ages 65 and older)

In addition, preliminary estimates of treatment needs met by DMH and prevalence among the poor, is discussed briefly at the end of the chapter. Phase II of the NARI will develop these topics in greater detail.

Children & Adolescents (Ages 4-17)

Mental Illness

Estimates of the percentage of U.S. children suffering from SED range from 5% to 9%. According to the National Survey of Children’s Health (NSCH, 2003), 8.7% of children and youth (ages 4 – 17) in Missouri have moderate or severe difficulties in the areas of emotions, concentration, behavior, or the ability to get along with others, compared to 9.2% of the national population of children of the same age. The National Health Interview Survey (NHIS, 2005), reported that 5.4% of children ages 4 to 17 had severe difficulties in 2004. The variation in the statistics reported by NHIS (2005) and by NSCH (2003) is due to the inclusion of both moderate and severe emotional disturbance by the NSCH, while the NHIS only includes severe emotional disturbances. The table below shows the estimated number of Missouri children with moderate and/or severe emotional and behavioral difficulties.

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

<table>
<thead>
<tr>
<th>Estimated Missouri Child Population 2005</th>
<th>Prevalence of “Moderate or Severe” SED</th>
<th>Prevalence of “Severe” SED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,076,206</td>
<td>8.7% (93,629)</td>
<td>5.4% (54,115)</td>
</tr>
</tbody>
</table>

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

The 2004 and 2005 National Survey on Drug Use and Health (NSDUH) provide data on illicit drug use for children and adolescents aged 12-17 (Wright, Sathe, and Spagnola, 2007). The results indicate that, overall, Missouri adolescents use illicit drugs at a rate higher than national averages. The rate of marijuana use among Missouri youth aged 12-17 in the last year (15.0%) is higher than the national average of 13.9%. The Missouri rate of use of illicit drugs other than marijuana (5.7%), non-medical use of painkillers (7.7%), and cocaine use (1.7%), were also slightly higher than the national averages (Wright, Sathe, and Spagnola, 2007). The rate of illicit drug abuse or dependence for Missouri youth aged 12-17 was 5.67%, once again slightly above the national average of 5.0% (see figure at right).

Alcohol Use and Abuse

According to the 2004 and 2005 NSDUH, the rate of alcohol dependence or abuse in the past year among youth was 7%, compared to 5.8% for that age group nationally (see figure at right).

Co-occurring Mental Illness/Substance Use Disorders

Data on the percentage of Missouri children or adolescents experiencing co-occurring alcohol or substance dependence and SPD are not available. However, existing national data indicate that the rates of SPD and substance abuse among adolescents aged 12-17 tend to be lower than those for youth ages 18-25, but higher than rates for adults (Wright, Sathe, and Spagnola, 2007). Since, according to the 2005
NSDUH, the rate of co-occurring disorders among youth ages 18-25 is 6.6%, and the rate for adults 26-64 is 1.6%, it is likely that the rate for adolescents aged 12-17 is somewhere in between those two numbers.

Mental Retardation/Developmental Disabilities

State-level prevalence data for mental retardation/developmental disabilities among children and adolescents do not exist. The most recent national prevalence data for mental retardation/developmental disabilities come from the disability supplement of the 1994/1995 National Health Interview Survey (Larson, Lakin, Anderson, Kwak, Lee, & Anderson, 2001). The results of the survey are shown in the table below. Since developmental disabilities are automatically diagnosed for children under the age of 5 with mental retardation, the prevalence of “mental retardation not developmental disabilities” is zero. Approximately 38 per 1,000 children aged 0-5 had mental retardation and/or developmental disabilities, as well as 32 per 1,000 children aged 6-17 (Larson et. al., 2001). Application of these figures to the 2005 U.S. Census Missouri population estimates yields 17,182 Missouri children aged 0-5 with mental retardation and/or developmental disabilities and 29,505 children aged 6-17. That is a total of 46,687 children under the age of 18 with mental retardation/developmental disabilities (a combined rate of 33.9 per 1,000 population).

Estimated Prevalence Rates of MR/DD in the U.S. Population among Children and Adolescents
(per 1,000 population)

<table>
<thead>
<tr>
<th>Age</th>
<th>DD not MR</th>
<th>MR not DD</th>
<th>Both MR and DD</th>
<th>MR and/or DD</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>33.9</td>
<td>0</td>
<td>4.5</td>
<td>38.4</td>
</tr>
<tr>
<td>6-17</td>
<td>11.4</td>
<td>12.2</td>
<td>8.1</td>
<td>31.7</td>
</tr>
</tbody>
</table>

Transitional Youth (Ages 18-25)

Mental Illness

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

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

Illicit Drug Use and Abuse

The rate of marijuana use in the last year (27.0%) for Missourians aged 18-25 is lower than the national average. The Missouri rate of use of illicit drugs other than marijuana (8.6%) was in the average range compared to the nation, as was the Missouri rate of non-medical use of painkillers (12.8%) (Wright, Sathe, and Spagnola, 2007). However, the rate of cocaine use in the past year among Missourians aged 18-25 was high at 8.2%, compared to the national average of 6.8% (SAMHSA Office of Applied Studies, 2007). Overall, according to the 2004 and 2005 NSDUH, the rate of illicit drug dependence or abuse in the past year among Missourians aged 18-25 was 9.6%, compared to a national rate for that age group of 8.4% (see figure at right).
Alcohol Use and Abuse

According to the 2004 and 2005 NSDUH, the rate of alcohol dependence or abuse in the past year among Missourians aged 18-25 was 21% (see figure at right), compared to 18% for that age group nationally, and 7% for Missourians 26 and older (Wright, Sathe, and Spagnola, 2007).

Co-occurring Mental Illness/Substance Use Disorders

State data on the percentage of Missouri youth ages 18-25 experiencing co-occurring alcohol or substance dependence and SPD are not available, but nationally an estimated 6.6% of the national population (aged 18-25) experienced co-occurring SPD and alcohol or drug dependence in 2005 ((Wright, Sathe, and Spagnola, 2007). However, among those transitional youth with mental illness, an estimated 43% also have a co-occurring substance use disorder.

Mental Retardation/Developmental Disabilities

State rates of mental retardation/developmental disabilities specific to the 18-25 age group are not available. However, the disability supplement of the National Health Interview Survey (NHIS) 1994/1995, cites national rates for adults ages 18 and older (Larson et al., 2001). Approximately 0.79% of the population aged 18 and older experienced mental retardation and/or developmental disabilities in the NHIS sample. Application of that percentage to 2005 U.S. Census population estimates for Missouri yields approximately 4,661 youth aged 18-25 with mental retardation/developmental disabilities.
**Adults (Ages 26-64)**

**Mental Illness**

Based on average estimates from the 2004 and 2005 NSDUH, approximately 12.8% of Missourians aged 26 and older experience SPD in any given year, compared approximately 10% of adults in the United States\(^{14}\) (Wright, Sathe, and Spagnola, 2007; See table below). Because the NSDUH does not provide separate estimates for those 26-64, estimates of SPD are derived from the 2005 U.S. Census population count. Based upon these data, approximately 297,455 adult Missourians aged 26-64 experienced SPD in the last year (see elderly section for estimates for adults 65 and older). The rate is even higher among young adults aged 18-25 (see section on transitional youth).

![State Percentages of Serious Psychological Distress among Persons Aged 26 and Older](image)

**Prevalence of Serious Psychological Distress (SPD) among Adults in Missouri Aged 26-64.**

<table>
<thead>
<tr>
<th></th>
<th>Estimated SPD Adult One-year Prevalence Percent</th>
<th>Estimated Adult (26-64) Population 2005</th>
<th>Estimated SPD Adult Prevalence One-year Count 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>10%</td>
<td>156,852,548</td>
<td>15,685,254</td>
</tr>
<tr>
<td>Missouri</td>
<td>12.8%</td>
<td>2,974,552</td>
<td>380,742</td>
</tr>
</tbody>
</table>

Source: Percents based on aggregate adult (age 26 and older) prevalence rates from the 2004 & 2005 National Survey on Drug Use and Health (NSDUH).

\(^{14}\) Estimates of SPD, and alcohol and drug use and abuse specific to the 26-64 age range were not available, so estimates for individuals aged 26 and older were used. Since older adults tend to have lower rates of psychological distress and substance abuse than younger adults, the rates of SPD and substance abuse for the 26 and older population may be an underestimate of SPD and substance abuse for the population aged 26-64.
Illicit Drug Use and Abuse

Data from the 2004 and 2005 NSDUH suggests adults 26 and older are much less likely to use illicit drugs than their younger counterparts (Wright, Sathe, and Spagnola, 2007). Furthermore, Missouri adults 26 and older of age are less likely to use illicit drugs than adults of other states. For example, in Missouri, the rates of marijuana use in the last year (7.1%) and cocaine use in the past year (1.5%) were much lower than the national averages. The Missouri rate of use of illicit drugs other than marijuana (2.5%) was in the average range compared to the nation, as was the rate of non-medical use of painkillers (3.2%). Finally, according to the 2004 and 2005 NSDUH, the rate of drug dependence or abuse in the past year among Missourians for adults was lower than national rates (see figure at right).

Alcohol Dependence and Abuse

Although the rate of alcohol use is generally lower in Missouri compared to the rest of the nation for the 26 and older age group, the rate of alcohol dependence or abuse is higher (maps for 26-64 year olds not available) (Wright, Sathe, and Spagnola, 2007). Alcohol abuse and dependence among Missourians in the 26 and older age range was 7%, compared to 6.3% for the same age group nationally (Wright, Sathe, and Spagnola, 2007). The figure at right contrasts rates of use for adults (26 and older) in Missouri compared to the rest of the nation (maps for 26-64 year olds are not available). Alcohol dependence and abuse was higher in Missouri than most other states.
Co-occurring Mental Illness/Substance Use Disorders

State data on the percentage of Missouri adults experiencing co-occurring alcohol or substance dependence and SPD are not available, but nationally, an estimated 1.6% of adults (26 and older) experienced co-occurring SPD and alcohol or drug dependence in 2005 (data for 26-64 year olds not available) (Wright, Sathe, and Spagnola, 2007). This is compared to a national average of 2.3% for all age groups.

Mental Retardation/Developmental Disabilities

State rates of mental retardation/developmental disabilities specific to the 26-64 age group are not available. However, national rates are available based on the disability supplement of the National Health Interview Survey (NHIS) 1994/1995. Approximately 0.9% of the adult population (aged 26-64) experienced mental retardation and/or developmental disabilities in the NHIS sample. Application of that percentage to 2005 U.S. Census population estimates for Missouri yields approximately 26,771 Missourians aged 26-64 with mental retardation/developmental disabilities.

Elderly (Ages 65 and Older)

Mental Illness

Although the NSDUH does not supply Missouri estimates of SPD specific to older adults, national estimates were available. According to the 2005 NSDUH, an estimated 4.6% of older adults experienced SPD in 2005. This is much lower than the Missouri SPD average of 12.8% for all adults older than age 26. Applying the national rate of 4.6% to the Missouri elderly population yields approximately 35,566 elderly Missourians with SPD.

However, although the rate of SPD among the elderly is low, there is still reason to be concerned about mental illness among the elderly. First, the prevalence of mental illness among the elderly may be higher in certain settings. For example, recent study of elderly Missourians in long-term care found that 6 percent of older adults had major depression and 19% had sub-threshold depression, of which 40% were persistently depressed over a one-year period (Missouri Senior Report, 2006). Second, research indicates that elderly individuals are very likely to under-report mental illness (Missouri Senior Report, 2007). Since the NSDUH relies on self-report, this is a methodological issue that may have resulted in an underestimate of elderly SPD in the NSDUH sample. Third, suicide rates are high among the elderly. The suicide rate of Missourians 65 years and older is the highest rate of any age group, while the rate for Missourians 85 years and older is twice the national average (CDC 1999). Overall, elderly suicides account for approximately 18% of all suicides (Missouri Suicide Prevention Plan, 2004). Furthermore, approximately 70% of seniors see their primary care physician in the month before they commit suicide (Miller and Druss, 2001). Finally, research suggests that individuals with serious mental illness may die up to 25 years earlier than the general population, often due to preventable medical conditions such as heart disease and diabetes (Parks, Svendsen,
Singer, Foti, and Mauer, 2006). This statistic illustrates the importance of considering mental illness within the framework of overall health and wellness.

Finally, the proportion of the population aged 65 and older will increase dramatically over the next few years. According to the 2000 U.S. Census, elderly individuals made up approximately 13.5% of the Missouri population. However, according to population projections consistent with the 2000 Census, the elderly population is expected to grow by 546,335 individuals between 2000 and 2030 (U.S. Census, 2005). Therefore, while the percentage of all elderly individuals experiencing mental distress may remain small, the proportion of the total population that is elderly and experiencing mental distress is expected to increase dramatically over the next 15 years. Since elderly Missourians make up a larger percentage of the population in rural areas, lack of transportation is likely to be among the largest barriers to accessible services for elderly Missourians in distress.

Alcohol and Illicit Drug Use and Abuse

State estimates of alcohol and illicit drug use for those 65 and older are not available, but national rates of alcohol and drug abuse and dependence have been published. As can be seen in the figure above, rates of alcohol and illicit drug dependence decrease steadily throughout the lifespan, and reach their lowest rate among the elderly. In 2005, only 0.1% of older adults experienced illicit drug abuse or dependence at some point during the year (Wright, Sathe, & Spagnola, 2007; this percentage includes prescription drug dependence). Approximately 1.6% experienced alcohol abuse or dependence (Wright, Sathe, & Spagnola, 2007). Application of those percentage to 2005 U.S. Census population estimates yields 773 elderly Missourians addicted to drugs and 12,371 addicted to alcohol in 2005. However, as mentioned previously, seniors are likely to underreport mental health issues, so it is possible that these numbers are underestimates.

Co-occurring Mental Illness/Substance Use Disorders

State data on the percentage of Missouri elderly experiencing co-occurring alcohol or substance dependence and SPD are not available, but nationally an estimated 0.2% of elderly individuals
(approximately 1,546 Missourians) experienced co-occurring SPD and alcohol or drug dependence in 2005 (Wright, Sathe, & Spagnola, 2007). This is compared to an average of 2.3% for all age groups.

Mental Retardation/Developmental Disabilities

State rates of mental retardation/developmental disabilities specific to the 65 and older age group are not available. However, based on the disability supplement of the NHIS 1994/1995, national rates were available for elderly adults age 65 and older. Approximately 0.4% of the elderly population experienced mental retardation and/or developmental disabilities in the NHIS sample. Application of that percentage to 2005 U.S. Census population estimates for Missouri yields approximately 3,093 Missourians aged 65 and older with mental retardation/developmental disabilities.
Financial Expenditures and Consumer Profiles

In FY 2006, the State of Missouri spent at least $2.07 billion on mental health services. Over half of these expenditures ($1,107,734,479), serving 144,644 consumers, flowed through DMH. The agency with the next largest percentage of total mental health expenditures (41%) was the MO HealthNet (Medicaid) Division Fee for Service ($854,884,180) within the Department of Social Services, serving 305,566 consumers. MO HealthNet Children’s Services Division’s Comprehensive Psychiatric Rehabilitation program accounted for $68,979,703 in expenditures. All other state agencies reporting at the time of this analysis made up the final two percent of expenditures, or $40,019,141. The following section details these expenditures, profiles consumers and examines the needs met through state departments. Note: In addition, MO HealthNet Managed Care (MC+) spent $895,336,173 in 2006 and some portion of that was spent on behavioral health which is not included in the figures above.

Consumer and Expenditures in Other State Departments

DMH and MO HealthNet serve the highest percentage of consumers of mental health care currently being served by state departments. Consumer numbers were not available for other departments at the time of this writing given difficulties in discerning mental health costs from other health-related costs. The task of discerning these costs will be undertaken next year and reported in the expanded version of the needs assessment.
Expenditures for these agencies included the Department of Corrections (DOC) ($11,336,974)\(^{15}\), the Department of Health and Senior Services (DHSS) ($6,845,406), the Department of Social Services (DSS) (non-MOHealth Net) ($200,368)\(^{16}\), the Department of Elementary and Secondary Education’s (DESE) Supported Employment (SE) expenditures ($7,534,376), and DESE’s non-SE expenditures ($14,102,017). Expenditures from the Department of Public Safety were reported to be zero for FY2006; expenditures for the Office of State Courts could not be identified in time for this report.

### Other (2%) Mental Health Expenditures:
**Non-DMH, Non-MO Health Net**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOC</td>
<td>28%</td>
</tr>
<tr>
<td>DHSS</td>
<td>17%</td>
</tr>
<tr>
<td>DSS</td>
<td>1%</td>
</tr>
<tr>
<td>DESE: SE</td>
<td>19%</td>
</tr>
<tr>
<td>DESE: NonSE</td>
<td>35%</td>
</tr>
</tbody>
</table>

**Key:**
- **DOC** – Department of Corrections
- **DHSS** – Department of Health and Senior Services
- **DSS** – Department of Social Services
- **DESE: SE** – Department of Elementary and Secondary Education: Supported Employment
- **DESE: NonSE** – Department of Elementary and Secondary Education: Non-Supported Employment

### Additional Considerations

Mental health service needs vary by socioeconomic group. The state system primarily serves individuals unable to pay for insurance themselves, or who lack insurance through employment or other sources.

### Department of Mental Health

\(^{15}\) The Missouri Department of Corrections (DOC) had expenditures of $8,836,974 for substance abuse services including $8,013,869 for prison and $823,105 for community-based services. The DOC transferred $3,541,048 to the DMH for community-based substance abuse services. The DOC also reported $2,500,000 in mental health-related pharmacy expenditures. However, the DOC contracts for Mental Health Services in prison could not be identified; in FY2006, the costs of mental health and medical services were combined in one contract and could not be differentiated. The DOC did not provide community mental health services in FY2006.

\(^{16}\) The Missouri Department of Health and Senior Services (DHSS) had expenditures of $6,845,406 for behavioral health related services including $60,000 for Bright Futures; $485,406 for Alcohol, Tobacco and Other Drug Prevention and Awareness Program; $2,200,000 for Comprehensive Tobacco Use Prevention Program; and $4,100,000 for Ryan White HIV Prevention.
Consumer Profiles

DMH is Missouri’s public mental health authority and, in FY 2006, served approximately 158,000 people statewide last year in its three divisions. (Note: the preceding number is a duplicated count because individuals may be served by one or more divisions.)

- 53,000 Division of Alcohol and Drug Abuse (ADA)
- 75,000 Division of Comprehensive Psychiatric Services (CPS)
- 30,000 Division of Mental Retardation and Developmental Disabilities (MR/DD)

In the same year, DMH served 144,644 unduplicated consumers including (a) 43,531 (or 30%) received substance abuse services, (b) 62,377 (or 43%) received psychiatric services, (c) 25,892 (or 18%) received mental retardation and developmental disability services, and (d) 12,844 (or 9%) received dual disorder services. Another 19,095 consumers were served by ADA’s Substance Abuse Traffic Offender Program (SATOP) who are court-ordered to attend DWI classes at their own expense.

FY 2006 DMH Consumers Served

Note: Figure above includes consumers funded from all sources including General Revenue, Federal, and MO Healthnet.

Age and Race/Ethnicity of DMH Consumers. A majority of consumers were adults between the ages of 25 through 64 (64.1%), followed by children/youth less than 18 years of age (20.5%), transitional youth 18 through 24 years of age (13.1%), and the elderly (greater than 64 years of age) (2.2%). More males (57.8%) were served than females (42.2%).
FY 2006 DMH Consumers by Age

Note: Figure above includes consumers funded from all sources including General Revenue, Federal, and MO Healthnet.

Around three-fourths (75.2%) of consumers were White, 20.5% were African-American, and 4.3% were of other racial or ethnic groups. The racial/ethnic makeup of the general population in Missouri is 85.4% White, 11.5% African-American, and 4.4% of other racial/ethnic groups.

**Needs Met by DMH**

The figure below depicts the mental health needs of Missourians met by DMH, estimated by using prevalence data and the numbers of consumers served by DMH. The needs met by DMH represent the numbers of consumers served in FY 2006. For persons with mental illness, approximately 12% of treatment needs were met by DMH, although a large number of individuals who did not receive services through DMH may have been served through other means. Around 5% of individuals with substance abuse difficulties (alcohol or drugs) were treated by DMH. DMH meets the needs of approximately 34% of people with mental retardation/developmental disabilities.

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17 To provide comparisons with the duplicated prevalence counts described earlier in this chapter, numbers in this bar graph are duplicated counts as well and meant to approximately the treatment needs meet by the Department of Mental Health.
**DMH Expenditures**

DMH provides services for persons with substance abuse, psychiatric and MR/DD disorders. In FY2006, most expenditures were for persons with psychiatric or mental retardation and developmental disabilities disorders. Specifically, $77,878,614, or 7% of funds were expended for substance use services, $419,655,616, or 38% were expended for psychiatric services, $473,541,393, or 43%, were expended for mental retardation and developmental disabilities services, and $136,658,852, or 12% was expended for persons with dual diagnoses. Any person served in FY2006 by two or more divisions of the DMH is counted in the dual disorders category.

**Expenditures by Type of Service.** DMH expenditures supported a variety of services including (a) inpatient care ($207,026,652), (b) less than 24 hour care, including acute care treatment ($582,683,618),

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Note: Figure above includes consumers funded from all sources including General Revenue, Federal, and MO Healthnet.
(c) other 24-hour care, including community supported housing, respite care, residential detoxification, crisis stabilization, and other community services ($196,846,024), (d) pharmacy costs ($10,515,209), (e) professional services (psychiatrists, psychologists, social workers, etc. ($96,308,323), (f) supported employment ($420,058), and (g) prevention (substance abuse, suicide prevention) ($13,934,594). The majority of costs were for less than 24 hour care. The fewest expenditures were for prevention services and pharmacy costs.18
MO HealthNet

Consumer Profiles

A large percentage of consumers of mental health care in Missouri are served through the MO HealthNet Division (Medicaid). In fiscal year 2006, a total of 305,566 consumers were served either through the MO HealthNet Division (301,490 consumers) or the Children’s Division (4,076 children and youth). Exact percentages by type of mental health problem (substance abuse, mental illness and MR/DD) will be available in future updates.

Of the consumers served through the MO HealthNet division, 59,983 (19.6%) were under 18, 22,404 (7.5%) were 18 to 24 years of age, 156,974 (51.4%) were 25 to 64 years of age, and 65,597 (21.5%) were 65 years of age or older.

Note: Figure above does not include MC+ and DMH MO HealthNet

Needs Met by MO HealthNet

The availability of MO HealthNet funds substantially lessens the overall treatment gap in Missouri, filling around 23% of the total mental health needs in Missouri. Given that DMH serves around 10% of Missourians with mental health needs, these two funding sources together provide the ability to serve around one-third of those in need.

MO HealthNet Expenditures

Forty-six percent ($963,883,024) of mental health-related expenditures flowed through agencies other than the DMH. Most of these expenditures were Medicaid expenses that flowed through the MO HealthNet (Medicaid) Division for general Medicaid expenditures and the Children’s Services Division for Children’s Psychiatric Rehabilitation services. In FY2006, MO HealthNet expenditures supported these services: (a) inpatient ($143,857,429); (b) less than 24 hour care ($61,400,069); (c) other 24 hour care ($198,871,395); (d) pharmacy ($323,174,514); (e) professional ($160,390,099); (f) supported
employment ($76,782); and (g) Medicaid costs associated with individuals who are both Medicaid and Medicare eligible (or Medicare cross-over costs) ($36,093,594).

MO HealthNet Expenditures by Service FY06

Note: Figure above does not include MC+ and DMH MO HealthNet

Estimates from the Economic Research Division of the U.S. Department of Agriculture placed the Missouri 2006 poverty rate at 13.6%, resulting in 788,842 Missourians below the poverty line. The rate of mental illness in this population is greater than the general population. The rate of substance abuse among Missouri poor, while not as drastic as the rate of mental illness, is still estimated to be 10% greater than that of the general population (Maukish et. al., 2001).

Summary

This chapter has outlined the prevalence of mental health issues in the state of Missouri, and described the number of consumers and related expenditures served by DMH and MO HealthNet, the two largest providers of mental health care among Missouri state agencies. It has also begun to explore expenditures and consumers of services within other state departments. Next year’s expansion of the needs assessment will explore this issue further by assessing the prevalence of mental illness among poor Missourians and the number of low-income Missourians served by the state system.
Chapter Two: NARI Key Themes

The Missouri Institute of Mental Health (MIMH) researchers identified more than twenty overarching themes that emerged from the review of existing literature and Needs Assessment and Resource Inventory (NARI) data collection and analysis. These themes are clustered into six domains: (1) Safety; (2) Access to Care; (3) Mental Health Wellness; (4) Consumer-direction and Empowerment; (5) Quality Mental Health Care; and (6) Mental Health System Fragmentation. A listing of the key needs organized according to stakeholder group is provided at the end of the chapter.

Safety

The Transformation Initiative articulates a vision that Communities of Hope throughout Missouri will support and sustain a system of care where everyone at any stage of life has access to effective treatment and supports essential for living, working, learning, and participating fully in the community. The foundation for building this must be safety. Thus, an overarching goal embraced by the Transformation team is creating a safe environment for consumers of mental health services. The Quality of Health Care in America Committee of the Institute of Medicine (IOM) in their landmark report “To Err is Human: Building a Safer Health System” concluded that harm caused by the health care system is unacceptable, and the delivery system should “First, do no harm.” (IOM, 1999) The NARI identified four primary issues related to safety where there is a documented need for system reform: (1) abuse and neglect; (2) trauma; (3) preventable medical errors; and (4) occupational safety.

Abuse and Neglect

Regardless of the type of disability or whether the abuse is emotional, physical, or sexual, research has demonstrated that people who provide care and support to individuals with disabilities are often the same people who victimize them – people the victims know and trust (Petersilia et al., 2001; Nosek et al, 1997; Marchetti & McCartney, 1990). This is true whether those who are the targets of abuse and neglect live in facilities or in the community.

In large part, the needs related to institutional abuse and neglect in Missouri’s mental health system have been recently addressed in response to incidents in habilitation centers that rose to the public’s attention in 2006. Missouri Governor Matt Blunt responded to public concern by appointing a Mental Health Task Force (MHTF), whose charge was to review best practices and make recommendations for changes to the mental health system to improve safety for consumers. A series of public hearings were held at six locations across the state where over 300 Missouri citizens spoke about their
concerns. The MHTF issued its report in November, 2006, describing 25 action steps for improving consumer safety. Key action steps included: (1) recruiting and retaining staff by offering more competitive pay; (2) improved staff training; (3) centralized data collection and analysis capabilities; (4) leadership stability; and (5) systemic reforms around abuse and neglect reporting.

In December 2006, Governor Blunt issued an Executive Order directing safety-related action by the Missouri Department of Mental Health (DMH). Subsequently, mental health reform legislation (SB 3) was passed by the Missouri legislature that incorporated many of the key recommendations of the MHTF and the Commission. Additional details about the series of steps and activities undertaken and the progress to date are fully documented in the final report (Missouri Mental Health Task Force, 2006)

From these reports, 25 action steps for improving consumer safety emerged, including: (1) recruiting and retaining staff by offering more competitive pay; (2) staff training; (3) centralized data collection and analysis capabilities; (4) leadership stability; and (5) abuse and neglect reporting; and (6) accreditation. Many of these actions steps have been completed; remaining steps include:

1. National accreditation of mental retardation/development disabilities habilitation centers;
2. Hotline ties between Department of Health Senior Services (DHSS) and Department of Social Services (DSS);
3. Salary enhancement for direct service staff;
4. Standardized training for consumer, families and staff to identify and report abuse and neglect;
5. Licensure redesign;
6. Legislation and regulation amendment for administrative actions, fines for failure to implement;
7. Background checks on new employees;
8. DMH Fatality Review Board;
9. Review and revise DMH MOU with Missouri Protection and Advocacy Services;
10. Public access to non-confidential information in final reports of substantiated abuse and neglect; and
11. Triage of incidents for joint investigation of all deaths or near deaths that are suspect for abuse and/or neglect. (Missouri Mental Health Task Force, 2006)

While institutional abuse and neglect has garnered attention recently, much abuse, neglect and exploitation also occurs in the community. People with disabilities may suffer from and be victimized by acts of abuse and neglect wherever they live. Community-based abuse and neglect is an important safety issue that will be explored more fully in the next NARI.

**Trauma**

Increasing attention has been paid to the inter-relationship between psychological trauma and psychiatric and substance abuse disorders. With this recognition has come an awareness that existing public mental health systems are not adequately prepared to help victims of trauma. Nationwide, mental health systems lack screening and assessment procedures for trauma identification, staff training on properly understanding trauma, information about trauma-related evidence-based
practices, and trauma diagnostic skills—all of which, lead to poorer treatment outcomes (Salasin, 2007).

Recognizing the seriousness of psychological trauma to consumer health, the DMH has recently introduced programs and policies to create a more trauma-informed system of care. Programs have included trauma training, development of a policy statement regarding trauma, and a Trauma Screening Program for Children.

While these efforts serve as a good start toward developing trauma-informed care, there is nonetheless a strong need for additional efforts in this area. A system of assessment for trauma-informed care with a formal plan of action has been suggested as a method to move away from fragmentation, towards a coordinated system of care for trauma victims.

In addition to addressing the needs of those entering the public systems with psychological trauma, there is also a significant need to address possible traumatization of individuals once they have entered the public system of care. In the daily care of individuals needing services, the potential for inducing trauma can arise, and in the past, some of the policies created to address consumer behaviors have been trauma-inducing. Examples of this include: restraint and seclusion methods used to prevent violent acts, and psychological trauma induced by treatment providers without appropriate trauma training who unwittingly traumatized consumers during the treatment process.

To address trauma resulting from restraint and seclusion, DMH is currently providing training on alternatives to restraint and seclusion at Fulton State Hospital, an intermediate and maximum-security forensic mental health care hospital. This training curriculum has been a significant first step toward the implementation of a comprehensive statewide plan to provide alternatives to restraint and seclusion. Learnings from the Fulton State Hospital project have been shared in training with all of the state-operated psychiatric and habilitation facilities. Further training programs throughout the state hospital system are needed, as well as statewide policies providing alternatives related to trauma sensitivity and trauma treatment. Additionally, more training of treatment providers on the effects of trauma on their clients is warranted.

**Preventable medical errors**

Nationally, an estimated 44,000 to 98,000 people die each year as the result of preventable medical errors. Adverse drug effects, surgical injuries, restraint-related injuries, falls, burns and mistaken identities are all types of medical errors which, when added together, exceed the number of deaths from motor-vehicle accidents, breast cancer and AIDS (IOM, 1999). Specific errors include errors in diagnosis and treatment, failure to use indicated tests, medication and dosage errors, delays in treatment, inappropriate care, inadequate monitoring, communication, equipment and other system failures.

The Division of Comprehensive Psychiatric Services (CPS), DMH, does not document all medical errors, but does document medication errors. Medication errors refer to inappropriate prescribing, distributing, administering, or monitoring of medications by CPS staff. There were 854 documented medication errors in 2007. Many of the mental health consumers participating in focus groups stated that there was a need to better monitor their care. They also reported errors and delays in the
diagnosis of their mental illness. The current safety plan developed in the past year addresses some of these concerns through additional staff training. Required preventable medical error training for all providers working with consumers should be a consideration.

**Occupational safety**

Bureau of Labor Statistics data show that in 2000, 48 percent of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services. Most of these occurred in hospitals, nursing and personal care facilities, and residential care services. Nurses, aides, orderlies, and attendants suffered the most non-fatal assaults resulting in injury.

Data from CPS indicate that Missouri has safety issues comparable to those in other states. In 2007, in-patient facilities reported 978 staff injuries, most of which occurred in the intermediate and maximum security forensic hospital. As described above, significant efforts are being exerted at Fulton State Hospital to address both client and staff safety through existing grant funds. Furthermore, as outlined in the Annual Safety Report, improving staff working conditions in DMH-run facilities is a high priority, and additional staff training on how to work with clients to avoid injury should be a priority.

**Access to Care**

Lack of information about mental health, embarrassment about seeking care, and belief that mental illnesses can be addressed without treatment are some of the many reasons that persons needing help do not seek services (Sale, Patterson, Evans, Kapp, & Taylor, 2007). But for those who want to get help, significant barriers impede their ability to access quality care in a timely manner. Data collected for the NARI strongly suggest that the following issues related to access are significant impediments to obtaining services:

1. Provider shortages, including child and geriatric psychiatrists and providers skilled in addressing co-occurring disorders;
2. Inpatient Psychiatric Bed shortages;
3. Lack of affordable services;
4. Lack of adequate transportation, especially in rural areas;
5. Housing and employment shortages;
6. Cultural disparities; and
7. Limited specialized services for children, transitional youth, and the elderly.

“Even if you know where to go for help, there are just long waiting lists......there is not access to services right away.” (Parent)
Provider and Bed Shortages

Provider Shortages

The shortage of mental health professionals and providers has been well documented. Nationally, the number of providers is especially low in rural areas, and there are shortages for children and older adults (Hanrahah & Sullivan-Marx, 2005; U.S. Department of Health and Human Services, 1999). Furthermore, there is a severe shortage of trained professionals to address the mental health needs of those with substance abuse and co-occurring disorders. The shortage of providers serving the needs of low-income persons is even greater.

As of 2004, only eight states in the nation have fewer psychologists than Missouri (population adjusted). Missouri fares better with the number of psychiatrists (16th in the nation) and social workers (19th). There are a total of 410 psychiatrists, 1,330 psychologists and 10,680 social workers reside in the state of Missouri. Adjusted for the population of Missouri, this amounts to 7.12 psychiatrists, 23.11 psychologists and 185.59 social workers for every 100,000 persons (New York Center for Health Workforce Studies, 2006). In Missouri, as of 2001, there were only 101 child psychiatrists, or 7.1 per 100,000 population. If true transformation of the mental health system is to occur, the number of mental health care professionals will need to expand to meet the greater demand for services.

Missouri Licensed Mental Health Service Providers, 2004

<table>
<thead>
<tr>
<th>Professional</th>
<th>Number</th>
<th>Average Number Per 100,000 Population</th>
<th>U.S. Avg. Per 100,000 Population</th>
<th>Ranking</th>
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<tr>
<td>Psychiatrists</td>
<td>410</td>
<td>7.12</td>
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<td>Psychologists</td>
<td>1,330</td>
<td>23.11</td>
<td>33.52</td>
<td>42</td>
</tr>
<tr>
<td>Social Workers</td>
<td>10,680</td>
<td>185.59</td>
<td>158.27</td>
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</tbody>
</table>

All data sources consulted for the NARI indicated that there is a significant need for providers in Missouri. In particular, specialized providers, particularly psychiatrists, and mental health professionals addressing co-occurring disorder needs are in need according to several groups, including consumers and agency staff. Many of the Division of Mental Retardation/Developmental Disabilities (MR/DD) providers felt that some provider shortage issues could be addressed with better coordination across different agencies within the state system.

- **89%** of all substance abuse and mental health providers felt that there was a high or critical need for co-occurring disorder out-patient providers.
Almost 70% of substance abuse and mental health providers expressed a high or critical need for more psychiatrists.

Approximately 63% indicated a high or critical need for more geriatric specialists, and

54% wanted more child specialists.

In addition, focus group members expressed the need to expand the workforce to include more geriatric psychiatrists, child psychiatrists, interpreters and providers trained to work with the deaf and hearing impaired, international, African-American, immigrants and refugees and Hispanic consumers.

Finally, many focus group members felt that mental health support and information could be obtained from “natural” community caretakers, including members of the faith community and nursing home personnel, provided that they were adequately trained in mental health care. They could then serve the role of providing more information to the community, help to reduce stigma and encourage accessing mental health services. Improved community crisis services so that they are able to provide immediate services to those in crisis were expressed as a need by several focus group members.
Service and Bed Shortages

The state mental health system delivers services to hundreds of thousands of individuals each year through its direct service system and MO HealthNet-financed services. Nonetheless, there is a shortage of services as evidenced by waiting lists and the declining number of staffed psychiatric beds.

According to data provided by the MR/DD, in January 2008, there were 3,629 individuals on waiting lists for in-home services and 393 on the waiting list for MR/DD residential services. While waiting list data were not available for those needing substance abuse and psychiatric services, high use of emergency room facilities indicates a lack of community service capacity.

Because of a dramatic decline (1,665) in privately and federally-funded beds between 1990 and 2005, the demand for state-funded beds continues to increase, with DMH beds now equaling 40% of all beds (2005) compared to 34% in 1990 (DMH, 2008). Mental health, substance abuse and MR/DD providers listed more inpatient and residential care as a major need, especially for persons with co-occurring substance use/mental disorders. This need was reinforced by focus group consumers. MR/DD providers especially expressed the need for better behavioral management services in inpatient facilities. Correcting this lack of inpatient and crisis beds was a particularly strong need for persons participating in rural focus groups, who reported traveling long distances to reach hospitals with psychiatric beds.

Lack of Affordable Services

Over the course of a year, three-fifths of people with severe mental illnesses do not receive specialty care. Lack of insurance and ineligibility for Medicaid services contribute to the problem. In the United States, one in five people with severe mental illness lack health insurance and only 37% of people with severe mental illness are covered by Medicare or Medicaid (NAMI Fact Sheet; 2004). According to a recent study by the Lewin Group, in 2007, an estimated 587,271 Missourians (or 10.1%) do not currently have health insurance or MO HealthNet coverage. The majority of these individuals make less than 300% of the poverty level (436,764). Around 44,000 uninsured Missourians are children 18 and under. (Lewin Group, 2007)

Across the board, the affordability of services was a predominant theme among Missouri stakeholder groups. Eight of the 10 focus groups held as part of the NARI identified affordability as a major issue, pointing to MO HealthNet restrictions as a significant impediment to obtaining care. These groups included the elderly, African-Americans, rural residents, homeless persons, transitional youth, refugees and immigrants, and persons on probation or parole. Transitional youth often age out of children’s services with no financial means or steady employment to provide them with health insurance. Prisoners transitioning to the community found several barriers to reinstating insurance upon reentry and the homeless often found endless bureaucracy gets in the way of receiving public assistance.
Transportation

Transportation is consistently cited as a major barrier to accessing care nationwide, particularly in rural areas. In a study of health care utilization, it was found that individuals with their own transportation made significantly more health care visits than did people who had to rely upon public transportation or others forms of transportation (Arcury, Preisser, Gesler, and Powers, 2005).

Transportation consistently was identified as a top need for providers and consumers consulted for the NARI. It was perceived to be a high or critical need among almost 90% of mental health care and substance abuse agencies. Among MR/DD providers, transportation emerged as the fourth most needed services. Transportation was a major problem for individuals in five of the ten focus groups, particularly those in rural areas. Elderly individuals who could not drive were in need of mobile services and youth in rural areas reported needing transportation to drive to the closest service providers, which are often in metropolitan areas. Transportation was a huge issue for the homeless, who have difficulty getting services and gaining employment without reliable transportation. Hispanics also reported that lack of transportation makes it less likely that they would seek services. Telehealth and in-home services were suggested as ways to provide services in rural areas which would alleviate the demand for transport. However, the provision of services in rural communities would be ideal.

Housing and Employment

Persons with substance abuse, mental illness and MR/DD face significant challenges in finding adequate housing and employment. It is estimated that the unemployment rates for persons with serious mental illness range from 70-90%, and that persons with disabilities have unemployment rates that are double those of the general population. It is also estimated that on any given night, 175,000 persons with serious mental illness are homeless. (U.S. Census Bureau, 2000; SAMHSA, 2004)

Considerable efforts are in place to provide housing and employment opportunities for consumers served by the state system. Housing supports include Supported Community Living, Housing and Urban Development (HUD) Shelter Plus Care grants, a housing registry accessible to all but originally initiated by MR/DD, Home and Community-based Services (HCBS), and many others. Employment supports include, but are not limited to Supported Employment programs, vocational rehabilitation programs, Project Success, Integrated Dual Diagnosis and Treatment Programs (IDDT), and Assertive Community Treatment programs. Information gathered by MIMH via surveys and focus groups indicate an even greater need for these services, particularly among MR/DD providers. These providers cited shorter waiting lists, and affordable and handicapped accessible housing as very high needs. Almost 80% of MR/DD providers expressed a need for more employment opportunities and better paying jobs. These needs were echoed by focus group members.
Age-Specific Disparities

Children and Youth

From focus groups held in Missouri in 2003 to formulate a shared agenda for children’s mental health, the following issues were identified as barriers to children needed mental health treatment: (1) adequate communication and collaboration; (2) stigma of mental illness; (3) training in the area of mental health; (4) family respect and support; (5) support for children inside and outside the school setting; and (6) support for schools (Shared Agenda, 2003). In addition, limited resources and provider shortages are also barriers to receiving care. Parents may have insurance plans that limits mental health and substance abuse treatment. Lower income parents may not qualify for MO HealthNet or the State’s Temporary Aid to Needy Families (TANF) Health Insurance Program (MC+).

A lack of providers specifically addressing children’s mental health is a serious issue both nationwide and in Missouri. Numerous studies have concluded that there is a severe shortage of child and adolescent psychiatrists in the United States (U.S. Department of Health and Human Services, 1999). This shortage is compounded by an inequitable distribution of child and adolescent psychiatrists such that children living in poverty or rural areas are least likely to have access to child and adolescent psychiatrists (Thomas & Holzer, 2006). In Missouri, as of 2001, there were only 101 child psychiatrists, or 7.1 per 100,000 persons.

To better address the needs of children and improve collaboration across state departments, the Comprehensive System Management Team and the Office of Comprehensive Child Mental Health were legislatively formed in 2006. Other significant efforts include expanded prevention efforts for children and youth, recommendations for statewide expansion of school-based mental health providers, and continued expansion of the System of Care programs addressing the needs of children. Transformation Work Group recommendations include promotion of protective factor prevention models, mental health consultation in early childhood and school settings, and the statewide development of the Missouri School-based Mental Health Model.

Transitional Youth

While transitional youth make up a relatively small percentage of the overall population, this age group is particularly vulnerable to alcohol and drug abuse. Transitional youth also represents an age group when many mental illnesses begin to present themselves. These characteristics accentuate the need for significant services. However, as these youth are transitioning from child to adult systems of care, services may, in fact, be cut. When youth age out of childhood services, including special education, child welfare and juvenile justice systems; they are often neglected (Davis and Vander Stoep, 1997; Davis 2003). Among transitional youth in Missouri these difficulties are compounded further by a lack of government assistance (few qualify for MO HealthNet and the SCHIP program discontinues at age 19) in a population that is largely uninsured--29% of women and 37% of men aged 21-24 were uninsured in 2006 (Fronstin, 2007).

One significant barrier to accessing care has been recently rectified. In 2007 foster children remained eligible for MO HealthNet until age 21, allowing for continued health care funding for this narrow
band of transitional youth. A large majority of transitional youth will continue to fall through the cracks as they try to maneuver through a complicated treatment system.

**The Elderly**

“*The current generation of older persons still views mental illness as a ‘personal flaw’, not an illness that can be successfully treated.*” *(Interview with Area Agency on Aging Director)*

Mental illness is a significant issue for older adults. As individuals age, factors such as chronic illness, institutionalization, isolation, and grief can lead to depression and other mental illness. These factors are also associated with an increased risk for suicide.

Barriers to appropriate older adult mental health treatment include: low MO HealthNet reimbursements, lack of training among primary care physicians, few geriatric psychiatrists, resistance to obtaining care, lack of recognition that seniors suffer from many types of mental illness, and lack of nursing facility staff training and knowledge of the mental health needs of residents. Based on three focus groups conducted with older Missourians (aged 65 and older) in both rural and urban areas, needs included: (1) reduction in stigma; (2) integration of physical and mental health care; (3) training of natural community supports; and (4) mobile services.

**Cultural Disparities**

African-Americans, Hispanics, deaf and hearing-impaired individuals, the homeless, immigrants and refugees, and lesbian/gay/bisexual/transgender individuals, all face unique barriers to receiving quality care. Major themes addressed by most focus groups with these individuals included: (1) stigma reduction; (2) public education about mental illness; (3) the need for culturally-similar and culturally-competent providers; (4) additional community supports; (5) translation of mental health information; (6) interpreter mental health care training; (7) additional community supports (housing, help finding care), and (8) training and education of the faith community on mental illness. Transformation Work Group members recommended that “everything that emanates from this Transformation Initiative be culturally/linguistically appropriate” *(Transformation Work Group Recommendations, 2007)*.

**Mental Health Wellness**

**Prevention and Early Intervention**

Emerging evidence suggests that certain mental health problems can be prevented, while in others onset may be delayed and severity of symptoms decreased. Prevention efforts are most successful when they use multi-faceted solutions that address, not only individuals, but also their environments, including home, work, and school *(Greenberg et al., 1999)*. Applying a primary prevention framework to mental health can support the care and treatment of those in need, while also reducing the stigma associated with mental health problems.
The NARI explored existing resources and expressed needs of stakeholders groups. Significant efforts have been made in the past several years to increase prevention and early intervention efforts in Missouri, including school-based substance abuse programming, after-school programs for youth, programming for pregnant women and young mothers, fetal alcohol awareness programs, systems of care initiatives, and delinquency prevention programs. Prevention and early intervention strategies can also be very effective with late-onset mental and substance abuse problems experienced by the elderly. There is a great need for expanded prevention programming.

Several stakeholder groups stressed the importance of prevention and early intervention. Among Transformation Work Group members, adoption of a public health model with a focus on prevention was listed as one of the top ten needs, followed by substance abuse education services and early intervention/screening. Among focus group participants, prevention programming for at-risk youth was particularly important, with many groups citing the need for more after-school programs for youth. Transitional youth, families with children and public hearing participants felt that mental health curricula should be placed in high schools, possibly as part of regular health classes. Public hearing participants cited the need to coordinate existing prevention plans and training providers on prevention strategies. Work group members recommended several prevention and early intervention strategies, including mental health screening, school-based mental health and curriculum development, expanded mobile services to address non-emergency situations, and expanded systems of care in local communities.

Stigma

Individuals with severe mental illness, substance abuse problems, or mental retardation and/or developmental disabilities are disparaged more often than persons suffering from physical illnesses (Corrigan et al., 2005; Fulton, R., 1999; Hinshaw & Cicchetti, 2000; Waldman, Swerdloff & Perlman, 1999). Stigma is not confined to the general population. Stigma among mental health professionals, the media, the faith community, primary care physicians, employers, and other professionals is equally or perhaps more pervasive.

While stigma nationwide is well documented, the only recent study of stigma in Missouri relates to mental illness stigma. This study found that a high percentage of persons in the general population would be unwilling to work with someone with a mental illness or have someone with a mental illness marry into their family (Sale, Patterson, Evans, Kapp, & Taylor, 2007). Persons with schizophrenia, who many perceived to be dangerous, were most stigmatized. Stigma was strongest among males (particularly upper-income males), and the elderly.

While stigma has decreased over time, it is still a significant issue for a large number of adults living in Missouri. The TWG ranked “improving the public perceptions of persons with mental health needs” as the third most critical action to be taken to transform the mental health system. Stigma reduction was mentioned by all of the focus groups conducted for the NARI, with many stating that
stigma from the community and mental health staff was impeding recovery. Future considerations include an anti-stigma and public education campaign, with targeted messages to males and the elderly, and training of service providers, including mental and physical health providers, employers, and the faith community.

Public Mental Health Literacy

It is becoming increasingly evident that improving the public’s level of knowledge regarding mental disorders (e.g., mental health literacy) is crucial for early recognition and intervention in mental disorders (Lauber, et. al., 2005; Kelly, Jorm, and Wright, 2007; Jorm, 2000). Knowledge about mental health is also an important determinant as to whether or not a person seeks help (Lauber et. al., 2005).

In Missouri, a recent survey on attitudes toward mental illness found that while a majority of respondents stated that chemical imbalances, genetics and stress are responsible for mental illness, 35% of respondents still thought that mental illness is likely to be caused by how the person was raised, almost 30% believed it was somewhat or very likely to be the result of bad character, and over 20% of individuals believed that mental illness was likely to be result of a higher power. A very high need for greater public mental health literacy efforts was expressed by mental health and substance abuse providers; 87% felt that public awareness and education were either high or critical needs. Anti-stigma campaigning, education of community professionals, youth training and creation of a peer speaker’s bureau were suggested by Transformation Work Group members as ways of addressing public literacy issues.

Mental and Physical Health Integration

Often, the first point of contact for someone with a mental illness is their primary care physician, and in many areas where access to mental health care professionals is limited, the primary care physician may be the sole mental health care resource. However, many primary care physicians lack knowledge regarding the relationship between mental and physical illness, and how mental health issues can present themselves as physical health conditions.

The critical relationship between physical and mental health care providers was noted by all stakeholder groups. Particularly in rural areas, where individuals rely more upon their physicians for all around care, physician education and/or strong linkages with a psychiatrist is needed. Stakeholders expressed the need to offer mental health care services in public health offices, move to collaborative care practices, encourage the use of technology to share records between mental and physical health care providers, and provide more education in medical schools on mental health care to help bridge the gap between physical and mental health care providers.
Consumer-directed Care and Empowerment

Consumer Decision Making in Care

A transformed consumer-driven system of care can be conceived of as one with consumers and their organizations at its hub, where consumers choose what they need from an array of services and supports (U.S. Department of Health and Human Services, 2005). According to the President’s New Freedom Commission Report, this includes enhancing consumer choice in their treatment, supports, and funding for services (President’s New Freedom Commission Report, 2006).

Consumer-driven care is a high priority need expressed by all groups, whether they were consumers, agency staff, workgroup members, or public hearing participants. Focus group members and public hearing participants believe they are not being heard in the current system and that they should be involved in the treatment decision-making process. Transformation Working Group members felt that consumer-driven care is a critical need and should be one of the first priorities taken in the transformation effort. Consumer-driven care was the third highest priority for MR/DD providers.

Consumer Recovery/Support Services

In addition to the housing, employment, transportation and provider needs discussed above, the need for additional recovery supports for consumers of mental health care were felt to be a strong need across all stakeholder groups. Provider agencies listed this as their 2nd most important need. Many focus group members, including transitional youth and rural consumers expressed frustration with the quality and accessibility of existing support services. Probationers expressed concerns that, after their release from correctional facilities, many support services are no longer available to them. Transformation Work Group members made several recommendations, including the expansion of evidence-based peer and family-run programs to help strengthen existing recovery and support services.

Consumer-run services and consumer-providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis. Because of their experiences, consumer-providers bring different attitudes, motivations, insights, and behavioral qualities to the treatment encounter (New Freedom Commission on Mental Health, 2003). Consumer organizations provide, within a non-stigmatizing environment, what the traditional mental health system cannot offer. They help integrate the fragmented services needed for recovery that span multiple systems of care, such as housing, employment, and social services. There are a number of organizations with consumer and family involvement in Missouri. Some of these have advocacy as their primary mission, some are primarily geared toward service, education and/or support, and others are affiliated with governmental agencies. As relates to traditional consumer/family member organizations, most have local geographic membership. In Missouri, several consumer-run organizations have regional or state-wide membership, including the National Alliance on Mental Illness (NAMI), Missouri Recovery Network, and MPACT (Missouri Parents ACT), Consumer-operated Service Programs (COSPs), drop-in centers and warm lines. However, expansion of these consumer-run organizations as well as
membership within current organizations was seen to be a way to help enhance existing recovery efforts across the state, particularly in rural areas where there are presently fewer recovery supports.

**Quality Mental Health Care**

**Workforce Development**

A well-trained workforce is an essential component to delivering high-quality mental health. However, the existing workforce lacks adequate training across a variety of areas, including mental health care promotion and prevention, training on trauma and co-occurring disorders, and training in the implementation of evidence-based practices.

The training needs in Missouri are similar to needs across the nation. According to recommendations that emerged from the recent Lieutenant Governor’s Report on safety, “training may be the most important factor in ensuring that individuals with disabilities are protected” (Missouri Mental Health Task Force, 2006, p. 29).

As part of the NARI, MIMH explored workforce training issues with consumers and providers. The following needs emerged:

- **Co-occurring Disorder Training.** Among providers, there was a very high need expressed for training of direct staff in the area of provider co-occurring disorder training with 82% of substance abuse and mental health respondents indicating that it is a high or critical need. Co-occurring disorders training and treatment ranked as the #1 need that mental health and substance abuse agencies would advocate for if they could choose only one issue. Co-occurring disorder training was the fourth greatest need for MR/DD providers. The need for more co-occurring services is also a theme among focus group consumers.

- **Evidence-based Practices.** Almost three-fourths of providers felt that training in evidence-based practices was either a high or critical need.

- **Quality Care.** Many focus group members felt that their counselors did not have adequate skills to provide quality counseling services, relying upon medication for mental illnesses that could have been treated through therapeutic interventions. In some cases, individuals cite instances where medication administration resulted in negative outcomes. Consumers reported that when they experienced poorly trained counselors their trust with the counselor was destroyed, thereby preventing any positive therapeutic outcomes or recovery.

The training needs of the mental health workforce are being addressed currently in several ways:

- Standardized training for all DMH and provider staff on identifying and reporting abuse and neglect;

- Salary enhancement for direct care staff are on the current FY 2008 DMH agenda.
➤ Development of e-learning through the current Network of Care contract;
➤ System wide workforce development for children;
➤ Standardized prevention training for all direct service staff;
➤ Cultural competency training for substance abuse prevention providers to address gender, ethnic, educational and age diversity; and
➤ Prevention certification for all direct service substance abuse prevention staff

For future consideration, recommendations from the Transformation Work Groups included: (1) pre-service provider training on predictive factors, prevention strategies and other topics; (2) in-service training on behavioral health to schools, etc.; (3) professional training to support best practices and integrated care and teach professionals to be able to communicate effectively across disciplines and settings (effective “crosstalk”); and (4) educational and reimbursement incentives to increase health and behavioral health specialists in areas of need across lifespan.

**Evidence-based Practices**

Evidence-based practices (EBPs) in the mental health and substance abuse fields are those practices that have been demonstrated effective through experimental research. EBPs can refer to either the type of method used in delivering mental health care interventions, or to the specific treatment or services shown to have positive outcomes on the individuals receiving treatment. In the mental health field, evidence-based practices generally describe different therapeutic approaches (cognitive behavioral therapy, IDDT, etc.) (Hoagwood et al., 2001) or clusters of practices, such as Assertive Community Treatment (ACT) defines a particular way of delivering treatment.

In the mental health, mental retardation/developmental disabilities and substance abuse prevention and treatment areas in Missouri, there is a concentrated effort to move toward the use of EBPs though systems of measuring the fidelity of implementation of EBPs are only now beginning to be implemented. Recovery programs are also focused upon the use of EBPs, including the widespread use of emerging programs such as COSP.

In the NARI survey of providers, 82% of the substance abuse and mental health provider agencies reported using EBPs. Cognitive Behavior Therapy, motivational interviewing, and medication management were reported as used most frequently. Trauma Recovery and Empowerment Treatment (TREM), and Supported Employment, though used less frequently, were ranked most effective. Among MR/DD providers, Positive Behavior Supports and Person Centered Planning were used most often and were rated as either extremely or very effective by most agencies that use them. This survey made no effort to verify EPB service delivery.

The EBP Transformation Work Group developed the following recommendations: (1) interdepartmental approach (e.g., EBP Committee) to develop policies, regulations and financing strategies that support EBP; (2) policy statement that ensures broad-based consumer and family input into EBP funding; (3) systematic and collaborative approach to EBP education/training and outcome measurement; (4) provider financing incentives to support EBP development and practice; (5)
consumer choice of providers certified in an EBP by DMH; (6) establishing “Coordinating Centers of Excellence” (7) training curriculum and implementation process for EBP core competency development; (8) education and licensure incentives for continuing education in evidence-based practices; and (9) partnerships with colleges and universities to incorporate EBP into course curriculum and provide training opportunities in practice and implementation. Assessment of program fidelity and on-going monitoring of new evidence-based practices should also be a priority.

Quality Management

Using evidence-based practices goes a long way toward improving the quality of care delivered to persons in need of mental health care. Adding an expanded and well-trained workforce builds this capacity further. A third necessary ingredient to assuring excellence in care is the development of a quality management system that monitors and evaluates the implementation of evidence-based practices and maximizes the use of existing informational and technological resources to better coordinate care. Quality management includes the establishment of uniform quality standards, periodic assessment and evaluation of program activities to assure high quality implementation. The NARI identified a myriad of quality management procedures implemented to assure quality service delivery across departments involved in mental health care, including MR/DD Quality Control Measures, Quality Service Reviews and Medication Risk Management, third-party evaluations of several large-scale grants, and the development of standardized outcome measures. The Technology Transformation Workgroup identified a myriad of technological quality management resources currently in place across all seven departments involved in the delivery of mental health care. However, considerable work to further improve quality service delivery is needed.

Future considerations to improve quality management, as recommended by the Transformation Work Groups, included perhaps first and foremost the development of a unique consumer identifier across departments to improve treatment coordination for individual consumers. Additional recommendations included: (1) regular statewide training on EBPs; (2) Advanced Information Technology systems that fully integrate Quality Management databases; (3) systematic and comprehensive evaluation of department quality management procedures and programming; (4) Electronic Health Record (EHR) system owned by the consumer and shared with providers; (5) Electronic Medical Records system (EMR); (6) systematic data analysis. (7) outcome analysis; (8) e-based information sharing system; (9) e-based system for training; and (10) expanded teleconferencing to improve program monitoring and communication.

Mental Health System Fragmentation

State-funded mental health, substance abuse, mental retardation and developmental disability services in Missouri are offered primarily through DMH and the Division of MO HealthNet within DSS. Within DMH, three divisions serve the mental health needs of the state: the Division of Comprehensive Psychiatric Services (CPS), serving those with mental illness, ADA, providing substance abuse treatment and prevention, and the Division of Mental Retardation/Developmental Disabilities (MR/DD), assisting those with mental retardation and developmental disabilities. The Division of MO HealthNet funds services for MO HealthNet recipients in need of mental health care.
In addition to DMH and the MO HealthNet Division of DSS, several other departments and divisions also provide treatment services or contract with CPS for care. These include the Department of Corrections (DOC), the Department of Elementary and Secondary Education (DESE), two additional divisions within DSS, DHSS, the Department of Public Safety (DPS) and the Office of State Courts Administrator (OSCA).

Despite several initiatives designed to link services across departments, many initiatives and financial resources are fragmented. Departmental systems are not adequately linked to each other to provide accurate and comprehensive information regarding the mental health care provided to individual consumers. DMH provider agencies surveyed for the NARI felt strongly that further collaboration between DMH, across departments, and public/private agencies is needed, with around 75% of providers expressing either a high or critical need for collaboration in these three areas. Individual consumers and public hearing members voiced concerns about fragmentation as well. They urged better coordination between schools and mental health care providers, substance abuse and mental health care services, and primary care and mental health care professionals. Transformation work groups suggested: (1) establishing state departmental coordinating teams; (2) establishing uniform geographic services areas across divisions and departments; (3) developing common eligibility standards; (4) developing shared information systems; (5) assigning a unique consumer identifier to each consumer; (6) utilizing one coordinator across state systems for each consumer; and (7) bringing together state, local, public and private payers to develop more effective funding stream strategies.
### Stakeholder Priority Needs: Workgroups, Focus Groups, Providers and Public Hearing Participants* (Needs Rank Ordered)

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<thead>
<tr>
<th>Stakeholder Group</th>
<th>Priority Needs</th>
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<td>Transformation Working Group members</td>
<td><strong>Most Pressing Needs</strong></td>
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<td>1. Improved financing</td>
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<td>2. Increased access to mental health care</td>
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<td>3. Agency collaboration</td>
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<td><strong>Critical Actions Needed</strong></td>
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<td>2. Consumer-driven care</td>
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<td>3. Stigma reduction</td>
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<td>Transformation Work Group members (n=108)</td>
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<td>4. Public mental health literacy/stigma reduction</td>
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<td>5. Consumer supports</td>
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<td>6. Prevention/Public Health Model/Across Lifespan</td>
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<td>7. Technology</td>
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<td>8. Early identification</td>
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<td>Focus group members</td>
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<td>1. Stigma reduction</td>
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<td>2. Community involvement/outreach</td>
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<td>4. Specialized Providers (esp. psychiatrists)</td>
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<td>5. Transportation</td>
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<td>6. Increased access to mental health care</td>
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<td>7. Prevention/Early Intervention</td>
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<td>Mental health and substance abuse providers</td>
<td><strong>Needs for System Change</strong></td>
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<td>1. Co-occurring disorders training/treatment</td>
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<td>5. Greater consumer choice</td>
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<td>MR/DD providers</td>
<td><strong>Consumer Needs</strong></td>
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<td>1. Single point of entry into system</td>
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<td>3. Ongoing recovery/support services</td>
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<td>4. Provider co-occurring disorder training</td>
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<td>5. Expanded school-based mental health services</td>
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<td>6. Better evaluation of persons with co-occurring disorders</td>
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<td><strong>Consumer Needs</strong></td>
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<td>1. Shorter waiting lists for housing</td>
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<td>2. Affordable housing</td>
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<td>5. Employment</td>
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<td>6. Better paying jobs</td>
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*Needs Rank Ordered*
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<th>Stakeholder Group</th>
<th>Priority Needs</th>
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<td>Public Hearing Participants</td>
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<td>1. Agency collaboration</td>
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<td>1. Workforce development</td>
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<td>4. Housing</td>
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<td>4. Revised MO HealthNet coverage/eligibility requirements</td>
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<td>4. Specialized providers (esp. psychiatrists)</td>
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<td>7. Transportation</td>
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<td>8. Co-occurring disorder services</td>
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*Duplicate numbers reflect ties.*
Chapter Three  

Needs According to Transformation Workgroups  

"We need to think outside the box"

Transformation Working Group (TWG) and Workgroup Surveys

To better assess the mental health needs of key Missouri stakeholders involved in planning, policy making, and service delivery, the Governor constituted a TWG to oversee the development of the Comprehensive Plan and to make recommendations to further inform this plan. The TWG chartered six additional workgroups to further inform the plan. The workgroups were centered on the six themes of the President’s New Freedom Commission Report.

The TWG was constituted by Missouri Governor Matt Blunt, and established through Executive Order 06-39 in April 2007. The original TWG was comprised of 18 members. This number was expanded to 24 by Executive Order 07-15. The TWG is composed of consumers, family members of consumers, key leaders from the Governor’s office, the Department of Mental Health (DMH) and other state departments/agencies (see the list at end of this chapter for more details regarding TWG composition). The TWG Leadership team has met once every quarter since January 2007 to develop and review workgroup charters, receive updates on the progress of the workgroups (culminating in the creation of the first year plan), and review and assist the Needs Assessment team.

Members of the six workgroups represented a wide range of constituencies including consumer and family members, consumer organizations, governmental agencies, mental health organizations, provider agencies, educational institutions, and corporations. The titles of each workgroup were as follows:

- Mental Health is Essential to Overall Health
- Consumer and Family Driven Care
- Easy, Early and Equal Access to Mental Health Care
- Disparities Are Eliminated
- Evidence Based Practices
- Technology

To assure effective collaboration and integration, a member of the Technology Workgroup was assigned to each workgroup. Likewise, at least one member of the evaluation team was also assigned to each group. The workgroups brought together 232 content experts from the public and private
sector. Content experts included consumer and family members, agency and program leaders, researchers and academics, providers and health care professionals. They convened in March 2007 and continued meeting through June 2007.

**Procedure**

The needs assessment of all groups was conducted in May 2007. A total of 108 workgroup members and 13 TWG members completed the survey. The on-line survey specifically examined participants’ identification of needs to five questions:

- What are the most pressing needs that should be addressed to successfully transform mental health care in Missouri?
- What three critical actions would have the most impact on transforming mental health care in Missouri?
- What would be the first step to transforming mental health for all Missourians?
- What significant opportunities do you think we need to take advantage of in order to transform mental health for all Missourians?
- What significant barriers do you think we need to be aware of in order to transform mental health for all Missourians?

**Summary of Findings (n=121)**

- **Most Pressing Needs.** Improved financing and increased access to mental health care were consistently regarded as one of Missouri’s most pressing needs. Also of importance were communication, collaboration and integration across both state agencies and entities external to state government.

- **Three Critical Actions.** The three most critical transforming actions were improved financing, consumer driven-care, and increased agency collaboration. Improving the public perceptions of persons with mental health needs was also ranked as an important action.

- **First steps.** First steps toward transforming the current mental health system were similar to the critical actions and included designing methods to increase easier, earlier and equal access to mental health care; improved financing; greater collaboration; educating the public on the importance of and need for transformation; and changing public perceptions of those with mental health needs versus mental illness.

- **Significant Opportunities.** Significant opportunities that TWG and work group members felt Missouri should take advantage of included: improving funding/financing opportunities and increasing programs through grants, addressing funding issues through the state’s new Medicaid redesign program (MO HealthNet), having dollars follow the person, passing local tax initiatives, and using electronic data systems to streamline funding. Also of importance was taking advantage of communication and collaboration opportunities.

- **Significant Barriers.** Significant barriers to transforming the mental health system were thought to be people’s perceptions of those with mental health needs versus mental illness (e.g. stigma), financing issues, resistance to system change/collaboration, and the perceived difficulties of implementing change throughout state government.
Detailed Findings

Although the TWG and work groups had similar responses to the questions (as summarized above), there were some differences in responses. This section provides detailed results from each group.

TWG Findings (n=13)

➢ **Most Pressing Needs.** The most pressing needs were identified as improved financing, access to care and coordination/communication across agencies.

➢ **Critical Actions.** The three critical actions necessary for transformation included improved financing, better agency collaboration, and consumer driven care. Developing a realistic plan and decreasing community stigma were also seen as important actions to take to transform the system.

➢ **First Steps towards Transformation.** TWG members listed improved financing, agency collaboration and consumer-driven care as the three most important first steps necessary to transform the mental health system. These needs were following by changing public perceptions of those with mental health needs vs. mental illness (e.g., stigma), access, workforce development, use of evidence-base practices and political buy-in.

➢ **Significant Opportunities.** The attention being placed on making changes to the system was seen as a definite positive opportunity among TWG members. Another often mentioned opportunity was the current work being done with the children’s mental health system initiative. The system changes occurring because of 2003 legislation to develop a children’s system of care in Missouri are seen as model by which to build collaboration across state and outside agencies.

➢ **Barriers.** Finally, financing issues and stigma were seen as barriers to achieving mental health transformation. Other barriers the need mentioning are state and federal policies that prohibit real systemic modifications in the way we do business and resistance to change among those engaged in the system.

Transformation Workgroup Findings (n=108)

➢ **Most Pressing Needs.** Access, improved financing, and communication/collaboration/integration were priority items. The first two of these are self-explanatory; communication/collaboration/integration, however, referred to not only those activities internal to the DMH, but also across state agencies, physical health entities, and across the lifespan. Next, frequently cited by respondents were overall system changes (n=10), education/stigma reduction/training (n=10), and consumer needs (n=7). Overall system changes engendered such specific issues as addressing the needs of youth transitioning from the children’s to the adult system, evaluating consumer core needs, and increasing service capacity. The other needs cited were more easily defined. For example, the education/stigma reduction/training category included changing public perceptions of those with mental health needs vs. mental illness, reducing stigma, increasing the understanding of mental illness and training staff. Several other categories were
mentioned to a lesser degree. These included: resources (n=5); prevention/public health model/across lifespan; technology; and, early identification.

- **Critical actions.** To identify the three critical actions that would have the most transforming impact, respondents rank ordered their responses. The rankings are as follows:
  1. Improved financing
  2. Consumer-driven care
  3. Agency collaboration
  4. Improving public perceptions of those with mental health needs
  5. Easier access
  6. System changes
  7. Workforce issues
  8. Political buy-in
  9. Treatment changes

  Adequate financing is clearly of concern to most persons as is consumer-driven care and interagency collaboration. Other issues such as improving public perceptions and easy, early and equal access are also of high interest.

- **First Steps toward Transformation.** First steps toward transformation generated a variety of answers. Most important first steps were easier, earlier and equal access; improved financing; greater collaboration; educating the public on the importance of and need for transformation; and changing perceptions of those with mental health needs versus mental illness. With regard to easier, earlier and equal access, the difficulties created by the large rural areas of Missouri and how they affect mental health services, were noted. Also of interest was addressing mental health at an earlier stage of illness.

- **Significant Opportunities.** The most frequently cited opportunities among work group members were financing opportunities, including the pursuit of applicable grants, addressing financial concerns through the Medicaid redesign program (MO HealthNet, exploring ways for), having dollars to “follow the person,” passing local tax initiatives, and using electronic data systems to streamline funding. Next in importance were communication and collaboration opportunities; among the suggestions made were ridding the system of duplication, developing regional collaboratives, utilizing data more effectively, and partnering with physical health. Overall system opportunities were also frequently listed with suggestions for more privatization of health services and the development of MO HealthNet. Effective use of technology by sharing data and other methods was also an important opportunity according to the work group members. Finally, changing public perceptions of mental health needs vs. mental illness, training opportunities, and taking advantage of current resources in new ways were also suggested.

- **Barriers.** Top among the barriers cited were perceptions of mental illness, finance-related issues, resistance to system change/collaboration, and the perceived difficulties of implementing change through state government. Also, the way Missourians perceive mental illness is itself a barrier--several respondents noted that even the way mental health is discussed imparts a negative connotation of illness in the public’s view. Turf issues were prominently cited under both improved financing and resistance to change/collaboration barriers. In addition, a number of
persons spoke of making sure that the executive and legislative branches of government understand and support the needs of persons with mental illness through improved financing and legislation.

Membership of the TWG includes the following:

- Chair
- Co-chair
- 2 Consumer Leaders
- 2 Family Leaders
- Senior Healthcare Policy Advisor, Office of Governor
- Director, Office of Comprehensive Child Mental Health
- State Advisory Council Chair, DMH Division of CPS
- Director, DMH Division of CPS
- Director, DMH Division of ADA
- Director, DMH Division of MR/DD
- Director, DSS Children’s Division
- Director, DSS Division of Youth Services
- Director of Program Management, DSS Division of Medical Services
- Prevention Services Coordinator, DHSS
- Representative, Division of Senior & Disability Services, DHSS
- Chief of Mental Health Services, Department of Corrections
- Public Safety Manager, Department of Public Safety
- Director of ITSD-IT, DMH Office of Administration
- Assistant Commissioner, DESE Division of Vocational Rehabilitation
- Assistant Commissioner, DESE Division of Special Education
- Representative, Missouri Housing Commission
- Representative, Office of State Court Administrators
Chapter Four

Summary of Needs from Department of Mental Health-related Sources

“Let me be part of the solution.”

Before conducting focus groups, Missouri Institute of Mental Health (MIMH) researchers reviewed recent mental health consumer reports conducted by the Department of Mental Health (DMH) and others to obtain a fully understanding of information in secondary sources related to needs and resources. The two major DMH-related studies of consumers were the “Voice of the Consumer” report that came out of focus groups conducted by the Change Innovation Agency, and “The Missouri Planning Council for Developmental Disabilities Statewide Needs Assessment,” a needs assessment of mental retardation/developmental disabilities consumers prepared by the Institute of Human Development at the University of Missouri-Kansas City (UMKC; Rinck, Graybill, Berg, & Horn, 2006). In addition, MIMH reviewed the public hearings conducted by the TWG in the summer of 2007 in order to get public input on the department’s plan. The goal of this chapter is to summarize all three of these secondary data sources in order to provide a context for the development of the focus groups, as well as provide additional perspectives regarding the needs of mental health consumers in Missouri.

“Voice of the Consumer” Focus Groups

In 2004, the DMH and the Change Innovation Agency partnered to conduct statewide focus groups to address satisfaction with the Department of Mental Health’s services. Many individuals participated in these focus groups and interviews, including consumers who access substance abuse and mental health services for themselves or others (i.e., family members), mental health providers, law enforcement, public administrators, and the deaf and hard-of-hearing. A total of 412 individuals took part in these focus groups. The feedback from this project was summarized in the “Capturing the Voice of the Consumer” report. The following information is excerpted directly from that report.

It should be noted that although MIMH gathered information and data for this needs assessment, MIMH did not collect the data for the “Capturing the Voice of the Consumer” report, nor did MIMH analyze that data. Information about this report has been taken directly from the DMH and Change and Innovation Agency report.
General Findings & Recommendations

Seven system wide recommendations, described in the document’s Executive Summary, were presented. (Change and Innovation Agency, 2003).

**After-care.** Consumers feel that there is a lack of follow-up treatment upon completing a program or leaving in-patient care. They often do not feel prepared to move on without some kind of support (i.e., counseling, life skills training, housing assistance, job assistance, etc.).

**Repeat Consumers.** Consumers want services and programming that are effective, meaning that they only go through once. It seems as though DMH puts consumers through the same exact treatment although it may not have been effective the first time – there is no alternative route specialized for the repeat client.

**One-on-one time with the counselor.** Youth and adults alike in out-patient and in-patient care overwhelmingly wanted more time with their counselor. They want to sit down and discuss an issue without getting a prescription handed to them. Consumers also want to talk to somebody on an “as-needed” basis. Counselors that “have been in my shoes” are in high demand, as well.

**Quality of Information.** Consumers, especially in the Division of Alcohol and Drug Abuse (ADA), expressed concern about the age of their education material – videos, hand-outs, etc. Their major complaint was about the age and usefulness of the materials. They complained that the videos seemed like they were 15 years old, and that the materials were often things they already knew. A better way to express the content would be to provide motivational learning experiences such as trips to hospitals to see people affected by their actions, speakers, who have been in their shoes and succeeded, consumers reported.

Consumers receiving in-patient care complained about repeating the same information repeatedly, especially if they were long-term consumers. There was a real sense that they are not getting anything out of programming once they have been there for a significant length of time.

**In-patient Quality of Life.** Many consumers in in-patient care expressed boredom. Many focus group members wanted to do more activities, get outside for fresh air, and work out and exercise. Unfortunately, they said, many activities are cancelled or avoided due to a feeling that there aren’t enough staff to allow consumers these opportunities.

**Speed and Access to the System.** Individuals representing referral agencies expressed strong concerns about the difficulty in getting consumers into the DMH system for anything beyond an assessment. This was particularly true for the Division of Comprehensive Psychiatric Services (CPS), where waiting lists, lack of available beds, and the inability of the Access Crisis System to carry out duties which Mental Health Coordinators used to do. They stated that response times are slow, and beds are very difficult to locate. In some cases, located beds disappear while filling out all of the paperwork that is required. The development of a Crisis Intervention team by the Lee’s Summit Police Department seems to eliminate many of the complaints. Lee’s Summit uses a system that was originally developed by the Memphis, Tennessee Police Department.
Staff Attitudes. Many comments centered on poor staff attitudes toward consumers. In the Methadone program, many consumers felt that staff was treating them like “criminals, not consumers” – with little respect. Many consumers in in-patient care discussed how they were held to rules that the staff don’t follow, such as prohibitions on cursing and smoking. There was a general feeling that the staff attitudes have a direct impact on consumer satisfaction or dissatisfaction.

Findings from Specific Groups

In addition to the seven system-wide recommendations presented above, findings related to specific subpopulations were also described in the Voice of the Consumer (Change Innovation Agency, 2003) report and summarized by MIMH staff for this needs assessment.

Youth in In-patient Care

Many youth in in-patient care felt that they needed better treatment from staff and greater respect. They expressed the need for more access to doctors, more appointments/visits with their doctors, and better community transition services that would improve their chances of recovery and remaining out of in-patient care. They would like to know more about their conditions and treatment.

Parents of Youth in In-patient Care

Parents expressed a desire for more accessible services and after-hour services. These parents worried that their children do not have adequate care and desired criminal prosecution for those who abuse/harm their children. Many encouraged team-oriented planning to maximize the benefit for their child. They requested that they not be isolated from their children when those children were in residential care. Parents also felt that staff should listen to them, better involve them in care decisions, and listen to their recommendations. They would like more individualized care and would like it better explained to them.

Adults in In-patient Care

Adults in in-patient care expressed the desire for more input into their treatment. They would like treatment that leads to a quicker discharge and which would better prevent relapse. Many said that they would like to become productive members of society with an ongoing system of support or after-care, including job training. They would like more access to their doctors, and requested doctors that could meet their specific needs, such as a Veterans Administration representative to meet the needs of veterans. They would like to be treated with respect and not threatened. The individuals who have been in the system over time do not like to have the same treatment constantly repeated.

Consumers Receiving Services in the Community

Consumers expressed the need for more information about their illness and treatment options; specifically related to information on anger, depression, and medications. Participants expressed a high need for independence, follow-up care, and more input in their services.
Clients Receiving Residential Care

The greatest needs of these consumers were after-care services to allow them to better transition into their communities. This included skill-building in areas such as budgeting and other practical skills. Faster access to professionals (including doctors), employment assistance, more social time, transportation and addition trips outside of the facilities were other needs expressed.

Residential Services Owners

Residential service owners participating in focus groups were very interested in improving the quality of life for residents in their facilities, and would like to be able to better meet the needs of their residents. Better communication with DMH was expressed as an important need. They would like to be notified of policy changes when they occur. There were complaints about billing and other financial issues.

Law Enforcement

Many law enforcement participants wanted a directory of services offered by DMH with contact numbers for the services. They also need facilities to provide beds in a timely manner, paperwork reduction, and additional beds. They wanted better definition of the process of commitment, including a list of reasons for a 96-hour commitment. The law enforcement participants also expressed concern that while they were dealing with the paperwork or waiting in the ER, deputies were being taken off of the road from their other work. The outcomes suggested are fast, effective treatment, minimal law enforcement contact, and long-lasting care for consumers.

Other Referral Sources Including Advocacy Organizations

CPS providers, housing/shelter providers, administrators with the Missouri Hospital Association, and members of advocacy organizations (including NAMI) were included in focus groups. Some stated that there is still a need for someone to perform the functions formerly performed by Mental Health Coordinators. They also need comprehensive services that are provided in a timely manner. Providers would like to break down the silos that fragments and isolates treatment between various departments and divisions; it takes too many steps to get to the right person. They would like individualized care and treatment and specialized services for children and promote the System of Care. According to many parents who are members of advocacy organizations, lasting results, rather than “temporary fixes” were a high priority to improve their children’s quality of life. They would also like their children to stay in their homes and work towards recovery. These parents would like the use of evidence-based programs that work, intensive services, long-term support, and they want the proper evaluation conducted at the hospital. They would like to have the family looked at as a whole. Parents would also like more inter-departmental and inter-divisional coordination.

Deaf and Hard of Hearing

Participants in these groups expressed the need for provider understanding of consumer needs, cultural exposure and sensitivity training for staff, and an assessment methodology developed for the deaf community. Many wanted mobile services to increase service access, and continued
improvement and education for physicians and professionals would work with the deaf and hard of hearing. Many felt that integrated services between DMH and the Department of Social Services (DSS) Children’s Division would be helpful, as well as hiring deaf professionals and more interpreters. Education and outreach would help reduce stigma and make individuals more culturally aware. Finally, participants requested early intervention with deaf children as well as support for deaf parents of children with mental health issues.

**Transformation Working Group (TWG) Public Hearings**

In August and September of 2007, the TWG held public hearings across the state to get public input regarding the Missouri Mental Health Transformation initiative. TWG priorities and recommendations were presented for comment and public hearing participants verified these as priorities. A total of 421 Missourians attended the public hearings in 13 Missouri cities and towns.

**Summary of Findings & Recommendations**

Following the public hearings, the Transformation Planning Team posted the public response to the DMH Office of Transformation website. The report documented the main themes that arose at each location, and this section summarizes responses above and beyond participant input that was gathered for the verification of the proposed comprehensive plan.

**Affordable Services**

*10 of 13 Sites*

One of the most common themes among public hearing participants was the affordability of mental health services for consumers. The issues of MO HealthNet cuts, eligibility for services, and service restrictions were points of discussion at many public hearing sites. In addition, public hearing participants were concerned about the uninsured population, as well as the affordability of psychotropic medications.

**Consumer Disparities**

*10 of 13 Sites*

Consumer disparities in the receipt of mental health services by age, diagnosis, geographic location, ethnicity, and disability was a major concern at the majority of public hearing sites. Particular concerns included:

- Need for mental health services for the elderly;
- Issues among individuals with hearing problems, such as the lack of counselors proficient in American Sign Language (ASL), certification of interpreters, and the dearth of mental health resources specific to the population;
- Disparities in quality and access to care among consumers with autism;
- Limited services and resources in rural areas; and
- Limited services for the Hispanic population.
Workforce Issues
9 of 13 Sites

People at most sites were concerned about the lack of mental health workforce, particularly psychiatrists (7 of 13 sites mentioned a need for psychiatrists). People noted recruitment and retention of psychiatrists and/or prescribing doctors as a major concern, particularly for special populations such as children and persons with autism. Telehealth was mentioned as a possible solution to this problem at one site, whereas it was suggested that psychologists should be given prescription privileges at another. Other issues included the need for mental health workers in rural areas, a better trained and educated mental health workforce, and a need for support for mental health workers.

Prevention/Early Intervention
8 of 13 Sites

The need for prevention and early intervention was recognized at a majority of sites. Participants at six of the eight sites that mentioned prevention specifically suggested placing mental health providers in schools or linking schools with mental health services. Suicide prevention was also a need mentioned at several sites.

Consumer Housing
8 of 13 sites

Difficulties finding appropriate housing for consumers was a concern at most sites. Public hearing participants felt that mental health consumers need more positive supports to make the transition into the community. Participants also wished for an expansion of housing options and programs.

Fragmentation/Local Collaboration
8 of 13 Sites

Public hearing participants at many sites felt that local involvement is key to the success of the transformation initiative. Participants at many sites felt that collaboration among local community mental health agencies is important, particularly in rural areas where resources are limited. In addition, better communication between the state department and local agencies was also desired.

Improved Financing
6 of 13 Sites

Participants at a number of sites were concerned about financing changes that might occur with the transformation initiative. In particular, there was concern about how transformation would address duplication of services and money per agency. In addition, there were concerns about insurance reimbursement for providers and the costs of implementing evidence-based practices.
Transitional Issues
6 of 13 Sites

Speakers at sites noted difficulties transitioning consumers from one system to another (e.g., in-patient to out-patient; child to adult system; corrections to community). In particular, transitional youth (those youth transitioning from childhood to adulthood) were a concern at a number of sites. Public hearing participants felt the system should provide better continuity of services and life-cycle transition planning.

Consumer-driven Care
6 of 13 Sites

Public hearing participants at six sites suggested a number of ways to create a more consumer- and family-driven mental health system. Training for providers and consumer family members was mentioned, as was a need for consumer advocates. Public hearing participants also desired more choice in providers and less service area limitations.

Transportation
6 of 13 sites

Limited public transportation was a concern expressed at many sites. Mental health consumers need better transportation to reach appointments, go to work, and receive the education and other services necessary for a full recovery.

More Mental Health Services/Beds
6 of 13 Sites

A need for more mental health services and in-patient beds was articulated at many public hearing sites. An increase in beds and services would reduce waiting lists and help close service gaps.

Consumer/Peer Supports
6 of 13 sites

Peer support services and consumer advocates were seen as important natural community resources for individuals in mental health treatment. Additional peer support services would help consumers in recovery. In particular, participants mentioned the need for more clubhouses (so consumers can “see that they are not alone”), foster parent advocates, and more involvement with the Vet to Vet program, a recovery based program that includes peer support.

Co-occurring disorders
5 of 13 Sites

More collaborative, integrated service for individuals with co-occurring disorders, such as a co-occurring mental illness and substance use disorder, or individuals dual diagnosed with mental illness and developmental disabilities, was noted.
Evidence-Based Practices
5 of 13 Sites

At five of the 13 sites, people mentioned the need for increased implementation of evidence-based practices, although there were concerns about the cost. It was also suggested that Centers of Excellence should partner with local universities to receive research and technical assistance in the implementation of EBPs.

Consumer Employment
5 of 13 sites

The lack of employment opportunities was cited as a major barrier for mental health consumers by some participants. An increase in employment supports was desired as a partial solution.

Integration of Physical and Mental Health/Medical Services
5 of 13 Sites

Public hearing participants mentioned a number of ways in which an integration of physical and mental health care could take place. Education and support for general practitioners was recommended, as well as training for staff in emergency rooms. It was also mentioned that mental health consumers need to be provided with essential medical services and dental care.

Crisis Services
5 of 13 Sites

Public hearing participants at some sites felt that crisis services need to be improved. Increased access to local crisis beds and hotlines was recommended, as well as the increased use of Crisis Intervention Teams (CIT). Disaster preparedness was also mentioned as an important component that should be instituted at all levels of the mental health system.

Public Stigma/Education
5 of 13 Sites

Public hearing participants felt stigma was a big problem, among consumers, the public, and professional personnel. A focus on mental health promotion and a public education campaign on the first signs of mental illness were recommended.

Other Issues

People at three sites were concerned about the cost and overuse of guardianship, speakers at two sites expressed a need for better collaboration with law enforcement in dealing with mental health issues. The importance of consumer safety was mentioned at one site, as was the need for accountability measures. Finally, public hearing participants felt that the mental health system should be simplified and kept flexible in order to best meet the needs of consumers.
The Missouri Planning Council for Developmental Disabilities
Statewide Needs Assessment

In 2004 and 2005, the Missouri Planning Council for Developmental Disabilities, in collaboration with the UMKC Institute of Human Development, conducted a statewide needs assessment. Individuals with disabilities and family members in each of the 11 mental retardation/developmental disabilities regions in Missouri completed a written survey (Rinck et al., 2006). There were a total of 737 returned surveys (response rates were between 6.2% and 12.8% depending on the region) representing the responses of both persons with a disability (36.5% of written survey respondents) and family members of persons with a disability (63.5% of written survey respondents). In addition, 127 focus groups were held in 110 of 114 of Missouri’s counties. There were 975 individuals who participated in the focus groups, 400 of which were disabled persons (41%) and 575 family members of disabled persons (59%). Approximately 64% of focus group participants and 70% of written survey respondents were served by the Division of Mental Retardation/Development Disabilities.

Summary of Findings & Recommendations

Both written survey respondents and focus group members were asked their opinion regarding a variety of issues relating to the needs of MR/DD consumers and their families:

- Employment Issues;
- Residential Setting Issues;
- Transportation Issues;
- Childcare Issues;
- Education/Early Intervention Issues;
- Health Care Service Issues;
- Recreational/Social Opportunity Issues;
- Community Resources/Support Issues;
- Safety and Quality Assurance; and
- Satisfaction with Services.

Employment Issues

People with disabilities were most likely to work in sheltered employment (42.2% of respondents) and least likely to have a regular job in the community. About half (55%) felt sheltered employment was good (35%) or excellent (20%), and the rest felt it was either inadequate (21%) or fair (24%). By far, the most important employment challenge for people with disabilities was finding job opportunities commensurate with their skills and abilities. Attitudes and perceptions among employers was also a big issue; respondents reported that employers had limited knowledge regarding people with disabilities, limited willingness to be flexible with disabled employees, and reluctance to hire disabled person due to fear of lawsuits.
**Housing Issues**

The majority of disabled persons lived with family or friends (57%), and such arrangements were seen as the most available source of housing by the majority (79%) of respondents. The biggest challenge relating to housing was the lack of accessible, affordable, safe housing in the community.

**Childcare Issues**

Child care was most likely to be supplied by family or friends (70%), and family care was also seen as the most adequate (by 69% of respondents). However, the number one childcare challenge for families was the lack of options for childcare in the community, followed by a lack of providers qualified to support kids with a disability and system requirements that limit childcare services.

**Education/Early Intervention Issues**

The most common early intervention service utilized by respondents was First Steps (42%), and the majority of respondents (61%) rated First Steps as either good or excellent. Over 73% felt that early intervention services were either mostly or somewhat available in their community.

In terms of education, the most utilized educational type was special public school education (46% of respondents), followed closely by regular public school (34%). Special public school education was seen as the most adequate educational type, with more than half (53%) of respondents regarding it as good or excellent. In terms of availability, inclusive educational opportunities were seen as either somewhat available or not available by 66% of respondents, transition services from school to work were seen as somewhat or not available by 71% of respondents, and post-high school educational services were seen as somewhat or not available by 78% of respondents. Finally, focus group respondents overwhelmingly stated that the lack of quality, individualized educational supports is the greatest challenge to maximizing student potential.

**Transportation Issues**

Public transportation was the most commonly used transportation among people with disabilities (47% of respondents), whereas self-transportation was least likely to be used (albeit the most desired option). By far, the number one transportation challenge for persons with disabilities is the lack of transportation availability, particularly in rural areas.

**Health Care Service Issues**

Respondents were most likely to use a doctor’s office for health care services (reported by 62% of respondents) and least likely to use a residential health care center (3.6%) or local health department (3.6%). Interestingly, residential health care centers and local health departments received the highest ratings for adequacy (45% for residential care centers and 29% for local health departments), whereas over 67% of respondents rated doctor’s offices as fair or inadequate. Hospital/emergency rooms were also considered inadequate by a majority of respondents (70%). When asked about the availability of health services for persons with disabilities, community health care services and dental services were rated as not available by 40% and 50% of respondents, respectively. Finally, respondents considered “public health insurance program (e.g., MO HealthNet) issues that impact persons with developmental disabilities” the most important health care challenge.
Recreational/Social Opportunity Issues
The number one recreational/social opportunity issue for focus group members was the lack of opportunities for recreation available in the community. The most common recreational opportunities in the community were special/segregated socializing/recreation (50%) and regular community sponsored recreation (34%). Both were rated inadequate by 60% and 72% of respondents, respectively.

Community Resources/Support Issues
The most commonly used community resource was family and friends (61%), and the least often used was civic organizations (10%; it was also seen as the most inadequate by 40% of respondents). Supports from family and friends were rated the most adequate (rated as excellent or good by 77% of respondents). Focus group members reported receiving community supports most often from family/friends and faith based organizations. The support offered by faith based organizations was rated either good or excellent by the majority of respondents (56%), whereas the majority found support from social organizations to be either inadequate or fair (60%)

Safety and Quality Assurance
Respondents were asked if they were aware of any incidents of abuse that affect the health, safety, and quality of life of individuals with disabilities. One out of every five respondents was aware of physical abuse, neglect, or financial exploitation in their community. Fully 25% were aware of human or legal rights violations, and 16% were aware of sexual abuse. About two-thirds of respondents said these violations were handled badly, or not at all. About 60% felt people with disabilities were mostly or very safe in their communities, however, 5.9% did not feel safe at all, and more than a third felt only somewhat safe.

Satisfaction with Services
Service coordination was rated good or excellent by over 70% of respondents. The quality of provider services/supports was rated good or excellent by almost 65% of respondents.

One Change to Community
Finally, respondents were asked what one change they would make in their community to make it better for persons with disabilities. Respondents wanted to enhance services for individuals with disabilities and to increase community understanding of persons with disabilities to help address attitudes and perceptions.
Chapter Five
Needs According to Mental Health Consumer Interviews and Focus Groups

Background

Mental health services and support needs often vary from community to community and group to group. Group-specific data were gathered to capture information about the unique mental health needs of specific groups which the current mental health service system may not be adequately addressing, or, in some cases, may be largely unrecognized.

During the summer of 2007, 15 focus groups (total n=191) and 23 in-person interviews with key agency informants were conducted across the state. The focus groups and interviews targeted groups often identified as being underserved or miss-served by the mental health system. Focus groups were conducted that explored how members of these groups perceived stigma, the adequacy and access to mental health information and services, quality of providers, consumer-driven care, and perceptions of the greatest mental health needs in both their local communities and across the state.

Some of the data gathered from the various groups are crosscutting, that is, multiple groups identified particular issues that were a common concern to them. These crosscutting data are presented first in a Summary of Findings and Recommendations, followed by the specific group analyses in a Detailed Focus Group and Interview Findings section.

Procedure

Prior to conducting the focus groups, the Missouri Institute of Mental Health (MIMH) staff conducted a thorough literature search to determine the extent of research that had previously been collected related to different populations of mental health consumers. This literature search indicated that additional information was needed for the following groups:

1) African-Americans (rural and urban)
2) Corrections—probation and parole
3) Elderly (rural and urban)
4) Families with children (rural and urban)
5) Hispanics (rural and urban)
6) Homeless
7) Lesbian, gay, bi-sexual, transgender (LGBT)
8) Refugees and immigrants

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6) Homeless
7) Lesbian, gay, bi-sexual, transgender (LGBT)
8) Refugees and immigrants
9) Rural adults
10) Transitional Youth

MIMH contacted agencies throughout the state to assist in the recruitment of focus group members. Focus group members received $10 gift cards for their participation in the group. MIMH also interviewed key personnel within the agency from which focus group members were recruited, exploring stigma, information in the community related to mental health, sufficiency of mental health providers in the community, and their perceptions of the greatest needs of the population they serve.

Two researchers attended each of the focus groups, one facilitator with experience in conducting focus groups, and one recorder who also coordinated logistics. All groups were taped to assure the quality of information collected. Focus groups of African American consumers were conducted by a skilled African American facilitator. The Hispanic focus group was conducted in Spanish by a bi-lingual Hispanic with extensive experience in focus group facilitation. A mental health consumer assisted with focus group and in-person interview coordination.

Demographic Characteristics

The tables on the following pages outline details of the subgroups surveyed and demographic characteristics of focus group participants.

Focus Group Locations and Demographics

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Location</th>
<th>Agency</th>
<th># of Participants</th>
<th>Average Age</th>
<th>% Female</th>
</tr>
</thead>
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<tr>
<td>African-Americans (rural)</td>
<td>Caruthersville</td>
<td>Family Counseling Center</td>
<td>13</td>
<td>42</td>
<td>62%</td>
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<td>African-Americans (urban)</td>
<td>Kansas City</td>
<td>Swope Health Services</td>
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<td>60%</td>
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<tr>
<td>Co-occurring disorders</td>
<td>St. Louis</td>
<td>Hopewell Center</td>
<td>30</td>
<td>36</td>
<td>40%</td>
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<td>Corrections--probation and parole consumers</td>
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<td>State Probation and Parole</td>
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<td>40</td>
<td>11%</td>
</tr>
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<td>Corrections--probation and parole staff</td>
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<td>State Probation and Parole</td>
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<td>47</td>
<td>73%</td>
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<td>Elderly, rural</td>
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<td>Bowling Green Nutrition Center</td>
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<td>88%</td>
</tr>
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<td>Elderly, urban</td>
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<td>Chillicothe Senior Center</td>
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<td>82%</td>
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<tr>
<td>Elderly, urban</td>
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<td>Five Star Senior Center</td>
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<td>72</td>
<td>100%</td>
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<tr>
<td>Families with children</td>
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<td>Family Bridges</td>
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<td>46</td>
<td>72%</td>
</tr>
<tr>
<td>Hispanics (rural)</td>
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<td>Clark Mental Health Center</td>
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<td>NA</td>
<td>NA</td>
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<tr>
<td>(Interviews only)</td>
<td>Kansas City</td>
<td>Mattie Rhodes Center</td>
<td>11</td>
<td>35</td>
<td>91%</td>
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</table>
Summary of Findings and Recommendations

The sections that follow this summary detail the results of focus groups for each specific consumer group. However, taken as a whole, the focus groups also represent a large subsection of mental health consumers. When the findings from all focus groups were combined, a number of crosscutting themes spanning multiple groups emerged. Those themes are as follows (in order of most common mention):

1. Reducing Stigma/Discrimination
2. Community Involvement/Outreach
3. Affordable Services
4. Specialized Providers
5. Transportation
6. Help Finding Services
7. Prevention/Early Intervention
8. Integration of Mental and Physical Health
9. Consumer-driven Care
10. Public Mental Health Literacy
11. Meeting Basic Needs
12. Co-occurring Mental Illness/Substance Use Disorders
13. Cultural Competence

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Location</th>
<th>Agency</th>
<th># of Participants</th>
<th>Average Age</th>
<th>% Female</th>
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<tbody>
<tr>
<td>Homeless</td>
<td>St. Louis</td>
<td>Community Alternatives</td>
<td>14</td>
<td>43</td>
<td>29%</td>
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<tr>
<td>LGBT community (interview only)</td>
<td>St. Louis</td>
<td>Southampton Healthcare Inc.</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Refugees and immigrants</td>
<td>St. Louis</td>
<td>International Institute, Islamic Center/Bosnian Cultural Center</td>
<td>8</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Rural adults</td>
<td>Kirksville</td>
<td>Mark Twain Counseling Center</td>
<td>14</td>
<td>53</td>
<td>79%</td>
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<tr>
<td>Rural adults</td>
<td>St. Joe</td>
<td>Northwest Behavioral Health</td>
<td>12</td>
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<td>83%</td>
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<tr>
<td>Rural adults (interview only)</td>
<td>Doniphan</td>
<td>Family Counseling Center</td>
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<td>NA</td>
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<td>Transitional youth</td>
<td>St. Charles</td>
<td>Missouri Foster Care Youth Advisory Board</td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
<td>191</td>
<td>49</td>
<td>65%</td>
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</table>
Reducing Stigma/Discrimination

*Mentioned by 10 out of 10 groups*

The need for a reduction in the discrimination against people with mental illness was a strong theme in every focus group. Rural respondents reported that mental illness stigma is most common among the elderly and in the workplace, and elderly respondents felt that, “there isn’t anything more demoralizing than a mental illness.” Transitional youth felt judged by other kids due to their mental illness. Persons in the families with children group reported that stigma leaves them feeling very isolated. Minorities suggested that culturally competent educational campaigns should avoid stigma-laden terms like “mental illness.”

The term “double stigma” was used by several groups, referring to the double discrimination these individuals face for both having a mental illness and being a member of a group that commonly faces discrimination. This was a strong concern among African-Americans, although they are not the only group to experience this phenomenon. For example, homeless individuals felt that people view them as “lazy bums” and thus are less motivated to help them get back on their feet or “cut them slack” for their symptoms of mental illness. A nurse interviewee, who often works with the lesbian, gay, bisexual, and/or transgender (LGBT) community, felt that the lack of legal protection against discrimination is impairing LGBT individuals’ ability to get equal treatment and access to mental health care. Finally, individuals in the corrections system reported that prisoners with mental illness are often stigmatized by prison staff, prisoners, the community, and even by their own family members.

Community Involvement/Outreach

*Mentioned by 8 out of 10 groups*

Focus group members felt mental health care should be integrated into communities, especially for individuals who are unable or disinclined to seek out mental health services, such as refugees and immigrants, the elderly, minorities, rural individuals, parolees, and children. For example, individuals in rural areas often must rely on other professionals (such as family doctors or pastors) for mental health treatment, so it was suggested that these professionals be better trained to deal with mental health problems and issues. Families with children believed that schools should offer more training for parents, teachers, and staff about how to work with mentally ill children. In addition, individuals in corrections felt that community-based assessment and treatment services would lead to better care for probationers and parolees.

Due to strong mental illness stigma and/or system distrust in homeless, minority, refugee/immigrant, and elderly communities, focus group members recommended providing mental health training to natural community supports such as the faith community, in-home providers, home health agencies, community centers, and transportation providers. It was suggested that training these individuals would allow them to support mental wellness, recognize risk factors, and counter social isolation.
Homeless individuals in particular reported needing more community support programs (life skills, vocational rehabilitation, job training, transportation etc.) to aid them in getting back on their feet.

**Affordable Services**

*Mentioned by 8 out of 10 groups*

Insurance was a major issue for individuals in a majority of the groups. Focus group participants, particularly those in the rural and elderly groups, pointed out that MO HealthNet (Medicaid) often has restrictions that impede the use of mental health services, such as limiting the number of doctors the insured can see in one day, or limiting the number of sessions an individual can have with a counselor. Recommendations included easing the restrictions or providing assistance with services that are not covered by MO HealthNet or Medicare. African-Americans also mentioned the need for affordable coverage for the uninsured.

Homeless persons, transitional youth, refugee/immigrants, LGBT focus group members, and prisoners/parolees mentioned difficulties finding appropriate coverage. Transitional youth often “age out” of their eligibility for children’s services with no financial means or steady employment to provide them with health insurance. Persons on probation and parole transitioning from the correctional system to society find barriers to reinstating insurance upon reentry, and LGBT individuals in committed relationships do not have the same benefits as married heterosexual couples, thus resulting in insurance gaps. The homeless often find bureaucracy gets in the way of receiving public assistance. Finally, many immigrants and refugees find it difficult to receive services given their status as non-citizens.

**Specialized Providers**

*Mentioned by 6 out of 10 groups*

Several groups mentioned the need for high quality specialists that can work effectively with their particular populations. For example, elderly focus group members mentioned the need for individuals trained in geriatric mental health care, and families with children reported needing mental health professionals who are more effective at helping their children. Additionally, there are few providers who have experience with LGBT issues or with the correctional system. Representatives from the international community reported a strong need for bilingual providers, as well as interpreters with mental health training. The need for mental health specialists, such as psychiatrists and professionals specializing in children and the elderly, is particularly strong in rural areas. It was suggested that telecommunication technologies (such as Telehealth) may give individuals in rural areas more convenient access to specialized providers located in metropolitan areas.
Transportation

*Mentioned by 5 out of 10 groups*

Transportation was a problem for a number of groups, particularly those in rural areas. Elderly individuals who cannot drive are in need of mobile services, and youth in rural areas reported needing transportation to drive to the closest service providers (which are often in metropolitan areas). Existing transportation services in rural areas are insufficient to meet the need, and it was suggested that Telehealth or in-home services may be ways to provide services in rural areas while alleviating the demand for transport. Transportation was a huge issue for the homeless who have difficulty getting services and gaining employment without reliable transportation. Hispanics also reported that lack of transportation makes it less likely that they will seek services.

Help Finding Services

*Mentioned by 5 out of 10 groups*

Difficulty finding information about available services is a barrier to services for many groups. LGBT and Hispanic group members find it difficult to know where to look for services that are most appropriate for them, and homeless focus group members wished for a “road map” of available services. Individuals in rural areas (as well as transitional youth in those areas) found it particularly difficult to find information about the services available. Many reported learning about services only through word-of-mouth.

Prevention/Early Intervention

*Mentioned by 5 out of 10 groups*

Several individuals in focus groups felt that prevention and early intervention are important. Rural groups, refugees/immigrants, and African-Americans reported that youth prevention programs may help prevent future mental health and substance use problems in at-risk youth. Persons with the families with children focus group believed that early intervention could save parents years of trying to diagnose their child, as well as providing help and guidance before the illness increases in severity. They felt that early intervention and screening should be offered to all youth. Finally, a better evaluation process, and an increase in drug and mental health courts, was suggested for corrections.

Integration of Mental and Physical Health

*Mentioned by 4 out of 10 groups*

Four out of ten groups noted that mental and physical health needs to be better integrated. This is particularly true for the elderly, where a very high proportion of seniors with mental health needs also have chronic physical illnesses that link them to the health care system. Therefore, training primary care physicians to recognize and appropriately treat geriatric mental health problems could
go a long way. The same is true for rural physicians, who are often the first point of contact for rural individuals with mental health issues and little access to mental health specialists. In addition, individuals from the families with children group pointed out that children with mental illness often have co-occurring physical illnesses, and that both should be considered in an integrated system of care. Finally,

**Consumer-driven Care**

* Mentioned by 4 out of 10 groups

A number of individuals reported that their voices were not being heard in the current mental health system. Transitional youth felt that counselors neither listen to nor care about them, and they are forced into counseling or onto medication when they are not ready. Parents of children with mental illness believed that professionals need to do a better job of listening to parents, and that it is wrong to remove children from their homes before trying to work with families. African-Americans and homeless individuals also reported that they are often not treated with respect or included in the treatment planning process.

**Public Mental Health Literacy**

* Mentioned by 4 out of 10 groups

Related to stigma, focus group members felt that local communities are not knowledgeable about mental illness, resulting in misperceptions of mental health treatment and increased stigma. Several individuals said that people are less likely to feel stigmatized and more likely to get help if they have more information about mental health and wellness. Transitional youth felt that mental health curricula should be placed in high schools, possibly as part of regular health classes, and the LGBT interviewee thought that diversity training would prevent the onset of mental health issues among LGBT youth. Hispanic and immigrant/refugee focus group members felt that all mental health information should be translated into the appropriate language, so that foreign-born individuals can be educated about mental illness.

**Meeting Basic Needs**

* Mentioned by 4 out of 10 groups

The basic needs (such as affordable housing and employment) are not being met for some consumers, which makes it difficult to treat mental health difficulties. Individuals transitioning into society from the correctional system find it difficult to gain employment required as a condition of their parole. In addition to employment supports, they also find it difficult to obtain transitional housing. The homeless have similar difficulties transitioning from the streets to society—they find few services available that can help them develop the basic skills needed to become independent members of society (e.g. life skills, job training, vocational rehabilitation, stable transitional housing, etc.). Refugees and immigrants also have a difficult time adjusting to a new country and navigating the
system in order to gain employment and housing. Finally, many African-Americans felt that not having basic needs met impedes their recovery from mental illness.

**Co-occurring Mental Illness/Substance Use Disorders**

*Mentioned by 3 out of 10 groups*

The problems people experience trying to get services for both a mental illness and a substance use disorder were mentioned by three groups. Families and children felt there should be better diagnosis and treatment for adolescents with co-occurring disorders, and African-Americans believed there is a lack of services and programs for consumers with co-occurring disorders. An officer interviewed in corrections estimated that co-occurring disorders occur in “at least half” of people in the correctional system, and stated that there are not enough services to address the many needs.

**Cultural Competence**

*Mentioned by 3 out of 10 groups*

Minority groups (Hispanic, African-American) and refugee/immigrants stressed the need for cultural sensitivity for mental health professionals, as well as culturally competent education campaigns and specialists. All groups felt that involving community leaders in this process is necessary to build trust.
Detailed Focus Group and Interview Findings

Transitional Youth
“Know me before you know my Problems.”

Summary of Findings and Recommendations:

The recommendations are derived from both a focus group conducted with transitional youth in foster care and other sources referenced in this section. The youth in the focus group were members of a statewide Department of Social Services youth advisory board in Missouri.

- Many youth felt their voices were not heard in making decisions about the system and the type of care they receive. Youth wanted a voice in policy and planning development for youth with mental illness.
- There were concerns about the quality of care received. Many youth felt their counselors did not listen or care about them, and they often felt they were forced into counseling or onto medication when they were not ready. High counselor turnover exacerbates their trust issues. Both urban and rural youth were concerned about the quality of their care.
- Many youth did not feel the counselors understood their issues, and wanted to talk to someone who knew what they were going through. Youth recommended establishing a peer mentoring program similar to KUTO (Kids under Twenty-One), a suicide prevention initiative in St. Louis. This request was specific to youth in foster care.
- Insurance coverage was a major issue for the youth. Many of them aged out of children’s services at age 19 or 21, and had no access to health insurance and no financial means to pay for the expensive mental health services they needed. They recommended that supports be put in place to help these young adults continue care after leaving the child system. Cost of services is a huge problem for these youth.
- Barriers to receiving services were different for urban and rural youth. Urban youth felt there were a number of services, but found it difficult to know where to go to learn about the available services. Rural youth, on the other hand, felt that there were very few available services in their area, and that a major barrier to receiving services was finding transportation to the closest service providers (which are often in metropolitan areas).
- Youth had a number of ideas for distributing mental health information. They felt that information distributed to youth should be eye-catching and placed in areas where youth will see them, such as schools, doctor’s offices, McDonald’s, Wal-Mart, the internet, and on television. They also felt mental health curricula should be placed in high schools, possibly as part of regular health classes.
Population and Prevalence of Mental Health Difficulties among Transitional Youth

In 2005, the number of youth between the ages of 18 and 24 was 505,007, or approximately 9% of the population in Missouri. As shown in the figure below, the number of transitional youth is highest in the higher population areas, (St. Louis County and Jackson County), but the percentage of transitional youth relative to the population within each county is higher in towns with large state universities. There are relatively few transitional youth in northern and southeastern Missouri, a reflection of fewer opportunities for employment in these areas and few or no higher educational institutions.

According to SAMHSA, at least 6.5 million transitional youth have a psychiatric disorder (Davis & Vander Stoep, 1997). More than three million transitional youth are diagnosed with a serious mental illness (Vanderstoep, Beresford, Weiss, McKnight, Cauce & Cohen, 2000). In Missouri, approximately 21.3% of all youth between the ages of 18 and 25 suffer from severe psychiatric distress (SPD) in any given year, one of the higher rates of psychological distress in the nation (Wright, Sathe, & Spagnola, 2007). The rates of alcohol dependence and abuse (21%) and illicit drug use and abuse (8.4%) are both very high when compared to other states. Furthermore, suicide is the third leading cause of death among the ages 15-24, and less than 40 percent of at-risk youth receive services (U.S. Department of Health and Human Services, 2002; Minino, Arias, Kochanek, Murphy, & Smith, 2002). This population has critical needs but limited access to services that address these needs.
Data Sources

The findings and recommendations are derived from a focus group conducted with transitional youth and a literature review on mental health issues specific to transitional youth. The focus group was conducted in the St. Louis suburb of St. Charles, Missouri with 10 foster youth who are members of a statewide DSS youth advisory board. The youth were between the ages of 16 and 23, and the average age was 19.4 years. The group was a mixture of rural and urban youth, and 70% (n=7) were female. All but two youth were MO HealthNet recipients (the other two youth had no insurance). Six youth were Caucasian and four were African-American.

Detailed Findings: Key Themes

Voice in policy making. According to Davis (2003) and focus group youth, young people need a voice in mental health policy-making. Youth in the focus group had many ideas for improving the system. They experience the system daily, live in it, and believe that their input would help to improve their care, as well as care for other transitional youth. Throughout the focus group, these youth suggested ways to make individuals aware of mental health issues and resources and improve the quality of care in the current service system. However, they did not feel their suggestions and voices were being heard in the current system.

Quality of Services. There were mixed impressions regarding service quality. Around half of the group felt that they had received good care. Others strongly expressed the need for changes:

Listening Skills. Many youth strongly felt that the most important factor in shaping the quality of their relationship with any mental health staff (particularly counselors) was the mental health professional’s ability to listen. Youth said that many of the counselors did not listen well and therefore they relied upon other people (foster parents, grandparents, friends, etc.) for support.

“We just need someone who knows how to listen.”

-- Transitional youth focus group participant

Therapeutic Relationship. The youth expressed a desire to trust their counselor with their private issues, experiences and thoughts. To these youth, confidentiality is vital to a successful counseling relationship. It is extremely important that they are not seen as a number or a diagnosis, but as a person. The youth in the focus group said there should be more focus on the person instead of the diagnosis. They thought that their counselor should meet with them first, before reading their file, to prevent inaccurate preconceptions as to who the client is. They would also like a counselor to admit when the youth is not ready for counseling, and then pursue treatment at a later date so the youth is eventually treated when he or she is ready to talk and benefit from treatment. Many of these youth felt forced into counseling and treatment when they were not ready to talk about the trauma in their lives.

“If you are abused at home, they just put you on meds.”

-- Transitional youth focus group participant
Continuity of Care. Turnover was a significant issue for most youth. Many had seen several counselors because of high turnover which made the youth reluctant to confide in their counselors. They suggested having an agreement between the counselor and the client which would allow both parties to know what they can expect from each other.

Changes in Medication Management. Many youth were critical of the system’s tendency to medicate for mental health issues rather than provide quality individual therapy. Several said that the medications they received made them worse rather than better. They reported wanting some say in whether they are prescribed medications.

Transition from Child to Adult System. When youth age out of childhood services, including special education, child welfare system and juvenile justice systems; they are often neglected in terms of service transfer for adulthood (Davis and Vander Stoep, 1997; Davis 2003). In Missouri, this is further confounded because fewer adults qualify for mental health care through MO HealthNet than children and the SCHIP program discontinues coverage once a child reaches the age of 19. Furthermore, many young adults are no longer covered under their family insurance policy and may not yet be employed full-time (and thus not covered under an employer’s policy). Therefore, it is unsurprising that young adults are most likely group to be uninsured, with 29% of women and 37% percent of men aged 21-24 uninsured in 2006 (Fronstin, 2007). This was confirmed through the focus groups. Youth stated that they were frustrated because there were no longer supports in place to obtain mental health care once they were no longer eligible to receive children’s services, and treatment options are expensive. According to youth in the focus group, unless they are working and receive benefits through their employer, they have no access to insurance.

Peer Mentoring. The youth in the focus group recommended peer mentoring in foster care. They felt frustrated by counselors who often stated that they knew what the youth were experiencing. The youth expressed that there was no way an individual could know what they were experiencing unless they had gone through it themselves. A peer mentoring program would put them in touch with someone who has had similar experiences to the youth in foster care, which would be helpful for youth currently in the foster care system or just leaving that system. Youth who have been in foster care would be able to understand their specific issues and concerns better than counselors. The youth suggested there be more programs like the KUTO (kids under 21) peer mentoring program.

Stigma and Mental Health Information. Focus group participants felt there was significant stigma around mental health issues and expressed concern that they are judged by their illness. They had many ideas for addressing stigma and increasing knowledge related to mental illness. They emphasized the need for information with “eye appeal” (not just plain brochures) and for information to be available in places where youth would visit (doctor’s office, schools, McDonalds, Wal-Mart, etc.). The internet and TV commercials were also

“Know me before you know my problems.”

-- Transitional youth focus group participant

“People are afraid that what they say will be leaked and people will look at them differently, judge and act different around them.”

-- Transitional youth focus group participant
mentioned as good ways to reach youth. They also suggested introducing mental health curricula into high schools, possible in health classes.

**Barriers to Services.** Rural and urban youth had differing views on the difficulties in accessing services. Urban youth reported having a number of available services, but not always knowing where to look to find the services they need. Youth from rural areas, on the other hand, said that there were very few providers in their areas, with the exception of southeast Missouri. Like their adult counterparts, transitional youth living in rural areas reported that transportation is a barrier for them when trying to get services. For example, one youth reported driving 45 miles to get services. Transportation is even more difficult for low income youth who do not drive and who do not own an automobile.
The Elderly

“The current generation of older persons still views mental illness as a ‘personal flaw,’ not an illness that can be successfully treated.”

Summary of Findings and Recommendations:

The findings and recommendations in this report are derived from focus groups conducted with older adults and other sources referenced in this section.

- Provide mental health services and supports that focus on late life mental disorders that include dementia, anxiety, depression and depressive symptoms, alcohol and prescription drug abuse; emotional problems adjusting to old age (developmental changes); and persons with long-term psychiatric disabilities who are aging.
- Integrate and coordinate mental health and primary health care. A very high proportion of seniors with mental health needs also have chronic physical illnesses that link them to the health care system and the aging services system. Train primary care physicians to recognize and appropriately treat geriatric mental health problems.
- Make the portion of mental health services not covered by MO HealthNet or Medicare affordable. Make sure both consumers and providers are educated as to how to maximize available coverage.
- Engage and train natural community supports such as the faith community, in-home providers, home health agencies, senior centers, Area Agencies on Aging (AAAs), transportation providers, etc., to support mental wellness, recognize risk factors in the elderly, and counter social isolation.
- Assure appropriate access to mental health services by the elderly. Mobile services should be available in homes and in community settings, as well as increased transportation to more traditional mental health services settings.
- Provide appropriate access and development/expansion of geriatric mental health services and health and mental health professionals trained in geriatric care. This includes addiction services aimed at seniors.
- Provide more public education on aging and mental health issues including education on mental wellness, depression, stigma, and ageism.
- Study the issues raised by the need for mental health treatment in nursing facilities to craft recommendations for meeting the many unmet needs in those facilities. This could include a recommendation as to the best state home for the treatment and care of irreversible dementias in both nursing home and home-based settings.
Population and Prevalence

For purposes of this report, elderly Missourians shall be defined as persons 65 years of age or older. The choice of age 65 as the lower limit is only somewhat arbitrary. Based on 2006 data, there are 788,891 seniors in Missouri constituting 13.3% of the population (U.S. Census, 2006). By comparison, the elderly constitute 12.5% of the national population (U.S. Census, 2006). As can be seen in the map below, the elderly make up a large percentage of the population in several rural counties. In Missouri, the “old elderly” or persons aged 85 and over total 113,789 or 1.9% of the Missouri population (U.S. Census, 2006). Based on the latest available data from 2000, about 6% of elders in Missouri are institutionalized (Missouri Senior Report, 2007).

Determining the prevalence of mental health problems among the elderly in Missouri is problematic and varies depending on the criteria for mental health problem that are used. According to the 2005 National Survey on Drug Use and Health (NSDUH), an estimated 4.6% of older adults experience severe psychological distress (Wright, Sathe, & Spagnola, 2007). This percentage increases as people

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19 Most developed nations generally accept this limit (World Health Organization, Definition of an Older or Elderly Person, http://www.who.int/healthinfo/survey/ageingdefnolder/en/print.html, accessed October 23, 2007). Likewise, for purposes of Medicaid waivers, the Center for Medicare and Medicaid Services (CMS) uses 65 as the lower limit for persons who are “aged” (42 CFR 441.301(b) (6)). Much population data also uses the 65 year lower limit to set age categories. However, the Older Americans Act defines the term as 60 or older (42 U.S.C. 3002, Title I, Sec. 102 (40)). Given that people in developed countries have greatly expanded life expectancy and that most individuals are still in their work career at age 60, the use of 65 and over is seems eminently reasonable.
Some mental problems, such as depression, also are associated with an increased risk for suicide. Elderly white males have the highest suicide rate of any age/gender group in the state, rising from about 30 suicides per 100,000 persons to 47 per 100,000 as white males age from 65 to 85 and over (“Mental Illness,” 2007).

Data Sources

In addition to a literature review, the findings and recommendations in this report are derived from three focus groups conducted with older adults and a literature review on mental health issues specific to older adults. Two of the focus groups were in rural areas and one was in an urban area. A total of 31 individuals were in the focus groups, which were 90% female. The racial make-up of the groups was 68% Caucasian and 32% African-American. Participants were between the ages of 60 and 91 with an average age of 76 years. Almost all participants (97%) were Medicare recipients, with the exception of one individual, who did not have insurance at all. In addition to Medicare, 32% had private insurance, 29% had MO HealthNet, and 16% had some other form of insurance (such as Medigap or AARP). Only 13% of those with Medicare did not have some form of supplementary insurance.

Detailed Findings: Key Themes

Needs of Seniors in the Community

Focus group participants report that older adults commonly turn to their church when faced with emotional problems, grief, depression, or anxiety that they feel they cannot handle themselves. The church, as well as family and friends, provides the bulk of mental health supports and help many elders receive. The type of support received from these sources can be spotty and fragmented, and varies considerably based on perceptions of normal aging, sin, and salvation. While such natural supports are vital, faith-based support cannot serve all who need help and a significant proportion of persons have mental health needs that go beyond what clergy or lay person can do.

“Lots of elderly don’t have anyone that cares about them.

-- Elderly focus group participant

“I would tell a friend but there are very few people I can confide in -- you can’t trust people. I talk to God.”

-- Elderly focus group participant discussing what he would do if he had a problem with depression
The majority of older adults receiving mental health care are treated by their primary care physicians (Administration on Aging, 2001). While many primary care physicians provide excellent care, there are also many who confuse mental health problems with the debilities caused by chronic physical disease or may consider late onset mental illnesses to simply be a part of normal aging (AA, 2001). When mental health treatment is attempted by these physicians, older adults commonly receive inappropriate prescription of psychotropic medications (AA, 2001). Despite these problems, both substance abuse and mental health problems in the elderly are “highly treatable and often preventable” (Substance Abuse, and Mental Health Services Administration, 2002, p. 2). Seniors often express a desire to utilize primary care for mental health issues—it is both convenient and is provided in a setting where many older adults feel less stigmatized (Center for Mental Health Services, 2005). However, according to many focus group participants, their primary care doctors were often too busy to address their mental health needs or failed to ask them if there was anything wrong.

“**You have five minutes [with the doctor] unless you tell them there is something wrong. You spend $50 - $100 and they don’t ask.**”

*Elderly focus group participant*

Furthermore, the state mental health system is neither accessed by the elderly nor does it reach out to elders. Community Mental Health Centers [CMHCs] are neither specifically trained nor funded to address the mental health problems of older adults (CMHS, 2005). Since many of the mental health problems experienced by elderly Missourians only develop later in life, one would expect a substantial proportion of the elderly population to recent mental health services through state. However, such is not the case. In Missouri, only 294 persons aged 65 or more, out of a total for all age groups of 22,467 were served by the Division of Comprehensive Psychiatric Services (CPS) for the first time in State Fiscal Year 2006. Put otherwise, only 1.3% of first-time consumers of CPS were older adults in SFY 2006. As a point of comparison, the elderly population in Missouri constituted 13.3% of the state’s population in calendar year 2000 (U.S. Census, 2000).

In addition to mental health treatment, activities geared toward preventing depression and suicide have proven to be effective. Specifically, both support groups and peer counseling have been shown to be effective for older adults at risk for depression. Bereavement support groups, in particular, can help improve mental health status for widows and widowers (CMHS, 2005). Of course, there are many barriers hindering the utilization of mental health services by elderly Missourians. One of the most important is stigma. All three focus groups identified stigma as a major problem. Participants said that they didn’t want to “be a burden” on anyone and that “there isn’t anything more demoralizing that a mental illness.”

“The current generation of older persons still views mental illness as a “personal flaw,” not an illness that can be successfully treated.”

*-- Area Agency on Aging Director*

The cost of mental health treatment is also a problem for seniors. Medicare payment for mental health treatment is less than for physical health care (Friedman and Steinhagen, 2006). While some Medicare recipients have supplemental (Medigap) insurance that may pay Medicare co-pay for
outpatient mental health treatment, many do not. Many focus group participants echoed the sentiment of one individual who said that, “affordable mental health care is the key.”

Focus group members also identified transportation as a problem. Some persons cannot access services because of lack of transportation and isolation; others are homebound or largely homebound and, physically, are unable to leave the home.

**Institutional Resources and Service Needs**

The number of older adults nursing facilities suffering from mental health needs is very high. In the United States it has been suggested that up the 88 percent of all nursing home residents suffer from some mental health problem, including dementia with older adults who live in the incidence of depression in nursing homes. It has been estimated at 12 to 22.4% for major depression, in addition to another 17 to 30% for minor depression (AA, 2001).

Nursing facilities in Canada are also places with a high incidence of mental health needs. With prevalence data for American nursing facilities hard to obtain, prevalence rates in Canadian facilities may be cited with the expectation that they are not completely unlike those in U.S. nursing facilities. In Canada, prevalence rates for mental health issues are estimated at 80 to 90%. Studies indicate that between 15 and 25% of residents in Canadian facilities suffer from major depression, while another 25% have depressive symptoms. “More the two thirds of the residents suffer from some form of dementia, 10% suffered from affective disorders and 2.4% were diagnosed as having schizophrenia or another psychiatric illness. Forty percent of the residents suffering from dementia had psychiatric complications such as depression, delusions or delirium” (Canadian Coalition for Seniors’ Mental Health, 2004, p. 14).

So common is mental illness in American nursing facilities that a recent Center for Mental Health report concluded that “...nursing homes have become the new mental institutions for older adults affected by mental health problems.” (CMHS, 2005, p. 7)

Mental health services available in nursing facilities are severely lacking. In the United States, most long-term nursing facility residents are funded through Medicaid. Medicaid reimbursement is made to the facility to provide for all the needs of the resident. Unfortunately, funding for mental health services has not been budgeted as a part of the reimbursement structure. Most residents do not receive the mental health care they need (AA, 2001). Although facilities must have the capacity to deliver mental health services to long-term residents funded through Medicaid, this seldom is possible.

“...Medicaid policies [have] discouraged nursing homes from providing specialized mental health services, and Medicaid reimbursements for nursing home patients have been too low to provide a strong incentive for participation by highly trained mental health providers. The
emphasis on community-based care, combined with inadequate nursing home reimbursement policies, has limited the development of innovative mental health services in nursing homes.” (SAMHSA, 1999, p 70)

Specific barriers to appropriate mental health assessment and treatment for residents of nursing facilities include:

- Lack of adequate MO HealthNet and Medicare reimbursement for mental health treatment;
- Lack of adequate reimbursement to secure the services of psychiatrists and other mental health professionals;
- A shortage of mental health professionals trained in geriatric mental health; Lack of nursing facility staff training and knowledge of the mental health needs of residents; (AA, 2001) and
- Lack of housing alternatives to nursing facilities (Friedman and Steinhagen, 2006). This lack can include a paucity of less restrictive environments, such as assisted living facilities, but also may be due to a lack of affordable housing and/or home and community-based service supports to make community living possible.
Individuals in Rural Communities

“It’s hard to find out where to go for help.”

Summary of Findings and Recommendations

The findings and recommendations are derived from 6 rural focus groups conducted with Caucasian, African American, and elderly adults, 6 interviews with key staff members at agencies serving the these rural residents, and other sources referenced in this section.

- Focus groups elucidated several reasons why rural individuals may not access care or receive timely care, including lack of information about how to get mental health services, lack of transportation, and lack of insurance or sufficient means to pay for care, shortage of services or service providers, and mental illness stigma.
- Most focus group members said that it was difficult to find information about available services and most had learned of services through word-of-mouth. This indicates a real need for rural agencies to do more publicity and outreach.
- Although some agencies provide transportation for people in outlying regions or even provide in-home services, it is insufficient to meet the need. A solution might be to provide outreach transportation and in-home services in rural areas, as well as making greater use of telecommunication technologies (e.g. Telehealth).
- Access to services in rural areas is also impeded by lack of mental health specialists and few choices for mental health care. An increase in the use of Telehealth technologies may be a way to help alleviate these problems.
- Substance abuse services and in-patient and crisis beds were particularly strong needs of rural focus group members. Focus group participants reported traveling long distances to reach AA meetings and hospitals that provide substance abuse services or crisis care.
- Less access to mental health professionals means that rural individuals often rely on other professionals, such as family physicians or clergy, for their mental health needs. Therefore, it is recommended that these professionals are trained to confront mental health issues.
- Approximately 23% of the rural population are MO HealthNet recipients. Focus groups suggested easing MO HealthNet restrictions to make it easier to get mental health services.
- Mental illness stigma was an issue for some, but not all, focus group members. However, most focus group members felt mental illness stigma was a larger issue among the elderly and in the workplace. They felt that early intervention was key, as was public education about mental illness.
Population and Prevalence of Mental Health Difficulties in Rural Areas

According to the 2000 census, 103 counties, or 89% of Missouri’s counties, are considered rural, i.e., not containing urbanized areas (Missouri Office of Rural Health Biennial Report 2004-2005). The prevalence of mental illness in general is virtually the same for rural and urban areas with the exception of youth’s alcohol use, adult stimulant use, depression in women and suicide rates which are higher in rural areas (Van Gundy, K. 2006).

In a survey of over 1000 residents of northeast Missouri, 31.9% of the respondents listed “depression” as the most important unmet service need (Northeast Missouri Regional Health Assessment Project, 2005). Suicide was the second leading cause of death for rural (national) 24-35 year olds and the fourth leading cause for this age group as a whole. Even though rates are not available for 40 Missouri rural counties, 100% of the counties in which suicides are greater than the state rate are rural (Missouri Office of Rural Health Biennial Report 2004-2005).

However, problems of accessibility, acceptability and availability cause many rural consumers to enter into treatment at a later stage than urban consumers, by which time their symptoms are more persistent, serious and disabling, requiring more expensive and intensive care. Accessibility of services is a barrier in rural areas because of the distances between residents and services, the limited number of emergency and regular services, difficulties recruiting and keeping mental health service providers, and inadequate transportation. Services tend to be located in the larger towns and cities within an area with some satellite offices spread throughout the region. Although some agencies provide transportation for people in outlying regions or even provide in-home services, it is insufficient to meet the need. In a study of health care utilization, it was found that individuals with their own transportation made significantly more health care visits than did people who had to rely upon public transportation or other forms of transportation (Arcury, Preisser, Gesler, and Powers, 2005).

Data Sources

The findings and recommendations are derived from six focus groups conducted with two groups of rural elderly adults, two groups of white rural adults, one group of African-American rural adults, six interviews with service providers in rural areas, and a literature review on mental health issues specific to rural individuals. The focus groups were conducted throughout the state with 57 adults recruited by local mental health agencies and senior centers. The participants were between the ages of 24 and 91, and the average age was 58 years. Seventy-eight percent were females; 6% had no health insurance; 38% were MO HealthNet recipients; 55% were on Medicare; 31% had private insurance; and 11% indicated that they had “other” insurance. Many participants endorsed having more than one insurance source. Approximately 66% were Caucasian, 28% were African-American, 2% were Native American, and 5% were “Other.” There were no Hispanics or Asians in the groups.
Detailed Findings: Key Themes

**Information about Services.** Most focus group members said that it was difficult to find information about available services and most had learned of services through word-of-mouth. This indicates a real need for agencies to do more publicity and outreach. Members of the clergy were mentioned frequently both as sources of information and as supports. Since so many individuals rely upon clergy for support and referral, it is important to provide them with general mental health information as well as referral information. Interviews with staff at senior centers revealed that they did not have referral information readily available and that their focus was primarily on the physical status of the seniors. The seniors themselves denied having any mental health problems—just grief when a friend passes away, yet it is estimated that as many as a quarter of seniors have mental health needs. Lack of information about culturally appropriate services was also a concern for rural ethnic minorities.

**Transportation.** Lack of transportation and the need to travel long distances were specifically mentioned as significant barriers to accessing care. Some agencies provide transportation and there was mention of limited access to rural buses, but the need for these methods of transportation to make multiple stops to pick up passengers increases the amount of time spent accessing services. Additionally, these modes of transportation are limited in number and availability.

**Insurance and MO HealthNet (Medicaid).** Lack of insurance coverage is a major barrier to service according to focus group members and staff interviewed. Insurance is often tied to employment, so high unemployment in rural areas impacts insurance availability. Furthermore, small businesses located in rural areas often do not offer insurance benefits. In rural areas, 22.7% of the population are MO HealthNet recipients, compared to 10.7% of the urban population (State Profiles of Medicaid and SCHIP in Rural and Urban Areas, 2007). Little more than 12% (12.3%) of Missourians lack health care insurance. In the 11-county rural area of the northeast, 18.42% lack insurance (Northeast Missouri Regional Health Assessment Project, 2005). In the referenced Northeast Missouri survey, 56.3% of respondents said that insurance was unaffordable, 44% said that prescription drugs were unaffordable, and 36.9% did not know whether mental health care was affordable.

Restrictions that are a part of MO HealthNet also impact access. For example, one restriction allows only one visit to a mental health provider on any given day, so people have to make two visits to see both a therapist and a psychiatrist. Focus group members stated that many medications were unaffordable. MO HealthNet reimbursements for psychiatric services are also very low, according to staff.
Lack of Choice. Agencies are located in the largest towns in the region, sometimes with satellite offices in smaller towns, but there are still many people who are geographically isolated. Focus group members stated that there is a lack of choice of services because there are so few services available. In one focus group, most participants had reportedly received poor care from their original mental health provider, but found good care at an agency addressing both physical and mental health care needs. This is a choice that is not available in most communities where there is a single service provider in remote parts of the state.

Shortage of specialists. The need for mental health specialists is great. In fact, 37% of state and local rural health leaders responding to a survey selected mental health and mental disorders as one of their top rural health priorities, after access, oral health, and diabetes (Gamm, Hutchison, Bellamy, et al., 2002). Nationally, among 1,253 smaller rural counties with populations of 2,500 to 20,000, nearly three-fourths of these rural counties lack a psychiatrist, and 95% lack a child psychiatrist (Holzer, Goldsmith, and Ciarlo, 1998). At all focus groups, the shortage of psychiatrists was mentioned, particularly for children and seniors. There are only 85 geriatric psychiatrists in all of Missouri and child psychiatrists are clustered in the urban areas.

Due to the shortage of specialists, primary care physicians are the principal mental health providers in many rural areas. Nationally, 60% of the rural population lives in areas of shortage of professionals (both mental and physical health) and 65% receive mental health treatment from primary care physicians (Gale & Lambert 2006). According to researchers, many rural physicians may intentionally under-diagnose mental illness due to doubts about the patient’s acceptance of a mental disorder diagnosis, stigma, or a concern about the patient’s future insurability (Gamm, Stone and Pittman 2003). According to a national study, rural doctors detected depression 50% less than physicians in urban areas (Mental Health and Rural America: 1994-2005, 2006).

Members from one focus group discussed the lack of continuity of care that results from a shortage of psychiatrists and resultant reliance on primary care physicians. Since a local rural agency contracts with four different part-time psychiatrists, focus group members stated that they rarely know which doctor will treat them when they make an appointment. Although the psychiatrist prescribes the medication, they see their primary care physician for follow-up and continued care and usually the physician has little understanding of their diagnosis or the effects and side-effects of their medications. This situation points out the need for more intensive mental health training and continuing education for general practitioners in rural areas, as well as more psychiatrists in rural areas or access to Telehealth services.

Telehealth. Telehealth has shown promise as a means to provide services to individuals in medically underserved areas and allow consumers in those areas more service options. In northeast Missouri, a telehealth system is under construction. Presently it serves individuals from 11 sites with planned expansion of services. Of 965 uses to date, 90% have been for mental health. Research shows a high level of consumer satisfaction with telehealth services (Hilty, Nesbitt, Kuenneth, Cruz, and Hales, 2007; O’Reilly, Bishop, Maddox, Hutchinson, Fisman, and Takhar, 2007). Telehealth may offer individuals in rural areas easier access to mental health specialists and more treatment options, and remove transportation as a barrier to receiving services.
Inpatient and Crisis Care. People in rural areas have to travel to larger towns or cities to access inpatient care. Hospitals find it too expensive to maintain units for children and youth, so children are often transported long distances if there is need for hospitalization (Redfedder, 2005). In Missouri, extra beds have been added to hospitals in St. Louis to accommodate young people from rural areas in southeast Missouri.

In some areas law enforcement is called upon to transport suicidal individuals to hospitals, and they don’t always know in advance whether the hospital will accept the patient. The distance from the hospital also makes it difficult for family members to visit or participate in treatment conferences. In one of the focus groups we learned that the community had a bed in one of the agencies reserved for crisis situations, but some individuals stated that they were denied access for reasons unknown. There are Access Crisis Intervention (ACI) hotlines available for crisis situations and the numbers are publicized through public service announcements (PSAs) and brochures in doctor’s offices. Most people in the focus groups, with the exception of elderly focus group members, were aware of these hotlines.

Availability of Substance Abuse Treatment. Care for substance abuse in rural areas is limited and focus group members were particularly concerned about adolescents needing care. There is an enormous difference in the availability of treatment with 26.5% of urban hospitals offering substance abuse as compared to 10.7% of rural hospitals. Additionally, the federal government provides greater funding for treatment to urban areas (Hutchison and Blakely, 2003). Alcoholics Anonymous (AA) is a source of support, but often people have to travel considerable distances to get to a meeting. Additionally, adult stimulant abuse is prevalent in rural areas and there are few, if any, Narcotics Anonymous groups in rural areas.

Stigma. When asked about stigma, there were varying opinions. Some focus group members believed that there were more social supports available in rural areas, while others said they would not even reveal their mental health conditions to close friends. Some members believed that stigma was lessening, but others disagreed. It was agreed that stigma in the workplace was a significant problem. Among the elderly in particular, stigma often prevents seniors from attempting to access services. A strong rural ethic dictates that people should solve their own problems. Focus group members agreed that more mental health education was needed in all sectors of society in order to reduce stigma and increase identification of individuals needing treatment, and particularly that it should begin at an early age.

“They got rid of a pastor who admitted to being depressed.”

-- Rural focus group participant
African-Americans

“No matter what the situation, you have a right to your own opinion.”

Summary of Findings and Recommendations

The following findings and recommendations were derived from two focus groups with African-American consumers, two in-person interviews with staff at agencies who serve the African-American population, and other sources cited in the report.

- Conduct public awareness campaigns to educate and reduce the shame and stigma of mental health issues. Involve community leaders in anti-stigma campaigns and outreach initiatives to eliminate mental health disparities among the African-American community.
- Develop public education campaigns that target stigma and discrimination and are which are tailored to the needs and culture of the African-American community. Many individuals felt doubly stigmatized by their mental illness and by being an African-American. Provide intensive cultural competence programs for mental health professionals.
- Provide youth prevention programs particularly in the rural areas may help prevent future mental health and substance use problems in African-American youth. Provide more recreational and enrichment activities for youth.
- Increase the number of mental health professionals (psychologists, psychiatrists, social workers, therapists, case workers) and providers. Match consumers and mental health professionals appropriately, reduce caseworker turnover, and train health care professionals to both treat consumers with respect and to include consumers in the treatment process.
- Train mental health professionals around medication management and delivery. In addition, train providers to incorporate consumers in the medication administration and delivery process.
- Educate the community as to the scope of available mental health services. Create drop-in centers for consumers, particularly during the evening and weekend hours. Conduct outreach to the faith community as a means to educate African-Americans about mental illness.
- Meet basic needs (i.e., healthcare, transportation, and housing) and reduce waiting lists and wait times for consumers.
- Increase services and programs for consumers with co-occurring disorders.
Population and Prevalence of Mental Health Difficulties among African-Americans

Next to Caucasians, the largest racial/ethnic group in Missouri is African-American (11.2%) (U.S. Census Bureau, 2006). As can be seen on the map below, a large majority of African-Americans reside in either in St. Louis, Kansas City, or along the Interstate 70 corridor, with almost a third living in St. Louis County (U.S. Census Bureau, 2006). In addition, African-Americans make up a large percentage of the population in the southeast region, known as the Bootheel. Overall, the African-American population in Missouri is growing at a faster rate than the White population (4.2% vs. 2.3% rate of growth between 2000 and 2004) (Office of Social and Economic Data Analysis, 2007).

Percent of Missouri Population that is African-American, by County, 2006

According to the Behavioral Risk Factor Surveillance System, 13% of the African-American population reported having eight or more mentally unhealthy days out of the past thirty, a rate similar to Caucasians. However, there are significant differences across the state, with almost 30% of African-Americans in the northeast and southwest reporting eight or more mentally unhealthy days out of the last 30 days. (Missouri Information for Community Assessment, 2007)
Furthermore, national data show that African-Americans generally have less access to care than Caucasians, receive poorer care, and have longer wait times to receive services (Wells, 2001). In Missouri, African-Americans tend to use emergency rooms to access mental health care. In 2005, the Missouri African-American population utilized the emergency room for mental disorders at a higher rate (approximately 15 visits per 1,000), than both the White (10 visits per 1,000) and Hispanic (3 visits per 1,000) population. The rate of visits is particularly high for African-Americans aged 25-44 (approximately 24 visits per 1,000).

**Data Sources**

The data from this section were derived from two focus groups with African-American consumers conducted by the MIMH, two in-person interviews with staff at agencies who serve the African-American population and other sources cited in the report. The two focus groups conducted by the MIMH included a total of 23 African-Americans living in either Kansas City or Caruthersville, MO. The group was 60% female and the average age of participants was 44. Approximately 70% of the participants were MO HealthNet recipients, 18% Medicare, 4% had private insurance and 4% had medical coverage (4% missing).

**Detailed Findings: Key Themes**

**Stigma in the African-American Community.** As with other racial/ethnic groups, focus group members in urban and rural areas felt there was a significant amount of stigma associated with mental illness in their community, though they felt they could turn to their families for support. They mentioned that the community does not understand persons with mental illness—they are perceived as being “less worthy” or that they “did something” to bring this upon themselves. Other focus group members mentioned not only stigma from the general public but stigma from the service system. Focus group members and Gary (2005) reported that, as a result of being stigmatized, they felt shame which contributed to an unwillingness to seek help. Therefore, it is recommended that public awareness and understanding be enhanced in an effort to reduce the shame and stigma of mental health issues. Another recommendation is to better involve community leaders in anti-stigma campaigns and outreach efforts.

**Double Stigma.** Focus group members felt a “double stigma” due to being both mentally ill and African-American. Some of the focus groups members, particularly in the rural communities, expressed feelings of discrimination. Several mentioned that the “black” side of town is littered with unsafe parks, liquor stores, and junk yards while the “white” side of town has clean neighborhoods with sidewalks and safe parks. They also wanted to know why the “government” comes to their neighborhoods around elections, but at no other times. They indicated that there are very few health care professionals that represent the African-American community—actually there is very little diversity at all among health care professionals. This was also mentioned by the African-American key informant (from the urban community), who stressed the need for more culturally competent providers. Rural focus group members also mentioned that cultural competency as a big issue. This...
“double stigma” is one reason why African-Americans may decide not to seek or adequately participate in mental health treatment (Gary, 2005). It is felt that public education campaigns targeting stigma and discrimination that are tailored to the needs and culture of the African-American community, and efforts to increase the diversity and cultural competency of mental health professionals will help. However, problems will still remain as a concomitant to the basic structure of racism and discrimination in Missouri.

Youth Programs. Focus group members, particularly in the rural communities, mentioned that there is not enough for young people to do in their community. They recommended establishing youth programs because many youth are becoming involved in several risk-taking behaviors. They reported that many youth may end up using alcohol and drugs because they have nothing to do all day except sit at home and watch television—they have nowhere to socialize. The parks are not safe and there is no movie theater or skating rink. There are also not many jobs available. They also mentioned that the neighborhoods are often littered with liquor stores and car lots. Focus group members in a rural community stated, “The church is the only place to go but they don’t have activities for the youth.” Therefore, it is recommended that more recreational and enrichment activities be available for youth, particularly in the rural communities. Focus group members in an urban community also mentioned providing classes and/or education to youth who have a parent with a mental illness to help them better understand their parent’s circumstance.

Mental Health Professionals. Focus group members and key informants in both urban and rural communities mentioned that individuals felt that there is a real lack of providers and mental health professionals available in their communities. Focus group members also said that the mismatch of counselors, therapists, and case workers makes it difficult for consumers to trust and work well with some of these professionals. As was seen with other groups (e.g., transitional youth and refugee/immigrant consumers), there is a sentiment that appropriate matching of consumers and counselors encourages consumers to enter and stay in treatment. Focus group members also stressed the difficulties that they have with the high turnover of case managers. They felt like they are being “bounced around” from one caseworker to another, which makes it difficult to connect with their caseworker. They indicated that a lot of the caseworkers quit because they felt overloaded.

Focus group members in both urban and rural areas also commented that they are treated like “children,” that the mental
health care professionals are not including them in the their treatment, and are making all the decisions for them. A culture of consumer-participation in the treatment process and the adoption of a consumer-driven services system is recommended.

**Medication Administration.** Some focus group members felt primary care physicians prescribed medications without the full understanding of their mental health needs and that they would rather be referred directly to a mental health professional for medication. Training for primary care physicians around medication management and delivery is recommended. Focus group members also felt like they were not sufficiently involved in medication issues—particularly as to the type of medication and the number of different medications.

**Community Outreach.** Focus group members and the key informant from the rural community mentioned that people do not know what services are available in their community. They suggested educating the community about mental health services by having a rally or barbeque and providing pamphlets on mental illness, in addition to creating media campaigns on the radio and television to help inform the public. Focus group members from urban areas indicated that they know about the services in the community but they want access to more services in the evening and on weekends. They mentioned creating drop-in centers where people can come together to socialize, participate in activities (e.g., arts and crafts, games, etc.), and take care of their hygiene (i.e., take a shower, change clothes, use restroom). Another suggestion made by the key informant was to hire a public relations person that understands mental health, alcohol/drug addiction, and has a working relationship with the community mental health agencies. This individual would work in the community to educate individuals, schools, businesses, etc., about services available to mental health consumers. Research indicates that African-Americans may turn to informal sources of care such as pastors, friends, and family (Neighbors & Jackson, 1984). Pastors often play the role of counselor, diagnostician, or referral agent for African-Americans (Levin, 1986). Therefore, outreach to pastors as a means to educate African-Americans about mental illness is recommended critical need.

**Housing, Transportation, and Health Care Coverage.** Key informants and focus group members, particularly in urban areas, mentioned that there is very little affordable and safe housing. In addition, almost all focus group members in both urban and rural areas felt that transportation is a significant issue. They reported that transportation by van or bus is often unreliable because of inconvenient running times, schedule conflicts, and inaccessible routes (e.g., rural locations). In addition, almost all focus group members and both key informants mentioned making health care and affordable medicine available to uninsured individuals. Focus group members also experienced long waiting lists and wait times to access services.

**Co-occurring Services.** Most focus group members and key informants indicated that there is need for more services for consumers with co-occurring disorders.
**Hispanic Community**

“We live in isolation that [may] make us more susceptible to depression.”

**Summary of Findings and Recommendations**

The findings and recommendations in this section were derived from a focus group with Hispanic Missourians, interviews with key informants from a mental health agency serving Hispanics in southwest Missouri, as well as secondary sources.

- Wide distribution of mental health information within Hispanic communities is wanted in order to educate Latinos about mental health issues and provide referrals. It was suggested that these materials steer away from stigmatizing language linking mental health with severe mental illness.
- There is a demand for Spanish translations of mental health related materials (brochures, PSAs, etc.). Hispanic-serving agency staff and focus group participants felt that the Hispanic population would become better informed about mental illness and seek needed help if materials were translated.
- Research on cultural competence and focus groups stressed the need for cultural sensitivity training for mental health providers, including better education about the Hispanic culture. Cultural sensitively needs to be considered in the development of mental health materials as well.
- Non-mental health providers, including the faith community, physical health providers, and schools, were perceived to be important to providing mental health care outreach to the Hispanic population. Specifically, through education of these natural providers, members of the Hispanic community could better understand mental illness and accept assistance when needed.
- Additional mental health service providers within Hispanic communities are needed. Currently, communities have very few Latino providers. Language and transportation barriers make many Hispanics less likely to seek services.

**Population and Prevalence of Mental Health Difficulties among Hispanics**

Hispanics in Missouri represent a diverse mix of cultural groups, including those who identify themselves as Mexican, Mexican-American, Chicano, Puerto Rican, Cuban or those who indicate origins in Spain, Spanish speaking countries of Central or South America, or the Dominican Republic (Missouri Foundation for Health, 2005). At present, around 3% of the population in Missouri is Hispanic, but this is increasing rapidly. While the total population for Missouri increased by 2.8% between 2000 and 2004, the Hispanic population, according to population projections, shows a 24.9%
increase (Missouri State Data Center, 2005). The largest population increases were among young adults (20- to 24-year-old males had the single largest increase) and young children under five.

While the greatest number of Hispanics live in the St. Louis and Kansas City areas, many rural areas, particularly in southwest Missouri, have a significant Latino population, many of whom were recruited to work in meat and poultry processing plants (Missouri Foundation for Health, 2005).

Missouri Hispanic Population Growth, 2000-2006

[Map showing Missouri Hispanic population growth from 2000 to 2006]

Source: U.S. Census, 2000-2006

It estimated that approximately 11.7% of Hispanics age 18 and older experience frequent serious psychological distress (SPD) in any given year, slightly higher than the prevalence rate for non-Hispanic Caucasians (NSDUH, 2006). Hispanic public middle and high school students in Missouri reported higher rates of suicide ideation (17%) than non-Hispanic youth (14%) (Missouri Student Survey, 2006). In a national study of mental health disparities, Hispanics were less likely to be receiving active alcoholism, drug abuse or mental health treatment than non-Hispanics, in part because they are less likely to pursue getting help. Fewer than one out of eleven individuals contact mental health specialists and even fewer (one out of five) contact health care providers (NOPCAS, 2003). When Hispanics do obtain services, their mental health care is insufficient (Hough, et al., 1987) and they are more likely to have delayed care than Whites (Wells et al. 2001).

Data Sources

The information in this section is derived from a focus group held at the Mattie Rhodes Center in Kansas City, Missouri, from interviews with mental health staff at the Clark Center in Monett, Missouri, and from a literature review. In the focus group held in Kansas City, there were 11 Spanish-speaking focus group participants, most of whom were women and an average age of 35.
The focus group was conducted in Spanish by a mental health professional and has been transcribed into English.

**Detailed Findings: Key Themes**

**Public Information and Stigma.** In general, there is stigma attached to mental illness in this community (NOPCAS, 2003). Focus group findings and interviews with service providers support this finding. Many individuals stated that within the Hispanic community, the stigma against mental illness is strong and inhibits people with needs from seeking help from mental health care providers. Those with mental health issues are still regarded as “crazy” and are socially ostracized, and issues are either discussed only within the family or by their family physician. Education of the community regarding the benefits of seeking help was encouraged. It was suggested that even the terms “mental health” and “mental illness” promote negative stereotypes of persons with mental illness, and it was suggested that other terminology be used in all informational materials (U.S. Department of Health and Human Services, 1999; focus group participants, agency interviews).

**Language Barriers.** In the year 2000, about 42% of Hispanics reported that they did not speak English very well (U.S. Census, 2000). Particularly in Missouri, because the Hispanic community is very small compared to the White and African-American community, resources have limited providing mental health services in Spanish, as well as the translation of mental health materials into Spanish. In the survey of mental health agencies in Missouri conducted for this needs assessment (see Chapters 6 & 7), only 11.7% of agencies/organizations surveyed reported serving the Hispanic/Latino population compared to the 93.3% that served Whites. The result is that most Missouri Hispanics have limited access to information about mental illness and to ethnically or linguistically similar providers. There is therefore a strong need both for translated materials and for training Hispanics to become mental health professionals to better serve this population.

**Cultural Sensitivity Training.** Because the number of Hispanics is very small compared to the number of Caucasians and African-Americans in Missouri, focus group members and agency personnel felt that there is a lack of understanding of the Hispanic culture among service providers. Some focus group members cited racial discrimination as an issue among mental health providers. Elsewhere, training in cultural sensitivity for health care providers working with Hispanics has been encouraged (Moran, 2004).

**Training of Non-mental Health Providers.** Mental health training of faith-based organizations, schools, and physical health providers has been shown to be a good place to start in introducing concepts of mental health (Chalfant, 1990). Many Hispanics trust their pastors and feel more comfortable approaching them than they feel approaching mental health agencies. In part, there is a general fear of government among many Hispanics due to INS concerns.

"Use simple language...remember that there are many Hispanics here who have hardly finished elementary school.”

-- Hispanic focus group participant

"We thought that a therapist only treated crazy people. Now we have learned that a therapist is just somebody that can help us to deal with the problems we are suffering.”

-- Hispanic focus group participant
Language barriers between Spanish-speaking Hispanics and most mental health agencies also prevent many Hispanics from seeking services (agency interviews). In addition, schools provide a natural training ground for Hispanic children to learn about mental health issues. Finally, Hispanics tend to talk to their physicians about any mental health care issues that they may have. Establishing collaborative relations between primary care providers and mental health care specialists can increase accessibility to mental health care and improve consumers’ mental health status (Wells, Sherbourne et al., 2000). By training non-mental health providers (pastors, teachers, physicians, etc.), the understanding of mental health issues may increase within the general Latino community. One resource for the faith community is the Pathways to Promise, a national, interfaith technical assistance organization that focuses upon mental health issues for pastors (pathways2promise.org).

Additional Providers within the Hispanic Community. Because of the reticence of many Hispanics to seek services outside of their community, a need for mental health providers within their communities was expressed in interviews and focus groups and supported in mental health research. Focus group members stated that there are language barriers, transportation issues, and issues related to cultural sensitivity that discourage them from seeking help, and that there are a limited number of providers within the Hispanic communities. Training of Hispanics to enter the mental health field was encouraged (agency interviews).

“Most of us have suffered the experience of going to big hospitals and we have to wait a lot or we have to go accompanied by somebody who speaks English if we want to be helped faster.”

-- Hispanic focus group participant
Families with Children

“The current system traumatizes kids and parents.”

Summary of Findings and Recommendations

The recommendations presented are derived from a focus group that was held in southwest Missouri. The participants were family members of children with mental and physical health problems. Some of the recommendations come from an interview with the executive director of a family organization in the area.

- There are not many resources for families with children, particularly in rural areas. Families need more diversity in both providers and services options in their area.
- Sometimes families fear having law enforcement involved with their children’s issues, because law enforcement does not always know how to handle the problem correctly. There should be more training for law enforcement on handling situations involving people with mental health issues.
- Parents have the most contact with their children and in many cases can thoroughly describe their child’s illness. Training of professionals to carefully listen to parents to further their understanding of the child’s health issues would help with diagnosis and treatment.
- The parents in the focus group expressed great concern that the crisis services in their areas are inadequate to meet their needs.
- The school systems do not always know how to handle situations involving children with mental illness. Better mental health training for teachers might help improve their understanding of the symptoms of mental illness and how to get help.
- Participants in the focus group felt that children are often removed from their homes before the situation is assessed and a plan is developed. The system should try to work with families before youth are removed from their homes.
- Many parents do not understand the symptoms of mental illness. Early screening and assessment could save these parents many years in trying to find a diagnosis for their child, and early invention could provide help and guidance before the situation increases in severity.
- Many children suffer from both a physical illness and a mental illness, or a substance abuse issue. There should be better diagnosis and treatment for youth with co-occurring disorders.
- Stigma can leave families feeling very isolated. An anti-stigma campaign may help to improve public perceptions of persons with mental illness.

Population and Prevalence of Mental Health Difficulties among Children

As described in Chapter One, an estimated 5-9% of children nationally suffer from serious emotional disturbance (SED). According to the National Survey of Children’s Health (NSCH, 2003), 8.7% of children and youth (ages 4 – 17) (93,629 children) in Missouri have moderate or severe difficulties in
the areas of emotions, concentration, behavior, or the ability to get along with others, and 5.4% (54,115) suffer from severe SED.

Data Sources

One focus group of 18 families members with children were included as part of the needs assessment. Participants in this focus group were ages 18 to 79 with a mean age of 46.2. They were from a family organization located in a rural area in southwest Missouri. The group was mostly female and primarily Caucasian. The type of insurance that these individuals had was split almost evenly between private insurance, MO HealthNet, and self-pay.

Detailed Findings: Key Themes

Lack of Choices in Providers and Services. Parents would like more options when trying to obtain services. Parents felt that the lack of choices in their community makes it difficult to find appropriate care for their children. In addition, they stated that there is a high turnover rate among workers in this field, hence parents are constantly starting over with new providers and caseworkers. The southwest portion of Missouri is mostly rural, with the exception of Springfield. With many services only available in urban areas, these parents have to travel a considerable distance to access services.

Parents in this group also expressed frustration because their children sometimes receive different diagnoses from different providers. One woman stated it took eleven years for her child to be diagnosed with autism.

There is also a problem accessing only the services that a child needs. For example, parents have to access the “whole pie,” instead of just the resources that their child needs. They felt that better individualized care could benefit both the child and the system costs.

The focus group participants had major concerns about crisis services in their area. Some participants had stories of great difficulty in accessing services regarding their crisis situations they had faced. Resources are insufficient and unsatisfactory when there is an emergency.

School and Law Enforcement. According to the focus group participants, law enforcement needs better training on handling youth with mental and/or physical health issues. One woman explained that law enforcement is called to the school if a child has a “melt-down,” regardless of the age of the child. Many of the parents in this group stated that they home school their children because they do not want their children to have negative experiences with the police. There is a general consensus that, while trying to keep people safe, Law enforcement often uses unnecessary force when dealing with SED youth. This can cause youth to fear law enforcement.
Parents believed that crisis planning is weak and employees in the juvenile justice system need to be better trained.

Parents were also concerned that many requirements stemming from the No Child Left Behind Act of 2001 (Public Law 107-110) are not having the intended effect of helping children succeed. Finally, there are often issues with medication in the schools; sometimes schools will not permit certain medication to be provided.

“Parents believed that crisis planning is weak and employees in the juvenile justice system need to be better trained.”

Lack of High Quality Staff. The parents in this focus group were extremely knowledgeable about youth and mental health issues. They deal with these issues every day. One parent, who is a mental health worker, stated that she felt like she spent most of the meeting time with her counselor having to educate the counselor, rather than the counselor helping her to understand her child. While she felt there was no productive reason to continue to see this counselor, the need for a good counselor is still there. Some of the parents explained that their children have had five or more caseworkers, and they have to start over each time they have a new caseworker. Also, these parents stated that sometimes parents just need a break, and help would be greatly appreciated. Caseworkers are young and not well-trained. They often have far less experience than the parents, yet they have the right to take children out of the home. These parents feel that it is difficult to understand these issues unless it is actually experienced in one’s home.

Backwards System. Parents felt that the current system is “backwards.” Too often children are removed from the home as a first step, instead of a last resort. The parents in this group would prefer help being offered before the child has to leave the home. The current system traumatizes both the child and the family. It would be best if the parents could work with the children in the home, instead of having them immediately removed. Litigation is expensive when the courts become involved in these cases. Parents know their children and feel they can participate in their care. Hoagwood, Horowitz, Stiffman, Weisz, et. al (2000) found that parents are accurate reporters of their children’s mental health service use. Parents can be relied on to give accurate reports of mental health service use in in-patient, out-patient, or school settings.

Early Intervention. The parents also recommended early intervention and screening for youth. They urged that physicians use a screening tool at their regular doctor’s visits. According to this group, primary health care doctors do not talk with mental health providers, and vice versa. It is the parents’ job to go back-and-forth to relay messages between providers. This is not only inefficient, but, at times, it results in “disconnects” that have tragic consequences.

Parents stated that it is extremely difficult to diagnosis children with co-occurring Serious Emotional Disorders and mental retardation/developmental disabilities, for example, a child who is both autistic and bi-polar. It is difficult to serve these children as well. Better training and earlier intervention can help these children and their families.
**Stigma.** Many of these parents felt that people, even those working in the field, do not understand their children and their mental health problems. Neither do people in the community understand. People in the community are often so uncomfortable around such children that some parents feel forced to keep their children at home most of the time. One parent explained that she does not want her community to know about her children’s problems, and take measures to make sure it is kept quiet. She moved out to the country, home schools, and gets their medication from out of town.

According to the parents in this group, other children ridicule their children and this makes it difficult. One woman told a personal story about an acquaintance whose daughter had an accident that resulted in a mental/physical disability. She stated that this woman expressed to her how she used to be one of those people who judged and she really did not understand the personal difficulties of the situation until she was forced to deal with it every day with her own daughter.
Summary of Findings and Recommendations

The findings and recommendations are derived from a focus group conducted with adults on probation and parole, a literature review, interviews with probation and parole officers, and an interview with the Chief of Mental Health Services at the Missouri Department of Corrections (DOC).

- Consider increasing the number of drug courts and mental health courts to divert individuals from the prisons.
- Evaluate the process for diagnosing, monitoring and treating the mental health needs of prisoners to assure that the mental health needs of all offenders are met.
- Increase the number and qualifications of psychiatrists serving the prison population. The number of psychiatrists treating the prison population is very low.
- Provide mental health education, both within the correctional system and in the community at large, to overcome the double-stigma that mentally ill offenders face.
- Carefully evaluate the need to use punitive practices in prison that may exacerbate mental health issues and limit access to therapeutic offerings.
- Assure that released offenders have adequate medications to meet their needs during reentry.
- Take steps to speed up the evaluation process for probationers and parolees by providing more community-based assessment/treatment services, increasing the number and qualifications of psychiatrists, and monitoring compliance of agreements with mental health care agencies to assure that no one is denied services due to lack of insurance.
- Provide resources for full implementation of the Transition Accountability Plan (TAP).
- Suspend rather than terminate MO HealthNet and Medicare coverage when individuals enter the correctional system. Require that applications for MO HealthNet and Social Security Disability (SSD) be made during the transitional phase from prison.
- Provide more services for co-occurring disorders and increase case management.
- Assure greater access to low-cost/free medications.
- Provide more subsidized transitional housing, transportation options, access to vocational rehabilitation, and employment supports.

Establish linkages with dentists and physicians to assure that physical health needs are met.

Population and Prevalence of Mental Health Difficulties among Corrections Population

In 2006, Missouri ranked seventh in the U.S. in the rate of overall incarceration, with 30,859 offenders in the Missouri correctional population. Incarceration rates are highest in Lafayette and Saline Counties, the Bootheel region, and in the City of St. Louis where poverty and unemployment are also high (Missouri Department of Corrections, 2006). Most offenders were white, male, and between 20-39 years old. African-Americans have higher rates of incarceration than Caucasians, (1,979 per 100,000 compared to
Female offenders accounted for 8.4% of the prison population. Drug manufacturing, sale, and possession offenses equaled about 20% of all offenses in 2006. Over half (59.5%) of offenders have a high school diploma/GED or higher, while 12.8% of offenders attain only 0-2nd grade educations at assessment (MO DOC, 2006). One study reports that over half of the prison population is functionally illiterate (Schniro, 2000).

At the end of 2005 there were 71,673 active probation and parole cases in Missouri. Missouri ranked seventh in the U.S. for the number of persons under community supervision with a rate of 414 per 100,000 population (U.S. Department of Justice, November 2006).

**Mental Health.** Out of 30,141 offenders in the Missouri Department of Corrections (MO DOC) assessed in 2006, only 14.8% were diagnosed as requiring treatment, and 33.8% were considered as having “minimal impairment” (MO DOC, 2006). Nationally, 56% of state prisoners were diagnosed with a mental illness (U.S. Department of Justice, September 2006). It should be noted that a significantly higher percentage of females are classified as needing services than males. In Missouri, offenders with mental illness are 4% more likely to return to prison within two years of release than other offenders. A 2006 U.S. Bureau of Justice Statistics report stated that almost a quarter of offenders in jails and state prisons who suffered from mental illness had three or more prior sentences (News Release, 2007).

**Substance Abuse.** In Missouri, 77% of offenders were identified as in need of substance abuse treatment upon admission, although this is most likely an underestimate as almost one-sixth of the population was not evaluated. DOC estimates that 55% of offenders need substance abuse education and 20% need treatment. The success rate of offenders completing institutional substance abuse treatment was over 75% and the rate for completing community-based rehabilitation programs was around 50% (MO DOC, 2006).

Behavioral health services for the Missouri correctional system are contracted to Mental Health Management which in turn subcontracts psychiatric services. Additionally, the DOC staff work closely with the Department of Mental Health (DMH) to provide in-patient mental health treatment. DMH provides a total of 242 beds for psychiatric treatment, over 850 beds for drug/alcohol treatment, and 60 beds to serve offenders with mental retardation and developmental disabilities to prepare them for return to the general prison population (Offender Behavioral Health Services, n.d.).
Data Sources

The findings and recommendations are derived from a focus group conducted with adults on probation and parole, and probation and parole staff. Interviews with two probation and parole staff and the Chief of Mental Health Services at the Missouri Department of Corrections (DOC). The focus group of probationers and parolees was conducted in the St. Louis City, with nine individuals who were recruited by probation and parole officers. Participants were between the ages of 22 and 59, with an average age of 40 years. Eight were males and one was female. Thirty-eight of the participants had no health insurance, and the rest (63%) were MO HealthNet recipients. Twenty-two percent were Caucasian and 78% were African-American.

Detailed Findings: Key Themes

Increase Diversion Programs. Adult and Juvenile Drug Courts and Mental Health Courts have been set up to divert offenders with chronic alcohol/drug addictions or mental illness from the correctional setting (Your Missouri Courts, n.d.). The recidivism rate for drug court graduates is about 5% compared to about 45% for those not in drug court (22nd Judicial Court of Missouri, n.d.). Currently, there are approximately 3,000 individuals under Drug Court supervision in 108 Drug Courts throughout Missouri. The program is driven by funding. There are a full range of services provided through the Drug Courts, including treatment, housing and job assistance and educational assistance. By contrast, there are only five counties with Mental Health Courts, and they are not able to provide housing, job assistance, or educational assistance due to lack of funding. They serve approximately 150 individuals.

Need for Education. The need to better educate prison staff, prisoners, and community and family members was mentioned by focus group participants, particularly in relation to the double-stigma that they felt. Many individuals stated that even their own family members stigmatized them because they don’t understand mental illness. One parole officer said, “It’s really almost ignorance to even call what they experience ‘stigma,’ because it’s not a high enough level to even be stigma. It’s just complete utter ignorance, and very much mystical or supernatural.” Parole officers stated that most parolees do not receive an explanation of their diagnoses or of the potential effects or side-effects of their medications. This failure to involve them negatively affects medication compliance.

Diagnostics and Monitoring. Many focus group members were concerned about the quality of psychiatry staff willing to serve those in prison. Parole officers reported that when a prisoner is released, only a “face sheet” with a diagnosis is available to them. They feel that the mental illness is often misdiagnosed. “I don’t think they get evaluations. They get whatever meds they have available because what they get out on the private sector is different from the institution.” Prison diagnostic procedures include an immediate screen upon entry to identify seriously mentally ill individuals in order to send them to appropriate institutions and a full diagnostic evaluation within 48 hours of incarceration. Those with more severe ratings (3-5) receive more intensive care. In prison, individuals are given up to a 90-day supply of medication and are seen periodically (about every three months) by a psychiatrist. There are therapeutic programs offered, but not therapy.
Prison Practices. Some focus group members found the conditions in the prison made it difficult for them to sleep or function. One individual, diagnosed with depression while incarcerated, stated he was no longer depressed after release. Parole officers indicated that is not uncommon.

Medication and Evaluation. All offenders with a Mental Health 3, 4 or 5 level of diagnosis are mandated to have an evaluation completed as a condition of parole. Upon release from prison, they are given a 30-day supply of medication, but it often takes 30 to 60 days to get an evaluation and then another 30 to 60 days to see a psychiatrist and obtain a prescription “if they get to the appointments.” This gap in medication increases the likelihood that both physical and mental functioning can be impaired without gradual tapering down on psychotropic medications. The likelihood of self-medication with street drugs increases, as does recidivism and the possibility of self-injury. The problem is confounded because some providers will not take individuals without insurance. From a parole officer: “So you hope for them to get so sick or suicidal, or you hope that they commit a minor crime. It’s pathetic to be put in that position—when that’s what we’re waiting for, and hoping that that happens, so that we can get them help. That’s the reality of it.” Speeding up the evaluation process was stated as a top priority by the officers. “If we just had, by region, an LCSW or MSW that could diagnose and make referrals, or where we could call a number instead of having to patch together their treatment here. . .” The parole officers strongly expressed the need to have on staff or direct access to a mental health professional to do evaluations and referrals for the parolees.

Transitional Services. The need for transitional services from prison to community was expressed by focus group members. Ninety-seven percent (97%) of all Missouri offenders are returned back to their communities necessitating careful planning for successful reentry. In 2006, almost a third of the prison population (11,334 offenders) and over half of all admissions were made up of returnees to prison from parole for either technical or legal violations showing a high rate of recidivism (Transition Accountability Plan, n.d.). In response to this situation, the governor directed the Corrections Department to formulate an effective re-entry plan (Missouri Reentry Process, 2006). The DOC has begun to implement a 5 phase Transitional Accountability Plan (TAP), beginning with the initial diagnostic screening and continuing through release from prison and completion of parole (Transition Accountability Plan, n.d.). TAP, through the cooperative efforts of numerous state agencies, will assist with housing, medical appointments, employment and provision of a state ID card prior to release from prison. It is now in the initial phase of implementation.

MO HealthNet (Medicaid). According to both focus group members and parole officers, it takes a long time to be approved for MO HealthNet. Several focus group members said that they had to use lawyers in order to obtain standing and to be placed on Social Security Disability, in part, they said, because the correctional system will not release medical records. Some service providers will not see an uninsured individual, so MO HealthNet approval is essential. Parole officers reported that some states have agreements to suspend Medicaid for qualified individuals rather than terminating it. This would speed reinstatement. Applications for both MO HealthNet and Social Security Disability (SSD) should be completed in prison prior to release to assist the transition.
**Treatment.** More services for co-occurring disorders are needed. Many offenders need services for both substance abuse issues and a co-occurring mental illness. One officer stated that “at least half of the people [have] co-occurring [mental illness and substance abuse difficulties].” Probation and parole officers also believed that access to individual therapy is needed. According to the literature, the most effective treatment for any mental illness is a combination of drugs and therapy. However, focus group members stated that they had a difficult time affording medications, even when available at reduced cost or for just for an insurance co-pay. Probation and parole officers stated that more case management is needed because many of the individuals on their caseloads cannot manage the affairs of daily living. They do not remember to take medications, their personal hygiene is poor, and they have difficulty getting to scheduled appointments: “They don’t even know what day it is.”

**Basic Needs.** Reentry into society requires that individuals obtain stable housing and employment, if they are capable of handling a job. These are conditions of probation and parole, yet unemployment of persons reentering society is greater than the general unemployment in the state. That the majority of institutionalized individuals lack education and skills needed to gain employment, adds to the problem. DOC has limited training opportunities available for offenders who are serving long-term sentences, providing GED programs for both probationers and institutionalized offenders. Until offenders with mental health issues are stable, however, these programs have limited success. None of the focus group members had been able to access vocational rehabilitation services, and probation and parole officers stated that few qualified. In addition, focus group members stated they cannot afford decent housing, especially upon release and before they obtain employment or Social Security Disability, yet stable housing is a requirement of probation and parole. Transportation both in urban and rural areas is a problem for these individuals. Several of the focus group members stated that lack of access to telephones made it difficult for them to find housing, employment or to contact their probation/parole officers. People with mental illness often have more physical illnesses than the general population, so access to general medical care is also a basic need. Officers mentioned that people who abused drugs, particularly meth, desperately needed access to dentistry.

**Training for Probation and Parole Officers.** Although some of the larger municipalities have probation and parole officers who are designated for offenders with mental health needs, most areas do not have specialized officers. Previous training in mental health is not a requirement for designation as a mental health probation/parole officer, but most have some background. Most probation and parole officers have clients with mental illness on their caseload and in our interview, most believed they could benefit from more training.
Refugee and Immigrants

“People come [to seek services] but very infrequently because there is so much shame to speak of these problems”

Summary of Findings and Recommendations:

The following recommendations are based on a focus group conducted with Bosnian refugees and five interviews conducted with staff members from a local agency that works with the refugee and immigrant population in the St. Louis area.

- Due to the stigma and cultural barriers to receiving mental health treatment, integration of mental health services into the refugee and immigrant community is vital.
- Culturally competent educational campaigns that incorporate community leaders and avoid stigma-laden terms like “mental illness” were suggested.
- Providing youth prevention programs specific to refugee and immigrant youth may help prevent future mental health and substance use problems in this at-risk population.
- It is important to increase the number of professionals trained to work with the international community, potentially by increasing the number of training courses and providing incentives for refugees and immigrants to go into the mental health field.
- There is a need to train interpreters about confidentiality, mental health issues, and trauma and torture. It is also important to ensure that the interpreter and the client are a good fit.
- Many immigrants and refugees are victims of mass violence and persecution. It is important that mental health professionals working within those communities understand the impact of those types of traumatic experiences on the individual and the community.
  - It was suggested that work be done to meet basic needs of arriving refugees and immigrants (i.e., health care, public assistance, and housing), as well as providing additional MO HealthNet coverage for therapy services, to account for the extra therapeutic challenges in treating this population.

Population and Prevalence of Mental Health Difficulties among Immigrants and Refugees

Missouri’s population has been slowly increasing over the years. However, the foreign-born population in Missouri has been increasing at a dramatically rapid pace. Between 2000 and 2006 the foreign-born population in Missouri increased by 28.6% (FAIR, 2006).

As the refugee and immigrant population grows, so do their needs. When considering those needs it is important to know that refugees and immigrants have sometimes endured significant hardships in their homeland (i.e., poverty, war trauma, persecution, terrorism, natural disasters, and famine). These stressors often have a painful effect on individuals’ mental health and ability to successfully acculturate into their new communities. Not only are pre-migration and migration stressors difficult for this population, but post-migration stressors (e.g., language barriers, unsafe and unaffordable housing, poverty, job security, discrimination, and prejudice) also have an adverse affect on refugees’ and immigrants’ mental health (Pumariega, Rothe, & Pumariego, 2005). According to Keyes (2000) these...
traumas and stressors that refugees and immigrants have experienced put them at high risk for mental health problems. It has been reported that many refugee and immigrant adults suffer from depression, anxiety disorders, and post-traumatic stress disorder (PTSD) (Mollica, et al., 2001; Maddern, 2004). A study conducted by Fazel & Stein in 2003 reported that over one quarter of refugee children were found to have psychological disturbances. Another study conducted with Cambodian refugees found that 86% of the Cambodians interviewed met the DSM-IV-R criteria for PTSD. Substance misuse may be another risk factor for refugees and immigrants. However, there is very little systematic data available about the types of substances and the patterns of use among refugees and immigrants (D’Avanzo, 1997).

**Data Sources**

The findings and recommendations are derived from a focus group conducted with eight adult Bosnian refugees, five key informants, and a literature review. The key informant interviews were conducted with staff members from an agency that works with the refugee and immigrant population in the St. Louis area. Information gathered from a literature review on mental health issues specific to refugees and immigrants was also incorporated into the recommendations. The demographic information for six of the eight focus group participants included one female and five males, ages ranged from 37-53, all were married, and their incomes ranged from $25,000 to over $70,000.

**Detailed Findings: Key Themes**

**Community-based Mental Health Services.** Key informants recommended taking a community-based approach to providing mental health services to refugee and immigrant populations. They stated that the mainstream mental health system has a hard time meeting the needs due to lack of resources, language barriers, cultural differences, and stigma. It was suggested that creating more refugee and
immigrant oriented services within the community and partnering with agencies to train staff to be cultural competent would better serve this vulnerable population. The community–wide approach also includes, but is not limited to, mental health services based in schools (Fazel & Stein, 2002), community agencies, and prevention programs (Palinkas et al., 2003), and programs to teach immigrants and refugees about cultural norms in the U.S. (Pumariega, Rothe, & Pumariego, 2005). According to Pumariega, Winters, & Huffine (2003) the integration of community mental health services and the natural environment of refugees and immigrants are vital when addressing the mental health needs of refugee and immigrant children, adults, and their families. The focus group members mentioned that they would all “feel better” if the Bosnian community was able to build a planned cultural center where individuals could come and socialize with each other – a place for common sharing.

**Stigma.** Key informants suggested the language “mental health” be changed to something less stigmatizing so the refugee and immigrant population feels more comfortable accessing services. The majority of the refugee and immigrant cultures view individuals with a mental illness as being “crazy” and if you have a mental illness you are either “put in an insane asylum, locked in the back room of the family’s home” or left out on the street (personal communication, July 5, 2007). It was also mentioned that alcoholism is a major problem in immigrant and refugee communities, but that many individuals will not seek treatment because they see their alcoholism as normative behavior. Therefore, it is recommended that public information campaigns be conducted to educate and reduce the stigma of mental health issues. It was also recommended to involve community leaders in an anti-stigma campaign and outreach to break down cultural barriers.

“A child is not a weed that grows by itself.”
-- Staff member at an agency that serves immigrants and refugees

**Youth Programs.** Key informants recommended establishing youth prevention programs because refugee and immigrant youth are becoming involved in several risk-taking behaviors. They reported that many youth (particularly males) have been using alcohol, drugs, and driving recklessly. In addition, key informants and Pumariega, Rothe, & Pumariego (2005) explain that many refugee and immigrant youth go through an identity crisis when they arrive in the United States. The youth are often unsure of which culture to identify with, which may lead to them feeling alienated from their families and their mainstream peers. In addition, many male youth lack male role models because their fathers, uncles, brothers, etc. have been killed in the war, and as a result they experience difficulties reconciling cultural differences in gender roles. Providing youth prevention programs will help to ensure youth have positive role models and may aid in youth development, self-confidence, and community building.

**Mental Health Professionals.** Focus group members and all key informants suggested there be an increase in the number of caseworkers, therapists, psychiatrist, psychologists, and primary care physicians that are trained in identifying and treating mental illness and trained to work with the international community (Walker, 2005). Pumariega, Rothe, & Pumariego (2005) also recommended that mental health professionals be knowledgeable of the circumstances of the refugee’s crisis and that they speak the same language or have competent interpreters available to interpret. Key informants suggested offering incentives to refugees and immigrants to work as mental health professionals within the international communities. They indicated that refugees and immigrants typically are very uncomfortable discussing mental health issues and they would be more comfortable talking about their problems to mental health professionals who were from their homeland and spoke the same language. Therefore, it was recommended that individuals within refugee and immigrant communities be
empowered, encouraged, and provided incentives to seek employment in the mental health field. In addition, they recommended that providers be educated about the traditional cultures of their refugee and immigrant consumers, and that social work and psychology students be required to take more courses geared toward the refugee and immigrant populations.

**Interpreters.** Several recommendations from focus group members and key informants were made in regards to training interpreters. For example, they felt there was a need to train interpreters around confidentiality, mental health issues, war, trauma, torture, and cultural competency. They mentioned that many interpreters do not understand or support mental health, which has made it difficult for the interpreters to interact well with the therapists and/or consumers during sessions. In addition, it was reported that many interpreters do not understand the U.S. concept of client confidentiality, which may be problematic because the interpreter and the client often live within the same community. Therefore, consumers have been hesitant to confide in therapists because interpreters may let other people in the community know about their mental health status. Another suggestion made by a key informant was to screen all interpreters to ensure that all interpreters have a mental health background and that the interpreter and client are the correct “fit”. For example, although Muslim and Serb Bosnians both speak the same language it would be detrimental to have Serb interpreting for a Muslim, and vice versa, due to historical tensions between the two ethnic groups.

**Victims of Trauma and Violence.** Also mentioned was the need for more supportive services to assist victims of human rights violations and mass violence. It was explained that the “single” trauma (e.g., rape, murder, etc) that Americans experienced are very different than the traumas (e.g., war, persecution, mass violence) refugees and immigrants have experienced. These traumas often affect and dismantle entire communities. Therefore, mental health agencies and professionals need to be better equipped to address mass violence and human rights violations among refugees and immigrants.

**Housing and Health Care Coverage.** Key informants made several recommendations based on basic needs for refugees and immigrants. They report that public housing in Missouri has been closed which creates a big barrier for new arrivals, so it is recommended that there be an increase in the supply of safe and affordable housing for refugees and immigrants. They also mentioned making health care and affordable medicine available to uninsured individuals. In addition, key informants suggested increasing the number of therapy sessions allotted under MO HealthNet, since it often takes time for consumers to “feel safe” with their therapists and that many mental health issues do not appear until long after the individual has arrived in the U.S. They also suggested increasing the amount that MO HealthNet reimburses for therapy services, so more refugee and immigrants can receive services.
Homeless Community

“Tough love doesn’t work…I’ve had tough love my whole life.”

Summary of Findings and Recommendations

The findings and recommendations are derived from both a focus group conducted with homeless adults, an interview with a key staff member at an agency that serves the homeless, and other sources referenced in this section.

- Homeless focus group members wished for a “road map” of available services. Homeless individuals found they could not rely on providers or staff to help them find needed services.
- An increase in public assistance programs is needed. Many services are reportedly inaccessible due to long waiting lists, bureaucracy, and/or lack of insurance or financial resources.
- Existing services were reportedly ineffective, and do not address homeless individuals’ myriad needs. Community support programs (life skills, vocational rehabilitation, job training, transportation, etc.) in addition to shelters and mental health services are needed.
- Transportation was a huge issue. Focus group members recounted the challenges of maintaining employment or going back to school without reliable transportation. Programs that provide reliable and inexpensive access to transportation are needed.
- More shelters and beds would get more homeless individuals off the streets, and reduce waiting lists. Also, revising shelter rules and regulations to be less strict would help those who work late.
- Screening and follow-up services would ensure that the homeless are getting the mental health services they need. Follow-up can also prevent future relapses.
- Many individuals felt doubly stigmatized by their mental illness and homelessness. Focus group members felt they were often treated unfairly and did not have say in their care due to preconceptions about homelessness and mental illness. Training of shelter staff, mental health providers, nurses, and police who have contact with the homeless and/or mentally ill was recommended.

Population and Prevalence of Mental Health Difficulties among the Homeless

The National Alliance to End Homelessness reported that on any given night in January 2005, 744,313 people in the United States experienced homelessness. Of those, an estimated 7,135 were living in Missouri, and of those, almost a third (an estimated 1,974 Missourians) were unsheltered and sleeping on the streets. Although the largest concentration of homeless individuals are in St. Louis City and in and around the Kansas City metropolitan area, the largest number of unsheltered homeless live in the Columbia/Boone County area, where 62% (795 individuals) of the homeless are estimated to be unsheltered on any given night. In addition, the most recent Missouri data suggests the homeless
population is growing at a rapid pace. In the three years between 1998 and 2001 there was more than a 42% increase in homelessness in Missouri, and it continues to grow (Gould et al., 2002).

There are also an estimated sixteen hundred chronically homeless Missourians. Chronic homelessness is defined by HUD, and refers to individuals who are homeless repeatedly or for long periods, and have a disability that makes it difficult for them to achieve stable housing (National Alliance to End Homelessness, 2007). Many of the chronic homeless are individuals who are experiencing disabling mental illness and substance use difficulties. Research estimates that two-thirds of those people with serious mental illness have at some point in their lives either experienced homelessness or have been at risk for homelessness (Tessler & Dennis, 1989). In addition, it has been reported that about 50% of all homeless adults with serious mental illness have a co-occurring substance use disorder (Fischer & Breakey, 1991). In 2001 it was reported that 28% of the sheltered homeless population in Missouri had a severe mental illness, 34% were addicted to drugs or alcohol, and 10% were both mentally ill and addicted (Gould et al., 2002).

**Data Sources**

The findings and recommendations are derived from a focus group conducted with homeless adults, an interview with an individual from a St. Louis homeless agency, and a literature review on mental health issues specific to homeless individuals. The focus group was conducted in the St. Louis City, with 14 homeless adults who were recruited by a local mental health agency. The participants were between 18 and 65 years old, and were recruited through local homeless shelters and community centers.
the ages of 23 and 52, with an average age of 43 years. Seventy-one percent were males and 29% were females. Fifty percent of the participants had no health insurance, 29% were on Medicaid, 7% had private insurance, and 14% indicated that they had “other” insurance. Fourteen percent (14%) were Caucasian and 64% were African-American. One individuals was Native-American (7%) and two (14%) marked their ethnicity as “other.”

**Detailed Findings: Key Themes**

**A “Road Map” for Available Services.** Many homeless individuals in the focus group said that they had little knowledge of the available services for substance use and mental health before they became homeless. Most knew of AA and NA, but had no knowledge of where to go for help with mental illness. Most reported that other homeless individuals, rather than agencies or providers, were the most helpful for telling them where to go to seek services. In addition, they expressed frustration that there was no one agency that could give them the information to get all the services (e.g. transportation, food, shelter, mental health, and substance abuse treatment) they need. Therefore, locating services and treatment within the community for homeless consumers and educating consumers, shelters, and the public about the available resources may alleviate these barriers. A similar recommendation was included in the needs assessment conducted by Rinck & Graybill (2005).

**Inaccessible Services.** Focus group members mentioned long waiting lists and wait times to access services. They mentioned that often the only way to get help was to say that they were a threat to themselves or others. Focus group members also admitted to relying on second-hand medication because of the wait and/or lack of resources for needed prescriptions. Recommendations made by Gould et al. (2002) included increasing the accessibility of public assistance programs to all impoverished individuals by making the application process more efficient, decreasing the amount of time it takes to determine a person’s eligibility, enroll impoverished individuals in all programs for which they are eligible, and ensure public assistance programs are adjusted to a reasonable standard of need. A key informant also recommended an increase in public assistant programs; specifically, increasing access to social security benefits for the homeless population. He asserted that there were two deaths in the past year that could have easily prevented if the individuals were receiving benefits so they could access the appropriate medical services.

**Ineffective Services.** Not only did the focus group members report that receiving assistance for the services they need was difficult, but they also reported that the existing services often do not address their needs. They reported that some providers will “do something” but that it isn’t usually enough to get them off the streets for good. They expressed frustration that they were placed straight into shelters, and that no one took the time to help them find the right services. One woman reported having to go to substance abuse treatment even though she never used substances, just to get services in St. Louis. Providing training (life skills, vocational rehabilitation, job training, etc.) programs that take into account individual needs was recommended by Gould et al. (2002).
Screening and Follow-up. Focus group participants reported a need for screening and follow-up services. Many homeless individuals continue to have undiagnosed mental health issues. Many homeless individuals at the focus group had seen severely mentally ill individuals slipping through the cracks and not receiving services, some of whom have become dangerous to themselves or others. Conducting more screenings for homeless individuals will increase the number of individuals diagnosed and the number of homeless individuals receiving treatment for their mental illnesses. Identifying, treating, and providing follow-up services may provide the homeless population with an opportunity for recovery and progression, especially for those individuals that have severe mental illness and/or co-occurring disorders.

Transportation. Transportation was a major issue for the focus group members. They reported that transportation by van or bus was often unreliable because of inconvenient running times, schedule conflicts, and inaccessible routes (e.g., rural locations). One man reported that he was capable of working or going back to school, but that lack of transportation was a huge barrier. Regularly providing bus passes, metro links, and/or taxi fare to homeless individuals may help elevate some of these barriers.

Double Stigma. Focus group members felt a “double stigma” due to their status as both mentally ill and homeless. They felt that people in general, including mental health providers, nurses, and police, viewed them as “lazy bums.” They felt that their mental health difficulties, combined with the stigma of being homeless, was impeding their efforts to get back on their feet. One woman reported that a treatment program used “tough love,” focusing more on the clothing she was wearing than what would help her as an individual. Focus group members reported that many providers do not care about them or what happens to them, and providers do not give them the opportunity to participate in their own treatment. Rinck & Graybill (2005) and focus group members recommended mental health training for shelter and law enforcement staff. In addition, focus group participants mentioned training for local agency providers to reduce stigma.

Housing. Focus group members, a key informant, and Gould et al. (2002) suggested an increase in affordable housing which includes an increase in stock housing and transitional housing, so that individuals have a stable environment while they are trying to secure their own housing. Gould et al. (2002) also recommended that Shelter Plus Care for permanent housing be reauthorized. In addition, Gould et al. (2002) and Rinck & Graybill (2005) suggested that housing and community based services be incorporated into public and private institutions to help individuals during the transition from public or private institutions (i.e., jails, hospitals, mental health facilities, etc.).

Shelters. Focus group members recommended an increase in the numbers of shelters, drop in centers, and beds. In addition, they reported that the rules and regulations of the shelters were too strict. Therefore, extended shelter hours would ensure consumers have access to a bed later in the evening. Several participants experienced being late (because of job obligations) and were denied a place to sleep for the night. One man stated that it was easier to say sober when he had a place to sleep at night.
**Increased Psychiatrists.** Gould et al. (2002) and the key informant suggested that incentives be provided to increase the number of psychiatrists available to work with homeless consumers.

**Prevention.** Gould et al. (2002) recommended an increase in funds to set up programs to reduce/prevent the loss of current residences. Another recommendation was that a statewide data information system be set up to monitor homelessness. In addition, focus group members suggested providing rehabilitative services and intensive community support networks to reduce homelessness. Lastly, Rinck & Graybill (2005) suggested creating prevention and intervention programs for children of homeless consumers.
Lesbian, Gay, Bi-sexual, Transgender Community

“There is a shortage of folks who work in this area.”

Summary of Findings and Recommendations

Findings and recommendations presented are derived from an interview with a registered nurse who specializes in LGBT issues as well as from literature on the topic.

- LGBT individuals with mental health issues face double stigma, the stigma associated with being LGBT and the stigma associated with having a mental health problem. Stigma exists not only among the general population but also among physical and mental health providers. Stigma reduction would improve persons in the LGBT community’s ability to access more health care, including mental health care.

- LGBT youth could benefit from mental health education and learning about resources to help educate them to know where to go if they suspect they may be suffering from a mental health issue.

- The LGBT community and the population at large could benefit from general positive public health messaging (on-line messages, magazines, TV, billboards). Public health messages could contain information regarding healthy behaviors, including substance use and safe sexual practices, mental illness, and where to go to get help for a mental illness.

- Insurance and MO Health Care coverage is a significant barrier to accessing care among LGBT individuals. There are many limitations in the current MO HealthNet system as well as with private health care insurance for LGBT individuals. It can be difficult to get psychiatric medications paid for by MO HealthNet.

Population and Prevalence of Mental Health Difficulties among Persons Who are Lesbian, Gay, Bi-sexual, and Transgender

The gay population in Missouri is growing. An estimated 161,000 gay individuals reside in Missouri, and this trend is predicted to continue to increase (Lysen, 2007). According to Huygen (2006), research indicates that gay men and lesbians are at greater risk for psychiatric morbidity than heterosexuals, but there is not a lot of literature on the topic. Huygen reports that research has indicated that bisexually-identified youth are at higher risk for suicide (Ramafedi, French, Story, Resnick, & Blum, 1998). This is similar for homosexually-oriented youth (Russell & Joyner, 2001) and for adults (Gilman, Cochran, Mays, et al., 2001). Gilman and colleagues also found that people reporting same-sex partners were more likely to experience symptoms of psychiatric problems and suicide more so than their heterosexual counterparts. Huygen acknowledges that LGBT individuals may have higher resilience due to the stresses they have to face in their daily lives.

Approximately 3-5% of the U.S. population identifies as gay or lesbian, yet up to 40% of homeless youth identify as lesbian, gay, bisexual, and/or transgender (www.thetaskforce.org/node/2114/print). LGBT youth also report experiences discrimination and harassment at shelters and service providers. Clements-
Noelle, Mars, Guzman, and Katz (2001) stated that higher rates of attempted suicide among gay youths compared with heterosexual youths may be partially due to discrimination and victimization.

**Data Sources**

Data from this section comes from a review of secondary sources and interviews with a registered nurse and medical director at a clinic that specializes in serving LGBT youth and adults.

**Detailed Findings: Key Themes**

**Access to Care and Resources.** There is a shortage of providers who specialize in LGBT issues in Missouri. The clinician we spoke with sees patients from all over the state, since there are so few providers. Not only is there limited access to care and resources, many public health messages are not directed toward LGBT individuals. There is an extreme shortage of professionals who can even take patients who can pay for services within this community, and if the consumer has no money, they have even less access to service.

**Access to Insurance.** Insurance and MO HealthNet coverage was reported as a significant barrier to accessing care among LGBT individuals. There are many limitations in the current MO HealthNet system as well as with private health care insurance for LGBT individuals.

**Stigma.** LGBT individuals with mental illness suffer from two types of stigma, both stigmatization due to sexual orientation and stigmatization due to mental illness. Members of the LGBT community may feel stigmatized at their workplace as well as in their communities. Stigma is stronger for transgender individuals who are often rejected by persons in the gay and lesbian community (personal communication, 2007).

**Training in Schools.** Diversity training for students in elementary school and high school would be helpful in fighting stigma. Public Service Announcements (PSAs) would also be useful in educating the public, and thus, reducing stigma.


Chapter Six
Substance Abuse and Mental Health Provider Agency Surveys: Consumer Needs and Resources

Background

Seventy-four mental health and substance abuse agencies completed a web-based survey designed to assess the resources of agencies and the needs of consumers of mental health and substance abuse services. While drawn from a Missouri Department of Mental Health (DMH)-contractor provider list, DMH also has contracts with other entities, including MO HealthNet, other state departments, Medicare employer-sponsored plans, etc. The majority of agencies (78%) served both persons with mental illness and substance abuse problems, 74% were primarily not-for-profit organizations, and half (50%) were located in urban areas. Approximately 74% of agencies provided out-patient services, and 54% offered case management. Approximately 13% of the sample was Non-Medicaid C-STAR and MO HealthNet providers.

Major Findings

- When asked what one change to the mental health system they would advocate for, the most common answers fell into the following categories: co-occurring disorders training and treatment, services to the under-insured, better co-ordination of services, community support services, greater consumer choice, more funding for services, and more long term care services.

- Co-occurring disorders training and treatment was the #1-ranked change for which providers said they would advocate. Many providers reported that cross training and certification of substance abuse and mental health professionals are needed, as well as better co-ordinated care for severely ill clients.

- When mental health and substance abuse agencies were asked to rate the needs for individuals with mental illness and substance use, the top five ranked needs were: transportation assistance, ongoing recovery/support services, provider co-occurring disorder training, expanded school-based mental health services, and better evaluation of persons with co-occurring disorders.

- Other highly ranked (#5-#10) needs included: residential and outpatient co-occurring treatment providers, housing and employment assistance, and early intervention.

- Overall, themes revolved around community and recovery supports, better treatment for co-occurring disorders, and early intervention as the most pressing needs.
- The majority (82%) of mental health and substance abuse agencies reported using Evidence-based Practices (EBPs), with the most commonly used EBP being Cognitive Behavior Therapies (n=49, 88% of agencies who reported using EBPs), Motivational Interviewing (n=37, 63%), and Medication Management (n=35, 61%). All were rated as “very effective” on average, strongly suggesting that other mental health and substance abuse agencies may also benefit from the use of these EBPs.

**Mental Health and Substance Abuse Survey Response**

Of the 129 substance abuse and mental health agencies asked to participate in the survey, 74 responded, a response rate of 57%. Of the agencies responding, four out of five (78%) characterized their agency as one that serves consumers with both mental illness and substance use disorders. Very few described their agency as serving only those with mental illness (10%) or only those with substance use disorders (12%).

**Agency Characteristics**

Agencies were asked basic questions regarding the type of business entity they are, their appointment availability, and the geographic areas they serve. The large majority of agencies (74%) were private, not-for-profit agencies, while 18% were for-profit. None were solo private agencies. Half serve urban areas, although there was a good representation of agencies that primarily serve rural areas as well (29%). Almost all agencies offer evening (87%) or weekend (79%) appointments.

Agencies were also given a list of agency classifications and asked to check all that apply to them. As shown below, approximately 74% of agencies provided outpatient services, and 54% offered case management. Approximately 13% of the providers were General C-STAR POS and Mo HealthNet providers.
Workforce

Most mental health and substance abuse agencies surveyed were medium or large sized agencies. The chart below shows 67% had 30 or more employees.

The agencies were also asked what types of employees they had in-house to provide services (see table next page; highest frequencies are in bold). Most agencies had at least one social worker or counselor, while a little more than half kept a psychologist or psychiatrist on staff. Paraprofessionals and case managers were the most common employees, with approximately a third of agencies employing more than 16. Physicians, nurses, and vocational counselors were least likely to be employed in house.

Agencies were also asked which professionals they contracted with to provide services. With the exception of psychiatrists (54.1% contracted with at least one psychiatrist), contracting was a relatively uncommon practice, particularly with paraprofessionals and case managers, which are commonly hired in-house. It was also relatively uncommon to contract for nurse practitioners, registered nurses, vocational/education counselors, and certified substance abuse counselors. Agencies tended to contract with professionals who may be
prohibitively expensive to keep in-house—most commonly psychiatrists, but also physicians (17.3% contracted with at least one physician), and psychologists (13.7% contracted with at least one).

### Substance Abuse and Mental Health Care Agencies

Types and Numbers of Professionals In House (n=74)

<table>
<thead>
<tr>
<th>Professionals</th>
<th>0</th>
<th>1</th>
<th>2-3</th>
<th>4-7</th>
<th>8-15</th>
<th>16+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists (n=55)</td>
<td>49.1%</td>
<td>18.2%</td>
<td>18.2%</td>
<td>10.9%</td>
<td>0.0%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Psychiatrists (n=59)</td>
<td>44.1%</td>
<td>15.3%</td>
<td>18.6%</td>
<td>10.2%</td>
<td>8.5%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Licensed clinical social workers (n=66)</td>
<td>13.6%</td>
<td>15.2%</td>
<td>21.2%</td>
<td>24.2%</td>
<td>13.6%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Licensed counselors (n=63)</td>
<td>19.0%</td>
<td>11.1%</td>
<td>14.3%</td>
<td>27.0%</td>
<td>22.2%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Paraprofessionals (n=56)</td>
<td>30.4%</td>
<td>7.1%</td>
<td>12.5%</td>
<td>8.9%</td>
<td>8.9%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Case managers (n=67)</td>
<td>25.4%</td>
<td>6.0%</td>
<td>3.0%</td>
<td>17.9%</td>
<td>11.9%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Certified substance abuse counselors (n=70)</td>
<td>18.6%</td>
<td>12.9%</td>
<td>15.7%</td>
<td>27.1%</td>
<td>15.7%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Nurse practitioners (n=53)</td>
<td>62.3%</td>
<td>13.2%</td>
<td>5.7%</td>
<td>15.1%</td>
<td>1.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Registered nurses (n=67)</td>
<td>33.8%</td>
<td>20.6%</td>
<td>22.1%</td>
<td>7.4%</td>
<td>10.3%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Licensed practical nurses (n=59)</td>
<td>49.2%</td>
<td>18.6%</td>
<td>15.3%</td>
<td>10.2%</td>
<td>3.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>General practitioner physicians (n=56)</td>
<td>76.8%</td>
<td>14.3%</td>
<td>0.0%</td>
<td>3.6%</td>
<td>3.6%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Vocational/education counselors (n=55)</td>
<td>69.1%</td>
<td>10.9%</td>
<td>5.5%</td>
<td>7.3%</td>
<td>1.8%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

### Sources of Consumer Funding

Agencies were asked to identify the funding sources from which consumer services are paid. If an agency specialized in consumers receiving a certain type of funding, they were also asked to choose the “Specialize” box. Almost all agencies reported that their consumers receive funding from the DMH (61 agencies, 88% of those who responded to the question), an unsurprising finding given that the agencies were chosen from a list of DMH contracted providers. Self-pay and sliding scale payments were also commonly reported sources of funding. Other sources of funding included grants, the Children’s Division, and mental health tax levees (see chart below).
Consumer Characteristics

Agencies were asked various questions with the goal of understanding the populations they serve. Agencies were not only asked whether they served consumers with particular characteristics, but they were also asked to check “Specialize” if they specialized in serving that type of consumer.

Demographic Characteristics

The ages served by agencies are shown at right. Almost all agencies served adults, and approximately half served children and adolescents. The least commonly served group was children under the age of 5 years.
old. The most common age specialization was adolescents aged 13-17. Very few agencies who responded to the survey specialized in elderly adults. Agencies were also asked what genders they served. Almost all agencies served both males and females with the exception of two agencies: one only served females and one only served males. Four agencies (4.9%) reported specializing in serving males and seven agencies (8.6%) specialized in serving women.

**Cultural Characteristics**

*Ethnicity/Race/Sexual Orientation*

We were interested in knowing not only the cultural characteristics of the population, but also to what extent the treatment staff shares the cultural background of the treatment population. “Cultural” was broadly defined as ethnicity, gender, age, and sexual orientation. As shown in the chart at right, approximately 80% of agencies reported that Caucasian clients make up more than 20% of their clientele. About 50% reported that African-American individuals were more than 20% of their clientele. In terms of treatment staff, a large majority of agencies (70%) reported that around 75% or more of their treatment staff shares the cultural background of the individuals seeking treatment. About 17% of agencies reported that around 25% or less of their treatment staff shares the cultural background of the clientele.

Agencies were also asked about the languages their programs can support. The most commonly supported language was Spanish (n=24, about 1/3 of agencies). No other language was commonly offered. Several agencies (n=9)
reported contracting out for language interpretation/translation services as needed.

**Physical/Sensory Impairment**

Mental health and substance abuse agencies were asked if they serve individuals with specific impairments, and if they specialize in serving any particular population with various sensory and physical impairments. Results indicate that agencies are more likely to serve individuals with mobility impairments than sensory impairments. Almost three out of four agencies serve individuals with mobility impairments versus approximately 60% that serve the deaf or hard of hearing. While the deaf and hard of hearing were served by the lowest number of agencies overall, three agencies specialized in serving that population. There were no agencies that specialized in serving individuals with speech, visual, or mobile impairments specifically. Nonetheless, a majority of agencies reported serving those populations.

**Agency Services**

Agencies were given a large list of services, and asked which ones they offer on-site and by referral. For purposes of presentation, services are divided into several categories: Psychological Services, Addiction/Substance Abuse Services, Educational and Vocational Services, Medical Services, Social Services, Prevention Services, and Other Support Services.

**Psychiatric Services**

Psychiatric services included basic mental health services such as therapy, support groups, psychological assessment, and psychotropic medication. The results are shown in the chart below. Of the 74 substance abuse and mental health care agencies surveyed, most (85% and 84% respectively) offered individual and group counseling or therapy on-site, and most of those who did not offered referrals to therapy. The least commonly offered service on site was psychological testing – 13 sites did not even offer it by referral. Home-based treatment and psychiatric assessment were also uncommonly offered on-site, and several agencies did not offer them even by referral.
Addiction/Substance Abuse Services

As is shown in the chart below, most, but not all, mental health and substance abuse agencies offer some kind of substance abuse screening for their consumers. Most of the other services are offered either on-site or by referral.
**Educational and Vocational Services**

Most sites (about two thirds) offer vocational services upon referral only. Vocational counseling and tutoring were the most commonly offered on-site services, offered by 24% and 30% of sites, respectively. Vocational job training, job placement, and vocational testing were offered on-site by about 18% of sites.

**Social Services**

The majority of sites offered parent training, life skills training, recreational services, and community support services on-site. Housing and transportation assistance were offered on-site by less than half of all sites. Day care was offered least, with 47 out of 74 sites (64%) offering it either on-site or by referral.

![Social Services Offered (n=74)](image)

**Prevention Services**

It was common for sites to offer substance abuse education, suicide prevention education, social skills training, and screening on-site. Approximately one-third of sites offered prevention programming in or after school. Very few sites offered mentoring on site.

**Medical Services**

Sites were asked what kind of medical services they offered to their consumers. Approximately 26% of sites (20 sites) offered on-site medical exams upon admission, 46% (34 sites) through referral, and 23% (17 sites) did not offer them at all. Fifteen sites (20%) offered an annual medical exam on site, 39 (53%) offered them through referral, and 15 (20%) did not offer them at all.
Other Support Services

Thirty-five sites (46%) offered psychosocial rehabilitation on-site, and 20 (27%) offered it through referral. Benefit acquisition assistance was offered on-site by 32 (43%) sites, school-based services were offered by 26 (35%) sites, children services were offered on-site by 32 (43%) sites, faith-based services were offered by 9 (12%) sites, and legal services were offered on site by 6 (8%) sites—(5 offered both legal advocacy and legal service counseling and 1 offered legal service counseling only).

Agency Ranking of Needs

Ranking of Needs of Individuals with Mental Illness/Substance Use Disorders

Substance abuse and mental health agencies were asked what they felt were the strongest needs of individuals with mental illness and substance use disorders. “Strength of Need” was determined through use of response options on a Likert Scale, where 1 = “No need at all” and 4 = “Critical need.” The mean of all respondents’ answers was taken to get the strength of need for that question. Respondents had a tendency to rate all needs as “High Need. The following needs emerged as being most critical (list is not rank ordered because many needs were found to be identically strong.

- Single point of entry into system
- Transportation assistance/more transportation
- Ongoing recovery/support services
- Provider co-occurring disorder training
- Residential co-occurring treatment providers
- Expanded school-based mental health services
- Housing assistance
- Employment assistance
- Better evaluation of persons with co-occurring disorders
- Outpatient co-occurring treatment providers

Respondents also had an opportunity to list other needs if they didn’t see it on our list. The most commonly listed other needs include medical detoxification, prevention programs, more staff (and not more agencies), more child psychiatrists, and co-occurring treatment services.
### Mental Health and Substance Abuse Agency Ratings of Needs of Individuals with Mental Illness and Substance Use Disorders (n=74)

<table>
<thead>
<tr>
<th>Service</th>
<th>No Need At All</th>
<th>Low Need</th>
<th>High Need</th>
<th>Critical Need</th>
<th>Don’t Know</th>
<th>Strength of Need (1-4 Scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single point of entry into system</td>
<td>12.9%</td>
<td>17.1%</td>
<td>30.0%</td>
<td>25.7%</td>
<td>14.3%</td>
<td>3.82</td>
</tr>
<tr>
<td>More available transportation</td>
<td>1.5%</td>
<td>8.8%</td>
<td>30.9%</td>
<td>57.4%</td>
<td>1.5%</td>
<td>3.47</td>
</tr>
<tr>
<td>Transportation Assistance</td>
<td>1.4%</td>
<td>7.2%</td>
<td>40.6%</td>
<td><strong>47.8%</strong></td>
<td>2.9%</td>
<td><strong>3.40</strong></td>
</tr>
<tr>
<td>Ongoing recovery/support services</td>
<td>0.0%</td>
<td>7.1%</td>
<td><strong>51.4%</strong></td>
<td>38.6%</td>
<td>2.9%</td>
<td>3.33</td>
</tr>
<tr>
<td>Provider co-occurring disorder training</td>
<td>1.5%</td>
<td>10.3%</td>
<td>39.7%</td>
<td>42.6%</td>
<td>5.9%</td>
<td>3.31</td>
</tr>
<tr>
<td>Expanded school-based mental health services</td>
<td>2.9%</td>
<td>4.3%</td>
<td>43.5%</td>
<td>34.8%</td>
<td>14.5%</td>
<td>3.30</td>
</tr>
<tr>
<td>Residential co-occurring treatment providers</td>
<td>1.5%</td>
<td>11.8%</td>
<td>39.7%</td>
<td>39.7%</td>
<td>7.4%</td>
<td>3.30</td>
</tr>
<tr>
<td>Housing assistance</td>
<td>1.4%</td>
<td>7.2%</td>
<td>50.7%</td>
<td>36.2%</td>
<td>4.3%</td>
<td>3.28</td>
</tr>
<tr>
<td>Employment assistance</td>
<td>1.4%</td>
<td>7.2%</td>
<td>52.2%</td>
<td>36.2%</td>
<td>2.9%</td>
<td>3.28</td>
</tr>
<tr>
<td>Better evaluation of persons with co-occurring disorders</td>
<td>1.5%</td>
<td>4.4%</td>
<td>55.9%</td>
<td>35.3%</td>
<td>2.9%</td>
<td>3.28</td>
</tr>
<tr>
<td>Outpatient co-occurring treatment providers</td>
<td>1.5%</td>
<td>7.5%</td>
<td>55.2%</td>
<td>32.8%</td>
<td>3.0%</td>
<td>3.23</td>
</tr>
<tr>
<td>Early intervention/screening</td>
<td>1.5%</td>
<td>7.4%</td>
<td>47.1%</td>
<td>26.5%</td>
<td>17.6%</td>
<td>3.21</td>
</tr>
<tr>
<td>Self-help/support groups specific to co-occurring disorders</td>
<td>1.5%</td>
<td>10.3%</td>
<td>48.5%</td>
<td>32.4%</td>
<td>7.4%</td>
<td>3.20</td>
</tr>
<tr>
<td>Public awareness/education</td>
<td>0.0%</td>
<td>5.6%</td>
<td>66.2%</td>
<td>22.5%</td>
<td>2.8%</td>
<td>3.19</td>
</tr>
<tr>
<td>Transitional services (inpatient to outpatient)</td>
<td>1.4%</td>
<td>5.8%</td>
<td>58.0%</td>
<td>26.1%</td>
<td>8.7%</td>
<td>3.19</td>
</tr>
<tr>
<td>Substance abuse education services</td>
<td>2.9%</td>
<td>7.2%</td>
<td>49.3%</td>
<td>27.5%</td>
<td>13.0%</td>
<td>3.18</td>
</tr>
<tr>
<td>Inpatient co-occurring treatment providers</td>
<td>1.5%</td>
<td>17.6%</td>
<td>33.8%</td>
<td>36.8%</td>
<td>10.3%</td>
<td>3.18</td>
</tr>
<tr>
<td>Residential treatment programs</td>
<td>0.0%</td>
<td>14.1%</td>
<td>47.9%</td>
<td>32.4%</td>
<td>5.6%</td>
<td>3.17</td>
</tr>
<tr>
<td>Fewer days from initial contact until appointment</td>
<td>4.3%</td>
<td>7.2%</td>
<td>59.4%</td>
<td>27.5%</td>
<td>1.4%</td>
<td>3.12</td>
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<tr>
<td>Medication monitoring</td>
<td>1.4%</td>
<td>11.6%</td>
<td>40.6%</td>
<td>23.2%</td>
<td>23.2%</td>
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<tr>
<td>Transitional support (adolescent to adult system)</td>
<td>1.4%</td>
<td>13.0%</td>
<td>43.5%</td>
<td>24.6%</td>
<td>17.4%</td>
<td>3.11</td>
</tr>
<tr>
<td>Inpatient treatment programs for children</td>
<td>1.4%</td>
<td>12.9%</td>
<td>40.0%</td>
<td>22.9%</td>
<td>22.9%</td>
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<td>Detox Services</td>
<td>2.8%</td>
<td>14.1%</td>
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<td>26.8%</td>
<td>8.5%</td>
<td>3.09</td>
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<tr>
<td>Family support groups</td>
<td>1.4%</td>
<td>8.7%</td>
<td>62.3%</td>
<td>18.8%</td>
<td>8.7%</td>
<td>3.08</td>
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<tr>
<td>Youth social skills development services</td>
<td>1.4%</td>
<td>7.2%</td>
<td>58.0%</td>
<td>15.9%</td>
<td>17.4%</td>
<td>3.08</td>
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<tr>
<td>Inpatient treatment programs for adults</td>
<td>2.8%</td>
<td>15.5%</td>
<td>49.3%</td>
<td>26.8%</td>
<td>5.6%</td>
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<td>Additional psychiatrists</td>
<td>5.8%</td>
<td>18.8%</td>
<td>33.3%</td>
<td><strong>36.2%</strong></td>
<td>5.8%</td>
<td><strong>3.06</strong></td>
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<tr>
<td>Childcare during treatment</td>
<td>1.4%</td>
<td>12.9%</td>
<td>57.1%</td>
<td>20.0%</td>
<td>8.6%</td>
<td>3.06</td>
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<tr>
<td>Inpatient beds</td>
<td>1.4%</td>
<td>20.3%</td>
<td>33.3%</td>
<td>26.1%</td>
<td>18.8%</td>
<td>3.04</td>
</tr>
</tbody>
</table>
If you were to advocate for one change to the mental health care system, what would it be?

In order to further assess the needs of substance abuse and mental health agencies, respondents were asked to describe what change they would advocate for if they could only choose one issue. Sixty-nine individuals responded to the question. Analysis of the responses indicates that answers revolved around several key issues.

**Co-occurring Disorders (n=12)**

The number one change requested by respondents (12 individuals) was to improve services for individuals with co-occurring disorders. Several providers felt that cross training and certification of mental health and substance abuse providers are needed. Providers reported that there are not enough places to refer co-occurring clients, and that care for these individuals is not coordinated well. One provider felt

---

“One change needed in the mental health system is cross training and certification of ADA professionals and CPS professionals.”

-- Mental Health/Substance Abuse Agency Respondent
that the CPR service menu should include reimbursement for services provided to consumers with co-occuring disorders, and another person mentioned blending funding streams. Lack of housing and inpatient treatment for these individuals was also a concern.

**Services to Under-insured (n=10)**

Providers see a great need for DMH to make mental health services accessible for individuals who are under-insured or without insurance. Many of these suggestions focused on expanding MO HealthNet coverage beyond current levels. In addition, providers felt that their rates should increase and that benefits under MO HealthNet should be broadened.

> “Make mental health/psychiatric treatment services more available for the “walking wounded” those without a serious mental illness, without Medicaid or some other form of health insurance but who have a mental illness that makes their chances of sustained recovery from AOD disorders more challenging.”
>
> -- Mental Health/Substance Abuse Agency Respondent

**Coordination of Services (n=8)**

Related to the issue of co-occurring disorders, providers believe that services between DMH divisions and between state departments need to be better coordinated. A few providers suggested this could be done by integrated treatment planning between divisions, and one person suggested that the Division of Alcohol and Drug Abuse (ADA) and the Division of Comprehensive Psychiatric Services (CPS) be combined. Another felt that each consumer should have only one caseworker arranging and coordinating all their care.

**Community Supports (n=5)**

A number of providers recommended that more community supports be available to consumers so that they might have access to affordable transportation, employment, and housing. One individual felt that the mental health service community should be more involved in community organizations such as churches.

**More Consumer Choice/Consumer Driven (n=6)**

Providers felt that consumers should have greater choice and say in their own care. Some providers suggested a more flexible use of treatment dollars to enable them to better individualize treatment.

> “Allow the providers that have good outcomes and who consistently provide quality services to expand those services so that all consumers have a choice as to who provides their services and funding to drive those services. Level the playing field among the CMHC and the affiliates.”
>
> -- Mental Health/Substance Abuse Agency Respondent
More In-patient and Residential Care (n=5)

A number of providers recommended that more in-patient and residential beds be made available for the seriously mentally ill. One individual suggested that the system should move from an acute care model to a chronic care model with funding for long-term support.

Other Suggestions

There were a number of other suggestions given by mental health and substance abuse agency respondents that did not fall into the above categories. Among those, the most common were a desire to localize and privatize services (or increase collaboration with private agencies) and a desire for more money for prevention. Other suggestions included more psychiatrists, better integration of physical and mental health, parity for mental health and substance abuse, shorter waiting lists, and an increase in reimbursement rates to providers.

Effectiveness and Use of Evidence-Based Practices by Mental Health and Substance Abuse Agencies

All agencies were asked if they used EBPs in their facilities. Of the 68 mental health and substance abuse agencies that responded to the question, 82% reported that they use EBPs (for a total of 56 agencies). Agencies were also asked whether they use various selected EBPs, and if so, to rate their effectiveness. The list of EBPs, shown below, was based on a list developed by Washington State, and modified by researchers at the Missouri Institute of Mental Health (MIMH) with assistance from DMH. MIMH researchers reviewed prevention literature and added various prevention EBPs not on the original list. In addition, EBPs of interest to DMH were added.

The table below shows all EBPs used by five or more agencies, and their ratings. Of the 47 EBPs agencies could choose from, five or more agencies used 32 (65%) of the EBPs listed. The most commonly used EBPs were Cognitive Behavior Therapies (n=49, 88% of agencies using EBPs), Life Skills Training (n=38, 68%), Motivational Interviewing (n=37, 63%), and Medication Management (n=35, 61%). As can also be seen in the table, each EBPs was also given a number meant to indicate its “effectiveness,” as judged by agency respondents. Effectiveness was determined by putting the response options on a Likert Scale, where 1 = “A little effective” and 4 = “Extremely effective.” The mean of all respondents’ answers was taken to get the overall effectiveness for that EBP. The resulting number allowed a ranking as to which EBPs were rated as most and least effective by the agencies that use them. A number of EBPs were used by very few agencies, so their ratings may be a less reliable indicator of effectiveness in MR/DD agencies than those with more agencies using them. Furthermore, the fact that an EBP is used by a large number of agencies may, in some cases, be a testament to its success with the MR/DD population. In fact, the two most commonly used EBPs, Cognitive Behavior Therapies and Motivational Interviewing, were among the highest rated EBPs as well. The top three rated EBPs were Trauma Recovery and Empowerment Treatment (TREM; n=6), Supported Employment (n=17), and Cognitive Behavior Therapies (n=49).
### Effectiveness and Use of Selected Evidenced Based Practices by Mental Health and Substance Abuse Agencies (n=56)

<table>
<thead>
<tr>
<th>Practice</th>
<th>Number who Offer EBP</th>
<th>A Little Effective</th>
<th>Somewhat Effective</th>
<th>Very Effective</th>
<th>Extremely Effective</th>
<th>Overall Effectiveness of EBP (1-4 Scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression Replacement Training</td>
<td>10</td>
<td>20.0%</td>
<td>40.0%</td>
<td>40.0%</td>
<td>0.0%</td>
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<td>Assertive Community Treatment (ACT/PACT)</td>
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<td>30.0%</td>
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<td>Behavioral Treatment for Substance Abuse in Schizophrenia</td>
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<td>10.0%</td>
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<tr>
<td>Big Brothers/Big Sisters</td>
<td>5</td>
<td>20.0%</td>
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<td>60.0%</td>
<td>0.0%</td>
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<td>Brief Strategic Family Therapy</td>
<td>22</td>
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<td>Cognitive Behavior Therapies (CBT)</td>
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<td>18.4%</td>
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<td>Contingency Management (co-occurring)</td>
<td>17</td>
<td>5.9%</td>
<td>35.3%</td>
<td>35.3%</td>
<td>23.5%</td>
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<td>Dialectical Behavioral Therapy (DBT)</td>
<td>16</td>
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<td>31.3%</td>
<td>37.5%</td>
<td>18.8%</td>
<td>2.62</td>
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<td>Family Psycho education</td>
<td>24</td>
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<td>12.5%</td>
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<td>Functional Family Therapy</td>
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<td>52.9%</td>
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<td>Illness Self-Management/Illness Management and Recovery</td>
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<td>14.3%</td>
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<td>42.9%</td>
<td>0.0%</td>
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<td>Integrated Dual Diagnosis Treatment</td>
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<td>Interpersonal Therapy</td>
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<td>Life Skills Training</td>
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<td>Medication Management</td>
<td>35</td>
<td>2.9%</td>
<td>25.7%</td>
<td>48.6%</td>
<td>22.9%</td>
<td>2.91</td>
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<td>Motivational Enhancement Therapy (MET)</td>
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<td>Multi-Family Group Treatment (MFG)</td>
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<td>80.0%</td>
<td>0.0%</td>
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</tr>
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<td>Multidimensional Family Therapy</td>
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<td>20.0%</td>
<td>40.0%</td>
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<td>Multi-systemic Therapy</td>
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<td>7.7%</td>
<td>46.2%</td>
<td>30.8%</td>
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</tr>
<tr>
<td>Parent-Child Interaction Therapy</td>
<td>12</td>
<td>8.3%</td>
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<td>58.3%</td>
<td>8.3%</td>
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<td>Peer Support</td>
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<td>45.8%</td>
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<td>Person Centered Planning (PCP)</td>
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<td>8.3%</td>
<td>75.0%</td>
<td>8.3%</td>
<td>2.83</td>
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<td>Positive Behavior Supports</td>
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<td>64.7%</td>
<td>17.6%</td>
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<tr>
<td>Promoting Alternative Thinking Strategies (PATH)</td>
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<td>0.0%</td>
<td>33.3%</td>
<td>66.7%</td>
<td>2.67</td>
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<tr>
<td>Seeking Safety: A Psychotherapy for Trauma/PTSD and Substance Abuse</td>
<td>11</td>
<td>9.1%</td>
<td>27.3%</td>
<td>45.5%</td>
<td>18.2%</td>
<td>2.73</td>
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<td>Signs of Suicide (SOS)</td>
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<tr>
<td>Strengthening Families Program (SFP)</td>
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<td>42.9%</td>
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<td>Supported Employment</td>
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<td>Supported Housing</td>
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<td>Therapeutic Foster Care</td>
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<td>28.6%</td>
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<tr>
<td>Trauma Recovery and Empowerment Treatment (TREM)</td>
<td>6</td>
<td>16.7%</td>
<td>0.0%</td>
<td>50.0%</td>
<td>33.3%</td>
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Chapter Seven
Mental Retardation/Developmental Disabilities Provider Agency Survey

Background

One hundred and eleven Department of Mental Health (DMH)-contracted MR/DD agencies completed a web-based survey designed to assess the resources of the Division of Mental Retardation/Developmental Disabilities (MR/DD) agencies and the needs of consumers of MR/DD services. The agencies were primarily not-for-profit organizations, and almost half (44%) were located in rural areas. The most commonly offered services on-site were social skills training (68%), life skills training (66%), community supports (66%), recreation (64%), transportation (61%), and medication monitoring (46%).

Major Findings

- When asked what one change to the mental health system they would advocate for, the most common answers fell into the following categories: improved financing, better coordination and consistency of services, consumer-driven care, better pay for providers and staff, community support services, and psychiatric services.
- Overall, there was a strong feeling among agency respondents that the relationship between DMH and community providers needed to be improved. Respondents felt that lack of clarity regarding regulations and expectations, bureaucratic red tape, and lack of consistency between regional centers was severely limiting their ability to provide quality consumer-driven care.
- The highest ranked needs for individuals with mental retardation/developmental disabilities were housing, behavior management services, transportation, and employment.
- Housing is perhaps one of the most important issues for those who serve individuals with mental retardation/developmental disabilities. The #1 need as reported by agencies was shorter waiting lists for housing, and second ranked need was affordable housing (tied for #2).
- There is also a very high need for behavior management services, a need tied with affordable housing as second most critical.
- Although transportation was offered by 61% of agencies (indicating that some need is being met), they still reported a need for more convenient (#4) and affordable transportation (ranked #8) for those with mental retardation/developmental disabilities. Handicapped accessible public transportation was ranked #9.
- Employment came up many times on the list of needs. Agencies reported that those with mental retardation/developmental disabilities need more employment opportunities (#6) and better paying jobs (#7). More employment supports was also a highly ranked need (#10).
- Slightly more than half (56%) of MR/DD agencies reported using Evidence-based Practices (EBPs), with the most commonly used EBP being Positive Behavior Supports (n=49, 89% of agencies who reported using EBPs) and Person Centered Planning (n=47, 85%). Both were rated...
as “very effective” on average, strongly suggesting that other MR/DD agencies may also benefit from the use of these EBPs.

**MR/DD Survey Response**

Of the 808 MR/DD agencies asked to participate in the survey, 124 unique agencies responded, a response rate of 15%. Only surveys that were more than 25% complete were included in our analyses, resulting in completed surveys from 111 unique agencies, 14% of all MR/DD agencies contacted to participate. Of the 111 completed agency surveys, 18% reported that they served mental illness in addition to mental retardation/developmental disabilities, and 18% served both substance use disorders and mental illness in addition to mental retardation/developmental disabilities.

**MR/DD Agency Type, Availability, and Geographic Area Served**

Agencies were asked basic questions regarding the type of agency they consider themselves, their appointment availability, and the geographic areas they serve (see results below). About half of the agencies (52%) were private not-for-profit agencies. Almost half serve rural (44%) areas, and surprisingly few cities and suburban areas. It is unclear whether this is due to a concentration of DMH contracted MR/DD agencies in rural areas or a response bias that resulted in a stronger response from rural areas. It may also be that there are fewer, larger facilities in urban areas, and a larger quantity of smaller, independent agencies in rural areas. A large majority of agencies reported offering evening (80%) or weekend (75%) appointments.

**MR/DD Agency Characteristics**

Agencies were also given a list of classifications and asked to check all that apply to them. About a third of the agencies were group homes, independent supported living (ISL), and/or offered community support. Approximately 14% of the MR/DD sample offered case management. Respondents were also asked to list any classifications that were not on the list. Commonly stated classifications included day
habilitation programs (12 agencies), recreation services (5 agencies), supported employment (5 agencies), transportation (4 agencies), Senate Bill 40 Board (4 agencies), foster home (3 agencies), and respite (3 agencies).

**MR/DD Agency Workforce**

About half of MR/DD agencies surveyed were medium or large sized agencies. As is shown below, 49% had 30 or more employees. The majority (51%) were small to medium sized agencies, with 14% having 1 to 4 employees.

The agencies were also asked what types of employees they had in-house to provide services. Of the 111 agencies, very few had psychiatrists (less than 1% employed at least one in-house), nurse practitioners (less than 1%), physicians (less than 1%), psychologists (2%), certified substance abuse counselors (2.7%), vocational/educational counselors (4.5%) or licensed professional counselors (5.4%). The majority of employees were registered nurses (57% employed at least one in-house), case managers (28%), licensed practical nurses (22%), paraprofessionals (19%), or social workers (14%).

In general, contracting for professionals was not a popular practice among MR/DD providers. The most common professionals were registered nurses (23% agencies contracted with at least one) and case managers (12%). It was more common for MR/DD agencies to contract with professionals such as physicians (12% contracted with at least one), psychiatrists (11%), psychologists (7%), licensed professional counselors (6%), and nurse practitioners (6%) than to employ them in house.

**MR/DD Agency Sources of Consumer Funding**

 Agencies were asked to choose the sources from which their consumers pay for services. If they specialized in a consumer receiving a certain type of funding, they were also asked to choose the “Specialize” box. Almost all agencies reported that their consumers receive funding from DMH (101 agencies, 91% of all agencies), an unsurprising finding given that the agencies were chosen from a list of DMH contracted providers. Self-pay and sliding scale payments were also commonly reported sources of funding. Other common sources of funding included tax levees (8), SB40 boards (5), and DESE (7).
**MR/DD Agency Consumer Characteristics**

Agencies were asked various questions with the goal of understanding the populations they serve. Agencies were not only asked whether they served consumers with particular characteristics, but they were also asked to check “Specialize” if they specialized in serving that type of consumer.

**Demographic Characteristics**

The ages served by the agencies are shown in the figure below. Almost all agencies served adults, and approximately half served children and adolescents. The least commonly served group was children under the age of six years, followed closely by those aged 7-12. The most common age specialization was adolescents aged 13-17. Almost all agencies served adults, both younger adults (e.g., transitional youth) and older adults (aged 55-64), although fewer served the elderly. Agencies were also asked what genders they served. Almost all agencies served both males and females; six agencies specialized in serving females and five specialized in males.
Cultural Characteristics

We were interested in knowing not only the cultural characteristics of the population, but also to what extent the treatment staff shares the cultural background of the treatment population. “Cultural” was broadly defined as ethnicity, gender, age, and sexual orientation. Approximately 85% of agencies reported that Caucasian clients make up more than 20% of their clientele. About a third reported that African-American individuals were more than one fifth of their clientele, and 8% reported that Hispanics consisted of more than 20% of their clientele. In terms of treatment staff, the pie chart below shows that a large majority of agencies (78%) reported that around 75% or more of their treatment staff shares the cultural background of the individuals seeking treatment. Only 8% of agencies reported that around 25% or less of their treatment staff shares the cultural background of the clientele.

Agencies were also asked about the languages their programs can support. The most commonly supported languages were American Sign Language (9 agencies) and Spanish (5 agencies). German, French, & Bosnian were each supported by one agency. Five agencies reported that they can support any language through contracted interpreters.
Physical/Sensory Impairment

MR/DD agencies were asked if they serve individuals with specific impairments, and if they specialize in serving any particular population with various sensory and physical impairments. Results (see chart below) indicate that almost all MR/DD agencies serve individuals with various impairments. Fewer report specializing in serving those populations.

MR/DD Agencies that Clients with Physical or Sensory Impairments (n=111)

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Yes</th>
<th>No</th>
<th>Specialize</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaf/Hearing Impaired</td>
<td>87</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>Blind/Visually Impaired</td>
<td>82</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Speech Impaired</td>
<td>101</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Mobility Impaired</td>
<td>92</td>
<td>14</td>
<td>2</td>
</tr>
</tbody>
</table>

MR/DD Agency Services Offered

Agencies were given a long list of services, and asked which ones they offer on-site and by referral. For purposes of this report, services are divided into several categories: Psychological Services, Addiction/Substance Abuse Services, Educational and Vocational Services, Medical Services, Social Services, Prevention Services, and Other Support Services.

Psychiatric Services

Of the 111 MR/DD agencies surveyed, the most commonly offered service on-site was medication monitoring (46%), followed by home-based treatment (34%). Individual therapy, psychiatric assessment, psychological testing, and psychotropic medication were commonly offered through referral. About half of the sites could offer most services through referral. Outreach, family therapy, and group therapy were the least often offered services.
Addiction/Substance Abuse Services

Substance abuse screening and other addiction services were generally not offered on-site. About one-third to one-half of sites could give referrals if needed.

Educational and Vocational Services

Sheltered workshops, supervised on-site job placement, and job placement were offered either on-site or through referral by the majority (about two-thirds) of MR/DD agencies. Tutoring/homework assistance and supervised on-site job placement services were the most commonly offered on-site educational and vocational services (offered on-site by about 20% of agencies), although tutoring/homework assistance was not commonly available through referral if it was not offered on-site (only a quarter of sites offered it through referral). Overall, special education, GED/college preparation, and tutoring/homework assistance were the least commonly available services, with about half of MR/DD agencies not offering those services on-site or through referral.

Social Services

Social services were among the most common on-site services offered, with the majority of sites offering life skills training, recreational services, transportation services, and community support services on-site. Housing assistance was offered on-site by less than one-third of all sites. Day care and parent training were offered least.
Prevention Services

It was common for sites to offer social skills training, with more than two-thirds (n=76, 68%) offering it on-site. About a third of sites offered other kinds of prevention services either on-site or, more commonly, through referral.

Medical Services

Sites were asked what kind of medical services they offered to their clients. Approximately 7% of sites (8) offered on-site medical exams upon admission, 44% (50 sites) upon referral, and 44% (50) did not offer them at all. Seven sites (6%) offered an annual medical exam on-site, 54 (47%) offered them on referral, and 48 (42%) did not offer them at all.

Other Support Services

Fifteen sites (13%) offered psychosocial rehabilitation on-site and 39 (34%) offered it through referral. Benefit acquisition assistance was offered on-site by 16 (14%) sites, school-based services were offered by 8 (7%) sites, children services were offered on-site by 16 (14%) sites, faith-based services were offered by 16 (14%) sites, and legal services were offered on-site by three (2.6%) sites (1 offered legal service counseling and 3 offered legal advocacy).

Sites were also asked to list any services they offer that were not on the list. MR/DD agencies offer a wide array of services to those with mental retardation and developmental disabilities. Commonly listed services offered included the following: independent supported living (ISL), residential rehabilitation,
day habilitation, respite, recreation, community integration, personal care assistance, and 24-hour nursing care.

**MR/DD Ranking of Needs**

Ranking of Needs of Individuals with Mental Retardation/Developmental Disabilities

MR/DD agencies were asked what they felt were the strongest needs of individuals with mental retardation and developmental disabilities. See the table on page 17 for a list of all needs and their calculated strength. “Strength of Need” was determined through response options on a Likert Scale, where 1 = “No need at all” and 4 = “Critical need.” The mean of all respondents’ answers was taken to get the strength of need for that question. Respondents had a tendency to rate all needs as “High Need” so the strength of the need was calculated so that the needs could be ranked.

*The top ranked needs were:*

- Shorter waiting lists for housing.
- Behavior management services (tied with #3).
- Affordable housing (tied with #2).
- More convenient transportation. (tied with #5 and #6)
- Handicapped accessible housing. (tied with #4 and #6)
- More employment opportunities. (tied with #4 and #5)
- Better paying employment opportunities.
- More affordable transportation.
- Handicapped accessible public transportation.
- More employment supports.

The list primarily includes needs for affordable, handicapped accessible housing and transportation, behavior management services, and an increase in better paying employment opportunities. Respondents also had an opportunity to list other needs if they didn’t see it on our list. The most commonly listed other needs included dental services, consistency between regional centers, and more housing choices.
### MR/DD Providers Ratings of Needs (n=111)

<table>
<thead>
<tr>
<th></th>
<th>No Need At All</th>
<th>Low Need</th>
<th>High Need</th>
<th>Critical Need</th>
<th>Don’t Know</th>
<th>Strength of Need (1-4 Scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public MR/DD education/awareness</td>
<td>0.9%</td>
<td>21.3%</td>
<td>55.6%</td>
<td>17.6%</td>
<td>4.6%</td>
<td>2.96</td>
</tr>
<tr>
<td>Adult day programming services</td>
<td>3.7%</td>
<td>19.3%</td>
<td>46.8%</td>
<td>23.9%</td>
<td>6.4%</td>
<td>2.97</td>
</tr>
<tr>
<td>Early intervention services</td>
<td>4.7%</td>
<td>11.3%</td>
<td>52.8%</td>
<td>15.1%</td>
<td>16.0%</td>
<td>2.93</td>
</tr>
<tr>
<td>Employment support</td>
<td>2.8%</td>
<td>17.6%</td>
<td>52.8%</td>
<td>21.3%</td>
<td>5.6%</td>
<td>2.98</td>
</tr>
<tr>
<td>Individualized education supports</td>
<td>1.9%</td>
<td>19.6%</td>
<td>53.3%</td>
<td>11.2%</td>
<td>14.0%</td>
<td>2.85</td>
</tr>
<tr>
<td>Available/affordable recreation activities</td>
<td>2.7%</td>
<td>20.7%</td>
<td>53.2%</td>
<td>18.9%</td>
<td>4.5%</td>
<td>2.94</td>
</tr>
<tr>
<td>Available/affordable physical care</td>
<td>3.8%</td>
<td>24.5%</td>
<td>47.2%</td>
<td>17.9%</td>
<td>3.8%</td>
<td>3.00</td>
</tr>
<tr>
<td>Case Management</td>
<td>10.4%</td>
<td>31.1%</td>
<td>44.3%</td>
<td>8.5%</td>
<td>5.7%</td>
<td>2.55</td>
</tr>
<tr>
<td>Counseling Services</td>
<td>5.7%</td>
<td>23.6%</td>
<td>44.3%</td>
<td>16.0%</td>
<td>10.4%</td>
<td>2.81</td>
</tr>
<tr>
<td>Qualified MR/DD service providers</td>
<td>5.6%</td>
<td>29.0%</td>
<td>40.2%</td>
<td>19.6%</td>
<td>5.6%</td>
<td>2.76</td>
</tr>
<tr>
<td>Additional MR/DD providers/staff/sites</td>
<td>8.7%</td>
<td>28.8%</td>
<td>33.7%</td>
<td>19.6%</td>
<td>5.6%</td>
<td>2.70</td>
</tr>
<tr>
<td><strong>Access Needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordable transportation</td>
<td>1.8%</td>
<td>22.0%</td>
<td>37.6%</td>
<td>32.1%</td>
<td>6.4%</td>
<td>3.09</td>
</tr>
<tr>
<td>More convenient transportation services</td>
<td>2.8%</td>
<td>17.4%</td>
<td>36.7%</td>
<td>34.9%</td>
<td>8.3%</td>
<td>3.14</td>
</tr>
<tr>
<td>Handicapped accessible public transportation</td>
<td>1.9%</td>
<td>21.5%</td>
<td>36.4%</td>
<td>30.8%</td>
<td>9.3%</td>
<td>3.08</td>
</tr>
<tr>
<td><strong>Child Care Needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More childcare options</td>
<td>6.6%</td>
<td>16.0%</td>
<td>33.0%</td>
<td>12.3%</td>
<td>32.1%</td>
<td>2.77</td>
</tr>
<tr>
<td>Affordable childcare</td>
<td>6.6%</td>
<td>8.5%</td>
<td>34.0%</td>
<td>19.8%</td>
<td>31.1%</td>
<td>3.00</td>
</tr>
<tr>
<td>Qualified childcare providers</td>
<td>3.8%</td>
<td>15.1%</td>
<td>33.0%</td>
<td>15.1%</td>
<td>33.0%</td>
<td>2.91</td>
</tr>
<tr>
<td><strong>Family Mental Health Needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-home supports and services</td>
<td>2.7%</td>
<td>23.6%</td>
<td>47.3%</td>
<td>21.8%</td>
<td>4.5%</td>
<td>2.93</td>
</tr>
<tr>
<td>Respite care</td>
<td>2.7%</td>
<td>21.8%</td>
<td>44.5%</td>
<td>23.6%</td>
<td>7.3%</td>
<td>2.97</td>
</tr>
<tr>
<td>Behavior Management Services</td>
<td>1.8%</td>
<td>12.8%</td>
<td>45.0%</td>
<td>32.1%</td>
<td>8.3%</td>
<td>3.17</td>
</tr>
<tr>
<td>Family Support Groups</td>
<td>2.8%</td>
<td>25.7%</td>
<td>41.3%</td>
<td>11.0%</td>
<td>19.3%</td>
<td>2.77</td>
</tr>
<tr>
<td><strong>Housing Needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe housing</td>
<td>5.5%</td>
<td>20.0%</td>
<td>44.5%</td>
<td>18.2%</td>
<td>11.8%</td>
<td>2.87</td>
</tr>
<tr>
<td>Affordable housing</td>
<td>3.6%</td>
<td>11.8%</td>
<td>44.5%</td>
<td>32.7%</td>
<td>7.3%</td>
<td>3.17</td>
</tr>
<tr>
<td>Handicapped accessible housing</td>
<td>1.8%</td>
<td>13.6%</td>
<td>49.1%</td>
<td>29.1%</td>
<td>6.4%</td>
<td>3.14</td>
</tr>
<tr>
<td>Shorter waiting lists for housing</td>
<td>1.9%</td>
<td>12.0%</td>
<td>40.7%</td>
<td>34.3%</td>
<td>11.1%</td>
<td>3.23</td>
</tr>
<tr>
<td><strong>Employment Needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More employment opportunities</td>
<td>2.8%</td>
<td>10.1%</td>
<td>51.4%</td>
<td>27.5%</td>
<td>8.3%</td>
<td>3.14</td>
</tr>
<tr>
<td>Better paying employment opportunities</td>
<td>1.9%</td>
<td>13.9%</td>
<td>50.9%</td>
<td>26.9%</td>
<td>6.5%</td>
<td>3.11</td>
</tr>
<tr>
<td>Decreased employer stigma</td>
<td>2.9%</td>
<td>19.6%</td>
<td>39.2%</td>
<td>23.5%</td>
<td>14.7%</td>
<td>3.01</td>
</tr>
<tr>
<td>Sheltered workshops</td>
<td>12.1%</td>
<td>30.8%</td>
<td>32.7%</td>
<td>15.0%</td>
<td>9.3%</td>
<td>2.56</td>
</tr>
<tr>
<td>Vocational training</td>
<td>1.9%</td>
<td>17.9%</td>
<td>51.9%</td>
<td>18.9%</td>
<td>9.4%</td>
<td>2.97</td>
</tr>
<tr>
<td>More employment supports</td>
<td>2.8%</td>
<td>13.2%</td>
<td>47.2%</td>
<td>25.5%</td>
<td>11.3%</td>
<td>3.07</td>
</tr>
</tbody>
</table>
If you were to advocate for one change to the mental health care system, what would it be?

In order to further assess the needs of MR/DD agencies, respondents were asked to describe what change they would advocate for if they could only choose one issue. One hundred thirty-five individuals responded to the question. Analysis of the responses indicates that they revolved around several key issues.

“[My group home is very under funded and is still based on a 60 year old rate system…[it] is not funded for [the] service it is expected to provide. This home has 5 consumers that have lived here for over 30 years.”

-- MR/DD Agency Respondent

Funding for Services

The number one change requested by respondents (23 individuals) was to increase the funding for individuals with mental retardation/developmental disabilities and those with mental health issues so that additional services could be offered and more individuals could be served. Some suggestions for the extra funding included providing money for recreation, quality day programs and workshops, and assistance with daily skills. Respondents also suggested more MO HealthNet funding for psychiatrists, doctors, and dentists. One individual suggested better allocation of the Division of Comprehensive Psychiatric Services (CPS) funding for services other than those offered through the Community Psychiatric Rehabilitation (CPR) program, “since that program is not the solution for every mental health program.” Another individual suggested low cost mental health services for those who could not reach the closest CPS provider.

Better Coordination and Consistency of Services

Twenty-one respondents listed a number of issues affecting the coordination between systems and resultant lack of consistency of services across services within DMH. Agencies emphasized a need for a better relationship between DMH and community providers. Different paperwork and procedures between regional centers, as well as lack of clarity regarding regulations and expectations were very commonly listed concerns. Providers were also concerned about a change in case management services. A couple individuals suggested keeping the service coordinator in place at the Regional Centers. Finally, one agency felt that that “fee for service” reimbursement required a “constant balancing act on the part of providers to meet budget” which made it difficult to provide a consistent quality services.

The difficulty in serving mental retardation/developmental disabilities individuals with co-occurring disorders, and the need to coordinate services for these individuals, was also mentioned by several respondents. One respondent felt there needed to be a “better partner relationship...less negative, punitive role” for MR/DD within DMH. More assistance from mental health providers for individuals with mental retardation/developmental disabilities in crisis was also a stated concern.
Consumer-driven Care

“I have seen the system fail individuals and their situations because power/pride from the Regional Center got in the way of doing what was truly best for the individual…many desperate situations are created because consumers are waiting for a decision from the Regional Center.”

-- MR/DD Agency Respondent

Related to the relationship between DMH and community providers was the feeling of several agency respondents that bureaucracy sometimes got into the way of providing quality consumer-driven care. Some respondents felt that services were driven more by the DMH budget rather than what was best for consumers. One individual felt that the “maze of bureaucracy” should be replaced with “one stop shopping.”

Better Pay for Providers/Staff

A number of respondents (10) felt that the key to improving the system lies in paying competitive wages in order to retain competent, well-trained staff. Agency respondents felt the only way to ensure high quality, dedicated staff, was to pay them commensurate to similar staff working in the for-profit sector. There was recognition among agency respondents that the responsibilities and difficulties of providing direct personal care to individuals with mental retardation/developmental disabilities and mental illness often outweigh the wages currently offered to staff.

Community Support Services

Many agency respondents (10) felt that there were not enough community based resources to help individuals with mental retardation/developmental disabilities become independent members of the community. Respondents gave several examples of why more services are needed, from a rural individual who does lives too far from a sheltered workshop, to a person with MR/DD and co-occurring disorders who does not have the transitional services needed to move from institutional to independent living. Respondents mentioned needs for better transportation, more education and employment opportunities, help with daily skills, and more funding for recreational activities. One respondent suggested that programs incorporate a “safe way to experience actual consequences” so that individuals with mental retardation/developmental disabilities are better prepared for entering the community.

“Unfortunately, there are people who work in fast food who make as much as our employees do.”

-- MR/DD Agency Respondent
Psychiatric Care/Psychiatrists

The lack of psychiatric services for individuals with mental retardation/developmental disabilities and mental illness were among respondents’ concerns. Many comments were related to the lack of coordination between different agencies within DMH, as well the difficulties of accessing psychiatric services in rural areas. One individual suggested an increased capacity of short-term in-patient beds and mental health services for individuals with mental retardation/developmental disabilities.

Other Suggestions

There were a number of other suggestions given by MR/DD agency respondents that did not fall into the above categories. Among those, the most common were a desire to localize and privatize services and a need for more training of staff. A few respondents felt that more autonomy on a local level and some privatization would allow for more consumer choice. Training issues were noted, included comments from several respondents indicating that staff needed training on how to deal with difficult situations encountered while serving individuals, and that case managers also needed more training. A few individuals also mentioned a need for more family support services, including respite care and help dealing with behavior difficulties.

Effectiveness and Use of Evidence-based Practices by MR/DD Agencies

All agencies were asked if they used EBPs in their facilities. Of the 98 MR/DD agencies that responded to the question, 56% reported that they use EBPs (for a total of 55 agencies that use EBPs). Agencies were also asked whether they use various selected EBPs, and if so, to rate their effectiveness. The list of EBPs, along with the ratings, is shown below. The list of EBPs was based on a list developed by Washington State, and modified by researchers at the Missouri Institute of Mental Health (MIMH) with assistance from DMH. MIMH researchers reviewed prevention literature and added various prevention EBPs not on the original list. In addition, EBPs of interest to DMH were added.

The table below shows all EBPs used by five or more agencies, and their ratings. Of the 47 EBPs from which agencies could choose, five or more agencies used 23 (49%) of the EBPs listed. As shown in the table, the most commonly used EBPs were Positive Behavior Supports (n=49, 89% of agencies who reporting), Person Centered Planning (n=47, 85%), Life Skills Training (n=33, 60%), and Medication Management (n=27, 49%). As can also be seen in the table, each EBP was also given a number meant to indicate its “Effectiveness” as judged by agency respondents. Effectiveness was determined by putting the response options on a Scale of 1 to 4, where 1 = “A little effective” and 4 = “Extremely effective.” The mean of all respondents’ answers was taken to get the overall effectiveness for that EBP. The resulting number allowed us to determine which EBPs were rated as most and least effective by the agencies that use them. A number of EBPs were used by very few agencies, so their ratings may be a less reliable
indicator of effectiveness in MR/DD agencies than those with more agencies using them. Furthermore, the fact that an EBP is used by a large number of agencies may, in some cases, be a testament to its success with the MR/DD population. In fact, the two most commonly used EBPs, Positive Behavior Supports and Person Centered Planning, were among the highest rated EBPs as well. Both were rated “very effective” overall by the agencies that used them.

**Effectiveness and Use of Selected Evidenced Based Practices by MR/DD Agencies (n=55)**

<table>
<thead>
<tr>
<th>Dialectical Behavior Therapy (DBT)</th>
<th>Number who reported offering EBP</th>
<th>A Little Effective</th>
<th>Somewhat Effective</th>
<th>Very Effective</th>
<th>Extremely Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialectical Behavioral Therapy (DBT)</td>
<td>5</td>
<td>20.0%</td>
<td>20.0%</td>
<td>60.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Peer Support</td>
<td>10</td>
<td>10.0%</td>
<td>30.0%</td>
<td>40.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Person Centered Planning (PCP)</td>
<td>47</td>
<td>2.1%</td>
<td>23.4%</td>
<td>48.9%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Positive Behavior Supports</td>
<td>49</td>
<td>0.0%</td>
<td>26.5%</td>
<td>49.0%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Sharing our Strengths</td>
<td>10</td>
<td>30.0%</td>
<td>20.0%</td>
<td>20.0%</td>
<td>30.0%</td>
</tr>
</tbody>
</table>
Chapter Eight
Missouri Mental Health Services and Resources

Introduction

This chapter of the Needs Assessment and Research Inventory (NARI) describes the resources offered by state departments for addressing mental health treatment needs. The chapter aims to both describe these services and identify collaborative efforts and levels of fragmentation that exist between state departments.

State-funded mental health services in Missouri are funded primarily through the Missouri Department of Mental Health (DMH) and the Missouri HealthNet Division (formerly the Medicaid Division) within the Department of Social Services (DSS). Within DMH, three divisions serve the mental health needs of the state: the Division of Comprehensive Psychiatric Services (CPS), serving those with psychiatric disorders, the Division of Alcohol and Drug Abuse (ADA), providing substance abuse treatment and prevention services, and the Division of Mental Retardation/Developmental Disabilities (MR/DD), assisting those with mental retardation and developmental disabilities. The Missouri HealthNet Division purchases and monitors health care services for low income and vulnerable citizens of the State of Missouri (Medicaid and MC Plus).

In addition to DMH and the MO HealthNet Division of DSS, several other departments also provide treatment services or contract with CPS for care. These include the Department of Corrections (DOC), the Department of Elementary and Secondary Education (DESE), two additional divisions within DSS, the Department of Health and Senior Services (DHSS), the Department of Public Safety (DPS) and the Office of State Courts Administrator. The organizational chart below illustrates the state departments involved in the delivery of mental health care services in Missouri. This chapter contains a list of specific state and consumer services and resources, and technological resources.
The Office of State Courts Administrator is involved in mental health care through its mental health courts. This office reports to the Supreme Court.
Missouri Department of Mental Health

As the primary department responsible for mental health care service delivery, DMH provides services for those with psychiatric, substance abuse and gambling disorders, and mental retardation and developmental disabilities. Psychiatric services are offered through CPS. Substance abuse and gambling services are offered through ADA. Services for those with mental retardation and developmental disabilities are offered through MR/DD. DMH services are funded through a variety of sources such as: MO HealthNet, general revenue allocated by the state, federal grants, insurance, and self-pay determined by the Missouri state sliding scale. The state receives a 62% federal match for all MO HealthNet (formerly Medicaid) recipients.

Division of Comprehensive Psychiatric Services (CPS)

CPS provides mental health treatment and recovery services for persons with mental illness. In-patient care is offered at eleven division-operated facilities that provide acute, long term rehabilitation, and residential care for youth and adults; as well as forensic, sexual predator and corrections services for adults. Out-patient services are contracted out to provider agencies across the state. The maps below indicate the service areas for adult and children’s services throughout the state.
Eligibility Criteria

CPS is committed to serving four target populations: persons with serious and persistent mental illness (SMI); persons suffering from acute psychiatric conditions; children and youth with serious emotional disturbances (SED) and forensic clients. In addition, CPS has identified four priority groups within the target groups; (1) individuals in crisis, (2) people who are homeless, (3) those recently discharged from in-patient care and (4) substantial users of public funds. These target populations currently constitute the majority of consumers whom the Division serves both in in-patient and ambulatory settings.

CPS Programs and Services

<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient long term psychiatric care (adults)</td>
<td>Four facilities in eastern, western, central and southeast Missouri; one long-term facility for sexual offenders in southeast Missouri.</td>
</tr>
<tr>
<td>In-patient acute psychiatric care (adults)</td>
<td>Four hospitals located in eastern, western, central and southeast Missouri.</td>
</tr>
<tr>
<td>Children’s in-patient psychiatric and residential treatment</td>
<td>1. One residential facility for children aged 6-17 who have severe emotional disturbance, as well as those children dually diagnosed with emotional disturbance and mental retardation.</td>
</tr>
<tr>
<td></td>
<td>2. One facility with in-patient, residential and day treatment care.</td>
</tr>
<tr>
<td>Out-patient psychiatric services (adults and children)</td>
<td>25 community mental health centers (CMHCs) and their affiliates. Services include screening, assessment, individual treatment plan development, crisis intervention, case management, medication management and community support.</td>
</tr>
<tr>
<td>Day Treatment/Partial Hospitalization</td>
<td>Services may include vocational education, rehabilitation services, and educational services. The focus is on developing supportive medical, psychological and social work services.</td>
</tr>
<tr>
<td>Respite Care</td>
<td>Temporary care given to individuals by specialized, trained providers for the purpose of providing a period of relief to the primary care givers.</td>
</tr>
<tr>
<td>Community Psychiatric Rehabilitation (CPR) services</td>
<td>The Community Psychiatric Rehabilitation Program offers services to Medicaid-eligible persons living in the community with severe, disabling mental illnesses. Services include evaluations, crisis intervention, community support, medication management, and psychosocial rehabilitation.</td>
</tr>
<tr>
<td>Community placement</td>
<td>The Supported Community Living program offers community placement in nursing homes, apartments and other standard living arrangements in the community. Persons receive case management and support through Community Psychiatric Rehabilitation Programs.</td>
</tr>
<tr>
<td>Program or Service</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Licensed treatment family homes</td>
<td>Private family residences licensed to provide specialized, 24-hour support, case management, and out-of-home care for youths with Serious Emotional Disturbances.</td>
</tr>
<tr>
<td>Crisis Services</td>
<td>Hotlines: CPS funds 10 mental health care Access Crisis Intervention (ACI) hotlines. These hotlines operate 24 hours a day every day. Crisis training; Law enforcement officers are trained to better respond to persons in crisis due to mental illness and to get them to treatment.</td>
</tr>
<tr>
<td>Disaster Services</td>
<td>The Office of Disaster Readiness (ODR) conducts planning and development activities to support a coordinated mental health response for Missourians in disaster situations. This includes preparedness training in psychological first aid.</td>
</tr>
<tr>
<td>Trauma services</td>
<td>Policy statement regarding trauma including identifying general and trauma informed competencies. Trauma training in children's residential facilities, annual trauma training, and trauma training for returning veterans with PTSD; Trauma Screening Program for Children training; training on Trauma Focused Cognitive Behavioral Therapy.</td>
</tr>
<tr>
<td>Services for the homeless</td>
<td>The Projects for Assistance in Transition from Homelessness (PATH) Program supports service delivery to individuals with serious mental illnesses, as well as individuals with co-occurring substance use disorders, who are homeless or at risk of becoming homeless. There are eleven PATH programs across Missouri in both rural and urban areas.</td>
</tr>
<tr>
<td>Rental assistance for homeless and disabled (with ADA and MR/DD)</td>
<td>Rental assistance provided through Shelter Plus Care (SPC), a HUD-funded rental assistance program that brings together housing and mental health services.</td>
</tr>
<tr>
<td>Employment assistance for persons with mental illness and co-occurring disorders</td>
<td>Several evidence-based programs including (1) Supported Employment (SE) (job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision); (2) Integrated Dual Diagnosis and Treatment (IDDT) for individuals with co-occurring disorders, which requires a vocational specialist; and (3) Assertive Community Treatment (ACT) requires a vocational specialist and it will be implemented at six Community Mental Health Centers in 2008. (with DESE’s Division of Vocational Rehabilitation)</td>
</tr>
<tr>
<td>Alternatives to restraint and seclusion</td>
<td>Fulton State Hospital is using a restraint and seclusion training curriculum developed by National Association of State Mental Health Program Directors (NASMHPD) to train staff within the intermediate and maximum-security forensic units. All facility staff has completed this training program, and other facility administrators and managers across the state are being trained through this facility as well.</td>
</tr>
</tbody>
</table>
Division of Alcohol and Drug Abuse (ADA)

ADA is responsible for making prevention and treatment services accessible to persons with substance abuse disorders, to those at risk of substance abuse, and to problem gamblers. Services are provided through a statewide network of contracted community agencies that provide substance abuse prevention and treatment, recovery supports, compulsive gambling and the substance abuse traffic offender program. The Division directly operates one small outpatient clinic. The map of District Offices identifies the counties in each District and contacts for each region of the state.

ADA Programs and Services

<table>
<thead>
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<td>Community 2000 is a network of 150 volunteer community teams focusing on reducing the incidence of substance use and abuse in their communities and changing community norms toward substance use by youth and others.</td>
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<tr>
<td>Regional Support Centers</td>
<td>Regional Support Centers are the primary source of technical assistance support for the Community 2000 Teams. Each center has a prevention specialist who works directly with the teams to assist with development of teams and task forces in communities. The center plays a key role in Missouri’s efforts to limit the sale of tobacco products to underage youth.</td>
</tr>
<tr>
<td>School-based Initiative (Missouri SPIRIT)</td>
<td>SPIRIT supports the development and implementation of a continuum of substance abuse prevention services in five public schools in Missouri.</td>
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<tr>
<td>Community-Based Services</td>
<td>Community-based prevention services for youth are offered by community agencies utilizing science-based programs. These programs target youth at high risk of early use of alcohol and other drugs.</td>
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Legend

- **District Boundaries**
- **District Offices**
- **SATELLITE OFFICES**
- **WESTERN DISTRICT**
- **EASTERN DISTRICT**
- **CENTRAL DISTRICT**
- **SATELLITE OFFICE**
- **CENTRAL DISTRICT SATELLITE**
- **SATELLITE OFFICE**
- **CENTRAL DISTRICT SATELLITE**
- **EASTERN DISTRICT SATELLITE**
- **SATELLITE OFFICE**

+ Missouri Department of Mental Health, Division of Alcohol and Drug Abuse
+ ADA
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<td>Statewide Training and Resource Center</td>
<td>This center provides resources, training, and technical assistance to Regional Support Centers and community-based providers. Prevention conferences and workshops are provided by the center. The center operates the Community 2000 mini-grant program and the statewide Regional Alcohol and Drug Abuse Resource network (RADAR) resource site.</td>
</tr>
<tr>
<td>Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs</td>
<td>Substance abuse services are provided in a community-based setting by contracted providers. The intensity of services is based upon a consumer’s assessed needs and provided on a continuum from daily treatment with residential support to monthly outpatient sessions. Services are available to both the consumer and their families. If the consumer is Medicaid eligible services are funded through the state and MoHealthNet.</td>
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<tr>
<td>Primary Recovery Plus Programs/Enhanced Primary Recovery Plus Programs</td>
<td>Comprehensive substance abuse treatment services are provided through contracted treatment providers. Services include social setting detoxification and intensive treatment including supportive housing when needed. A primary focus is provision of a complete continuum of recovery services including intensive outpatient and supported recovery levels of care. Enhanced programs offer modified medical detoxification services by medical personnel.</td>
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<tr>
<td>Recovery Support Services</td>
<td>Recovery support services are a complementary array of activities, resources, and services designed to assist an individual’s integration into the community, participation in treatment, improved functioning and recovery. The services are provided by trained clergy, ministers, mentors, and lay people who have experience in addiction recovery. These supports provided by community- and faith-based organizations introduce a person to recovery and offer long term connectedness.</td>
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<tr>
<td>Compulsive Gambling Counseling</td>
<td>Treatment for problem gambling is provided through a network of contracted treatment providers by specially trained and certified counselors. Individuals with gambling problems and their families can receive free counseling services along with referrals for other supportive interventions.</td>
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<tr>
<td>Substance Abuse Traffic Offender Program (SATOP)</td>
<td>SATOP is Missouri’s education and intervention program for drinking drivers. DWI offenders are required to complete this program for reinstatement of their driving privileges. The SATOP program provides screening for level of service, education programs, intervention programs and treatment.</td>
</tr>
</tbody>
</table>
Division of Mental Retardation and Developmental Disabilities (MR/DD)

MR/DD, established in 1974, serves a population that has developmental disabilities such as mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. The Division, as outlined in 633.010 RSMo, is charged with the responsibility of insuring that mental retardation and developmental disabilities prevention, evaluation, care, habilitation and rehabilitation services are accessible, wherever possible. Furthermore, the division has supervisory responsibilities for division residential facilities, day programs and other specialized services operated by the department, and oversight over facilities, programs and services funded or licensed by the department. In 1988, the Division began participation in the Medicaid home and community-based waiver program, designed to help expand needed services throughout the state.

Mental health services offered to individuals with mental retardation or developmental disabilities are provided in most part by CPS division within DMH. Approximately 60% of all MR/DD clients were served by CPS in 2006.

Division of MR/DD Regional Centers and Habilitation Centers

Eligibility Criteria

Eligibility for MR/DD services is determined by a functional assessment as opposed to linking eligibility to a specific diagnosis. It must be determined that the mental retardation/developmental disability is likely to continue indefinitely and that it results in a substantial functional limitation in two or more of the following six areas of major life activities: self care, receptive and expressive language development and use, learning, self-direction, capacity for independent living or economic self sufficiency and mobility. All persons who are eligible for services receive service coordination services.
MR/DD Programs and Services

<table>
<thead>
<tr>
<th>Program or Service</th>
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</thead>
<tbody>
<tr>
<td>Habilitation centers for persons with MR/DD</td>
<td>MR/DD operates six habilitation centers throughout the state which provide institutional care for persons with mental retardation or developmental disabilities. These centers offer training and habilitation for consumers unable to live in community settings because of the severity of their disabilities or for behavioral reasons.</td>
</tr>
<tr>
<td>Community MR/DD treatment services</td>
<td>MR/DD operates 17 entities that provide or purchase specialized services, assessment, and service coordination services, which include coordination of individual’s person-centered plan. Eleven (11) are regional offices that provide service coordination and work with individuals, families and providers. Regional offices coordinate with Senate Bill 40 boards to assure service provision to MR/DD clients statewide.</td>
</tr>
<tr>
<td>Autism services</td>
<td>Five regional autism projects that collectively provide services to approximately 2500 families statewide. Individuals are referred to their autism projects through their regional office.</td>
</tr>
<tr>
<td>Transition services for MR/DD consumers</td>
<td>Using a variety of Medicaid waivers, MR/DD consumers are provided with transitional services to successfully transition from habilitation centers to the community. Services vary depending on the type of waiver, but can include personal assistance, behavior therapy, respite care, counseling, crisis intervention services, supported employment, individualized supported living and residential habilitation, counseling, and other needed support services.</td>
</tr>
<tr>
<td>Work incentives planning and assistance</td>
<td>The Benefits Planning, Assistance and Outreach (BPAO) Program provides funding to community-based organizations, called BPAO Projects, to provide all SSA beneficiaries with disabilities access to work incentives planning and assistance services. The Ticket to Work and Work and Self Sufficiency Program provide access to employment training and placement services.</td>
</tr>
<tr>
<td>Self-directed care</td>
<td>A consumer or family may choose to hire, train, supervise and schedule their own workers who are not licensed professionals. The consumer or family who chooses to direct their own personal assistant services becomes the employer of record for the workers they hire. The fiscal intermediary provides all necessary payroll functions for the employer of record (the consumer or family) and acts as a liaison with various regulatory and governmental agencies.</td>
</tr>
</tbody>
</table>
DESE is charged with providing elementary and secondary education in the State of Missouri. In the area of mental health, DESE provides funding for vocational rehabilitation within the Division of Vocational Rehabilitation (DVR) and these services are coordinated with the DMH. The figure to the right presents the breakdown of persons who exited DVR’s Supported Employment program.

DESE also provides services for those with developmental disabilities in the schools through the Division of Special Education (DSE). Services and programs related to mental health are listed below.

**Department of Elementary and Secondary Education Programs and Services**

<table>
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<tr>
<th>Programs and Services</th>
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</thead>
<tbody>
<tr>
<td>Vocational rehabilitation for persons with mental health disorders</td>
<td>Vocational Rehabilitation Counseling &amp; Diagnostic Services</td>
<td>DVR</td>
</tr>
<tr>
<td></td>
<td>Supported Employment provides employment supports in an integrated work setting in which individuals are working toward competitive employment. VR could provide up to nine months of community-based job training if other funding sources are available to provide long-term, follow-along, on-the-job support services that the individual needs to remain employed.</td>
<td>DVR</td>
</tr>
<tr>
<td></td>
<td>Physical Restoration</td>
<td>DVR</td>
</tr>
<tr>
<td></td>
<td>Training: Proprietary, Skills, Technical non-degree</td>
<td>DVR</td>
</tr>
<tr>
<td></td>
<td>Training: College University</td>
<td>DVR</td>
</tr>
<tr>
<td></td>
<td>Secondary Support Services (Transportation, Room &amp; Board, etc.)</td>
<td>DVR</td>
</tr>
<tr>
<td></td>
<td>Assistive Technology</td>
<td>DVR</td>
</tr>
<tr>
<td>Programs and Services</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Special Education Services</td>
<td>For children with MR/DD, in response to the Individuals with Disabilities Education Act (IDEA), DESE coordinates with individual school districts to increase the number of persons able to serve students with disabilities, provide in-service training to staff, train paraprofessionals and disseminate information related to best practices, teaching approaches and other relevant information.</td>
<td>DSE</td>
</tr>
<tr>
<td></td>
<td>DESE offers Positive Behavior Supports, a whole school evidence-based prevention and early intervention program across the state.</td>
<td></td>
</tr>
<tr>
<td>Early childhood services</td>
<td>The First Steps program offers coordinated services and assistance to children from birth to age three who have delayed development or diagnosed conditions that are associated with developmental disabilities.</td>
<td>DSE</td>
</tr>
<tr>
<td>Elementary and secondary school social development and guidance</td>
<td>The Missouri Comprehensive Guidance Program (MCGP) is a program that teaches knowledge and skills that can instill in students the resilience and competencies to lead successful and healthy lives and in addition provides mental health services to help remove barriers that prevent positive growth and development.</td>
<td>DSE</td>
</tr>
</tbody>
</table>
Department of Social Services (DSS)

Within DSS are three divisions that, in addition to other services, address the mental health needs of its clients. These three divisions are the MO HealthNet Division, the Children’s Division, and the Division of Youth Services.

MO HealthNet Division (MHD)

In 2007 Missouri Medicaid was renamed MO HealthNet and the Division of Medical Services in DSS became the MO HealthNet Division (MHD). The purpose of the MHD is to purchase and monitor health care services for low income and vulnerable citizens of the State of Missouri. The agency assures quality health care through development of service delivery systems, standards setting and enforcement, and education of providers and participants. MO HealthNet processes claims for MO HealthNet recipients across the state of Missouri, including mental health claims for any mental health service received by any MO HealthNet recipient in the state. What is now MHD processed mental health claims of over $700,000,000 for slightly more than half a million individuals (547,763) in 2006.

These claims primarily covered expenses for visits to physicians and mental health professionals for mental health concerns, pharmacy prescriptions, and in-patient mental health care services at non-state-funded hospitals or treatment centers.

Children’s Division (CD)

CD provides treatment for all children and families in need of treatment services because of 1) abuse or neglect, or 2) at risk of abuse or neglect; and 3) children who have committed statute offenses such as repeated absences from school or who are in danger of becoming delinquent. Services include behavioral health services such as individual and group therapy, family therapy and other behavioral health interventions. The Office of Comprehensive Child Mental Health within DMH is working closely with the Children’s Division to create a more coordinated system of care for children and families eligible for CD services. The Custody Diversion Protocol was developed in conjunction with DMH to prevent families from having to relinquish custody solely in order to obtain necessary mental health services for their child.

Division of Youth Services (DYS)

DYS is the state agency charged with the care and treatment of delinquent youth committed to its custody by one of the 45 Missouri juvenile courts. DYS is administratively organized into one central office and five regional offices. Services include assessment, care and treatment, and education of all youth committed to its care. Toward this end, DYS operates treatment programs ranging from non-residential day treatment centers through secure residential institutions. Additionally, DYS administers the Interstate Compact on Juveniles, operates an accredited school program, and maintains a statewide statistical database of juvenile court referrals. Youth offenders can be on probation or parole status or in the residential or diversion programs. All youth in residential programs are assessed using the Healthy Children and Youth screen that identifies existing and potential problems with health, including mental health. Planning for each
individual youth is based on this assessment which presumes that unless health needs are mediated, youth cannot be successfully rehabilitated. The total number of youth served by DYS in 2006 was 2,793; 83% of whom were male. Of these youth, an estimated 63.5% had either serious or moderate incidents of substance use, and 64.8% had either a diagnosed psychological/psychiatric disorder or behavioral indicators of a mental health disorder.

### Department of Social Services Programs

<table>
<thead>
<tr>
<th>Program or Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td>MO HealthNet and MO HealthNet Managed Care reimbursements</td>
<td>MO HealthNet processes claims for mental health, substance abuse, MR/DD costs for MO HealthNet (formerly Medicaid) and MO HealthNet Managed Care (formerly MC+ Managed Care) recipients.</td>
</tr>
<tr>
<td>Behavioral health care services for children and family who are victims of abuse and neglect</td>
<td>The Children’s Division (CD) provides treatment for all children and families in need of treatment services because of 1) abuse or neglect, or 2) at risk of abuse or neglect; and 3) children who have committed statute offenses such as repeated absences from school or who are in danger of becoming delinquent. Services include behavioral health services such as individual and group therapy, family therapy and other behavioral health interventions. (mental health services funded through DMH)</td>
</tr>
<tr>
<td>Custody diversion</td>
<td>The Custody Diversion Protocol was developed in conjunction with DMH to prevent families from having to relinquish custody solely in order to obtain necessary mental health services for their child (with DMH)</td>
</tr>
</tbody>
</table>
| Juvenile Court diversion (mental health services through DMH) | The Juvenile Court Diversion program is designed to divert juveniles from commitment to the Division of Youth Services through early intervention (family therapy, group counseling, etc.) and by working with less serious offenders at home. The programs are designed and implemented at the local level. Current programs funded include:  
1. Drug Court Services Program, providing an array of services intent upon helping youth become clean, sober and successful in school, community and family.  
2. Juvenile drug court, which treats juveniles committed for non-violent offenses and have substance abuse problems.  
3. Residential treatment, targeted toward mentally disordered offenders within correctional facility. DMH provides on-site psychiatric care, psychiatric nursing care, licensed therapists, and targeted case management services. Services provided include individual and group therapy, substance abuse counseling and how to maintain non-violent lifestyle, especially for those associated with gang activity.  
4. Advocacy/mentoring. Youth linked with adults who provide assistance and direction. Youth provided opportunities for skills-based learning in areas of team building, anger management, substance abuse through group classroom experience, and group recreation activities.  
5. Drug abuse intervention program, which provides services to youth identified as “at risk” or whom have been identified as having alcohol or substance abuse problems. Initial drug screening to measure compliance; parent education on the effects of drugs and alcohol usage,  
6. Parent Adolescent Conflict Education (PACE) – Parent Adolescent Communicating
Together (PACT) & Mental Health/Substance Abuse Assessment And Treatment – (a) PACE offers services to youth and families referred to the court for assaults and other offenses. Program addresses responsibilities, life skills needed to manage anger, and education on conflict and anger; (b) PACT provides parents and youth with mediation services; and (c) RESPECT - is a restorative justice program holding youth accountable for their actions and making them part of the solution. Then Mental Health program contracts with social workers and treatment providers to address mental health and substance abuse issues of youth and in families.
Department of Health and Senior Services (DHSS)

DHSS is organized into three programmatic divisions: Community and Public Health, Regulation and Licensure, and Senior and Disability Services.

Division of Community and Public Health (DCPH)

DCPH administers programs addressing disease prevention and nutrition services, healthy families and youth, community protection, and provides public health practice and administrative support. DCPH currently provides a myriad of health prevention services to children and adults; some of which target similar issues as those targeted by ADA (tobacco use, fetal alcohol syndrome). Below are inventoried the DCPH programs which interface with mental health or substance abuse concerns, or the concerns of persons with developmental disabilities.

DCPH Programs and Services

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<tr>
<td>Alcohol, Tobacco and Other Drug (ATOD) Prevention and Awareness Program</td>
<td>Targets the prevention and/or reduction of the incidence of alcohol, tobacco, and other drugs in the preconception and prenatal periods. Provides substance use in pregnancy assessment and counseling forms to health care providers and ATOD educational brochures.</td>
</tr>
<tr>
<td>Injury and Violence Prevention</td>
<td>(1) Nine local Safe Kids coalitions in Missouri provide services to parents and children about the prevention of unintentional injuries among children under age 15. (2) ThinkFirst Missouri provided head and spinal cord injury prevention services to students in middle, junior high and senior high schools (3) Sexual assault awareness and to create community change needed to prevent sexual assault. (4) 25 agencies provide counseling, advocacy and support groups services for victims of sexual assault, including men, women, and children. (5) Forensic examinations for 263 adult and child victims of sexual assault. (6) Training module for local public health agency child care health consultants to train local child care providers about child passenger safety.</td>
</tr>
<tr>
<td>Building Blocks of Missouri</td>
<td>This nurse-family partnership operates in four sites: St. Louis, Kansas City, Springfield, and Cape Girardeau. It provides home visitation services for low-income, first-time mothers. Registered nurses begin services early in pregnancy and continue visitation through the child’s second year. Nursed provide support, education and counseling on health, behavioral, self-sufficiency, and parenting issues. In FY07, 4,799 visits were completed serving 455 families through the Building Blocks program.</td>
</tr>
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<td>Comprehensive Tobacco Use Prevention Program</td>
<td>This program is dedicated to preventing tobacco use in youth, promoting quitting among youth and adults, eliminating exposure to secondhand smoke and reducing the impact on populations disproportionately affected by tobacco. To increase quitting among tobacco users, the Missouri Tobacco Quitline (1-800-QUIT-NOW) provides free cessation counseling services and referrals for local assistance. This program is coordinated with DMH’s Division of Alcohol and Drug Abuse.</td>
</tr>
<tr>
<td>Special Health Care Needs</td>
<td>Individuals with special health care needs include those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by individuals generally.</td>
</tr>
<tr>
<td>Hope Program</td>
<td>Hope Program provides assistance for children from birth to age 21 who meet financial and medical eligibility guidelines. Hope focuses on early identification of children with special needs; funds preventive, diagnostic, and treatment services; and provides service coordination for families. Service coordination is provided through 13 contracts and by Special Health Care Needs staff in regional offices in the state.</td>
</tr>
<tr>
<td>Council on Adolescent and School Health (CASH)</td>
<td>The purpose of CASH is to inform and advise the DHSS decision-makers regarding adolescent and school health issues and initiatives. CASH has members representing the DMH’s Divisions CPS and ADA.</td>
</tr>
<tr>
<td>Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP)</td>
<td>MOFASRAPP is a Fetal Alcohol Syndrome Project Collaborative project involving DHSS, DMH, Missouri Institute of Mental Health(MIMH), University of Missouri-Columbia, and St. Louis ARC. The project covers 71 rural counties. Activities include: (1) Reducing alcohol-exposed pregnancies in at-risk women ages 18-44; (2) Educating health care providers on Fetal Alcohol Syndrome (FAS), alcohol exposure and reproductive risk factors for women of childbearing age (12-44); (3) Establishing a FAS Center to provide diagnostic, referral and follow-up services for persons suspected of having an alcohol related condition and their families; and (4) Enhancing existing surveillance systems to monitor the prevalence of alcohol consumption and contraceptive practices in women of childbearing age, and the incidence of AFAS.</td>
</tr>
<tr>
<td>Missouri Fetal Alcohol Syndrome Action and Care Team (MOFASACT)</td>
<td>The mission of MOFASACT is to raise public and professional awareness of Fetal Alcohol Syndrome, one of the leading preventable causes of mental retardation, through prevention, education and advocacy.</td>
</tr>
<tr>
<td>Missouri Community-based Home Visiting Program</td>
<td>This funds an interdisciplinary team intervention to support women and their families through the post-partum period or through the growth of a child to age three. This is a home visiting model.</td>
</tr>
<tr>
<td>Suicide Prevention Plan and Suicide Prevention Advisory Council</td>
<td>While DMH is the lead agency on this initiative, DHSS partnered with DMH to design a Missouri Suicide Prevention Plan and sits on the Suicide Prevention Council which helps to coordinate and guide prevention activities. DHSS is also the repository of data on suicide and suicide attempts in Missouri through DHSS’ Missouri Information for Community Assessment (MICA) data tables.</td>
</tr>
</tbody>
</table>
Division of Regulation and Licensure (DRL)

DRL regulates and licenses child care facilities, hospitals and ambulatory surgical centers, home health and hospice providers, long-term care facilities including assisted living, residential care, intermediate care, and skilled nursing facilities, emergency medical services, pharmacies and persons authorized to prescribe or dispense controlled substances. Some residential care facilities are co-licensed by both the DRL and the DMH. Many consumers reside in DRL licensed facilities.

Division of Senior and Disability Services (DSDS)

DSDS serves as the State Unit on Aging, and carries out the mandates of the State of Missouri regarding programs and services for seniors and adults with disabilities. DSDS investigates allegations of elder abuse and administers programs designed to maximize the independence of seniors and persons with disabilities who are at risk of unnecessary or premature institutionalization.

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<tr>
<td>Adult Protective Services</td>
<td>DSDS maintains an Elder Abuse and Neglect Hotline (1-800-392-0210) which operates 24-hours a day, 365-days a year. It responds to reports of alleged abuse, neglect or financial exploitation of persons 60 years of age or older and other eligible adults between age 18 and 59. The program provides investigation, intervention and follow-up services to victims and stresses the mentally competent adult’s right to make their own decisions. Persons with developmental disabilities and/or mental illness who cannot protect their own interests are among the eligible adults. Reports of abuse, neglect or other complaints regarding Long Term Care Facilities are also registered at the Elder Abuse and Neglect Hotline. Investigations are completed by Long Term Care survey staff around the state.</td>
</tr>
<tr>
<td>Area Agencies on Aging</td>
<td>The Area Agencies on Aging (AAAs) are not part of DSDS, but, as the State Unit on Aging, DSDS has the responsibility of coordinating and overseeing the AAA state plans. One of the assurances which the State must see is met by each AAA reads as follows: Each area agency will, in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations.</td>
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### Program or Service

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<tr>
<td><strong>Home and Community Services</strong></td>
<td>Many seniors and disabled younger adults can remain in their own homes and avoid or delay institutionalization with the help of support services. The Division of Senior and Disability Services administers a coordinated, integrated home and community service delivery system to assure that the needs of Missouri’s elderly and persons with disabilities are met. Through statewide staff, services such as personal care, homemaker, chore, nursing, respite, adult day health care, counseling, and consumer-directed services are made available to the elderly and persons with disabilities in their homes. These supportive services are provided to eligible persons 60 years of age or older and to adults with disabilities between the ages of 18 and 59. Generally, the service recipient must meet specific guidelines concerning economic, social, and care needs in order to be eligible for home and community based services. Through an assessment process, the division determines the services necessary to meet the needs of each eligible person. The primary funding sources for home and community based services are General Revenue, MOHealthNet, Social Services Block Grant, and the Older Americans Act. Through these programs, approximately 66,000 elderly and persons with disabilities receive supportive services each year.</td>
</tr>
</tbody>
</table>

| Case Management            | Case management provides ongoing assessment and service coordination provided by DSDS staff for elderly and disabled persons receiving in-home and/or adult protective services. Persons with developmental disabilities and/or mental illness are eligible for and receive case management services. |

### Department of Corrections (DOC)

DOC provides a wide array of mental health and substance abuse services to inmates its prison population, referring its offenders with mental illness issues to the sexual offender treatment at Farmington; level 4 and 5 treatment at Fulton; MR/DD housing and treatment at Potosi and substance abuse treatment at several DMH facilities. All inmates receive mental health and substance abuse screening and assessment upon entry into the correctional facilities. Treatment beds are spread throughout the state from minimum- to maximum-security institutions. A total of 242 beds are available for those with mental illness, 850 beds for substance abuse treatment, and 46 beds for MR/DD clients. In 2006, 4473 offenders were classified at levels 3-5 in 2006 which entitled them to services. This represents 38.4% of the prison population.

Fewer services are available to transition inmates with mental illness into the community. Currently, DOC is collaborating with DMH on an initiative wherein the DMH Community Mental Health Centers (CMHCs) provide services to mentally ill persons recently released from correctional facilities. Out-patient services provided through the DOC for mental health issues are also available to those with substance abuse issues including the Post-conviction Drug Programs and the Cocaine Addiction Program. Both triage approaches
to serving those with mental illness as well as diversion programs are expressed needs for these individuals.
## Department of Corrections Services and Programs

<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inmate screening and assessment for mental illness and substance abuse</td>
<td>All inmates receive screening and assessment upon entry into correctional facility</td>
</tr>
<tr>
<td>Mental health treatment services (inmates)</td>
<td>DOC contracts with a private company to provide mental health treatment services to inmates. Private contractor has staff of over 150 providing services in all 21 correctional facilities.</td>
</tr>
</tbody>
</table>
| In-mate substance abuse treatment services             | (1) The Cocaine Addiction Program lasts up to 18 months for offenders who are in need of long-term drug treatment for long-term addictions.  
(2) Offenders Under Treatment is a 180-day treatment program for those whose drug problem was a precipitating factor in their offense.  
(3) The Post Conviction Drug Treatment Program is designed for probationers who have failed to complete treatment within the community.  
(4) 12-step programs (in prison and in the community) and other support and education programs |
| Alternative to traditional incarceration for substance abusers | Department Institutional Treatment Centers (ITCs) provide substance abuse treatment for inmates, parole, and probation violators at eight correctional centers.                                                                                                                     |
| Drug screening                                         | Routine drug screening for all inmates and offenders. Screenings assist corrections professionals in assessing, evaluating and referring inmates and offenders to appropriate substance abuse programs within the institutions and the community. |
| Probationer substance abuse treatment services          | Required Assessment, Education and Treatment (REACT) is a statewide program for persons placed on probation by the Court for a felony drug offense. Offenders must submit to an assessment within 60 days of their term of probation as a condition of probation and then address the causes identified in that assessment through substance abuse education and treatment programs. REACT also increases offender accountability by requiring probationers to pay for all or a significant portion of the program services, depending on financial ability (with ADA). |
Department of Public Safety (DPS)

DPS Juvenile Services Division has the goal of creating opportunities for youth to prevent them from engaging in violent activities. The Division receives funding through the U.S. Office of Juvenile Justice Prevention to fund programs including those that focus upon risk and protective factors. The Division also has a block grant program that funds programs on school safety, juvenile drug courts, training for law enforcement and court personnel to control crime. Programs also exist to enforce Underage Drinking Laws within the Division of Tobacco and Alcohol Control. The Drug Awareness and Resistance Education (D.A.R.E) program offered throughout the state is funded through the DPS. Details regarding each of the implemented programs will follow in Year Two.

Office of State Courts Administrator (OSCA)

OSCA operates five mental health courts (in St. Louis City, Jackson County, St. Louis County, Greene County and Boone County) While offering no mental health services, they also route youth in the juvenile justice system to the DMH to receive treatment for mental health issues.
### Cross-departmental Initiatives

Mental health care at the state level is offered primarily through the DMH, but six other departments either directly offer or contract with DMH for substance use, mental health and/or MR/DD services, resulting in a fragmented system of care. Advisory boards and commissions often involved multiple departments. Some initiatives are coordinated across departments, and grants have required the creation of state advisory boards for the duration of the grant period. Examples of current collaborative efforts are listed below.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
<th>Departments/Divisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of Comprehensive Child Mental Health</td>
<td>The Office of Comprehensive Child Mental Health (OCCMH), in partnership with other child serving entities, has helped develop local community-based services for children with serious mental health needs and their families (Systems of Care). Available in seven counties and the City of St. Louis. OCCMH is working closely with DMH and DSS’s Children’s Division to create a more coordinated system of care for children and families eligible for CD services. State efforts through the legislatively mandated Comprehensive System Management Team (CSMT) have helped to establish an integrated, inter-agency, community-based system of care in 11 Missouri counties and the City of St. Louis.</td>
<td>DMH, DSS, DHSS, DESE, DOC, DPS, OSCA</td>
</tr>
<tr>
<td>Suicide Prevention Advisory Committee</td>
<td>The Suicide Prevention Advisory Committee is directed to advise on and promote suicide prevention and review related policy and promote the use of evidence-based practices. The Committee is charged with producing a bi-annual report on the status of suicide prevention in Missouri, establishing annual goals and objectives for suicide prevention in Missouri, reviewing programming to prevent suicide across the state, and identifying areas for policy change including legislation.</td>
<td>DMH, DHSS, DSS, DESE, DOC, Department of Higher Education, Missouri House of Representatives and Missouri Senate</td>
</tr>
<tr>
<td>Child Abuse Prevention</td>
<td>DSS has convened a cross-departmental, public/private agency collaborative to develop a Child Abuse Prevention Plan for the state. Called Missouri Prevention Partners, the group conducted an inventory of child abuse prevention programs, reviewed initiatives from other states and is developing goals and objectives for Missouri’s Plan.</td>
<td>DSS, DMH and other departments</td>
</tr>
<tr>
<td>Strategic Prevention Framework State Incentive Grant (SPF-SIG) Advisory Committee</td>
<td>The SPF-SIG, operated out of DMH’s ADA, requires an advisory committee to oversee the grant efforts. Committee members include representatives across seven departments involved in prevention efforts.</td>
<td>DMH, DHSS, DSS, DESE, DOC, OSCA</td>
</tr>
<tr>
<td>Initiative</td>
<td>Description</td>
<td>Departments/ Divisions</td>
</tr>
<tr>
<td>------------------------------------------------</td>
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</tr>
<tr>
<td>Pre-release planning</td>
<td>DOC and DMH collaborative to work with DMH Community Mental Health Centers to plan mental health programming for prisoners transitioning into the community CMHCs will be providing services to mentally ill persons recently released from correctional facilities. Service activities include (1) reviewing inmate history, (2) providing clinical information to CMHC providers who will serve the transitioning inmate upon release, (3) participation in the development of transition plans, and (4) scheduling immediate services for the offender to receive from CMHC staff following release.</td>
<td>DOC/DMH</td>
</tr>
<tr>
<td>The Offender Reentry Program</td>
<td>The Offender Reentry Program, led by the DOC, is an interagency team addressing offender reentry.</td>
<td>DOC, DSS, OSCA, DMH, DOR, DHSS, DED, DESE</td>
</tr>
<tr>
<td>Process Success</td>
<td>Project Success is a demonstration project to expand employment opportunities for individuals with mental and/or physical disabilities who receive public support.</td>
<td>DESE: DVR and Division of Adult and Vocational Education; DSS, DMH, DED.</td>
</tr>
<tr>
<td>Bright Futures</td>
<td>Bright Futures targets current and emerging preventive and health promotion needs of infants, children and adolescents who have mental and emotional disorders. Also targeted are other issues such as developmental problems, educational failure, too much risk taking, lack of supervision, and child abuse.</td>
<td>DHSS, DESE</td>
</tr>
<tr>
<td>Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP)</td>
<td>MOFASRAPP involving DHSS, DMH, MIMH, University of Missouri-Columbia, and St. Louis ARC. The project covers 71 rural counties and addresses alcohol-exposed pregnancies, health care provider education, establishing a FAS Center to provide diagnostic referral and follow-up service, and enhance existing surveillance systems to monitor the prevalence of alcohol consumption and contraceptive practices in women of childbearing age.</td>
<td>DHSS, DMH, MIMH University of Missouri-Columbia, St. Louis ARC</td>
</tr>
<tr>
<td>Initiative</td>
<td>Description</td>
<td>Departments/Divisions</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Other Initiatives</td>
<td>Other cross-departmental services/initiatives not listed above include:</td>
<td></td>
</tr>
<tr>
<td>-(2)</td>
<td>Missouri Alliance for Youth,</td>
<td>DMH and DSS</td>
</tr>
<tr>
<td>-(3)</td>
<td>the Missouri Student Survey,</td>
<td>DMH and DESE</td>
</tr>
<tr>
<td>-(4)</td>
<td>The School-based Services Committee.</td>
<td>Chaired by DSS, includes several state agencies</td>
</tr>
<tr>
<td>-(5)</td>
<td>A proposal to expand school-based mental health services is currently under</td>
<td>DES and DMH</td>
</tr>
<tr>
<td>under review.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-(6)</td>
<td>Medicaid Pharmacy Project</td>
<td>DMH and DSS</td>
</tr>
<tr>
<td>-(7)</td>
<td>Medical Risk Management</td>
<td>DMH and DSS</td>
</tr>
</tbody>
</table>
Other Mental Health Services and Funding

In addition to mental health services provided through the state departments and described above, there are also mental health resources that are available through the Federally Qualified Health Centers (FQHCs), not-for-profit agencies (United Way, etc.), private foundations and local hospitals. Furthermore, for those individuals with the ability to pay for services or those with health insurance with mental health care coverage, the network of providers expands to include all professionals and/or facilities providing mental health care services to individuals in Missouri. Services are available through local mental health care agencies, hospitals and clinics, psychiatrists, private psychologists, licensed clinical social workers, licensed marriage and family counseling therapists, and other mental health professionals. Funding is provided from an equally varied assortment of sources, including mil taxes (11 counties).

The second year NARI will include a more complete inventory of other mental health services, resources, and funding that is available in Missouri.
Statewide Consumer-operated Services

Consumer-directed Service Programs (COSPs) in Missouri

During the first year of the Transformation grant, the environmental scan of consumer involvement in the mental health system was limited to consumer and family support services and a cursory look at consumer/family member organizations. The planned census of consumer and family involvement in the mental health service delivery system in year two will provide a comprehensive overview of peer resources, supports, and service gaps by geographic and demographic characteristics of the consumer population. However, some patterns have emerged from this preliminary survey.

There are a number of organizations that are either consumer-run or which have consumers as providers. Some of these have advocacy as their primary mission; some are primarily geared toward service, education and/or support; and others are affiliated with governmental agencies. As relates to traditional consumer/family member organizations, most have local geographic membership. There are, however, several organizations with regional or state-wide membership for persons with mental illness, substance abuse problems and MR/DD. In the mental health area, consumer-run organizations include but are not limited to COSPs, drop-in centers and warm lines.

Consumer-operated Organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Alliance on Mental Illness (NAMI)</td>
<td>NAMI is the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. NAMI of MO has 13 affiliates in Missouri with over 909 members. NAMI is involved in legislation, fundraising, facilitator training, warm line provision, Family-to-Family, Peer-to-Peer, In Our Own Voices, and NAMI Connections (NAMI Care) program. NAMI Connections trains peer facilitators to conduct support groups and runs support groups for consumers.</td>
</tr>
<tr>
<td>Consumer-Operated Service Programs (COSPs)</td>
<td>COSPs are peer-run service programs that are owned, administratively controlled, and/or operated by mental health consumers. They emphasize self-help as their operational approach. COSPs may be called by other names, such as consumer-run organizations, peer support programs, peer services, or peer service agencies. The services offered by COSPs often include: peer counseling and peer-to-peer support; assistance with basic needs or benefits; help with housing, employment or education; linkage to services or resources; social and recreational opportunities; arts and creative expression; formal support groups and structured educational groups and training.</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Missouri Recovery Network (MRN).</td>
<td>The MRN membership includes persons who are in personal recovery from substance abuse, their family and friends. There is a state-wide council of 17 members with representation across the five ADA regions (NW, C, S, SE, and SW) with half of those on the council in personal recovery. There are currently 1,138 members statewide. MRN is also working with Committed Caring Faith Communities in St. Louis to educate the clergy and others about substance abuse.</td>
</tr>
<tr>
<td>MPACT (Missouri Parents Act).</td>
<td>MPACT is a statewide, non-profit, independent parent center, serving parents of children with all disabilities. MPACT was started by parents of children with disabilities and is staffed primarily by parents. Serves approximately 10,000 people a year and employs staff in various parts of Missouri.</td>
</tr>
<tr>
<td>Self Advocates and Families for Excellence (SAFE).</td>
<td>SAFE is a statewide volunteer organization consisting of people with developmental disabilities, self advocates, and family members of people with developmental disabilities. Trained SAFE volunteers work in conjunction with the DMH’s MR/DD to help gather information directly from individuals with developmental disabilities about the services and supports they receive; how individuals with developmental disabilities feel about their lives; and to help determine the presence of the Missouri Quality Outcomes in their lives.</td>
</tr>
<tr>
<td>Arc of the United States, Missouri Chapter.</td>
<td>The ARC of the U.S., Missouri Chapter, is an organization of parents of children with disabilities, family members, self-advocates and disability professionals working together to support and empower individuals with developmental disabilities and their families through advocacy and education. It aims to expand individual choices and promote community inclusion.</td>
</tr>
<tr>
<td>Retardation Association of Missouri (RAM).</td>
<td>RAM is an organization of parents and friends working on behalf of persons in Missouri with mental retardation. The organization promotes issues on behalf of persons who reside in Missouri’s state-run habilitation centers including lobbying for more funding on behalf of the residents, for pay increases for direct care staff, and ensuring that staffs who have abused persons in state facilities are terminated.</td>
</tr>
<tr>
<td>The Family Bridges (regional)</td>
<td>The Family Bridges serves families whose children have severe emotional disorders and co-occurring diagnosis. The organization is 2 years old and was incorporated in January 2007. A paid membership available in the following Missouri counties: Greene, Christian, Taney, Stone, Barry, and Lawrence and plan to expand throughout the southwest region of Missouri. In January 2007 there were 200 participants including children/youth and adults.</td>
</tr>
<tr>
<td>SCOPE (Supporting Consumer Operated Program Enhancements)</td>
<td>SCOPE is a statewide consumer provider network composed of staff and members of the drop-in centers, whose mission is mutual support and empowerment among peer programs through shared skills and learning, leadership building, and community collaboration.</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>Procovery™</td>
<td>The Procovery™ program, developed by Kathleen Crowley, author and Executive Director of the Procovery Institute, emphasizes a hope-centered, forward-focused, and skills-based partnership of the consumer, the family, the service provider, and the community. It includes eight principles for resilience in healing, twelve strategies for action, and a highly structured system, known as the Procovery Circle, for group training and support.</td>
</tr>
<tr>
<td>BRIDGES (Building Recovery of Individual Dreams and Goals Through Education and Support)</td>
<td>BRIDGES is a peer-to-peer education and support group program for adults. The program has two components. It provides a 10-week education course followed by a support group with trained teachers and facilitators. The program is modeled after the “Journey of Hope” family-to-family education course.</td>
</tr>
</tbody>
</table>
**Technological Resources**

The technology working group assembled as part of the transformation planning stage identified 46 data sources that serve to inform the state regarding its mental health care system. Below is a table listing all of the current technology resources.

### Current Inventory of Technological Resources

<table>
<thead>
<tr>
<th>#</th>
<th>System Name</th>
<th>Owner</th>
<th>What it Tracks</th>
<th>Purpose/Scope*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CIMOR</td>
<td>DMH</td>
<td>Consumer demographics, Providers, Services, Billing and payment, Assessments, Admissions, Program assignments</td>
<td>Track all information needed for consumers, services provided, and payment for services. Includes Substance Abuse Treatment program and interface with DOR for driver licenses.</td>
</tr>
<tr>
<td>2</td>
<td>MO Telehealth</td>
<td>University of Missouri</td>
<td>No stored data</td>
<td>Service Delivery - Telemedicine including tele-psychiatry. (Some locations across the State.)</td>
</tr>
<tr>
<td>3</td>
<td>CIMOR EMT</td>
<td>DMH</td>
<td>Abuse / neglect, grievances, incidents</td>
<td>Event Management and Tracking for all consumer-related risk incidents, investigation, and follow-up. Adding staff misconduct functionality.</td>
</tr>
<tr>
<td>4</td>
<td>ACTS – Alternative Care Tracking System Being replaced by FACES see # 43</td>
<td>DSS</td>
<td>Demographic data; placement information; federal funding eligibility</td>
<td>Tracks information regarding child’s placement; Medicaid, IV-E, EAS, and Rehab federal funding; legal status, court information, handicapping conditions, etc.</td>
</tr>
<tr>
<td>5</td>
<td>CSIPS – Children’s Services Integrated Payment System - Being replaced by FACES</td>
<td>DSS</td>
<td>Child-specific payments</td>
<td>Tracks vendor and child specific payment information by payment date, funding source, and service.</td>
</tr>
<tr>
<td>6</td>
<td>SEAS - Being Replaced by FACES see # 43</td>
<td>DSS</td>
<td>Service Authorization System</td>
<td>Tracks authorization by child/family and vendor by service.</td>
</tr>
<tr>
<td>7</td>
<td>REJIS (Regional Justice Information System)</td>
<td>City &amp; County of St. L.</td>
<td>Access to State and National criminal records.</td>
<td>REJIS provides access to the state and national criminal databases maintained by the MSHP (MULES system) and the FBI (NCIC) system. Access is limited, within DMH, to specific individuals working in Forensic Services.</td>
</tr>
<tr>
<td>8</td>
<td>CHRIS – Client Habilitation Records Information System</td>
<td>Boone County Family Resources</td>
<td>Consumer demographics; plan of care authoring and management; service authorization; providers; admission and discharge; billing and payment</td>
<td>Track consumer information, manage plans of care, procure services, and documentation of expenditures. Used by some SB-40 Boards for TCM billing. (Some locations across the State)</td>
</tr>
<tr>
<td>#</td>
<td>System Name</td>
<td>Owner</td>
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<td>Purpose/Scope*</td>
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<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9</td>
<td>Missouri Rehabilitation Information System</td>
<td>DESE</td>
<td>VR Case Management</td>
<td>Comprehensive case management system including VR case work flow from intake to closure. Integrated with the SAMII accounting to provide an efficient method for making all case service payments using paper checks or direct deposit. Provides financial and statistical reports and case management reports.</td>
</tr>
<tr>
<td>10</td>
<td>OPII</td>
<td>DOC</td>
<td>Offender information – institution; probation &amp; parole</td>
<td>Tracks information needed to manage offenders that are being supervised by the department of corrections.</td>
</tr>
<tr>
<td>11</td>
<td>MARS (Medical Assessment and Reporting System)</td>
<td>DOC</td>
<td>Mental Health; substance abuse; medical</td>
<td>Tracks health information for offenders under the supervision of the department of corrections.</td>
</tr>
<tr>
<td>12</td>
<td>DMS-MMIS, EMOMED, Cyber Access</td>
<td>DSS</td>
<td>Medicaid payments, services, eligibility</td>
<td>This system authorizes Missouri Medicaid payments for eligible clients and services.</td>
</tr>
<tr>
<td>13</td>
<td>Child &amp; Adolescent Functional Assessment System (CAFAS)</td>
<td>DMH</td>
<td>Basic Child demographics, assessment results.</td>
<td>Assessment for children, support for treatment/service planning and outcomes over time. (A few locations across the State - plan to go to all DMH locations and others)</td>
</tr>
<tr>
<td>14</td>
<td>QSR – Quality Services Review</td>
<td>DMH / Children’s Division</td>
<td>Not sure</td>
<td>Quality Service Review (QSR) developed by Dr. Ivor Groves is used to measure system of care quality improvement. It measures the quality of interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided. It is a case based review of practice, results, and working conditions used to both evaluate and stimulate practice development</td>
</tr>
<tr>
<td>15</td>
<td>Network of Care</td>
<td>DMH - outsourced to Trilogy vendor</td>
<td>Informational site for family and stakeholders. Little or no transactional data.</td>
<td>Website for service access, research, etc.</td>
</tr>
<tr>
<td>16</td>
<td>Community Connections</td>
<td>University of Missouri</td>
<td>Community Providers; Human Services</td>
<td>Resource for various human services and organizations searchable by area and specialties. May be closing down.</td>
</tr>
<tr>
<td>17</td>
<td>SAMHI</td>
<td>MIMH</td>
<td>Contact information for mental health, substance abuse, and mental retardation service organization</td>
<td>Substance Abuse Mental Health Information (SAMHI) Online is a publicly funded site designed to help consumers, families, and professionals locate services and information relating to mental health, addiction, and mental retardation services in the St. Louis, Missouri area. <a href="http://samhi.mimh.edu">http://samhi.mimh.edu</a></td>
</tr>
<tr>
<td>#</td>
<td>System Name</td>
<td>Owner</td>
<td>What it Tracks</td>
<td>Purpose/Scope*</td>
</tr>
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</tr>
<tr>
<td>18</td>
<td>MOHSAIC</td>
<td>DHSS</td>
<td>Health/Scorecard info for Senior Services; VR; NB Screening; Immunization; Communicable Disease. Program enrollment, participation demographics, progress notes, services authorized, provider information, and claims management</td>
<td>This is a web-based data system that collects information for newborn screening, lead and immunization. There are other databases within DHSS that collects immunization information and communicable diseases that are fed into MOHSAIC. MOHSAIC Service Coordination is the electronic record for Special Health Care Needs Programs.</td>
</tr>
<tr>
<td>19</td>
<td>MOJIS</td>
<td>OSCA</td>
<td>Contacts and some information about juveniles served by various agencies</td>
<td>Allows sharing of information across agencies for coordinated services and decisions regarding children</td>
</tr>
<tr>
<td>20</td>
<td>IDEA (Individuals with Disabilities Education Improvement Act)</td>
<td>DESE</td>
<td>Guidelines and standards</td>
<td>Sets standards for improved education for individuals with disabilities.</td>
</tr>
<tr>
<td>21</td>
<td>DWITS</td>
<td>MSHP</td>
<td>Drinking; DWI</td>
<td>The DWI Tracking System (DWITS) is a secure Internet-based computer application that improves the collection and dissemination of case information on alcohol/drug-involved driving and traffic related offenses. It can be used to track driving while intoxicated (DWI) cases through their entire life cycle including arrest, prosecutorial action, and court disposition.</td>
</tr>
<tr>
<td>22</td>
<td>FAMIS</td>
<td>DSS</td>
<td>Provider Registration, Child Care, Food Stamps, Temporary Assistance for Needy Families, and Family Medicaid</td>
<td>FAMIS is a statewide, automated, integrated eligibility system for DSS programs including Child Care, Food Stamps, Temporary Assistance and Medicaid.</td>
</tr>
<tr>
<td>23</td>
<td>MACCS</td>
<td>DSS</td>
<td>Child Support Enforcement</td>
<td>MACSS processes and tracks the child support payments made to all persons in the State of Missouri, as well as some in other states and countries.</td>
</tr>
<tr>
<td>24</td>
<td>MMIS – Medicaid</td>
<td>DSS</td>
<td>Medicaid claims processing system.</td>
<td>Pays vendors for medical services provided to clients based on eligibility.</td>
</tr>
<tr>
<td>25</td>
<td>Common Client/DCN</td>
<td>DSS</td>
<td>Maintains basic non-changing demographic information i.e. race, sex, DOB, Name, etc. Also, Department Client Number (DCN) is a unique identification number used by DSS, DHSS and others to track participation in programs.</td>
<td>Client identification and participation tracking.</td>
</tr>
<tr>
<td>#</td>
<td>System Name</td>
<td>Owner</td>
<td>What it Tracks</td>
<td>Purpose/Scope*</td>
</tr>
<tr>
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<td>---------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>26</td>
<td>LTACS – Long-Term Alternative Care Systems</td>
<td>DHSS</td>
<td>Tracks client data</td>
<td>Includes level of care, types of services, funding sources, protective services information and Title XIX eligibility for persons in Long Term Care.</td>
</tr>
<tr>
<td>27</td>
<td>Family Care Safety Registry</td>
<td>DHSS</td>
<td>Persons who have been disqualified from providing care</td>
<td>Provides background information on potential caregivers. Families and employers can call the registry’s toll-free telephone line to request background information on registered child-care, elder care, and personal caregiver workers or to request licensure status information on licensed child-care and elder care providers.</td>
</tr>
<tr>
<td>28</td>
<td>Missouri Sex Offender Registry</td>
<td>MSHP</td>
<td>People convicted of Sexual Offense</td>
<td>Provides public access to information about persons registered as sexual offenders. Individuals included on the site are included solely by virtue of their conviction record and Missouri state law. The primary purpose of providing this information is to make the information easily available and accessible, not to warn about any specific individual.</td>
</tr>
<tr>
<td>29</td>
<td>Traumatic Brain Injury Registry</td>
<td>DHSS</td>
<td>Hospitals submitted registry on incidents of traumatic brain injury, demographics of injured person, and cause of injury.</td>
<td>The registry data provides information on incident rates, location of injuries, and causes. Customized reports of registry information can be obtained from the DHSS website.</td>
</tr>
<tr>
<td>30</td>
<td>EMSSystem</td>
<td>MHA</td>
<td>ER Availability; Psychiatric Bed Availability</td>
<td>Missouri Hospital Association’s (MHA) statewide, Internet-based communications system linking hospitals, major metropolitan emergency services providers, local public health agencies and the DHSS. Used daily to help hospitals update, monitor, and report ambulance diversions. Real-time communications of public health alerts and clinical treatment information between public health agencies and hospitals.</td>
</tr>
<tr>
<td>31</td>
<td>No Interface Exists - all services are tracked through FACES</td>
<td>DYS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>DSS Vendor System - Being replaced by FACES see # 43</td>
<td>DSS</td>
<td>Vendors utilized by CD clients</td>
<td>Tracks vendor licensure and contract information, including address, capacity, services, etc.</td>
</tr>
<tr>
<td>33</td>
<td>Child Abuse/Neglect System - Replaced by FACES see # 43</td>
<td>DSS</td>
<td>All reports of abuse/neglect</td>
<td>Tracks allegations, alleged victims, alleged perpetrators, disposition of investigation or assessment</td>
</tr>
<tr>
<td>#</td>
<td>System Name</td>
<td>Owner</td>
<td>What it Tracks</td>
<td>Purpose/Scope*</td>
</tr>
<tr>
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</tr>
<tr>
<td>34</td>
<td>EARN Works</td>
<td>Office of Disability Emp.</td>
<td>National Job Bank for Employment</td>
<td>Provides information on employment opportunities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Policy (federal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Ticket To Work - MAXIMUS</td>
<td>SSA</td>
<td>Provides Reports, Sends list of participants who just were determined to be</td>
<td>Encourages individuals to earn a living wage. Resource to organizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>disabled</td>
<td>providing employment services to target individuals who need employment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>services</td>
</tr>
<tr>
<td>36</td>
<td>One Stop Tool Kit</td>
<td>DOL (federal)</td>
<td>List of resources for organizations to use for training and also training</td>
<td>Resources for organizations delivering Employment services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>materials</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>RCEP 7</td>
<td>University of Missouri</td>
<td>Provides information on training opportunities and entitlements</td>
<td>Resources for organizations delivering Employment services. This is a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rehabilitation Continuing Education Program in 4 states (MO, KS, NE, IA)</td>
</tr>
<tr>
<td>38</td>
<td>REAC-Real Estate Assessment Center</td>
<td>HUD</td>
<td>Information assessing the condition of HUD’s portfolio</td>
<td>Provides information to help ensure safe, decent and affordable housing.</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>Verification of information for recertification process; Verification of</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>payment and non-payment and reason.</td>
</tr>
<tr>
<td>39</td>
<td>WIA (Workforce Investment Act)</td>
<td>DED</td>
<td>unemployment</td>
<td>Offers career development, skill development, employer job posting, job</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>search and job matching, all in an environment that is known as Missouri</td>
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<td></td>
<td>Career Centers. Centers are located throughout the state; they have about</td>
</tr>
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<td></td>
<td></td>
<td>41 Missouri Career Centers. Virtual (Internet) access to the system is</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>provided by a web-site called GreatHires.</td>
</tr>
<tr>
<td>40</td>
<td>Access Crisis Intervention (ACI)</td>
<td>DMH Providers</td>
<td>No stored data</td>
<td>DMH contracts with providers to staff phone lines 24/7 with mental health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>professionals who can respond to a personal crisis. They help determine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>what further help is needed immediately or later.</td>
</tr>
<tr>
<td>41</td>
<td>2-1-1 System</td>
<td>United Way</td>
<td>Social services contacts</td>
<td>Phone Information and Referral system for health and human services Now</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>largely statewide in Missouri.</td>
</tr>
<tr>
<td>#</td>
<td>System Name</td>
<td>Owner</td>
<td>What it Tracks</td>
<td>Purpose/Scope*</td>
</tr>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>42</td>
<td>Family and Children Electronic System (FACES)</td>
<td>DSS</td>
<td>Demographic data; placement information; federal funding eligibility, child-specific payments, service authorizations, vendors and all reports of abuse and neglect</td>
<td>Tracks information regarding child’s placement; Medicaid, IV-E, EAS, and Rehab federal funding; legal status, court information, handicapping conditions, vendor and child specific payment information by payment date, funding source, and service. Tracks vendor licensure and contract information, including address, capacity, services, allegations, alleged victims, alleged perpetrators, disposition of investigation or assessment</td>
</tr>
<tr>
<td>43</td>
<td>Fetal Alcohol Syndrome Surveillance System</td>
<td>DHSS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>IAN (Interactive Autism Network)</td>
<td>Kennedy Kieger Foundation</td>
<td>A variety of self reported demographics, medical, social and treatment history on persons with ASD history.</td>
<td>A voluntary online national registry designed to accelerate the pace of autism research and treatment.</td>
</tr>
<tr>
<td>45</td>
<td>ScreenMO</td>
<td>MIMH</td>
<td>Anonymous screening information</td>
<td>ScreenMO offers free self-assessments to help adolescents (or concerned others) decide if they have difficulties for which professional assistance is available. Individuals can take a brief (less than one minute) screen to help identify problems and get referral information. Areas assessed include Employment, Legal problems, Substance use, Depression, MR/DD, Housing, Tobacco use, Medical, Bipolar. Based on the screening information the system offers referral suggestions (in the St. Louis area) and includes specific authoritative information links. <a href="http://www.ScreenMO.org">www.ScreenMO.org</a></td>
</tr>
</tbody>
</table>

*Purpose/Scope*
References


Canadian Coalition for Seniors’ Mental Health. (2006). *National Guidelines for Seniors’ Mental Health: The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behavioural Symptoms)* Toronto, ON.


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