

**Missouri**

**UNIFORM APPLICATION  
2011**

**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.

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

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**FACE SHEET**  
**FISCAL YEAR/S COVERED BY THE PLAN**  
  X   **FY2011**

STATE NAME: Missouri

DUNS #: 780871430

**I. AGENCY TO RECEIVE GRANT**

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Division of Comprehensive Psychiatric Services

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

CITY: Jefferson City                      STATE: MO                      ZIP: 65102

TELEPHONE: 573-526-5890    FAX: 573-751-7815

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

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

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT:

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

CITY: Jefferson City                      STATE: MO                      ZIP CODE: 65102

TELEPHONE: (573) 751-3070    FAX: (573) 526-7926

**III. STATE FISCAL YEAR**

FROM: 07/01/2010                      TO: 06/30/2011

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

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

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Division of Comprehensive Psychiatric Services

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

CITY: Jefferson City                      STATE: MO                      ZIP: 65102

TELEPHONE: 573-526-5890    FAX: 573 751-7815    EMAIL: rosie.anderson-harper@dmh.mo.gov

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

## Executive Summary

The Missouri Department of Mental Health (DMH) submits this Fiscal Year (FY) 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. In 2011, DMH is also focusing on SAMHSA's 10 Strategic Initiatives.

Missouri has experienced the devastating effects of the economic downturn. The severe reductions in state general revenue have caused the DMH to face core budget reductions. In State FY 2010, to balance the budget in an economy that repeatedly failed to meet projections, Governor Nixon required expenditure restrictions (withholdings) of General Revenue (GR) and Federal Budget Stabilization funding several times during the year. DMH's restrictions totaled \$15,375,044 from July 2009 to April 2010. These restrictions were in addition to a \$47.2 million cut to DMH's SFY 2010 GR core budget.

DMH has lost the most jobs in state government in the last 18 months. Mental Health lost the fulltime equivalent (FTE) of 952 jobs from the end of fiscal year 2008 to beginning of fiscal year 2011. The department is slated to drop another 92 positions among the 255 new cuts Gov. Jay Nixon announced in June, the most of any state agency.

Due to the budget reductions, tough decisions have been made regarding closure of acute care settings and emergency rooms operated by the department. Missouri has closed its two remaining psychiatric emergency rooms and five acute psychiatric units in St. Louis and Farmington. Last year, DMH closed its ERs and acute units in Columbia and Kansas City. DMH anticipates a reduction of approximately 300 FTE through the downsizing process. The closures place an additional stress on community providers.

DMH continues to apply for funding through outside entities and thoroughly investigates Federal and private grant sources. Emphasis has been placed on implementing evidence-based practices to create greater efficiency and effectiveness. To maximize dollars, fiscal management of mental health services is coordinated with other human services departments, the Medicaid agency (MO HealthNet), and the Governor's Office. The DMH has been designated as an Organized Health Care Delivery System, which allows reimbursement for some of the administrative services provided for Medicaid. Budgetary planning is formalized and continues to include consumer and public input.

The Mental Health Authority for Missouri, the Division of Comprehensive Psychiatric Services (CPS), continues initiatives that are enhancing 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 Office of Transformation is currently in the final year of the grant. 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, focus on evidence based practices (EBP) and public education on mental health.

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. 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. Children's mental health staff continues to work with others partners to improve treatment for youth with co-occurring disorders and address the transition from youth to adult services.

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 made great strides in State Fiscal Year 2010 on implementing EBPs.

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

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

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 continues to fund and support 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. Housing for Veteran's has recently been attained in the St. Louis area.

Children's core services are case management, psychiatry, medication management, crisis services, treatment family homes, and day treatment. 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 children's services 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. 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.*

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 serious mental illness and severe emotional disturbances. DMH 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 2011

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

### **Section 1911:**

Subject to Section 1916, the State<sup>1</sup> will expend the grant only for the purpose of:

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

### **Section 1912**

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

### **Section 1913:**

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

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

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

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

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

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<sup>21</sup>. The term State shall hereafter be understood to include Territories.

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

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

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

**Section 1914:**

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

(b) The duties of the Council are:

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

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

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

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

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

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

**Section 1915:**

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

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

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

**Section 1916:**

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

(1) to provide inpatient services;

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

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

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

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

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

**Section 1941:**

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

**Section 1942:**

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

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

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

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

(c) The State will:

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

**Section 1943:**

- (a) The State will:
  - (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
  - (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
  - (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
  - (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section
  
- (b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

---

Governor  
Kent Schaefer, Ed.D., Director  
XXXXXXXX

Date

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

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

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

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

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

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

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

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

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

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

### 3. CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

**5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

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

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

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

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

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

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

## DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB  
0348-0046

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

<b>1. Type of Federal Action:</b>  <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. Status of Federal Action</b>  <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. Report Type:</b>  <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change  <b>For Material Change Only:</b> Year _____ Quarter _____  date of last report _____
<b>4. Name and Address of Reporting Entity:</b>  <div style="display: flex; justify-content: space-between;"> <span>Prime</span> <span>Subawardee</span> </div> <div style="text-align: center; margin-top: 10px;">         Tier _____, if known:       </div> <div style="margin-top: 20px;">         Congressional District, if known:       </div>		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>     Congressional District, if known:
<b>6. Federal Department/Agency:</b>	<b>7. Federal Program Name/Description:</b>   CFDA Number, if applicable: _____	
<b>8. Federal Action Number, if known:</b>	<b>9. Award Amount, if known:</b>  \$ _____	
<b>10. a. Name and Address of Lobbying Entity</b> <i>(if individual, last name, first name, MI):</i>	<b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>	
<b>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</b>	Signature: _____  Print Name: _____  Title: _____  Telephone No.: _____ Date: _____	
<b>Federal Use Only:</b>		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.

**ASSURANCES - NON-CONSTRUCTION PROGRAMS**

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

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

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

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

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

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

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

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

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

## **Public Comments on the State Plan**

In accordance with Section 1941 of the Block Grant legislation, the State of Missouri has provided ample opportunity on an ongoing basis for public comments on the State Plan. The fiscal year 2005, 2006, 2007, 2008, 2009 and 2010 State Plans are posted on the DMH website at <http://www.dmh.mo.gov/cps/rpts/blockgrant/blockgrant.htm> with instructions to send comments to the department. The 2006, 2007, 2008 and 2009 Implementation Reports are also posted on the DMH website for comment.

The Mental Health Planning Council for Missouri has instituted a regular review of the Block Grant at their monthly open meetings. Meeting agendas are posted to the DMH website at least 24 hours before the open public meetings. Block Grant Discussion is clearly labeled on the agendas, thus giving the general public opportunity to attend the meeting and make comment. The Planning Council regularly engaged in discussion about evidence-based practices, mental health transformation, budget and data analysis throughout the fiscal year 2010 relevant to the Block Grant state plan. The Planning Council has direct access to the Department and Division Directors, at meetings and by phone/email/DMH blog, to offer opinions and comments on the adequacy of mental health services within the State.

The Planning Council was emailed copies of the draft State Plan for comment. The July and August 2010 meetings provided specific time for discussion of the draft State Plan. The Planning Council was provided the website and login information to review the state plan online at WebBGAS. All comments have been considered and incorporated where applicable.

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

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

### Data Reported by:

State FY   X   Federal FY \_\_\_\_\_

### State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2009	Estimate/Actual FY 2010
<u>\$14,716,201</u>	<u>\$28,899,982</u>	<u>\$26,705,621</u>

### Waiver of Children's Mental Health Services

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

### III. MAINTENANCE OF EFFORT(MOE) REPORT

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

#### **MOE Exclusion**

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

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

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

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

#### **MOE information reported by:**

State FY   X   Federal FY \_\_\_\_\_

#### **State Expenditures for Mental Health Services**

**Actual FY                  Actual FY                  Actual/Estimate FY**

2008	2009	2010
<u>\$130,806,271</u>	<u>\$136,681,726</u>	<u>\$135,412,476</u>

## MOE Shortfalls

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

These conditions are described below.

### (1). Waiver for Extraordinary Economic Conditions

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

### (2). Material Compliance

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

**TABLE 1.  
Members**

**List of Planning Council**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Anderson, Barbara K.	Consumers/Survivors/Expatrients(C/S/X)		5577 Connecticut St. Louis, MO 63139 PH:314-781-5492 FAX:	BKanderson2@att.net
Bussabarger, Mary Louise	Family Members of adults with SMI		1914 Princeton Dr. Columbia, MO 65203 PH:(573) 445-4147 FAX:	
Chase, Stewart	Providers	ReDiscover	901 NE Independence Avenue Lee Summit, MO 64086 PH:816-246-8000 FAX:816-246-8207	sachase@rediscovermh.org
Clements, Lisa	State Employees	Medicaid	P.O. Box 6500 Jefferson City, MO 65102-6500 PH:573-522-8336 FAX:	Also Represents Department of Social Services
Cushing, Heather J.	Family Members of Children with SED		106 Distinction Lake St. Louis, MO 63367 PH:314-608-	hjcushing@gmail.com

Evers, Randall L.	Consumers/Survivors/Ex- patients(C/S/X)	1206 FAX: 209 Pierce Street Jefferson City,MO 65101 PH:573-353- 2162 FAX:	synkronicite@yahoo.com
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**TABLE 1.  
Members**

**List of Planning Council**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Giovanetti, Scott	State Employees	Mental Health	Department of Mental Health 5400 Arsenal Street St. Louis, MO 63139 PH:314-877-0372 FAX:314-877-0392	scott.giovanetti@dmh.mo.gov
Greening, Andrew B.	Providers	Preferred Family Healthcare	900 East La Harpe Street Kirksville, MO 63501 PH:573-248-3811 FAX:573-248-3080	agreening@pfh.org
Hagar-Mace, Liz	State Employees	Housing	1706 East Elm P.O. Box 687 Jefferson City, MO 65102 PH:(573) 522-6519 FAX:(573) 526-7797	liz.hagar-mace@dmh.mo.gov
Harper, John	State Employees	Vocational Rehabilitation	3024 DuPont Circle Jefferson City, MO 65101 PH:(573) 526-7040 FAX:(573)	john.harper@vr.dese.mo.gov

			751-1441	
Hawkins, Robert	Consumers/Survivors/Ex- patients(C/S/X)		43 Catamaran Drive Lake St. Louis,MO 63367 PH:636-352- 6648 FAX:	JudyWilga@charter.net
Johnson, Jessica	Consumers/Survivors/Ex- patients(C/S/X)		1118 London Drive Columbia,MO 65203 PH:(417) 343-1634 FAX:	jessicajohnson22@gmail.com

**TABLE 1.  
Members**

**List of Planning Council**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Jones, Karren	Consumers/Survivors/Ex-patients(C/S/X)	NAMI of Missouri	1210 Linden Drive Apt. 13 Jefferson City, MO 65109 PH:(573) 636-6188 FAX:	mocamiksj@yahoo.com
Markway, Ph.D., Gregory	State Employees	Criminal Justice	2729 Plaza Drive P.O. Box 236 Jefferson City, MO 65102 PH:(573) 526-6523 FAX:(573) 526-8156	greg.markway@doc.mo.gov
Meachum-Cain, Glenda	State Employees	Other	Department of Health and Senior Services 930 Wildwood Jefferson City, MO 65102 PH:(573) 751-6064 FAX:	glenda.meachum-cain@dhss.mo.gov
Minth, Helen	Consumers/Survivors/Ex-patients(C/S/X)	St. Louis Empowerment Center	3024 Locust St. Louis, MO 63118 PH:(314) 652-6100 FAX:(314) 652-6103	hminth@sbcglobal.net
			P.O. Box 140671 Kansas	mh-advocate@live.com

Nugent, Jennifer L.	Consumers/Survivors/Ex- patients(C/S/X)		Kansas City,MO 64114 PH:816-286- 8224 FAX:	
Qualls, Robert	Consumers/Survivors/Ex- patients(C/S/X)		2145 W. Brower Springfield,MO 65802 PH:(417) 831- 2985 FAX:	robert-qualls@sbcglobal.net

TABLE 1.

## List of Planning Council

## Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Riley, Jerome	Consumers/Survivors/Ex-patients(C/S/X)		1248 Linden, Apt. 3 Cape Girardeau,MO 63703 PH:573-339- 6148 FAX:	jriley@cccctr.com
Robbins, John	State Employees	Education	Department of Elementary and Secondary Education 205 Jefferson Jefferson City,MO 65102 PH:(573) 522- 1488 FAX:(573) 526-4261	john.robbs@dese.mo.gov
Stephens, Erica	Providers	Missouri Protection & Advocacy	925 South Country Club Drive Jefferson City,MO 65109 PH:(573)-893- 3333 FAX:(573) 659-0677	erica.stephens@mo-pa.org
Thomas, Tish	Others(not state employees or providers)	UMKC - Institute for Human Development	1706 East Elm Jefferson City,MO 65102 PH:573-751- 8076	tish.thomas@dmh.mo.gov

			FAX:573-751-9207	
Thomason, Qiana	Providers	Swope Health Services	3801 Blue Parkway Kansas City, MO 64130 PH:816-922-7645 FAX:816-922-7683	QThomason@swopecommunity.org

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

Type of Membership	Number	Percentage of Total Membership
<b>TOTAL MEMBERSHIP</b>	23	
Consumers/Survivors/Ex-patients(C/S/X)	9	
Family Members of Children with SED	1	
Family Members of adults with SMI	1	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	1	
<b>TOTAL C/S/X, Family Members and Others</b>	12	52.17%
State Employees	7	
Providers	4	
Vacancies	0	
<b>TOTAL State Employees and Providers</b>	11	47.83%

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

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

reviewing plans and submitting to the State any recommendations for modification

serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems, monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.

the role of the Planning Council in improving mental health services within the State.

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

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



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

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

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

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

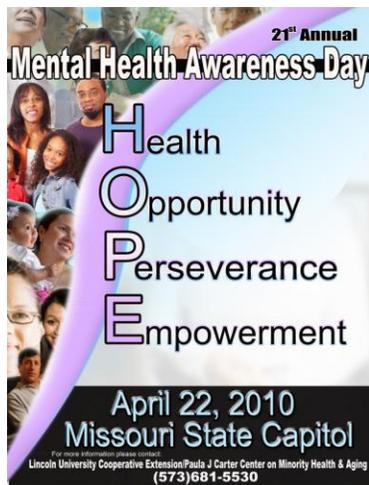
The State of Missouri is committed to ensuring the voice and perspective of mental health consumers inform the provision of mental health services throughout the state. The CPS/SAC has played an active role in developing and fulfilling this commitment by convening on a monthly basis to review plans and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

### **Advocacy**

The CPS/SAC serves as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems. CPS/SAC advocacy activities include promoting the Consumer/Family/Youth Conference, 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, and Mental Health Transformation activities to name a few. Presentations were provided at monthly meetings on topics such as Mental Health Block Grant, Budget Priorities, Performance/Outcome Data, Evidence-Based Practices, Tobacco Cessation, Suicide Prevention, Consumer Involvement in Monitoring Community Agencies, Mental Health Transformation, Consumer Operated Drop-In Centers, Wellness Recovery Action Planning, Peer Specialist Certification, Protection and Advocacy, Mental and Physical Health Connection, Person Centered Planning, Homelessness and Housing Report, Employment, Mental Health First Aid and Communities of Hope, Consumer/Family/Youth Summit, Dialectical Behavior Therapy Overview, Mil Tax Boards, Children's Mental Health, Placement of Individuals in the

Community and Guardianship Issues, By-Law Revisions, Library Services and Technology Act, Heartland Consumer Network, Missouri Cadre for Co-Occurring Excellence, Crisis Intervention Teams, Veterans Services in the State, Minds on the Edge Video and Discussion, Federally Qualified Health Centers/Community Mental Health Centers Initiative, and State Fiscal Year 2012 Budget Development.

There are plans to include consumers in legislative discussions to provide their personal stories of recovery during the upcoming session.



**Mental Health Awareness Day 2010, Hope, Opportunity, Perseverance, Empowerment**, at the State Capitol on April 22<sup>nd</sup> was a success. Over 360 consumers and advocates converged on the Missouri State Capitol for educational opportunities and advocacy. The event included a welcome from Helen Minth, Chair of the State Advisory Council; Robert Qualls, Mental Health Champion; and Keith Schafer, Director of the Department. Workshops on How to Start a Wellness Program and Person-Centered Planning were provided. Individuals with mental illness and their families made appointments with their legislators to share their personal stories.

### **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 2010 meetings focused on discussion and review of the Block Grant proposal.
2. CPS/SAC meetings often include presentations on the budget, current programming, grants, and initiatives for the purpose of allowing input and feedback on the adequacy of mental health services within the State.
3. CPS/SAC meetings include monthly conversations with the Department and Division Directors or designees allowing feedback and ideas to be presented directly to decision makers.
4. CPS/SAC members are full team members for certification surveys of the community mental health centers. These reviews evaluate the quality of care from a consumer/family perspective. Seventeen organizations have been reviewed with the Consumer/Family Monitors as team members since 2008.

### **The Role of the Planning Council in Improving Mental Health Services**

The goal of the CPS/SAC is to improve mental health services within the State of Missouri. The Office of Transformation Director continues to attend CPS/SAC meetings to provide updates on the plan implementation and obtain input from members. The Chair of the CPS SAC continues to serve on the



Transformation Working Group to provide oversight of the Mental Health Transformation grant. Two CPS/SAC members have been trained in Mental Health First Aid as part of the Mental Health Transformation Show Me Series. Past Block Grant Plans present detailed descriptions of the significant CPS SAC involvement in the Transformation process over the past four years. As the final year of the grant wraps up, the CPS SAC will continue to be involved in sustaining the gains made and assisting with implementation as appropriate.

After the *Minds on the Edge* video and discussion meeting, the Department of Corrections representative on SAC incorporated the video into the DOC system. He brought the training and discussion tool to the national meetings he attends and is working towards integrating it into statewide training of DOC staff.



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 third annual Mental Health Champions recognition. Three persons were selected from statewide nominations as Mental Health Champions. A member of CPS/SAC was nominated for the Champions award. The nominees were representative of individuals with mental illnesses, developmental disabilities, and persons in recovery from substance or gambling addictions. They were persons who have overcome their personal challenges to make life better for others and for their communities. The third Mental Health Champions Banquet was held April 7, 2010, 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.*

Several of the CPS/SAC members are also members of the National Alliance for the Mentally Ill (NAMI). There have been several collaborative activities with NAMI Missouri regarding reducing stigma. An attorney from the Missouri Protection and Advocacy organization is a member of CPS/SAC. In 2009, a Veteran's representative was added to the council. A staff person with the Centers for Medicare and Medicaid Services Person Centered Planning grant is a member of the SAC. She keeps the SAC updated on progress and requests their feedback at meetings. CPS SAC has accomplished representation of individuals over the life span from college age to seniors.

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

To ensure excellent mental health care is delivered and research is accelerated, CPS/SAC has had discussions on evidenced based practices including Integrated Dual Disorders Treatment, Assertive Community Treatment, Dialectical Behavior Therapy, and Supported Employment for adults and Comprehensive System of Care for children. One of the Consumer Operated Drop-In Center Executive Directors actively participates on CPS/SAC.

### **Planning Council Goals**

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

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

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

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

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

The Division Director approved the recommendations. CPS/SAC developed a survey tool with interview questions and training curriculum for consumer monitors. Seventeen agencies have received certification surveys in 2008-2010 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**

Several members of the CPS/SAC were involved in planning the first statewide consumer/family/youth conference with the Office of Consumer Affairs that occurred in November 2008. A second annual consumer/family/youth conference occurred August 23-25, 2009. The third annual Consumer/Family/Youth Conference occurred on August 23-25, 2010, with 340 individuals participating. CPS SAC members played a major role in planning the conference. CPS/SAC members will continue their involvement in this annual event to train consumer/family/youth leaders.

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



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

With the oversight of the CPS/SAC, Peer Specialist Basic Trainings have been conducted since 2008. The week-long training has been conducted by Mental Health America of the Heartland staff and a trained CPS SAC member. Four additional Missouri Peer Specialist Trainers have been trained. To date 157 individuals have been trained and 90 have reached the goal of Certified Missouri Peer Specialist status. Twenty community mental health centers have sent individuals to the training and 12 have certified peer specialists working in their agencies. Ten Consumer Operated Services Program Drop-In Centers and Warm Lines sent individuals to the training. Additionally, the Veteran’s Administration, residential providers, Services for Independent Living, and a substance abuse treatment agency have sent individuals to the training. Two Peer Specialist Supervisor Trainings were conducted. In 2010-2011, additional Peer Specialist Basic Trainings and Supervisors trainings will be planned. Additionally, there are plans for a more cohesive network to be formed with regular conference calls of the trained individuals to provide ongoing support and consultation.

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



## BYLAWS OF THE STATE ADVISORY COUNCIL FOR COMPREHENSIVE PSYCHIATRIC SERVICES

### *Article I – Mission*

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

### *Article II – Responsibilities*

In order to accomplish this mission the SAC shall:

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

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

Provide education and information about mental health issues.

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. Exceptions to terms of office can be made at the discretion of the State Advisory Council with approval by 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.

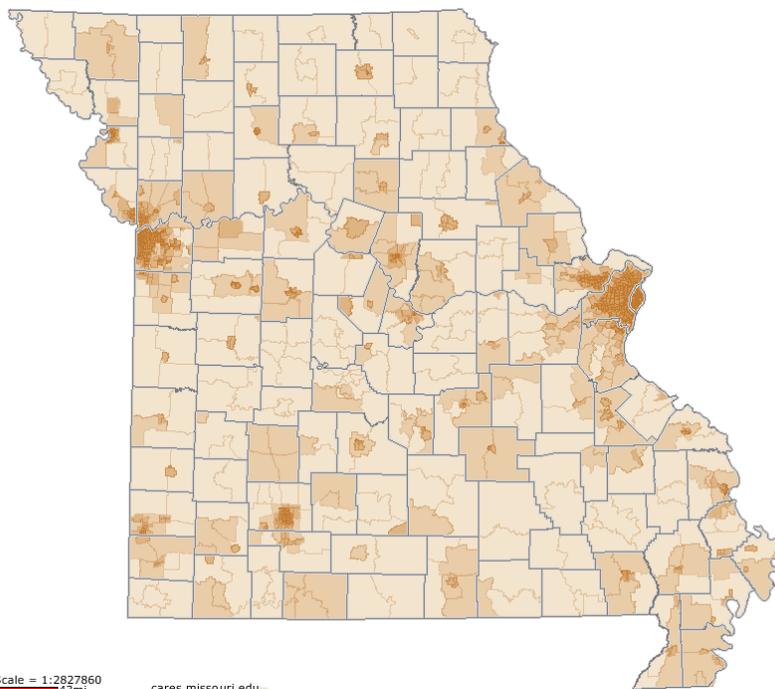
Approved 9/24/09

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

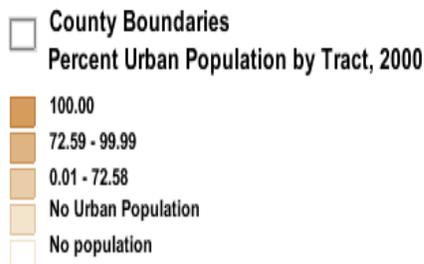
Named after the Siouan Indian tribe meaning "town of the large canoes", Missouri is a Midwestern State, but its culture has some Southern influences, especially in the lower third of the state and away from the urban centers. Missouri earned the nickname "Gateway to the West" because it served as a departure 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.



Map Scale = 1:2827860  
0 43mi

cares.missouri.edu



State Capital: Jefferson City

Governor: Jay Nixon

Population: 5,842,713 (2006)

Area: 68,886 sq miles

Counties: 141 + 1

Cities > 100K: (2005)

445K Kansas City

344K St Louis City

159K Springfield

110K Independence

Counties > 250K: (2006)

1,001K St Louis

County

664K Jackson

County

339K St Charles

255K Greene

The Bureau of Economic Analysis estimates that Missouri's total gross domestic product (GDP) in 2008 was \$193.7 billion. Per capita GDP in 2008 was \$32,779, 29<sup>th</sup> in the nation. Major industries include aerospace, transportation equipment, food processing, chemicals, printing/publishing, electrical equipment, light manufacturing, and beer. Tourism, services, and wholesale/retail trade follow manufacturing in importance.

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

The DMH has three operating divisions: Division of Comprehensive Psychiatric Services (CPS), Division of Alcohol and Drug Abuse (ADA), and the Division of Developmental Disabilities (DD). 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 five regional hospital systems comprised of nine CPS inpatient facilities. Each hospital system has a single Regional Executive Officer (REO) and each facility within a hospital system has its own chief operating officer (COO). For the provision of community based services, Missouri's 114 counties and the City of St. Louis are subdivided into 25 mental health service areas, each with an Administrative Agent (AA). AA's are community mental health centers responsible for the assessment and provision of services to persons in their designated area and for providing follow-up services to persons released from State-operated inpatient services. The Office of Comprehensive Child Mental Health (OCCMH) was established within DMH in 2004. This office assures the implementation of a Comprehensive Children's Mental Health Service System and is advised by the Comprehensive Child Mental Health Clinical Advisory Council.

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

## Missouri DMH Overview Statistics

### Department of Mental Health

- Annual budget: \$1.1 billion -- 53% GR, 43% Federal, 4% Other Funds
- DMH contracts with over 1,600 providers employing over 30,000 people in communities statewide.
  - Certifies 674 providers
  - Licenses 405 community facilities and programs
- Community Based Services = 67% of total budget and serve 95% of all DMH clients.
- DMH employs 7,873 Full-Time Equivalent positions statewide.
- State operated services = 27% of total budget and serve 5% of all DMH clients.

### Comprehensive Psychiatric Services

- 9 state operated facilities
  - 7 State psychiatric hospitals for adults with SMI
  - 2 Child psychiatric hospitals for children with SED
- 75,838 unduplicated consumers served in FY10



## Mission

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

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## 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.*

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## Values



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



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



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



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



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



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



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

January 2008

The DMH Division of CPS operates nine facilities, providing acute, long term rehabilitation and residential care for youth and adults as well as forensic, sexual predator and corrections services for adults. The number of statewide psychiatric beds in Fiscal Year 2010 was 1,334.

CPS is responsible for statewide mental health services. It operates two children and seven adult hospitals. CPS contracts with 26 community-based agencies to provide psychiatric rehabilitation services. ADA contracts with 44 community based organizations to provide the full spectrum of substance related services (prevention through inpatient/residential care). There are a total of 33 ADA-only community contract agencies, 15 CPS-only contractors, and 11 agencies with both a CPS and ADA contracts, 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. The DMH has a Housing Unit that coordinates housing for thousands of individuals and families. The Housing Unit coordinates housing utilizing an array of federal and state dollars.

Seventeen counties and the city of St. Louis have passed Mental Health Mil Taxes and have Mental Health Boards. Six counties have passed a Children's Services Tax to provide an array of treatment and prevention services. Six additional counties have formed task forces to propose ballot issues in the next year. Six counties are participating with one additional pending in a program that facilitates the use of federal funds to expand the amount of funds and services available in the county. The combined revenue available for services in these counties is approximately \$69 million.

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

The department continued its suicide prevention efforts by contracting with 14 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 and five Peer Support Phone Lines for persons with mental illness. Jean Campbell, Ph.D., principal investigator of the COSP Multi-site Research Initiative, continues to work as a consultant to determine the fidelity of the Drop-In Centers to peer support evidence based practices as determined by the Fidelity Assessment/Common Ingredients Tool (FACIT). Peer Evaluators have been trained and are currently monitoring the agencies. Results of the findings are helping each program to improve the quality of services delivered.

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

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

1908 Olive Blvd.

St. Louis, MO 63103

Phone: (314) 652-6100

Fax: (314) 652-6103

Contact: Helen A. Minth

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

**Mental Health America of the Heartland**

**ARK of Friends**

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

**NAMI of Southwest Missouri**

**“The Hope Center”**

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

**Self-Help Center**

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

**Truman Behavioral Health**

**“Consumer Run Drop-In Center”**

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

## Warm Lines/Peer Phone Support Services

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

**“Compassionate Ear Warm line”**

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

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

739 Minnesota Avenue

Kansas City, KS 66101

Agency phone: (913) 281-2221

Fax (913) 281-3977

Contact: Petra Robinson

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

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

### **Community Counseling Center’s**

**Consumer Advisory Board**

**TLC Warm Line**

**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@ccentr.com](mailto:jjohnson@ccentr.com)

### **NAMI of Missouri**

**WARMLine**

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

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

3405 West Truman Blvd., Suite 102

Jefferson City, MO 65109

Agency phone: (573) 634-7727

Fax: (573) 761-5636

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

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

### **NAMI of Southwest Missouri**

**“The Hope Center”**

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

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

1701 S. Campbell

Springfield, MO 65807

Agency phone: (417) 864-7119

Fax: (417) 864-5011

Contact: Dewayne Long

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

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

**Depressive and Bipolar Support Alliance of Greater St. Louis**

**“Friendship Line”**

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

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

2734 Gravois

St. Louis, MO 63118

Agency phone: (314) 865-2112

Fax: (314) 652-6103

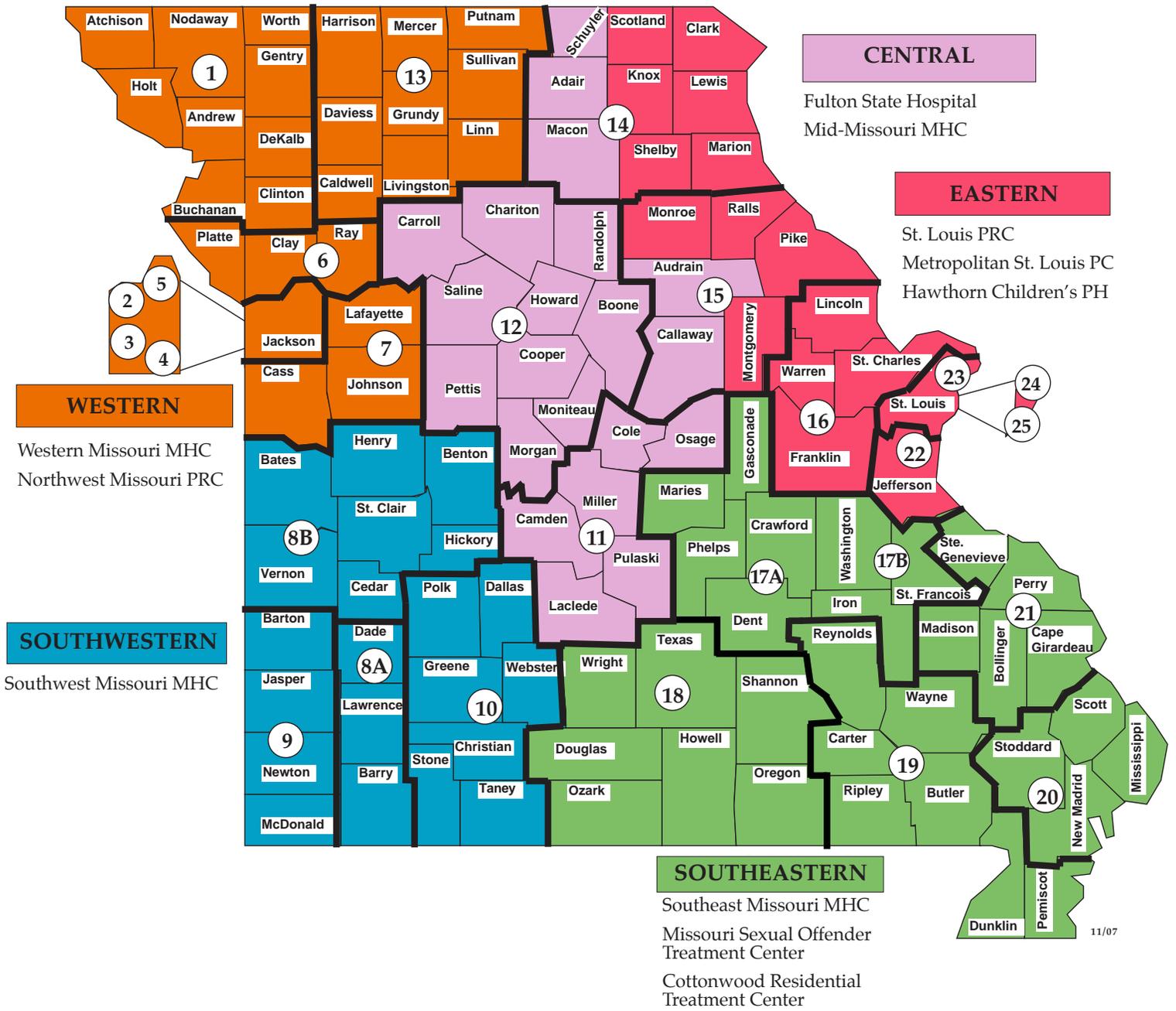
Contact: Helen A. Minth

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

# MISSOURI DEPARTMENT OF MENTAL HEALTH

## Division of Comprehensive Psychiatric Services

### ACUTE AND LONG-TERM INPATIENT CARE



**WESTERN REGION**  
*Dick Gregory, REO*  
 Western Missouri Mental Health Center - Felix Bldg.  
 2211 Charlotte  
 Kansas City, MO 64108  
 816-512-4900

**SOUTHWESTERN REGION**  
*Denise Norbury, REO*  
 Southwest Missouri Mental Health Center  
 1301 Industrial Parkway East  
 El Dorado Spring, MO 64744  
 417-876-1002

**SOUTHEASTERN REGION**  
*Karen Adams, REO*  
 Southeast Missouri Mental Health Center  
 1010 West Columbia  
 Farmington, MO 63640  
 573-218-6792

**CENTRAL REGION**  
*Robert Reitz, Ph.D., REO*  
 Fulton State Hospital  
 600 East 5th St.,  
 Fulton, MO 65251  
 573-592-4100

**EASTERN REGION**  
*Laurent Javois, REO*  
 St. Louis Psychiatric Rehabilitation Center  
 5300 Arsenal St.  
 St. Louis, MO 63139  
 314-644-8001

CPS FACILITY LISTING – August, 2010

CENTRAL REGION	EASTERN REGION	WESTERN REGION	SOUTHEAST REGION	SOUTHWEST REGION
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<p><b>Chief of Children's Community Operations</b>  <b>Beth Ewers BB 573-418-6211</b>                      Fulton State Hospital                      600 E. Fifth                      Fulton, MO 65251                      (573) 592-2124 FAX: (573) 592-2119</p>	<p><b>Chief of Children's Community Operations</b>  <b>Al Eason BB 314-609-0789</b>                      Dome Building                      5400 Arsenal, Mail Stop A-413                      St. Louis, MO 63139                      (314) 877-3371 FAX: (314) 877 - 6130</p>	<p><b>Chief of Children's Community Operations</b>  <b>Bonnie Neal 816-803-0865</b>                      821 E. Admiral                      PO Box 412558                      Kansas City, MO 64141                      (816) 889-3458 FAX: (816) 889-3325</p>	<p><b>Chief of Children's Community Operations</b>  <b>Betty Turner BB 573-576-9448</b>                      Jane McDonald, Administrative Assistant                      1903 Northwood Dr., Suite 4                      Poplar Bluff, MO 63901                      (573) 840-9275 FAX: (573) 840-9191</p>	<p><b>Chief of Children's Community Operations</b>  <b>Betty Turner BB 573-576-9448</b>                      Jane McDonald, Administrative Assistant                      1903 Northwood Dr., Suite 4                      Poplar Bluff, MO 63901                      573-840-9275 FAX 573-840-9191</p>
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**Missouri Department of Mental Health**  
**Division of Comprehensive Psychiatric Services**  
**ADMINISTRATIVE AGENTS & AFFILIATES**

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| <p><b>4 ReDiscover</b><br/>901 NE Independence Avenue<br/>Lee's Summit, MO 64086<br/>Alan Flory, President<br/>816-246-8000<br/>Fax: 816-246-8207<br/>Email: <a href="mailto:alflory@rediscovermh.org">alflory@rediscovermh.org</a></p>   |   |
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- 10 Burrell Behavioral Health**  
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- 12 Burrell Behavioral Health – Central Region**  
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- 14 Mark Twain Behavioral Health**  
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- 19 Family Counseling Center**  
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- 20 Bootheel Counseling Services**  
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**Independence Center**  
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Revised: July 15, 2010

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**

### **Health Care Reform (SAMHSA Strategic Initiative 4 Health Reform Implementation)**

National Health Care Reform is on the 2014 horizon, and it offers the greatest potential for parity and dramatic growth in behavioral health services for Missourians that has been seen in many years. DMH is already turning its attention to maximizing that opportunity. DMH is involved in Governor level committees to plan for Health Care Reform. Collaboration is occurring with all the state agencies involved in Health Care Reform from the Department of Insurance to the Medicaid agency.

DMH has identified nine provisions in the Affordable Care Act that provide opportunities for DMH to improve services to its consumers through new funding streams, demonstration grants, Medicaid expansion, FMAP increases or other means. DMH is exploring the following Health Care Reform provisions: Medicaid expansion to 133% FPL, basic health plan & coverage to age 26; CHIP FMAP Increase; Medicaid Plan Options (1915i & 1915k); Health Care Homes for Chronically Ill, including Medicaid Chronic Disease Prevention; Money Follows the Person (MFP); Centers of Excellence for Depression; Medicaid IMD Demo Project; ABA credential; and State Health Care Workforce Development. Nine project teams have been formed and are meeting regularly. In August, 2010, the project teams provided an overview to the Mental Health Commission and reported their progress. One significant accomplishment reported to the Commission was DMH staff participation in a State Health Care Workforce Development planning grant with the Missouri Department of Economic Development to the U.S. Department of Health and Human Services, Health Resources and Services Administration.

Although Health Care Reform and Parity requirements have the potential to significantly reduce the numbers of uninsured and improve access to mental health services, DMH believes there will continue to be need for the public mental health authority to serve as a safety net of services to individuals with serious mental illnesses.

A recent Department of Social Services letter is at the end of this section detailing Missouri's efforts around the Affordable Care Act.

### **Mental Health Transformation (SAMHSA Strategic Initiative 10 Public Awareness and Support)**

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. Transformation has implemented several initiatives designed to improve public knowledge, eliminate stigma and empower people to move their lives forward regardless of their illness or disability: RESPECT Seminars/Institutes, Mental Health First Aid, and Communities of Hope.

## **RESPECT Seminars/Institutes**

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 were provided throughout Missouri in 2008-2010 with over 1700 participants across the state.

The Respect Institute is a four-day training program designed to teach consumers of mental health services how to share their own personal stories to educate others. In 2009, Missouri worked in partnership with its state psychiatric regional hospital system to develop an infrastructure to support statewide expansion of the RESPECT Institute and a RESPECT Speakers Bureau in each of its five regions. The Institute and Speakers Bureau developed based upon the successful model established by Chaplain Jane Smith at Fulton State Hospital in Central Missouri and was expanded to include consumer participants from the broader community and across disability groups. Graduates of the program are provided opportunities for public speaking. The DMH Office of Consumer Safety works with Joel Slack, Jane Smith and regional designees to coordinate this statewide expansion.

The St. Louis Regional Health commission has incorporated RESPECT training and policy development extensively into its Eastern Region Behavioral Health Initiative, resulting in board approval of "RESPECT Guiding Principles." The state's Department of Corrections and the U.S. Department of Veterans Affairs also have participated in training.

The final phase of RESPECT consists of the development of a two-part graduate program, which involves (1) training staff and consumers to conduct and to assist in conducting the four-day RESPECT Institutes and (2) training consumers to conduct RESPECT Seminars based on their own life experiences."

Missouri Transformation also has partnered with NAMI-Missouri to promote statewide expansion of both RESPECT Speakers and NAMI's signature In Our Own Voice (IOOV) Speakers Program. Transformation grant funds will help to support IOOV trainings and NAMI has agreed to waive membership fees for RESPECT graduates who wish to become IOOV speakers.

## **Mental Health First Aid**

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 mental health distress or a crisis even though they are more likely to encounter such a situation. 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. Research protocol on participants of the 12-hour MHFA course established that First Aiders demonstrate improved confidence in providing initial help, increased the amount of help

given, and displayed reduced stigma regarding mental health disorders. As a result, MHFA has quickly gained international adoption and adaptation.

Missouri is working collaboratively with a team from Maryland and the National Council of Community Behavioral Healthcare to launch the American version of Mental Health First Aid. The MHFA-USA manual, Instructor materials, draft certification standards and business plan have been developed by the national consortium. Additionally, work has progressed with the University of Maryland to identify standards of fidelity for evaluation and teaching both the 12-hour MHFA course and the 5-day Instructor Certification course with consistency.

Missouri has continued to provide leadership across the nation by training Instructors both within the state and in other states. Our trainers offered ten 5-day Instructor training courses certifying 104 individuals as MHFA-USA Instructors in Missouri and 66 in other states. Fifty-two 12-hour MHFA courses were taught with 797 individuals graduating as “First Aiders.” A \$300,000 grant was received from the Missouri Foundation for Health to provide the 12-hour MHFA course within faith-based organizations in 17 rural Missouri counties. An “Immersion Project” is underway with the Moberly School District concentrating fiscal and human resources involving MHFA in an effort to make an impact.

In the coming year Missouri anticipates certifying an additional 60 individuals as instructors, 2,000 as First Aiders; releasing curriculum modules targeting audiences in higher education and faith based communities; identifying Ambassadors for MHFA within the state; completing a business plan for MHFA including viable strategies for sustainability; and, publishing evaluation results of the effectiveness of MHFA. We will continue to contribute to the expansion of Mental Health First Aid USA by assisting with the finalization of standards, curriculum standardization relative to Instructor Certification, the potential for on-line MHFA education and webinars, and the development of curriculum specificity that will enable MHFA to respond to Americans with a variety of backgrounds and orientations.

### **Communities of Hope Initiative**

The Communities of Hope Initiative is a cornerstone of the state’s efforts to transform its mental health system to make it more responsive to actual need by using a public health model of service delivery. A public health model provides a continuum of services that focuses on an entire population rather than individuals or their separate illnesses and disabilities. The Communities of Hope Initiative takes transformation to scale by mobilizing communities to develop data-driven mental health and wellness plans, implement targeted interventions with community-specific outcomes, and sustain their efforts through the expansion of existing partnerships.

DMH released a request for proposal in November with the submission deadline by the end of December. In February, contracts were awarded to eight agencies referred to as Mental Health Transformation Support Centers. The Transformation Support Centers are working with twenty-one community-based coalitions throughout Missouri. To assist with the sustainability of the Initiative, contractors are required to work with existing coalitions who are already addressing or willing to address mental health-related issues.

The Transformation Support Centers are in the process of assessing the coalitions' community readiness to address mental health-related issues. They are in the initial stages of analyzing existing needs assessment data, available resources and identifying gaps. Each coalition will develop a mental health and wellness plan that is community-specific based on the community's assessed stage of readiness, needs assessment data, resource and gap analysis and the selection of evidence-based interventions based on their locally-identified issues and target populations. The plan will be designed to transform the local mental health system – moving away from the primary target of clinical services to one that has a vision of good mental health for all. Funding for the Initiative is available through June 2011.

### **Metabolic Syndrome Screening (SAMHSA Strategic Initiative 8 Behavioral Health Workforce)**

Effective January 1, 2010, all Community Psychiatric Rehabilitation (CPR) programs must conduct an annual screening of risk factors for metabolic syndrome for all adults and children receiving antipsychotic medication. Contracts have been amended with the following expectations.

DMH and the MO HealthNet division have been collaborating on a series of initiatives involving disease management (DMH NET), to improve the health of persons with serious mental illnesses and reduce health care costs. The department has facilitated hiring nurses for most of the providers to help implement these initiatives. The most recent initiative is to screen for metabolic syndrome, which is a combination of medical disorders that greatly increase the risk of developing cardiovascular disease and diabetes, specifically: obesity, hypertension, lipid level, and blood glucose and/or HgbA1c. This is a high priority for this particular population since studies show persons with serious mental illness die 20-25 years earlier than others. Often the causes of death are related to cardiovascular disease and diabetes. For more information please see <http://dmh.mo.gov/MorbidityandMortalityReport.pdf>

A form has been developed, the Metabolic Syndrome Screening and Monitoring Tool, which must be completed by a nurse (either an RN or LPN), to verify that the metabolic syndrome screening is completed. Providers may use this form, or develop their own form, so long as the content is consistent. If a provider chooses to develop their own recording form this must be approved by the Department.

The DMH expectation is that the nurse will take the vital signs, obtain data required for a BMI, measure weight circumference, and then verify the lipid level, and blood glucose and/or HgbA1c, in one of the following ways:

- The nurse or other qualified staff may conduct the lab tests to assess lipid level and blood glucose levels and/or HgbA1c by using the Cholestech LDX analyzer or other machine approved by the Department. Funding for the Cholestech LDX analyzer is available per agency request.
- The nurse may arrange for and coordinate lab tests from a health care provider to assess lipid level and blood glucose levels and/or HgbA1c.

- The nurse may obtain results of recently completed lipid panel and blood glucose levels and/or HgbA1c from other health care providers. When the client is already being followed regularly by a health care provider, the nurse may obtain results of the most recently completed lipid panel and blood glucose levels and/or HgbA1c from that provider in order to complete the metabolic syndrome screening process for Department clients.

It is estimated that the activities involved in this screening will average about 30 minutes per client. The department is reimbursing providers \$35.38 for this screening, which is the equivalent of 30 minutes of our current flat rate for nursing services. DMH intends to monitor and evaluate this new service and the time spent conducting the screening to determine the appropriateness of the time assumption and rate. The service will be billable to both MO HealthNet and the DMH POS system, based on the Medicaid eligibility status of the client.



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August 17, 2010

TO: Jeff Harris  
CC: Health Care Cabinet  
FROM: Ron Levy  
SUBJECT: Update on Affordable Care Act (ACA) Activities

Please find attached a report on recent activities related to the requirement of the ACA. Most of the activity since the effective date of the law has focused on submitting grant applications to gain additional federal funds in support of important public health, wellness and work force development activities and insurance market reform.

**INSURANCE MARKET REFORM:**

Missourians can now enroll in the new Federal Pre-Existing Condition Health Insurance Plan. Missouri is scheduled to receive \$81,000,000 to subsidize the operations of this program that is administered by the Missouri Health Insurance Plan – the state's high risk pool.

A number of key insurance reform elements are also being implemented (see outline)

The federal focus is now shifting to providing funds and resources to the states to establish health insurance exchanges – the cornerstone of the federal health insurance reform legislation. It is anticipated that an exchange will foster competition in the private health insurance market for individuals and small employers. It is intended that the competition will focus on affordability, quality and value rather than risk avoidance. Missouri will submit a grant application for a total of \$1,000,000 to jumpstart the planning process for our exchange. Applications are due by the end of the month with awards being made by the end of September.

**GRANTS:**

To date 8 grants have been submitted with a potential dollar impact to the state of \$10,945,087 and two grants have been received for \$2,500,096. Another 6 grants are in process for submission.

I will ask the staff to update this report on a monthly basis to keep you posted as to our activities. If you have additional questions or need for follow up please let me know

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## REPORT ON ACA ACTIVITIES

### I. Grant Opportunities

#### **Grants Awarded: (2 – Total \$2,500,096)**

- Missouri has been awarded \$1,500,096 for the Maternal, Infant, and Early Childhood Home Visiting Programs (DHSS)
- Health Insurance Premium Review – Cycle 1 (DIFP) \$1,000,000 Award Date: 8/03/2010

#### **Grant Applications submitted and pending (8 submitted – Total \$ 10,945,087):**

- Work Force Expansion/Training
  1. State Health Care Workforce Development Grant (DHSS/DED) \$150,000 Award Date: 9/30/2010
- Prevention and Wellness/Public Health
  2. Support for Pregnant and Parenting Teens and Women (DHSS) \$1,994,991 Award Date: 9/01/2010
  3. Maternal, Infant, and Early Childhood Home Visiting Programs (DHSS) \$1,500,096 Award Date: 7/28/2010
- Delivery System Reform
  4. Prevention and Public Health Fund: Strengthening Public Health Infrastructure for Improved Health Outcomes (DHSS) \$2,700,000 Award Date: 9/30/2010
- Medicaid Payments
  5. Money Follows the Person Rebalancing Demonstration – Extension of the grant through 2016 with an additional four years (2020) to spend monies awarded in 2016. (DSS/MHD/DMH/DHSS) Extension will be renewed annually. No new funds to Missouri.
- Long Term Care
  6. Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers (DHSS) \$3,000,000 Award Date: 9/30/2010
  7. ADRC Nursing Home Transition and Diversion Programs (MHD) \$1,200,000 Award Date: 9/30/2010
  8. Outreach and Assistance for Low-Income Programs, Medicare Improvement for Patients and Provider Act (MIPPA) Collaborative Grants (DHSS/DIFP) \$400,000 Award Date: 9/30/2010

**Grant applications in process (6 to be submitted – Total \$3,895,660):**

- Insurance Reform
  1. Health Insurance Consumer Assistance Offices and Ombudsmen (DIFP) \$600,000
- Insurance Exchange
  2. State Planning and Establishment Grants for the Affordable Care Act's Exchanges (DIFP) \$1,000,000 Date Awarded: 9/30/2010
- Prevention and Wellness/Public Health
  3. Epidemiology and Laboratory Capacity (DHSS) \$305,000 Date Awarded: 9/30/2010
  4. Personal Responsibility Education Program (PREP) Act (DHSS) \$991,673 Date Awarded: 9/30/2010
  5. Restoration of Abstinence Education Funding Grants (DHSS) \$934,278 Date Awarded: 9/30/2010
  6. State Supplemental Funding for Healthy Communities, Tobacco Prevention and Control, Diabetes Prevention and Control, and Behavioral Risk Factor Surveillance Systems (DHSS) \$64,709 Date Awarded" 9/30/2010

**Grants Not Submitted: (2)**

- Multi-Payer Advanced Primary Care Practice Demonstration Project – Not processed due to lack of infrastructure for multi-payer collaboration in Missouri.
- HIV/AIDS Surveillance: Enhanced Laboratory Testing (DHSS)

**II. Actions designed to strengthen the current health insurance marketplace that become operational in 2010.**

- The federally funded high risk insurance pool for people with pre-existing conditions is now operational. Missouri will receive \$81,000,000 in federal funds to subsidize the operation of this program. Missourians may apply for coverage through the state's Missouri Health Insurance Pool (high risk pool) [www.mhip.org](http://www.mhip.org) .
- MCHCP has applied to participate in the federal reinsurance pool for Employers Providing Health Benefits to Early Retirees (MCHCP) Estimated annual funding: \$2,000,000 to \$2,600,000
- Tax credits to small employers. According to a study by The Lewin Group, 85,100 small businesses in Missouri are eligible for the tax credit. Of that number, 25,100 are eligible for the full tax credit of 35% of employee premium costs.

- A reinsurance program is being established to help employers who continue to offer a health benefit to early retirees absorb high cost claims. Missouri has applied for funding from this program through MCHCP.
- Insurers will be prohibited from denying coverage to children because of pre-existing health conditions.
- The first step in closing the Medicare Part D donut hole begins in 2010 with a \$250 payment to each Medicare Part D beneficiary that becomes subject to the provisions of the donut hole
- Parents may continue to cover their children through age 26 under the parents' insurance policy.
- Insurers are prohibited from imposing out-of-pocket costs for preventive health services.
- Insurers are prohibited from imposing lifetime limits on health coverage.
- Insurers are prohibited from making rescissions for existing coverage.
- Establishes state offices of health insurance consumer assistance and/or Ombudsman.

**III. Other funding opportunities being pursued:**

- Financial incentives to states for enhancing home and community based services through 1915 (i) State Plan Amendment (MHD, DMH, DHSS)
- Mental Health Resources Study Group is conducting research to determine whether additional state expenditures in support of low-income populations are eligible for Federal Financial Participation. (MHD, DMH)

August 17, 2010

Adult - Legislative initiatives and changes, if any.

## Legislative Initiatives and Changes

### SFY 2011 Budget

#### SFY 2010 and 2011 Budget Recap

SFY 2010 was a difficult year for DMH. To balance the budget in an economy that repeatedly failed to meet projections, Governor Nixon required expenditure restrictions (withholdings) of General Revenue (GR) and Federal Budget Stabilization funding several times during the year.

DMH's restrictions were as follows:

<u>Date</u>	<u>Amount</u>
July 2009	\$4,750,602
October 2009	\$6,665,066
February 2010	\$1,092,483
March 2010	\$2,032,657
April 2010	\$834,236
<b>TOTAL</b>	<b>\$15,375,044</b>

These restrictions were in addition to a \$47.2 million cut to DMH's SFY 2010 GR core budget. SFY 2010 revenues were projected to decline 6.4% below SFY 2009 revenues. Current projections, as of this writing, anticipate a decline of 9.5% for SFY 2010.

Governor Nixon submitted his SFY 2011 budget in January 2010 anticipating a modest economic recovery in mid-to-late SFY 2010 in Missouri. That did not occur. By mid-March, it was clear that the Governor's budget recommendations needed to be reduced by approximately \$500 million. Working collaboratively with the Senate Appropriations, and later with the House and Senate Budget Conference Committee, the Governor's Budget Office and Legislature cut an additional \$12.6 million from DMH's budget below the Governor's initial budget recommendations.

DMH's SFY 2011 cumulative core cuts are as follows:

<u>SFY 2011 Core Cut Area</u>	<u>Amount</u>
Non-Medicaid (safety net) Community Services	\$12,878,000
DD Habilitation Centers – Conversion to State-Operated Waiver	\$4,017,233
Dept-wide Personal Services and Expense/Equipment Restrictions	\$3,471,821
Overtime Reduction for State Holidays and Administrative Leave	\$1,767,302
Metropolitan Psychiatric Center Ward Closure	\$1,311,122
CPS – Switch from GR to Other Funds	\$1,300,000
CPS Inpatient Redesign	\$924,958
Miscellaneous Reductions	\$295,483
<b>TOTAL</b>	<b>\$25,965,919</b>

Although the SFY 2011 budget process was assertive in addressing the state's continuing economic downturn, even as the SFY 2011 budget was passed in May, both the Legislature and the Governor indicated it would be necessary for the Governor to make extraordinary

expenditure restrictions in state agency spending during SFY 2011. In signing the SFY 2011 appropriations bills passed by the Legislature, Governor Nixon announced an additional \$300 million in spending restrictions to balance the SFY 2011 budget. DMH's expenditure restrictions are as follows:

<u>SFY 2011 Expenditure Restrictions</u>	<u>Amount</u>
Travel Reimbursement	\$29,650
5.5% Reduction in Professional Services Expenditures	\$800,000
2% Provider Rate and Allocation Reductions	\$7,700,000
15% Reduction in Services for Veterans Project	\$45,000
2% Personal Services and Expense/Equipment Reductions at CPS and DD Facilities	\$3,600,000
5% Personal Services and Expense/Equipment Reductions at DD Regional Offices	\$600,000
Accelerate Nevada Habilitation Center Transition	\$1,300,000
Accelerate CPS Inpatient Redesign	\$1,100,000
<b>TOTAL</b>	<b>\$15,174,650</b>

### **DMH Budget Issues**

**Medicaid Caseload Growth:** The Governor's SFY 2011 recommendations for Medicaid caseload growth were reduced by 33% during the Legislative process as part of the effort to reduce the Governor's January budget recommendations by \$500 million. We do not know what the actual caseload growth in SFY 2011 or 2012 will be, but it could well exceed the modified funding provided in the SFY 2011 budget. If so, great budget pressure will be felt in the form of SFY 2011 supplemental appropriation requests for caseload growth as well as expanded expectations regarding caseload growth in the regular SFY 2012 budget. DMH Medicaid caseload growth is likely to be one of a very limited number of new decision items in SFY 2012, and perhaps in the SFY 2011 supplemental process.

**Sexual Offender Treatment Services (SORTS):** Referrals from the Department of Corrections to the SORTS program continue to grow at the rate of one new treatment unit per year. While the state has avoided the construction costs of a new SORTS facility due to the Fulton State Hospital transition, increased funding for ongoing operating costs are necessary to open a new SORTS unit in SFY 2012.

**Overtime:** DMH continues to make progress in containing its growth in overtime expenditures except at Fulton State Hospital (FSH). DMH hopes to impact FSH overtime by moving approximately 170 patients from FSH to other state facilities in St. Louis, Farmington, and Kansas City during SFY 2011, although there will be overtime costs associated with preparing for the SORTS population to be transferred to FSH. It is likely that the transfer of FSH patients will increase overtime costs in the other facilities in the transition stages due to the training costs associated with preparing for new patient populations.

**Eating Disorders:** Legislation was passed in FY 2010 establishing a new Eating Disorders Council that requires staffing and facilitation by DMH, along with a legislative mandate to launch a public education effort regarding eating disorders. This legislation will require modest funding at a level of \$150,000 to \$200,000 to meet the legislative mandate.

### **Summary**

SFY 2011 will be a year of cost containment and major system redesign. DMH is confident it can achieve both. Between now and SFY 2014, DMH expects difficult budget decisions requiring our greatest creativity to protect the fragile safety net for the people we serve as best we can.

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

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

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

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

### **Mental Health Transformation**

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

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

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 has helped support building an infrastructure required for transformation, such as planning, workforce development, evidence-based practice implementation, and technology enhancements.

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

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

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

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

The initial charge of the MHTWG was to:

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

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

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

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

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

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

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

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

The final year of the grant will focus on four important issues: 1) employment, 2) evidence based practices, 3) housing, and 4) health care reform. DMH wants to put individuals with mental illness to work in accordance with their interests and abilities and make adequate and appropriate housing available. DMH will continue to apply the latest behavioral health techniques and information technologies to improve outcomes and reduce costs. DMH has already starting preparing for the opportunities available under Health Care Reform.

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

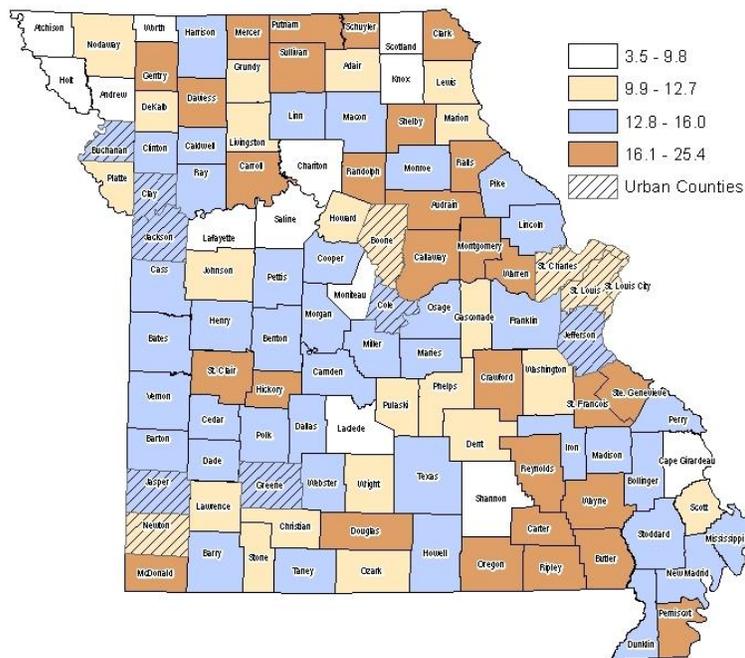
Joseph Parks, M.D., Director of the Division of Comprehensive Psychiatric Services and Chair NASMHPD Medical Directors Council, was lead author of a report from eight states — Maine, Massachusetts, Rhode Island, Oklahoma, Missouri, Texas, Utah and Arizona — that was presented at a meeting of state hospital 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**

Missouri ranks 17<sup>th</sup> in the nation in its rate of reported suicides and it ranks among the top leading four causes of deaths for Missourians between the ages of 10 and 54. Developed under

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

### Missouri Suicide Rates by County 2009



### Consumer Tobacco Recovery Efforts

In 2007, The Missouri Foundation for Health granted DMH funding to conduct a study to assess tobacco use by consumers of DMH services, and to assess tobacco related policies and practices of contracted providers of DMH services. Based on the data, tobacco use is twice as high for consumers of substance abuse and psychiatric services as use by adult Missourians and three times the use rate of the general population nationally. Nine percent of consumers receiving developmental disabilities services reported using tobacco products which is lower than tobacco use rates by the adult general population in Missouri and nationally but consistent with the national use rates of persons with developmental disabilities. The study also identified that few contracted providers of DMH services have tobacco-free campuses and the majority do not offer tobacco cessation services. Because of the high tobacco use prevalence, in the fall of 2009, the Missouri Foundation for Health awarded funding to DMH to develop a plan to reduce tobacco-related disparities among consumers of DMH services.

In November 2009, DMH convened a statewide steering committee and workgroup to help develop the plan. Members represented staff and providers of the Department's three divisions; Alcohol and Drug Abuse, Comprehensive Psychiatric Services and Developmental Disabilities; as well as consumers, and staff from other key stakeholders.

The Workgroup reviewed evidence-based toolkits and resources targeting persons with mental disorders, substance use disorders, developmental disabilities and co-occurring disorders; identified differences between them and made recommendations regarding which to use. The Workgroup also examined issues involved with agency level implementation such as, policies to support cessation; workforce supports, including training of those responsible for implementing tobacco cessation programs and services; motivational techniques; and employee health issues and needs related to tobacco prevention and cessation. The review also considered experiences of other states and Missouri providers who are addressing tobacco dependence among this target population.

After careful review and consideration, the Workgroup determined there was no *single* toolkit targeting tobacco use by individuals with mental illness, substance use disorders and/or developmental disabilities, which they believed met the needs of all three target populations. As a result, the Workgroup recommended the Missouri Department of Mental Health develop its own “Mental Health Guide to Tobacco Recovery” utilizing information and resources from existing tobacco cessation toolkits and support group curricula. It is not the intention to recreate the wheel, but to utilize the best information and resources to develop a “Guide” specific to the needs of DMH consumers.

The Workgroup and Steering Committee developed the following logo and slogan for the DMH consumer tobacco cessation and prevention initiative: “Living Tobacco Free – Recovery and Prevention for Our Mental Health and Wellness.”



The DMH executive team recently reviewed and approved the draft plan with the inclusion of additional tobacco policy related strategies. The plan is due to the Missouri Foundation for Health by the end of August. The Department plans to seek additional funding from MFH to implement the plan.

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

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, Division of Insurance, Office of State Court Administrators, Department of Public Safety, Department of Economic Development and the Governor’s Office of Administration. A few examples are listed below.

#### **Department of Corrections Collaboration**

CPS has a joint project with Department of Corrections to provide services to mentally ill persons recently released from correctional facilities through the CMHCs. The Department of

Mental Health has added a service code for “Intake Screening-Corrections” to allow for the pre-release planning and intake screening of persons with serious mental illness being discharged from correctional facilities in the DMH/DOC Mental Health 4 project.

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

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

#### **Department of Social Services Collaboration**

DMH and DSS have implemented many cross-departmental initiatives to promote the use of best practices in the prescribing of psychiatric medications for Medicaid recipients. The Health Care Optimization (HCO) project with Medicaid has evolved. HCO is a disease management approach for Medicaid recipients diagnosed with mental illness, who are at highest risk for adverse medical and behavioral outcomes. These complicated patients commonly have combined behavioral and medical care expenditures can be significantly higher than other Medicaid recipients. HCO technology creates an integrated health profile (IHP) for each patient to:

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

#### **Department of Elementary and Secondary Education Collaboration**

DMH embraces the importance of employment as critical to recovery of mental health consumers. DMH and Division of Vocational Rehabilitation (DVR) have a long history of working collaboratively to assure individuals with psychiatric disorders have access to employment. Over the past fifteen years, DMH and DVR have collaborated on training, joint programming, and promoting of EBP. More recently, DMH and VR partnered to write a grant application for a Missouri Mental Health Employment Project. The National Institute of Health grant was awarded to Missouri and a Stakeholders group was formed. The Institute for Community Inclusion from Boston, Massachusetts, provided experience and expertise. Joe Marrone and Susan Foley conducted a survey to discover strengths and weaknesses with the

current methods of providing supported employment services to the Department's consumers. The survey informed the Stakeholders group about current best practices and gaps in the system. DMH applied for the second phase of the NIH grant funding to continue to enhance our supported employment programming. While this grant was not awarded, DMH and DVR did receive a Johnson & Johnson grant for Supported Employment. Pilot sites were chosen and technical assistance from Dartmouth University has been provided. A manager for the supported employment project was hired and ongoing technical assistance and fidelity monitoring has been conducted. Especially notable is the Benefits Planning training provided to community support workers in the community mental health centers.

### **Department of Public Safety Collaboration**

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.

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

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

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

See also Child Strengths and Weaknesses section for additional details.

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/CPS 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. With Circle of Hope, the Division has attempted to allow more independence in decision making for the local site. With this, the site was granted to permission to select a new fiscal agent. The site is now addressing issues related to sustainability of wraparound and their model for Family Support Partners. The division continues to provide guidance and support in these areas.

The Custody Diversion Protocol was developed in cooperation with child welfare, juvenile justice and family members in 2005. As part of the protocol families can enter into a Voluntary Placement Agreement with child welfare without the state taking custody, but the state will pay for up to 180 days of out of home placement if clinically indicated. This initiative continues to be successful with 96% of the 1033 children referred diverted from state custody and approximately half remaining in their home and community.

In 2007, CPS in conjunction with its provider network provided an alternative eligibility criteria for Community Psychosocial Rehabilitation based on the youth's functioning using the Child and Adolescent Functional Assessment Scale (CAFAS<sup>®</sup>). Youth who have a SED diagnosis and have a total score of 100 on the CAFAS, reflecting impaired functioning in multiple domains, are eligible for the intensive community-based service packet. The treatment plan generated by the CAFAS has been approved for use by the Division. In the last year, CPS has moved over to the web-based version of the CAFAS and has expanded to the use of the PECFAS (Preschool and Early Childhood Functional Assessment Scale) to determine eligibility and track progress for the younger children. Additionally, the web-based version allows for the use of the Caretaker Wish List which aids the parent and provider to identify parent's needs in supporting their child.

CPS is currently exploring adding supports for intensive evidence based practices, Treatment Family Homes and Professional Parent Homes, to the menu of services available under the psychiatric rehabilitation option under Medicaid. These services would include individualized service planning as well as supports for the "treating parents." These are some initial steps towards moving the state toward increased access to community services as well as enhancing the array of services through provision of research based services.

CPS has continued 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 as well as serving on the statutorily defined Coordinating Board for Early Childhood. Additionally, CPS has been a member of the Special Quest state team for the last three years to focus on enhancing opportunities for inclusion of all young children in early

learning centers independent of their needs or disability. Through these efforts, two training modules were developed to be included in the state required Child Care Orientation training that address social and emotional development and identification of mental health risk factors respectively. In partnership with the Department of Health and Senior Service, Division of Maternal and Child Health, an early childhood training summit is being planned for this fall to incorporate the learning's from the Center for Social and Emotional Foundations of Early Learning.

In 2005, the Departments of Health and Senior Services and DMH partnered on what was identified as Bright Futures: Promoting Resiliency in Children through Partnerships. This initial grassroots effort grew to the development of a multi-agency state strategic team to devise a plan to assist communities in support of schools to address the social and emotional development of children. Through continuous and growing partnerships, it has morphed into a major initiative that is supported for three years through Missouri Foundation for Health funding to work with three communities to provide training, technical assistance and support funding to create continuous surveillance systems that allow a community to identify their mental wellness and health priorities; develop effective policies to address these priorities; and monitor systems to assess the real impact of the policies. This initiative won the Governor's Award for Quality and Productivity in the category of Innovation, and has been accepted for presentation at the American Public Health Association conference this Fall.

Another example of looking at the range of interventions from universal to tertiary is the model being developed, in partnership with the Department of Elementary and Secondary Education, in the area of school mental health services through partnering with schools who have implemented Tier 1 of the Positive Behavior Interventions and Supports with fidelity and wish to move on enhancing services at the Tier 2 and Tier 3 levels (Targeted and Intensive respectively). In support of this effort, CPS participates on an interagency team to identify the needed training and support components for PBS.

Child - Legislative initiatives and changes, if any.

See Legislative Initiatives and Changes in Adult section

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

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

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

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

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

The DMH received notice in October, 2006 that Missouri had been awarded a Mental Health Transformation State Incentive Grant: Creating Communities of Hope. The model for Missouri's application and plan was based on the work that had been accomplished in the children's system in moving towards a system of care that was based on the public health model. The Proof of Concept for Children's Mental Health is around a state initiative to evaluate the impact of Family Support services. Other partnerships with the Office of Transformation include the Show Me Bright Futures initiative, and infrastructure development for evidence based practices.

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

## **Collaborative Initiatives**

### **Show Me Bright Futures**

CPS continues its collaboration on the Show Me Bright Futures Initiative that was initially developed as a training project, but has now blossomed in to the basis of moving to a public health model for children's mental health and was included as a model within the state's Transformation grant application. The Department received a grant through the Missouri Foundation for Health to work with three communities to implement the public health model in regards to social and emotional wellness of children. Two Learning Academies have been held with these communities to teach the foundation of the public health model, the impact early environments have on social and emotional development, creating a surveillance system for their communities and assistance on development and management of their first required project. The identified projects include infusion of social and emotional learning and screening into early learning centers, addressing impact of domestic violence and assisting students around school transitions.

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

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

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

Accomplishments include: the use of data to determine causal factors, select programs, and evaluate their process and outcomes; 18 coalitions now have a strategic prevention plan based on the SPF; elements of those plans have been successfully integrated into applications for additional prevention funding (e.g., EUDL, DFC, MFFH); local law enforcement agencies have markedly improved their enforcement of alcohol laws; and Local financial and in-kind resources

are being tapped to support local prevention; organizations or individuals that historically competed for resources now are at the table together; and Community readiness to address alcohol prevention has improved in all coalitions.

### **Other Collaborative Initiatives**

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

- Cross-departmental initiative to promote the use of best practices in the prescribing of psychiatric medications and insure better care coordination for children in state custody placed in residential treatment centers.
- Coordinating Board for Early Childhood which is charged with developing a comprehensive statewide long-range strategic plan for a cohesive early childhood system; identify legislative recommendations to improve services for children from birth through age five; promote coordination of existing services and programs across public and private entities; promote research-based approaches to services and ongoing program evaluation; and to identify service gaps and advise public and private entities on methods to close such gaps. Additionally, Division staff chair the workgroup on the Social and Emotional Development for the Early Childhood Comprehensive System Maternal/Child Health Grant.
- The Division has developed a working partnership with the state Medicaid authority, Missouri HealthNet, to improve the quality of services provided to recipients. This has included active participation in the standing Non-Pharmaceutical Prior Authorization Group and participation in clinical audits of Medicaid managed care behavioral health services. Through this partnership providers now have access electronically to services provided to individual consumers to help in the coordination of care.
- CPS continues to partner with Children's Division (child welfare) to improve the Custody Diversion Protocol so that families do not have to voluntarily relinquish custody solely to access mental health services. To date 991 or 96% of the children referred have been diverted from state custody.
- CPS Children's Services is leading the trauma initiative that involves the Division of Youth Service and Children's Division.
- CPS Children's Services received a Healthy Transitions Initiative cooperative agreement and has engaged Children's Division, one of their statewide intensive services contract providers, and the Division of Vocational Rehabilitation in this effort (along with the adult services in CPS).

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

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

### **Strengths**

Strengths identified by the Mental Health Planning Council were as follows: peer specialist initiative, Consumer and Family Monitors, Consumer/Family/Youth Conference and “sense of partnership with DMH”, consumer operated services of warm-line peer phone support and drop-in centers, expansion of evidence based practices, behavioral and medical health collaborations, Mental Health First Aid, RESPECT Seminars, collaboration and positive relationships with other state agencies, emphasis on wellness and prevention, initiatives on veterans issues, advocacy efforts, person-centered planning taking hold in community agencies, mental health champions award and banquet, anti-stigma public education efforts, number of grants received from federal government - 8<sup>th</sup> in country in awards of SAMHSA discretionary grants, Mil tax boards, cooperation with Medicaid agency, Shelter Plus Care housing grants and VA per diem grant, Crisis Intervention Team training of police officers, cooperation with NAMI and push for public health model, public/private cooperative efforts like the Truman Medical Center use of a Probation and Parole officer in program - only 13% recidivism back to DOC institutions, assertive leadership in department listening to consumers/providers/staff, and CARF training and push for CARF or Joint Commission accreditation of CMHCs. (See also sections on Recent Significant Achievements; New Developments and Issues; Planning Council Charge, Role and Activities; and Description of State Agency Leadership.)

### **Evidence Based Practices**

#### **Federally Qualified Health Centers/Community Mental Health Centers (FQHC/CMHC) (NFC Goal 1) (SAMHSA Strategic Initiative 8)**

Missouri is beginning the third year of its three-year pilot project designed to integrate primary and behavioral health care. Seven sites were selected to receive \$200,000 a year in state general revenue, each, for a period of three years to integrate primary care into a CMHC setting, and behavioral health services into an FQHC primary care setting. Six of the seven sites involve collaboration between an FQHC and a CMHC. The seventh site involves a single agency which is designated as both a CMHC and FQHC. Technical assistance and training were initially provided to the sites through the Missouri Coalition of Community Mental Health Centers with funding from an 18 month grant from the Missouri Foundation for Health. Upon expiration of the grant, the Department of Mental Health has continued to support the technical assistance and training team. A May 2009 article published in *Psychiatric Services* called *Mending Missouri* detailed the lessons learned and progress made on the initiative at that time.

The first two years of the initiative involved addressing the issues raised by bringing two systems of care together, and understanding, adopting, and implementing successful models of service delivery. Issues surrounding sustainability are the focus of the third year of the pilot.

Each FQHC now operates a primary care clinic on site at a CMHC facility. These primary care clinics are generally staffed by a Nurse Practitioner, though in some cases, a physician also provides services on site. The payer mix and hours of operation, as well as number of patients, vary significantly across the primary clinic sites, demonstrating the need to tailor the integration

of primary care into a CMHC setting to meet local conditions. The key challenge in the third year for primary care provided in the CMHC setting is improving the volume of CMHC consumers who utilize these services.

Initially, the Department of Mental Health did not promote a specific model for integrating behavioral health services into FQHC primary care clinics. As a result, some sites chose to simply co-locate traditional mental health counseling services on site at one or more primary care clinics. Over time, however, the Department began to promote a truly integrated approach, using behavioral health consultants as integral members of primary care teams. As the pilot enters its third year, those sites that originally adopted a co-location model are making the transition to a truly integrated approach, and so addressing the challenges of introducing a new model. Because understanding and commitment to a truly integrated model has developed slowly, training and technical assistance remain of critical importance for all of the sites. The key sustainability challenge for integrating behavioral health into primary care involves securing Medicaid reimbursement for Health Behavior Assessment and Intervention services, and devising approaches for continued funding for sites with a very high percentage of uninsured consumers.

In addition to integrating behavioral health consultants into primary care, two sites are providing psychiatric services at FQHC primary care clinics. At one site, a psychiatrist maintains a small caseload of consumers, but provides consultation to assist FQHC primary care clinicians in managing patients with mental illnesses. The key issue for sustainability at this site is developing an approach to routinely supporting psychiatric consultation. At the other site, a psychiatric nurse provides medication management services, under the supervision of a psychiatrist, for FQHC primary care patients. Here the key sustainability issue involves the very high percentage of uninsured patients.

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

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

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

Health, the Missouri Foundation for Health and the Cadre for Co-Occurring Excellence to move the mental health system to fully integrated treatment for co-occurring psychiatric and substance use disorders. 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.

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

Assertive Community Treatment (ACT) is a necessary part of the service array to serve a specific portion of adults with the most serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring alcohol and drug diagnoses, 3) have involvement with the criminal justice system, and 4) are homeless/unstably housed.

The Missouri General Assembly approved funding the EBP of ACT in 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, enrolled consumers and are providing services. DMH has worked with agency staff to identify the high end users of crisis services. 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. Staff of Missouri ACT teams have attended the annual ACTA meeting to stay in touch with developments in the field.

Data show that in the Eastern Region of the state, a subset of ACT clients who were “high users” of Medicaid services reduced spending on services very significantly after ACT enrollment. Homelessness was reduced for all the ACT teams compared with status before ACT. Variations on the ACT model for special populations, such as Forensic consumers, are under discussion.

### **Supported Employment (NFC Goal 5)**

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

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

Supported Employment services continue in cooperation with Division of Vocational Rehabilitation with the goal of providing clients with the choice to be employed in the competitive workforce. The department received a Johnson and Johnson grant. Technical assistance and fidelity to the SE model are being provided through cooperation with the Dartmouth University national experts.

### **Illness Management and Recovery (NFC Goal 5)**

The division is reshaping Psychosocial Rehabilitation programming (PSR) to a wellness, recovery and illness management approach. An enhanced PSR billing rate has been given to seventeen agencies that are providing treatment focusing on core components including psychoeducation, relapse prevention and coping skills training. The menu of possible wellness/recovery services includes health and wellness approaches, an illness management & recovery approach, the use of Peer Specialists as health coaches, Wellness Recovery Action Planning, or other approaches that support a deeper understanding of recovery.

There has been a lot of interest from the community mental health centers in providing both diabetes conversation maps and smoking cessation groups as part of the new enhanced PSR-IMR service. Twenty agencies have nurses trained to do the diabetes conversation map groups. At least six agencies are currently running smoking cessation groups. The Coalition of Community Mental Health Centers and the American Lung Association recently provided training on smoking cessation. DMH expects many additional agencies to have staff with competencies to conduct smoking cessation groups.

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

The Missouri Department of Mental Health began a wide-scale DBT implementation effort three years ago. In that time, over 3000 clinicians have received introductory and advanced training in the model and approximately 50 DBT teams have been developed in diverse regions and clinical settings in the state. Beginning and advanced “training packages” comprised of leading books, training DVD’s, CD’s, and online programs have been provided to teams in order to structure ongoing self-study in the DBT model.

Currently, efforts are underway to enhance specialized DBT treatment in the areas of substance abuse, eating disorders, and with adolescents and families. International experts have been brought in to provide training in these areas, and ongoing consultation is being provided to numerous agencies that provide services specifically to adolescents and their families. The Department of Mental Health in collaboration with the University of Missouri Psychiatric Center have produced an online training in communication strategies entitled “Validation 101”. The intent is to require this training of all inpatient direct care staff in settings run by the State of Missouri, and to make this training available to any other setting where there is a desire to train staff in effective communication strategies.

In April of 2010 the new [www.dbtmo.org](http://www.dbtmo.org) website went live. In addition to providing written and online resources for clinicians and consumers of DBT services, it is the place where providers can pursue DBT Certification in the state of Missouri. This certification initiative is an effort to bring all DBT teams practicing in the state of Missouri to a high standard of adherence

to the DBT model and to prepare them to meet national certification requirements when those become available in 2012.

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

**DBT Introductory 2-Day Training**

January 24-25, 2008 – (Joplin) – 35 Trained  
March 26-27, 2008 – (St. Louis) – 101 Trained  
April 10-11, 2008 – (Kansas City) – 200 Trained  
April 14-15, 2008 – (Cape Girardeau) – 85 Trained  
July 21-22, 2008 – (Kansas City) – 212 Trained  
July 24-25, 2008 – (Columbia) – 233 Trained  
September 30, October 1, 2008 – (Farmington) – 30 Trained  
October 30-31, 2008 – (Kansas City) – 210 Trained

January 26-27, 2009 – (St. Louis) – 340 Trained  
February 24-25, 2009 – (Marshall) – 88 Trained  
March 16-17, 2009 – (Kirksville) – 81 Trained  
April 1-2, 2009 – (Sikeston) – 83 Trained  
June 8-9, 2009 – (St. Louis) – 37 Trained  
August 3-4, 2009 – (Kansas City) – 15 Trained  
September 9-11, 2009 – (Sikeston) – 11 Trained  
September 15-16, 2009 – (Kansas City) – 55 Trained  
November 9-10, 2009 – (Rolla) – 53 Trained  
December 9-10, 2009 – (Kansas City) – 121 Trained

January 21-22, 2010 – (Ferguson) – 327 Trained  
April 15-16, 2010 – (St. Joseph) – 164 Trained  
May 27-28, 2010 – (Fulton) – 83 Trained  
June 7-8, 2010 – (Kansas City) – 97 Trained  
June 10, 2010 – (St. Louis) – 82 Trained (Individual DBT-Based Psychotherapy)  
June 11, 2010 – (Farmington) – 9 Trained (Consultation DBT Team Startup)  
June 14, 2010 – (Columbia) – 14 Trained (DBT Basic Competencies: Individual DBT Based Therapy)

**Total – 2766**

**Advanced DBT Training**

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

**Total - 286**

## Best Practice Initiatives

### Peer Specialist Certification (NFC Goal 2)

CPS has adopted the Appalachian Consulting Group “Georgia Model” for Peer Specialist training and certification. It is the intent of the Division to move the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. Certified Peer Specialists are a part of this process. CPS contracted with Larry Fricks to provide the first training in Missouri. Ike Powell and Beth Filson of his staff conducted the first training on September 29 through October 3, 2008. CPS has five individuals trained to be the Missouri trainers. Six week-long Peer Specialist Basic Trainings have been conducted thus far. The next week-long training is scheduled for September 13-17, 2010. Four Peer Specialist Supervisors trainings have also been conducted. Seventeen community mental health centers have certified peer specialists working in their agencies. Two State adult psychiatric hospitals and all ten of the Consumer Operated Services Program Drop-In Centers and Warm Lines have certified peer specialists actively working. Additionally, the Veteran’s Administration, residential providers, Services for Independent Living, and two substance abuse treatment agencies have sent individuals to the training. CPS has contracted with Wichita State University to provide the web site support for the training and certification process. The web site is [www.peerspecialist.org](http://www.peerspecialist.org).

CPS has trained a total of 157 individuals with the peer specialist training. Ninety individuals have passed the certification exam and reached the credential for Certified Missouri Peer Specialist (CMPS). The Medicaid reimbursement rate was increased to incentivize the hiring of Peer Specialists in the CMHCs. The rate is comparable to the community support worker rate. In 2010-2011, additional basic trainings and continuing education trainings are scheduled. Regular conference calls are occurring to provide support to the CMPS. The MIMH is conducting a Proof of Concept evaluation to determine if individuals with CMPS have improved outcomes.

### Person Centered Planning (NFC Goal 5)

Missouri was one of the 17 states awarded funds for the Centers for Medicare and Medicaid Services Person-Centered Planning (PCP) Implementation Grant. Projects and initiatives are focused on the Divisions of Developmental Disabilities and Comprehensive Psychiatric Services (CPS). This has been the final year of the grant which ends September 29, 2010. The following summary will provide an overview of CPS activities. Grant funds supported the following training programs:

- Mental Health First Aid (project director is a certified instructor and has co-instructed 3 different MHFA workshops).
- Wellness Recovery Action Planning (WRAP) workshops – one held in March, 2009 for Peer Support Specialists and another held July 28 & 29, 2009 for state hospital and community mental health center employees in the Central Region. A total of 88 people participated in WRAP training. Two WRAP Instructor Certification Courses were held: December 1 – 4, 2009 and June 15 – 18, 2010. A total of 19 people completed the course to become Certified WRAP Instructors.
- The PCP Project Director participated in a series of CPS Documentation & Compliance seminars for community mental health center program directors and regional supported

community living personnel. Over 500 people received training on the philosophical foundation of resilience, recovery, and person-centered treatment planning along with information on documentation and compliance; and

- Neal Adams, MD, and Diane Grieder, M.Ed, provided consultation with CPS Central Office and selected CMHC's related to person-centered treatment planning. They assisted in the initial training and development of a Learning Collaborative in Kansas City in December 2009 with participation from 3 mental health centers and one state agency. Members of the Collaborative are still actively engaged in transitioning their treatment plans, assessments, and other documentation to be more person-centered and to involve family members and other natural supports in the lives of the people they serve.
- Mike Mayer, Ph.D., has provided consultation services and training seminars related to persons with the dual diagnoses of developmental disabilities and mental illness. One of his grant projects was focused on helping the Hope Center, a transitional housing program administered by the Arthur Center (an administrative agent for CPS), transform their programming treatment process and philosophy to include person-centered planning and WRAP along with other innovative assessment techniques. His work began in April, 2009 and ended in May, 2010. Dr. Mayer provided workshops on Dual Diagnoses to the Grant Advisory Group, DMH Spring Institute, and at a regional workshop in Springfield, Missouri.
- The PCP Grant Project Director presented workshops at the 2009 and 2010 Consumer, Family, Youth Annual Conference on the following topics: Partners in Personal Service Design (2009) and True Person-Centered Planning: Expecting More Than the Same Ol' Song & Dance (2010).
- The grant sponsored the following additional workshops to both CPS and DD personnel and providers:
  - Person-Centered Career Planning Webinars – Teresa Grossi, instructor
  - Self-Determination, Community Supports and Culture Change – Peter Leidy, BA, national consultant & instructor
  - Effective Documentation of Stages of Change – Stephen Brazill, MA, MAC.

### **Missouri Mental Health Foundation (NFC Goal 1) (SAMHSA Strategic Initiative 10)**

The Missouri Mental Health Foundation (MMHF) was created in 2007 to provide a singular focus on raising awareness and public understanding to the many issues that impact individuals and families who live with mental illness, developmental disabilities and addiction disorders.

The Foundation is a 501(c)(3) public charity run by its own Board of Directors and a part-time Executive Director. Its mission is to increase public awareness and understanding of mental health conditions and to help dissolve stigma to open doors to treatment and equal opportunity for participation in schools, communities and the workforce.

The public's lack of understanding about mental health conditions and developmental disabilities keeps many Missourians on the sidelines of society and in the shadow of life. Stigma often shapes public policies that limit treatment options. Battling this stigma is the commitment of the Missouri Mental Health Foundation.

The MMHF organizes several activities to create the awareness and public understanding needed to dissolve stigma. Each spring the MMHF hosts the Mental Health Champions' Banquet to recognize three outstanding individuals who have battled through and "championed" mental health issues to become exemplary in their efforts to better their lives and positively impact their communities. Another annual event is the Director's Creativity Showcase in which the Foundation solicits and displays the artistic talents of people served by the Department of Mental Health (DMH). The Showcase helps acquaint the public with the talents of individuals with mental illnesses, developmental disabilities, or addictions disorders. The artwork is created not only for the Showcase, but is also sometimes used as a means of therapy. The MMHF also works with DMH to provide a consumer led conference to address issues important to mental health clients on how they can take more control of their own lives and recovery. In addition to these activities the MMHF also produces public service announcements and hosts important, informational meetings for state legislators with an interest in learning more the mental health system.

A major goal of the Missouri Mental Health Foundation is to identify potential fundraisers and contributors to ensure long-term success and sustainability of the Foundation and its projects. The Foundation makes a difference in *Changing Attitudes and Building Hope* for some of Missouri's most vulnerable citizens.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

During the last year, the project took a slightly different direction and decided to formally train consumers as Peer Evaluators to administer the FACIT to other COSPS funded within this project. A comprehensive curriculum was developed to train these Peer Evaluators. In November 2009, ten consumers attended a week long intensive training in St. Louis. Each state funded COSP designated a consumer to participate in this training and, in lieu of self-assessment done the previous year, teams of two Peer Evaluators are administering the FACIT to other state funded COSPS. All five drop-in centers have been evaluated by a Peer Evaluator Team. Each of the five warm lines will be evaluated over the next two months. The overall goal for COSPS is to develop, implement and maintain continuous quality improvement within their programs based upon the results of the FACIT.

Ongoing training is expected to continue throughout the year for the Peer Evaluator teams. The Peer Evaluators are paid an hourly wage or a stipend for time spent on this project.

All COSPS continue to participate in a monthly teleconference to share ideas and input to the process via a coalition called SCOPE (Supporting Consumer Operated Programs Enhancements). Members share the responsibility of facilitating these meetings; developing agendas, and taking minutes. Members made a presentation at the Real Voices/Real Choices Consumer Conference in August 2010. MIMH maintains a listserv that allows for continued communication and networking of the COSPS.

Approximately two review on-site visits per program were accomplished by the department this year for contract compliance and technical assistance. In addition to the 20 review visits, additional technical assistance has been provided by telephone and email.

### **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 statewide plan of suicide prevention strategies. Implementation has included passing legislation relative to suicide prevention and establishing a Governor-appointed Suicide Prevention Advisory Committee. The subsequent award of a two consecutive three-year federal grants to prevent

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

The fifth annual *Show-Me You Care About Suicide Prevention* conference occurred on July 29-30, 2010, with approximately 230 individuals participating. The conference, which was cosponsored by the Department of Mental Health, Lincoln University and the Missouri Institute of Mental Health helped to increase awareness and education. General session presenters included Dr. David Jobes, Dr. Paul Quinnett, Major General Mark Graham and staff from the Trevor Project. Attendees included educators, health-care providers, mental health care providers, military personnel, survivors and others. For more information on the suicide prevention activities in Missouri go to <http://www.dmh.mo.gov/cps/issues/suicide.htm>.

The DMH continues to implement suicide prevention services according to the legislative mandates and grant guidelines. The Suicide Prevention Advisory Committee, which met regularly between late 2006 and early 2010, is currently being transformed into a new state planning group along with the revision of the state plan. During this four year period the committee has supported efforts on college campuses as well as directing the Department to work collaboratively with federal initiatives to prevent suicides among veterans.

The Missouri Suicide Prevention Project continued to combine funding from the Federal Block Grant with that of the State Youth Suicide Prevention Grant from SAMHSA to operate the 14 Regional Resource Centers around the state. These Regional sites continue to experience increasing numbers of inquiries and requests for services. In addition to providing gatekeeper training the sites continued to offer a wide range of other services, including survivor support groups, depression screenings, facilitating local coalitions, etc.

During the grant year over 400 gatekeeper training presentations and other events were conducted to over 9,200 individuals. These sessions ranged from the one-hour QPR (Question, Persuade & Refer) program to the two-day ASIST (Applied Suicide Intervention Skills Training) workshop. The National Suicide Prevention Lifeline was heavily promoted through the distribution of magnets, stickers, wallet cards and billboards. In the summer of 2010, the Project hosted a QPR Instructor Certification course, establishing over 30 new trainers in the southwest area of the state.

The success of the Youth Suicide Prevention Initiative Community Incentive Award Program inspired the creation of mini-awards geared to the elderly and the youth initiative's format, documents and RFP served as models for the program. Using Block Grant funds, we were able to partner with the Missouri Office of Transformation to award five Older Adult Suicide Prevention Mini-Awards in November 2009. These new older adult-focused projects are progressing successfully.

Upcoming plans include:

- A partnership with several surrounding states to co-sponsor an “*Assessing and Managing Suicide Risk*” (AMSR) *Training for Trainers Workshop* to be held in Omaha, Nebraska in late August 2010;
- Sponsorship in early October 2010 of “Applied Suicide Intervention Skills Training” (ASIST) *Training for Trainers* course in Maryville, Missouri in order to establish ASIST trainers on the Western half of the state; and
- Planning for our sixth annual conference, expected to be held in July 2011, is already underway.

### **Office of Consumer Affairs**

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

### **Crisis Intervention Teams**

Across the state of Missouri, Crisis Intervention Team (CIT) continues to successfully partner with consumers, families and Community Mental Health Centers to divert persons with mental illness and co-occurring substance abuse disorders to treatment. CIT training in Kansas City, Lee Summit, Columbia, 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 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%.

A December 2009 evaluation of Jackson County CIT (Kansas City PD, Independence PD, Lee’s Summit PD, Blue Springs PD and Oak Grove PD), revealed that as it has been in previous years, 49.5% of CIT engagement dispositions were “evaluation,” referring to a mental health assessment performed by a qualified mental health professional. Additionally, arrest dispositions across Jackson County CIT departments remain low, falling under 6.4% in December 2009. These and other statewide CIT statistics illustrate the effectiveness of the program and highlight how far our state has come at bridging the gap between the criminal justice and mental health systems.

### **Disaster Services**

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

### **Increasing Housing Options for DMH Clients (SAMHSA Strategic Initiative 5)**

On July 7, 2010 the U.S. Department of Housing and Urban Development (HUD)) announced the results of their 2009 annual competition for homeless assistance fund through the Continuum of Care (CoC) process. Five of Missouri's eight CoC received a total of just under \$4,406,600 million in new grant awards. The Department of Mental Health received \$2,279,880 in new Shelter Plus Care grants, or 52% of the total new federal funding statewide. Two new grants in St. Louis County will fund units for chronically homeless individuals and units for homeless families. A new grant in Kansas City, will house chronically homeless individuals and chronically homeless families. Two new grants under the Balance of State will cover the rural counties of the St. Louis and Kansas City HMFA.

### **Services to Families of Veterans (SAMHSA Strategic Initiative 3 and 5)**

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

In SFY 2010 the funds for the program to serve family members of veterans were removed from the budget due to the budget shortfall. Many of Missouri's Community Mental Health Centers and their affiliates, which have been extensively trained in military culture and issues impacting veterans, have agreed to continue to provide the services using other funding sources.

The Division continues to work with the Missouri National Guard, Air Guard and Reserves to attend "Yellow Ribbon Events" across the state to provide information about mental health and mental health services for pre-deployed and post-deployed service members and their families.

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

### **Weaknesses**

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

Some of the areas for improvement mentioned by the Mental Health Planning Council were as follows: budget reductions and limited funding for mental health services, 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, limited to no psychiatric beds in rural areas, need for additional funding for CIT training, and relationships with some public administrators (guardians) regarding placement of individuals in the community.

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**

Missouri has experienced the devastating effects of the economic downturn. The severe reductions in state general revenue have caused the DMH to face core budget reductions. In State FY 2010, to balance the budget in an economy that repeatedly failed to meet projections, Governor Nixon required expenditure restrictions (withholdings) of General Revenue (GR) and Federal Budget Stabilization funding several times during the year. DMH's restrictions totaled \$15,375,044 from July 2009 to April 2010. These restrictions were in addition to a \$47.2 million cut to DMH's SFY 2010 GR core budget.

Due to the budget reductions, tough decisions have been made regarding closure of acute care settings and emergency rooms operated by the department. Missouri has closed its two remaining psychiatric emergency rooms and five acute psychiatric units in St. Louis and Farmington. Last year, DMH closed its ERs and acute units in Columbia and Kansas City. The closures place an additional stress on community providers. Missouri's current economic condition will prove problematic in the coming fiscal year.

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

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

### **Merger of Divisions of CPS and ADA**

The DMH is exploring the merger of the Divisions of CPS and ADA. The goal is to increase the administrative efficiencies and improve services for co-occurring psychiatric and substance use disorders integrated care. The Divisions are already making progress on integrating the monitoring functions. The State Advisory Councils for both divisions are meeting to create a plan for the merger.

### **Intensive Community Psychiatric Rehabilitation**

CPS has recently added an Intensive Community Psychiatric Rehabilitation option for adult services. A Code of State Regulations rule amendment has been finalized that allows for the services. The service is currently being developed in conjunctions with the community mental health center representatives.

The Intensive CPR service for adults will be made available for specific, targeted client populations and program initiatives, including initially:

- Clients living in residential facilities operated by administrative agents and affiliates;
- Voluntary by guardian clients who are hospitalized in DMH inpatient facilities and being discharged to community settings; and
- Programming for clients in the East and Southeast regions affected by the closing of state operated acute inpatient beds and emergency rooms.

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

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

One solution for assisting these individuals with returning to the community safely and successfully is the development of Transitional Community Programs (TCP's) to fill the gap between state hospital settings and existing community services. Such programs will provide higher levels of oversight and supervision than is typically provided currently in community settings and also will meet the special clinical needs of such consumers. These programs will afford opportunities to consumers who do not pose a risk to public safety, but who do not meet

the criteria for release to existing community services. These consumers often continue to exhibit challenging behaviors and ongoing symptoms; however, with adequate staffing, oversight, and intensive clinical services could live in the community safely. TCP's could not only serve to assist consumers with transitioning from state hospitals to the community, but also could avoid unnecessary re-hospitalizations by providing a temporary alternative setting for consumers currently in the community who are in danger of returning to inpatient care due to their clinical status or need for increased supervision.

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

### **Collaboration with Department of Corrections**

The Community Mental Health Project (CMHP) is a collaboration between DOC and DMH for offenders with mental health issues who are under the supervision of Probation and Parole. Offenders are referred for services by Probation and Parole officers and services are funded through the inmate revolving fund. Data for FY2010 indicated that 59% of the individuals referred successfully completed the program; an encouraging outcome for this difficult to manage population. Offenders who successfully completed the program had a 5% return-to-prison after 6 months compared to a 27% return-to-prison after 6 months for offenders who did not successfully complete the program. In FY2010 approximately 1200 inmates were referred for services through the CMHP.

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

## **Adult - Recent Significant Achievements**

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

**Integration of Behavioral and Medical Healthcare** – DMH has focused on the physical health as well as the mental health of consumers. FQHC/CMHC collaboration is occurring in seven locations statewide to co-locate medical and behavioral health staff. DMH Net and the nurse liaison initiative are providing nursing consultants to the mental health agencies. CyberAccess is providing health information online to community mental health center staff regarding Medicaid services billed. The Pharmacy Partnership continues to provide quality assurance on physicians prescribing practices. Metabolic screening has been added as a required annual service for mental health consumers served in the CMHCs.

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

**Trauma-Informed Care** – CPS hired a staff person to focus on implementation of the evidence based practice of Dialectical Behavior Therapy (DBT). She has trained 2766 individuals in the two-day DBT introductory training and 286 individuals in the advanced DBT training.

**Suicide Prevention** - The DMH continues to implement suicide prevention services according to the legislative mandates and grant guidelines. Annual Suicide Prevention Conferences have brought in national speakers.

**Screening, Brief Intervention, Referral and Treatment (SBIRT)**- The Department of Mental Health was awarded a \$12.3 million grant from the Substance Abuse and Mental Health Services Administration to support the initial development of the Screening, Brief Intervention, Referral and Treatment program in targeted areas of Missouri before expanding the program statewide. The program offers immediate medical response to Missourians with drug and alcohol problems who present at hospital emergency rooms. The SBIRT program will help emergency rooms by introducing evidence-based practices for screening and treating substance abuse problems. For additional details see the website: <http://www.mosbirt.org/Home/tabid/36/Default.aspx>.

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

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

- **American Psychiatric Association Bronze Achievement Award- Behavioral Pharmacy Management Program; Missouri Mental Health Medicaid Pharmacy Partnership Project – 2006** In recognition of a groundbreaking program that

continuously monitors statewide Medicaid pharmacy data and provides feedback to prescribers, encouraging them to modify their prescribing patterns to achieve best-practices standards

- **SAMHSA Science to Service Award -2008** Since 2003, the Behavioral Pharmacy Management Program (BPM) has been improving the psychiatric medication prescribing practices of thousands of Missouri physicians. The improved prescribing has resulted in better adherence, reduced inappropriate medication usage and reduced hospitalizations for many thousand patients and saved millions of dollars in healthcare costs. Behavioral Pharmacy Management (BPM) developed by a public private partnership between Missouri Department of Mental Health, Missouri Medicaid, and Comprehensive Neuroscience, Inc (CNS) utilizes the evidence based medicine approach of applying the available evidence for a specific individual clinical decision point in a manner consistent with physician and patient values. The intervention is educational, voluntary and protects patient-physician autonomy in making individual clinical decisions.
- **Utilization Review Accreditation Commission (URAC) 2008 Best Practices in Consumer Empowerment and Protection Award** to Missouri Department of Mental Health, Missouri HealthNet, Comprehensive NeuroScience, Inc. and Eli Lilly and Company as Silver Award winners in the Health Information Technology category for the Behavioral Health Pharmacy Management (BPM) program. The program also received an Honorable Mention Award in the Integrated Care Coordination category.
- **Tri-County Mental Health Services (Kansas City Area) – Drug Enforcement Administration Special Agent Michael Scalise** in 2009 presented Amy Tusso, a certificate of appreciation from the DEA for Tusso’s leadership efforts in combating substance abuse in the Liberty area community. Tusso is the chair of the Liberty Alliance for Youth (LAFYI) and prevention coordinator for the Liberty School District. Comprised of community volunteers, LAFYI is funded with the support of Tri-County Mental Health Services.
- **Truman Medical Center Behavioral Health (Kansas City) – Awarded the 2009 National Association of Public Hospitals and Health Systems (NAPH) President’s Vulnerable Population Award.**
- **Swope Health Services (Kansas City) – In 2008 received national recognition from the National Center for State Courts (NCSC) for the Jackson County Mental Health Court Diversion Program.** Programming is located within Kansas City Municipal Court, Lee’s Summit Municipal Court and the Jackson County Circuit Drug Court. Mental Health Court was subsequently selected for inclusion in the NCSC research project funded by the Bureau of Justice Assistance (BJA).
- **Burrell Behavioral Health – (Central and Southeastern Missouri) 2008 (awarded in 2009) SAMHSA, Science and Service Award** from the Department of Health and Human Services for our efforts with Integrated Dual Disorders programming within both our adult transitional services and homeless services programs in Springfield and Columbia;

National Council of Behavioral Healthcare Award of Excellence --- Community Provider; National Council of Behavioral Healthcare Award of Excellence --- Children's Continuum of Care; National Council of Behavioral Healthcare Award of Excellence --- Lifetime Achievement Award for CEO.

- **Independence Center** (St. Louis) –Eli Lilly Reintegration Award in 2000. They also received a 2008 Focus St. Louis “What’s Right with the Region” Award for Improving Racial Equality and Social Justice. Their new facility was recognized by the Landmarks Association of Greater St. Louis for Best Adaptive Reuse of a Historic Property.

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

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

- **Mending Missouri's Safety Net: Transforming Systems of Care by Integrating Primary and Behavioral Health Care** – Schuffman, Druss, Parks
- **Government Perspective** –Joe Parks, M.D
- **Implementing Practice Guidelines: Lessons from Public Mental Health Settings** – Joe Parks, M.D.
- **Impact of the CATIE Findings on State Mental Health Policy-** Parks, Radke, Tandon.
- **Program and System Level Interventions to Address Tobacco Amongst Individuals with Schizophrenia-** Ziedonis, Parks, Zimmerman, McCabe.
- **Smoking Cessation in Patients with Psychiatric Disorders-** Gelenberg, deLeon, Evins, Parks, Rigotti
- **Attention Shaping: a Reward-Based Learning Method to Enhance Skills Training Outcomes in Schizophrenia** –Silverstein, Spaulding, Menditto, Savatz, Liberman, Berten, and Starobin.
- **Trajectories of Seclusion and Restraint Use at a State Psychiatric Hospital-** Beck, Durrett, Stinson, Coleman, Stuve, Menditto.
- **The Use of Logistic Regression to Enhance Risk Assessment and Decision Making by Mental Health Administrators-**Menditto, Linhorst, Coleman, Beck
- **Collaboration in Action- The Discipline of Managing Value in Collaborative Health Care** Schaible, Thomlinson, Susan
- **Building a Stronger Workforce in Rural America-**Brian Martin, MBA
- **Differences Between Urban and Rural Cultural Competency Issues in Missouri-** Thomlinson, Maples, Rimel
- **Using Best Practices to Manage Psychiatric Medication Under Medicaid-** Parks, Surles
- **Pharmacy Costs: Finding a Role for Quality-** Ning, Dubin, Parks

- **When is Antipsychotic Polypharmacy Supported by Research Evidence: Implications for QI** - Goren, Parks, Ghinassi, Milton, Oldham, Hernandez, Chan, Hermann
- **Implementation of Monitoring and Management Guidelines for Second-Generation Antipsychotics** –Michael J. Sernyak, M. D.
- **Missouri Mental Health Medicaid Pharmacy Partnership Project**-A successful Partnership to Improve Prescribing Practices.
- **Impact of Staff Attention on Predicting Post-Discharge Community Tenure of Psychiatric Inpatients**-Coleman, Paul, Schatschneider
- **Restructuring for Partnerships Between Disability and Generic Service Systems: Mental Health and Vocational Rehabilitation; Mental Health and TANF** – Virginia Selleck, Ph.D.
- **A preliminary study on findings of psychopathy and affective disorders in adult sex offenders**-Stinson, Becker, Tromp
- **Self-Regulation and the Etiology of Sexual Deviance: Evaluating Causal Theory**-Stinson, Becker, Sales
- **Assessing Sexual Deviance: A Comparison of Physiological, Historical, and Self-Report Measures**-Stinson, Becker
- **The State of the Art: Psychiatric Rehabilitation As it Ought to Be -- Principles and Practice of Psychiatric Rehabilitation, An Empirical Approach By Patrick Corrigan** - Virginia Selleck, Ph.D.
- **Tipping the Balance Toward Strength?** R. Paul Thomlinson’s review of *Investing in Children, Youth, Families and Communities: Strength-Based Research and Policy*. Maton, Schellenbach, Leadbeater, and Solarz.
- **Are the Kids Alright?** R. Paul Thomlinson’s review of *America’s Teenagers-Myths and Realities: Media Images, Schooling, and the Social Costs of Careless Indifference*, Nichols and Good

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

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

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

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

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

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

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

### **Strengths**

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

#### **CAFAS**

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

#### **Family Support**

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

This service was added to our Community Psychiatric Rehabilitation Program in January 2008 to be eligible for funding under Medicaid. This year concerted efforts have been directed towards developing core curriculum and competencies for Family Support Workers and offering statewide trainings to Family Support Workers and agency supervisors to integrate this service into the continuum of care. Quality and fidelity will be monitored through the CPR certification

process. Through the System of Care Cooperative Agreement, an additional component of Family Support is being examined that would make a Family Support Partner the “front door” to services. The Family Support Partner would have initial contact with the family, identify the needs of the family, and connect the family with appropriate natural or community supports in lieu of or in addition to mental health services. The goal is to assist the family and ideally prevent deeper penetration into the mental health service system.

### **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. In order to provide a more consistent, cohesive Treatment Family Home (TFH) service across the state, CPS is redesigning its model to maximize therapeutic effectiveness while minimizing restrictiveness through consultation with Mary Grealish, M.Ed., Community Partners, Inc. The main focus is to switch to a more professional model with active treatment implementation and management through the TFH. This year the Division has worked on development of the Missouri “Toolkit for Treatment Family Home Care” and revising and updating contracts consistent with the toolkit. In this next year the Division will certify Treatment Family Home train-the-trainers and provide training to providers on the “Toolkit”. Additionally implementation of the toolkit will be monitored through CPS annual compliance review. CPS has proposed including Treatment Family Homes in the rehab option through Medicaid as well as offering a more intensive version called Professional Parent Homes as an alternative to inpatient and/or secure residential placements.

### **Quality Service Review**

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

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

therapists and staff are able to accomplish their jobs. The focus groups also identify the barriers they encounter in either receiving services or in delivering appropriate services.

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

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

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

### **Suicide Prevention**

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 statewide plan of suicide prevention strategies. Implementation has included passing legislation relative to suicide prevention and establishing a Governor-appointed Suicide Prevention Advisory Committee.

The subsequent award of a two consecutive three-year federal grants to prevent suicide in youth up to age 25 has enabled this high risk group to receive targeted services. DMH utilizes this SAMSHA funding in conjunction with block grant funding to provide state-wide suicide prevention services tailored to local needs and supplemented with local support. Strategies include gatekeeper training, policy change, a focused initiative on college campuses, regional

Resource Centers, survivor support groups, promotion of the National Suicide Prevention Lifeline, incentive awards geared to meet local needs, incorporating suicide prevention information in distance learning courses, raising public awareness through print and electronic media, and conferences.

The department continues its suicide prevention efforts by contracting with 14 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 fifth annual *Show-Me You Care About Suicide Prevention* conference occurred on July 29-30, 2010, with approximately 230 individuals participating. The conference, which was cosponsored by the Department of Mental Health, Lincoln University and the Missouri Institute of Mental Health helped to increase awareness and education. General session presenters included Dr. David Jobes, Dr. Paul Quinnett, Major General Mark Graham and staff from the Trevor Project. Attendees included educators, health-care providers, mental health care providers, military personnel, survivors and others. For more information on the suicide prevention activities in Missouri go to <http://www.dmh.mo.gov/cps/issues/suicide.htm>.

In the summer of 2010, the Project hosted a QPR Instructor Certification course, establishing over 30 new trainers in the southwest area of the state. Although unable to enter into a new contract with the MU *Center for Mental Health Practices in Schools* (CAMHPS) the former director continued to work on the project in order to not only complete the goals of their original contract but have since gone on to begin work on accomplishing the goals proposed for a new partnership under the current youth grant. CAMHPS worked closely with the *MU Partnership for Educational Renewal* (MPER) which brings together the MU College of Education, the Missouri Department of Elementary and Secondary Education, and local school administrators from 22 school districts across the state (representing over 194,000 students). The hope is CAMHPS will be able to expand use of the modules and promote and implement suicide prevention efforts within MPER. Accomplishments this year include working with the MU Center for Distance and Independent Study, finalization of modules to create the new online graduate level course, *Suicide Prevention for Educational Professionals*, which went online in mid-December 2009 and suicide prevention was selected as the focus of the 2009-2010 Mental Health Leadership Academy. In early 2010 a series of three “train-the-trainer” events were held across the state to disseminate the modules to school administrators from the 22 MPER school districts.

### **Medicaid Partnership**

Through the leadership of the Department’s Medical Director, the Division has an active partnership with MO HealthNet Division, the Medicaid division for the Department of Social Services, to enhance the quality of both fee-for-service and managed care behavioral health services. Specific activities include:

- Expansion of access to providers through CyberAccess, an electronic database that allows providers to access service history and results to improve coordination of care with physical health and across behavioral health providers;

- Active participation in development of policies for behavioral health fee-for-service to work towards enhancing quality of services and transition to evidence based practices;
- Planning in regards to grant applications to increase access to training of evidence based practices and creation of trauma-informed services and systems;
- Participation in MO HealthNet care coordination audit of managed care behavioral health contracts; and
- Improving access to screening of the early childhood population as well as shaping services towards best practice guidelines

### **Weaknesses**

Missouri faces several challenges in delivery of mental health services for children. Similar to national trends, there is a significant dearth of access to psychiatry, let alone child psychiatry. The Division has developed funding streams that allow enhancements to standing rates for psychiatry which assists the community providers; however, the need still far exceeds the availability particularly for specialized populations such as early childhood or co-occurring Mental Illness/Developmental Disabilities.

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

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

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. 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. There are approximately 1.5 million youth 19 years and younger in Missouri, equating to approximately 137,782 youth with a moderate or severe impact on functioning due to their mental health. The division of CPS is only able to serve approximately 10% of these youth.

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). 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.

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 2009, the Children's Division had approximately 9266 children in out-of-home placement. It is known that children in state custody have a higher rate of mental health issues than the general population.

The table below shows the estimated number of Missouri children with moderate and/or severe emotional and behavioral difficulties.

MO MAYSI Project: An examination of the mental health needs of youth in the juvenile justice system using the Massachusetts Youth Screening Instrument – 2nd Edition (2003) Jefferson City: Missouri Department of Mental Health and the Missouri Alliance for Youth: A Partnership between DMH and Juvenile Justice.

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

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

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

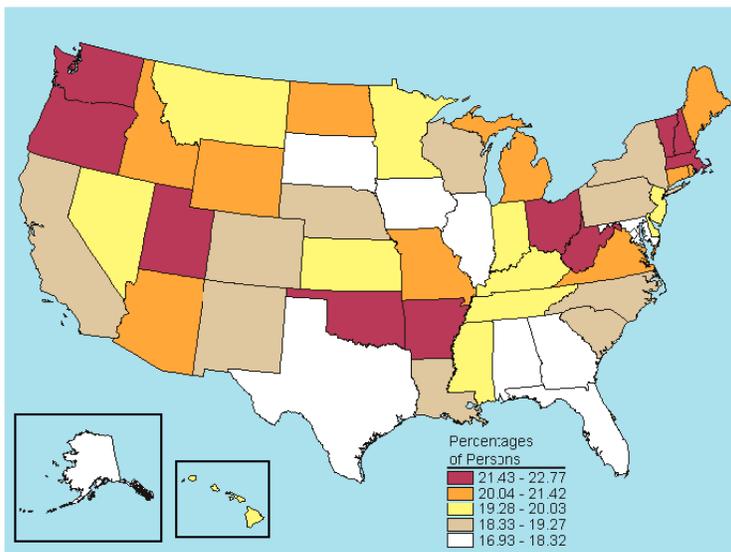
	<b>Estimated Missouri Child Population 2005</b>	<b>Prevalence of Moderate or Severe SED</b>	<b>Prevalence of Severe SED</b>
<b>Percent (Number)</b>	1,076,206	8.7% (93,629)	5.4% (54,115)

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

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

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

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



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

**Trauma** - The National Child Traumatic Stress Network (NCTSN) estimates that 25% of children will experience some form of childhood traumatic stress before they reach the age of 16. Extrapolating from state population data, these estimates suggest that more than 368,000 Missouri children will be exposed to trauma. Youth in child-serving systems are particularly at risk for trauma exposure. Although awareness of the recognition and impact of trauma is growing in Missouri, access to evidence based practices that can address exposure is still limited.

Additionally, many agencies/system unknowingly, “re-traumatize” individuals while engaging them in supports/treatment.

Young Children- There are approximately 400,000 children under the age of 5 years in Missouri. Per data reported by MO HealthNet, there are increasing admissions and lengths of stay in inpatient psychiatric facilities for this population; yet many of these children did not see a mental health professional prior to or after their admission. Access to mental health professionals with true expertise with this population is limited. Additionally, many times those providing services focus on the child alone, and do not meaningfully engage the family or look beyond the child to identify needs and resources.

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.

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

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

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

The Department of Mental Health continues to work with other child-serving agencies and departments to create data systems that can capture meaningful data, enhance the sharing and matching of data across systems and increase the use of data analytics to inform both policy and clinical decision-making. One example is the work the DMH has done with MOHealthNet (Medicaid) in their development of the CyberAccess system. This system allows for real-time monitoring of all services provided and allows for enhanced health monitoring and shaping toward best practices. Two projects related to children and youth utilizing the CyberAccess data tracks health information for Medicaid recipients receiving behavioral health services. These projects are described below in the policy section.

As noted in other sections, the Show-Me Bright Futures Initiative which is based fully on the public health model will not only teach communities how to use existing data, but how to create surveillance systems specific to their community using a number of different approaches such as field interviews and behavioral tracking. Through a partnership with University of Missouri Extension Office, these communities are trained on and utilized a Community Issues Management System (CIMS) a web-based collaborative management system designed for local and regional organizations to frame, manage and take action on complex issues. The foundation of this system is a process for framing issues through a wealth of GIS data, and mapping and reporting tools custom built for organizations to better understand how issues impact people and environments.

Specifically the Division is institutionalizing the use of the CAFAS as a required outcome measure for services which will allow CPS and its network of providers to track the major needs of children, youth and families, develop evidence based services and programs directed towards those needs, and assess the impact of those interventions. Through state and local reports based on the CAFAS, specific population of youth can be identified and subsequently evidence based practices implemented to meet the specific need for a community or the state.

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

The Division is also using a model for capacity development based on Friedman’s work in the 80’s to identify the gaps in the system to aid in moving towards a balanced system. The current focus is on revising the model and expanding access to Treatment Family Homes (therapeutic foster care).

### **Policy Development**

With further support and expansion of the Quality Service Review, CPS will be using the data generated in local sites to identify common weaknesses to prioritize areas of attention related to policy development. CPS will also be working with the local interagency policy teams to insure that locally they are identifying their specific weaknesses and strengths and addressing those through the local Policy Teams. Generally speaking then, the QSR will be the surveillance of the system to guide interagency policy development at the local and state level. An example is one community showed gaps in trauma identification and risk assessment. The local policy team then initiated training on trauma and identified a common tool to aid in identification of risk factors. At the state level, due to identified needs across multiple QSR’s in working with transition age youth, the state applied for and received a SAMHSA cooperative agreement around this population to test and refine a model locally to be able to implement on a statewide basis.

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

The focus for the coming year continues to be on both expanding the service capacity statewide and continuing to create the infrastructure to support the system. There will be several approaches to monitoring the service delivery system including both the QSR as well as the CAFAS as previously identified. The plan would include both of these tools being used to monitor quality and access at both the state and local levels. Additionally, the Division is creating a more focused monitoring system for its providers. Through this the Division will be able to better insure the provision of quality services and enhanced fiscal responsibility. As these surveillance and monitoring systems become fully actualized, the Division will look for additional opportunities to expand the service array as well as the target population on its own and through partnerships with other state and community agencies. As noted with the examples given under Policy Development, with repeated utilization of the monitoring tools over time, progress (or lack thereof) can be identified to insure policy interventions have been effective.

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.

### **Families Retaining Custody**

CPS continues to partner with Children's Division (child welfare) to improve the Custody Diversion Protocol so that families do not have to voluntarily relinquish custody solely to access mental health services. The Custody Diversion Protocol was developed through the shared efforts of DMH, DSS, courts and family members and implemented statewide in January, 2005 following extensive training of Children's Division (CD) staff, DMH provider staff and juvenile justice officers. In February of 2005, the CD was able to implement a Voluntary Placement Agreement (VPA) through an amendment to the state's IV-E plan. This allowed the CD to enter into a contract with parents to fund a child's out of home placement for a maximum of 180 days if deemed appropriate through a DMH level of care assessment without having to take custody. This VPA is only available in conjunction with the Custody Diversion Protocol. To date 991 or 96% of the children referred have been diverted from state custody. This has been considered a very successful initiative and been shared nationally as well as sharing with other states.

### **Finance**

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

- Expansion of access to providers through CyberAccess, an electronic database that allows providers to access service history and results to improve coordination of care with physical health and across behavioral health providers;
- Active participation in development of policies for behavioral health fee-for-service to work towards enhancing quality of services and transition to evidence based practices;
- Planning in regards to grant applications to increase access to training of evidence based practices and creation of trauma-informed services and systems
- Participation in MO HealthNet care coordination audit of managed care behavioral health contracts
- Improving access to screening of the early childhood population as well as shaping services towards best practice guidelines
- Providing Integrated Health Profiles for children in state custody placed in residential care that outlines medication adherence data, co-occurring health disorders and related health care needs, and identifies practices that are discrepant with practice guidelines
- Create an expanded funding stream through Medicaid for schools implementing School Wide Positive Behavior Supports in partnership with a community mental health center

- Current proposal under review at MO HealthNet to reshape Community Psychiatric Rehabilitation for children to include collateral supports for fidelity implementation of intensive evidence based practices, Treatment Family Homes (aka therapeutic foster care) and Professional Parent Homes.

CPS successfully applied for a SAMHSA cooperative agreement for transition age youth. This agreement has provided funds for a local community to implement the RECONNECT model, and some dollars for the state to convene an interagency team to address policy issues and work towards expansion of the model across the state.

The closure of a DMH operated psychiatric hospital on the west side of the state included a children/youth program. CPS was able to dedicate 50% of the funds that supported the children's inpatient unit to the community to create an enhanced array of services for youth that had required extended stays at the restrictive inpatient level due to a lack of effective community based services. An interagency group of community stakeholders developed the Children's Enhancement Project to not only identify an array of services, but training needs and creation of an interagency structure to oversee and coordinate the project.

CPS in conjunction with its Coalition of Community Mental Health Centers has been examining mechanisms and pathways to expand funding including clinic options, administrative billing, Money Follows the Person and 1915i waiver.

### **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. Although initially provided through a computer based system to allow statewide access for its providers and to create both local and statewide databases, CPS has moved to the new web-based version of the CAFAS which also expands access to the Preschool and Early Childhood Functional Assessment Scale (PECFAS) and the Caregiver Wish List. All agencies have been trained and retrained on the CAFAS. The first training of trainers on the PECFAS happened this year.

#### Evidence Based Practice

Training efforts around evidence based practices for children/youth have provided community access to a number of practices. The intent is not only to provide training to the administrative agents of CPS, but to also provide training to other community stakeholders such as school counselors and community providers identified by juvenile offices and child welfare. The practices for which training has been provided include 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. As

noted above, CPS is attempting to develop funding streams for those intensive EBP's that go beyond traditional therapies. Many of the administrative agents/community mental health centers have sought out and obtained training in other evidence based practices such as Parent Child Interaction Therapy, Parent Management Training and Functional Family Therapy. CPS is actively working with the Bureau of Child and Maternal Health to identify opportunities to identify effective home visitation programs for adult consumers with young children.

The Children's Trauma Initiative is providing consultation on creating trauma informed agencies and systems. The first group of early adopters includes the Division of Youth Services, five community mental health centers and two children's residential programs operated by the state. In addition to the work in creating a trauma informed and sensitive agency, training will be provided on a trauma focused evidence based practice.

### Prevention

The Show Me Bright Futures initiative has continued work through the state strategic team to identify mechanisms and funding to assist local communities in application of a public health approach to the social and emotional well-being of children. The Department received a grant through the Missouri Foundation for Health to work with three communities to implement the public health model in regards to social and emotional wellness of children. 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.

### 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. Additionally, DMH is represented on the statutorily defined Coordinating Board for Early Childhood (CBEC). 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, exploration of statewide implementation of Pre-K, support of a sustained P-20 Council and adjustment of the childcare subsidy formula.

DMH has partnered with the Department of Health and Senior Services as well as the MO Child Care Resource and Referral Network to include two new modules to the required Childcare Orientation Training. One module focuses on the promotion of healthy social and emotional development; the other focuses on identifying risk factors and early identification. Current planning is focusing next on providing training to inclusion specialists utilizing the Pyramid Model supported by the Center on the Social and Emotional Foundations of Early Learning.

### Juvenile Justice Activities

The Division continues to lead a state level mental health/juvenile justice policy team to identify and address issues related to the mental health needs of youth at risk of or currently in the juvenile justice system. MO HealthNet serves on this group to aid in leveraging Medicaid dollars in support of best practices. The Mental Health/Juvenile Justice Policy Group is now focusing on creating a continuum of services for youth with problem sexual behaviors. The first step was developing guiding principles, values and practices to insure a common vision. As this

step is being completed, the group has begun the process of examining different best practices that can be developed and accessed by juvenile justice, child welfare, mental health, schools and families. The Division of Youth Services and CPS developed a joint application to BJA to support dissemination of training on two evidence based practices related to problem sexual behavior. One is for 6-12 year olds; and the other is to enhance an existing Multisystem Therapy team with training related to working with juveniles with problem sexual behaviors.

#### 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. A first round of baseline reviews has been conducted. Sites are now going through their second review. 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. 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. 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. For example, 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 learning's from the "Show Me Kids" site is how they developed a family organization through a request for proposal process. This success is a blueprint for other sites in developing and supporting family organizations. The "Transitions" site is certifying high fidelity

wraparound trainers that in the near future can begin training not only in St. Louis, but throughout the state. “Transitions” is also piloting a merged DMH Quality Service Review with the Children’s Division Performance Development Review. This blending of resources will not only save costs, but will gather more information for both agencies. Finally, “Transitions” is about to begin a prevention effort whereby children in the custody of Children’s Division will receive a mental health screening in an attempt to intervene early before mental health issues have become severe. This too can be a model not only for prevention, but for enhanced partnerships between mental health and child welfare. These are just some examples of how Missouri is benefiting from the federal SAMHSA cooperative agreements.

### Family Involvement Activities

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

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

### Youth Leadership

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

Parents and guardians also are involved, discussing in separate sessions their leadership and support roles for their children. Young people and adults alike were excited with the outcomes and have had regular meetings to get an organization off the ground. The group has become a clearinghouse for information on mental illness and substance abuse.

REACCH won a grant from NAMI Missouri in 2009 and in 2010 to promote Children's Mental Health Week. Last year the group set up a Facebook page calling attention to anti-stigma public service announcements. The page is still active and boasts nearly 300 fans. In 2010, members distributed 2,000 green ribbons attached to cards with a message and a website to learn more about children's mental health.

In addition, the family/support arm of REACCH is planning to develop a welcome/orientation packet for new participants and explore training opportunities for family members/caregivers of youths as they transition to adulthood.

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

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

“Every child who needs mental health services and supports from the public mental health system will receive them through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. Missouri’s public mental health services system for children shall be easily accessible, culturally competent, and flexible to individual needs, accountable to those it serves, and shall result in positive outcomes for children and families.” (*Comprehensive Children’s Mental Health Plan*, 2004)

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

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

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

## **Desired System Results**

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

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

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

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

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

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

The State's Revised Statutes of Missouri 2008 RSMo 630.020 set the Departmental goals and duties. It states:

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

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

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

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

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

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

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

## **Adult Plan**

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

#### **Available Resources**

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

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

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

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

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

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

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

In 2001, the DMH promulgated "core rules" that provide common standards across the Divisions of CPS and ADA, where possible. These are also supplemented by specialized standards unique to the population served. Subsequently, in State FY 2003 a committee of provider and consumer

representatives met and developed draft recommendations to enhance the CPR program in several key areas, including the development of continuous treatment teams, increased physician involvement in service planning, and incorporating both substance abuse services and vocational supports more fully into the program. The division has established a collaborative partnership between CPS and ADA provider organizations to improve access and referral of individuals with co-occurring disorders to services.

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

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

### **Targeted Case Management**

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

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

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

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

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

### **Inpatient (Hospitalization)**

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

### **Employment Services**

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

### **Housing Services**

Residential services provide a variety of housing alternatives to meet the diverse needs of clients. Funds are used to support the cost of such housing services as nursing facilities, residential care facilities, group homes, and supported housing. Contractual arrangements are made to obtain these residential services in the community. As individuals move into more independent housing alternatives, they require intensive and flexible services and supports in order to maintain that housing. Provisions of these services and supports enable these individuals to successfully live and work in their communities.

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

### **Educational Services**

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

### **Substance Abuse Services**

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

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

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

### **Medical and Dental Services**

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

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

### **Support Services**

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

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

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

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

### **Case Management Services**

Targeted Case Management includes the following services: arrangement, coordination, and assessment of the individual's need for psychiatric treatment and rehabilitation, as well as other medical, social, and educational services and supports; coordination and monitoring of services and support activities; and documentation of all aspects of case management services, including case openings, assessments, plans, referrals, progress notes, contacts, rights and grievance procedures, discharge planning, and case closure.

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

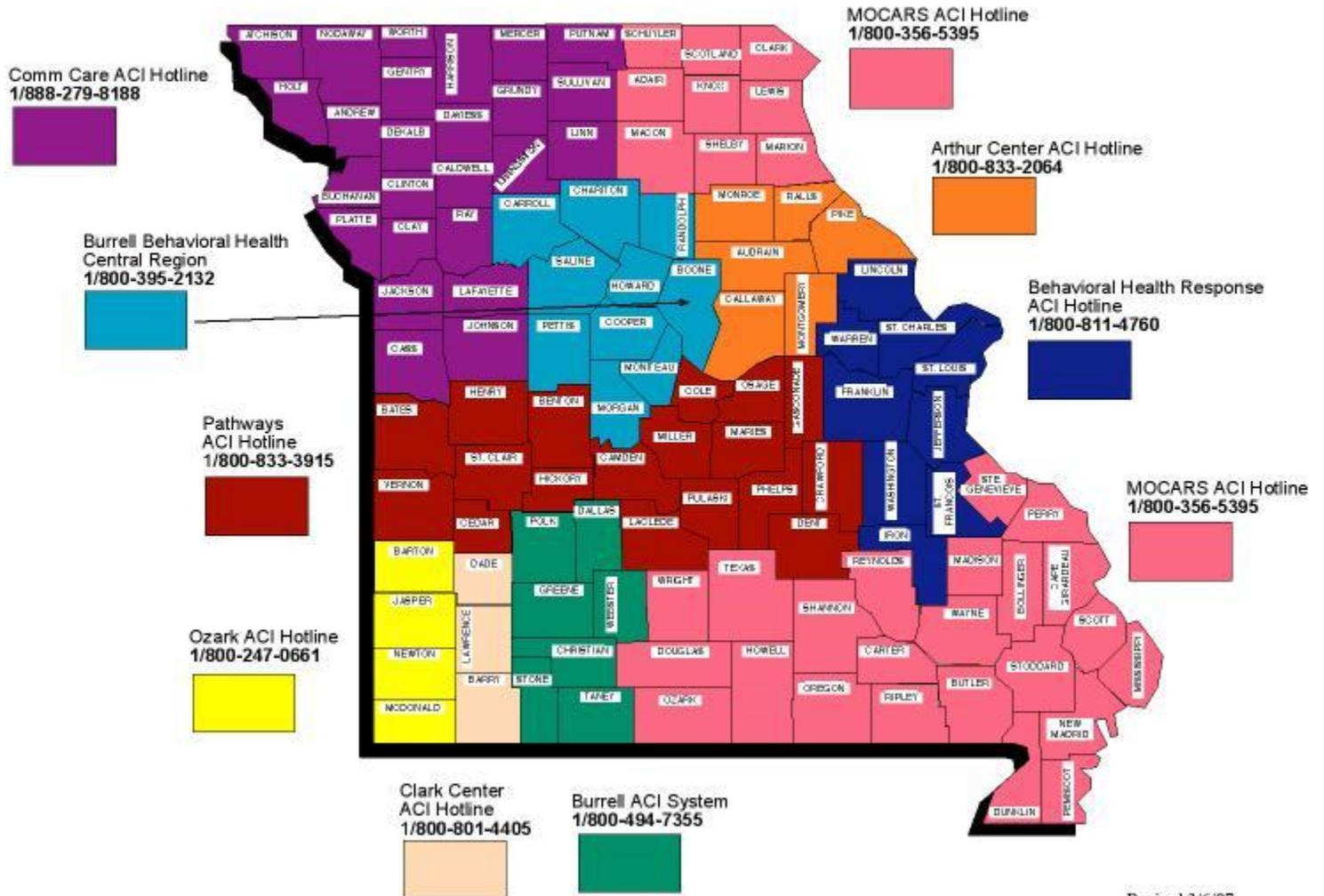
CPS has had a successful year for implementation of IDDT at the community mental health centers. Twenty agencies with thirty-two locations have committed to providing treatment for co-occurring psychiatric and substance abuse disorders according to the IDDT model. CPS has conducted fidelity reviews of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

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

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

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

# Access Crisis Intervention (ACI) Hotlines



Revised 3/6/07

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  
 2009 Estimated Census Data and Prevalence Rates  
 FY2010 Clients Served By Service Area

SA	Tot. Est. Popn 2009	Adults	Children	Adlt at 5.4%	Child at 7%	SMI Adults FY10	SED Child FY10	Rural Adult	Rural Child
01	181,178	140,490	40,688	7,586	2,848	1,569	879	1,569	879
02	0			0	0	4,287	791		
03	0			0	0	1,804	502		
04	0			0	0	1,726	497		
05	0			0	0	1,433	283		
KCsub	705,708	531,871	173,837	28,721	12,169	3,114	1,166		
KC	705,708	531,871	173,837	28,721	12,169	12,364	3,239		
06	342,404	257,163	85,241	13,887	5,967	3,261	602	3,261	602
07	185,413	139,244	46,169	7,519	3,232	987	509	987	509
08	190,132	144,842	45,290	7,821	3,170	2,259	679	2,259	679
09	209,749	155,211	54,538	8,381	3,818	3,655	1,112	3,655	1,112
10	510,347	393,087	117,260	21,227	8,208	3,651	1,503	3,651	1,503
11	235,951	180,252	55,699	9,734	3,899	1,395	450	1,395	450
12	326,063	252,576	73,487	13,639	5,144	2,354	687	2,354	687
13	77,964	58,979	18,985	3,185	1,329	1,205	390	1,205	390
14	105,114	80,970	24,144	4,372	1,690	1,535	406	1,535	406
15	118,014	90,688	27,326	4,897	1,913	1,676	499	1,676	499
16	541,426	403,264	138,162	21,776	9,671	2,545	972	2,545	972
17	203,349	156,337	47,012	8,442	3,291	3,006	561	3,006	561
18	122,967	93,743	29,224	5,062	2,046	1,289	178	1,289	178
19	128,562	96,853	31,709	5,230	2,220	1,731	308	1,731	308
20	100,670	76,088	24,582	4,109	1,721	1,336	676	1,336	676
21	134,528	103,753	30,775	5,603	2,154	1,748	599	1,748	599
22	219,046	164,958	54,088	8,908	3,786	1,846	252	1,846	252
23	992,408	758,813	233,595	40,976	16,352	3,732	638	3,732	638
24	0			0	0	3,040	372		
25	0			0	0	2,830	179		
STLsub	356,587	277,060	79,527	14,961	5,567	1,109	214		
STL	356,587	277,060	79,527	14,961	5,567	6,979	765		
Out of State						213	9		
Unknown						151	14		
TOTAL	5,987,580	4,556,242	1,431,338	246,037	100,194	60,487	15,927	40,780	11,900
			0						
RURAL (EXCLUDES COUNTIES 095 & 510)	4,925,285	3,747,311	1,177,974	202,355	82,458				

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

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

## **Adult and Child Plan**

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

#### **Estimates of Homelessness**

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

#### **PATH Grant**

Missouri has both urban and rural Projects for Assistance in Transition from Homelessness (PATH). The PATH Grant is a federal entitlement grant available to all states and territories to provide outreach and case management services to homeless individuals who are mentally ill and who may also have co-occurring substance abuse problems. PATH funds are used to continue services provided by the agencies originally funded through the Mental Health Services for the Homeless (MHS) Block Grant. In 2001, a new provider was added in St. Louis and in 2002 a provider serving the rural Southeast area was added with additional PATH funding. A rural Southwestern area provider was added in 2003. In 2008 Missouri became interested in SSI/SSDI Outreach, Access and Recovery (SOAR). Fifteen PATH Program staff from across the State attended the SOAR Train the Trainer events and provided some training in the State. Ms. Kendra Daniels, with Truman Medical Center, Behavioral Health's PATH program accepted the duties of State SOAR Coordinator. She organized four SOAR trainings across the State. This effort has been supported in part with PATH Grant dollars. In 2010 Missouri applied for and received technical assistance for the implementation of SSI/SSDI Outreach, Access and Recovery (SOAR). Two PATH providers are targeted as pilot sites for the SOAR initiative. The SOAR effort is being revitalized since Missouri is becoming a SOAR state. A State advisory group is being formed and State Employees focused on Quality Assurance and Evidence Based Practices will become SOAR trainers to help make training more assessable and consistent. Data collected from PATH agencies and others dealing with Missouri's homeless will be added to the national database. Missouri PATH programs meet 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**

The Missouri Department of Mental Health was awarded a Veteran's Administration Grant Per Diem Project in 2008. DMH partners with St. Patrick's Center to provide transitional housing, employment training and preparation, mental health services and substance abuse treatment services to 50 veterans throughout the St. Louis metropolitan area. Disabled Veterans who successfully complete the program transition to Shelter Plus Care, VASH and other permanent housing programs. The DMH Housing Team works with various communities across the state to link homeless veterans with mental illness to public housing agencies receiving VASH and other housing resources.

### **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 35 Shelter Plus Care grants covering the Kansas City, St. Louis, Springfield, Joplin and St. Joseph urban areas as well as a number of non-urban areas throughout the state such as Hannibal and the Bootheel.

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

On July 7, 2010 the U.S. Department of Housing and Urban Development (HUD)) announced the results of their 2009 annual competition for homeless assistance fund through the Continuum of Care (CoC) process.

Five of Missouri's eight CoC received a total of just under \$4,406,600 million in new grant awards. The Department of Mental Health received \$2,279,880 in new Shelter Plus Care grants, or 52% of the total new federal funding statewide. Two new grants in St. Louis County will fund units for chronically homeless individuals and units for homeless families. A new grant in Kansas City, will house chronically homeless individuals and chronically homeless families. Two new grants under the Balance of State will cover the rural counties of the St. Louis and Kansas City HMFA.

On December 23, 2009 HUD announced the approval of all DMH Shelter Plus Care grants that were eligible for renewal. DMH received \$8,601,452 in renewal grant awards. Combined with existing grants (that aren't yet required to renew) and the new grant awards, DMH operates 35 Shelter Plus Care grants totaling \$16,417,632. DMH currently assists over 1,600 households with S+C rental assistance.

The new grant amounts awarded for both Shelter Plus Care and the Supportive Housing Program Permanent Housing to individual Missouri Continuums by HUD consist of the following:

Missouri Balance of State	\$1,399,240
St. Louis City	\$1,498,846
Kansas City	\$ 511,560
St. Louis County	\$ 923,580
St. Charles	\$ 73,374
State Total	\$4,406,600

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

In December 2009, the Commissioners of the Missouri Housing Development Commission announced a total of \$4,506,904 in awards from the Missouri Housing Trust Fund (MHTF). Awards were made in the areas of homeless prevention (\$2,871,112), construction and

rehabilitation (\$893,659) with a good percentage as match to HUD funded Supportive Housing Permanent Housing projects), rental/mortgage assistance (\$193,844) home repair (\$444,000), and operating matching funds (\$820,094) which also provide the match requirement for HUD SHP grants). All funds must serve households at or below 50% of Area Median Income (AMI) and, at least 50% of the funds must serve households at or below 25% of AMI. Several DMH providers are the recipients of Missouri Housing Trust Funds. MHTF is an important resource in the state for matching various grants funded under the HUD Continuum of Care.

It is important to note that the Missouri Housing Trust Fund has been shrinking over the last two years and predicted to decrease even further for 2009. The MHTF is funded through a document recording fee (\$3) on real estate transfers. Due to the decline in the economy and housing market, less funding has been generated. The minimal \$3 fee has also been the same since the MHTF was passed in 1993. Efforts are underway by the Coalition for the Missouri Housing Trust Fund to increase the fee and/or create other funding sources. The DMH Housing Unit is a part of that effort.

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

The DMH Housing Unit has been working closely with providers throughout the state to implement and assist consumers in accessing Homeless Prevention and Rapid Re-housing Program (HPRP) funds allocated under the American Recovery and Reinvestment Act. The State of Missouri received \$12,011,062 in HPRP funding. In addition, St. Louis City received \$8,156,188; St. Louis County \$2,188,750; Kansas City \$3,628,139; Springfield \$551,673; and St. Joseph \$727,371.

### **DMH Rental Assistance Program**

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

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

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

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

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

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

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



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. **Updated 8/5/10**



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 30 Shelter Plus Care grants. **To obtain the most current version of the DMH Application for Shelter Plus Care, [go here](#).** Updated 8/4/2010



This page has links to funding sources, technical assistance and information for people and agencies involved in or interested in developing affordable housing or supportive housing for people with disabilities. **Updated 4/2/10**

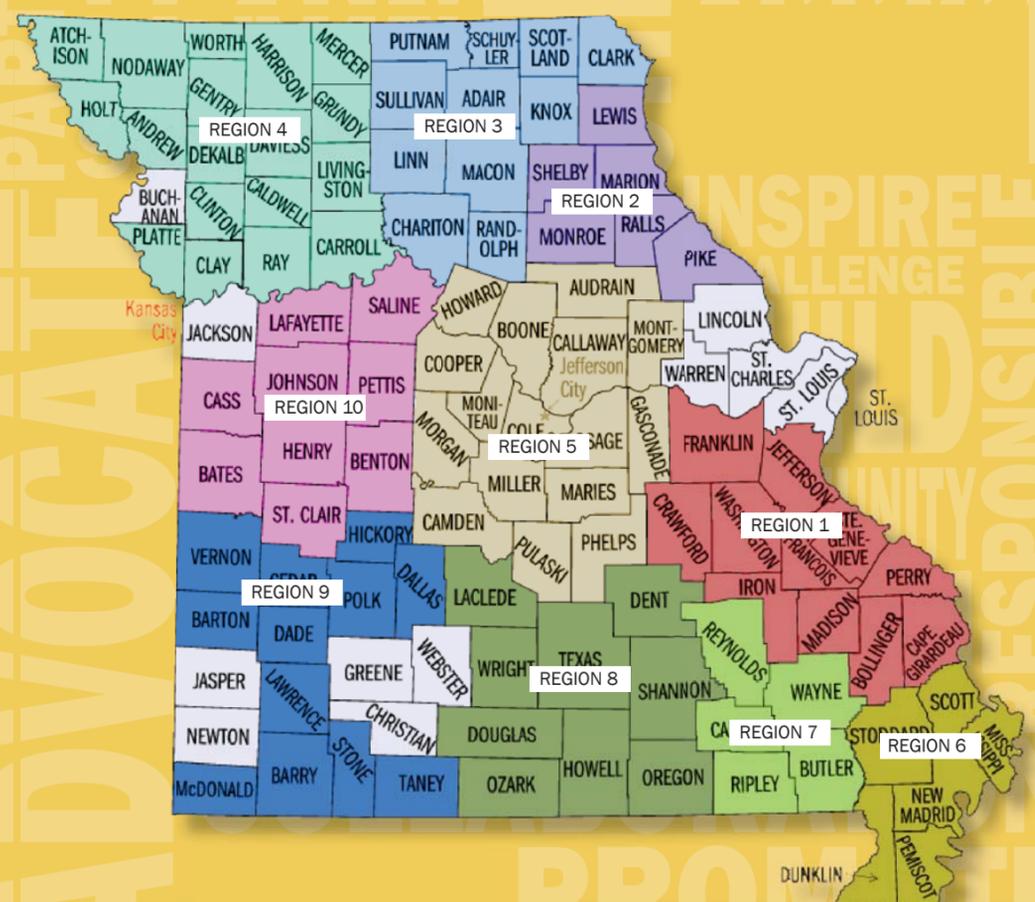


"Housing News" is a quarterly newsletter with articles for renters, homeowners, people with disabilities, housing providers, people who want to develop affordable housing for people with and without disabilities, and for anyone interested in housing issues generally. **Updated 2/8/10**



Here you'll find full contact information for each member of the DMH Housing Team and information about each person's area of expertise. **Updated 11/25/08**

# MISSOURI BALANCE OF STATE CONTINUUM OF CARE MAP



## HOUSING RESOURCES

EMERGENCY SHELTER GRANTS (ESG)	HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)	COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG)	SHELTER PLUS CARE (S+C)
Help local communities to meet the basic shelter needs of those experiencing homelessness and their families. They also provide transitional housing and a variety of support services designed to move the homeless away from a life on the street toward permanent housing.	The grants provide rental assistance and support services to individuals with HIV/AIDS and their families. The HOPWA program also helps many communities develop strategic AIDS housing plans and fill in gaps in local systems of care. Governed by DHSS.	This grant awards money to state and local governments to target their own community development priorities. The grant rehabilitates affordable housing and is an important catalyst for job growth and business opportunities. Governed by DED.	Program funded through HUD that provides rental assistance and supportive services for people with mental health disabilities. The Department of Mental Health administers this program.
HOUSING TRUST FUND	PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)	SUPPORTIVE HOUSING/ TRANSITIONAL HOUSING	HOME
Created by the State Legislature in 1994 to help meet the housing needs of very low-income families and individuals. The Trust Fund provides funding for homeless prevention, rehab or new construction of rental housing, rental assistance, and home repair. This is governed by MHDC.	Through the federally funded PATH, the Department of Mental Health provides outreach services to homeless persons who have mental health needs. PATH is administered through DMH.	This program provides leasing assistance for up to 24 months for individuals and families who are homeless. Only counties who do not receive HUD Supportive Housing funding directly are eligible (Balance of State Communities).	This program is designed exclusively to produce affordable housing for low-income families. HOME also assists with direct rental assistance. HOME is administered through MHDC.

## KEY AGENCIES

<b>MISSOURI HOUSING DEVELOPMENT COMMISSION (MHDC)</b> Heather Bradley-Geary Community Initiatives Manager hgeary@mhdc.com 816.759.7201	<b>MISSOURI ASSOCIATION FOR SOCIAL WELFARE (MASW)</b> Sandy Wilson Director of HMIS and Special Projects wilson@masw.org 573.634.2901	<b>DEPARTMENT OF MENTAL HEALTH</b> Liz Hagar-Mace Housing Director Liz.Hagar-Mace@dmh.mo.gov 573.522.6519	<b>DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)</b> Michael McLay Planner Michael.McLay@dhss.mo.gov 573.751.6439
<b>DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION (DESE)</b> Craig Rector Director Craig.Rector@dese.mo.gov 573.526.3232	<b>DEPARTMENT OF ECONOMIC DEVELOPMENT</b> Andy Papen CDBG Compliance Team Manager andy.papen@ded.mo.gov 573.751.3600	<b>US DEPARTMENT OF VETERAN'S AFFAIRS, VETERAN'S ADMINISTRATION</b> Denise Heet Homeless Program Coordinator Denise.Heet@va.gov 573.814.6654	<b>DEPARTMENT OF CORRECTIONS (DOC)</b> Vevia Sturm Reentry Coordinator Vevia.Sturm@doc.mo.gov 573.522.6128

# THE PLAN TO END HOMELESSNESS IN MISSOURI

Created by the Governor's Committee to End Homelessness

## Our Vision and Mission Statement

Homelessness is unacceptable in Missouri. Therefore, all individuals and families have the right to safe, affordable housing in healthy communities with access to a network of supportive services. It is our belief that housing is a right not a privilege.

- Our mission is to end homelessness by:
- || Establishing strategies to promote public and private coordination and collaboration
  - || Developing new strategies to evaluate and reallocate resources
  - || Removing barriers to access
  - || Meeting immediate support service and affordable housing needs
  - || Implementing effective solutions to build economic security
  - || Promoting and supporting activities that prevent homelessness
  - || Bringing awareness to the citizens of Missouri

## GOALS

- OMB No. 0930-0168
- Expires: 08/31/2011
- Page 162 of 319
- GOAL 1: Gather and maintain information about homelessness and resources within the state.
  - GOAL 2: Provide affordable housing and supportive services for people who are homeless.
  - GOAL 3: Encourage commitment from state leadership to use mainstream resources to end homelessness.
  - GOAL 4: Facilitate local planning collaboratives to address community housing and homeless service delivery strategies.
  - GOAL 5: Take the necessary actions to fully utilize federal, state, and other funds available to address the needs of those experiencing chronic homelessness.
  - GOAL 6: Take the necessary actions to fully utilize federal, state, and other funds available to end generational homelessness among families.
  - GOAL 7: Take the necessary actions to fully utilize federal, state, and other funds available to end homelessness among veterans and their families.
  - GOAL 8: Take the necessary actions to fully utilize federal, state, and other funds available to develop housing for ex-offenders.
  - GOAL 9: Assure that various state discharge policies do not increase the number of formerly institutionalized individuals that become homeless.

## INITIAL STEPS

- These steps were created in the early stages of the 10 Year Plan and have since been completed. The Committee was directed ,and completed the following tasks on June 30, 2004:*
- || The Governor's Committee to End Homelessness was composed of representatives from state departments and other homeless coordination service agencies (current member list included).
  - || The Governor's Committee to End Homelessness pursued all available federal funding to support the implementation of the Missouri Action Plan.
  - || Reviewed and recommended measures to improve access to state administered Mainstream Service Programs (Medicaid, TANF, SSI, CHIP, Workforce Investment Act, Food Stamps, and Veteran's Health Care and Benefits) by homeless individuals and families.
  - || Reviewed and recommended measures to establish state policies that affect housing for families and individuals such as affordable housing, work-force housing, institutional discharge planning, and reentry programs.
  - || Reviewed the State of Missouri Homeless Action Plan to End Homelessness annually and presented recommendations on the implementation strategy to state and federal policy makers.
  - || Established the Homeless Missourians Information System (HMIS) to collaborate data.

*These are steps the Governor's Committee to End Homelessness intends to accomplish in the coming years.*

- || Support collaborative efforts of shared information between all continua in the state of Missouri
- || Gain support for ex-offenders being released and increase reentry programs
- || Reduce the stigma on homelessness by raising awareness about homelessness
- || Implement Project Homeless Connect
- || Increase housing stock and affordable housing
- || Increase housing options
- || Increase subsidies
- || Create a relationship between the Consolidated Plan, the 10 Year Plan and the Balance of State Continuum of Care grant administered by HUD
- || Collaborate with State leadership in the adoption of strategies, allocation of resources, and implementation of the recommendations of this report

*"Homelessness is unacceptable in Missouri."*

## HISTORY AND OVERVIEW



Governor John Ashcroft established the Governor's Committee to End Homelessness in 1987. The Governor's Committee to End Homelessness has met continuously since its establishment. In the early years, the committee met quarterly to exchange information about programs and services, share funding opportunities, and discuss homeless needs in the state of Missouri.

In 1994, the committee began to meet monthly and take on a more active role in planning and developing services for homeless Missourians. Those activities include coordinating and facilitating a Balance of State Continuum of Care Plan, developing a plan to End Homelessness and providing technical assistance to non-profit agencies in accessing homeless assistance funds. From January through November 2003 Members of the Committee worked with the Governor's Office to gain official recognition. On November 7, 2003, the Governor's Committee to End Homeless received that recognition and was officially established with the Office of Boards and Commissions.

The Governor's Committee to End Homelessness has three primary responsibilities. First is facilitating the Balance of State Continuum of Care process. The second function of the Governor's Committee to End Homelessness is to raise awareness of homeless issues in Missouri. Third, the Committee maintains a list of resources and shares resources throughout the state. In addition, as part of our HUD requirements, the Committee ensures there is a valid Homeless Missourians Information System (HMIS) and conducts Regional Housing Team Meetings on a quarterly basis.

### GOVERNOR'S COMMITTEE TO END HOMELESSNESS MEMBER LIST

- |                                       |  |
|---------------------------------------|--|
| Denise Heet, GCEH Chair               | Michelle Garand  |
| Sandy Wilson, GCEH Vice Chair         | Randy Sharp  |
| Heather Bradley-Geary, GCEH Secretary | Dan Clark  |
| Liz Hagar-Mace, GCEH Historian        | Greg Vogelweid   |
| James Figueroa-Robnett, Jr.           | Doilnella Williams   |
| Craig Rector                          | Myra Callahan  |
| Carolyn Stemmons                      | Major George Windham   |
| Jeannie Chaffin                       | Tyrone J. Flowers  |
| Jennifer Carter                       | Gerry Hodge  |
| Michael McLay                         | Vacant Slot: Dept. of Social Services, Division of Youth Services      |
| Vevia Sturm                           | Vacant Slot: Dept. of Social Services, Medicaid Program Representative |
| Randy Griffith                        | Vacant Slot: Workforce Development                                     |
| Antoinette Triplett                   | Vacant Slot: Social Security Administration                            |
| Dana McAuliffe                        |  |
| Cynthia Larcom                        |  |

## NEXT STEPS

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

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

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

Rural areas are characterized by high levels of poverty, little access to specialty health care, low educational levels, and isolation imposed through geography and/or culture. Of the 25 service areas in Missouri, 16 are designated rural or semi-rural according to definitions based on boundaries of Metropolitan Statistical Areas adopted by DMH/CPS. Approximately 15% of the state's population live in rural areas, and 25% are concentrated in small towns and cities. Three-fourths of Missouri's counties are considered mental health professional shortage areas (Missouri Foundation for Health, 2002). In 2000, poverty rates in Missouri counties ranged from a low of 4% to a high of 30%. Of the 46 Missouri counties having poverty rates higher than 15%, 31 were rural and 10 were urban/suburban counties.<sup>1</sup> The poverty, in part, stems from the nature of available jobs. Jobs are often part-time or temporary and are less likely to pay benefits.<sup>2</sup>

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

**Rural Mental Health Care Access Assessment**

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

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

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

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

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

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

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

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

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

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

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

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

Primary care providers – As a result of the lack of available and accessible healthcare, 62 percent of the counties in Missouri have been designated as low-income health professional shortage areas (HPSA). Combined with geographic HPSAs, this leaves only 9 counties in the state that are not designated in part or in whole as health professional shortage areas. In total, 105 of the 114 counties in Missouri are considered to be health professional shortage areas, 92 percent of which are rural.

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

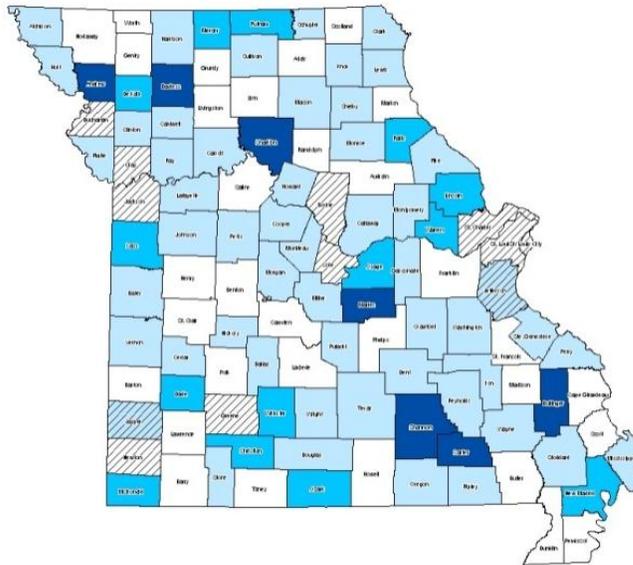
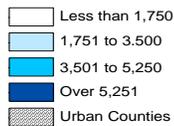
Twenty-five counties in Missouri, all rural, have a population to primary care physician ratio that exceeds 3,500 to 1, the federal standard for health professional shortage areas. Only one urban county (Jefferson) has a ratio of greater than 3,000 to 1, while one-third of rural counties exceed this ratio. Most urban counties (75 percent) have ratios of less than 1,400 to 1. Although 40 percent of Missouri's population lives in rural areas of the state, only 25 percent of the primary care physicians are located in rural areas. This shortage of primary medical practitioners is a critical factor in assuring access to preventive and health maintenance services in rural Missouri. The distribution of primary care physicians in Missouri is shown on the map below.

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

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

**Ratio of Population to  
Primary Care Physicians, 2004**



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

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

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

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

Administrative agents who serve rural communities across Missouri find that satellite offices in rural areas help them provide care for more individuals. These providers often have staff members that rotate between sites to see consumers. Several rural service providers are using tele-psychiatry to their most rural office sites.

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

## **Adult Plan**

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

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

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

In response to these debilitating effects of depression in older adults, the Mental Health and Aging Workgroup voted to encourage the development of Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), an evidence-based intervention effective with both major and subclinical depression. To this end, the Workgroup, with assistance from Washington University, sponsored a statewide informational summit in September 2009. Nancy Wilson (Baylor School of Medicine) and Alixe McNeill (VP, National Council on Aging), both leading lights in the development and dissemination of Healthy IDEAS, explained the program. More than 36 agencies were in attendance. Six senior service agencies (including four area agencies on aging) serving more than 38 counties applied and were approved for training and startup funds to implement Healthy IDEAS in collaboration with local CMHCs whose staff will serve as clinical coaches.

In conjunction with both the Healthy IDEAS initiative and the need to develop resources for older adults suffering from late onset mental illness, the Division of Comprehensive Psychiatric Services promulgated a change in the Code of State Regulations (CSR) that expanded the list of eligible diagnoses for participation in the Community Psychiatric Rehabilitation Program (CPRP) for person aged 60 and over. Previously, major depression recurrent was a qualifying diagnosis, but not major depression single episode. Because older adults may develop late onset depression without earlier episodes, the rule change will enable a greater number of older adults to be eligible for treatment from Community Mental Health Centers (CMHCs) and other agencies participating in the CPRP. This enables Medicaid funding for treatment for those persons who are Medicaid recipients. Agencies participating in the CPRP will also be able to

use their DMH allocations to cover the cost of treatment of older adults suffering from single episode depression who are not Medicaid recipients.

The success of the Youth Suicide Prevention Initiative Community Incentive Award Program inspired the creation of mini-awards geared to the elderly. The youth initiative's format, documents and RFP served as models for the program. Using Mental Health Block Grant funds, CPS partnered with the Missouri Institute of Mental Health and the Office of Transformation to award five Older Adult Suicide Prevention Mini-Awards in November 2009. These new older adult-focused projects are progressing successfully.

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

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

**Financial Resources**

Missouri has experienced the effects of the economic crisis. The reduction in general revenue growth has caused the DMH to face core budget reductions. Emphasis has been placed on implementing evidence-based practices to create greater efficiency and effectiveness.

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

The State has sought funding through various sources and has thoroughly investigated Federal grant sources. Missouri has been awarded many discretionary funding grants from SAMHSA. The Missouri Institute of Mental Health has collaborated with DMH to apply for many of these grants. The list of SAMHSA grants received in Missouri is attached at the end of this section.

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

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

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

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

The total budget for Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services is \$430,849,974 for State Fiscal Year 2011. The federal Block Grant portion of the budget is \$6,904,526. Please refer to the *Grant Expenditure Manner* section for detail on Fiscal Year 2011 Block Grant Expenditure Proposal.

### **Staffing**

Missouri also has a shortage in behavioral health primary care professionals such as psychiatrists and psychologists. Of the approximate 5.8 million people who live in Missouri, it is estimated that 5.4 percent adults and 7 percent children have a serious mental illness. Eleven percent are alcohol dependent, 3 percent are drug dependent and 1.5 percent experience mental retardation or a significant developmental disability, per the Needs Assessment and Resource Inventory (NARI 2008).

Given this prevalence, 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. 105 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.

### **Rural Mental Health**

According to the Rural Health Matters Report, Missouri has a mental health workforce shortage. "In 2000, Missouri had 8.9 non-federal psychiatric patient care physicians per 100,000 population; below the national rate of 12.1. Of the 497 non-federal MD's providing psychiatric patient care in Missouri, 11 had practices in rural counties. Twenty-six had practices in urban/suburban counties and the remainder (460) had practices in metro counties.<sup>1</sup> Psychologists, social workers, counselors and nurses are also part of the mental health workforce. Based on Missouri Department of Economic Development data, in 2002 there were 1,479 licensed psychologists, 4,721 licensed clinical social workers and 2,579 licensed professional counselors practicing in Missouri.<sup>2</sup> Nurses with special psychiatric training made up a smaller portion of the mental health work force. Most mental health professionals practiced in the metro areas of Missouri and clustered in four areas of the state, St. Louis, Kansas City, Springfield and Columbia. For example, almost 90% (3,691) of licensed clinical social workers practice in metropolitan counties. Residents living in rural areas of the state were least likely to

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

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

have access to mental health professionals. This was consistent with national trends.<sup>3</sup> About 4% of licensed psychologists, 4% of licensed clinical social workers and 7% of licensed professional counselors had practices in rural Missouri. In reality, these numbers might be somewhat higher because rural residents report that mental health providers from urban communities do come to rural areas to provide care. It is worth noting that most Missouri counties (94 out of 114) are classified as Mental Health Professional Shortage Areas (MHPSA) which means that there are not enough mental health providers in the county to meet the needs of the population. In addition, urban core areas in St. Louis City and Kansas City have these designations even though the cities themselves do not. Ninety-six percent of Missouri's rural counties are MHPSA. This compares to 62% of metro counties and 83% of urban/suburban counties.”<sup>4</sup>

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

#### Community Psychiatric Rehabilitation Programs

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

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

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

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

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

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

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 are 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 (1 = not urgent, 5 = very urgent).

<b>Clinical / Direct Consumer Care</b>	<b>Mean</b>
Handling Difficult Behavior	<b>3.90</b>
Crisis Intervention/Critical Incidents	<b>3.80</b>
Critical Incident Reporting and Documentation	<b>3.76</b>
Co-Occurring Disorders/Dual Diagnosis	<b>3.74</b>
Clinical Best Practices	<b>3.73</b>

Consumer Treatment Planning (e.g., person-centered)	<b>3.73</b>
Trauma and Abuse Issues	<b>3.66</b>
Special Populations (e.g., geriatric, children, sex offenders)	<b>3.63</b>
Relationships with Consumers	<b>3.60</b>
Assessment Skills	<b>3.57</b>
Counseling/Therapy	<b>3.56</b>
Abuse and Neglect (consumer)	<b>3.54</b>

The department has provided technical assistance and training on many evidence based practices to the community treatment providers. Treatment providers have received extensive training on Integrated Dual Disorders Treatment, Assertive Community Treatment, Supported Employment, Motivational Interviewing Skills, Dialectal Behavior Therapy and Trauma Informed Care. This addresses many of the areas identified in the needs assessment noted above. The children’s service providers have received extensive training on Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Twenty-four therapists have become certified in TF-CBT in the Central region of the state and 19 therapists have become certified in the Western region.

The Missouri Foundation for Health has also funded significant training and technical assistance for treatment providers on co-occurring psychiatric and substance abuse disorders. In 2006, the Missouri Foundation for Health (MFH), Missouri’s largest health care foundation and one of the nation’s largest, established a co-occurring disorders funding program for agencies to implement best practices aimed at producing efficient, coordinated care, improved clinical outcomes, stronger collaborative relationships among providers, better leveraging of resources; increased consistency in services, and creation of policy and procedures to sustain improvements. Unlike many grant opportunities, the focus was to impact the system of care while organizations worked to improve services internally. MFH contracted with Drs. Ken Minkoff and Christie Cline to provide technical assistance to grantees implementing their Comprehensive, Continuous, Integrated System of Care (CCISC), a continuous quality improvement approach to help treatment programs become welcoming, recovery-oriented and COD capable. CCISC is referenced as a best practice in SAMHSA’s Report to Congress on Co-occurring Disorders (2002). Related evidence-based practices were found to be complementary and synergistic with the CCISC model and also incorporated: the Integrated Dual Disorders Treatment (IDDT) toolkit (adopted by DMH’s Division of Comprehensive Psychiatric Services (CPS)), and Treatment Improvement Protocol #42: Substance Abuse Treatment for Individuals with Co-Occurring Disorders (adopted by DMH’s Division of Alcohol and Drug Abuse (ADA)).

In 2008, the Missouri Cadre for Co-Occurring Excellence was formed. During the past two years the Cadre has positioned itself as a change leader to “unite, shape, and change our system of care so that it becomes more responsive to individuals and families with co-occurring issues and needs.” The Missouri Foundation for Health, the Missouri Institute of Mental Health and ZiaPartners – Dr. Minkoff and Dr. Cline have provided a foundation for the Cadre to build upon. These core resources remain committed to assisting the Cadre with infrastructure development and implementation. At this time, the Cadre’s objective is to develop a comprehensive plan to partner with others while insuring Cadre independence and sustainability in their effort to “Change the World”.

Rapid Medicaid Eligibility Training has been conducted by DMH for providers around the state to increase the “nuts and bolts” knowledge of how to navigate the Medicaid eligibility system in Missouri.

#### Missouri Coalition of Community Mental Health Centers

Members of Missouri Coalition of Community Mental Health Centers subscribe to Essential Learning’s Learning Management System, which supports a blended training approach using classroom-based, community-based, and online educational programs. The custom course package is available to multiple employees through a customized site and can be created from an extensive library of accredited courses to meet regulatory and clinical training needs. Courses can be customized to meet organizational needs. A new course is added to the library each month. This learning management system includes automated tracking and reporting on training and licensing requirements and many more convenient features. It is cost-effective and easy to use. It is designed to help organizations stay compliant with training mandates and reduce overall training costs while expanding educational opportunities for staff. The Learning Management System helps to maximize efficiencies and deliver quality client care.

Missouri Coalition of Community Mental Health Centers has teamed with Lilly to offer an innovative, online educational resource that encourages individuals to be active and responsible participants in their own care. This state-of-the-art interactive website provides valuable information presented in a fun and engaging way. In addition to information on wellness, Health Education Answers includes information on the following health topics:

- ADHD (Attention–Deficit/Hyperactivity Disorder)
- Bipolar Disorder
- Depression
- Diabetes
- Diabetes Complications
- Managing Your Weight
- Medication Safety
- Men’s Health
- Schizophrenia
- Smoking and Addictions
- Women’s Health

Health Education Answers also features an exclusive Resource Center to link individuals to information on asthma, allergies, heart disease, and pregnancy.

The Coalition has also arranged for training and technical assistance to CMHCs on Disease Management and on the Cyber Access online Medicaid data base.

### 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 2010, over 900 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. For more information go to <http://www.mimhtraining.com/>.

**SAMHSA Grant Awards By State FY 2009  
Missouri Summary FY 2009/2010**

<b>Formula Funding</b>	<b>Fiscal Year 2009/2010</b>
Substance Abuse Prevention and Treatment Block Grant:	\$26,158,458
Community Mental Health Services Block Grant:	\$6,842,569
Projects for Assistance in Transition from Homelessness (PATH):	\$852,000
Protection and Advocacy Formula Grant:	\$550,483
National All Schedules Prescription Electronic Reporting (NASPER):	\$0
 <b>Subtotal of Formula Funding:</b>	 <b>\$34,403,510</b>
 <b>Discretionary Funding</b>	 <b>Fiscal Year 2009/2010</b>
Mental Health:	\$7,208,074
Substance Abuse Prevention:	\$2,305,287
Substance Abuse Treatment:	\$13,486,076
 <b>Subtotal of Discretionary Funding:</b>	 <b>\$22,999,437</b>
 Total Mental Health Funds:	 \$15,453,126
Total Substance Abuse Funds:	\$41,949,821
 <b>Total Funds:</b>	 <b>\$57,402,947</b>

**Discretionary Funds in Detail**

**Center for Mental Health Services (CMHS)**

**MISSOURI**

Grantee: <b>Missouri Department of Mental Health</b>	Jefferson City, MO
Program: Disaster Relief	SM000253
Congressional District: MO-01	
FY 2009 Funding: \$429,645	
Project Period: 11/01/2008 - 08/31/2009	
 Grantee: <b>COMMUNITY ALTERNATIVES, INC.</b>	 St Louis, MO
Program: AIDS TCE-Service Capacity Bldg in Minority Communities	SM057675
Congressional District: MO-01	
FY 2009 Funding: \$524,956	

Project Period: 09/30/2006 - 09/29/2011

The primary goal is to increase both the availability and the use of critical mental health services for minorities living with HIV/AIDS. We propose to increase the availability and use of mental health services by minorities who are HIV positive through four critical activities: A) Outreach minorities in non-traditional settings, B) Provide short-term Specialized Care Coordination to those we outreach to ensure linkage to mental health and HIV-related services, C) Provide Assertive Community Treatment to those identified with severe mental health and co-occurring disorders, and D) Provide Cognitive Behavioral Therapy interventions focusing on the specific conditions of depression or anxiety disorders, especially Post-Traumatic Stress disorders. Overall, we propose to improve the quality of life and increase the adherence to primary care/health care services for minorities who are HIV positive.

Grantee: **UNITED WAY OF GREATER ST. LOUIS**

St. Louis, MO

Program: 2009 CMHS EARMARKS

SM059374

Congressional District: MO-01

FY 2009 Funding: \$238,000

Project Period: 09/30/2009 - 09/29/2010

The United Way of Greater St. Louis with generous support from the Missouri Foundation for Health established 2-1-1, a Health and Human Services Information and Referral call center for 99 counties in Missouri in 2007. The federally funded element of this project will expand outreach and community education to rural counties in Missouri. This grass roots effort will directly reach hundreds of Missouri citizens through active meetings and presentations at businesses, libraries, etc. Targeted media marketing will be included to further promote this service through radio, print ad, or other media opportunities.

Grantee: **DEPRESSIVE AND BIOPOLAR SUPPORT ALLIANCE**

St. Louis, MO

Program: Statewide Consumer Network

SM059405

Congressional District: MO-01

FY 2009 Funding: \$70,000

Project Period: 09/30/2009 - 09/29/2012

The Heartland Consumer Network will fill the growing need to have a unified consumer voice in Missouri to address mental health policy issues and to ensure a recovery focus within the mental health system and the community at large. The Heartland Consumer Network will focus on organizing mental health consumers in general across the State of Missouri so that consumers can take the lead in the process of change to a consumer-directed, recovery-based mental health system. Underserved populations from the veteran community, the physically disabled, minority group members, and those in the justice system in particular will be recruited. Hubs, located in six cities across the state, will be established as locations for organizational infrastructure and activity. The project will provide initial infrastructure and capacity development through training, preparation, and implementation of an Action Assessment Project in the hub sites, based on the Consumer Operated Services Program (COSP) Multi-site Research Initiative and the Fidelity Assessment Common Ingredients or FACIT. In addition, facilitators from hub sites will receive training and provide outreach, and a Network Steering

Committee will be established and receive training. Activities also will provide for mentoring, formalization of infrastructure, increased organizational membership and networking, opportunities to collaborate with mental health transformation activities, and expanded peer-delivered services and partnerships through grassroots organizing.

Grantee: **NATIONAL ALLIANCE/MENTALLY ILL/MISSOURI**

Jefferson City, MO

Program: Statewide Consumer Network

SM056347

Congressional District: MO-04

FY 2009 Funding: \$70,000

Project Period: 09/30/2004 - 09/29/2010

NAMI of Missouri proposes a project to push Missouri's mental health system forward by providing consumers with a platform from which to engage decision makers in mental health and other related systems. Consumers will become leaders in their own communities as well as leaders in statewide mental health decisions. This project will have a distinct focus on underserved southeast Missouri and engage participation of teens with emotional disorders, Latinos and other culturally distinct groups. Finally we will conduct ongoing needs assessments.

Grantee: **MISSOURI STATE DEPT OF MENTAL HEALTH**

Jefferson City, MO

Program: Child Mental Health Initiative

SM057030

Congressional District: MO-04

FY 2009 Funding: \$2,000,000

Project Period: 09/30/2006 - 09/29/2012

Circle of H.O.P.E. (Home, Opportunities, Parents & Providers, Empowerment) plans to achieve a community-based, child-centered, family driven, culturally competent integrated system of care for delivering team-based behavioral and physical health care that focuses on coordinated supports for individualized and strengths-focused, responsive services to improve the health and well-being of children and their families. The goal is to provide services 'where children are', and more importantly, to meet the cultural preference of people to seek behavioral health services within the primary care setting, thus assuring a 'home' for every child.

Three objectives, specific to the issue of children with SED, support the Circle of H.O.P.E. goal. They are:

- 1) Integrate mental health within school-based service sites through the Federally Qualified Health Center and other providers in the community.
- 2) A family-driven, culturally competent system.
- 3) Build an infrastructure to sustain the system of care.

Grantee: **MISSOURI STATE DEPT OF MENTAL HEALTH**

Jefferson City, MO

Program: Youth Suicide Prevention & Early Intervention -  
Cooperative Agreement State-Sponsored

SM057376

Congressional District: MO-04

FY 2009 Funding: \$500,000

Project Period: 09/30/2005 - 09/29/2011

The Missouri Youth Suicide Prevention Project utilizes local community public-private partnerships to provide evidence based suicide prevention with an emphasis on gatekeeper training. A major function of the Project is to assist in achieving the goals of the Missouri Suicide Prevention Plan (MSPP) for reducing suicide and suicidal behaviors, specifically among at-risk youth ages 10 to 24 years old throughout the state. The MSPP is based on the National Strategy for Suicide Prevention and uses the AIM format (Awareness, Intervention, and Methodology). Guided by this Plan, the Project focuses on the following five objectives for the Youth Prevention and Early Intervention Grant activities:

1. Create additional regional suicide prevention sites to implement services locally.
2. Provide mini-awards to local organizations to fund suicide prevention projects, enabling the needs of underserved at-risk populations to be addressed at the community level.
3. Work with the University of Missouri to implement suicide prevention strategies on campuses, and to provide suicide prevention training in the MU teacher pre-service education program, as well as the graduate school counselor and school psychology programs.
4. Conduct evaluation to assure fidelity with best practices and measure outcomes.
5. Build statewide and local public/private partnerships of stakeholders to raise awareness and generate support for more suicide prevention resources.

The project is administered by the Missouri Department of Mental Health and is independently evaluated by the Missouri Institute of Mental Health, a part of the University of Missouri School of Medicine. The independent evaluation along with the Missouri Suicide Prevention Advisory Committee will assist the Department of Mental Health in assuring youth suicide prevention interventions are evidence based and tailored to the particular needs of Missouri communities.

Grantee: **MISSOURI STATE DEPT OF MENTAL HEALTH**

Jefferson City, MO

Program: Mental Health Transformation State Incentive Grants

SM057474

Congressional District: MO-04

FY 2009 Funding: \$2,190,500

Project Period: 09/30/2006 - 09/29/2011

The Missouri Mental Health Transformation Initiative: Creating Communities of Hope builds on both the Governor's stated commitment to reforming government to make it more efficient and responsive and initiatives currently underway that will transform the children's mental health services system, the state's suicide prevention process, and the relationship between consumers, families, and the mental health system. Creating Communities of Hope will transform the current system from one driven by disability to one based on public health principles. The Creating Communities of Hope initiative will attain the goals of the President's New Freedom Commission while building sustainable, needs-driven state and local partnerships. The Governor has designated a dynamic and experienced individual, Diane McFarland, to lead Missouri's transformation process and appointed the Transformation Working Group. Through this project, the state has conducted an assessment of current resources and needs, developed an initial strategic transformation plan, and will begin implementing their vision in 2008 of supporting and sustaining a comprehensive, integrated mental health system that is consumer and family driven, community based, easily accessible and where promoting mental health and preventing disabilities is common practice. The plan proposes a strategy for reducing stigma and local ownership of mental health and includes a diversion/re-entry system for individuals involved with criminal justice, the elimination of disparities through culturally competent services, improved access

for rural areas, effective screening/referral in early childhood, and expanded mental health within schools.

Grantee: **MISSOURI STATE DEPT OF MENTAL HEALTH** Jefferson City, MO  
Program: State Data Infrastructure Grants SM058113  
Congressional District: MO-04  
FY 2009 Funding: \$142,200  
Project Period: 09/30/2007 - 09/29/2010

This grant enhances DMH's ability to fully comply with data requirements for uniform reporting in the Community Mental Health Block Grant. Some of the key elements of this Grant are: the expansion of the collection of employment data; the implementation of a Consumer Satisfaction Survey utilizing the entire MHSIP Consumer Survey; the continued improvement of the data systems; expansion of reports to the Internet; development of two web based applications; and continuation of expansion of collection data to report all the URS tables. CPS has a goal of reporting those indicators already available and then place an emphasis on improvement of existing data systems and development of readiness to report all indicators.

Grantee: **MISSOURI STATE DEPT OF MENTAL HEALTH** Jefferson City, MO  
Program: Healthy Transitions Initiative SM059439  
Congressional District: MO-04  
FY 2009 Funding: \$479,506  
Project Period: 09/30/2009 - 09/29/2014

Through the Futures Now: Transitioning Youth Partnership, Missouri's Department of Mental Health (DMH), working with other state and community agencies, youth, young adults, families and adult consumers, will develop and implement a comprehensive approach to meet the needs of transitional youth/young adults through the implementation of Utah's Project RECONNECT model. The project's purpose is to provide quality, effective, culturally competent and developmentally relevant youth guided services and supports for youth with severe emotional disturbance (SED) and young adults with severe and persistent mental illness (SMI) in order for them to succeed in all realms of life. Jackson County, Missouri will be the site for the project. The project will capitalize on Jackson County's long history of interagency cooperation and rich cultural diversity. A Jackson county Transitioning Youth Report supports the high need for transitional services for youth with SED and young adults with SMI. Jackson County agencies, families and youth joined together with local foundations, in partnership with DMH to focus on meeting the need of these youth.

Grantee: **NORTHWEST MISSOURI STATE UNIVERSITY** Maryville, MO  
Program: Campus Suicide SM058474  
Congressional District: MO-06  
FY 2009 Funding: \$89,447  
Project Period: 09/30/2008 - 09/29/2011

Northwest Missouri State University is proposing a program to foster the healthiest learning

environment possible for its students through the collaboration of the university and its partners in the domain of suicide prevention and the promotion of mental health services. Through education, training, policy development, and collaboration, Northwest's program aims to reduce suicides and suicidal behaviors on its campus.

Grantee: **FAMILIES AS ADVOCATES**

Springfield, MO

Program: Statewide Family Networks

SM059299

Congressional District: MO-07

FY 2009 Funding: \$60,000

Project Period: 09/30/2009 - 09/29/2010

Grantee: **PHOENIX PROGRAMS, INC.**

Columbia, MO

Program: Supportive Housing

SM058323

Congressional District: MO-09

FY 2009 Funding: \$413,820

Project Period: 09/30/2007 - 09/29/2012

The program's Modified Therapeutic Community in Supportive Housing Program proposes to implement an evidence-based, long term modified therapeutic community system of care that combines existing permanent housing assistance and intensive individualized support services for rural, chronically homeless individuals who have a substance use disorder and a co-occurring mental illness and homeless families with co-occurring disorders who reside within Boone County, Missouri.

### **Center for Substance Abuse Prevention (CSAP)**

Grantee: **ROCKWOOD R-VI SCHOOL DISTRICT**

Eureka, MO

Program: Drug Free Communities

SP015642

Congressional District: MO-02

FY 2009 Funding: \$124,999

Project Period: 09/30/2009 - 09/29/2014

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and federal, state, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee: **WINDSOR C-1 SCHOOL DISTRICT**

Imperial, MO

Program: Drug Free Communities

SP014295

Congressional District: MO-03

FY 2009 Funding: \$100,000

Project Period: 09/30/2007 - 09/29/2012

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and federal, state, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee: **WASHINGTON UNIVERSITY**

St. Louis, MO

Program: Minority HIV Prevention

SP014973

Congressional District: MO-03

FY 2009 Funding: \$335,333

Project Period: 09/30/2008 - 09/29/2013

Project ARK, a program of the Washington University School of Medicine, will improve the identification, treatment, and prevention of substance abuse disorders and new HIV infections among minority young adults in the St. Louis region. This project will serve 2,500 young adults over the five year grant period. The focus of the program are young adults, ages 19-24 (homeless, run-away, recently released from jail or juvenile services, gay, lesbian, bisexual, and transgendered) in the St. Louis Metropolitan Statistical Area (MSA). Services will be provided at drop-in centers and the local community.

Grantee: **ACT MISSOURI**

Jefferson City, MO

Program: Drug Free Communities

SP012137

Congressional District: MO-04

FY 2009 Funding: \$100,000

Project Period: 09/30/2005 - 09/29/2011

The grantee will: (1) Reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse and; (2) Establish and strengthen community anti-drug coalitions.

Grantee: **ST. JOSEPH YOUTH ALLIANCE**

St. Joseph, MO

Program: Drug Free Communities

SP014465

Congressional District: MO-04

FY 2009 Funding: \$100,000

Project Period: 09/30/2007 - 09/29/2011

The grantee will: (1) Reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse and; (2) Establish and strengthen community anti-drug coalitions.

Grantee: **KANSAS CITY FREE HEALTH CLINIC**

Kansas City, MO

Program: HIV/Strategic Prevention Framework

SP013431

Congressional District: MO-05

FY 2009 Funding: \$254,320

Project Period: 09/30/2005 - 09/29/2010

The Kansas City Free Health Clinic has received a five year grant to provide integrated substance abuse and HIV/AIDS prevention services to the needs of minority populations and reentry population in communities of color in the 11-county Kansas City, MO metropolitan statistical area.

Grantee: **COMMUNITY ASSISTANCE COUNCIL, INC**

Kansas City, MO

Program: Drug Free Communities

SP014854

Congressional District: MO-05

FY 2009 Funding: \$125,000

Project Period: 09/30/2008 - 09/29/2013

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and federal, state, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee: **KANSAS CITY FREE HEALTH CLINIC**

Kansas City, MO

Program: Minority HIV Prevention

SP015205

Congressional District: MO-05

FY 2009 Funding: \$335,333

Project Period: 09/30/2008 - 09/29/2013

The Kansas City Free Health Clinic's All Stars Program will increase the local MSA's capacity to address substance abuse and HIV preventions needs among minority youth by involving key stakeholders, developing a strategic plan and creating more service opportunities. The program will target at least 630 adolescents between the ages of 13 and 17, at high risk for SA/HIV, including youth who are from minority, low-income families, sexually-active, pregnant or at risk for pregnancy, teen parents and who are experimenting with alcohol and drugs. The two primary service sites include the clinic and the DeLaSalle Education Center.

Grantee: **LEE'S SUMMIT CARES, INC.**

Lee's Summit, MO

Program: Drug Free Communities

SP015805

Congressional District: MO-05

FY 2009 Funding: \$125,000

Project Period: 09/30/2009 - 09/29/2014

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and federal, state, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee: **ALLIANCE OF SOUTHWEST MISSOURI**

Joplin, MO

Program: Drug Free Communities

SP012987

Congressional District: MO-07

FY 2009 Funding: \$80,000

Project Period: 09/30/2005 - 09/29/2010

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and federal, state, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee: **UNITED WAY OF THE OZARKS, INC.**

Springfield, MO

Program: Sober Truth on Preventing Underage Drinking Act Grants

SP015316

Congressional District: MO-07

FY 2009 Funding: \$49,815

Project Period: 09/30/2008 - 09/29/2012

The Sober Truth on Preventing Underage Drinking Act (STOP Act) grants is a program to prevent and reduce alcohol use among youth in communities throughout the United States. It was created to strengthen collaboration among communities, the Federal Government, and State, local and tribal governments; to enhance intergovernmental cooperation and coordination on the issue of alcohol use

among youth; to serve as a catalyst for increased citizen participation and greater collaboration among all sectors and organizations of a community that first demonstrates a long-term commitment to reducing alcohol use among youth; and to disseminate to communities timely information regarding state-of-the-art practices initiatives that have proven to be effective in preventing and reducing alcohol use among youth.

Grantee: **MISSION MISSOURI**

Sikeston, MO

Program: Drug Free Communities

SP013052

Congressional District: MO-08

FY 2009 Funding: \$100,000

Project Period: 09/30/2005 - 09/29/2010

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and federal, state, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee: **CHA LOW INCOME SERVICES**

Columbia, MO

Program: Drug Free Communities

SP011541

Congressional District: MO-09

FY 2009 Funding: \$125,000

Project Period: 09/30/2005 - 09/29/2014

The grantee will: (1) Reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse and; (2) Establish and strengthen community anti-drug coalitions.

Grantee: **UNIVERSITY OF MISSOURI-COLUMBIA**

Columbia, MO

Program: HIV/Strategic Prevention Framework

SP013274

Congressional District: MO-09

FY 2009 Funding: \$254,320

Project Period: 09/30/2005 - 09/29/2010

The purpose of this project is to deliver and sustain a culturally relevant and effective integrated substance abuse (SA), HIV, and hepatitis prevention project that seeks to prevent and reduce the onset of substance abuse and the transmission of HIV and hepatitis among African American populations and African American reentry populations located in two cities within the St. Louis, Missouri-Illinois Metropolitan Statistical Area and identified as areas disproportionately affected by substance abuse, HIV/AIDS, and hepatitis. The project will teach participants about the dangers of drugs and their

interrelationship with HIV/AIDS and hepatitis and will be delivered through a series of workshops utilizing an integrated SA, HIV/AIDS, and hepatitis science-based curriculum accompanied by a creative arts component that will allow for participant self-expression. The proposed project is also designed to equip faith-based institutions with the knowledge and skills they need to deliver effective prevention programs. In order to implement this project, the Missouri Institute of Mental Health (MIMH) has partnered with: the City of St. Louis Department of Health; the State of Missouri Department of Health and Senior Services (Office of Epidemiology, Office of Minority Health & Division of Environmental Health and Communicable Diseases); the State of Missouri Department of Corrections District 75 Missouri Board of Probation and Parole; the State of Missouri Department of Mental Health (Division of Alcohol and Drug Abuse-Eastern Region & Division of Comprehensive Psychiatric Services); the Drug Enforcement Administration; Office of the Mayor of St. Louis City; St. Louis ConnectCare (a local hepatitis screening and testing agency); Committed Caring Faith Communities (a nine year old nonprofit faith-based organization that works to empower and support religious institutions in their services to people suffering from substance abuse and related issues).

Grantee: **PREFERRED FAMILY HEALTHCARE, INC.**

Kirksville, MO

Program: Drug Free Communities

SP014190

Congressional District: MO-09

FY 2009 Funding: \$96,167

Project Period: 09/30/2006 - 09/29/2014

The grantee will: (1) Reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse and; (2) Establish and strengthen community anti-drug coalitions.

#### **Center for Substance Abuse Treatment (CSAT)**

Grantee: **QUEEN OF PEACE CENTER**

St Louis, MO

Program: Pregnant/Post-Partum Women

TI019583

Congressional District: MO-01

FY 2009 Funding: \$468,916

Project Period: 09/30/2009 - 09/29/2012

Queen of Peace Center (QOPC) seeks SAMHSA funding to implement a combination of evidence-based practices in the provision of residential substance abuse (SA) treatment- (CSTAR program), trauma recovery- (Seeking Safety and TREM programs) and family services (Family Behavior Therapy program and Network Therapy) services to pregnant and postpartum women (PPW), who suffer from alcohol and other substance use problems, their minor children, and families. The project aims to serve 72 low-income PPW and their minor children, and provide non-residential treatment services to 24 fathers of the children, partners of the women, and extended family of the women annually for three years, totaling 288 clients. Recruitment efforts will prioritize PPW women residing in the metropolitan St. Louis area who are low-income, single parents, homeless, underinsured, or uninsured. A significant proportion of the PPW will have histories of trauma and co-occurring mental health disorders. An outreach program will ensure access to the program which will utilize individualized family service plans to provide a comprehensive array of services, including SA treatment services, trauma recovery services, family counseling, family education, parenting skills, and

case management services to coordinate mental health treatment and linkages and referrals to prenatal care, and methadone maintenance treatment providers for PPW with opiate addiction. Key goals include the birth of drug-free infants, decrease in substance use for mothers, access to primary care, placement of mothers and their children in safe housing, and the provision of individualized family services to children, fathers of the children, partners, and extended family members of the mothers.

Grantee: **QUEEN OF PEACE CENTER**

St. Louis, MO

Program: Targeted Capacity - HIV/AIDS

TI018834

Congressional District: MO-01

FY 2009 Funding: \$469,525

Project Period: 09/30/2007 - 09/29/2012

The purpose of this project is HIV/AIDS prevention through targeted capacity expansion of substance abuse treatment targeted at at-risk substance abusing African American women residing in the City of St. Louis. This goal will be achieved by both expanding services by increasing the number of individuals who are in drug treatment, as well as enhancing services by adding an outreach and pre-treatment component to the existing services. The proposed service enhancement will be based on The NIDA Community-Based Outreach Model and will involve the deployment of two Outreach Workers to neighborhoods in the City of St. Louis that are characterized by high levels of drug use, HIV infection and poverty. Planned expansion of service will include the funding of new substance abuse residential treatment slots for 240 African American women at-risk for HIV infection. These individuals will primarily begin treatment by entering residential services but will be guided through a comprehensive continuum of wraparound including family and child counseling services.

Grantee: **ST. LOUIS DRUG COURT**

St. Louis, MO

Program: Adult Treatment Drug Courts

TI019925

Congressional District: MO-01

FY 2009 Funding: \$293,308

Project Period: 09/30/2008 - 09/29/2011

The St. Louis Drug Court created the "Possibilities Program" to enhance the current treatment services to substance abusing young adults ages 17-22 years old. The program will deliver intensive employment training/placement services augmented by an individualized program using peer mentors to deliver services. The enhancement piece will be built around issues of employment training/placement and retention services, career development, business development, mentoring, and life skills training to help these individuals. The program focuses on providing the clients, in addition to treatment, alternative lifestyles that promote their employability, decision making skills, health and wellness issues, family issues, and academic education services (GED). Individuals in the program will receive outreach, treatment, treatment support services, and culturally sensitive support groups. The program will serve 180 young adults during the three year grant cycle (50 in Year 1, 65 in Year 2 and 3).

Grantee: **COMMUNITY ALTERNATIVES, INC.**

St. Louis, MO

Program: Treatment for Homeless - Homeless

TI020617

Congressional District: MO-01

FY 2009 Funding: \$399,364

Project Period: 09/30/2008 - 09/29/2013

Community Alternatives, Inc. plans to expand and strengthen treatment services and the system of care for homeless people, including veterans, with alcohol disorders and mental health disorders. The evidence-based approaches to be implemented and services to be provided include the Community Reinforcement Approach, Assertive and Comprehensive Case Management, Assertive Community Treatment, Integrated Dual Disorder Treatment and residential support. It is anticipated that 362 unduplicated individuals will be served over the five year project period.

Grantee: **ST. LOUIS DRUG COURT**

St. Louis, MO

Program: Adult Treatment Drug Courts

TI021534

Congressional District: MO-01

FY 2009 Funding: \$299,893

Project Period: 09/30/2009 - 09/29/2012

St. Louis Adult Drug Court has created "Bridge the Gap" to expand current treatment and recovery support services for 360 inner city substance abusing adults from 17-65 years of age (90 in year 1, 130 in year 2, and 140 in year 3). "Bridge the Gap" will deliver integrated intensive case management/outpatient therapy for high risk participants coping with mental illness, trauma and the prospect of prison confinement and outpatient therapy for the massive caseload in need of treatment. The goals of the project are to: a) remove situational barriers from Drug Court admission and treatment access, b) provide additional treatment supports in order to prevent, reduce, or delay relapse episodes and the client's involvement in the criminal justice system, c) expand the availability of evidence based treatment to provide services to drug court participants to support program completion, and d) eliminate delay in treatment service delivery and improve program implementation.

Grantee: **COUNTY OF ST. CHARLES**

St. Charles, MO

Program: Adult Treatment Drug Courts

TI021898

Congressional District: MO-02

FY 2009 Funding: \$272,911

Project Period: 09/30/2009 - 09/29/2012

The Missouri 11th Circuit Drug Court's primary goal is participant compliance with court-imposed treatment, leading to the dismissal of the original charges or a reduction in the length of probation upon graduation from the new courts. The overarching goal of the proposed project is as follows: By September of 2012, a minimum of 55% of all participating co-occurring treatment court participants will "graduate" from court-monitored programming, will be psychologically stable, and will not have used alcohol or illegal street drugs. The project will serve 150 unduplicated individuals over the next three years.

Grantee: **MISSOURI STATE DEPT OF MENTAL HEALTH**

Jefferson City, MO

Program: Access to Recovery

TI019503

Congressional District: MO-04

FY 2009 Funding: \$5,248,835

Project Period: 09/30/2007 - 09/29/2010

Missouri's ATR II will improve and expand the statewide voucher system that affords genuine, free, and independent choice among a diverse group of clinical treatment and recovery support providers. MO-ATR II will enhance clinical services with evidence-based methamphetamine treatment tracks and expand the network of recovery support providers. A broad spectrum of people will be served, but priority services will be provided to critical populations including methamphetamine users, offenders transitioning from prison to the community, and veterans returning from the Iraq-Afghan War.

Grantee: **MISSOURI STATE OFFICE OF THE GOVERNOR**

Jefferson City, MO

Program: SBIRT (Screening, Brief Intervention, Referral & Treatment)

TI019549

Congressional District: MO-04

FY 2009 Funding: \$2,511,844

Project Period: 09/30/2008 - 09/29/2013

Missouri's SBIRT will promote screening, brief intervention, referral and treatment services by using evidence based practices and an automated system of tablet computers. Over five years the project will develop and demonstrate effective SBIRT processes in general and emergency medical settings. The project will screen over 80,000 individuals serving 25,000 with significant risk behaviors before they become dependent. The project will use trained substance abuse professionals conducting face-to-face screening of all individuals entering selected medical care facilities. Screening will detect misuse of alcohol, illicit and prescription drugs and tobacco. The goal is to fill a gap in the continuum of care, develop an effective SBIRT implementation, demonstrate the impact of SBIRT on the health of individuals and societal costs, and create an environment in which a sustainable SBIRT model can spread across the state.

Grantee: **UNIVERSITY OF MISSOURI KANSAS CITY**

Kansas City, MO

Program: Addiction Technology Transfer Center

TI013591

Congressional District: MO-05

FY 2009 Funding: \$600,000

Project Period: 09/30/2007 - 09/29/2012

The Mid-America Addiction Technology Transfer Center (Mid-America) at the University of Missouri-Kansas City (UMKC) will serve Arkansas, Kansas, Missouri, Oklahoma, and Nebraska by developing and conducting training and technology transfer activities to meet the identified needs of the addiction treatment workforce. With the addition of Nebraska to the region, the proposed plan focuses on expansion of the regional network by cultivating relationships, creating consortia, and assessing workforce interests, needs, and capacities in the five-state area. All of the Center for Substance Abuse Treatment's ATTC Network goals are addressed in the proposed work plan, which includes formalized ATTC assessment procedures. This work plan responds to areas of need indicated by SSAs, state substance abuse treatment strategic plans, certification bodies, provider associations, recovery communities, academic institutions, and other community organizations in the five states.

Grantee: **UNIVERSITY OF MISSOURI KANSAS CITY**

Kansas City, MO

Program: Addiction Technology Transfer Center

TI013592

Congressional District: MO-05

FY 2009 Funding: \$650,000

Project Period: 09/30/2007 - 09/29/2012

The Great Lakes Addiction Technology Transfer Center (GLATTC) proposes to use training, technical assistance, systems change, and technology transfer to improve the knowledge and practices of substance use disorder treatment providers, build culturally competent recovery-oriented systems of care, and develop the substance use disorders treatment workforce in the region. Project goals are to: maintain effective communication, coordination, and collaborative relationships with stakeholders and serve as a catalyst for collaborations among organizations and agencies within addictions treatment and recovery and related fields; use innovative, culturally appropriate technology-transfer strategies to promote the adoption of evidence-based and promising practices, and to disseminate relevant research; strengthen and expand the treatment workforce through workforce surveys, materials and services to pre-service students, the development of Technology Transfer Specialists within the region, Leadership Institutes based on the CSAT Partners for Recovery/ATTC Leadership Institute model; support the advancement of recovery-oriented systems of care; and work with the ATTC Network through cross-regional and Network-wide activities.

Grantee: **SWOPE HEALTH SERVICES**

Kansas City, MO

Program: Homeless Addictions Treatment

TI016593

Congressional District: MO-05

FY 2009 Funding: \$400,000

Project Period: 07/01/2005 - 06/30/2010

Swope Health intends to dramatically impact the community treatment philosophy by demonstrating the effectiveness of client directed treatment; offering a "housing first" option, treatment of varying lengths upon demand, and intensive case management services of approximately one year's duration. Case managers will be extensively trained and guided by the principles of "States of Change" theory and Motivational Interviewing.

Grantee: **BURRELL BEHAVIORAL HEALTH**

Springfield, MO

Program: Homeless Addictions Treatment

TI016666

Congressional District: MO-07

FY 2009 Funding: \$338,226

Project Period: 07/01/2005 - 06/30/2010

Burrell Behavioral Health, a community mental health center, in collaboration with Springfield, MO Area Homeless Continuum of Care partners, will develop a community-based homeless services program that will facilitate for homeless persons and families a successful and permanent journey out of homelessness and back into mainstream society, overcoming the added burdens of mental illness and/or substance abuse.

Grantee: **ALTERNATIVE OPPORTUNITIES, INC.**

Springfield, MO

Program: Pregnant/Post-Partum Women

TI019604

Congressional District: MO-07

FY 2009 Funding: \$408,896

Project Period: 09/30/2009 - 09/29/2012

Community Works will augment Greene County Missouri's current family centered service delivery system for Pregnant & Postpartum Women by 1) organizing substance abuse treatment using the Matrix Model, 2) adopting the Parent-Child Assistance Program's (PCAP) intensive case management 3) improving coordinated case management with Health Care, Mental Health and Social Services and 4) sponsoring a Peer Recovery Support Network. Community Works proposes to increase the well-being of and improve the permanency outcomes for pregnant and postpartum women and their children affected by alcohol or other substance use and abuse. Our treatment center, Carol Jones Recovery Services for Women (CJRC), supports in excess of 100 pregnant and postpartum women and their families per year. Faced with barriers to basic resources, these women (and their children) are at greater risk of experiencing serious physical and mental health problems, abusing their children, being victimized by domestic violence and securing and maintaining societal supports for their basic survival. Similarly, fathers of the children, partners of the women, and other extended family members of the women and children in treatment may face equally difficult challenges themselves, preventing the family from being safe, healthy and together.

Grantee: **PHOENIX PROGRAMS, INC.**

Columbia, MO

Program: Effective Adolescent Treatment

TI017724

Congressional District: MO-09

FY 2009 Funding: \$299,789

Project Period: 09/30/2007 - 09/29/2010

The Phoenix Programs, Inc.'s Assertive Family Centered Treatment (AFCT) project will implement the family centered Adolescent Community Reinforcement Approach (ACRA), coupled with Assertive Continuing Care (ACC) for underserved, rural adolescents who have substance abuse disorders (SUD) or co-occurring SUD and mental disorders (COD) and their caregivers in nine rural counties in mid-Missouri. The Goals of the AFCT project are to increase access to treatment and reduce substance abuse and co-occurring mental illness by expanding and strengthening Phoenix Programs of care.

Grantee: **UNIVERSITY OF MISSOURI-COLUMBIA**

Columbia, MO

Program: SBIRT-Medical Residency Program

TI020288

Congressional District: MO-09

FY 2009 Funding: \$374,569

Project Period: 09/30/2009 - 09/29/2014

The Missouri School of Medicine intends to coordinate and sustain training of residents across all specialties to enhance delivery and quality of SBIRT services. This will be a 5 year collaborative effort to provide SBIRT training for residents and medical students in the University of Missouri (MU) School of Medicine, and graduate nursing students in the MU Sinclair School of Nursing and participating residencies in ObGyn, Surgery and Psychiatry as well as emergency departments. Methods will include using the institution's new Clinical Simulation Center and mentored interactions

with actual patients. Also the project will collaborate with the Missouri Primary Care Association and large hospital-owned systems to reach the largest possible audience. Sustainable commitments have been made by the Dean of the School of Medicine, the Director of Graduate Medical Education and residency program directors who recognize the value of the SBIRT process.

Grantee: **PREFERRED FAMILY HEALTHCARE, INC.**

Kirksville, MO

Program: Targeted Capacity - HIV/AIDS

TI019834

Congressional District: MO-09

FY 2009 Funding: \$450,000

Project Period: 09/30/2008 - 09/29/2013

The Safe Haven Project will target groups in the St. Louis Metropolitan Statistical Area (MSA) and include: 1) women, 2) young adults, 3) men who inject drugs including men who have sex with men, and 4) individuals re-entering from the criminal justice system. The project will focus on providing immediate access to care, a supportive treatment environment, HIV testing and counseling, effective interactions with HIV/AIDS community resources, and post-treatment housing support. Potential clients will be directly admitted 24 hours/day, 7 days/week. HIV rapid testing will be offered to every Safe Haven client on the day of admission into treatment. The project will provide enhanced service to 60 unique clients per year, for a total of 300 clients over the life of the project. Group and individual counseling consistent with the best practices including Motivational Enhancement Therapy, Cognitive Behavioral Therapy and the Stages of Change Methodology will be provided.

Last Update: 10/29/2009

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 (DMH) as the public mental health authority coordinates 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.

The Office of Disaster Readiness includes a coordinator, part-time temporary 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 Office of Disaster Readiness is in the process of hiring a full time assistant coordinator. The ASPR Grant supports deliverables to DHSS and DMH under four overarching requirements and thirteen capabilities. The overarching requirements include:

1. National Incident Management System (NIMS)
2. Needs of At-Risk Populations
3. Education and Preparedness Training
4. Exercises, Evaluation and Corrective Actions

The capabilities include:

**Level 1 Sub-Capabilities**

1. Interoperable Communication Systems
2. Tracking of Bed Availability (HAvBed)
3. ESAR-VHP (Missouri's Show-Me Response program)
4. Fatality Management
5. Medical Evacuation/Shelter-in-place
6. Partnership/Coalition Development

**Level 2 Sub-Capabilities**

1. Alternate Care Sites
2. Mobile Medical Assets
3. Pharmaceutical Caches
4. Personal Protective Equipment
5. Decontamination
6. Medical Reserve Corps
7. Critical Infrastructure Protection (CIP)

Most of the DMH deliverables are in the categories of Education and Preparedness Training, Needs of At-Risk Populations, Exercises, ESAR-VHP (MO's Show Me Response Program), NIMS, Fatality Management, and Partnership/Coalition Development; DMH staff also responds to disasters through participation at the State Emergency Operations Center.

**Since August of 2009, the DMH has:**

- Continued to partner closely with other state level entities:
  - Department of Health and Senior Services: The Office of Disaster Readiness (ODR) continues to be an active participant of the Special Needs committee
    - Participation in understanding and implementing the new *Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters*
    - Development of *Missouri Emergency Preparedness Planning Kit for Small Residential Providers*, based on the Georgia template by: Lysak, Kathleen H., *Emergency Preparedness Planning Kit for Small Residential Providers*, prepared by Clarity Healthcare, Inc., under contract to the Georgia department of Human Resources/Division of Public Health. November 2007.
    - Participation on the Children's Sub-committee including planning for the seminar by Dr. David Schonfeld regarding children's bereavement on July 26, his keynote speech at the Public Health Conference on July 27 regarding the National Commission on Children and Disasters Interim report, and the follow-up state panel.
  - Department of Public Safety, State Emergency Management Agency(SEMA) and FEMA
    - Worked on the mental health pieces of the New Madrid Seismic Zone Joint Operations Plan (OPLAN) for ESF 6, Mass Care and ESF 8, Public Health for a catastrophic earthquake.
    - Exhibition of Mental Health TIPS and other information for first responders for coping in emergency and disaster situation was offered at the annual SEMA conference with an attendance of 500+ attendees.
- Developed and led various workshops using curriculum jointly developed with St. Louis University Heartland Centers. Some examples of training that occurred include:
  - From August 9, 2009 to August 31, 2010, The Office of Disaster Readiness provided presentations and workshops to 1638 individuals. In addition, the office provided displays that reached an additional 1869 people including 1090 attendees at 11 Faith Based Initiative Workshops.
  - Provision of *Psychological First Aid Train-the-Trainer* course for hospital staff, public health care workers and mental health was provided through the sponsorship of the St. Louis Area Regional Response System (STARRS) on January 26 – 27 and again on March 23 - 24; provided a refresher course on March 17, 2010.
  - Provided the Medical Reserve Corp (MRC) specific Psychological First Aid Course for the MRC in Kansas City on March 6, 2010.
  - Provided the Disaster Mental Health and PFA course for North Kansas City Hospital and surrounding hospitals; revised to include behavioral health scenarios that the hospitals had to work through as well as a session on grief when health workers lose loved ones, co-workers, and clients in a mass fatality incident.

- Signed a Memo of Understanding with DHSS to become a unit within the Show-Me Response Program (ESAR-VHP). Developed DMH policies and began recruitment of mental health volunteers.
- Developed draft Standard Operating Guidelines for the DMH READI Team. These Guidelines should be finalized within the next month.

### **Disaster Services Continuing Projects: Future Plans**

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

Other plans include:

- The Office of Disaster Readiness also plans to write a template for behavioral health emergency planning for Missouri's Hospitals.
- Complete revision of the DMH Central Office Continuity Plan
- Revise the DMH All-Hazards Emergency Operations Plan

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

Department of Mental Health  
Division of Comprehensive Psychiatric Services  
State Fiscal Year 2011 Estimated Block Grant Expenditures

Provider	Adult	Youth	Total
Adapt of Missouri	\$ 13,080	\$ -	\$ 13,080
Alliance for the Mentally Ill	\$ 13,318	\$ 1,902	\$ 15,220
East Central MO BH (formerly Arthur Center)	\$ 118,731	\$ 7,843	\$ 126,574
Bootheel Counseling Services	\$ 219,534	\$ 60,702	\$ 280,236
Bi-Lingual International	\$ 855	\$ 122	\$ 977
Burrell Center	\$ 385,882	\$ 38,502	\$ 424,384
Clark Community Mental Health	\$ 106,948	\$ 5,268	\$ 112,216
Community Counseling Center	\$ 6,528	\$ 932	\$ 7,460
Community Health Plus - St. Louis	\$ 1,798,080	\$ 256,454	\$ 2,054,534
Community Treatment	\$ 135,439	\$ 11,941	\$ 147,380
Comprehensive Mental Health	\$ 102,631	\$ 10,183	\$ 112,814
Crider Center for Mental Health	\$ 588,609	\$ 60,468	\$ 649,077
Comprehensive Psychiatric Services CO	\$ 315,324	\$ 45,033	\$ 360,357
Family Counseling Center	\$ 313,803	\$ 8,990	\$ 322,793
Family Guidance Center	\$ 240,706	\$ 11,391	\$ 252,097
Hopewell Center	\$ 183,126	\$ 3,229	\$ 186,355
Kids Under Twenty One	\$ 5,571	\$ 796	\$ 6,367
Linn County Health Department	\$ 998	\$ 143	\$ 1,141
Mark Twain Mental Health	\$ 97,031	\$ 4,430	\$ 101,461
North Central	\$ 45,528	\$ 4,592	\$ 50,120
Ozark Center	\$ 203,668	\$ 22,412	\$ 226,080
Ozark Medical Center	\$ 132,319	\$ 18,582	\$ 150,901
Pathways Community Behavioral Health	\$ 251,187	\$ 27,979	\$ 279,166
Preferred Family Health Care	\$ 14,176	\$ 2,024	\$ 16,200
Prevention Consultants of Missouri	\$ 15,259	\$ 2,179	\$ 17,438
ReDiscover Mental Health	\$ 155,980	\$ 51,175	\$ 207,155
Swope Parkway Mental Health Center	\$ 227,930	\$ 138,051	\$ 365,981
Tri-County Mental Health Services	\$ 44,147	\$ 38,139	\$ 82,286
Truman Behavioral Health	\$ 292,579	\$ 3,116	\$ 295,695
University of Missouri	\$ 34,110	\$ 4,871	\$ 38,981
<b>Total</b>	<b>\$ 6,063,077</b>	<b>\$ 841,449</b>	<b>\$ 6,904,526</b>

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

**Table C. MHBG Funding for Transformation Activities**

**State: Missouri**

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the <i>actual or estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY2011	
		Actual	Estimated
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	<input checked="" type="checkbox"/>		144,279
GOAL 2: Mental Health Care is Consumer and Family Driven	<input type="checkbox"/>		
GOAL 3: Disparities in Mental Health Services are Eliminated	<input checked="" type="checkbox"/>		916,243
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	<input type="checkbox"/>		
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	<input type="checkbox"/>		
GOAL 6: Technology Is Used to Access Mental Health Care and Information	<input type="checkbox"/>		
<b>Total MHBG Funds</b>	N/A	0	1,060,522

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

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

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

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

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

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** [ ]

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	58,941	61,554	60,250	58,926
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

**Goal:** Increase access to services

**Target:** Maintain the number of adults with SMI receiving mental health services above FY2007 level

**Population:** Adults with SMI

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

**Indicator:** Number of adults with SMI receiving CPS funded services

**Measure:** No numerator or denominator on this performance indicator

**Sources of Information:** CIMOR

**Special Issues:** Mental health services are underfunded both nationally and in the State of Missouri. Missouri has experienced the devastating effects of the economic downturn. The severe reductions in state general revenue have caused the DMH to face core budget reductions. In State FY 2010, to balance the budget in an economy that repeatedly failed to meet projections, Governor Nixon required expenditure restrictions (withholdings) of General Revenue (GR) and Federal Budget Stabilization funding several times during the year. DMH's restrictions totaled \$15,375,044 from July 2009 to April 2010. These restrictions were in addition to a \$47.2 million cut to DMH's SFY 2010 GR core budget.

The target is set at the 2007 number for adults with SMI receiving services due to the reduction in budget and the uncertainty regarding the ability to continuously increase the numbers served. Additionally, the numbers may be reduced due to the closing of acute care and emergency room settings.

**Significance:** Due to fiscal constraints, Missouri CPS is only meeting 25% of the estimated prevalence of SMI.

**Action Plan:** The DMH and CPS will continue to explore funding opportunities to meet the mental health needs of Missourians. CPS will continue to utilize funding on evidence based practices to wisely use the limited funding in an efficient and effective manner.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	7.46	6.98	5.47	6.96
Numerator	501	400	--	--
Denominator	6,720	5,728	--	--

Table Descriptors:

- Goal:** Reduce 30 day readmission percentage to state psychiatric hospital inpatient beds
- Target:** Reduce or maintain 30 day readmission percentage to state psychiatric hospital inpatient beds
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of adults readmitted to state psychiatric hospitals within 30 days of discharge
- Measure:** The numerator is number of clients readmitted to state psychiatric hospitals within 30 days of discharge. The denominator is total discharges from state psychiatric hospitals in year.
- Sources of Information:** CIMOR
- Special Issues:** Adult SMI admissions are frequently linked to involuntary commitments and forensic issues beyond the control of the department.
- Significance:** Community Psychiatric Rehabilitation programs serve adults with Severe Mental Illness within their community with the goal of reducing admissions and readmissions into State psychiatric hospital beds. The program provides medication and psychiatric services in the community. The program provides case management activities and community support, linking individuals with appropriate programs and services within their community, providing experiential training in social and professional settings, and helping individuals access treatment and follow a treatment regimen.
- Action Plan:** State hospitals and community service providers will continue collaborative activities to keep individuals out of the state hospitals and receiving services in the community. The evidence based practice of Assertive Community Treatment works with the most vulnerable population. The six ACT teams will continue to focus on keeping their clients in the community. Additionally, Peer Specialists will work to transition clients from the hospital to the community and encourage engagement in the community treatment program.

## ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	23.63	22	16.63	22
Numerator	1,588	1,260	--	--
Denominator	6,719	5,728	--	--

Table Descriptors:

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

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

**Population:** Adults with SMI

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

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

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

**Sources of Information:** CIMOR

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

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

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

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

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

Table Descriptors:

- Goal:** Increase the number of Evidence Based Practices utilized in the Missouri mental health system
- Target:** Increase or maintain the number of Evidence Based Practices utilized in the Missouri mental health system
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of Evidence Based Practices utilized in the Missouri mental health system
- Measure:** No numerator or denominator.
- Sources of Information:** Department of Mental Health, Division of Comprehensive Psychiatric Services
- Special Issues:** Missouri has been implementing the EBP of Supported Employment for years. In 2007, the Integrated Dual Disorders Treatment EBP was added. In 2008, Assertive Community Treatment started implementation in the State. In 2009 Illness Management and Recovery has been added to the EBP implemented in Missouri. Missouri is also implementing Dialectical Behavior Therapy across the state. DBT is an EBP, but not one recognized by the Block Grant application.
- Significance:** CPS has the Evidence Based Practice of Supported Employment implemented in multiple agencies across the State. CPS has implemented in 20 agencies and 32 sites the Integrated Dual Diagnosis Treatment since fiscal year 2007. The level of fidelity to the EBP toolkit model has been assessed for both EBP. Assertive Community Treatment is the third EBP in process of implementation. Six ACT teams are operational and data is being collected. The ACT Teams have received technical assistance and initial visits to discuss fidelity. Over the next year, monitoring visits will be implemented to assess baseline ACT fidelity.
- Action Plan:** CPS continues working towards integrating employment activities into all consumer individualized treatment plans, when appropriate, in the Community Mental Health Center system. CPS will use the Johnson and Johnson Supported Employment grant to provide technical assistance to providers to continue the process of enhancing fidelity. CPS will continue working to consistently implement Integrated Dual Diagnosis Treatment and Assertive Community Treatment evidence based practices in the mental health system to fidelity of the models. Illness Management and Recovery is being implemented; however fidelity is not currently being measured. CPS will continue to monitor fidelity and assure best practice implementation as resources become available.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

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

Table Descriptors:

**Goal:** Not applicable

**Target:**

**Population:**

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

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	6.63	6.02	8	6
Numerator	3,908	3,702	--	--
Denominator	58,941	61,473	--	--

Table Descriptors:

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

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	1.64	1.18
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

- Goal:** Increase the percentage of individuals receiving the evidence based practice of Assertive Community Treatment
- Target:** Increase or maintain the percentage of individuals receiving the evidence based practice of Assertive Community Treatment
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of individuals receiving the evidence based practice of Assertive Community Treatment
- Measure:** The numerator is the number of individuals receiving Assertive Community Treatment.  
The denominator is the number of individuals receiving Community Psychiatric Rehabilitation services.
- Sources of Information:** CIMOR
- Special Issues:** Assertive Community Treatment teams started in Missouri in 2008. Individuals have been enrolled, multidisciplinary teams have formed and ACT services are being provided. Training and technical assistance from CPS has been provided for the ACT team providers.
- Significance:** CPS will slowly increase the number of individuals receiving ACT services as money becomes available and teams become fully functional.
- Action Plan:** CPS will continue to identify high end users of services (crisis, emergency room, homeless, etc.) and place them in ACT services as appropriate. CPS will continue to provide technical assistance and training to providers as they fully implement ACT. CPS will measure fidelity over the next year of the six existing ACT teams.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

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

Table Descriptors:

**Goal:** Not Applicable

**Target:**

**Population:**

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

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	3.40
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

- Goal:** Increase the percentage of adults with SMI receiving evidence based integrated treatment for co-occurring psychiatric and substance use disorders
- Target:** Increase or maintain the percentage of individuals receiving the evidence based practice of Integrated Dual Disorders Treatment (IDDT)
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of individuals billed by providers to CPS receiving the evidence based practice of Integrated Dual Disorders Treatment
- Measure:** The numerator is number of individuals being billed by providers to one of the four co-occurring IDDT billing codes.  
The denominator is the number of adults served in the Community Psychiatric Rehabilitation programs.
- Sources of Information:** CIMOR
- Special Issues:** CPS is measuring fidelity to the IDDT model. Not all of the clients receiving co-occurring psychiatric and substance use services are billed to CPS. There are other funding sources such as the Division of Alcohol and Drug Abuse and the Missouri Foundation for Health that pay for co-occurring services. These individuals are not captured in this data.
- Significance:** The projected number for SMI adults receiving IDDT services billed to CPS is 1759. This is a significant increase over the the FY 2008 number of 414 and FY 2009 number of 1056.
- Action Plan:** CPS will continue to implement IDDT services to fidelity. Twenty agencies with 32 locations have voluntarily implemented IDDT in their community mental health centers. CPS will continue to provide technical assistance and training on the IDDT model. CPS will continue to collaborate with the Missouri Foundation for Health as they provide training with Drs. Ken Minkoff and Christine Cline on co-occurring disorders treatment. CPS will continue to collaborate with the Missouri Institute of Mental Health as they provide co-occurring treatment fidelity reviews for Missouri Foundation for Health grant funded programs.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

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

Table Descriptors:

**Goal:** Not Applicable

**Target:**

**Population:**

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

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

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

Table Descriptors:

**Goal:** Not Applicable

**Target:**

**Population:**

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

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** [ ]

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	91.77	91.50	91.95	87
Numerator	4,792	3,832	--	--
Denominator	5,222	4,188	--	--

Table Descriptors:

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

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** [ ]

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	14.26	14.68	14	14
Numerator	544	1,381	--	--
Denominator	3,814	9,408	--	--

Table Descriptors:

- Goal:** Increase or maintain the percentage of consumers employed
- Target:** Increase or maintain the percentage of consumers employed
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adults with SMI receiving CPS funded services working or involved in educational activity
- Measure:** The numerator is the number of adults with SMI working or involved in educational activity.  
The denominator is the total number of adults working and not working in sample.
- Sources of Information:** Adult Status Reports
- Special Issues:** An Adult Status Report sample is used to obtain this percentage. The low sample size can lead to fluctuations in percentages based on small actual number changes. As CPS refines the new CIMOR database, the hope is that data will be more accurate and easily collected. Data will eventually be obtained and analyzed on every consumer rather than a sample.  
  
The economic downturn and high employment rates both nationally and in Missouri may also effect this percentage in the future thus effecting targets.
- Significance:** Nationally and in Missouri the numbers of adults with severe mental illness who are competitively employed is fairly low.
- Action Plan:** DMH will continue to implement EBP of Supported Employment with the goal of increasing the number of individuals with psychiatric illness who are competitively employed. CPS has provided Benefits Planning training in conjunction with VR for community support workers in the community mental health centers. CPS will continue to focus on reducing barriers to the SMI population working in competitive employment. One of the barriers is perception regarding the loss of benefits if employed. CPS and VR are working to assure accurate information is available to consumers to make informed decisions regarding work.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** [ ]

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	4.90	4.74	5	5
Numerator	254	197	--	--
Denominator	5,181	4,153	--	--

Table Descriptors:

- Goal:** Decrease the percentage of adults with SMI receiving treatment involved in the criminal justice system
- Target:** Decrease or maintain the percentage of adults with SMI receiving treatment who are involved in the criminal justice system below 5%
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of adults with SMI receiving treatment involved in the criminal justice system
- Measure:** The numerator is the number of adults completing the criminal justice questions on the consumer satisfaction survey arrested in the last 12 months.  
The denominator is the total number of adults completing the criminal justice questions on the consumer satisfaction survey.
- Sources of Information:** Consumer Satisfaction Survey
- Special Issues:** CPS is using a modified MHSIP for the Consumer Satisfaction Survey. CPS has collected only two years of data for this performance indicator. The target has been set a maintaining a percentage below 5%, as this is a fairly new indicator and CPS believes the data can realistically stay below the rounded up number. Sample size is low and can flutuate due to small actual number changes.
- Significance:** A low number of adults with SMI have been arrested in the past 12 months.
- Action Plan:** CPS will continue to support mental health courts to encourage consumers to live healthy lifestyles free of criminal activity. CPS will continue to support the Crisis Intervention Team collaboration with police departments to appropriately handle mental illness behaviors in the community.

## ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: [ ]

### Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	76.43	76.69	78.20	76.70
Numerator	2,977	7,079	--	--
Denominator	3,895	9,231	--	--

#### Table Descriptors:

**Goal:** Increase stability in housing

**Target:** Increase or maintain the percentage of consumers living in home or home-like settings

**Population:** Adults with SMI

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

**Indicator:** Percentage of adults with SMI living in their own home or home-like settings

**Measure:** The numerator is the number of adults with SMI sampled living in home or home-like settings.  
The denominator is the total number of adults with SMI sampled living in all settings.

**Sources of Information:** Adult Status Reports

**Special Issues:** An Adult Status Report sample is used to obtain this percentage. As CPS refines the new CIMOR database, the hope is that data will be more accurate and easily collected. Data will be obtained and analyzed on every consumer rather than a sample.

**Significance:** Currently DMH has thirty-five Shelter Plus Care grants. These grants provide rental assistance for over 1900 individuals and their family members throughout fifty different counties spending over \$6.5 million a year in rental assistance and \$9 million in supportive services. The program allows for a variety of housing choices, and a range of supportive services funded by DMH, in response to the needs of the hard-to-reach homeless population with disabilities.

**Action Plan:** DMH will continue to support housing options that offer independent housing in the consumers community of choice. DMH provides an array of housing options from residential care facilities to independent housing. Funding is competitively received through Shelter Plus Care grants, Missouri Housing Development Commission Housing Trust Funds, Rental Assistance Program, PATH grants, State general revenue dollars, supportive community living, and most recently Homeless Prevention and Rapid Re-housing Program funds.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** [ ]

**Name of Performance Indicator:** Adult - Increased Social Supports/Social Connectedness  
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	68.65	68.10	68.53	68
Numerator	3,517	2,790	--	--
Denominator	5,123	4,097	--	--

Table Descriptors:

- Goal:** Increase or maintain the social supports/social connectedness reported by consumers of CPS services
- Target:** Increase or maintain the social supports/social connectedness reported by consumers of CPS services
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of consumers reporting social connectedness on the Consumer Satisfaction Survey
- Measure:** The numerator is the number of consumers reporting social connectedness on the Consumer Satisfaction Survey.  
The denominator is the number of consumers completing the Consumer Satisfaction Survey.
- Sources of Information:** Consumer Satisfaction Survey
- Special Issues:** CPS uses a modified MHSIP for the Consumer Satisfaction Survey. The low sample size can lead to fluctuations in percentages based on small actual number changes.
- Significance:** 68% of consumers report being socially connected
- Action Plan:** Additional Consumer Satisfaction Surveys will be collected and data analyzed over time.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	70.10	69.56	70.76	69
Numerator	3,564	2,841	--	--
Denominator	5,084	4,084	--	--

Table Descriptors:

**Goal:** Improve level of functioning

**Target:** Improve or maintain consumer reported level of functioning

**Population:** Adults with SMI

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations

**Indicator:** Percentage of consumers reporting improved level of functioning on Consumer Satisfaction Survey

**Measure:** The numerator is the number of consumers reporting improved level of functioning on the Consumer Satisfaction Survey.  
The denominator is the total number of consumers responding to the Consumer Satisfaction Survey.

**Sources of Information:** Consumer Satisfaction Survey

**Special Issues:** CPS uses a modified MHSIP for the Consumer Satisfaction Survey. The low sample size can lead to fluctuations in percentages based on small actual number changes.

**Significance:** Over 70% of consumers report improved level of functioning on the Consumer Satisfaction Survey.

**Action Plan:** Additional Consumer Satisfaction Surveys will be collected and analyzed over time.

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 2009 RSMo 630.020 set the Departmental goals and duties. It states:

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

- (1) Reduce the incidence and prevalence of mental disorders, developmental disabilities and alcohol or drug abuse through primary, secondary and tertiary prevention;
- (2) Maintain and enhance intellectual, interpersonal and functional skills of individuals affected by mental disorders, developmental disabilities or alcohol or drug abuse by operating, funding and licensing modern treatment and habilitation programs provided in the least restrictive environment possible;
- (3) Improve public understanding of and attitudes toward mental disorders, developmental disabilities and alcohol and drug abuse.

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

#### **Comprehensive Children's Mental Health Service System State Statute**

The State's Revised Statutes of Missouri 2008 RSMo 630.097 and 630.1000 set the Departmental Comprehensive Children's Mental Health Service System:

“Comprehensive children's mental health service system to be developed--team established, members, duties--plan to be developed, content--evaluations to be conducted, when. 630.097. 1. The department of mental health shall develop, in partnership with all departments represented on the children's services commission, a unified accountable comprehensive children's mental health service system. The department of mental health shall establish a state interagency comprehensive children's mental health service system team comprised of representation from:

- (1) Family-run organizations and family members;
- (2) Child advocate organizations;
- (3) The department of health and senior services;
- (4) The department of social services' children's division, division of youth services, and the division of medical services;

- (5) The department of elementary and secondary education;
- (6) The department of mental health's division of alcohol and drug abuse, division of mental retardation and developmental disabilities, and the division of comprehensive psychiatric services;
- (7) The department of public safety;
- (8) The office of state courts administrator;
- (9) The juvenile justice system; and
- (10) Local representatives of the member organizations of the state team to serve children with emotional and behavioral disturbance problems, developmental disabilities, and substance abuse problems.

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

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

- (1) Describe the mental health service and support needs of Missouri's children and their families, including the specialized needs of specific segments of the population;
- (2) Define the comprehensive array of services including services such as intensive home-based services, early intervention services, family support services, respite services, and behavioral assistance services;
- (3) Establish short- and long-term goals, objectives, and outcomes;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Are coordinated with the range of social and human services provided to children and their families by local school districts, social services, health and senior services, public safety, juvenile offices, and the juvenile and family courts;

(d) Provide a comprehensive array of services through an integrated service plan;

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

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

(6) Include early screening and prompt intervention to:

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

(b) Prevent further deterioration;

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

(a) Access to private insurance coverage;

(b) Public funding, including:

a. Assuring that funding follows children across departments; and

b. Maximizing federal financial participation;

(c) Private funding and services;

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

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

(10) Be outcome based.

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

### **Missouri State Statute 630.1000**

“Office of comprehensive child mental health established, duties--staff authorized.

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

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

### **Current Status**

The CSMT continues to meet and is staffed by the Office of Comprehensive Child Mental Health. The two priority goals of the CSMT are to expand System of Care statewide and infuse System of Care values into the cultures of all partner organizations. The Division of CPS is a member of the CSMT and as it is charged with the operational management of strives to create, with its partners, an infrastructure, programs and practices/policies in support of children with SED and their families. To this end current and active initiatives include creating a trauma-informed service delivery system; expansion of the National WrapAround Initiative model to all providers including training, policies and funding; evaluation of a model for Transition Age Youth and creation of an infrastructure to bring the successful components statewide; and implementation of the public health model in application to child mental health through identifying opportunities to partner around social and emotional development in children, prevention and creation of a surveillance and monitoring system that directs policy.

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

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

## **Child Plan**

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

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

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

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

Community Support Services within the CPR program provide a range of support to consumers in the community. Support begins with discharge planning at the institutional level or with

admission and intake in the community. Families and youth plan and direct the supportive services that they receive and are assisted with community integration so that they are able to draw on natural and family supports within their community. In FY08 the Division worked with MOHealthNet (Missouri's division that manages Medicaid) to add 4 additional services to CPR. These services include Family Support, Family Assistance, Day Treatment and Psychosocial Rehabilitation for children.

### **Educational services and Employment services**

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

### **Housing Services**

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

**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**

**Family Support Partners** 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. Activities must be directed and authorized by the treatment plan. 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.

**Family Assistance Worker** services are provided for a child/adolescent and/or the family. The services can be provided in the home or in a variety of settings; e.g., school, travel to and from school, home, social/peer settings, or in a group or one-to-one supervisions. Services may be provided during varying hours of the day to best fit the need of the child/adolescent/family. Activities provided in the delivery of services may include home living and community skills, transportation, working with the adult members on parenting skills, communication and socialization, arranging appropriate services for family and child/adolescent including services and resources available in the community and leisure activities for the child/adolescent.

**Parent Support and Education** services are contracted with the 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. During the last fiscal year, CPS provided funding to NAMI to obtain training on Basics, a 6-session course for the parents of children and adolescents with mental health needs. By the end of the first year, NAMI graduated more than 90 parents, foster parents and custodial relatives from courses in Moberly, Springfield, Joplin, Farmington, Wentzville, Rolla, Marshall, Waynesville and Jefferson City. Participant evaluations indicated the course is greatly appreciated and meeting parents' needs. Basics is taught by a team of two volunteers who are parents/direct care providers of a child/youth or an individual who has aged out of child serving systems. Each session runs from 1.5 to 2 hours. They are usually taught one night a week for 6 consecutive weeks. Due to the number of foster parents that participated, CPS facilitated a discussion with

Children's Division (child welfare) to assist NAMI in obtaining a contract to work with foster parents.

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

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

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

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

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

The first online program of its kind nationally is the result of this unique partnership. ESCP has two graduate programs accredited by the American Psychological Association; the master's

program includes 24 hours of required course work and nine hours of electives, for a total of 33 hours. The educational specialist requires a total of 30 credit hours. Each course emphasizes the prevention of mental health problems-within schools, families and communities-and the promotion of positive mental well-being for all children and adolescents, to make you a better, more effective educator, administrator or health services professional.

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

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

### **Case Management Services**

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

### **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**

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

Missouri has funded system of care cooperative agreements within the state. The overarching goals for these sites are to:

- expand the capacity for community based services and supports,

- create an infrastructure for cross agency individualized care planning,
- incorporate culturally and linguistically competent practices for serving children, and
- promote full participation of families and youth in service planning and in development of services and supports.

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

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

See Adult Plan section Estimate of Prevalence columns for Child Estimate of Prevalence

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

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

The Comprehensive Children's Mental Health State Management Team continues to function as oversight, coordination, and technical assistance to ensure implementation of a comprehensive children's mental health system. This committee consists of representatives from: The Department of Social Services: Children's Division, Division of Youth Services and Division of Medical Services; The Department of Elementary and Secondary Education: Division of Vocational Rehabilitation and Division of Special Education; The Department of Public Safety; The Department of Mental Health: Divisions of Alcohol and Drug Abuse, Comprehensive Psychiatric Services, and Mental Retardation and Developmental Disabilities; The Department of Health and Senior Services; Office of State Court Administrators; juvenile offices; parents; parent advocacy groups; and representatives from each of the geographic local systems of care. This group meets at least once a month.

There are many current initiatives that cross many state department lines including Show Me Bright Futures; Early Childhood Comprehensive System and the related Coordinating Board for Early Childhood. Additionally, at the start of the fiscal year 2010, DMH closed inpatient psychiatric units in two regions of the state including two children's units. Due to the different funding streams for children as opposed to adults for state operated facilities, the dollars supporting one children's unit remained within the community to enhance the existing system and create a safety mechanism for children with extreme and complex needs. A stakeholders' group was convened to make recommendations to the Division regarding what those services might look like. In addition to representatives from the community mental health centers, others involved in this group included juvenile officers, judges, child welfare administrators, private hospitals, providers for those with developmental disabilities, schools, advocacy organizations, HeadStart and family members. At present the Children's Enhancement Project (CEP) in the Northwest region directs approximately \$600,000 to enhance the quality, diversity and intensity of services to meet the needs of youth who previously had extended stays on a state inpatient unit due to the lack of community resources to meet their needs. The project has done extended training with staff on wraparound, positive behavior supports, and trauma. They have developed a system and array of services that insure quality clinical assessments, integrated service planning and enhanced services such as Professional Parent Homes.

## Social Services

CPS works closely with three divisions of the Department of Social Services: Children's Division (child welfare); Division of Youth Services (youth adjudicated as delinquent and committed to state custody); and MO HealthNet (Medicaid agency).

Children's Division: The Children's Division has been concerned over the lack of oversight they have in mental health services provided to children/youth in their custody either through Medicaid funding or through Comprehensive Treatment Services funding (general revenue). CPS along with MO HealthNet worked with the Children's Division to devise a quality improvement initiative that holds treatment providers more accountable for planning, providing and documenting effective clinical services. An additional area of clinical concern for the Children's Division was the number and types of medications children in residential treatment centers were prescribed. Modeled after a similar initiative for adults that helped in changing prescribing practices, CPS contracted for creation of an Integrated Health Profile for each child in Children's Division Custody in a residential placement based on Medicaid billing information. This profile includes information in regards to clinical guidelines related to type and dose of medications for a specific child, medication adherence and red flags related to co-occurring health issues. Some examples of quality indicators are more than three concurrent psychotropic medications for those under age 12, more than two antipsychotic medications concurrently prescribed, and timeframes for required labs and follow ups for health conditions. The Integrated Health Profile also contains information regarding primary care physician, treating psychiatrist, and case worker to aid in coordination of care. CPS continues to lead the Department of Mental Health in collaboration with Children's Division to implement, monitor and as necessary revise the Custody Diversion Protocol to prevent parents from having to voluntarily relinquish custody solely to access mental health services and transferring custody back to the parent if custody was based on mental health needs only. Children's Division has been an active partner in the Healthy Transition Initiative Cooperative Agreement. Through the initiative, in addition to examining a model for young adults, specialized consultation related to the special needs and system's issues of child welfare has been identified.

Division of Youth Services: The Missouri Division of Youth Services (DYS) has been touted as an exemplary model for working with youth adjudicated as delinquent. Many states have come to Missouri to learn and attempt to learn from this Division. CPS has continued to work with DHS in identification of evidence based practices, including provision of training to staff on Dialectical Behavior Therapy which may be incorporated into their existing programs. DHS is a participant in the CPS Children's Trauma Initiative in examining how agencies/systems can be more trauma informed. CPS has arranged for targeted consultation with DHS to address their population and agency's need. Additionally, DHS is engaged with CPS around the expansion of wraparound to enhance transitions to the community and aftercare services.

MO HealthNet: CPS has multiple joint initiatives with the Medicaid agency for Missouri. The majority address quality of care both for managed care and fee-for-service. MO HealthNet started a case management review of the behavioral health managed care providers. CPS serves on the review teams to provide clinical expertise. Additionally CPS staff several MO HealthNet workgroups related to creation of Dashboard indicators, case management, etc. MO HealthNet

also is gradually bringing in a quality initiative for fee-for-service care. In this initiative, prior authorization is required to guide care towards best practices related to diagnostic or age groups, and to insure appropriate documentation and coordination with other stakeholders. CPS staff serves on these standing committees. CPS staff partner with MO HealthNet staff in the review of the managed care contracts related to system and service best practices.

### **Educational Services including services provided under the Individuals with Disabilities Education Act**

For two years CPS has been exploring the implementation of a school mental health model. The Show Me Bright Futures, although not a school program, encourages communities to interact with their community schools to support healthy social and emotional development. This year a strong dialogue was initiated with the Department of Elementary and Secondary Education (DESE) to learn more of their plans, goals and outcomes for students. DESE has worked for the past year to create the Missouri Integrated Model which merges components of three-tiered models in enhancing school responsiveness, academic performance as well as development of students. DESE has long supported the implementation of School Wide Positive Behavioral Supports (SWPBS) and is well on its way across the state in schools having Universal Tier 1 environments in place. CPS, in planning with DESE, has developed a model with leveraged Medicaid funding to help those schools/districts that have implemented Tier 1 to move on to implementation of Tier 2 and 3 for those youth who are at risk or already displaying social and emotional impairments. The model proposed allows for local development and governance with an effective partnership between the school or district, community mental health center and families. This allows for a model that serves all youth at their level of need, independent of their special education status. Several partnerships are forming around this initiative. CPS is participating in the interagency planning to create and sustain a training initiative to support the implementation of SWPBS including components on wraparound and functional assessments.

For additional information on IDEA services, see Child Plan: Criterion 1: Comprehensive Community-Based Mental Health Services, Available Services.

### **Juvenile Justice Services**

The Division continues to lead a state level mental health/juvenile justice policy team to identify and address issues related to the mental health needs of youth at risk of or currently in the juvenile justice system. In 2008, 113 individuals representing child welfare, juvenile justice and mental health were trained on the Assessment Guidelines. A survey sent out six months later, showed that the majority of respondents felt they had gained knowledge about when to refer, what can be learned from mental health assessments, were better able to use the information provided by the assessment, and how to use the assessment to guide service provision. CPS continues to provide training to circuits upon request. One hundred and thirty-nine therapists in two communities were trained and certified on Trauma-Focused Cognitive Behavioral Therapy. Another community provided training to 181 staff on Dialectical Behavior Therapy, with a core adolescent team receiving targeted training to provide therapy. Forty-eight juvenile officers and therapists received training in motivational interviewing and Strengthening Families and a final

community provided training to 22 school and mental health staff on Too Good for Drugs and/or Reconnecting Youth.

The Mental Health/Juvenile Justice Policy Group is now focusing on creating a continuum of services for youth with problem sexual behaviors. The first step was developing guiding principles, values and practices to insure a common vision. As this step is being completed, the group has begun the process of examining different best practices that can be developed and accessed by juvenile justice, child welfare, mental health, schools and families. MO HealthNet serves on this group to aid in leveraging Medicaid dollars in support of best practices. The MHJJG applied for a grant through BJA to expand access to evidence based practices for youth with problem sexual behaviors. Although the success of this application is currently unknown, the MHJJG continues to focus on improving access to evidence based practice.

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

### **Substance Abuse Services**

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

### **Health and Mental Health Services**

Over the last few years, CPS has been building a collaborative relationship with the Department of Health and Senior Services around several different initiatives, many of which have already been mentioned in other sections and include Show Me Bright Futures which provides support for communities to apply the public health approach to children's mental health in teaching how to do surveillance to identify needs, institute policies/interventions to address these needs, and to provide monitoring and assurances that these policies/interventions have the intended impact. This model has been presented at national conferences both in the mental health and public health field. Another strong partnership is around the Early Childhood Comprehensive System which identifies social and emotional development as a major goal and is devising ways to enhance knowledge regarding social and emotional wellness as well as identifying young children in their natural environments (early learning centers, pediatricians, families) who may need targeted assistance. Current initiatives include development and inclusion of training

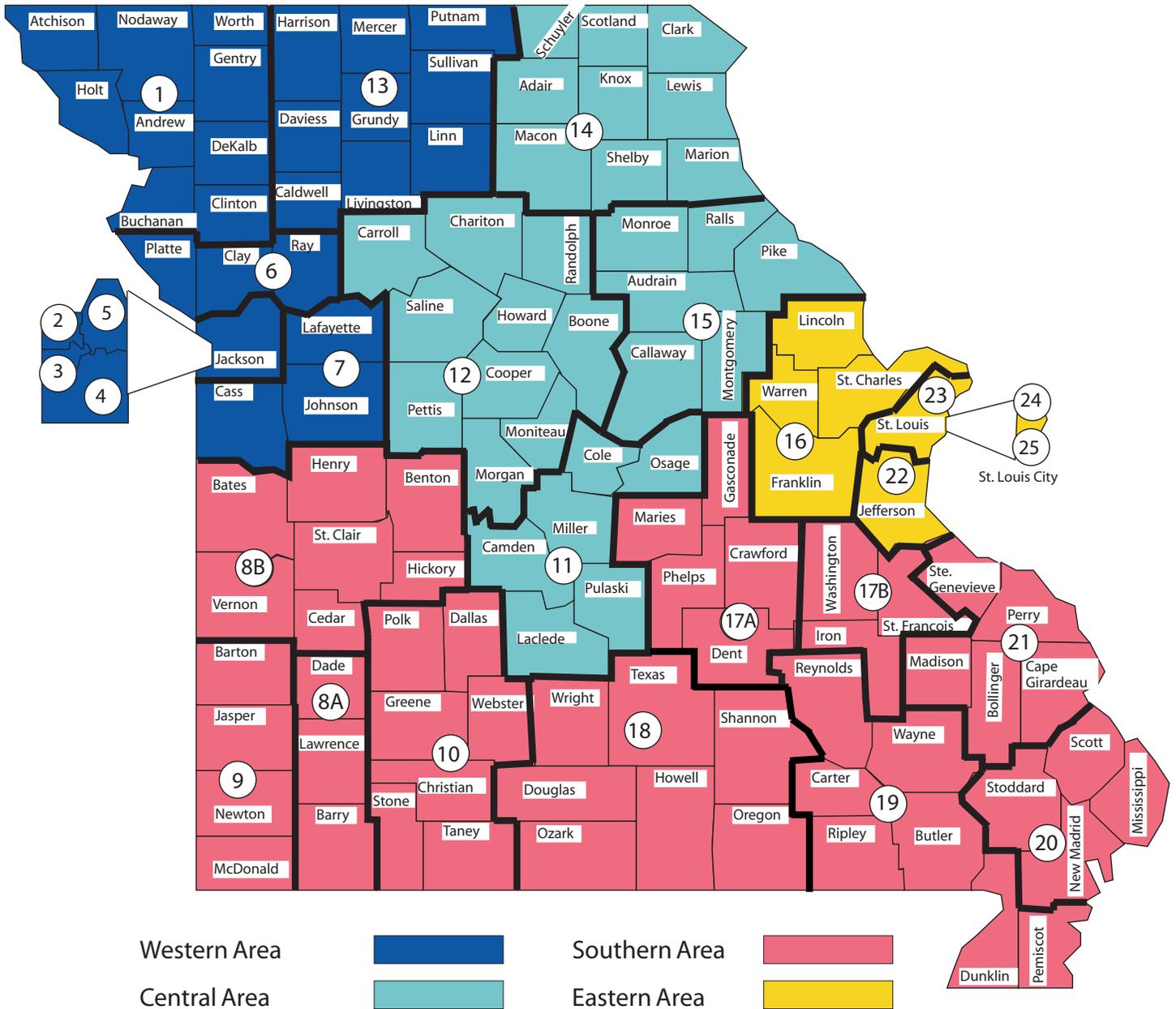
modules on social and emotional development and identification of risk factors in the Child Care Orientation Training that is required for licensed early learning providers. CPS is providing dollars for DHSS to provide training to inclusion specialists on social and emotional development based on the Pyramid Model of the Center for Social and Emotional Foundations of Early Learning. Dialogues have now begun to develop a training series for mental health providers on early childhood development.

Community Support Workers assigned to children and youth receiving services assure that consumers receive physical healthcare. CSWs will make medical appointments for children and youth and assist families in gaining transportation to appointments if this is a barrier. The most recent initiative is to screen for metabolic syndrome, which is a combination of medical disorders that greatly increase the risk of developing cardiovascular disease and diabetes, specifically: obesity, hypertension, lipid level, and blood glucose and/or HgbA1c. This a high priority for this particular population since studies show persons with serious mental illness die 20-25 years earlier than others. Often the causes of death are related to cardiovascular disease and diabetes. CPS has made this screening an annual requirement for all persons enrolled in the Community Psychiatric Rehabilitation (CPR) program who are also on antipsychotic medication. With the growing number of youth on antipsychotic medications as well as the growing number of youth with obesity and developing diabetes, CPS believes this is a critical health intervention for children and youth as well as adults.

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

MISSOURI DEPARTMENT OF MENTAL HEALTH  
Division of Comprehensive Psychiatric Services

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04/10

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

## **Child – Outreach to Homeless**

See Adult Plan section on Outreach to Homeless for details on services to families.

### **Services to Homeless and Abused Youth**

#### **Kansas City**

Synergy Services currently provides emergency shelter for homeless & abused teens at Synergy House. On any given night in Greater Kansas City there are 2,000 “unattached” teens living on the streets, sleeping in cars, or “couch surfing” with friends because they do not have a safe place to live. Many are abused and neglected kids who have run away from home or been thrown out by their family.

Synergy has Kansas City’s only Homeless Youth Campus. Located just 10 minutes from downtown, the campus includes a shelter and resource center. Synergy helps these young people, and others experiencing family crisis, through a wide range of programs and services that help build resiliency and provide the necessary tools to heal and grow into healthy, productive adults.

#### **Safe Housing**

Since 1971, Synergy has been providing emergency shelter and support services for young people in crisis. Synergy House is a short-term emergency shelter that serves young people ages 12-18 who are in crisis due to abuse, neglect, running away, abandonment and homelessness. Placement and intervention services are also offered to families in crisis. Shelter clients can access all services at the Youth Resiliency Center and on-site schooling, if needed. They also try to prevent crisis situations by helping families that are overwhelmed by serious problems such as youth with substance abuse problems or mental health disorders. For longer term housing needs, Synergy's Transitional Living Program strives to support teens in achieving self-sufficiency.

#### **Good Physical & Mental Health**

Good physical and mental health is the foundation of living well. The Teen Clinic at Synergy's Youth Resiliency Center is dedicated to providing young people, aged 12-18, with the highest quality medical, dental and mental healthcare available in Kansas City. Free services are provided through a unique collaboration of Children's Mercy Hospital, Miles of Smiles and therapists from Synergy's family care team.

#### **Healing Programs**

In the Youth Resiliency Center's Creative Arts Center, Synergy’s partnership with Kansas City Young Audiences, the largest provider of art programs in the Kansas City area, allows them to provide a wide variety of therapeutic arts-based programs delivered by the finest teaching artists in the community. Budding musicians can express themselves and learn tangible skills at the recording studio, while those with a flair for food benefit from culinary classes in the commercial kitchen. Job readiness programs in the computer lab give youth the opportunity to receive job search assistance, G.E.D. help

and participate in a variety of educational classes. The gym and fitness center offer workout equipment and classes for overall well-being. The YRC'S Youth Advisory Council gives young people leadership opportunities and a way to give back.

### **Outreach & Access**

For many youth, the journey to Synergy's shelter and other services begins with the recognition of the SafePlace logo at a community site or through a connection with their Street Outreach team. Synergy's violence prevention specialists also reach out to students throughout the metro with STOP Violence programs that focus on overcoming bullying and teen dating violence.

### **St. Louis**

Covenant House Missouri is a non-profit organization that empowers homeless, runaway and at-risk youth to live independently and become contributing members of the community. Covenant House Missouri is the only St. Louis agency serving solely unfunded youth – those kids who are not wards of the state or juvenile court – who have nowhere else to turn. The Center for Youth is home to 20 Crisis Center beds, 16 Transitional Living beds and an array of supportive services. Covenant House serves 1,263 youth every year.

Covenant House Missouri's Rights of Passage Transitional Living Program (ROP-TLP) offers homeless youth safe, stable living arrangements to help them develop the skills necessary to become independent, productive citizens within their community.

The ROP-TLP two bedroom suites are located on the third floor of the new Center for Youth building. The program accepts single males and females ages 16-21 and offers housing for up to 24 months. Components of the ROP-TLP program are:

- Individual and family counseling by an L.P.C.
- Money Management
- Life Skills
- Employment Assistance
- Educational Assistance including evening tutorial services
- Recreation
- Community Service

## Missouri Runaway and Homeless Youth Programs

Program	Basic Center Program	Transitional Living Program	Street Outreach Program
<b>Rainbow House</b> Columbia, MO (573) 474-6600 <a href="http://www.rainbowhousecolumbia.org">www.rainbowhousecolumbia.org</a>		X	
<b>Stepping Stone</b> Kansas City, MO (816) 356-0187 <a href="http://www.newbeginnings-ech.org">www.newbeginnings-ech.org</a>		X	
<b>reStart</b> Kansas City, MO (816) 472-5664 <a href="http://www.restartinc.org">www.restartinc.org</a>	X	X	
<b>Synergy Services</b> Parkville, MO (816) 777-0356 (888) 233-1639 (crisis line) <a href="mailto:info@synergyservices.org">info@synergyservices.org</a> <a href="http://www.synergyservices.org">www.synergyservices.org</a>	X	X	X
<b>Boys and Girls Town of Missouri</b> Springfield, MO (417) 865-1646 <a href="http://www.bgtm.org">www.bgtm.org</a>	X		
<b>The Kitchen</b> Springfield, MO (417) 837-1500 <a href="mailto:rarebreed@thekitchen.org">rarebreed@thekitchen.org</a> <a href="http://www.thekitcheninc.org">www.thekitcheninc.org</a>		X	X

<b>Youth in Need</b> St. Charles, MO (636) 946-3771 (BCP) (636) 946-1815 (TLP) <a href="http://www.youthinneed.org">www.youthinneed.org</a>	x	x	
<b>Epworth Children and Family Services</b> St. Louis, MO (314) 862-1334 (800) 899-KIDS (crisis line) <a href="mailto:communityservices@epworth.org">communityservices@epworth.org</a> <a href="http://www.epworth.org">www.epworth.org</a>	x	x	
<b>Youth in Need</b> St. Louis, MO (314) 752 3585 <a href="http://www.youthinneed.org">www.youthinneed.org</a>			x

Source: U. S. Department of Health and Human Services, Administration for Children & Families  
<http://www.acf.hhs.gov/programs/fysb/content/youthdivision/programs/locate/mo.htm#rhy>

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

See Adult Plan section on Rural Area Services

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

## **Child – Resources for Providers**

See also the Adult Plan section on Resources for Providers.

### **Financial Resources**

Like many states, Missouri is in a budget crisis. Children's mental health services have been cut by approximately \$2.2 million since FY2009. The majority of these cuts were taken in dollars that support contracts with residential care providers, with about 20% taken in the community dollars. A plan has been developed and being proposed to MO HealthNet (Medicaid) to maximize general revenue dollars through inclusion of new services into the rehab option.

DMH submitted a budget item in the FY 2009 legislative session in support of school mental health. This was not selected for funding. Some steps have been achieved to make available additional funding options in support of school mental health. Previously MO HealthNet (Medicaid) would allow billing only for mental health services delivered at the school identified through an Individualized Education Plan with the school making the match. Through work with MO HealthNet, DMH was able to expand funding for such services to youth who are not eligible for special education services, but still need mental health services if the school has entered into collaboration with the local community mental health center or mental health provider, again with the school or other community resource making the match. The collaboration is around implementation of School Wide Positive Behavior Supports to insure that the school policies and environments support healthy social/emotional development and functioning; and for those youth still needing a level of mental health support or intervention, there is an integration of the schools and community mental health center's resources to address the student's need.

CPS continues to work closely with its providers to identify needs and gaps and to advocate for new policies or services when appropriate with MO HealthNet (Medicaid). Most recently CPS has broadened the array of services provided through community support and increased the monthly cap on this service to support meeting the needs of youth with significant and chronic mental health impairments.

Due to ongoing budget crisis in the state, closure of DMH operated hospital facilities continues. In the last two years, 4 acute children and youth units have closed in DMH operated hospitals, two in the western part of the state and two in the central part of the state. In the western region, it was determined that acute bed capacity within the private sector could meet the needs of the majority of youth in an acute crisis. However, as the DMH operated units also functioned as the safety net for the region for those youth with severe but chronic needs, 50% of the children's units' budget was transferred to the community to support the creation of the Children's Enhancement Project. These funds and the project are designed to meet the safety net needs of a

small population of youth by providing intensive and enhanced services in the community including, but not limited to, Professional Parent Homes; highly trained staff to address significant behavior risk factors in the community and specialized care providers. The funding increases the capacity of staff to provide higher and more frequent supervision and services in the community. In the Central region, the DMH children's acute inpatient capacity was replaced by a private, university provider.

### **Staffing**

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

Missouri faces several challenges in delivery of mental health services for children. Similar to national trends, there is a significant dearth of access to psychiatry, let alone child psychiatry. The Division has developed funding streams that allow enhancements to standing rates for psychiatry which assists the community providers; however, the need still far exceeds the availability particularly for specialized populations such as early childhood or co-occurring Mental Illness/Developmental Disabilities.

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

### **Training for Mental Health Service Providers**

The department has provided technical assistance and training on many evidence based practices to the community treatment providers. Treatment providers for children and youth have received extensive training on Motivational Interviewing Skills, Dialectal Behavior Therapy and Trauma Informed Care. The children's service providers have received considerable training on Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Twenty-four therapists are certified in TF-CBT in the Central region of the state and nineteen therapists are certified in the Western region. There are currently 10 functioning DBT children's teams across the state. The Children's Trauma Initiative is providing training on creating trauma informed environments and policies within the community mental health centers. CPS Children's Services is currently implementing

a Trauma Initiative that assists early adopters in conducting a self assessment on whether their agency's policies, practices and environments are trauma informed as well as providing technical assistance in addressing the agency's needs and gaps. Paired with this support, those early adopters will also receive training on trauma screening, assessment and evidence based practices.

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

See Adult Plan section on Emergency Service Provider Training

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

See Adult Plan section for Grant Expenditure Manner column labeled Youth

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	16,517	15,809	16,000	15,773
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

- Goal:** Increase access to mental health services for children/youth
- Target:** Increase the number of children/youth receiving CPS funded services
- Population:** Children and youth with SED
- Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services
- Indicator:** Total number of children/youth receiving CPS funded services
- Measure:** No numerator or denominator
- Sources of Information:** CIMOR
- Special Issues:** Mental health services for children/youth are underfunded both nationally and in the State of Missouri. While our goal is always to increase the numbers served, due to the national and state level economic downturn, the numbers of children/youth served may stay level or possibly decrease in the coming year.
- Significance:** Due to fiscal constraints, Missouri is only meeting the mental health needs of 16% of the estimated prevalence of children/youth with severe emotional disorders. With core budget cuts, it will be difficult to maintain the numbers of children/youth served in Missouri.
- Action Plan:** CPS will continue to build community based services for children and youth with SED based on Missouri's Comprehensive Children's Mental Health Plan. CPS will continue to explore alternative funding sources, expand the use of EPB to accomplish efficiencies, and collaborate with other State departments/organizations to maximize funding options.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** ]

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	6.87	6.69	8.70	8
Numerator	46	40	--	--
Denominator	670	598	--	--

Table Descriptors:

**Goal:** Reduce the rate of readmission within 30 days to State psychiatric hospital beds

**Target:** Reduce the rate of readmission within 30 days to State psychiatric hospital beds

**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:** Due to ongoing budget crisis in the state, closure of DMH operated hospital facilities continues. In the last two years, 4 acute children and youth units have closed in DMH operated hospitals, two in the western part of the state and two in the central part of the state. This reduction effects the denominator. It also puts a strain on community services to serve children that previously would be placed in inpatient care.

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

Missouri has funded system of care cooperative agreements within the state. The overarching goals for these sites are to:

- expand the capacity for community based services and supports,
- create an infrastructure for cross agency individualized care planning,
- incorporate culturally and linguistically competent practices for serving children, and
- promote full participation of families and youth in service planning and in

development of services and supports.

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

The closure of a DMH operated psychiatric hospital on the west side of the state included a children/youth program. CPS was able to dedicate 50% of the funds that supported the children's inpatient unit to the community to create an enhanced array of services for youth that had required extended stays at the restrictive inpatient level due to a lack of effective community based services. An interagency group of community stakeholders developed the Children's Enhancement Project to not only identify an array of services, but training needs and creation of an interagency structure to oversee and coordinate the project.

CPS in conjunction with its Coalition of Community Mental Health Centers has been examining mechanisms and pathways to expand funding including clinic options, administrative billing, Money Follows the Person and 1915i waiver.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** ]

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	19.40	18.90	21.16	21
Numerator	130	113	--	--
Denominator	670	598	--	--

Table Descriptors:

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

**Target:** Maintain or decrease the rate of readmission to State psychiatric hospital beds within 180 days

**Population:** Children and youth with SED

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

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

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

**Sources of Information:** CIMOR

**Special Issues:** CPS makes every effort to keep children/youth out of the inpatient setting and safe in their communities. Due to closure of acute care hospital beds for children and youth, the number of psychiatric beds has been reduced. This reduction effects the denominator. It also puts a strain on community services to serve children that previously would be placed in inpatient care.

**Significance:** A desired 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. See Action Plan section for Child Reduced Utilization of Psychiatric Inpatient Beds - 30 days for more details on enhanced community programming.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** ]

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

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

Table Descriptors:

- Goal:** Provide one Evidence Based Practice of Therapeutic Foster Care Programs to children and youth with SED
- Target:** Maintain the number of EBP for children and youth in Missouri
- Population:** Children and Youth with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of Evidence Based Practices approved by SAMHSA for the Block Grant utilized in Missouri
- Measure:** Number of Evidence Based Practices approved by SAMHSA for the Block Grant utilized in Missouri (No numerator or denominator)
- Sources of Information:** Missouri Department of Mental Health
- Special Issues:** The Department of Mental Health meets the federal definition for Therapeutic Foster Care listed in the Block Grant application. Therapeutic Foster Care Programs licensing requirements define program as "Family living arrangement, a residential facility operated in the owned or leased permanent residence of the licensee, serving no more that three (3) residents who are integrated into the licensee's family unit. The facility does not normally use direct-care staff other than members of the household."
- Significance:** Therapeutic Foster Care (Treatment Family Homes) provide 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.
- Action Plan:** The Department of Mental Health, Division of Comprehensive Psychiatric Services currently provides one evidence based practice approved by SAMHSA for the Block Grant to children, youth and families using the State licensed Therapeutic Foster Care Programs.

## CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	.76	.49	.47	.47
Numerator	127	78	--	--
Denominator	16,723	15,771	--	--

Table Descriptors:

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

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

**Population:** Children and youth with SED

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

**Indicator:** Percentage of children and youth with SED receiving Therapeutic Foster Care

**Measure:** The numerator is the number of children and youth in Therapeutic Foster Care. The denominator is number of children and youth with SED diagnosis receiving CPS funded services.

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

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

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

Additionally, inconsistencies in contracts with providers were found leading to resubmission of all contracts. New Therapeutic Foster Care homes were not being recruited as CPS made adjustments to the system that has led to decrease projected numbers.

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

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

diverse. CPS plans to continue implementing greater fidelity to the model.

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

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

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

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

Table Descriptors:

**Goal:** Not Applicable

**Target:**

**Population:**

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

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

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

Table Descriptors:

**Goal:** Not Applicable

**Target:**

**Population:**

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

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	84.72	87.34	89.34	84
Numerator	610	476	--	--
Denominator	720	545	--	--

Table Descriptors:

- Goal:** Maintain high level of consumer satisfaction
- Target:** Maintain level of consumer satisfaction higher than or equal to the national average rate of 84%
- Population:** Children and youth with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of parents of children with SED satisfied or very satisfied with services received
- Measure:** The numerator is number of parents of children and youth with SED receiving services who are satisfied or very satisfied with those services.  
The denominator is total number of parents of children and youth with SED receiving services who responded to the consumer satisfaction survey.
- Sources of Information:** Consumer Satisfaction Survey (Youth Services Survey for Families)
- Special Issues:** CPS has 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. The trend since FY2008 show an increase in the percentage of parents satisfied or very satisfied with services received.
- Action Plan:** CPS will continue to receive the YSS-F survey results implemented on a continuous basis.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	94.82	95.01	95.35	94
Numerator	805	933	--	--
Denominator	849	982	--	--

Table Descriptors:

**Goal:** Children and youth will return to or stay in school

**Target:** Children and youth will return to or stay in school equal to the national average rate of 94%

**Population:** Children and youth with SED

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

**Indicator:** Percentage of children and youth returning to or staying in school

**Measure:** The numerator is the number of children/youth attending school at time assessment was completed.  
The denominator is the total number of children/youth in sample.

**Sources of Information:** Child/Youth Status Report

**Special Issues:** The Child/Youth Status Report is a sample of the total number served. With the management information system (CIMOR), CPS eventually plans to collect data on all consumers served by the division.

**Significance:** According to the President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America, "the mission of public schools is to educate all students. However, children with serious emotional disturbances have the highest rates of school failure. Fifty percent of these students drop out of high school, compared to 30% of all students with disabilities. Schools are where children spend most of each day. While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success, schools must be partners in the mental health care of our children." Missouri's Comprehensive Children's Mental Health System is working if over 94% of children and youth with SED are returning to or staying in school.

**Action Plan:** CPS will continue to revise the management information system to improve collection of data on all consumers served. CPS will continue to support children and youth with SED in their communities to maintain consistent school attendance.

## CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	19.55	23.52	24.70	25
Numerator	182	231	--	--
Denominator	931	982	--	--

### Table Descriptors:

**Goal:** Decrease the percentage of children and youth with SED involved in the Juvenile Justice system

**Target:** Decrease or maintain the percentage of children and youth with SED involved in the Juvenile Justice system

**Population:** Children and Youth with SED

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

**Indicator:** Percentage of children and youth with SED involved with Juvenile Justice

**Measure:** The numerator is the number of children and youth involved with Juvenile Justice.  
The denominator is the total number of children and youth in sample.

**Sources of Information:** Child/Youth Status Report

**Special Issues:** The Child/Youth Status Report is a sample of the total number served. With the management information system (CIMOR), CPS eventually plans to collect data on all consumers served by the division.

**Significance:** 75% of the children and youth with SED are not involved with the Juvenile Justice system. Sample size is small and effected by small changes in actual numbers.

**Action Plan:** CPS will continue to revise the management information system to improve collection of data on all consumers served.

The Division continues to lead a state level mental health/juvenile justice policy team to identify and address issues related to the mental health needs of youth at risk of or currently in the juvenile justice system. A grant funded partnership exists between the Office of State Courts Administrator and the Division to improve the quality of assessments provided on youth involved the juvenile justice system, to develop evidence based practices geared towards this population of youth and develop/enhance community collaboration. Five sites were selected to receive training on assessments, provided dollars to train on their selected evidence based practice, and consultation and technical assistance to enhance the local infrastructure to sustain these practices. In 2008, 113 individuals representing child welfare, juvenile justice and mental health were trained on the Assessment Guidelines. A survey sent out six months later, showed that the majority of respondents felt they had gained knowledge about when to refer, what can be learned from mental health assessments, were better able to use the information provided by the assessment, and how to use the assessment to guide service provision. One hundred and thirty-nine therapists in two communities were

trained and certified on Trauma-Focused Cognitive Behavioral Therapy. Another community provided training to 181 staff on Dialectical Behavior Therapy, with a core adolescent team receiving targeted training to provide therapy. Forty-eight juvenile officers and therapists received training in motivational interviewing and Strengthening Families and a final community provided training to 22 school and mental health staff on Too Good for Drugs and/or Reconnecting Youth.

The Mental Health/Juvenile Justice Policy Group is now focusing on creating a continuum of services for youth with problem sexual behaviors. The first step was developing guiding principles, values and practices to insure a common vision. As this step is being completed, the group has begun the process of examining different best practices that can be developed and accessed by juvenile justice, child welfare, mental health, schools and families. MO HealthNet serves on this group to aid in leveraging Medicaid dollars in support of best practices.

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

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** ]

**Name of Performance Indicator:** Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	80.88	78.29	79.35	78
Numerator	753	797	--	--
Denominator	931	1,018	--	--

Table Descriptors:

**Goal:** Increase stability in housing for children/youth

**Target:** Increase or maintain stability in housing for children/youth

**Population:** Children and youth with SED

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

**Indicator:** Percentage of children and youth with SED living in home or home-like setting

**Measure:** The numerator is the number of children and youth with SED living in home or home-like setting.  
The denominator is the total number of children and youth with SED in the sample.

**Sources of Information:** Child/Youth Status Report

**Special Issues:** The data is taken from a small sample of total consumers served. This can lead to fluctuations in the outcomes based on small number size. Additionally, the current budget cuts may affect this number.

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

**Action Plan:** The department will continue to place children and youth with SED in a home or home-like setting whenever possible.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** ]

**Name of Performance Indicator:** Child - Increased Social Supports/Social Connectedness  
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	83.43	86.47	86.29	86
Numerator	594	473	--	--
Denominator	712	547	--	--

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:** CPS has implemented the Youth Services Survey for Family (YSS-F) recommended by SAMHSA.

**Significance:** A high rate 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.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** ]

**Name of Performance Indicator:** Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	60.96	64.50	63	63
Numerator	434	347	--	--
Denominator	712	538	--	--

Table Descriptors:

- Goal:** Improve or maintain children/youth level of functioning
- Target:** Maintain 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:** CPS has implemented the Youth Services Survey for Family (YSS-F) recommended by SAMHSA.
- Significance:** The data is demonstrating some fluctuation over three years from 60.96% to 64.50% to 63%.
- Action Plan:** CPS will continue to receive the YSS-F survey recently implemented on a continuous basis.

Upload Planning Council Letter for the Plan

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**State Advisory Council  
For  
Comprehensive Psychiatric Services**



Missouri Department of Mental Health  
1706 E. Elm St., P.O. Box 687  
Jefferson City, MO 65102  
Telephone: 573-751-8017  
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August 26, 2010

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 2011 Community Mental Health Services Block Grant Application. The State Advisory Council is committed to Mental Health Transformation and assures that the system is consumer and family driven. We approve of the state plan written under our guidance.

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

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

Sincerely,

Helen Minth, Chair  
CPS State Advisory Council

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, national origin, disability or age of applicants or employees.

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



State of Missouri



# Comprehensive Plan for Mental Health

## Federal FY 2010 Action Plan Update

*Creating Communities of Hope*





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

*Cooperative Agreements for Mental Health Transformation State Incentive Grants. Request for Applications No. SM-05-009. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Missouri Comprehensive Plan for Mental Health Federal FY 2010 Action Plan Update.*

To ensure 24/7 availability and widest distribution, the *Missouri Comprehensive Plan for Mental Health Federal FY 2010 Action Plan Update* is available electronically at:  
<http://www.dmh.mo.gov/transformation/transformation.htm>

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October 2, 2009

Marian K. Scheinholtz, Public Health Advisor  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road, 6-1010  
Rockville, MD 20857

Dear Marian:

On behalf of the Mental Health Transformation Working Group (TWG), I am pleased to present the **Federal FY10 Plan Update** to Missouri's *Comprehensive Plan for Mental Health 2008-2013* approved by SAMHSA in June 2008.

The Plan Update was reviewed and approved by the TWG this past week and serves as a supplemental document to the Comprehensive Plan. It provides a detailed update to **Part 3-Initial Action Plan** that includes the following:

- A brief summary of progress through September 2009 for each of the 57 action items included in the action plan; and
- Updates to implementation steps, measures, and timelines for the federal Fiscal Year 2010 timeframe.

As you will see from this update, Missouri has made significant progress across the numerous action items outlined in the Comprehensive Plan. As always, we appreciate the ongoing leadership and support of SAMHSA on this very important national initiative and look forward to continuing this productive partnership in the year ahead.

Sincerely,

A handwritten signature in black ink that reads "Diane McFarland".

Diane McFarland  
Project Director & Chair  
Missouri Mental Health Transformation Working Group

cc: Governor Jay Nixon  
Mental Health Transformation Working Group  
Human Services Cabinet Council  
Alan Kauffman, SAMHSA State Advisor

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, religion, national origin, disability or age of applicants or employees.





## Missouri's Vision

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

### Background and Overview

Through a bipartisan, cross-agency, public-private effort spearheaded by the Governor-appointed Transformation Working Group (TWG) and funded by the federal Substance Abuse Mental Health Services Administration (SAMHSA), Missouri created its first **Comprehensive Plan for Mental Health** <http://www.dmh.mo.gov/transformation/FINALVERSIONJULY12008.pdf> in the spring of 2008 to address the mental health needs of Missourians across the lifespan.

Hundreds of Missourians dedicated their time and expertise to create the plan through participation in workgroups, focus groups, interviews, and public hearings throughout the state. What emerged was a **shared vision and common agenda** for a transformed mental health system in Missouri. The common agenda is reflected through the **six strategic themes, six goals, and twenty-one objectives** outlined on the following pages. Core strategies were developed for each of the objectives, along with an action plan initially containing 61 priority action items. The Comprehensive Plan was adopted by Missouri leaders, submitted to SAMHSA in March 2008, and approved by SAMHSA in June 2008. The first update to the Comprehensive Plan, completed in the fall of 2008, included two additional action items, which brought the total to 63.

As the state's mental health authority, the Department of Mental Health is in the forefront of the effort to improve the quality of life for Missourians who face mental health issues. However, recognizing that the duty to fulfill mental health services and meet mental health needs is not confined to any one particular group or agency, the TWG is focused on collaboration of the state's human service agencies, education agencies, and other public and private service entities and organizations for the benefit of all Missouri's citizens.

### Action Plan Organization

This document provides an update of activities overseen by the TWG during Federal Fiscal Year (FFY) 2009, beginning October 1, 2008, and ending September 30, 2009. As in last year's **Plan Update**, the table that begins on page 9 includes a description and a progress update of each Action Item. This year, the items are organized under the four major initiatives of mental health transformation: ***Changing Attitudes and Building Hope, Advancing Community Health and Wellness, Building Strong Systems of Care, and Promoting Real Voices and Real Choices***. In addition, any items included in the previous **Plan Update** that were completed in FFY 2008 are not listed in this report.

For the sake of efficiency and tracking, several action items have been combined and some others added, deleted or updated. Those changes include the following:

(See appendix for Legend of Abbreviations.)



- ▶ All activities related to **School-Based Mental Health Services** have been combined into one priority action item.
- ▶ All activities related to **Suicide Prevention** have been combined into one priority action item.
- ▶ The item on **Capacity Development Analysis** has been deleted as new priority was established.
- ▶ The **Housing Workgroup** and **Housing Registry** action items have been combined.
- ▶ The **Language Translation** item has been deleted, and all actions related to **Cultural Disparities** have been combined.
- ▶ The **Children's System High User Analysis** item was eliminated, and the **Children's System of Care** has been added, incorporating **Wrap-Around Fidelity** and **Transitional Youth** items.
- ▶ An item was added on **Mental Health Prisoner Re-entry**.

Accounting for the combined, deleted, and added items, this **Plan Update** provides progress on 57 action items. Each entry includes information on lead agency, related goals, level of complexity, target population, and proposed start and end dates. The legend of abbreviations and acronyms used in the **Action Plan** is contained in the Appendix on page 36.

(See appendix for Legend of Abbreviations.)



 <b>MISSOURI MENTAL HEALTH TRANSFORMATION STRATEGIC THEMES</b> "Creating Communities of Hope" <i>Moving Missouri Toward a Public Health Approach</i> 		
MOVE FROM:		MOVE TO:
CULTURE OF CRISIS/ RISK OF HARM	→	CULTURE OF HOPE/ FIRST..."DO NO HARM" 
"NO WHERE TO GO"	→	EASY, EARLY AND EQUAL ACCESS 
DISABILITY FOCUS	→	WELLNESS FOCUS WITH PREVENTION AND EARLY INTERVENTION 
BUREAUCRACY/ PROVIDER DRIVEN CARE	→	CONSUMER DIRECTION AND EMPOWERMENT 
"POCKETS" OF EXCELLENCE	→	UNIVERSAL BEST PRACTICES 
FRAGMENTED & CENTRALIZED SYSTEM	→	SHARED OWNERSHIP & INVESTMENT (STATE-LOCAL, PUBLIC-PRIVATE) 

(See appendix for Legend of Abbreviations.)



# Missouri Comprehensive Plan for Mental Health Federal FY 2010 Action Plan Update

<b>GOAL 1: MISSOURIANS UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH</b>	<b>OBJECTIVE 1.1:</b>	INCREASE PUBLIC UNDERSTANDING AND REDUCE STIGMA OF MENTAL ILLNESS, SUBSTANCE ADDICTIONS AND DEVELOPMENTAL DISABILITIES.	
	<b>OBJECTIVE 1.2:</b>	DEVELOP AND IMPLEMENT A STATE-WIDE PREVENTION FRAMEWORK THAT ADDRESSES COMMON RISK AND PROTECTIVE FACTORS.	
	<b>OBJECTIVE 1.3:</b>	INTEGRATE PUBLIC, PRIMARY AND MENTAL HEALTH CARE PRACTICES.	
<b>GOAL 2: MISSOURI'S MENTAL HEALTH CARE IS CONSUMER AND FAMILY DRIVEN</b>	<b>OBJECTIVE 2.1:</b>	INCREASE CONSUMER DECISION-MAKING AND SELF-DIRECTION OF INDIVIDUALIZED PLANS OF CARE.	
	<b>OBJECTIVE 2.2:</b>	EXPAND AND INTEGRATE PEER AND FAMILY SUPPORT SERVICES INTO THE SYSTEM OF CARE.	
	<b>OBJECTIVE 2.3:</b>	CREATE A CULTURE OF RESPECT, DIGNITY & WELLNESS AS THE MILIEU IN WHICH ALL MENTAL HEALTH SERVICES ARE PROVIDED.	
	<b>OBJECTIVE 2.4:</b>	INCREASE THE NUMBER OF CONSUMERS FULLY PARTICIPATING IN THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF THE SYSTEM.	
<b>GOAL 3: MENTAL HEALTH DISPARITIES ARE ELIMINATED IN MISSOURI</b>	<b>OBJECTIVE 3.1:</b>	IMPROVE ACCESS TO QUALITY CARE IN RURAL AND GEOGRAPHICALLY REMOTE AREAS.	
	<b>OBJECTIVE 3.2:</b>	IMPROVE ACCESS TO CULTURALLY COMPETENT CARE	
	<b>OBJECTIVE 3.3:</b>	INCREASE CONSUMER ACCESS TO PROGRESSIVE EMPLOYMENT OPPORTUNITIES IN INTEGRATED COMMUNITY SETTINGS.	
	<b>OBJECTIVE 3.4:</b>	INCREASE CONSUMER ACCESS TO SAFE AND AFFORDABLE HOUSING IN INTEGRATED COMMUNITY SETTINGS.	
<b>GOAL 4: EARLY SCREENING, ASSESSMENT AND REFERRAL TO SERVICES ARE COMMON PRACTICE</b>	<b>OBJECTIVE 4.1:</b>	PROVIDE TIMELY OUTREACH, SCREENING AND REFERRAL TO CARE THAT IS AGE AND CULTURALLY APPROPRIATE.	
	<b>OBJECTIVE 4.2:</b>	PROVIDE MENTAL HEALTH CONSULTATION AND SERVICES IN EARLY CHILDHOOD AND SCHOOL SETTINGS.	
	<b>OBJECTIVE 4.3:</b>	EXPAND COMMUNITY CAPACITY TO REDUCE AVOIDABLE USE OF EMERGENCY ROOMS, HOSPITALS AND OTHER INSTITUTIONAL CARE.	
<b>GOAL 5: EXCELLENT MENTAL HEALTH CARE IS DELIVERED AND RESEARCH IS ACCELERATED</b>	<b>OBJECTIVE 5.1:</b>	DEVELOP THE MENTAL HEALTH WORKFORCE	
	<b>OBJECTIVE 5.2:</b>	EXPAND EVIDENCE-BASED PRACTICES (EBPs) ACROSS THE STATE.	
	<b>OBJECTIVE 5.3:</b>	APPLY RESEARCH EVIDENCE MORE QUICKLY AND INVEST IN RESEARCH FOR NEW AND PROMISING PRACTICES.	
	<b>OBJECTIVE 5.4:</b>	DEVELOP AND IMPLEMENT A COMPREHENSIVE QUALITY MANAGEMENT SYSTEM.	
<b>GOAL 6: MISSOURI COMMUNITIES ARE PROFICIENT IN MEETING LOCAL MENTAL HEALTH NEEDS.</b>	<b>OBJECTIVE 6.1:</b>	CREATE CONSISTENT & FLEXIBLE POLICY/PRACTICES ACROSS STATE AGENCIES THAT ARE INFORMED BY CONSUMERS & LOCAL NEEDS.	
	<b>OBJECTIVE 6.2:</b>	CREATE AND/OR EXPAND LOCAL PUBLIC-PRIVATE COLLABORATIVES TO IMPROVE SERVICE ACCESS, CAPACITY AND INTEGRATION.	
	<b>OBJECTIVE 6.3:</b>	EXPAND THE ROLE AND CAPACITY OF COMMUNITIES TO IDENTIFY THEIR NEEDS, PROMOTE MENTAL HEALTH & CREATE OPPORTUNITIES FOR CONSUMER INCLUSION.	



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<b>Changing Attitudes and Building Hope</b> ~ Public Education & Stigma Reduction ~									
<p><b>1. Mental Health Foundation:</b> Work will continue to develop public-private partnerships for a permanent Missouri Mental Health Foundation that supports public education, stigma reduction and consumer empowerment initiatives.</p> <ul style="list-style-type: none"> <li>• Develop strategic plan and business plan.</li> <li>• Identify potential projects and contributors to foundation and implement for long-term success and sustainability of fund projects.</li> </ul>	DMH & Midwest Special Needs Trust	1.1	C	1368	M	All	Qtr. 3 2007	Qtr. 3 2011	<ul style="list-style-type: none"> <li>➤ The Foundation was established as a separate 501C3 entity and named a board of directors, which will hold its first meeting in October.</li> <li>➤ The Foundation sponsored the second annual Mental Health Champions Awards banquet in April.</li> <li>➤ The Foundation co-sponsored the Consumer, Family and Youth Leadership Conference in August.</li> </ul>
<p><b>2. Mental Health Promotion and Public Education:</b> The TWG chartered a cross-departmental workgroup to promote the understanding that <i>mental health is essential to overall health</i> that included creation of two subcommittees to increase mental health literacy and reduce stigma.</p> <ul style="list-style-type: none"> <li>• The Anti-Stigma subcommittee plans to launch a public awareness campaign during FFY 2010 to include a social marketing plan and toolkit for public education and stigma reduction.</li> <li>• The Mental Health First Aid (MHFA) Advisory Committee will continue to provide guidance to Missouri MHFA program roll-out.</li> </ul>	TWG	1.1 1.2	C E	1 8	M	All	Qtr. 3 2008	Qtr. 1 2010	<ul style="list-style-type: none"> <li>➤ The Workgroup adopted risk and protective factors to be used in moving the mental health system to a more population-based approach.</li> <li>➤ The Stigma-Reduction Subcommittee was established and has been working on the development and testing of state messages and the creation of a local social marketing toolkit.</li> <li>➤ The workgroup is addressing the issue of mental health literacy through its support and promotion of Mental Health First Aid (see Action Item #4).</li> </ul>

(See appendix for Legend of Abbreviations.)



Missouri Comprehensive Plan for Mental Health  
Federal FY 2010 Action Plan Update

FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>3. Respect Seminars &amp; Institute:</b></p> <p>The RESPECT Seminar was developed by international consultant Joel Slack to teach people about the powerful impact that respect (and disrespect) has on a person recovering from a mental health disability. The RESPECT Institute is a four-day training program that teaches consumers to tell their personal stories.</p> <ul style="list-style-type: none"> <li>• Continue statewide training and organizational consultation to build a culture of respect.</li> <li>• Continue to offer sessions to train consumers and families through the four-day RESPECT Institutes.</li> <li>• Establish statewide infrastructure to support/sustain RESPECT Institutes and continue development of a Peer Speakers Bureau in Missouri.</li> </ul>	DMH OOT & Mental Health Promotion and Public Education Workgroup	1.1 2.3	C E	1 2 3 4 6 7 8	M	All	Qtr. 4 2007	Qtr. 3 2011	<ul style="list-style-type: none"> <li>➤ Over 750 additional Missourians attended RESPECT Seminars in FY2009.</li> <li>➤ Infrastructure was put in place to support RESPECT Institutes in four of the state's five regions, with 29 additional consumers trained.</li> <li>➤ An organizational agreement/contract was reached with NAMI Missouri to provide "In Our Own Voice" (IOOV) training and waive membership fees for consumer Respect Speakers who want to participate.</li> <li>➤ 15 consumers completed IOOV training.</li> <li>➤ A draft statewide RESPECT Institute operations manual was completed.</li> </ul>
<p><b>4. Mental Health First Aid (MHFA):</b></p> <p>Continue to Implement this evidence-based, 12-hour mental health literacy training program as part of a public education campaign.</p> <ul style="list-style-type: none"> <li>• Continue work with the state of Maryland, the National Council of Community Behavioral Health Care and SAMHSA to convert training curricula and certification standards for use in the United States.</li> <li>• Implement MO Foundation for Health Grant working with the faith community and CMHCs to implement MHFA in rural communities.</li> <li>• Develop a business plan for long-term sustainability. This includes both a Missouri-specific plan and a national plan with MHFA-USA partners.</li> </ul>	DMH OOT & Mental Health Promotion and Public Education Workgroup	1.1 1.3 5.3	C E	1 2 3 4 7 8	M	MI ADA All	Qtr. 1 2008	Qtr. 3 2011	<ul style="list-style-type: none"> <li>➤ Missouri currently has 3 certified Trainers and 48 Certified Mental Health First Aid instructors.</li> <li>➤ The Mental Health First Aid – USA National Manual and Instructor's training kit have been finalized and were submitted for publishing in September.</li> <li>➤ The Missouri Foundation for Health awarded Missouri's Mental Health First Aid program a grant to support expansion of the program into 17 counties in rural Missouri. This project will be done in collaboration with Missouri Committed Caring Faith Communities (CCFC) and local CMHCs.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>5. Transformation Communications and Accountability Plan:</b></p> <ul style="list-style-type: none"> <li>Initiate a new website for Missouri Mental Health Transformation.</li> <li>Produce regular briefings on key issues, successes and progress through prepared media releases, newsletters and other communications.</li> <li>Produce annual reports.</li> </ul>	DMH & OOT	1.1	A	8	M	All	Qtr. 4 2008	Qtr. 3 2011	<ul style="list-style-type: none"> <li>A new website and annual report have been drafted. The web site is to be launched in the fourth quarter of 2009, which includes updates on workgroup activities and Transformation action items.</li> </ul>
<p><b>Promoting Health and Wellness</b> ~ Prevention and Early Intervention ~</p>									
<p><b>6. Early Childhood Initiative:</b> Work will continue on identifying the infrastructure for a service delivery system that is based on evidence-based practices for the early childhood population through the Coordinating Board for Early Childhood and the Early Childhood Comprehensive System Steering Committee.</p> <ul style="list-style-type: none"> <li>A second Childhood Mental Health Summit will be planned.</li> <li>A childcare orientation/training series (2 modules) on social and emotional development and inclusion of children with social, emotional and behavioral concerns will be completed and training of the early childhood workforce initiated.</li> <li>Screening and service protocols will be developed for children of adults with serious mental illnesses.</li> </ul>	DMH OCCMH, HeadStart, MO HealthNet, DHSS, DSS, DESE	4.2	E	1 2	L	CY&F All	Qtr. 1 2008	Qtr. 3 2010	<ul style="list-style-type: none"> <li>The Coordinating Board for Early Childhood Education has incorporated mental health and social and emotional development goals and objectives into its strategic plan.</li> <li>Two childcare orientation/training modules were developed.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>7. School-Based MH Services:</b> A school-based mental health services model will continue to be developed to expand services statewide.</p> <ul style="list-style-type: none"> <li>The School-based Mental Health Workgroup chartered by the TWG will develop recommendations for the Children's Services Commission.</li> <li>Continue promotion of the School-wide Positive Behavior Support (SW-PBS) model.</li> <li>Continue implementation of Olweus Bullying Prevention program.</li> <li>Implement DMH/CPS School-based services model for designated mental health providers that includes services for tiers 2 &amp; 3 of SW-PBS.</li> </ul>	DMH, DESE, Coalition of CMHCs, Individual School Districts, DHSS, MO Center for Safe Schools	4.2	C E	1 2 3 5 7	H	MI CY&F	Qtr. 3 2007	Qtr. 2 2010	<ul style="list-style-type: none"> <li>The TWG chartered the School-based Mental Health Workgroup to develop recommendations for the Children's Services Commission.</li> <li>The number of Missouri schools implementing the school-wide positive behavior support (PBS) three-tiered model increased by 131.</li> <li>The number of schools formally collecting and analyzing data in accordance with the Positive Behavior Support practice model has increased by 66. These schools achieved 80% or higher School-wide Evaluation Tool (SET) scores.</li> <li>Eight schools adopted the Olweus Bullying Prevention program training. Booster training was provided for eight instructors in April 2009.</li> </ul>
<p><b>8. Healthy IDEAS for Older Adults:</b> The Mental Health and Aging Workgroup will continue to promote Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), a case-management enhancement initiative that prepares trained staff to identify depression in at-risk elders and to facilitate access to treatment and empower seniors to manage their depression through an approach that encourages involvement in meaningful, positive activities.</p> <ul style="list-style-type: none"> <li>Develop application process for organizations interested in implementing.</li> <li>Provide training to approved organizations.</li> <li>Propose a financing change to add a single episode of major depression to the service menu.</li> </ul>	Mental Health and Aging Workgroup, TWG, DMH, DHSS, Other agencies	4.1	E	1 2 7	M	OA	Qtr. 3 2009	Qtr.3 2011	<ul style="list-style-type: none"> <li>The Mental Health and Aging Workgroup sponsored an informational Forum on Healthy IDEAS Sept. 10, 2009. Sixty-seven (67) individuals representing 36 state and private agencies that provide services to Missouri seniors attended to learn more about the program and how to incorporate it into their operations.</li> <li>An application process has been developed for organizations interested in implementing Healthy IDEAS.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>9. Suicide Prevention:</b> Continue suicide prevention initiative to expand training and intervention to include:</p> <ul style="list-style-type: none"> <li>• An annual conference.</li> <li>• Expansion of suicide prevention efforts to older adults through development of mini-grants.</li> <li>• Finalize the content/design of a graduate-level course in suicide prevention.</li> <li>• Bring on-line 10 one-hour modules on suicide prevention created through the University of Missouri.</li> </ul>	DMH, DHSS, University of Missouri	1.2	C	1 2 3 4	L	All	Qtr. 1 2008	Qtr. 1 2010	<ul style="list-style-type: none"> <li>➤ Annual conference was held in July 2009 with more than 230 persons in attendance.</li> <li>➤ The graduate-level course in suicide prevention has been completed and is in review.</li> <li>➤ The 10 one-hour modules are complete and will initially be vetted through schools rather than online.</li> <li>➤ Work has been completed on development of a mini-grant proposal for communities to expand suicide prevention efforts to older adults.</li> </ul>
<p><b>Promoting Health and Wellness</b> ~ Integrated Care ~</p>									
<p><b>10. CMHC-FQHC Collaborative Care Project:</b> Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs) in seven Missouri communities entered into partnerships in 2008 in a project to integrate physical and behavioral health services in general health-care settings.</p> <ul style="list-style-type: none"> <li>• Continue the seven collaborative care projects between federally qualified health centers (FQHCs) and community mental health centers (CMHCs).</li> <li>• Assist additional interested sites to establish collaborative care partnerships.</li> <li>• Evaluation will guide needed policy changes and additional expansion in the future.</li> </ul>	DMH Division of CPS, Missouri Coalition of CMHC's, Missouri Primary Care Association	1.3	C E	1 2 3 4 7	M	MI ADA All	Qtr. 4 2006	Qtr. 3 2011	<ul style="list-style-type: none"> <li>➤ Mini-grants were awarded to six sites for planning. These additional sites have leveraged their dollars to meet or exceed the expectations of the collaboratives.</li> <li>➤ Organizational training and technical assistance has been provided to all sites. As of June 30, 2009, over 600 CMHC and FQHC clinical staff have received formal training to implement integrated care.</li> <li>➤ An article on this initiative was published in the May 2009 online issue of <i>Psychiatric Services</i> – <a href="http://ps.psychiatryonline.org">http://ps.psychiatryonline.org</a>.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>11. DMH NET Integrated Care:</b> This initiative is comprised of two components—Disease Management and Health Care Homes:</p> <ul style="list-style-type: none"> <li>• Continue designation of Community Mental Health Centers as health care homes for persons with serious mental illnesses under the MO HealthNet Plan (formerly Medicaid). These services will enhance the care provided by combining physical and mental health care in one location.</li> <li>• Expand disease management services through a statewide network for Medicaid-eligible individuals with mental illnesses and co-occurring chronic physical health conditions.</li> <li>• Expand CMH provider use of Cyberaccess electronic claims reporting system to review client histories for the purpose of coordinating care.</li> <li>• Continue to provide data analysis and educational materials to health care providers regarding good psychiatric prescribing practices.</li> </ul>	DMH & DSS Division of MO HealthNet	1.3	A E	1 2 3 4 5 7	M	MI All	Qtr. 3 2007	Qtr. 4 2011	<ul style="list-style-type: none"> <li>➤ More than 70 trainings of 1,100 nurse liaisons and community support workers have taken place, and monthly meetings of nurse liaisons are being held.</li> <li>➤ CMHCs have approved 10% of the healthcare home plans of care in the State Medicaid program.</li> <li>➤ More than 70% of patients have had a primary care visit within a 12-month period.</li> <li>➤ More than 35,000 patient histories have been reviewed in Cyberaccess.</li> <li>➤ CMHC Nurse Liaisons have participated in implementing a diabetes pilot enhancement.</li> <li>➤ The pharmacy management component has recently been expanded to include child welfare and long-term-care agencies.</li> </ul>
<p><b>12. Psychiatric Acute Care Transformation (PACT):</b> The Department of Mental Health will continue to work with communities to transition psychiatric acute inpatient care services to private integrated hospital systems.</p>	DMH Division of CPS	4.3 6.2	C	1 3 4	H	MI Adult OA	Qtr. 3 2007	Qtr. 3 2009	<ul style="list-style-type: none"> <li>➤ Legislation was passed that allowed the transfer of Mid-Missouri Mental Health Center to University of Missouri health care for operation of regional acute-care services.</li> <li>➤ DMH established an organizational agreement with Truman Medical Center to expand psychiatric acute care operations and operate an emergency department on the campus of Western Missouri Mental Health Center, which ceased operations of two units and changed its name to reflect continuing services.</li> </ul>

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<p><b>13. Screening, Brief Intervention, Referral and Treatment (SBIRT):</b></p> <p>Continue implementation of the SBIRT program to identify and provide services to individuals with risky behaviors in their use of alcohol and other drugs. A key aspect of SBIRT is the integration of this project in general medical settings and linkages with specialized treatment programs.</p> <ul style="list-style-type: none"> <li>• Increase number of screenings performed.</li> <li>• Expand program to Central Missouri region.</li> </ul>	DMH Division of ADA	1.3 4.1	A E	2 7	M	ADA OA Adult	Qtr. 1 2008	Qtr. 1 2009	<ul style="list-style-type: none"> <li>➤ Initial trainings have been completed. Burrell Behavioral Health staff began providing SBIRT services in Cox North Emergency Room in Springfield, Missouri, on March 31, 2009.</li> <li>➤ To date, almost 3,000 individuals have been screened.</li> <li>➤ SBIRT services will be expanded for implementation in the fall of 2009 at the University of Missouri Hospital and clinics in Columbia, Missouri.</li> </ul>
<p><b>Promoting Health and Wellness</b> ~ Public Health ~</p>									
<p><b>14. Community of Hope Coalitions:</b></p> <p>Develop criteria and a proposal to provide seed funding to local communities to begin the process of community assessment and capacity building. Identify state and local partners and linkages with public education actions. Provide recommendations to the TWG for implementation.</p>	DMH OOT & OCCMH	6.3	C E	2 3 4 5 7	H	All	Qtr. 2 2009	Qtr. 3 2011	<ul style="list-style-type: none"> <li>➤ Criteria have been developed for Request for Proposals (RFPs). RFPs are targeted to go out in the fall of 2009.</li> </ul>
<p><b>15. Bright Futures Targeted Capacity Building:</b></p> <p>Continue support for 3 community coalitions to implement Missouri Bright Futures. The communities, which are developing implementation strategies, will participate in training and support in mapping the resources and needs of the community, organizing the resources of the community to address system needs, and individualizing resource allocations within the community to improve the outcomes for individual youth.</p>	DMH, DHSS, DSS, DESE, University of Missouri Center for the Advance- ment of Mental Health Practices in Schools, Head Start Collab., Missouri Student Success Network	4.2	C E	1 2 3 5 7	M	CF&Y MI	Qtr. 1 2008	Qtr. 3 2011	<ul style="list-style-type: none"> <li>➤ The Missouri Foundation for Health awarded a three-year, \$300,000 grant to fund Bright Futures in three communities: Rolla, Joplin and Moberly.</li> <li>➤ A total of 35 community and state staff were trained on the Bright Futures public health model and the requirements for completion of a local plan.</li> <li>➤ The Missouri Bright Futures State team received the Governor's Award on Quality and Productivity - announced in September 2009.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>16. Higher Education Mental Health Homeland Security Initiative:</b></p> <ul style="list-style-type: none"> <li>Continue to foster collaborative relationships on college campuses across the state to implement recommendations to involve mental health expertise in emergency planning for campuses.</li> <li>Education/training on how to access 24/7 mental health services by campus authorities and students, either CMHCs and/or on-campus expertise.</li> <li>Education/training on linkages for activating civil commitment if needed.</li> <li>Initiate Mental Health First Aid training for campus personnel and students.</li> </ul>	<p>Homeland Security Taskforce, Department of Higher Education and Public Safety Subcommittee, DHE, DMH</p>	<p>1.1 1.2 1.3 4.2 6.2</p>	<p>C</p>	<p>1 4 7</p>	<p>M</p>	<p>All</p>	<p>Qtr. 3 2007</p>	<p>Qtr. 3 2011</p>	<ul style="list-style-type: none"> <li>A web site <a href="http://campussecurity.missouri.org">campussecurity.missouri.org</a> was created as a communications method of issuing postings of policies and resources on disaster mental health and campus violence.</li> <li>The Department of Higher Education has formally sanctioned Mental Health First Aid – four campuses have incorporated the program into their campus plans.</li> <li>A toolkit was developed and posted on the web site for use by mental health providers and colleges to facilitate effective campus emergency planning related to mental health.</li> </ul>
<p><b>17. Disaster Services and Special Needs Shelters:</b></p> <p>DMH will continue a partnership with DHSS to address the needs of special populations, particularly people with mental disabilities, in the aftermath of a disaster.</p> <ul style="list-style-type: none"> <li>Develop training modules and conduct webinars to train staff at the local level on the Special Needs Annex and Sheltering Standard Operating Guide.</li> <li>Develop a Memorandum of Understanding (MOU) between the Departments of Health and Senior Services and Mental Health for management of the Show-Me Response volunteer registration system.</li> <li>Develop a disaster mental health activation policy protocol for shelters to facilitate mental health referral through the statewide 24-hour access crisis intervention (ACI) response system.</li> <li>Develop/adapt first-responder guidelines (TIPS) for special needs populations and publish for distribution to identified community first responders.</li> </ul>	<p>Special Needs Committee DHSS, DMH</p>	<p>1.3 4.3 6.2</p>	<p>C</p>	<p>1 2 4</p>	<p>M</p>	<p>All</p>	<p>Qtr. 1 2008</p>	<p>Qtr. 3 2010</p>	<ul style="list-style-type: none"> <li>Disaster Behavioral Health Competencies for behavioral health and health care professionals and paraprofessionals have been approved and employed.</li> <li>An All-Hazards Planning Guide for use by DMH facilities and contracted providers was developed and issued.</li> <li>Annex X, the Special Needs section of the Missouri State Emergency Management Operations Plan, has been revised.</li> <li>The Special Needs Sheltering Standard Operating Guide (SOG) for local and county emergency management was developed.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRAs	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>18. Tobacco Prevention &amp; Cessation (NO BUTTS About It):</b></p> <ul style="list-style-type: none"> <li>Develop a comprehensive statewide plan based on the "No Butts About It" assessment results of tobacco use among mental health consumers.</li> </ul>	DMH, DHSS, Mental Health Promotions and Public Education Workgroup	1.2	C	1 7 8	M	All	Qtr. 1 2007	Qtr. 3 2010	<ul style="list-style-type: none"> <li>An assessment of tobacco use among mental health consumers, based on a survey of more than 1,100 consumers, was completed by MIMH.</li> <li>The Missouri Foundation for Health awarded a \$46,682 grant to develop a comprehensive statewide plan designed to address the issues cited in the assessment and work to prevent tobacco use among consumers of mental health and alcohol and drug abuse services.</li> </ul>
<p><b>Building Strong Systems of Care</b> ~ Access &amp; Coordination ~</p>									
<p><b>19. State-Local Infrastructure Development Plan:</b></p> <ul style="list-style-type: none"> <li>Establish a subcommittee to review current state and local cross-departmental initiatives, statutory mandates and department regulations.</li> <li>Propose recommendations to the full TWG and HSCC for an enduring state and local infrastructure to continue transformation efforts beyond the grant to include cross-departmental structure for consumer input.</li> </ul>	TWG	6.1 6.2 6.3	C	N/A	H	All	TBD	TBD	<ul style="list-style-type: none"> <li>TWG approved the creation of a sub-committee. The start-date was deferred – to be determined in the upcoming year.</li> </ul>

(See appendix for Legend of Abbreviations.)



<b>FFY 2010 Priority Actions</b>	<b>Lead Agency/Group and partners</b>	<b>Goal/Objectives</b>	<b>ACE Goal</b>	<b>Primary GPRA</b>	<b>Complexity</b>	<b>Target Population</b>	<b>Start Date</b>	<b>End Date</b>	<b>Progress – October 2008 through September 2009</b>
<p><b>20. Regional Planning Partnerships:</b></p> <p>Continue implementation of regional collaboratives that integrate mental health with overall local community health planning and initiatives.</p> <ul style="list-style-type: none"> <li>• Begin development of a sustainability plan and integrate planning with other key initiatives, including PACT (see Action #12) and Integrated Care initiatives.</li> <li>• Continue the next phase of the Eastern Region Behavioral Health Initiative to include Regional Health Commission (RHC) Access to Behavioral Healthcare Task Force recommendations, development of an access center and implementation of Regional Respect principles across organizations.</li> <li>• Implement Phase 2 of the Greater Kansas City initiative to include integrated care, plan for high users of care and completion of housing assessment/matrix and plan and Children's system enhancement project.</li> </ul>	<p>DMH OOT, TWG</p>	<p>6.2</p>	<p>C</p>	<p>3 4 5</p>	<p>H</p>	<p>All</p>	<p>Qtr. 1 2007</p>	<p>Qtr. 1 2009</p>	<ul style="list-style-type: none"> <li>➤ The Greater Kansas City Regional Initiative (GKCRI) completed a needs assessment and regional plan priorities in January 2009.</li> <li>➤ The GKCRI began implementation of a Housing Assessment and held a planning retreat to transform housing for persons with behavioral health needs.</li> <li>➤ The GKCRI was awarded a children's system enhancement project by DMH.</li> <li>➤ The Eastern Region Behavioral Health Initiative (ERBHI) completed Phase 3 work in 3 major initiatives (see Action items 21-23).</li> <li>➤ The ERBHI developed and implemented a plan for ongoing project financing.</li> <li>➤ The RHC established a high-level Access to Behavioral Health Task Force to develop systemic structure and financing recommendations to improve service access.</li> <li>➤ The RHC ERBHI integrated planning efforts with the DMH to develop a regional plan to expand access and community services in conjunction DMH PACT implementation.</li> </ul>

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<p><b>21. Improving Entry Project:</b> Service providers in the eastern region will develop a regional access center and implement a standardized screening tool across mental health and substance abuse providers in the region with the objective of increasing access to care. A subsequent evaluation will guide further refinement and potential for statewide expansion.</p> <ul style="list-style-type: none"> <li>Operationalize an access center plan to increase access to care. Evaluation will guide further refinement and potential for state-wide expansion.</li> </ul>	SLRHC Behavioral Health Steering Team, DMH OOT & Divisions of CPS and ADA	4.1	A E	2 4 5 7	M	MI ADA OA Adult	Qtr. 1 2008	Qtr. 3 2010	<p><b>COMPLETE - ongoing activity incorporated in Action # 20.</b></p> <ul style="list-style-type: none"> <li>65 individuals completed screening tool training workshops to increase provider knowledge of the new cross-agency screening system, common screening tool and regional database.</li> <li>20 mental health, substance abuse and health organizations implemented a common screening tool and data system.</li> <li>35 regional providers developed and adopted a Barriers Buster Release Form and Missouri Confidentiality Agreement to allow for the collection and analysis of screening data across organizations.</li> <li>A business plan for a regional Access Center was developed for the next Phase of work.</li> </ul>
<p><b>22. Coordinating Care for High Utilizers Project:</b> The Eastern Region Behavioral Health Initiative will develop and implement cross-agency “coordinated care plans” for identified high users of care in the Eastern region. The intent of the project — and any subsequent policy changes — is to improve care for consumers who utilize public health-care services at a high frequency due to limited care coordination and/or limited availability of treatment options.</p>	SLRHC Behavioral Health Steering Team, DMH OOT & Divisions of CPS/ADA	4.3	A E	1 4 5 7	M	MI ADA OA Adult	Qtr. 2 2009	Qtr. 3 2010	<p><b>COMPLETE - ongoing activity incorporated in Action # 20.</b></p> <ul style="list-style-type: none"> <li>Data was collected and analyzed to identify top service users in the region.</li> <li>15 programs participated in a cross-agency team to review data for high users and develop/implement care plan recommendations.</li> <li>Data collection and reporting was initiated to track outcomes.</li> </ul>

(See appendix for Legend of Abbreviations.)



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<p><b>23. Reducing Stigma and Increasing Cultural Competency Project:</b></p> <p>Continue roll-out of a project in the Eastern region to change the current culture of the health care system by addressing barriers to quality care related to stigma and cultural competency. Provide organizational consultation and seminars to implement regional respect policy guidelines with targeted organizations. Evaluation will guide statewide expansion in partnership with the MO Coalition of CMHCs.</p>	<p>SLRHC Behavioral Health Steering Team &amp; Workgroup, DMH OOT &amp; Divisions of CPS and ADA</p>	<p>1.1 2.3 3.2 5.1</p>	<p>A C E</p>	<p>1 2 7</p>	<p>M</p>	<p>MI ADA All</p>	<p>Qtr. 2 2008</p>	<p>Qtr. 3 2008</p>	<p><b>COMPLETE - ongoing activity incorporated in Action # 20.</b></p> <ul style="list-style-type: none"> <li>➤ 154 persons attended a three-part Cultural Conversation two-day seminar titled "Seeing the Person beyond the Label," which included both presentations and time to converse and brainstorm with other participants about respect and cultural competence related issues.</li> <li>➤ A Regional Respect Policy was adopted by the Regional Health Commission and by leadership across multiple health and mental health providers in the Eastern Region with commitment to implement/adapt principles within each organization.</li> </ul>
<p><b>24. Common State Identifier:</b></p> <ul style="list-style-type: none"> <li>• Complete assignment of Document Control Numbers (DCNs) to all DSS, DHHS and DMH consumers who currently don't have one.</li> <li>• Continue discussions with the Departments of Corrections and Elementary and Secondary Education to adopt the common identifier or a common methodology to link consumers within their systems to those in the other human service agencies.</li> </ul>	<p>OOA &amp; State Human Service Departments</p>	<p>5.4</p>	<p>A E</p>	<p>1 2 5</p>	<p>M</p>	<p>All</p>	<p>Qtr. 1 2009</p>	<p>Qtr. 2 2009</p>	<ul style="list-style-type: none"> <li>➤ Missouri state agencies (DSS, DHSS and DMH) have adopted common document control numbers (DCN) as a single state identifier to facilitate shared information across state agencies.</li> <li>➤ Staff has been trained on assigning DCNs to DMH admissions in accordance with procedures established with DHSS and DSS when the individual does not already have one.</li> <li>➤ There has been a 95% DCN assignment/match between DMH clients and other departments.</li> </ul>

(See appendix for Legend of Abbreviations.)



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<p><b>25. Eliminating Cultural Disparities:</b> A six-month study group will be established to review state data and perform environmental scan to</p> <ul style="list-style-type: none"> <li>Identify current cultural disparities in mental health in Missouri,</li> <li>Identify best practices and resources available within state and nationally to address disparities, and</li> <li>Formulate initial priority recommendations to TWG to consider for action.</li> </ul>	TWG, DMH	3.1	A C E	8	M	All	Qtr. 3 2009	Qtr. 2 2010	<ul style="list-style-type: none"> <li>Six-month Study Group approved by TWG.</li> <li>Scope of worked completed for group and technical consultant.</li> <li>Start-up planned for Fall 2009.</li> </ul>
<p><b>26. Cultural Disparities-Deaf Services Capacity Development:</b> DMH will continue to 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.</p> <ul style="list-style-type: none"> <li>Begin implementation of priorities as outlined on the approved Deaf Services Priority Matrix.</li> </ul>	DMH Office of Director	3.2	A C E	1 4 7	H	All	Qtr. 2 2009	Qtr. 3 2009	<ul style="list-style-type: none"> <li>A Deaf Services Advisory Committee was established as a collaborative initiative between the DMH and deaf community to identify and participate in tangible actions and tools that result in improved care and delivery of service for deaf Missourians who are suffering with mental illnesses.</li> <li>A Deaf Services Priority Matrix was reviewed and approved by the DMH leadership team.</li> </ul>
<p><b>27. Data Warehouse:</b> Identify the best solution to developing and housing an interagency data warehouse containing data from all state human service agencies to provide more accurate and timely information concerning individuals served across the agencies.</p> <ul style="list-style-type: none"> <li>Develop the interagency data warehouse.</li> <li>Begin with a children's services data warehouse and then expand across the lifespan.</li> </ul>	OOA & State Human Service Departments	5.4	A E	9	H	CF&Y All	Qtr. 3 2006	Qtr. 3 2011	<ul style="list-style-type: none"> <li>Discussions continue with other human service agencies, but no action has been taken as yet.</li> </ul>
<p><b>28. Electronic Records:</b> Based on an FY 09 budget item, evaluate, select and implement a bar-coding solution for electronic records in state psychiatric facilities. DMH will also continue to work with MO HealthNet (Medicaid) to coordinate development of an electronic Medical Health Record.</p>	DMH Division of CPS	5.4	A E	9	H	MI All	Qtr. 2 2009	Qtr. 1 2011	<ul style="list-style-type: none"> <li>DMH is in the process of developing a request for proposal for an electronic medical record, including provisions for interfacing with bar-code technology. The intent is to initiate the project at Fulton State Hospital, followed by expansion to the other long-term-care facilities.</li> </ul>

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<p><b>29. Employment:</b> The TWG-chartered Employment Workgroup will continue plan to implement employment strategies. Workgroup recommendations will be prioritized for implementation. The expanded supported employment program will be implemented.</p>	TWG	3.3	C	2 8	M	All	Qtr. 3 2008	Qtr. 4 2009	<ul style="list-style-type: none"> <li>➤ The workgroup sponsored a teleconference training on new regulations pertaining to the Ticket to Work program.</li> <li>➤ The workgroup submitted a set of recommendations to the Transformation Working Group for its consideration. Implementation feasibility and prioritization are now underway.</li> <li>➤ DVR applied for and received stimulus funding to expand evidenced-based supported employment to 3 additional sites in partnership with DMH.</li> </ul>
<p><b>30. Housing:</b> The TWG chartered the Housing workgroup to identify current resources and gaps in affordable and integrated housing and begin implementing housing strategies. The group will 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. Work includes:</p> <ul style="list-style-type: none"> <li>• Completion of a Housing plan.</li> <li>• Coordination with the MPC as they pilot an on-line housing resource, which includes a registry of affordable, accessible, integrated housing in Missouri, as well as resources to rent, buy or modify a home of one's own.</li> </ul>	TWG, DMH, MHDC, MPC	3.4	A C	1 8	M	All	Qtr. 3 2008	Qtr. 4 2009	<ul style="list-style-type: none"> <li>➤ The Housing workgroup has reviewed best practices nationally and in Missouri. Work continues on the development of a housing plan for people with disabilities.</li> <li>➤ The Housing resource website is up and running. The Missouri Planning Council for DD is hosting a series of information meetings around the state.</li> </ul>
<p><b>31. Statewide Expansion of Police Crisis Intervention Teams (CIT):</b> Building on the successful Police Crisis Intervention Teams initiated in the Greater Kansas City and St. Louis areas, work will continue to develop and implement CIT statewide in partnership with the Chief Justice Initiative.</p>	DMH Division of CPS, Office of State Courts Admin. Chief Justice Initiative	4.1	C E	2 3 7	H	MI All	Qtr. 1 2007	Qtr. 3 2009	<ul style="list-style-type: none"> <li>➤ Local CIT Coordinators report 20 jurisdictions implementing general orders.</li> <li>➤ 1,258 persons completed the 40-hour CIT training program.</li> <li>➤ Ongoing project support funding was secured for next year through DMH.</li> </ul>

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<p><b>32. Telehealth:</b> DMH Waiver amendments will be developed to include telehealth services for behavior analysis, behavior intervention specialist, behavior therapy and crisis intervention.</p> <ul style="list-style-type: none"> <li>Amendments to the existing waivers will be submitted to CMS for approval to provide these services via telehealth.</li> </ul>	DMH Division of DD	3.1 4.3	C	1	Low	DD All	Qtr. 4 2008	Qtr. 4 2011	<ul style="list-style-type: none"> <li>One waiver was submitted to the Centers for Medicare and Medicaid Services in March 2009 and approved in July 2009. Amendments to additional waivers are under development.</li> </ul>
<p><b>33. Mental Health Prisoner Re-entry:</b> The Department of Mental Health and the Department of Corrections will continue an agreement to provide pre-release intake/assessment, planning and transition activities for seriously mentally ill offenders from correctional facilities.</p>	DMH, Department of Corrections	4.3	C E	3 4 7	M	Adults/ All	Qtr. 1 2007	Qtr. 2 2009	<ul style="list-style-type: none"> <li>DMH and DOC developed an MOU to implement pre-release mental health services for DOC offenders.</li> <li>DMH made a financing policy change to allow providers to bill for pre-release services.</li> <li>To date, 19 mental health programs provide pre-release intake services for DOC clients.</li> </ul>
<p><b>34. Children's System of Care:</b> Expand principles and practices of the Children's System of Care (SOC) across child-serving entities.</p> <ul style="list-style-type: none"> <li>Expand the number of system of care teams statewide.</li> <li>Include system of care values and principles as a component of DMH contracts with child-serving agencies.</li> <li>Increase the number of SOC teams using and analyzing Quality Service Review data.</li> <li>Identify wraparound values/principles that all state child-serving departments can endorse. Once values/principles are developed and endorsed, departments will identify system and infrastructure changes necessary to support them.</li> <li>Incorporate planning for transitional youth.</li> <li>Finalize the DMH practice model for work with SOC teams.</li> </ul>	CSMT, Office of Child MH, All Child- serving State Agencies	2. 1 6.1	A C E	1 4 7	H	Youth/ All	Qtr 3, 2008	Qtr 3, 2011	<ul style="list-style-type: none"> <li>The Comprehensive System Management Team completed a strategic plan and presented it to the TWG with a focus on System of Care expansion.</li> <li>A DMH practice model was developed outlining cross-divisional roles and responsibilities in implementing SOC.</li> <li>The CSMT has been meeting to identify values/principles of wraparound. On Sept 24, John VanDenBerg and Kelly Pipkins-Burt from Vroon VanDenBerg LLP met with the CSMT along with other state child agency leaders to discuss what would be required to sustain a state infrastructure for wraparound.</li> <li>Criteria for designation of local system of care teams were reviewed/revise.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>35. Older Adult Workgroup:</b> This workgroup was chartered by the TWG to complete an operational plan for addressing mental health issues among the elderly population and to propose a management structure for ongoing monitoring and oversight of the operational plan. The group's plans are as follows:</p> <ul style="list-style-type: none"> <li>• Complete the operational plan and propose a management structure for ongoing monitoring and oversight of the operational plan.</li> <li>• Identify key stakeholders to propose the next steps in implementing a system of care plan in local communities.</li> <li>• Continue to provide direction to the Healthy IDEAS implementation team and in development of Community Coalitions.</li> </ul>	TWG	3.2	C	8	H	OA All	Qtr. 2 2008	Qtr. 2 2011	<p>➤ The Mental Health and Aging Workgroup completed an operations plan, proposed a structure for ongoing oversight, and developed recommendations for the TWG, including a proposal to implement Healthy IDEAS, an initiative to address depression in older adults (see Action # 8 description of Healthy IDEAS).</p>
<p><b>Building Strong Systems of Care</b> ~ Best Practices ~</p>									
<p><b>36. Evidence Based Practices Workgroup:</b> The Evidence-based practices Workgroup will finalize a white paper for public input. The TWG chartered a cross-cutting Evidence-Based Practice Workgroup to:</p> <ul style="list-style-type: none"> <li>• Establish an evidence ruler, with input from stakeholders.</li> <li>• Determine implementation methodology.</li> <li>• With information from divisions, compare current fund distributions to the ruler.</li> </ul> <p>An additional update was approved by TWG to identify, expand and track EBPs. Given the extensive number of EBPs being implemented, this was established as a separate action item (see # 37).</p>	TWG, EBP Workgroup	5.1 5.2 5.3 5.4 6.1 6.2	A E	8	H	All	Qtr. 3 2008	Qtr. 2 2010	<p>➤ The workgroup chairs drafted a white paper outlining guiding principles to consider when determining whether a practice is considered evidence based.</p> <p>➤ In addition, the group is tracking evidence-based practices currently being used in the department: ADA Dual Diagnosis Services, Assertive Community Treatment, Dialectical Behavior Therapy, Integrated Dual Diagnosis Treatment, Motivational Interviewing, Positive Behavior Supports, Recovery Services Implementation, Supported Employment Implementation, and Trauma Focused Cognitive Behavioral Therapy.</p>

(See appendix for Legend of Abbreviations.)



Missouri Comprehensive Plan for Mental Health  
Federal FY 2010 Action Plan Update

FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>37. Evidence-based Practices Implementation:</b> Evidence-based practice implementation will continue to be tracked, expanded and monitored to include policy and financing changes, # of programs implementing and trainings. A data system will be explored for uniform collection and tracking of programs and trainings.</p>	DMH	5.1 5.2	A E	1 2 3 4 5 7	M	All	Qtr.3 2008	Qtr.3 2011	<ul style="list-style-type: none"> <li>➤ 6 programs began implementing Assertive Community Treatment, Program and 136 staff. completed approved training</li> <li>➤ 36 programs began implementing IDDT services and 87 persons completed training.</li> <li>➤ 71 programs are implementing ADA co-occurring disorder services.</li> <li>➤ 1,750 providers have completed DBT initial training.</li> <li>➤ 6 programs are implementing supported employment services.</li> <li>➤ Multiple service financing policy changes have been made by DMH and MOHealthnet to support evidence-based services implementation.</li> </ul>
<p><b>38. Direct Care E-learning Core Safety Platform and Quality Management:</b></p> <ul style="list-style-type: none"> <li>• DMH will continue implementation of e-learning accounts for direct-care staff in all DMH facilities. Core training will be available on the web with safety as an important component.</li> <li>• SB 3 safety recommendations requirements will continue to be implemented.</li> </ul>	DMH	5.1	C E	1 2 3 4 5 7	M	All	Qtr. 2 2007	Qtr. 4 2009	<ul style="list-style-type: none"> <li>➤ Thirty (30) DMH facilities using the e-learning system and regularly tracking and analyzing training data.</li> <li>➤ DMH developed and implemented an Event Management Tracking (EMT) program to generate aggregate data and analyze safety-related incidents &amp; information.</li> <li>➤ A memorandum of understanding was established between DMH and Missouri Protection and Advocacy Services to clarify roles.</li> </ul>
<p><b>39. College of Direct Support:</b> DMH will continue training through the College of Direct Support (CDS) -- a web-based training for direct-support professionals currently being used by DD service providers The department will explore expansion of the College of Direct Support to other segments of Missouri's long-term-care system.</p>	DMH Division of DD, MPC, UMKC IHD, MACDDS, MARF, MO- ANCOR	5.1	E	8	M	DD All	Qtr. 4 2007	Qtr. 4 2011	<ul style="list-style-type: none"> <li>➤ To date, 2,613 staff members have enrolled in the CDS courses and 390 have completed the assigned courses and received certificates.</li> </ul>

(See appendix for Legend of Abbreviations.)



Missouri Comprehensive Plan for Mental Health  
Federal FY 2010 Action Plan Update

FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>40. Crisis Prevention and Response:</b> The Division of DD continues to phase in restructuring of regional offices, which began in 2008 and is anticipated to be a 3-5 year process. Partnerships with local county DD boards are increasing, which in-turn enables regional offices to enhance functions such as behavioral resource teams. Training for physicians is planned for FY 2010.</p>	DMH Division of DD	4.3	C	9	M	DD All	Qtr. 3 2008	Qtr. 3 2010	➤ A certified behavior analyst has been appointed to the division's central office and provides consultation and training to the regional offices. Habilitation centers are shifting away from long-term residential supports to crisis stabilization and short-term respite. Planning is underway for training for physicians who prescribe psychotropic medications to people with developmental disabilities.
<p><b>41. Trauma Informed Care:</b> An organizational assessment of trauma care will be completed. Workforce development and training needs will be identified and prioritized. Technical assistance will be secured and training implemented and evaluated.</p> <ul style="list-style-type: none"> <li>A training is scheduled for Oct. 1, 2009, that addresses developing trauma-informed agencies. The training has two components – one at the administrative track, the other on the clinical track. The goal is to create environments and service delivery systems that are trauma informed, which includes recognizing trauma and its impact in service planning and delivery. This training will be followed by technical assistance to agencies in providing trauma-informed care.</li> </ul>	DMH OOT & OCCMH	5.1 2.4	E	2	M	All	Qtr. 1 2007	Qtr. 4 2009	➤ 4 trainings and 6 monthly supervisory trainings on Trauma-focused Cognitive Behavioral Therapy were provided to 38 cross-organizational staff as part of the Juvenile Justice Initiative.
<p><b>42. Autism Treatment Services:</b> Autism Services planning is now being directed through the Council on Autism Spectrum Disorders. Final action in this plan was to develop a waiver for persons with autism spectrum disorders.</p>	DMH, MO Healthnet	3.1 4.2 5.2 6.2	C	1	M	DD All	Qtr. 4 2008	Qtr. 3 2009	<b>COMPLETED</b> ➤ The Center for Medicaid and Medicare Services approved Missouri's Autism Waiver application.

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>43. Consumer Operated Service Program (COSP) Quality Improvement Initiative:</b></p> <p>DMH will continue Phase 2 of a COSP Quality Improvement Initiative to continue self -assessment of fidelity for COSP services. Objectives:</p> <ul style="list-style-type: none"> <li>Expand Fidelity Assessment Common Ingredient Tool (FACIT) training to all COSPs.</li> <li>Train a peer evaluator team to implement FACIT at local COSPs.</li> <li>Continue implementation of Supporting Consumer Operated Programs Enhancement (SCOPE) leadership network.</li> </ul>	DMH Division of CPS, MIMH	2.2	A E	1 2 4 5 6 7	M	MI Adult OA	Qtr 4, 2006	Qtr 3, 2011	<ul style="list-style-type: none"> <li>➤ Thirty (30) staff members representing Consumer-operated Drop-in Centers completed prescribed training in FACIT in 2008 to conduct fidelity self-assessment of their programs.</li> <li>➤ DMH has formally adopted the COSP as an evidenced-based practice to be fully incorporated into the service delivery system to promote well-being and recovery.</li> <li>➤ A FACIT fidelity review scale for consumer-operated warm-lines has been developed and tested.</li> <li>➤ New contract requirements were established for the use of FACIT for all COSPs.</li> <li>➤ The statewide leadership network (SCOPE) held regular meetings/tele-conferences to advance best practices statewide.</li> </ul>
<p><b>44. Positive Behavior Support Training:</b></p> <p>Positive Behavior Support (PBS) is a set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment.</p> <ul style="list-style-type: none"> <li>Positive Behavior Support training will be provided to the mental health workforce to increase skills in serving persons with dual DD and MI diagnoses.</li> <li>Utilize certified trainers to expand knowledge of the principals and practices of positive behavior supports.</li> </ul>	DMH Division of DD	2.3 5.1 5.2	C E	2	M	MI DD All	Qtr. 4 2008	Qtr. 4 2010	<ul style="list-style-type: none"> <li>➤ To date, 58 persons have completed an 11-day trainer-credentialing process, certifying them to provide a 3-day PBS training course to direct-support professionals, service coordinators, and other DD professionals, as well as conducting the 11-day trainer-credentialing course.</li> <li>➤ 341 persons have completed the 3-day training.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>45. Recovery Management for People with Substance Use Disorders:</b></p> <ul style="list-style-type: none"> <li>• Develop and operationalize a plan to shift the focus of care from program-centered episodes of assess, admit, treat and discharge to management of long-term recovery.</li> <li>• Treatment will become a long-term relationship which supports development of recovery maintenance skills, flexible service menus, delivery methods, and intensity.</li> <li>• These principles and values include:               <ul style="list-style-type: none"> <li>• Emphasis on resilience and recovery processes as opposed to pathology and disease processes;</li> <li>• Recognition of multiple long-term pathways and styles of recovery;</li> <li>• Development of highly individualized and culturally sensitive services;</li> <li>• Increased collaboration with diverse communities of recovery; and</li> <li>• Commitment to best practices and the National Institute on Drug Abuse “Principles of Drug Addiction Treatment.”</li> </ul> </li> </ul>	Division of ADA	4.3	A C E	1 7 8	M	ADA All	Qtr. 1 2009	Qtr. 2 2011	<ul style="list-style-type: none"> <li>➤ The ADA SAC Treatment Committee has developed criteria for Centers of Excellence for treatment providers; SAC Prevention Committee is developing criteria for prevention programs to be considered Centers of Excellence.</li> <li>➤ The Division is making changes to its service delivery model to give providers greater flexibility in order to individualize treatment.</li> <li>➤ A new service category will be implemented on 10-1-09 that allows providers to offer brief interventions, education, and behavioral health consultation.</li> <li>➤ Draft White Paper, "Recovery Oriented Systems for the Prevention and Treatment of Substance Use Disorders" has been shared with members of the SAC, Missouri Recovery Network and other stakeholders for comments. Final report will be available in early 2010.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<b>Promoting Real Voices Real Choices</b> ~ Self-Determination ~									
<b>46. Person-Centered Planning:</b> Enhance Person-Centered Planning within the Division of DD and implement Person-Centered Planning principles and processes within the CPS provider system. <ul style="list-style-type: none"> <li>• Issue a policy affirming person-centered values as the foundation for the entire mental health services system.</li> <li>• Conduct training for all staff, including administration and direct support, on person-centered thinking/philosophy, followed by training on person-centered planning.</li> <li>• Provide access to mentors to facilitate person-centered planning and implementation of plans.</li> </ul>	DMH Divisions of DD and CPS & UMKC Institute for Human Development	2.1 2.3 2.4	E	2	H	MI DD All	Qtr. 2 2008	Qtr. 4 2009	<ul style="list-style-type: none"> <li>➤ A Person-Centered Leadership Training was held for 67 individuals. The training provided a high-level overview of Person-Centered Planning, helped align Evidence-Based Practice initiatives, determined an action plan and assured that transformation is occurring at all levels.</li> <li>➤ A total 508 members of the mental health workforce have received training.</li> <li>➤ A two-day Wellness Recovery and Action Planning (WRAP) was provided to 26 Peer Specialists and an additional 48 staff with the goal of helping others to self-direct their treatment planning process.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>47. Self-Directed Supports and Services:</b> In an effort to enhance self-directed care for persons with developmental disabilities, DMH made application to amend its DD Medicaid Waivers to include self-directed care as an option.</p> <ul style="list-style-type: none"> <li>Continue to provide outreach and training to service coordinators, consumers and families regarding choices, risks and benefits of self-directed options to enable informed decisions to self-direct.</li> <li>Explore methods to expand self-directed options to other services.</li> </ul>	DMH Division of DD, MPC, UMKC IHD	2.1	E	8	M	DD All	Qtr. 1 2007	Qtr. 3 2011	<ul style="list-style-type: none"> <li>All waivers were approved for addition of self-directed care.</li> <li>A training curriculum was completed and 272 individuals received training on the options.</li> <li>The division contracted with ASI Works to provide fiscal management services in 2008. ASI Works provides access to insurance and workman's compensation for staff hired by consumers or family. DD staff and self-advocates are now able to manage services online.</li> <li>The Division of DD has established an advocacy specialist position in each of its 12 Regional Offices to be liaisons with the community, provide training to families and self-advocates about self-determination and provide input to the division on policies that promote independence and self-determination.</li> </ul>
<p><b>48. Network of Care Personal Folder:</b> Continue to Increase consumer use of the Network of Care web site and personal folder options through training of local consumer leaders affiliated with mental health organizations to assist other consumers in accessing and using the system, including use of personal folders.</p>	DMH, Local MH providers	1.1 2.1	C	2 7	M	MI DD All	Qtr. 2 2007	Qtr. 3 2009	<ul style="list-style-type: none"> <li>Four consumers from mental health organizations received training to assist other local consumers with accessing the Network of Care web-based system and use of personal folders.</li> </ul>
<p><b>49. Consumer Principles for Practice Workgroup:</b> Charter a 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.</p>	TWG	2.1	E	N/A	L	All	Qtr. 3 2009	Qtr. 3 2011	<ul style="list-style-type: none"> <li>A charter was drafted for consideration for presentation to the Transformation Working Group at the Sept 30 meeting.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>50. Procovery®:</b> Continue statewide implementation of the Procovery® program, developed by Kathleen Crowley, author and Executive Director of the Procovery Institute</p> <ul style="list-style-type: none"> <li>Implement a new contract and begin scaling services using facilitators in good standing and developing sustainability at the state level.</li> </ul>	DMH Division of CPS & OOT	2.3	C E	1 2 3 7	M	All	Qtr. 4 2007	Qtr.3 2009	<ul style="list-style-type: none"> <li>Introductory and facilitator training were completed; 257 persons completed Procovery Circle facilitator training.</li> <li>Facilitators received provisional licenses.</li> <li>Sixty-six (66) circles were in operation as of March 2009.</li> <li>A new contract was developed for continuation of the Procovery program.</li> <li>Service billing mechanisms were established for Procovery Circles delivered as a component of CPS enhanced psychosocial rehabilitation services.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<b>Promoting Real Voices Real Choices</b> ~ Workforce Development ~									
<b>51. Peer Specialists Training and Certification:</b> Continue training primary consumers to provide direct services within the CPS provider network using a training and certification model developed by Larry Frick/ Appalachia. <ul style="list-style-type: none"> <li>Continue development of a Peer Specialist Support Network.</li> <li>Continue development of Missouri Trainers.</li> <li>Review rules, regulations and certification standards and modify or develop new rules as needed.</li> <li>Develop a mechanism for Peer Specialist Training to support Services to be provided as a DHE approved proprietary school.</li> <li>Work with the Veteran's Administration to establish a joint training partnership.</li> </ul>	DMH Division of CPS & OOT	2.2	C E	1 2 3 4	M	MI Adult	Qtr. 4 2006	Qtr. 2 2011	<ul style="list-style-type: none"> <li>Three trainings have occurred: 90 consumers have completed the training statewide and 48 have been certified.</li> <li>Twenty-eight (28) supervisors have completed supervisory training.</li> <li>Additional peer specialist trainers have been trained.</li> <li>The Mental Health America of the Heartland submitted an application for proprietary school certification.</li> </ul>
<b>52. Family Support Training:</b> Family Support Training provides participants – including parents of children with mental illnesses – the core competencies and skills sets to become Family Support Providers (FSP) within the comprehensive children's mental health system statewide. <ul style="list-style-type: none"> <li>DMH will continue to provide training for family support provider trainees and their supervisors.</li> <li>Quarterly in-service trainings will be scheduled for continuing education.</li> <li>The DMH will develop policy and propose a rule change to incorporate family support into the service delivery system for youth.</li> </ul>	DMH OCCMH & Division of CPS	2.2	C	1 2 3 7	M	MI CY&F	Qtr. 2 2007	Qtr. 3 2010	<ul style="list-style-type: none"> <li>A second round of two-part training occurred in January and March of 2009. Training of supervisors was incorporated into the trainings.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<b>Promoting Real Voices Real Choices</b> ~ Leadership ~									
<p><b>53. Consumer/Family and Youth Leadership Summit:</b> Hold a Consumer, Family and Youth (CFY) Leadership summit to facilitate CFY leader dialogue, education and information-sharing across populations and lifespan that results in:</p> <ul style="list-style-type: none"> <li>• Improved understanding of issues related to the different population and age groups, and knowledge of existing CYF resources currently available;</li> <li>• Identification of mutual goals and sharing strengths across populations and lifespan; and</li> <li>• Identification of priorities for a common agenda that promotes a CFY driven system and next steps that include focus areas/tracks for a 2009 Statewide Conference.</li> </ul>	DMH and TWG	2.1 2.2 2.3 2.4	A C E	2 8	L	All	Qtr. 3 2008	Qtr. 3 2008	<p><b>COMPLETED</b></p> <ul style="list-style-type: none"> <li>➤ The results of the summit, held in November 2008 produced a subsequent action item to establish a statewide consumer conference in 2009 and build the infrastructure for an annual conference. A conference planning committee was formed to plan the first conference. (See Action item #54.)</li> </ul>
<p><b>54. Consumer/Family and Youth Leadership Conference:</b> Establish a committee of consumers to plan and implement an annual Consumer/Family/Youth conference. Based on recommendations of the Consumer, Family, and Youth Leadership Summit, the conference will focus across consumers, family, and youth of all the populations served by the DMH and across age span.</p> <ul style="list-style-type: none"> <li>• A new conference planning committee will be formed.</li> <li>• Attendance goal set for the 2010 conference of 500-600 participants.</li> </ul>	DMH and TWG	2.1 2.2 2.3 2.4	A C E	2 6 8	L	All	Qtr. 3 2008	Qtr. 4 2011	<ul style="list-style-type: none"> <li>➤ Missouri's first statewide Consumer, Family and Youth Leadership Conference was held August 2009, with 304 individuals in attendance, which exceeded the conference attendance goal.</li> <li>➤ Scholarships for attendance were provided to 88 consumers.</li> <li>➤ A new conference committee has been formed to plan for the 2010 conference.</li> </ul>

(See appendix for Legend of Abbreviations.)



<b>FFY 2010 Priority Actions</b>	<b>Lead Agency/Group and partners</b>	<b>Goal/Objectives</b>	<b>ACE Goal</b>	<b>Primary GPRA</b>	<b>Complexity</b>	<b>Target Population</b>	<b>Start Date</b>	<b>End Date</b>	<b>Progress – October 2008 through September 2009</b>
<p><b>55. Transitional Youth-Statewide Youth Network Development:</b> Continue development of a cross-state representative statewide youth organization comprised of both consumers and other youths interested in mental health, substance abuse and developmental disability issues.</p> <ul style="list-style-type: none"> <li>Develop a strategic plan for creation of a formal statewide leadership network.</li> </ul>	<p>TWG</p>	<p>2.1 2.2 2.3 2.4</p>	<p>A C E</p>	<p>4 6</p>	<p>L</p>	<p>Youth All</p>	<p>Qtr. 4 2009</p>	<p>Qtr. 3 2011</p>	<ul style="list-style-type: none"> <li>A Youth advisory group has been established to provide a voice for young people in mental health policy.</li> <li>An initial plan was developed and approved by the group.</li> <li>A name (Missouri Youth REACCH – Responding through Empowerment and Action to Create Communities of Hope), logo and mission was developed.</li> <li>The group established a Facebook page as part of Children’s Mental health Awareness Week.</li> </ul>
<p><b>56. Peer and Family Participation in Certification, Monitoring and Quality Service Reviews:</b></p> <ul style="list-style-type: none"> <li>Implement guidelines developed by the CPS State Advisory Council to include peers and family members in the monitoring and certification of CPS funded community-based programs.</li> <li>Provide additional family training for participation in Quality Service Reviews (QSR) conducted at local system of care sites for children.</li> <li>Quality of life surveys will continue to be conducted through the DD Division’s Money Follows the Person (MFP) initiative for each individual transitioning from a habilitation center to the community, and by the Self Advocates and Families for Excellence (SAFE) program for individuals residing in the community. MFP surveys are conducted prior to leaving the facility as well as 1 year and 2 years after transitioning. Surveys for both initiatives are conducted by family members and self advocates.</li> </ul>	<p>DMH Divisions of CPS &amp; DD, OCCMH, CSMT</p>	<p>2.4 5.4</p>	<p>A E</p>	<p>9</p>	<p>M</p>	<p>MI DD All</p>	<p>Qtr. 1 2008</p>	<p>Qtr. 3 2011</p>	<ul style="list-style-type: none"> <li>The Division of CPS has implemented guidelines to include peers and family members in the monitoring and certification of CPS funded community-based programs. Consumers participated in four certification site visits this past year.</li> <li>Training continues to be provided for families to participate in Quality Service Reviews. 23 persons were trained, including family members and 4 System of Care site visits were completed by trained team members.</li> <li>MFP reports 101 transitions from the habilitation center to the community for the DD population and 211 quality of life surveys completed on all target populations. SAFE reports 22 surveys completed, two being scheduled, and six pending consent for visit from the individual or a guardian. To date, there are 53 individuals trained in the SAFE program and nine others either waiting to be trained or working to complete paperwork.</li> </ul>

(See appendix for Legend of Abbreviations.)



FFY 2010 Priority Actions	Lead Agency/Group and partners	Goal/Objectives	ACE Goal	Primary GPRA	Complexity	Target Population	Start Date	End Date	Progress – October 2008 through September 2009
<p><b>57. Quality Service Review (QSR):</b> The quality service review is a tool that measures the quality of interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided. Plans for FY 08 and 09:</p> <ul style="list-style-type: none"> <li>• Baseline data will be obtained from the 11 system of care sites and follow-up QSR will be conducted for mature sites.</li> <li>• Increase the number of local system of care teams using Quality service review (QSR) data.</li> </ul>	DMH OCCMH & Division of CPS & CSMT	2.4 5.4 6.3	A E	2 5	M	MI All	Qtr. 3 2006	Qtr. 2 2009	➤ Four local system of care teams are using Quality Service Review (QSR) data as part of follow-up site visits.

(See appendix for Legend of Abbreviations.)



## Appendix

### Legend of Abbreviations used in Action Plan

**ACE Goals-measures of anticipated long-term impact**

- A-Improved Accountability
- C- Increased Service Capacity
- E-Increased Service Effectiveness

**GPRA Goal-measures of infrastructure changes completed:**

- 1= Policy Changes Completed
- 2= # of Persons in Workforce Trained
- 3= Financing Policy Changes Completed
- 4= Organizational Changes Completed
- 5= # of Organizations that Regularly Obtain and Analyze Data
- 6= # of Members in Consumer and Family Run Networks
- 7= Programs Implementing Practices Consistent with CMHP
- 8= Separate Evaluation Process
- 9= To Be Determined

**Target Populations:**

Persons served across agencies and/or systems that are at risk for or experiencing:

- MI = Mental illness
- ADA = Addictions
- DD = Developmental Disabilities

Note: This also covers the general public and service providers.

Age Group:

- CY&F = Children, Youth and Families
- A = Adults
- OA = Older Adults

**Complexity of Implementation:**

L = Low - action will be completed with ease during established timeframes

M= Medium - major components of action will be realistically achieved over course of plan timeframe/grant period resulting in significant progress to achieving overall objective

H= High - Action will require multiple years that will likely extend beyond plan timeframe

**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  
 DHE – Department of Higher 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  
 HSCC – Human Services Cabinet Council  
 MACDDS – Missouri Association of County Developmental Disabilities Services  
 MARF – Missouri Association of Rehabilitation Facilities  
 MHDC – Missouri Housing Development Commission

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  
 MOU – Memorandum of Understanding  
 MIMH – Missouri Institute of Mental Health  
 MPC – Missouri Planning Council  
 DD – Division of Developmental Disabilities  
 OCCMH – Office of Comprehensive Child Mental Health  
 OOA – Office of Administration  
 OOT – Office of Transformation  
 PACs – Parent Advisory Council  
 SAC – State 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

(See appendix for Legend of Abbreviations.)



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