Report to the Governor on

building a safer mental health system

issues and recommendations

Prepared by:

The Missouri Mental Health Commission

MISSOURI DEPARTMENT OF MENTAL HEALTH

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Department of Mental Health
PO Box 687
Jefferson City, Missouri 65102
MHCommission@dmh.mo.gov

Phone: 573-751-4122
Toll Free: 800-364-9687
TT Phone: 573-526-1201
Fax: 573-751-8224

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Acknowledgement

The Mental Health Commission gratefully acknowledges the time, effort, and commitment of all those who came forward at the Commission's public hearings to share their views on improvements that would result in a safer, more accountable mental health system.

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Foreword

In November 2005, Michael Pallme, a resident of Northwest Habilitation Center in St. Louis, died from complications resulting from swallowing part of a pen. In March 2006, Rudy Wallace, also a resident of Northwest Habilitation Center, died from scalding burns suffered at the center. The magnitude of these tragedies, and the extent to which they might reflect ongoing safety risks in the DMH system are poignantly summarized in a letter from Senator Joan Bray published in the St. Louis Post-Dispatch on April 13, 2006:

> "*I was shocked and saddened by the news of the recent deaths of two of my constituents, Rudy Wallace and Michael Pallme…The fact that these two men died in the same care facility within such a short span of time should be enough to throw up every red flag and trip every alarm in state government. These deaths bring to light other incidents…in which overworked, underpaid staff function in circumstances that breed the climate for negligently inadequate care, abuse overlooked by supervisors, and the rights and dignity of residents ignored…**We must take it upon ourselves to see that the significance of these tragedies is not lost in the haze of politics.** The state must seriously re-evaluate how we go about the inviolable task of providing for those who rely on our care. Every one of us must be able to go to sleep at night satisfied that we have done all in our power to ensure the highest quality of life and safety for the people entrusted to the Division of Mental Retardation and Developmental Disabilities. The state's most basic and sacred duty is the protection of the well-being of the weakest among us…"*

The Commission's response to these tragic events was to solicit comprehensive information on the full array of potential contributing factors (direct and indirect) to lapses in safety in our system.

First, was to ensure that an appropriate and comprehensive set of internal and external investigations was pursued, in order to understand as fully as possible what contributed to these specific incidents. It is important to note that the Department was asked to suspend its internal investigation of the Wallace tragedy pending completion of a full police investigation, details of which have not yet been made available to the Commission. The Commission has been apprised of the results of a comprehensive external investigation* of Northwest Habilitation Center that was focused on these incidents and on conditions at the Center surrounding these events—the findings contributed to a number of corrective measures that have already been implemented by the Department (see Appendix D) and informed the Commission's recommendations for building a safer system, detailed below.

Second, in consideration of broader systems issues that relate directly or indirectly to the safety of consumers of MRDD services, the Commission was apprised of an in-depth review of the Division's Regional Centers, which was conducted in May, 2006. Details on the findings from this review are provided in Appendix A.

(*conducted by The Columbus Organization, http://www.columbusorg.com)

Following assurance that the appropriate internal and external investigations were being pursued and after reviewing numerous preliminary reports, the Commission sponsored a series of public hearings to identify concerns of DMH stakeholders and to garner their input regarding needed changes and improvements to address those concerns.

Through this series of six public hearings across the state and solicitation of written testimony, the Mental Health Commission specifically asked the following: What specific steps can DMH take to better assure the safety of consumers and improve the quality of services and supports they receive? Should the scope of services and supports offered by DMH be redefined? Which of the existing services and supports should be expanded, modified or discontinued? Which functions should be maintained at the highest levels of priority within the overall mission of DMH?

Public Hearing Site	**Date**
St. Louis	May 1, 2006
Kirksville	May 3, 2006
Columbia	May 10, 2006
Cape Girardeau	May 15, 2006
Springfield	May 18, 2006
Kansas City	May 23, 2006

Based on this input, information gathered from all of the above sources, and on those summarized in the appendices of this report, the Commission is aware of a number of potential contributing or causal factors, which need to be addressed in order to improve safety for persons receiving DMH services.

This report addresses the overarching safety and care issues identified in the aftermath of the Pallme and Wallace deaths, incorporates public input from Commission-sponsored hearings and provides recommendations regarding issues that may compromise the safety and well being of Department consumers. The Missouri Mental Health Commission feels these recommendations are critical to achieving a mental health system that prioritizes safety and accountability as its primary responsibilities.

Although not specifically outlined in this report, the Commission recognizes that over the past five years both wise and difficult decisions were made to cope with a shrinking relative budget. The focus of this report is to identify problems that need to be addressed. Thus, the critical nature of this report should not be taken to indicate that it represents the totality of the Commission's perspective on the department. The report serves as a vehicle for offering a number of recommendations that the Missouri Mental Health Commission feels are critical to achieving a safer, better managed mental health system.

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Recommendations for Building a Safer System

There are many responsibilities of the leadership of DMH. They include full and accurate characterization of the needs of the State's mentally ill, management of an approximately one billion dollar budget, and balancing the direct provision of service with the delegation of authority to provide service more efficiently, across the disparate domains of substance abuse, developmental disability, and psychiatric care. First, however, is the charge represented by the oath of every physician in the system: to do no harm (*primum non nocere*). In the case of the leadership of DMH, this requires the establishment of a comprehensive system of safety measures, the securing of adequate resources to apply and maintain those measures, and the promotion of immediate and reliable communication of the inevitable breakdowns that occur in any system run by humans.

The Missouri Mental Health Commission recommends the following:

1. **Accreditation of all habilitation centers should be pursued immediately**. The level of accreditation should be commensurate with complex medical and mental health needs of persons that utilize these facilities. This includes provision and oversight for medical personnel and for training of staff to manage mentally ill patients. Similarly, an appropriate and feasible method for accrediting those community service providers who have not yet achieved accreditation must be pursued.

2. **Information management methods must be implemented to rapidly and effectively track critical data on abuse, neglect and safety information**. This means that all such data is organized in such a way that clusters of incidents are readily identifiable and reviewed by a member of the executive team. A dedicated information management staff should be appointed with responsibility to maintain surveillance over these events. If it is possible to dovetail this system with CIMOR (*Consumer Information Management and Outcomes Reporting*, the department's new management information system), it will be ideal since safety information and other indices of quality and utilization of care will allow for powerful resolution of weaknesses in the system. A critical aspect of the management of abuse, neglect and safety information must be to cross-refer data that is acquired in primary reporting systems with that acquired through back-up systems (see #4 below), to ensure integrity of the flow of control information.

3. **There must be a proper balance of investigative responsibility that incorporates external resources (such as law enforcement, outside consultants, or other Missouri departments, etc.) to supplement internal investigation functions.** Internal and external investigative functions in combination yield the best results maximizing the benefits of both. The primary responsibility for investigation of most serious incidents related to abuse, neglect or client safety should be placed with external review mechanisms to eliminate the appearance of a conflict of interest.

RESPECTIVE BENEFITS OF INTERNAL / EXTERNAL INVESTIGATION

Internal	External
o Specialty Expertise o Operational knowledge of systems o In some cases, enhanced ability to establish trust of consumer for interviews o Line authority and accountability for rapid responses/fixes, if needed	o Objectivity, no conflicts o Consumer Advocacy o Transparency o Public Trust
Shared commitment to safety as first priority	

4. **Every DMH facility and residential service provider must be held responsible for instituting and monitoring a fail-safe methodology for timely reporting of crucial incidents to Central Office. Such methods should include clear duality in the pathways through which this critical information flows.** The submission of dual reports (one to facility leadership, the other to DMH Central Office), even if highly summarized (e.g., a mailed or electronically-submitted communication card), would allow for surveillance over the appropriate handling of such reports, and would protect against the information being dismissed or sequestered by administrators. All staff should be educated regarding the pathways of flow of the information. Thresholds for moving information to higher levels of authority must be clarified system-wide and specific protocols for reporting abuse and neglect information to the Mental Health Commission should be established.

5. **The Department of Mental Health must separate the internal authority for investigative procedures from its legal counsel**, in order to alleviate the inherent conflict of interest that is created when those who are charged with protecting the Department's legal interests are simultaneously charged with investigative authority.

6. **The Department of Mental Health should aggressively support and facilitate the creation of legislation to allow for non-confidential information regarding abuse and neglect to be made public.** The information should be analyzed and structured for ease of use by stakeholders, similar to formats used in public financial statements or annual reports. However, the department must be diligent in its analysis and presentation of the data to assure that it is fair, accurate, and respectful of the privacy of consumers and their families.

7. **As a matter of policy, a fixed proportion of facility operating expenses should be set aside for the exclusive purpose of supporting continuing education and training of staff.**

8. **A system needs to be implemented by which supervisors are consistently held responsible for the actions of staff under their supervisory authority. Supervisors must also be accountable for information gathered by ombudsman related to the**

quality of service, their professionalism and the appropriateness of their human interactions with co-workers and clients.

9. **Consumers, families and their advocates should have access to both an internal and external designated ombudsman whose responsibility is to independently collect complaints and reports of incidents, to preliminarily investigate those reports, and to provide summaries of its findings to both the executive team of the Department of Mental Health and to Missouri Protection and Advocacy**. In addition, dedicated telephones should be readily available to consumers to allow unrestricted access for reporting to ombudsmen.

10. **All deaths in DMH-funded facilities should be reported to a coroner or medical examiner**. In addition, a dedicated DMH workgroup supervised by the executive team should review all deaths on a weekly basis and communicate any and all suspicious circumstances to the executive team.

11. **The Department of Mental Health must explore multiple options for external review and involvement of family and natural supports in all aspects of service delivery.** Facilitated by principles of open public disclosure and quality improvement, the department should provide meaningful venues for feedback and input.

12. **The relationship between regional centers and community service providers must be clarified, and their work integrated to achieve efficiency and improve both accountability and quality of care.** This will help address a problematic trend in which each presumes that control over programming lies with the other; the result of which is that effective leadership and decision-making are undermined.

13. **Establish minimum requirements for facility directors to be present during night and weekend shifts in their respective facilities, as well as minimum requirements for unannounced site visits to all facilities.**

14. **Clear expectations must be maintained at all times about which incidents are reported to police, and surveillance of reporting to police (via cross-referencing of incident information and police reporting) must be maintained by DMH Central Office.** A uniform protocol for interface with law enforcement must be established, based on legal precedent, and enforced.

15. **The Department of Mental Health and the Governor must make a clear and unequivocal commitment to providing a <u>continuum</u> of facility and community-based services that afford real choices to all Missourians who require DMH services.** The experiences of other state departments of mental health in the U.S. have demonstrated that there are clients with specific profiles of disability and or medical/psychiatric co-morbidity, who may be better served in dedicated centers than in community settings. Fear regarding loss of this option is a divisive element in undermining unified advocacy for severely-affected individuals served by DMH. Partnership with agencies that provide up-to-date information to consumers and their families about quality residential services should be actively cultivated, and clients and their families should be assisted in the decision making process through a combination of

individualized services: one-to-one mentoring, education regarding housing and provider resources, Medicaid training and advocacy, and support groups.

16. **When funding is inadequate to provide service, the scope of service must be reduced, the public informed, and the decisions about service reduction/prioritization should rest with the director of the department.** Such decisions should not be thrust upon the Regional Centers to "make do" with the money that is available.

17. **The Mental Health Commission strongly supports flexible funding options, including the full implementation of *Olmstead*, which mandates that funding follow the consumer, allows their choice of support providers, including allowing families to care for their loved ones in their own homes utilizing natural supports.**

18. **The Department Director must augment the executive team in such a way that it improves inter-divisional communications, with adequate staffing to carry out the overarching mission of the Department of Mental Health.**

19. **Video camera surveillance should be strongly considered for all DMH facilities.**

20. **The Department should facilitate the development of drug and mental health courts which serve as a diversion from incarceration and have begun to successfully combine treatment with rehabilitation.**

21. **Crisis Intervention Training (CIT) should be further expanded in the state as a method to prevent persons with mental illness from being inappropriately placed in the criminal justice system.** Police CIT teams can also prevent suicides and physical harm through intervention.

22. **The Department must develop a comprehensive plan, including adequate staffing, for addressing the unique mental health needs of aging DMH clients.**

23. **The DMH budget must stabilize, recover (to compensate for relative losses suffered over the past decade), and be further supplemented to implement these recommendations**. This will require legislative action. The "wait list" for MR/DD services, unavailability of appropriate inpatient and residential beds in the Division of Comprehensive Psychiatric Services (CPS), and inordinate delays in availability of treatment for ADA clients, represent a direct result of inadequacy of funding. In the interim, given the fact that these recommendations relate to abuse, neglect and safety, if it becomes apparent that adequate levels of funding are not available, we recommend a constriction of DMH services in order to direct funds to these critical efforts. The maintenance of safety must be an absolute priority in our system

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PUBLIC TESTIMONY

The Mental Health Commission appreciates the time, effort, and commitment of those who came forward at the hearings to share their views on improvements that would result in a safer, more accountable mental health system. The Commission recognizes the hardship undertaken by many who traveled long distances at personal expense, shared emotional and personal experiences in a public context, and required accommodations to participate such as respite, interpreter services, or personal care assistance.

The testimony offered has been given serious consideration by the Mental Health Commission. It has been and will continue to be utilized to find ways to better serve all Missourians requesting or receiving mental health services. In reviewing the summary information included in this report, the reader should keep in mind that:

Attendance at most locations was excellent. Testimony was sincere and was moving. At times, Commissioners and the audience were spellbound by the life stories and situations that were shared by loving and caring families and caregivers. Commissioners and staff heard experiences both good and bad. Some heart wrenching others inspirational. Testimony for some was clearly an opportunity to be openly heard in public. For others, to speak in front of an audience was daunting and overwhelming. They are to be recognized for their courage and commitment.

The Commission has used (and will continue to use) the testimony to find ways to better serve all Missourians. It is further understood that the praise or criticism offered in testimony depended to some degree on the experience with the Department. A majority of the testimony came from those served by the Division of Mental Retardation & Developmental Disabilities; a smaller number spoke on issues regarding the Division of Comprehensive Psychiatric Services and Division of Alcohol and Drug Abuse. All testimony from the public hearings was either audio taped, submitted in writing, or both; it is archived at the central offices of the Department of Mental Health. What became apparent to the Mental Health Commission over the course of the hearings were a number of common themes, a summary of which is as follows:

Safety

Family members discussed many concerns, foremost they wished for their child (adult/child) to be safe. Fears about safety both in facilities and in the community were expressed. Families throughout the state offered positive comments regarding habilitation centers and stressed that their loved ones were safer, better supervised and the care was more consistent in state operated facilities. The message to the Mental Health Commission was the need for continuing to finance state operated programs. Families commented on specific habilitation centers and highlighted the loving care and safety they felt regardless of issues being showcased in the press.

Reservations were expressed about the Department investigating itself in the process of investigating abuse and neglect issues.

Training and salary were issues for direct care workers. Comments were provided that with better pay and more training, the safety of consumers would be assured. This underlying thread of issues was true in community settings as well as state operated programs.

The system needs to be coordinated so that when problematic events occur in residential placements in the community or in facilities, the parents, families, and guardians of all individuals residing in those facilities must be notified.

Other themes emerged regarding safety:

- Availability of phones at facilities to contact Missouri Protection & Advocacy
- Staffing after hours and weekends are a concern
- Bad staff should not be retained or rehired.
- A "Code of Silence" creates an unsafe atmosphere.
- Lack of day programs
- Staff needs training in anger management
- Staff "cover ups" should not be allowed
- Nursing homes should not be used unless medically necessary.
- Budgets need to be increased to insure pay raises, training and cost of care

Habilitation Centers

Each habilitation center was highlighted for uniqueness. Families with loved ones in the habilitation centers praised the good work of staff and the leadership provided at the facilities.

Testimony was given at each hearing stressing the importance of the habilitation centers for the mental health system. The state should not be closing habilitation centers. Families believe that not all individuals can live in the community successfully and habilitation centers are a needed safety net.

Protection & Advocacy staff and others testified that such centers should be closed, but also raised the question whether the Department of Mental Health has a clear plan for resettling clients. There should never be a forced movement into the community and families should be involved at every step and decision point.

Community Programs

Families who wanted their loved ones to live in the community were grateful for services provided by Regional Centers. Several parents were able to keep their family member at home but felt they should be compensated for the care. "Dollars should follow clients".

Speakers in Kirksville were almost unanimous in their enthusiasm for the Regional Center. Case workers were mentioned by names and quite lavishly praised.

Parents with family members receiving services either living at home or in other settings echoed worries and concern that the resources and capacity of the mental health system will not be adequate to care for their family member when they can no longer do so.

Regarding options, the word “choice” was used in many instances, In particular in the case of housing, services, and jobs. The Department of Mental Health does not address these issues in all cases.

In addition the department does not currently address the issue of the aging population. Nursing homes should not be the only choice of services.

There must be better coordination between the mental health system and local schools to provide educational opportunities for persons receiving mental health services.

There is a real need for more community-based programming for individuals as they transition from the children’s system to the adult system.

Deaf Services

Probably the most concentrated testimony came from the deaf community. The Commission heard from individuals who are deaf or hard of hearing, families and professionals throughout Missouri. Clearly there is a lack of interpreter’s services which was repeated again and again. This was not limited to mental health services but a problem throughout the human service industry.

Deaf individuals cannot communicate with family, community and the larger world without access to interpreters. Budget cuts in recent years have reduced the number of trained interpreters; some hospitals do not have one on call nor are they required to provide these services according to testimony. Overall health care and especially mental health care is jeopardized when a person cannot communicate with a doctor, nurse, case manager or support services. In many instances those who are deaf are cut off from normal social interactions without the support of an interpreter. An example was the lack of access to such community groups as AA.

A further problem as seen by those who are deaf is the lack of knowledge about the deaf culture on the part of the Department of Mental Health in areas such as jobs, housing, employment, even basic education.

Funding

Funding was a topic of testimony in various contexts. A general issue was that additional financial resources are needed in the mental health system.

The impact of Medicare and Medicaid reductions in the past year were referred to often. Testimony was given that the cuts are causing hardships for those served by the department. The loss of dental care was a particular example as dental service is especially vital to good health.

Reference to Senate Bill 40 funds, which apply only to MRDD, were seen as a source to improve such services as planning and pilot programs in case management. One individual proposed that DMH provide better oversight and accountability of county usage of SB 40 Funds.

Several individuals pointed out disparities in funding and services across various regions of the State.

The lack of sufficient funds jeopardizes the safety of consumers and quality of services as do low wages for direct care staff.

Direct care staff in particular does not receive adequate compensation for the crucial work they perform. Additional funds are needed to recruit as well as retain quality staff. Such funding would reduce workloads, especially the need for many hours of overtime. Better reimbursements for providers was a need universally echoed across the state.

Other

In several locations, some discussions were devoted to privatization and managed care. Arguments were both pro and con. In particular, the privatization of case managers was supported.

Some ADA issues were raised; services are often limited "which results in wait time" for appropriate treatment. In some geographic areas especially rural areas it is difficult to access any services at all. This can result in individuals ending up in the criminal justice system. The outcome can have tragic consequences for the individual, the family, and society in general.

Substance abuse services need to be expanded in order to provide services for those persons who end up incarcerated because of drug-related offenses. The increase in incarcerations takes state funding away from mental health and other services.

Speakers at several hearings spoke passionately that lack of services to the mentally ill have turned prison systems into mental health facilities. Those with mental illnesses can become warehoused. The acute shortage of beds, which has increased over the years, has as a consequence resulted in homeless and incarceration. Some jails may provide treatment and psychotropic medications. Most do not. Because of a dearth of transitional programs that are sensitive to mental health issues, many mentally ill individuals return to jail soon after they are released.

Testimony referenced the Department's contract with the Columbus Organization to provide training and consultation at habilitation centers. Those testifying on the issues generally stated that it was a very costly contract and funds could be better used elsewhere.

While the Department of Mental Health's budget was mentioned a number of times, there seemed to be an incomplete understanding among the speakers as to how the Department of Mental Health and Commissioners function in the budget process.

In conclusion the Commission hopes that, based on these remarks and suggestions of those most impacted by the system, the recommendations in this report will represent substantive steps toward resolving the complex problems raised. Direct quotations that illustrate the tone and content of public input are provided below:

"A one size fits all approach will not work for my son or many of the other individuals DMH serves."

Parent of 18 year old son with
development disabilities
Kirksville

"There was one particular direct care staff that met me at the door when she was on duty to tell me all the things my daughter had done wrong the previous week. When I questioned the support coordinator she admitted the lady did not like my daughter whose behavior was worse anytime that employee was on duty."

Parent of an MRDD consumer
Columbia

"What will happen when parents die and cannot watch out for the care of their children living in the community?"

Parent
St. Louis

"Consumers have difficulty making co-pays for medication, especially those living in residential care facilities."

NAMI Member
Kirksville

"Many consumers no longer qualify for Medicaid at all."

SB40 Staff Person
Kirksville

"When hiring staff, background checks, drug screens, driving records and FBI finger-printing need to be completed before contact with consumers."

Parent
St. Louis

"Improvements are needed to increase training including anger management training for staff and standardized curricula for staff and supervisors."

Parent of an MRDD consumer
Columbia

"I want you to imagine with me right now how your life would be if the only human contact you had was with the people who are paid to be with you… Institutional closure is one of the primary issues facing us today."

Consumer

"…individuals are dying on your watch. Consumers are being abused and neglected under your watch. Remember Mr. Holmes, Mr. Rutherford and Mr. Pallme. Your investigators in two of those three cases did not find abuse and neglect.…This is old information…You as Commissioners must demand the exposures of information…
You have APPS, Accurate Planned Practice System; you have IIPS – Incident Investigation Practice System; you have HIPS, Health Identification Planning System,

nursery, service library, CATS- Consumer Affairs Tracking Systems; CETS – Community Events Tracking System; CTR Client Tracking Registration; Commitments to Quality Management; State Auditor Report. Are you folks getting this information; are you being told what's happening in this department? This data is telling you, telling the staff of the Department of Mental Health that there are patterns here; it's identifying exactly what trends are in a particular facility…Where is that analysis?"

Executive Director
Missouri Protection and Advocacy Services

"Please help us ensure families will have the flexibility and funding to set up the community supports necessary to allow individuals with disabilities to have a quality of life in the community free from abuse and neglect."

Parent of 18 year old son with
developmental disabilities
Kirksville

"DMH should not recommend downsizing or closing of state-operated habilitation centers without having placements that are equal or better. Habilitation centers should be one of the highest priorities for DMH."

Parent of a hab center resident
St. Louis

"I now live in the community after living in a nursing home. I worry that if funding cuts continue, I would have to go back to a nursing home."

Self Advocate

"We need the ability to hire and pay good caregivers to work with my son."

Parent of 18 year old son with
developmental disabilities

"There is no meaningful oversight of community provider systems."

Parent
Kansas City

"Missouri is a state in which the legislature has pounded the public mental healthcare system with budget cuts. At some point, cuts mean more than trimming fat or saving money; instead they become harms, cutting muscle and bone, translating into needless suffering and early deaths"

National Alliance for the Mentally Ill
Grading the States 2006
http://www.nami.org

"Of all the incredible information I was able to absorb at the psychiatric acute care center, habilitation centers and private centers we toured, the most important point was made by a man whose brother had recently transitioned from a state habilitation center to a private center... what he said that struck me the most was that the fear of the unknown was the most difficult for the families who have developmentally disabled relatives. With the Department of Mental Health working to close one of the state-run

habilitation centers, parents there are faced with fear about the future and safety of their children. But it doesn't stop there. The parents we met at another habilitation center we visited shared the same fear although there were no plans to close that center. Safety for the families includes knowing what the future may bring. We must stop the debate of whether state-run or private run facilities are better and recognize that each offers safety and a better quality of life dependent on the person they are serving. We should focus on improving both private and public centers, and well as having the two systems cooperate to provide what is best for the people they serve. "

Senator Michael Gibbons
Gibbons Capitol Report
August 11, 2006

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About the Missouri Department of Mental Health

The Missouri Department of Mental Health was 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:

- Prevention of mental disorders, developmental disabilities, substance abuse and compulsive gambling;
- Treatment, habilitation and rehabilitation of Missourians who have those conditions; and
- Improvement of public understanding and attitudes about mental disorders, developmental disabilities, substance abuse and compulsive gambling.

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About the Missouri Mental Health Commission

The Mental Health Commission, composed of seven members, appoints the director of the Department of Mental Health with confirmation by the state Senate. Commissioners are appointed to four-year terms by the Governor, again with the confirmation of the Senate. There are currently two vacant positions, one of which was recently created by the appointment of Commissioner Ron Dittemore, Ed. D. to the position of interim director of the Missouri Department of Mental Health. The Commissioners serve as principal policy advisors to the department director. The Commission, by law, must include an advocate of community mental health services, a physician 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 consumers of psychiatric services, and a citizen who represents consumers of developmental disabilities services.

John N. Constantino, M.D. St. Louis (Commission Chair), is an Associate Professor of Psychiatry and Pediatrics at Washington University School of Medicine. He earned a bachelor's degree from Cornell University in Ithaca, New York. Dr. Constantino received his M.D. from Washington University School of Medicine, and completed residency training in psychiatry and pediatrics at the Albert Einstein College of Medicine. He is director of a nationally recognized research program in child social development.

Mary Louise Bussabarger, M.A., Columbia, is a former English instructor for the University of Missouri. Bussabarger serves on the Boone County Mental Health Board. Bussabarger has served on numerous Board of Directors including the Missouri Family Trust and the Protection and Advocacy-PAIMI Advisory Council. Bussabarger was a member of the Comprehensive Psychiatric Services (CPS) regional and state councils for CPS and served as chairman of both. She served as a member of the Missouri Planning Council and the NAMI of Missouri Board of Directors. She was honored by the DaVerne Callaway Award given by Women Legislators of Missouri (2000) and is a member of Who's Who of American Women (1987-present). She was also invited and attended the Kennedy School of Government, “Leadership for the 21st Century” at Harvard University in 2004. Ms. Bussabarger is involved with many community and political organizations.

George J. Gladis, St. Louis (Commission Secretary), a parent of a child with Down Syndrome, is a broker and agent for Huntleigh McGehee. He has served on the Rainbow Village Board of Directors and as chairman of the St. Louis Office for Mental Retardation/Developmental Disabilities. He has been a board member of the St. Louis Association for Retarded Citizens and the St. Louis Down Syndrome Association. Gladis earned a bachelor's degree in business administration from Saint Louis University.

Beth L. Viviano, Fenton, is a long-time children's advocate. She co-chaired the Stakeholders Advisory Committee, which was formed to create the Comprehensive Children's Health Care System. In 2004 she was appointed to the Children's Services Commission Subcommittee on Mental Health, which resulted in passage of the Comprehensive Children's Mental Health

Reform Bill. Viviano currently serves on the Missouri Family Trust Board which helps families provide long term care for their disabled children. She is co-founder of the St. Louis Attachment Network, a support group for families and professionals dealing with children, either adopted or foster, with Reactive Attachment Disorder and related mental disorders.

Phillip McClendon, Joplin, is the Senior Pastor of Calvary Church in Joplin and presently serves on the Ozark Center Advisory Board of Directors and the Community Blood Center of the Ozarks Advisory Council. He is a member of the Christians for World Peace and has served as president of the Pastor's Conference of the Missouri Baptist Convention and Chaplin at the V.A. Hospital in Big Springs, Texas. Reverend McClendon is the Spiritual Director for a methamphetamine group called God's Awesome Power. He is a frequent visitor to the Middle East, delivering medicines and bibles each year to the Holy Land, as well as to Minsk Belarus, Russia. He serves as an advisor to the Bethlehem Bible College in Bethlehem, Israel.

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APPENDIX

A. May 2006 Regional Center Review (DMH)

In order to identify broader system issues in the Division of Mental Retardation and Developmental Disabilities (extending beyond a specific focus on Northwest Habilitation Center), which might directly or indirectly relate to client safety, the Commission was highly interested in the results of a review of the Department's Regional Centers, which was conducted in May 2006. This review was conducted by 3 teams, which between them spent 3-4 days in May 2006 in each of Missouri's 11 MRDD Regional Center areas – in each area interviewing consumers, families, provider staff and DMH staff. A preliminary report of this review is currently posted for stakeholder review on the internet at http://www.dmh.mo.gov/mrdd/rcreviewreport.doc. Many aspects of this review were relevant to the identification of potential contributors to safety risk in our system, and are abstracted here to provide further background for the Commission's recommendations.

In all, there were 41 reviewers contributing their time to this project; between them they interviewed various levels of staff at each of the 11 Regional Centers; over 60 provider sites (including large and small providers, providers covering a spectrum of rates for services, accredited and certified providers, and a variety of services – in each area); and over 100 consumers, family members and advocates. The teams accommodated specific meetings when these were requested and accepted written feedback when offered, including several anonymous written reports.

The interviews were semi-structured, following a predefined script of open ended questions tailored for each interview category and encouraging a broad conversation regarding the strengths and weaknesses of all areas of the Division's operations.

All of the teams reported that very open and often frank discussions resulted in every area visited. Each team compiled a brief 3-5 page synopsis of findings for each regional area.

STRENGTHS OF THE REGIONAL CENTER SYSTEM

There are many good things going on around the state but the reviews found the system is stretched. Many leaders, staff, providers, consumers and families identified committed and dedicated staff overall. In every area, there is a core group of staff with longevity and experience. We heard numerous comments about staff working as a team, both from providers and regional centers, yet not always between the two. Staff expressed support from their peers, willing to step up and help each other. There were areas in which creativity in staff deployment was recognized-- weighted case loads, business office working with provider on budget, use of intake team, redirecting positions to allow more flexibility, to mention a few examples. Overall, regional centers were described as a resource to the local area with staff knowledgeable about resources, community and culture.

OPPORTUNITIES FOR IMPROVEMENT

The various interviews and reviews highlighted a number of issues of concern that were consistently reported around the state. This report categorizes these issues as falling under the broad headings of "Leadership and Culture", "Services and Access", and "Staffing and Resources" and presents them all as opportunities for improvement.

Leadership and Culture

Philosophy, Vision, Mission

The most frequently and emphatically voiced concern throughout this review was the general observation of a complete "pendulum swing" away from person centered and habilitation towards mere compliance with health and safety directives – when what our consumers need from us is a more consistent sense of balance of all of the above.

This shift in priorities conflicts with the previously understood mission, but is not a deliberate restatement of the mission so much as a conflict between a reactive management style and the stated mission. The process goes something like this:

- Something bad happens somewhere and the reaction is to over-generalize from the specific problem and impose new requirements everywhere, somewhat indiscriminately. (The "water temps" scenario was typically referenced as only the most recent of a more general and long standing phenomenon.)
- The new requirements then tend to be implemented with insufficient forethought and lend to inconsistent practice between regions, and often even within a region.
- There are many issues that are top priorities but only for the day – we don't seem to operate in terms of systems and processes supporting long term priorities.
- This results in too many requirements in the sense that there are more than we have the capacity to enforce on providers or providers can enforce on themselves – this in turn adds to the "gotcha" nature of the Quality Assurance concerns below.

A related concern raised in a variety of contexts was a general lack of clarity in roles and expectations: What is the role of the Regional Center, what do we really expect of a provider, what are the respective roles of various Regional Center staff, what is the role of Central Office? These uncertainties combine with the reactive posture of management and translate directly into fear for both Regional Center and provider staff. All levels of staff report needing permission for just about anything, just to be safe, and many staff (provider and DMH) report working in ongoing fear of losing their jobs or possibly their careers to any misstep within a complex system of rules they don't completely understand. This in turn leads into defensive behaviors that further undermine our mission.

There is a consistently different perception of the respective authority between Regional Centers and providers – each sees the other as too powerful. Providers report that part of their fear is of getting a "bad reputation" (by complaining, for example) and that word of mouth at the Regional Center translates into empty beds and lost revenue, and that this "punishment" isn't based on objective standards. Conversely, Regional Centers report that it is too hard to implement corrective actions (up to closing in extreme cases) at any well connected provider, thus confounding their oversight of services in the region.

One observation, variously repeated, summarizing all of this was that we need to move beyond a narrow focus on compliance with directives to more of a focus on what positive actions lead to the outcomes we desire for our consumers, and be guided more by an assessment of those outcomes than by a reaction to isolated failures. The latter must be addressed, but leadership demands a broader vision than avoiding failure.

Quality Assurance System

The Quality Assurance (QA) system is seen by providers as intrusive and ineffective, and by various Regional Center staff as inefficient and time consuming.

The MRDD QA system has an almost exclusive focus on provider compliance. The system does not result in feedback to management regarding the compliance or enhancement of MRDD's internal processes, which are viewed by the providers as often larger concerns than – or in exceptional cases even the root causes of -- the issues the system cites as provider deficiencies.

Abuse & Neglect Reporting and Investigation

The universal concern raised regarding the Abuse/Neglect (A/N) process was the timeliness of investigations, which were reported as often stretching into months in duration, with staff on leave in the meantime and (possibly innocent staff) quitting for work elsewhere.
(See Appendix 2)

Another concern often cited was for the scope of what is classified as neglect – this issue was raised more frequently by providers than by DMH staff, but the provider consensus seems to be that some of the "Neglect 2" classifications could be dealt with more effectively as supervisory issues. Since that is the broadest category of allegations this could also free resources to allow for more timely review of the more serious allegations.

Another timeliness issue raised was the initial reporting of events to the regional centers. The general consensus was that the more serious events do get reported but not always within the expected 24 hour standard. Concerns about under reporting were raised specifically regarding minor incidents of less than abuse or neglect priority. The latter issue was clearly identified as provider specific in that many providers in each region routinely report the minor events and some do not.

Outside of the timelines issue, there was general support for the centralization of investigations and (with occasional exception) support regarding the quality of investigations themselves. One centralization related observation made in several locations was that the Regional Center Director is no longer effectively the determiner, but is potentially still required to testify as if that were still the case. The comments were to let them be determiners or admit they are not -- either way would be preferable.

Effects of Consolidation

The consolidation of the Regional Centers was consistently reported as a resource driven decision that has diluted the leadership in each region, slowed decision making, and impaired communications at the local level. With that said, everyone also reported coping with the situation, just that it was not ideal and that the Regional Center Director position, in particular, is a full time job.

Communication

Providers and Regional Center staff alike report that providers often know issues, changes, and announcements from Central Office before the Regional Centers are informed. This makes our own staff appear ill informed. Similarly, the broad consensus from the field is that Central Office is insufficiently aware of local problems or dismissive of the magnitude of them. The most frequently referenced example of this was the local costs of last minute information requests from Central Office. In either case, the larger communications disconnect appears to be between Central Office and the Regional Center, not within the region.

Services and Access

Gaps

There is consistency across the state identifying several service gaps. These gaps include:

- crisis intervention and support/crisis teams,
- respite, especially in-home respite,
- services for the co-occurring MR/MI population,
- placements for the forensic population, especially sexual offenders,
- dental services,
- transportation,
- services to address behavioral challenges,
- more support for families with an adult with special needs in their home;
- autism services; and
- transition from children's services to adult.

Although these are state-wide issues, there were additional needs for services identified for specific regional center service areas, such as services for the deaf and visually impaired in the southwest and need for First Steps therapists in the north/northeast.

Relationships with Psychiatric Services Providers

The need for cooperation and collaboration internally with the Division of Comprehensive Psychiatric Services was identified, as well as the same need for cooperation, collaboration and services with community mental health centers. There is a perception that, once an individual is known to have an MR/DD diagnosis, psychiatric providers step out of the picture and give the entire responsibility to MRDD.

Waiting Lists

Leadership, staff, providers and consumers/families discussed several issues in regard to waiting lists. There was anxiety expressed that MRDD, and DMH more globally, has become a Medicaid-only system – if an individual is not eligible for Medicaid, that person will not receive services and may languish on the waiting list. It was stated frequently that individuals and families on the waiting list must go into crisis and then services may be approved. There was a great deal of frustration expressed about this, explaining that some temporary or interim type of service might avoid a crisis and the ensuing disruptions for families and consumers.

UR Process

The UR process had mixed reviews. There were groups that saw it as an opportunity to be more consistent in decisions surrounding needs and services. Others saw the process as intimidating and sometimes misleading, in addition to just more paperwork. It was reported in some regions that applicants are told not to sign up with the regional center as there is no money; and that service coordinators are saying "no" to service requests in anticipation of the UR result. Crisis situations may increase the UR score for someone on the waiting list, but that is not seen as a preferred way to access services, as described above. There is also a perception in at least three regional center areas that UR decisions may be adjusted and the waiting list "jumped" because of phone calls to central office, legislators, and those otherwise well-connected.

Rate Structure

Providers and center staff expressed dissatisfaction with the current rate structure. Providers indicated that rate increases were few and far between, when costs continue to rise. Rates vary significantly across the state and the rationale for the rates may not always be apparent or known. Providers that have been in the system a number of years may be paid less than new providers entering the system for what is perceived as the same service. There is also a perception of disparity based on size—smaller providers being paid less that the larger providers. In some areas of the state, staff were concerned that smaller providers are having difficulty staying financially solvent and may have to close. Groups also recognized, however, that many factors are and should be considered when setting rates and there is likely to be some variability; for example, geographically, for special expertise serving medically or behaviorally challenging individuals, and other factors.

Staffing and Resources

Workload and Caseload Sizes

Service Coordinator (SC) caseload sizes range widely across the state – the lowest being about 1:40 and the highest about 1:72. Large caseloads are compounded by growing monitoring and documentation requirements; examples included service monitoring process and real-time logging for billing purposes, to name just two. This contributes to the general trend away from person-centeredness and contributes to fears of "missing something" or "making a wrong decision", adding stress levels and general job dissatisfaction among SC in particular, but not

limited only to them. Although there was a good deal of satisfaction expressed about SC from families and providers, there were also multiple observations made about how valuable a "good" SC is and how devastating a "bad" one can be. Providers commented that there is not a way, or at least a consistent method, of resolving problems with SC and providing feedback for SC performance assessment. Larger providers in particular may have many SC assigned and find that there are inconsistencies in the information given by the SC and in the manner in which the SC interact.

Overall, leaders and staff express being spread too thin with multiple tasks and responsibilities which put them into the position of managing the paperwork instead of focusing on the consumer. The amount and type of paperwork and other requirements has grown, yet there seems to be little evaluation of what tasks might be removed or revised in some way to assist in managing the workload.

Turnover and Recruitment

SC turnover is a challenge in many parts of the state and the turnover may even vary by satellite offices within the same regional center. There were many comments from leaders, staff and providers about SC salaries and caseload sizes, comparing the regional centers with the SB40 Boards that conduct case management and identifying this as competition for staff. These SB40 Boards were reported as having caseloads ranging anywhere from 18 to 30 per case manager and acknowledged that salaries were higher at the boards. Comments were that there are staff who work to gain some experience, then leave for better pay and lower caseload somewhere else. Salaries and workload limit recruitment of persons having the quality and experience needed for the positions. Also, the feeling of heightened vulnerability that was expressed in relationship to the abuse and neglect system, inconsistent training and the current climate of DMH has an effect on the ability to recruit and retain staff. There are staff who have longevity in the system as well, who stay in spite of the competition in the private sector, the workload and the climate. There is a need for assistance in creative methods of recruitment and finding ways to tap the right markets for good candidates for positions.

Those consumers, families and providers who have experienced frequent changes in their SC identified how difficult it is to maintain any kind of consistency and familiarity with the needs of the consumer; the changes are very disruptive.

Training

Orientation of SC varies significantly throughout the system. In some areas, the SC orientation consists of self-study, didactic and on the job orientation; others give a basic overview and immediately pair up the new employee with a more experienced SC; the new SC may be rotated among several other SC for their on the job training; and still other areas assign responsibility for training to the SC supervisor who uses his/her own methods. Staff and providers expressed a need for more consistency in orientation and questioned how the current lack of standardized orientation may affect turnover and retention, if new staff does not feel prepared for the responsibilities of the position.

The needs for staff training mirror the gaps in services in many instances.

Needs for Specialty Expertise

Staff and providers identified a need for staff with specialty expertise. These mirror the gaps in services in many instances, and include the areas of:

- behavior specialist;
- children's behavior specialist;
- crisis intervention and support;
- dual diagnosis (MI/MR) expert;
- autism; and
- forensics.

Loss of Supports and Resources

Throughout the last several years of budget adjustments, consolidations were attempted and staff was lost through attrition, lay-off, and the restrictions on replacement of retirees in some circumstances. There are comments about the consolidation of leadership of the regional centers in the Leadership and Culture section. Other positions lost at various regional centers include support staff, accounting and business office staff, QA, supervisors and trainers. The mix and number of positions varied among the regional centers; however, the result universally has been that the workload of those no longer employed was absorbed by the staff that remained in the respective areas. The domino effect is that this impacts all along the organizational structure as well; for instance, some teams no longer have support staff, so SC spend more time on typing plans and other traditionally support duties, leaving less time for service coordination visits, arranging resources, and monitoring. In some areas, the staff that would recruit and develop providers to meet demands for services was either eliminated or became a shared position between two regional centers. QA teams in some areas absorbed crisis support and training.

B. REVIEW OF LITERATURE, BEST PRACTICES, AND GOVERNMENT FUNDING TRENDS

At the request of the Commission, DMH staff reviewed the literature and other resource information for applicable technologies and principles that can be used to shape solutions, including but not limited to:

- Quality improvement technologies with special attention to:
  - Internal and external investigative activities
  - Reporting strategies and incentives for identification of risks (including potential
  - risks, near misses as well as failures and omissions)
  - Process analysis
  - Root cause analysis
  - Data-driven decision making
  - Training and staff development strategies

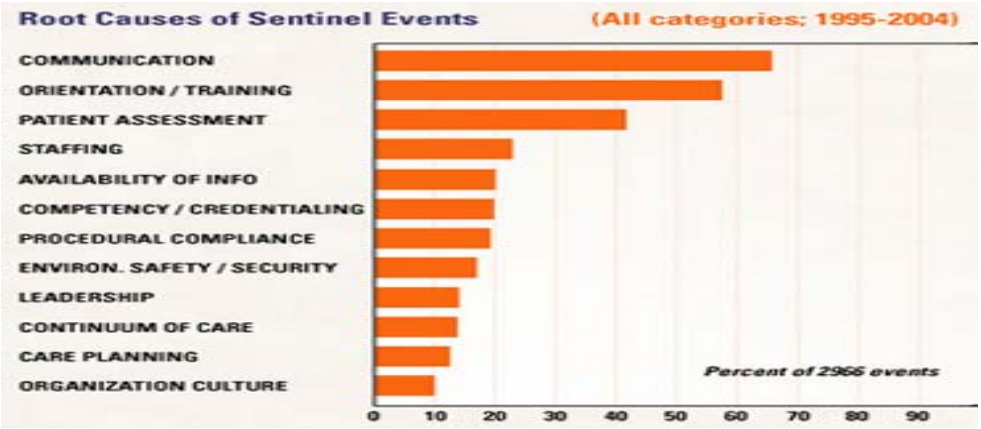
- Organizational Change Management

- Best practices in public mental health systems for safety management
  - Investigative processes & structures
  - Leadership
  - Resource development

The following principles emerged as considerations in structuring recommendations and solutions to promote and assure safety of DMH consumers.

- When quality suffers in a service delivery system, it is generally recognized that systemic fixes are required and that affixing blame is counterproductive in terms of both reporting and improving quality. In examination of root causes for sentinel events (catastrophic incidents), the Joint Commission on Accreditation of Health Care Organizations (JCAHO) has identified the following domains that need to be explored:
  - Communication
  - Orientation/Training
  - Patient assessment
  - Staffing
  - Availability of information
  - Competency/Credentialing
  - Procedural compliance
  - Environmental Safety and Security
  - Leadership
  - Continuum of care
  - Care planning
  - Organizational Culture

These key areas may provide strategic guidance for formulating an operational plan for change.



Source: www.perfectserve.com/benefits/sentinel-events.html

- Systems that are most effective at protecting the safety of consumers are those that maximize transparency in decision-making and operations by:
    - Establishing a balance of internal and external investigations and quality review mechanisms;
    - Building partnerships with consumers, families, staff and other stakeholders with shared visions and responsibilities for safety and quality;
    - Promoting openness, permeability and accessibility of the facility to stakeholders as well as regulators, partners, and the general community; and
    - Structuring decision-making processes at all levels that rely on data analysis of trends and issues that translate to safety and quality of life for DMH consumers and their families.

- Specific examples of strategies for maintaining a high-performing system for safety include:
    - Collection and analysis of data regarding safety measures to be determined by the Department in conjunction with external partners to identify trends and corrective actions as necessary.
    - Norming and comparing safety performance to other public mental health systems or other comparable facility types.
    - Compiling regular reports for public review related to safety performance.

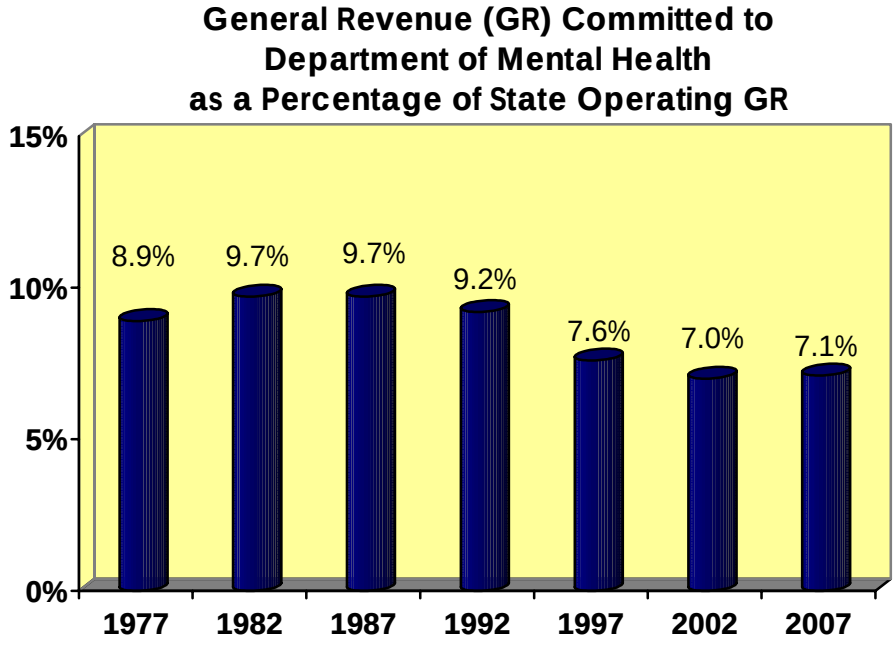
- Inherent in the challenge of responding to sentinel events is the recognition that:
    - Meaningful change, particularly in organizational culture, requires long term strategy and investment in addition to short term actions.
    - Because of different roles and responsibilities within the service delivery system, different perspectives will lead to conflict and disagreement regarding appropriate strategies and resource investment. Accommodation of these legitimate differences to identify creative and mutually sanctioned solutions is the job of effective leaders.
    - The process will require tough decisions. Leadership must be prepared to act decisively based on sound information and in a timely way.

  - Roadmaps for successful amelioration of problems must be established to allow generalization and adaptation of successful quality improvement strategies throughout the system. An example the significant improvements made recently at Bellefontaine Habilitation Center. (Key activities are outlined in section D of this appendix)

- Sustaining improvements requires ongoing evaluation and continued monitoring for accountability and transparency, at the highest levels of Department administration, in partnership with key stakeholders

- To establish and sustain an organizational culture of safety requires significant investment of time, funding and human resources, including leadership from top level executives. This will require concerted and strategic leadership by the Director in the state budget process, in partnership with the Governor's Office and the legislature. Specifically, investments must be made to:
  - Improve staff recruitment and retention
  - Increase staff orientation, training and development
  - Enhance intensity and quantity of active habilitation, treatment and rehabilitation consistent with individual needs and preferences
  - Promote efficiency and effectiveness of services through:
  - development of a range of service options to include acute and emergency services to prevent need for more restrictive placements
  - funding flexibility to allow dollars to follow the consumer
  - early access to services to reduce need for more costly services later.

The state's general revenue commitment to the Department of Mental health has waned over the years. While general revenue has increased over the years, the department's share of the general revenue pie has shrunk. In 1977, 8.9% of the state's general revenue was committed to the department. This commitment has dropped to 7.1%, as shown in the graph below:



The Department of Mental Health's staffing peaked in 2001 at 10,555 FTE. By FY-2007, this has been reduced to 8,826 FTE, a 16.4% decline. This compares to a decline in all the state departments of 4.7% over the same time period.

In addition, the Department has the highest proportion (1 in 3) of employees making less than $20,000 per year of all state departments.

C. A MODEL FOR CHANGE: IMPROVEMENT STRATEGY FOR BELLEFONTAINE HABILITATION CENTER

Project Direction

- Analyzed BHC's staffing and produced staffing recommendations for the department.
- Developed material to be used during the entrance conference of the ICF/MR survey team.
- Provided consultation to management on various administrative and clinical issues.
- Organized and assigned work of all Columbus Organization staff to address the needs of the facility.
- Obtained additional consultant services to address Human Resource issues raised by the superintendent.

Quality Assurance and Risk Management

- Assisted quality assurance staff to implement an effective system to monitor and track facility Plans of Correction for the ICF/MR surveys.
- Developed effective system to track incidents from the initial report to completion of the investigation.
- Assisted with the development of drat and final policies including protection issues.
- Provided support to facility quality assurance staff on all aspects of the facility operations.
- Conducted and completed numerous abuse and neglect investigations.
- Reviewed completed investigation reports and conducted additional work, if necessary.
- Developed a report for BHC and DMH management on the status of the investigation issues.

Psychology and Behavioral Services

- Developed new process for reviewing restraint procedures and written guidelines for psychologists to use in the process of a review.
- Provided individual case specific consultation.
- Worked with Bellefontaine staff to revise the level system of behavioral services from a level system to embrace positive behavioral supports. Recommended suggestions eliminated level 0 for approximately 29 individuals' plans as of December 2004. Allowed facility to phase-out level system.
- Assisted BHC staff to eliminate the use of prone restraint from individuals' behavior support plans.
- Produced guidelines for the Development of the Psychological Evaluation, Program Recommendations and the Positive Behavior Support Plan.
- Conducted training sessions for BHC psychologists on the principles of positive behavior support.
- Provided consultation on provision of sexuality education and treatment services to BHC staff and consultants.

Active Treatment Services

- Provided assigned staff to each of the units to improve the delivery of active treatment services to individuals residing at BHC.
- Monitored activities and interactions of individuals and Bellefontaine staff during mealtime and other critical times during the day.
- Developed an implemented scheduled activities and lesson plans for each program area.
- Conducted multiple on-site observations of all program areas.
- Prepared list of statewide active treatment issues to be shared with management.
- Consultation with Unit Manager, Habilitation Specialist, and other facility staff to enhance services to individuals..

D. Department's Progress to Date for Improving Safety

Under the direction and the guidance of the Mental Health Commission, the Department has taken a number of steps in immediate response to the need for a safer mental health system. These preliminary corrective actions will be integrated into a broader implementation plan that will incorporate the Mental Health Commission's recommendations outlined in the next section. The following activities have been set in motion or completed:

Reorganized the investigation of abuse and neglect as a centralized function. Centralized oversight of all facilities to assure uniform safety and reporting standards statewide, including establishment of a Facilities Operations Team as an independent division of the Department.

Appointed a Director for the Division of Mental Retardation and Developmental Disabilities (MRDD) with a focus on reporting and investigating abuse and neglect.

Conducted comprehensive reviews of the regional and habilitation centers to develop recommendations for improving the operations and safety at the facilities.

Enhancement of staff coverage for Northwest Habilitation Center via the hiring of new staff.

Quarterly cross-referencing of the employee disqualification list with the Division of Employment Security for abuse/neglect or misuse of funds.

Initiated a cost analysis for the accreditation of MR/DD facilities and community service providers.

NETWORK OF CARE, a web-based resource access and education program was launched in the summer of 2006; it will greatly facilitate access to critical information and services for DMH consumers, which is highly relevant to crisis prevention.

Implemented an interim policy of notification of Missouri Highway Patrol whenever mentally retarded or mentally ill residents die or when there is suspicion of resident assault in private or state-run facilities.

Updated a memorandum of understanding between DMH and the Department of Social Services (DSS), requiring that all child deaths in DMH facilities are referred to the State Technical Assistance Team (STAT) of DSS. In addition, a DMH representative will participate in every Child Fatality Review Panel evaluation of a child death in DMH-licensed or contracted facilities.

Beta testing of a web-based management information system (CIMOR) which will aid in the tracking and analysis of incident reports.

Development of a plan and restructuring of funding to allow for a comprehensive revision of DMH program for rendering care to deaf and hard-of-hearing clients. The services will be integrated across the state. A central inpatient facility (for individuals requiring that level of care) is planned.

Implementation of a state-wide random drug-screening program involving DMH employees.

Removal of obstacles to provision of abuse/neglect information to Missouri Protection and Advocacy.

Achieved a 5 working-day turnaround-time in the completion of investigations of serious incidents of abuse and neglect in all Intermediate Care Facilities-Mental Retardation (ICF-MR).

Appointed an Interim Director for the Department.