MISSOURI DEPARTMENT OF MENTAL HEALTH

LEGISLATOR BRIEFING

January 2018

Mental Health Highlights and Issues

Department of Mental Health Overview

The Department of Mental Health (DMH) annually serves more than 170,000 Missourians with mental illness, developmental disabilities, and substance use disorders. It is a safety net for the state's most vulnerable citizens and their families. Our primary populations include:

- **Adults with serious mental illness and children with severe emotional disorders**
- **People with developmental disabilities**
- **People with severe substance use disorders (SUDs).**

Community-based contract providers serve more than 95% of these individuals. Approximately half are Medicaid eligible.

MENTAL HEALTH COMMISSION

The seven-member Mental Health Commission appoints the DMH director with Senate confirmation. Commissioners serve as the principal policy advisers to the department. The Governor with Senate confirmation appoints commissioners to terms of varying length.

Commission member positions must include individuals who represent Missourians with mental illness, developmental disabilities, and substance use disorders, and who have expertise in general business matters (630.010 RSMO).

DMH MISSION (RSMO Chapter 630.020)

Prevention: Reduce the prevalence of mental disorders, developmental disabilities, and substance use disorders.

Treatment and Habilitation: Operate, fund, and license or certify modern treatment and habilitation programs provided in the least restrictive environment.

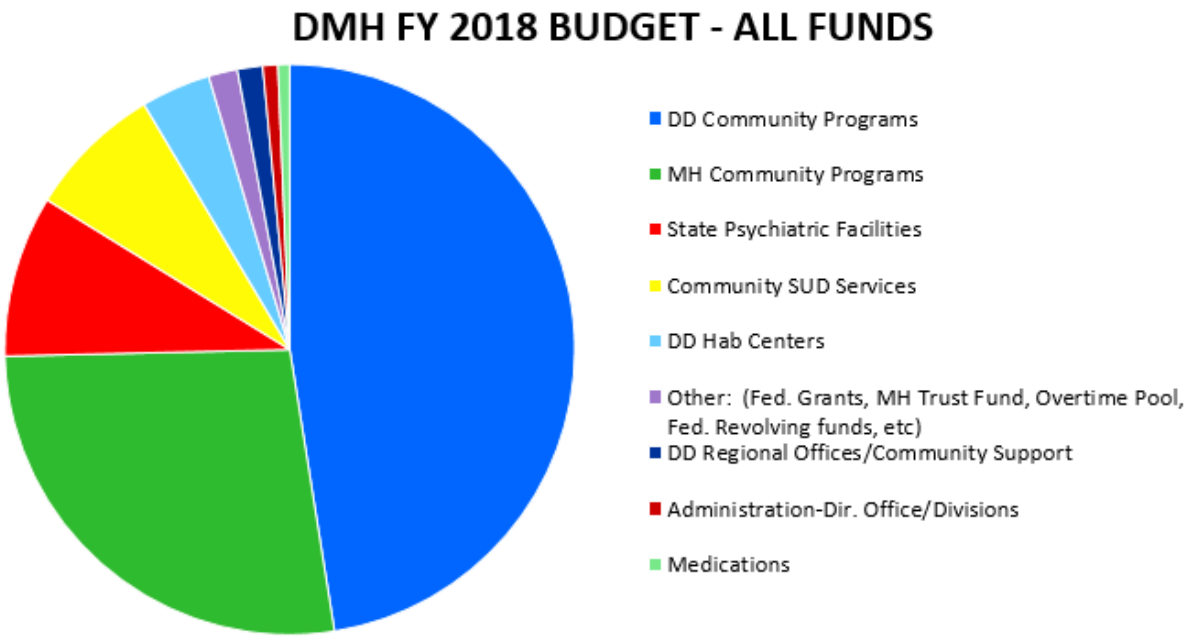
Improve Public Understanding: Improve public understanding and attitudes toward individuals with mental illness, developmental disabilities, and substance use disorders.

DMH DIVISIONS

- **Division of Behavioral Health (DBH) –** RSMO Ch. 631 and RSMO Ch. 632
  (formerly the divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services)
- **Division of Developmental Disabilities (DD) –** RSMO Ch. 633
- **Division of Administrative Services**

FY 2018 DMH Budget by Program Category

Budget Category	Amount	% Total	FTE
DD Community Programs	$1.034 billion	47.5%	25 FTE
Mental Health (MH) Community Programs	$591 million	27.1%	30 FTE
State Psychiatric Facilities	$199 million	9.2%	3,769 FTE
Community SUD Services	$167 million	7.7%	34 FTE
DD Habilitation Centers	$86 million	3.9%	2,478 FTE
Other (Federal Grants, Mental Health Trust Fund, Overtime Pool, Federal Revolving Funds, etc.)	$36 million	1.6%	11 FTE
DD Regional Offices/Community Supports	$31 million	1.4%	693 FTE
Administration: Director's Office/Divisions	$18 million	0.9%	220 FTE
Medications	$14 million	0.7%	0 FTE
TOTALS	$2.176 billion	100.0%	7,260 FTE



- In FY 2018, the DMH budget is 8% of the total state operating budget.
- DMH generates $322 million per year in reimbursements from Medicaid, Medicare, disproportionate share (DSH) and other third party pay.
- Approximately 60% of all DMH GR funding is used as state match for services funded through the Medicaid program.

DMH CONTRACTED SERVICES

- DMH contracts with more than 1,400 provider agencies employing 30,000 people statewide.
- More than 95% of the Department of Mental Health's 170,000 consumers receive their services through contracted community-based provider agencies.

STATE OPERATED SERVICES

BEHAVIORAL HEALTH	DEVELOPMENTAL DISABILITIES
6 hospitals for adults 1 hospital for children	4 state-operated habilitation centers 2 community support agencies 1 crisis community support agency 5 regional offices, 6 satellite offices

State operated services in the Behavioral Health division include the Sex Offender Rehabilitation and Treatment Services (SORTS) program for sexually violent predators. The SORTS program is located at Southeast Missouri Mental Health Center in Farmington and at Fulton State Hospital.

III. Program Highlights and Critical Issues

This section highlights seven programs and six critical issues for DMH.

PROGRAM HIGHLIGHTS	CRITICAL ISSUES
• **Avoiding Crisis for BH/DD Individuals** • **Evidence-Based Treatment of Substance Use Disorders-Medication Assisted Treatment** • **Excellence in Mental Health Act's Certified Community Behavioral Health Clinics Prospective Payment System Demonstration Project** • **Fulton State Hospital** • **Missouri Model of Crisis Intervention** • **Preventing DD Wait List** • **Zero Suicide Initiative**	• **Critical Clinical/Direct Support Professionals Staffing Shortages** • **Employment** • **Opioid Crisis** • **Provider Rate Inequities** • **State Inpatient Facility Capacity** • **Uninsured Individuals Seeking Services**

PROGRAM HIGHLIGHT: Avoiding Crisis for BH/DD Individuals

Every year people with both a behavioral health disorder and a developmental disability are referred to DMH. Some of these individuals do not fit into the current community service delivery system funded by the Department. Leaders of the Divisions of BH and DD are working together with providers to build systems ensuring individuals served by both Divisions receive effective services. These efforts include:

- Department leadership prioritizing effective services by establishing cross agency Centers of Excellence;
- Transformation Transition Initiative (SAMHSA) grant providing National Association of Dual Diagnosis (NADD) certification/accreditation for agencies supporting individuals with high needs;
- Dedicated staff performing risk assessment, identifying systemic interventions, reducing crisis events;
- Training and coaching for contracted agencies to prevent crisis events;
- Pilot implementation of the Department's Co-Occurring Protocol-coordinating services across Divisions;
- Increased enrollment of DBH providers into the DD system;
- Accessing the established, successful DBH crisis system.

Additional funding will be necessary to provide the full continuum of care for these individuals. The additional funding is needed to:

- Build capacity for implementation of preventative strategies;
- Expand accredited Mental Illness/DD Centers of Excellence;
- Develop an intensive behavioral respite for adults and children offering options other than the emergency room or jail;
- Create an intensive behavioral residential service for adults and children that are unsuccessful living in the community;
- Expanded coordination of services provided by the two Divisions.

PROGRAM HIGHLIGHT: Evidence-Based Practices in Treating Substance Use Disorders - Medication Assisted Treatment

Substance use disorders (SUD) are chronic medical conditions and should be managed like diabetes and heart disease. New medications can be very effective in treating opioid and alcohol use disorders. These medications drastically reduce cravings and allow the individual to

focus efforts on non-medical clinical treatment services. Individuals using medications for substance use disorders can become employed, attain stable housing, reduce criminal activity and rebuild relationships.

Deaths by opioid overdose have skyrocketed nationwide and across Missouri as well, impacting citizens of all ages and from all socio-economic backgrounds. Although the opioid crisis gets more media coverage, alcohol misuse remains the number one reason for admission to Missouri's safety net of substance use treatment agencies.

Unlike medications for other chronic illnesses, medications for SUDs have been adopted slowly, primarily because of the lack of education for prescribers and the general public. Despite the resistance in some parts of the country to using these medications, Missouri is nationally recognized as a leader in employing Medication Assisted Treatment (MAT) for substance use disorders. For many individuals, these medications have literally been lifesavers. However, as with all services for individuals with substance use disorders, the demand for treatment interventions far exceeds the available resources.

In May 2017, Missouri was awarded a two-year, $20 million dollar grant, called the Opioid State Targeted Response grant. More than half of the grant funds are being used for direct treatment services to individuals utilizing medication-assisted treatment for opioid use disorders. The grant also invests significantly into prescriber education regarding the use of addiction medications, to build capacity within communities over the next two years. Prevention and recovery support services are also critical grant components.

For more information visit https://dmh.mo.gov/ada/provider/medicationassistedtreatment.html and http://www.missouriopioidstr.org/.

PROGRAM HIGHLIGHT: Excellence in Mental Health Act's Certified Community Behavioral Health Clinics Prospective Payment System Demonstration Project

The Excellence in Mental Health Act, co-sponsored by Senator Roy Blunt, allows states to obtain federal funds for a demonstration program to develop Certified Community Behavioral Health Clinics (CCBHC) with a Medicaid Prospective Payment System (PPS) for service reimbursement. The demonstration award provides an enhanced federal match for two years and a platform for the federal recognition of CCBHCs to transform them closer to the Federally Qualified Health Center (FQHC) model of service and reimbursement. CCBHCs will provide the most comprehensive array of integrated, evidence-based behavioral health services for individuals with serious mental illnesses and substance use disorders. Missouri was one of 24 states to receive a planning grant to develop an application for the demonstration. DMH, DSS and OA ITSD collaborated on a successful application and demonstration implementation project which was awarded in December 2016 to Missouri, one of only eight states to receive an award. Both the DMH and MO HealthNet information systems have and continue to require substantial programming and development to process reimbursements and collect required

data. Missouri launched the pilot program on July 1, 2017, with 15 Community Mental Health Centers participating.

For more information visit https://dmh.mo.gov/CertifiedCommunityBehavioralHealthClinics.htm.

The Department is actively engaged in sustainability planning, looking towards the transformation of more Community Mental Health Centers into CCBHCs, as well as changing the reimbursement model for other DMH behavioral health providers to a PPS. This planning entails the consideration of state plan amendments and/or the development of new waivers through the Centers for Medicaid and Medicare (CMS).

PROGRAM HIGHLIGHT: Fulton State Hospital

The current Fulton State Hospital (FSH) facility consists of:

- A total of 291 beds in the Biggs maximum security center and the Guhleman intermediate security center for individuals with severe mental illness and histories of violence;
- An additional Guhleman building with 100 beds for sexual offenders committed by courts to the SORTS program; and
- The Hearnes Center Complex with 22 beds for individuals with intellectual disabilities and mental illness.

Biggs is old, inefficient, and rapidly deteriorating, with significant deferred maintenance. Three years ago the General Assembly, with bipartisan support, passed a bonding strategy to construct a new FSH building. The new facility is under construction on a 55-acre section of the FSH grounds where a mental health facility has continuously operated since 1851. The groundbreaking occurred in May 2015 and construction is scheduled for completion in October 2018.

The new hospital design provides a safer environment for patients and staff to comply with Centers for Medicare and Medicaid Services (CMS) certification standards for physical plant and safety. This certification is important because it enables the state to receive approximately $50 million per year in federal reimbursements for indigent care. The new facility will also free up an additional 91 beds for the SORTS program.

Follow the progress of the Fulton State Hospital rebuild by visiting http://fultonrebuild.mo.gov/.

PROGRAM HIGHLIGHT: Missouri Model of Crisis Intervention

The Missouri Model of Crisis Intervention represents a partnership between law enforcement, the Department of Mental Health, the Missouri Coalition for Community Behavioral Healthcare and community stakeholders. It addresses the needs of individuals in crisis with a focus on the right interventions provided in the right way at the right time to improve outcomes and efficiently manage resources. The Missouri Model will become the national standard for assisting individuals with mental illness and substance use disorders who are in crisis. Launched in 2013 the components of the Missouri Model are:

- **Community Mental Health Liaisons (CMHLs)**
  - Statewide, 31 Liaisons based at community mental health centers work with local law enforcement and court personnel to connect people experiencing behavioral health crises to treatment and community services.
  - CMHLs have referred over 30,000 individuals in crisis for services. CMHLs have provided more than 644 trainings on behavioral health topics with over 9397 officers trained. These trainings are provided at no cost to law enforcement and are Peace Officer Standards and Training (POST) certified.
- **Emergency Room Enhancement (ERE) Projects**
  - In 2017 ERE projects expanded from the original seven regions of the state to include an additional five areas.
  - More than 5,585 individuals have received services — the majority of participants identified at least one: mental health concern (99%), substance use concern (72%), or physical health concern (82%).
  - The most prevalent mental health concerns are depression (36%) and bipolar disorder (20%).
  - The most prevalent substance use concerns are alcohol use (26%) and methamphetamine use (14%).
  - The most prevalent physical health concerns are tobacco use (14%) and chronic pain (13%).
  - Individuals who remained engaged in treatment for six months showed a 69% reduction in ER visits, 72% decrease in hospitalizations, 56% reduction in law enforcement contacts, 31% decrease in unemployment, and a 73% reduction in homelessness.
- **Mental Health First Aid (MHFA) Training**
  - Over 30,000 Missourians have been trained in MHFA, a national program that teaches participants about the signs and symptoms of specific illnesses like anxiety, depression, schizophrenia, bipolar disorder, and addictions.
- **Crisis Intervention Team (CIT) Training**
  - Almost 8,000 law enforcement personnel have been trained on how to approach and assist individuals who are experiencing a crisis due to mental illness, substance use or developmental disability. Currently, CIT Councils cover 92 counties in Missouri. The State CIT Council recently developed the Missouri Model for CIT Training.
- **Kansas City Assessment and Triage Center (KC-ATC)**

- KC-ATC provides 23-hour crisis stabilization for individuals with mental illnesses and substance use disorders who are referred by local law enforcement and emergency rooms (ER), providing stabilization and referral to community services diverting unnecessary legal involvement or admissions to ERs.
- Since opening in October 2016:
    - There have been 2,157 referrals of individuals in crisis.
    - A total of 813 individuals have been diverted from ERs for an estimated cost savings of $**1,840,226.**

PROGRAM HIGHLIGHT: Preventing the DD Wait List

The FY 2018 budget is the fourth year the Division of Developmental Disabilities (DD) received adequate funding to serve all individuals on the wait list for in-home services, plus any new individuals who presented with a need for services. Increased funding and the success of the Partnership for Hope Waiver — a cooperative effort between the state, county developmental disability boards, and the federal Medicaid program — allowed the Division to serve 2,691 individuals under that Waiver, as well as 2,936 individuals in the Community Support Waiver in FY 2017. In FY 2018, the Division received increased funding of $8.6 million to serve approximately 1,151 additional consumers in the Partnership for Hope and Community Support Waivers. In FY 2019, the Division is requesting $7.9 million to serve an additional 1,018 individuals who present for services and who are Medicaid eligible.

PROGRAM HIGHLIGHT: Zero Suicide Initiative

The Show Me Zero Suicide Initiative core value is that suicide deaths are preventable. It is part of a national movement that is both a concept and a practice for systems of care. The concept makes suicide a never event, an aspirational goal through a high level of performance improvement within a health care system. The focus is to advance Zero Suicide practices in health and behavioral health care systems, challenging these systems to embrace Zero Suicide as an organizational culture. These practices begin with leadership's commitment to dramatically reduce suicide deaths by implementing evidence based practices, including standardized tools for suicide risk screening and assessment, pathways to care, collaborative safety planning, family engagement, and follow-up care. All of Missouri's Community Mental Health Centers are engaged in the Zero Suicide learning collaborative.

For more information visit https://dmh.mo.gov/mentalillness/suicide/prevention.html.

CRITICAL ISSUE: Critical Clinical/Direct Support Staffing Shortages

Missouri state-operated facilities and contracted providers are experiencing extreme shortages in clinical staff such as psychiatrists, nurses, psychologists, social workers, counselors, behavior analysts and direct support professionals (DSP). Behavioral difficulties of patients, poor working

environments, increased mandatory overtime and high turnover result in employee injuries and impact quality of care. Public sector salaries fall 30% or more below private health care industry salaries. DSP salaries, compared to those in 21 other states, are 89 cents per hour lower in Missouri. DSPs are paid on average $10.95 per hour. The hourly pay to keep a family of four at the poverty level is $11.00. Key concerns include:

- Mental health salary and retirement benefits offered for clinicians are no longer competitive; neither are recruitment and retention benefits, nor college tuition payback strategies.
- Turnover/vacancy rates of DMH facilities are more than double the national and state averages for nurses and other professional staff.
- Turnover rates for direct care staff are increasing. In FY 2017, the turnover rate for direct care staff working in high security at Fulton State Hospital was 37%, resulting in less experienced staff working at Missouri's only maximum security psychiatric hospital.
- In October 2017, the average RN vacancy rate at DMH psychiatric facilities was 13%. The vacancy rate at Fulton State Hospital is approximately 34%.
- DMH is implementing the Caring for Missourians Mental Health Initiative to improve the recruitment of licensed professionals and retention of quality staff.
- In 2016, Missouri providers of services for individuals with developmental disabilities experienced a 60.4% turnover rate for DSPs and an 8.2% vacancy rate. Only 61.5% of staff delivering services had been doing so for more than 12 months; 28.9% of DSPs employed for 12 or more months separated from employment after their first year. Survey data covers 68% of all individuals receiving division funded services.

CRITICAL ISSUE: Employment

The Department of Mental Health is committed to assisting the individuals it serves to find and maintain integrated, competitive employment. Currently, the employment rate for individuals served by the Division of DD is 13%. The national average is 19%. Employment rates for individuals in treatment for serious mental illness (11.4%) and substance use treatment (34%) were considerably lower than that of the general population (59.6%) We believe employment is a priority to achieve independence and improved quality of life.

In October 2008, DD initiated a statewide employment initiative resulting in an Employment First policy. Career planning and employment supports in integrated, competitive employment settings are priorities DD wants explored with all individuals who receive services. The expectation is that everyone of working age and those supporting them should consider work and vocational development as the first option. Today, only 3% of individuals accessing services are also accessing employment services. In October 2016, DD announced a goal to increase the utilization of employment services for individuals between the ages of 16 and 64. This new initiative, called Empowering through Employment, is a statewide effort involving the division's regional offices, support coordination providers and employment service providers to get 3,700

more Missourians into employment services. This increase would mean that 35% of Missourians are accessing employment services (which mirrors what is occurring in other states).

For more information visit https://dmh.mo.gov/dd/progs/taking-charge.html.

The Division of Developmental Disabilities knows that individuals who access waiver services are more likely to obtain an integrated job in the community and keep that job. The Division set milestones for provider agencies, regional offices and support coordination entities. Since launching this initiative, the number of individuals authorized for employment services has increased from 367 to 702, an increase of 91%. In addition, targets have been met in 30 counties, compared to only 1 county a year ago.

In 2009, DBH in partnership with Vocational Rehabilitation, implemented Individualized Placement and Support (IPS), a supported employment, evidence-based practice for individuals with serious mental illness. Seventeen programs provide IPS services. In 2017, 956 individuals received IPS with 44% successfully employed. Vocational Specialists serve on nine adult Assertive Community Treatment Teams and nine Assertive Community Treatment Teams for Transition Aged Youth (TAY). Additionally, Community Support Specialists on Community Psychiatric Rehabilitation teams provide services to support the employment goals of individuals served.

In October 2015, November 2016, and October 2017, DD and DBH were selected as a recipient of the US Department of Labor's Office of Disability Employment Policy's *Employment First State Leadership Mentoring Program*. By participating in this program, DD and DBH continue to enhance the systems and service structures in affirming employment rights and opportunities for individuals we serve. A Memorandum of Understanding has been signed by multiple state agencies to collaborate on Employment First for persons with disabilities.

For more information visit https://dmh.mo.gov/dd/progs/employment.html.

CRITICAL ISSUE: Opioid Crisis

Missouri is impacted heavily by the opioid crisis. Deaths associated with opioid overdoses have been rising exponentially, fueled by excessive opioid prescriptions beginning in the 1990s combined with the increased availability of cheap, pure heroin. Drug poisoning is now the leading cause of accidental death in Missouri, ahead of motor vehicle crashes, and is the leading cause of death among individuals aged 25-44 years worldwide. Missouri lost 908 citizens to opioid-related deaths in 2016, a 35% increase from 2015. Emergency services personnel and law enforcement throughout Missouri encounter overdose situations daily and administer the emergency overdose reversal medication, naloxone. However, these scenarios are stretching the already scarce resources of Missouri's emergency response systems.

While federal funds have helped frame Missouri's multi-faceted response to the opioid crisis, they cannot support the sheer numbers of individuals needing assistance, which include people with opioid use disorders, and the systems that are attempting to help address the crisis. And federal funds to address the opioid crisis are only assured for two years. Long-term treatment with FDA-approved medications for opioid use disorder, most notably buprenorphine and

methadone, combined with psychosocial services, are shown to be most effective in managing this chronic illness. However, federal requirements result in significant restrictions to the use of these medications, and physicians receive insufficient training on the treatment of substance use disorders in medical school. Buprenorphine can only be prescribed by specially trained physicians who then are limited in the number of individuals they can treat (30 patients in year one, up to 275 in year two). Although federally approved to prescribe buprenorphine, advanced practice nurses in Missouri are restricted to a five-day prescription and are required to be in a collaborative relationship with a waivered physician. In October 2017, there were 432 prescribers approved to use buprenorphine, but only 253 were publicly listed through the federal treatment locator. Methadone, another medication with a long history of success, can only be prescribed within specialty opioid treatment programs (OTPs), which further limits access.

For more information visit https://dmh.mo.gov/OpioidCrisisResponse.htm.

CRITICAL ISSUE: Provider Rate Inequities

Community-based services contracts comprise 80% of the Department's total budget yet serve more than 95% of DMH consumers. During the past 20 years, provider reimbursement rates lagged behind inflation due to the state's failure to adjust them each year. Providers struggle to meet costs for food, fuel, insurance and proper staffing; a 1.5% core reduction and an additional 1.5% expenditure restriction, eliminated the COLAs appropriated in FY 2016 and FY 2017.

- The following information shows how far contracted community providers have fallen below inflationary growth over the last ten years:
  - **DBH Contracted Providers for substance use disorder services 25%**
  - **DBH Contracted Providers for mental illness services 27%**
  - **DD Contracted Providers 24%**
- The community-based agencies face daunting challenges in recruitment and retention of qualified staff in clinical and direct care positions. It is difficult for community providers to compete with the US Department of Veterans Affairs and private health care organizations. Even in years where annual inflationary adjustments have been made, the costs of medicine, food, transportation and communication far exceeded the inflationary adjustments.
- DD just completed a third-party rate study for residential services. DD residential providers would need between $78 million and $118 million of General Revenue funding to enable them to compete in the current labor market to hire and keep qualified DSPs. Of that total, $64 million is needed to standardize individual provider rates; the rest would ensure rates are adequate. When DD providers standardize and improve rates, 67% of those rates fund staff salaries, 20% of rates paid support employee-related expenses and 13% of the rate will fund other service related costs and administration.

In FY 2014, DD received $23.4 million ($8.9 million GR) to address residential provider rate issues. Funding was targeted to begin to standardize the lowest rates for individuals who have

similar service needs. This has allowed the Division to move from a contracted/negotiated rate per provider to a standardized rate for serving adults with developmental disabilities.

In FY 2017, DD received $80 million ($29 million general revenue) to standardize rates and to fund a 2% inflationary increase for residential, day service, and personal assistance providers. This funding allowed the division to standardize day service rates, almost equalize personal assistance rates to the Department of Health and Senior Services and move residential rates to 70% of funding needed for rate standardization.

In FY 2018, DD received $9.5 million ($3.5 million general revenue) to standardize DD rates; however, this funding was placed in expenditure restriction.

CRITICAL ISSUE: State Inpatient Facility Capacity

Division of Behavioral Health inpatient hospitals are continually at absolute capacity and must schedule admissions for individuals committed by the criminal courts who have been found incompetent to stand trial. The list of scheduled admissions has been increasing over the last several years and recently has been as high as 55 individuals waiting for a bed. DBH has begun using alternative options for individuals with behavioral health conditions who become involved in the criminal justice system such as outpatient competency restoration.

CRITICAL ISSUE: Uninsured Individuals Seeking Services

It is very difficult for many Missourians to access behavioral health services, and it is particularly hard for those without insurance.

- Budget reductions in recent years have dramatically reduced the state funding available for uninsured individuals, resulting in DMH serving mostly people who are covered under Medicaid. While this stretches state dollars, it dramatically limits services for people who do not have health insurance or who have exhausted their insurance benefits. Many people who have substance use disorders or are in the early stages of serious mental illness often do not qualify for Medicaid:
    - Some college students experiencing serious mental illness like schizophrenia, bipolar disorder, or major depression do not have health insurance and are not Medicaid eligible.
    - Of the people leaving the Department of Corrections (DOC), 83% have histories of moderate to severe substance use disorders, 19% have serious mental illnesses, and most are not Medicaid eligible; yet their conditions of parole often require that they obtain behavioral health treatment.
    - In FY17, 23,226 individuals without insurance received treatment for substance use disorders (not SATOP). The demand for such services continues to increase.

- Without appropriate access to services, many people experiencing a behavioral health crisis seek help at emergency rooms, get in trouble with the law, become dangerous to themselves or others, and/or experience repeated hospitalizations.
- If treatment and recovery supports are not accessible through DMH, then hospitals, jails, DOC, police departments, and physicians provide patchwork services that often are inappropriate, expensive, and leave the individual without necessary follow-up care, creating a dangerous and costly cycle.

IV. DMH Constituent Issues

As an elected official, you may receive inquiries regarding DMH services from your constituents. All constituent needs and concerns are a priority for us. The following overview explains how we handle these requests and provides tips on information your office can obtain to expedite the process.

What we need:

- As much concise/precise detail as feasible, preferable by email.
  - Name, address, phone number, email of constituent.
  - Consumer full name, along with age or birthdate.
  - Services the person is receiving or seeking.
  - Concrete concerns about a provider or program.
  - Any deadline or timeframe they are addressing.
- Ask what they specifically want/need from you and from DMH. Sometimes constituents just want to vent to you about a personal situation which cannot be addressed by public servants.
- If they are difficult or upset, connect them with the Access/Crisis Intervention (ACI) line (see link below under Resources).

What we do with the information you provide:

- Check our system and appropriately follow-up with existing consumers:
  - Wellness check.
  - Investigate complaints or concerns.
  - Provide families/concerned citizens with educational information and resources on programs and services available through DMH.
- Triage with other agencies and partners.

- Many constituents receive services from multiple agencies; DMH, DSS and DHSS frequently share/refer/problem solve.

Restrictions:

- Health Insurance Portability and Accountability Act (HIPAA)—without permission from the person under care, we cannot discuss mental health records with anyone who is not authorized to review that information.
- DMH has no authority or influence with programs/services/providers that do not contract with us such as those who only accept private insurance.
- DMH cannot referee family disputes or issues with the public administrator but there are resources that can.

Resources:

- DMH ACI Line—listing by county of toll-free connection to a mental health professional 24/7 http://dmh.mo.gov/mentalillness/progs/acimap.html
- Legal Aid—for constituents who cannot afford an attorney www.lsmo.org
- Protection and Advocacy—for constituents who have complaints against state agencies and need an advocate www.moadvocacy.org

Help Us Combat Stigma:

Join us in following the guidance of People First Language.

Rule 1. Call the person by their name.
Rule 2. If you speak with someone living with a health or mental health disability, remember to speak to the person first and then the disability second. Here are some examples:

Say:	Instead of:
People with disabilities	The handicapped or disabled
Bob's son has autism	Bob's autistic son
Susan's daughter has Down Syndrome	Susan's Down syndrome daughter
Brain injury	Brain damaged
Accessible parking, hotel room, etc.	Handicapped parking, hotel room, etc.
Deb uses a wheelchair/mobility chair	Deb is confined to a wheelchair or is wheelchair bound
Jim has bipolar disorder	Jim is bipolar
Mark has a substance use disorder	Mark is an alcoholic (or druggie, pothead, substance abuser, etc.)

Words to Avoid

Harmful words are the driving force behind stigma. Words and phrases can impact how someone lives their life by making them feel not “good enough” or “less than” others.

Follow these links to our website for words to use and avoid in conversation. Thank you for being our partner in public service and choosing respectful language to assist our mission to reduce stigma.

Behavioral Health and Developmental Disability Language

Substance Use Disorder Language

V. DMH Contact Information

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