Missouri

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 08/27/2015 1.57.25 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 7808714300

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Missouri Department of Mental Health

Organizational Unit Division of Behavioral Health

Mailing Address PO Box 687

City Jefferson City

Zip Code 65102-0687

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Rick

Last Name Gowdy

Agency Name Missouri Department of Mental Health

Mailing Address PO Box 687

City Jefferson City

Zip Code 65102-0687

Telephone 573-751-4942

Fax 573-751-7814

Email Address rick.gowdy@dmh.mo.gov

State CMHS DUNS Number

Number 780871430

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Missouri Department of Mental Health

Organizational Unit Division of Behavioral Health

Mailing Address P.O. Box 687

City Jefferson City

Zip Code 65102-0687

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Rick

Last Name Gowdy

Agency Name Missouri Department of Mental Health

Mailing Address P.O. Box 687

City	Jefferson City
Zip Code	65101-0687
Telephone	573-751-4942
Fax	573-751-7814
Email Address	Rick.Gowdy@dmh.mo.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Christie
Last Name	Lundy
Telephone	573-526-1636
Fax	573-751-7814
Email Address	christie.lundy@dmh.mo.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
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Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for childrenâ€™s services and that all sub-recipients shall certify accordingly.

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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee[1]: _____

Title: Department Director Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

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1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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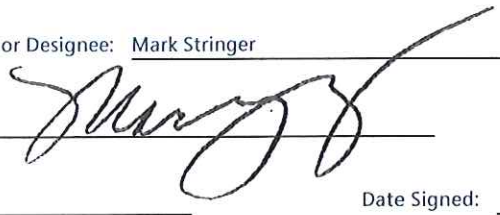
I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee[1]: 

Title: Department Director

Date Signed: 8-3-2015

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

GOVERNOR OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
GOVERNOR

P.O. Box 720
(573) 751-3222

August 11, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As the Governor of the State of Missouri, for the duration of my tenure, I delegate signatory authority to the current Director of the Department of Mental Health, or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the 1) Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG), 2) the Mental Health Block Grant (MHBG)], and 3) the PATH grant, until such time as I may modify or rescind this designation.

Sincerely,

Jeremiah W. (Jay) Nixon
Governor

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

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17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

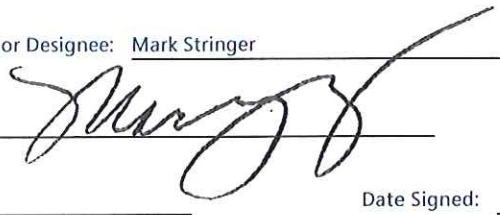
The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee[1]: 

Title: Department Director

Date Signed: 8-3-2015

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

GOVERNOR OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
GOVERNOR

P.O. Box 720
(573) 751-3222

August 11, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As the Governor of the State of Missouri, for the duration of my tenure, I delegate signatory authority to the current Director of the Department of Mental Health, or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the 1) Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG), 2) the Mental Health Block Grant (MHBG)], and 3) the PATH grant, until such time as I may modify or rescind this designation.

Sincerely,

Jeremiah W. (Jay) Nixon
Governor

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
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Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee[1]: _____

Title: Department Director Date Signed: _____

mm/dd/yyyy

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State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

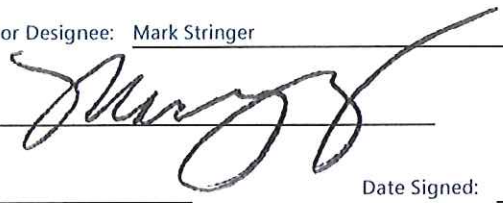
The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee[1]: 

Title: Department Director

Date Signed: 8-3-2015

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

GOVERNOR OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
GOVERNOR

P.O. Box 720
(573) 751-3222

August 11, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As the Governor of the State of Missouri, for the duration of my tenure, I delegate signatory authority to the current Director of the Department of Mental Health, or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the 1) Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG), 2) the Mental Health Block Grant (MHBG)], and 3) the PATH grant, until such time as I may modify or rescind this designation.

Sincerely,

Jeremiah W. (Jay) Nixon
Governor

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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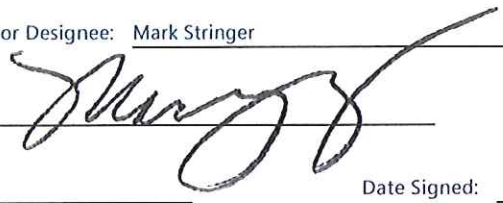
Signature of CEO or Designee[1]: 

Title: Department Director

Date Signed: 8-3-2015

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

GOVERNOR OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
GOVERNOR

P.O. Box 720
(573) 751-3222

August 11, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As the Governor of the State of Missouri, for the duration of my tenure, I delegate signatory authority to the current Director of the Department of Mental Health, or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the 1) Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG), 2) the Mental Health Block Grant (MHBG)], and 3) the PATH grant, until such time as I may modify or rescind this designation.

Sincerely,

Jeremiah W. (Jay) Nixon
Governor

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	Mark Stringer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: _____

Footnotes:

Not applicable.

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Missouri's Behavioral Health System of Care

Overview and structure

With a population of about six million people, Missouri provides a rich diversity of rural and urban landscapes. The state has 114 counties plus the city of St. Louis. Approximately 84 percent of the population is Caucasian, 11.7 percent are African-American, 1.7 percent are Asian, and 3.9 are of other race. About 3.9 percent of the state's population is Hispanic (U.S. Census Bureau, 2015). Large populations of African-Americans are present in the state's metropolitan areas of St. Louis and Kansas City as well as the rural southeast "Bootheel" area. The state's largest Hispanic population is in the Kansas City area. Although the state does not have any federally recognized tribes, small populations of Native Americans make their home near the Oklahoma border. Approximately 494,300 Missouri residents are veterans (Missouri Department of Public Safety, 2015).

At $276 billion, Missouri's Gross State Product (GSP) in 2013 ranked 22nd among states. The GSP consists of 51 percent Services; 18% retail, wholesale, utilities, and transportation; 12% government; 13% manufacturing; 4% construction; and 2% agriculture and mining (Missouri Department of Economic Development, 2015). Although agriculture makes up a relatively small portion of the state's GSP, it represents an important economic sector for the state – particularly for rural Missouri. As of December 2014, the state's unemployment rate stood at 5.4 percent which is slightly lower than that for the country as a whole (5.6%) (U.S. Bureau of Labor Statistics, 2012). Missouri has 42 counties plus the city of St. Louis that are designated as high-poverty counties (i.e. poverty rates of 20 percent or more) by the U.S. Department of Agriculture (USDA Economic Research Service, 2015). Most of these counties are located in the southern portion of the state.

The Missouri Department of Mental Health (DMH) is one of sixteen state agencies under the executive branch of state government. DMH collaborates on initiatives with other state agencies including the Departments of Corrections (DOC), Transportation, Elementary and Secondary Education (DESE), Health and Senior Services (DHSS), Public Safety (DPS), and Social Services (DSS). DSS is the Medicaid authority for the state. DMH's close, collaborative relationships with DOC and DSS, in particular, are strengths to the state's behavioral health system. The principal missions for DMH as established in state law are to: 1) prevent mental disorders, developmental disabilities, substance abuse, and compulsive gambling; 2) treat, habilitate, and rehabilitate Missourians who have these conditions; and 3) improve the public understanding and attitudes about mental disorders, developmental disabilities, substance abuse, and compulsive gambling. DMH has representation on various interagency groups including:

- Council for Adolescent School Health;
- Missouri Coordinated School Health Coalition;
- Stakeholders Advisory Group;
- Child and Family Services Review Advisory Committee;
- Children's Division Recruitment and Retention Workgroup;
- Missouri Alliance for Drug Endangered Children;
- Juvenile Crime Enforcement Coalition for Missouri School Violence Hotline;
- Task Force on the Prevention of Sexual Abuse of Children;

- Comprehensive System Management Team (for state agencies providing services to children);
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Children in Nature Committee (to increase education about nature and positive experiences with the outdoors);
- Missouri Behavioral Health Epidemiology Workgroup;
- Show Me Response (disaster & emergency coordination);
- Missouri Reentry Process Steering Team;
- MO HealthNet (Medicaid) Managed Care Quality Assurance & Improvement Advisory Group;
- Mo HealthNet (Medicaid) Behavioral Health Committee for Health Care Reform
- Missouri Alliance to Curb Problem Gambling;
- Midwest Consortium on Problem Gambling and Substance Abuse Committee;
- Governor's Committee to End Homelessness;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Missouri Drug Court Coordinating Commission;
- Governor's Faith-based and Community Service Partnership for Disaster Recovery;
- Maternal, Infant and Early Childhood Home Visiting Program State Steering Committee;
- Missouri Injury and Violence Prevention Advisory Council;
- Sexual Violence Prevention Planning Stakeholders Committee;
- Paula J. Carter Center on Minority Health and Aging;
- Eating Disorders Council;
- Missouri Behavioral Health Alliance;
- State of Missouri Brain Injury Advisory Council;
- Corrections Oversight Committee for Behavioral Health Services;
- Early Childhood Comprehensive System Steering Committee; and the
- Missouri Prevention Partners Coalition.

Historically, DMH has had the Divisions of Alcohol and Drug Abuse (ADA), Comprehensive Psychiatric Services (CPS), and Developmental Disabilities (DD). In January 2013, ADA and CPS integrated into a new division: the Division of Behavioral Health (DBH). The Department's supportive offices include the Offices of Deaf Services, Constituent Services, and Disaster Services. The state's behavioral health system has been challenged in recent years by reductions in federal and state funding for services. In November 2012, Missouri voters approved a measure that prohibits the Governor or any state agency from establishing or operating a state-based health insurance exchange without legislative or voter approval. At this time, it is unknown if Missouri will expand Medicaid coverage to 138% of the federal poverty level.

The director of the Department of Mental Health (DMH) is appointed by the Missouri Mental Health Commission and confirmed by the state Senate. Comprised of seven members appointed by the Governor, the Mental Health Commission serves as the principal policy advisory body to the department director. The Commission, by law, must include an advocate of community mental health services, a physician who is an expert in the treatment of mental

illness, a physician concerned with developmental disabilities, a member with business expertise, an advocate of substance abuse treatment, and a citizen who represents the interests of consumers of developmental disabilities services. Each of the DMH divisions report progress on identified performance measures to the Mental Health Commission on a quarterly basis.

The Department Director appoints the division directors. The director of the Division of Behavioral Health (DBH) is responsible for leading and managing the DBH division; directing policy and strategic plans for DBH; coordinating with other state officials; and representing DBH in discussions, negotiations and partnerships with other state and federal organizations. DBH is organized into the following functional units:

- Community Programs,
- Psychiatric Facility Operations,
- Children's Services,
- Recovery Services,
- Prevention and Mental Health Promotion,
- Administration, and
- Regional Operations.

Community Programs

Included under Community Programs are all mental health and substance abuse community-based treatment programs, the Substance Abuse Traffic Offenders' Program (SATOP), Healthcare Homes, certification, utilization review, and fidelity review. In addition to leading and managing these programs, the Director of Community Programs is also responsible for working with key stakeholders, to include other state agencies, to improve community-based services. In 2012, the Department of Mental Health (DMH) hired a Project Manager to oversee behavioral health services for Missouri's veteran population. The Division of Behavioral Health (DBH) contracts with 74 community-based agencies for the provision of substance abuse treatment and/or psychiatric rehabilitation services: 45 for substance abuse treatment only, 14 for psychiatric rehabilitation services only, and 15 for both. The certification standards of care contain core rules, adopted in 2001, which apply to both mental health and substance abuse programs. DBH staff conduct annual reviews of contracted community organizations. DBH certifies 110 organizations for substance abuse treatment, 22 organization for substance abuse prevention, and 43 organizations for mental health treatment.

The Department of Mental Health's (DMH) value statement specifies that "Missourians participating in mental health services are valued for their uniqueness and diversity and respected without regard to age, ethnicity, gender, race, religion, sexual orientation, or socioeconomic condition" (DMH, 2008). Core standards require that services be delivered in a manner that is responsive "to each individual's age, cultural background, gender, language and communication skills, and other factors, as indicated" (9 CSR 10-7.010). In addition, programs that provide meals must have a written plan to ensure that menus are responsive "to cultural and religious beliefs of individuals" (9 CSR 10-7.080). DMH requires through contract language that contractor staff be competent in the cultural, racial, and ethnic patterns of the geographic area being served. Interpreting services are provided to individuals in treatment whose preferred language is a language other than spoken English. DMH's Office of Deaf Services (ODS) is responsible for consultation and technical assistance to DMH facilities and contracted providers

delivering behavioral health services to eligible individuals who are deaf, hard of hearing or from cultural minority groups. The ODS also establishes minimum competencies for behavioral health interpreters, consistent with the federal Culturally Linguistically Appropriate Services Standards. Client complaints and grievances received either by DMH's Office of Constituent Services or by the provider organization are reviewed by DMH clinical staff for issues with cultural competency. DMH's information system collects data on client characteristics including race, ethnicity, preferred language, hearing status, and gender identity (ISO 5218). Such data is aggregated by geographical areas for analysis. DMH is a provider of cultural competency trainings for the state's behavioral health and prevention workforce. Cultural competency training is included in DMH's annual Spring Training Institute which is attended by approximately 800 behavioral health and human service professionals.

All individuals needing behavioral health services from facilities operated by the Division of Behavioral Health (DBH) or contracted service providers receive an initial assessment. For individuals needing substance abuse treatment, a department approved assessment tool is used facilitate the determination of level of care and treatment planning. The individual's structured interview is completed by a Qualified Substance Abuse Professional (QSAP). For agencies choosing the Addiction Severity Index for adults, the tool is integrated into the Department's information system. For individuals seeking services from the SATOP program, the self-administered Driver Risk Inventory II (DRI-II), in conjunction with an individualized interview with a QSAP, determines the level of program placement. For individuals needing mental health treatment, the Daily Living Activities (DLA-20) functional assessment tool is used with different modules for adults and youth age 6 to 18.

DBH substance abuse treatment programs include the Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for Women and Children (12 contracts), the General Population (32 contracts), the Opioid Program (3 contracts and 1 state-operated facility), and Adolescents (17 contracts). DBH's CSTAR programs are the only substance abuse treatment programs reimbursable by Medicaid in the state. The CSTAR programs offer a flexible combination of clinical and supportive services that vary in duration and intensity depending on the needs of the client. All but the Opioid programs offer a residential component for individuals needing that type of structure and support. Available services include assessment; individual and group counseling; group education; community support; residential or housing support, as appropriate; trauma-specific individual counseling and group education; individual co-occurring disorders counseling; family therapy; and medications, physician and nursing services to support medication therapy. In addition, families can also participate in individual and group codependency counseling. The Opioid programs provide outpatient services to individuals addicted to opiates and include the dispensing of clinically appropriate medications, primarily methadone, to prevent withdrawal and/or relapse. A designated Program Specialist, acting as the State Opioid Treatment Authority (SOTA), provides oversight and clinical assistance to the Opioid programs to ensure that treatment is consistent with best practices and federal requirements. In 2011, DBH was successful in amending the Medicaid state plan to include a CSTAR Modified Medical Detoxification Program (14 contracts). DBH also maintains the Primary Recovery Plus (PR+) program (13 contracts). Modeled after the CSTAR General Population Program, PR+ offers a full continuum of services within multiple levels of care to assist those individuals without Medicaid coverage. DBH oversees several programs designed specifically for Department of Corrections' offenders under community-

supervision who need substance abuse treatment. These include a CSTAR Women and Children Alternative Care (2 contracts), Community Partnership (1 contract), and Free N Clean (1 contracts). As established in contracts, priority populations for substance abuse treatment include:

- Women who are pregnant;
- Intravenous (IV) drug users who have injected drugs in the prior 30 days;
- Civil involuntary commitments;
- High risk offenders referred by the Department of Corrections' institutions and Division of Probation and Parole via referral form and protocol;
- Applicants and recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, Family Support Division, via referral form and protocol; and
- Adolescents and families served through the Children's System of Care.

All contracted agencies providing substance abuse treatment are required to screen individuals requesting services to determine potential eligibility as a priority population and/or a crisis situation. Individuals identified as a priority population who request or are referred to treatment must be assessed and admitted to an appropriate level of care within 48 hours of initial contact or scheduled release date, whichever is later. Otherwise, the provider must initiate interim services. Pregnant women and civil involuntary commitments, however, require immediate admission. Pregnant women are to be referred to a CSTAR Women and Children's Program unless there is clinical justification to admit her to a general treatment program. Billable interim services for IV drug users include HIV/TB test counseling, motivational interviewing, group education, and recovery support services accessed through the Access to Recovery III (ATR III) Program.

DBH's SATOP program serves more than 28,000 DWI offenders annually who are referred as a result of an administrative suspension or revocation of their driver's licenses, court order, condition of probation, or plea bargain. SATOP is, by law, a required element in driver license reinstatement by the Department of Revenue. The mission of SATOP is to: A) inform and educate DWI offenders as to the hazards and consequences of impaired driving; B) promote safe and responsible decision-making regarding driving; C) motivate for personal change and growth; and D) contribute to the public health and safety of Missourians. DBH certifies and monitors SATOP programs which offer varying levels of care. All SATOP consumers receive an assessment by an Offender Management Unit to determine the level of intervention required. The levels of service include: a 10-hour education course (level 1), a 20-hour intervention course consisting of intensive education and group counseling (level 2), a 50-hour outpatient counseling program for adults or a 25-hour program for youth (level 3), and traditional treatment (level 4). The Serious and Repeat Offender Program (SROP) (level 4) has been designed for chronic DWI offenders and consists of at least 75 hours of treatment in no less than 90 days. The SROP programs have referral agreements with the state's 41 DWI courts/hybrid courts approved by the Drug Court Coordinating Commission. SATOP is largely funded by offender fees.

Core services for the Division of Behavioral Health's (DBH) Community Psychiatric Rehabilitation Program (CPR) (29 contracts), targeted case management (20 contracts), and supported community living (219 contracts) are provided in a community-based and consumer-

centered manner. Services provided in DBH's Community Psychiatric Rehabilitation Program (CPR) for adults (29 contracts) and youth (22 contracts) are Medicaid reimbursable. The types of services provided in the CPR program include evaluation, crisis intervention, community support, medication management, and psychosocial rehabilitation. Outpatient community-based services provide the least-restrictive environment for treatment. Day treatment offers the least-restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than that provided in outpatient services but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services, and education services. Moderate-term placement in residential care provides services with non-acute conditions who cannot be served in their own homes. Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for persons who may be a danger to themselves or others as a result of their mental disorder. DBH also oversees Community Mental Health Treatment (CMHT) (29 contracts) for Department of Corrections' (DOC) offenders under community supervision and who have mental illness. Target populations for mental health treatment include:

- Forensic clients pursuant to Chapter 552 RSMo;
- Adults, children, and youth with serious mental illness (SMI) being discharged from DBH operated inpatient facilities, being transitioned from DBH-operated or contracted residential settings, being transitioned from DBH alternatives to inpatient hospitalization;
- Adults, children, and youth at risk of homelessness;
- Children and youth referred through the Custody Diversion Protocol;
- Individuals with a clinical or personality disorder, other than a principal diagnosis of substance abuse or mental retardation, who also qualify as an adult with severe disabling SMI or children and youth with serious emotional disturbance (SED), as defined by the Department.

DBH supports Assertive Community Treatment (ACT), a service-delivery model that provides comprehensive, community-based treatment to people with serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring alcohol and drug diagnoses, 3) have involvement with the criminal justice system, and/or 4) are homeless. ACT provides highly individualized, intensive services directly to consumers in their homes and communities as opposed to a psychiatric unit. ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. DBH contracts with six agencies to provide ACT.

For mental health treatment, the state is divided into 25 mental health service areas each with an administrative agent. These administrative agents are responsible for the assessment and provision of services either directly or through affiliate Community Mental Health Centers (CMHC) for individuals residing in the assigned service areas. The Administrative Agents are also required to have cooperative agreements with the state-operated inpatient hospitals and are responsible for the provision of follow-up services for persons released from the state hospitals. Of the 29 CMHC's, 27 are also contracted for Health Homes which was implemented in January 2012 and coordinated by the Department's Medical Director. For substance abuse treatment, individuals access services directly from the contracted service provider and may seek services

anywhere in the state regardless of their county of residence. DBH funds ten regional Access Crisis Intervention Hotlines that are staffed by mental health professionals 24 hours per day and 7 days per week to provide intervention and referral for persons experiencing a behavioral health crisis. DBH has arrangements with local taxing authority boards who have a Mental Health Mil tax or Children's Services tax to fund mental health services for adults (3 counties plus the city of St. Louis) and youth (4 counties) and substance abuse treatment for adults (3 counties) and youth (2 counties plus the city of St. Louis). Five regional offices provide consultation and technical assistance to community-based service providers and conduct regular reviews of provider systems.

DBH has implemented several programs to improve coordination of consumers' primary and behavioral healthcare. Disease Management 3700 started as a two-year collaborative demonstration project between DBH and the state Medicaid authority, MO HealthNet. Medicaid eligible individuals with co-occurring chronic medical conditions and serious and persistent mental illness, who are not current consumers of DBH, and who have had a minimum of $30,000 annual Medicaid claims are invited to participate. Persons successfully outreached and engaged through the project are enrolled in a CMHC and assigned a Community Support Specialist. The Disease Management program served as model for Missouri's Health Home initiative and the Alcohol and Drug (ADA) Disease Management. The ADA Disease Management program began in February 2014and targets Medicaid-enrolled adults with substance use disorders and high medical costs who are not currently engaged in treatment.

Missouri has two types of healthcare homes: 1) the CMHC's and 2) primary care including the Federally Qualified Health Centers, Rural Health Clinics, and Hospital-Operated Primary Care Clinics. Enrollment in the CMHC Health Homes began in January 2012. Eligible individuals must be covered by MO HealthNet and have 1) a serious and persistent mental illness, 2) a mental health condition and a substance abuse disorder, or 3) a mental health condition or a substance abuse disorder and a chronic health condition. Of those enrolled, approximately 85 percent are adults and 15 percent are children or youth. As a Health Home, the CMHC's provide comprehensive case management, care coordination and health promotion, patient and family support, comprehensive transitional care, and referrals to community and support services.

Psychiatric Facility Operations

Facility Operations includes management oversight of the nine state-operated psychiatric facilities – two children and seven adult hospitals. With limited exceptions, state operated facilities provide intermediate or long term stay inpatient hospital treatment for individuals with complex, treatment resistant mental illness and whose illness, treatment and recovery are complicated with legal issues and constraints. Adult facilities are located in St. Louis, St. Joseph, Fulton, El Dorado Springs, Kansas City, and Farmington. Youth facilities are located in St. Louis and Cape Girardeau. In 2009 and 2010, the Division of Behavioral Health (DBH) closed 4 emergency departments and 210 acute beds. As part of the DBH Inpatient Redesign, community services are being enhanced to include same-day/next-day appointments at CMHC's for individuals discharged from inpatient status, intensive residential options for crisis diversion and step-down, and a crisis stabilization unit in St. Louis. The number of inpatient psychiatric beds at the end of FY 2012 was 1,146.

Forensic services provides evaluation, treatment and community monitoring under the order of the circuit courts for individuals with mental illness and developmental disabilities involved in the criminal justice system. DBH provides four levels of security (maximum, intermediate, minimum, and campus), with the desired goal of progressive movement through the security continuum based on clinical condition and risk assessment. Within this continuum, forensic clients are provided treatment in a setting consistent with both the clinical needs of the client and safety of the public. Forensic programs are located at Southeast Missouri Mental Health Center, St. Louis Psychiatric Rehabilitation Center, Northwest Missouri Psychiatric Rehabilitation Center, and Fulton State Hospital. Forensic Case Monitors provide community monitoring, as required by state statute, to forensic clients acquitted as not guilty by reason of mental disease or defect who are given conditional releases by circuit courts. There are approximately 400 forensic clients on conditional release statewide.

Children's Services

Both substance abuse and mental health services for children are coordinated under the Division of Behavioral Health (DBH) Director of Children's Services. Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health services to children and youth with serious emotional disturbances (SED). These community-based services are designed to maximize independent functioning and promote recovery and self-determination. The Daily Living Activities Functional Assessment (DLA20) Youth Version is utilized as the standardized functional tool for children and youth entering CPR services. The DLA20 is a twenty-item functional assessment measure designed to assess what daily living areas are impacted by SED or disability. The assessment tool quickly identifies where outcomes are needed so clinicians/community support specialists can address those areas on the individualized treatment plan with the goal of improved functioning and symptom reduction. With the implementation of the DLA20 for adults and youth, eligibility for CPR services will be based not only on strict diagnostic codes, but on an individual's functional needs, allowing for transitional age youth (ages 16-25) to smoothly transition into the adult CPR program. An assigned Community Support Specialist monitors medical, dental, and support service needs and coordinates services and resources among community agencies. The CPR program includes an intensive level of care for acute psychiatric episodes as clinically appropriate. Approximately 90 percent of the youth receiving mental health treatment are in the CPR program. Community support services available to children and youth include day treatment, psychosocial rehabilitation services, intensive/non-intensive targeted case management, family support, and family assistance. Day treatment provides goal-oriented therapeutic services focusing on the stabilization and management of acute or chronic symptoms which have resulted in functional deficits. Day treatment may include physician services, psychiatric evaluations, medication management, age appropriate education services, skill building groups, individual and group psychotherapy, occupational/physical therapies, community support, and family support. Psychosocial rehabilitation services are a combination of goal-oriented and rehabilitative services provided in a group setting. Family support helps establish a support system for parents of children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance. With family assistance, a Family Assistant Worker may work with the individual and family on home living and community skills, communication and socialization, and conflict resolution.

In 2012, Professional Parent Home (PPH) services were added to the CPR array of services offered to youth. PPH exists to serve youth in a private home whose serious emotional needs lead to behaviors, that in the absence of such programs, they would most likely be placed in restrictive residential or inpatient settings. These youth have demonstrated an inability to be in the community free of emotional or physical difficulty and who, without a sustained intensive therapeutic intervention, would have significant physical, emotional, or relational consequences. PPH providers are responsible for participation in the development of the youth's treatment plan and record documentation related to implementation of the treatment plan within the home.

In 2013, DBH offered an introductory training to providers across the state on a specialized Assertive Community Treatment (ACT) service targeted for the transitional age youth (ages 16-25) population. The first Missouri Assertive Community Treatment Transitional Age Youth (ACT TAY) program was developed in the Central Region and began providing services to this population in January 2014. The ACT TAY program uses a team approach designed to provide comprehensive and flexible treatment, support, and rehabilitation services to transitional age youth in their natural living settings rather than in hospital or clinic settings. The multi-disciplinary team members include a physician, nurse, vocational specialist, substance use specialist, peer specialist and community support specialist.

For children and youth, the first signs of mental illness or emotional distress can emerge in the school environment. DBH has expanded the availability and accessibility of treatment services by authorizing the delivery of designated CPR services in school settings. These designated CPR services are provided to children with an Individualized Education Plan (IEP), as well as those without an IEP. DBH providers partnering with schools is effective because it enables specialists to quickly identify student issues and immediately triage care based on the severity of circumstances. Besides the students getting immediate assistance, the school personnel benefit from having CPR services provided in the school setting.

Substance use treatment for adolescents is provided in the CSTAR Adolescent program. Designed for youth age 12 to 17, the CSTAR Adolescent program offers a full spectrum of treatment services. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Youth in residential settings are offered academic support services to minimize disruptions in their education. For youth with co-occurring mental health and substance use disorders, CPR and CSTAR Adolescent programs will coordinate services. In the CSTAR Women and Children Program, daycare, codependency counseling, and community support services are available to those children whose parent is receiving substance use treatment.

DBH has made significant infrastructure changes targeted to the transitional age youth population. Both CPR and CSTAR programs now have the ability to pull from youth and adult services and funding to individualize treatment planning based on the developmental needs of the individual.

The Department of Mental Health (DMH) is partnering with the Department of Social Services (DSS) and the Office of State Courts Administrator (OSCA) to update and improve the existing custody diversion process established for child-serving agencies to follow in those cases involving parents who are considering voluntarily relinquishing custody of their child for the

sole purpose of accessing mental health care. For those children already in state custody solely for mental health services in the absence of child abuse or neglect and severe mental retardation disability, DMH and DSS have facilitated an evaluation and review process. DSS' Children's Division has established Family Support Teams for children identified to determine future custody status. In conjunction with the diversion protocol, voluntary placement under Title IV-E allows a family to relinquish physical custody but retain legal custody so that these children become eligible for mental health services funded by Medicaid and Title IV-E funds for a period of up to 180 days. The Comprehensive Children's Mental Health Plan and grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) have supported the development of local interagency teams to oversee children's services in the community. Missouri currently has 16 local System of Care (SOC) teams.

In 2012, DBH was awarded a SAMHSA-funded Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) Grant to create a coordinated system to support St. Louis City children, ages 0-8, in a supportive environment conducive to healthy development. The five-year grant will use a public health approach emphasizing prevention and promotion. The grant will implement screening and mental health assessment in a range of child-serving settings. The state team includes representation from DBH, the Department of Health and Senior Services, and the Missouri Institute for Mental Health. Grant partners include Vision for Children at Risk, the Council on Young Child Wellness, and the National Council on Alcoholism and Drug Abuse. Boone County (located in central Missouri) was awarded a Project LAUNCH Grant in 2010 to improve coordination of children's services in that county. DBH is represented on the Boone County Project LAUNCH Wellness Council.

Recovery Supports

The Division of Behavioral Health's (DBH) functional area of Recovery Services includes housing, employment, peer services, the Missouri Access to Recovery program, staff training and development, and coordination of the ADA and CPS state advisory councils. The Director of Recovery Services oversees DBH's housing unit who works to connect homeless individuals who are challenged with behavioral health issues with safe, decent, and affordable housing options that best meet their individual and family needs. In addition to providing education and technical assistance, DBH's housing unit manages 44 U.S. Department of Housing and Urban Development (HUD)-funded Shelter Plus Care Grants that provides rental assistance for individuals who 1) are homeless, 2) have a serious mental illness, a chronic substance abuse problem, a severe and chronic developmental disability, or a diagnosis of HIV/AIDS, 3) are receiving long-term behavioral health support services, and 4) meet the "very low" income requirement. Approximately 3,200 persons are served annually through Missouri's Shelter Plus Care program. Missouri has eleven federally-funded Projects for Assistance in Transition from Homelessness (PATH) grants to support service delivery to adults (age 18 or older) with serious mental illness, as well as those with co-occurring substance abuse disorders, who are homeless or at risk of becoming homeless. Services include community-based outreach; support services such as case management, employment skills training, psychosocial education, and group therapy; and some temporary housing services. Supported community living programs are provided for persons with mental illness who do not have a place to live or who need more structured services while in the community. Persons in these programs receive support through case management and community psychiatric rehabilitation programs provided by administrative

agents. Housing assistance is provided in the SAMHSA-funded Access to Recovery program for individuals in treatment and/or recovery from substance addiction.

DBH recognizes the tremendous therapeutic value of employment for working-age individuals with behavioral health disorders and is committed to enhancing employment options for those individuals. Supported Employment is an evidence-based practice that provides individualized services and supports to an individual in competitive employment to promote stable employment. DBH received a Johnson and Johnson grant for the provision of technical assistance and fidelity for Supported Employment. Although the grant ended in 2012, fidelity efforts are being sustained. DBH works with the Department of Elementary and Secondary Education, Vocational Rehabilitation (Voc Rehab) who provides job counseling, job-seeking skills, job placement, and vocational training. DBH also provides support services for mental health clients not currently eligible or ready for services from Voc Rehab. The Department of Mental Health's (DMH) Employment Workgroup has facilitated the development of benefits planning training materials and a web-based tool "Disability Benefits 101". In 2012, DBH staff developed a guidance document on appropriate community support interventions reimbursable under the CSTAR treatment program for consumers pursuing employment (DMH, 2012).

Peer services are available to individuals in mental health treatment to aid in the navigation of Medicaid program and establish linkages to other community resources. Missouri has certified over 160 Peer Specialists some of whom work at Community Mental Health Centers and state-operated hospitals. DBH funds through competitive bid 5 consumer-operated drop-in centers and 5 peer support phone lines that emphasize self-help for individuals with mental illness. These Consumer Operated Service Programs (COSP) use the Fidelity Assessment Common Ingredient Tool (FACIT) as a self-assessment tool to support continuous quality improvement efforts. Missouri was one of seven study sites for SAMHSA's Multi-Site Research Initiative to assess how consumer-operated service programs can, as an adjunct to traditional mental services, improve outcomes of adults with serious mental illness. The Missouri Institute of Mental Health was one of two coordinating centers for this initiative. Family Support Provider is a peer to peer service that provides support to parents/caregivers who have children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance. Peer services are available to individuals in recovery from substance addiction through the SAMHSA-funded Access to Recovery III program. Provided by credentialed Recovery Support Specialists, recovery coaching is the development of a supportive peer relationship to foster recovery-oriented problem solving skills. The recovery coach's role emphasizes reconnection to support systems in the community. Missouri has credentialed 52 Peer Recovery Support Specialists. In 2012, DBH worked with the Addiction Technology Transfer Center Network (ATTC) to bring the Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy to Missouri.

To address recovery from substance addiction, DBH established a network of community-based and faith-based recovery support providers under the SAMHSA-funded Access to Recovery (ATR) I grant implemented in 2005. Under ATR I, over 100 recovery support providers across the state were recruited, trained, and credentialed. With the ATR II grant, Missouri increased focus on the implementation of evidence-based practices, including Motivational Interviewing, the Matrix Model for Intensive Outpatient Treatment, as well as,

reducing barriers to service delivery. With the ATR III grant, the state has developed local recovery-oriented systems of care and implemented recovery coordination to sustain longer periods of client engagement. In spring 2015, SAMHSA has notified Missouri that the state will be receiving an ATR IV grant. Under ATR IV, Missouri will serve low-income adults with substance use disorders and priority given to 1) parole and probation offenders beginning community supervision, 2) African-Americans, and 3) women. An array of recovery support services will address important recovery domains including abstinence, wellness, stable housing, employment, spirituality, positive social connections, and crime-free lifestyles.

At this time, DBH has separate State Advisory Councils (SAC) for substance abuse and mental health. Each SAC is comprised of 25 members who advise and make recommendations to improve the system of care. Meetings typically include budget and programming updates from DBH staff as well as in-depth presentations and discussions on initiatives and strategic planning. Members have professional, research, and/or personal interests in the respective area. Membership on the Substance Abuse SAC must be at least one-half clients and/or family members of clients and have at least one member representing veterans and military affairs. Current membership includes representation from the Missouri National Guard, the Veteran's Administration, the Department of Corrections, the Department of Health and Senior Services, Drug Court, vendors, and people with lived experiences. Membership on the Mental Health SAC must have a majority of mental health clients and/or family members of clients and also representation from the Departments of Social Services, Medicaid, Corrections, Vocational Rehabilitation, Education, Housing, and Mental Health. Since work began to integrate the ADA and CPS divisions, the councils have held joint meetings on the integration process and state planning efforts for a behavioral health system of care. The December 2014 joint meeting reviewed a draft of the FY 2016 – 2017 Block Grant Behavioral Health State Plan.

Prevention and Mental Health Promotion

Prevention and Mental Health Promotion includes substance abuse prevention, suicide prevention, Crisis Intervention Teams (CIT), Mental Health First Aid, tobacco cessation, and tobacco retailer education. The Director of Prevention and Mental Health Promotion is also the project coordinator for the state's FDA tobacco enforcement contract. The Division of Behavioral Health (DBH) subcontracts with the Department of Public Safety, Division of Alcohol and Tobacco Control for enforcement of the federal Family Smoking Prevention and Tobacco Control Act. DBH uses a Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the Missouri's substance abuse prevention workforce. The STRC is also a member of Community Anti-Drug Coalitions of America (CADCA). DBH, in collaboration with the STRC and the Missouri Alliance for Drug Endangered Children, sponsored the 2014 Substance Abuse Prevention Conference attended by about 200 prevention professionals. DBH also provides funding to the Missouri Youth/Adult Alliance (MYAA), a statewide coalition that provides resource materials and education to local community efforts focused on underage drinking.

DBH contracts with 10 community-based Regional Support Centers (RSC) that are state-certified to provide prevention services on alcohol, tobacco, and other drug (ATD) issues. The RSC's are the primary source of training and technical assistance support for over 150 community coalitions located throughout the state. The coalitions are teams of volunteers of community leaders, parents, and youth who seek to address substance abuse in their

communities. The RSC's employ prevention specialist that serve as community-level experts to assess community needs, build capacity, develop strategic plans, and implement evidence-based prevention programming. The RSC's provide retailer education on state and federal tobacco regulations to local tobacco retailers and assist the state in compiling a list of tobacco retailers in support of federal Synar requirements as Missouri does not have tobacco licensure. DBH also provides funding to Partners in Prevention (PIP), Missouri's higher education substance abuse consortium representing 21 colleges and universities and serving about 161,000 college students. PIP administers the Missouri College Student Health Behavior Survey (MCHBS) which is completed by approximately 9,000 students each school year. The RSC's, PIP, and many community coalitions have been trained on and use SAMHSA's Strategic Prevention Framework planning process. In support of prevention planning at the local level, DBH funds the biennial Missouri Student Survey (MSS) to assess substance use and related behaviors among students in grades 6 through 12. In 2014, approximately 67,500 students participated in the MSS.

DBH's School-based Prevention, Intervention, and Resources Initiative (SPIRIT) implements school-based curricula of proven effectiveness for reducing substance use, preventing substance initiation, and reducing violent behavior among children in kindergarten through 12th grade. Age- and grade-appropriate programs are selected from SAMHSA's National Registry of Evidence-based Programs and Practices. SPIRIT currently operates in four sites serving six school districts across the state. These school districts serve high-risk populations characterized by: 1) high percentage of students qualifying for reduced/free lunches, 2) low standardized test scores, 3) high prevalence of substance use, 4) low graduation rates, and/or 5) high rate of juvenile justice referrals. Screening and referral services are provided. In FY 2014, about 7,800 students participated in the SPIRIT program. DBH contracts with the Missouri Institute of Mental Health to conduct an annual evaluation of the SPIRIT program.

DBH also funds other selective prevention services and early intervention activities for designated children, youth, and families. These services involve structured programming and/or a variety of activities including informational sessions and training. Target groups include youth experiencing academic failure and low-income youth and families. Programs are located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the "Bootheel". DBH contracts with the Missouri Alliance of Boys and Girls Club sites throughout the state for implementation of SMART Moves (Skills Mastery and Resistance Training) serving over 60,000 youth ages 5-18. DBH contracts with the Leadership Through Education and Advocacy for the Deaf (L.E.A.D.) for the provision of prevention services for deaf and hard of hearing youth. L.E.A.D. conducts the annual Teen Institute for the Deaf attended by approximately 40 youth ages 12 to 17.

In 2010, Missouri established an interagency Statewide Epidemiology Outcomes Workgroup (SEOW) through funding support from SAMHSA. The mission of Missouri's SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and

- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

Missouri's SEOW is chaired by a Research Assistant Professor at the Missouri Institute for Mental Health – University of Missouri, St. Louis. Membership includes data experts from mental health, social services, public safety, health, education, and the judicial system. DBH's Research Coordinator, Research Analyst, and Director of Prevention and Mental Health Promotion are SEOW members.

DBH's Crisis Intervention Team (CIT) training program is a community-based collaboration that trains law enforcement officers and first responders to take appropriate action with individuals having a mental illness or substance abuse crisis. The program provides specialized training under the instructional supervision of behavioral health providers, family advocates, and behavioral health consumer groups. Training provides an overview of mental illness and substance abuse, discussions with consumers and family members, the development of active listening skills and de-escalation techniques, and information on community resources. CIT training seeks to increase the safety of both the officer and the consumer and to divert the consumer from jail settings to behavioral health treatment and/or services.

In 2008, the Missouri Division of Behavioral Health, the Maryland State Department of Health and Mental Hygiene, and the National Council for Community Behavioral Healthcare worked to bring Mental Health First Aid (MHFA), initially developed in Australia, to the United States. MHFA-USA seeks to provide the general public with basic first aid interventions for common behavioral health problems. MHFA is a 12-hour health literacy program that teaches the public how to recognize the signs and symptoms of mental health problems. Over 20,300 individuals have taken the MHFA course in Missouri. A 5-day instructor course is also available for individuals seeking instructor certification. Over 200 individuals have been certified as MHFA instructors in Missouri. A Youth MHFA-USA course has been developed to teach individuals how to help a youth in crisis or experiencing a mental health or substance abuse issue.

Disaster Services

The Department of Mental Health's (DMH) Office of Disaster Services (ODS) conducts planning and development activities to support a coordinated mental health response for Missourians in disaster situations. ODS coordinates efforts with the State Emergency Management Agency (SEMA) and the Department of Health and Senior Services. ODS also develops and administers the FEMA Crisis Counseling Program grant when there is a federal declaration in Missouri. ODS coordinates the DMH Show-Me Response that deploys, in the event of a disaster, volunteers of licensed professionals such as psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, certified substance abuse counselors, and developmental disability professionals. ODS represents DMH on the Governor's Faith-Based & Community Service Partnership for Disaster Recovery to aid Missourians' recovery plans by developing and implementing a holistic approach to disaster recovery. In January 2012, a child trauma treatment center *Will's Place* opened in Joplin to provide ongoing specialized mental health treatment for children and training for adult responders. Will's Place received a SAMHSA grant that will enable the center to be a

Category III Community Treatment and Services Center of Excellence and will serve a regional four-state area that includes Missouri, Arkansas, Kansas, and Oklahoma.

Administration

The Division of Behavioral Health's (DBH) administration unit includes budgetary/financial analysis and monitoring, grants management, the Customer Information and Management Outcomes and Reporting (CIMOR) Help Desk, and Research and Statistics. In the Research and Statistics unit, DMH's Research Coordinator is also the Drug & Alcohol Services Information System/Treatment Episode Dataset (DASIS/TEDS) manager and the State Synar Coordinator. DBH's Director of Quality Improvement oversees the SAMHSA-funded State Data Infrastructure Grant for the collection, analysis, and reporting of client outcome data for individuals receiving mental health treatment. Process measures and client outcomes data are generated for program monitoring and federal reporting. DBH produces an annual Status Report on Missouri's Substance Abuse and Mental Health Problems that provides epidemiological profiles of the state, its counties, and planning regions. In FY 2014, DBH published its 20th edition of the annual status report and, in collaboration with the state epidemiology workgroup, has implemented a web-based querying tool to facilitate use of behavioral health data at the local level.

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Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

Assessment of Need

Behavioral Health Data

The Missouri Department of Mental Health (DMH) planning utilizes prevalence data, behavioral health indicators, treatment admissions data, population estimates, needs assessments, and outcomes data. DMH assimilates behavioral health-related data from several national and state surveys. DMH acquires state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH), state estimates from the Youth Risk Behavior Survey (YRBS), state estimates from the Behavior Risk Factor Survey (BRFS), state and county-level data from the Missouri Student Survey (MSS) for grades 6 through 12, and state data collected from 21 of Missouri's universities and colleges using the Missouri College Health Behavior Survey (MCHBS). DMH annually updates prevalence estimates using the most current survey data.

DMH collects an array of behavioral health indicator data, mostly from other state agencies. The indicators include traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements; methamphetamine lab confiscations; probation, parole, and prison admissions; and drug, DUI, and mental health court enrollments. DMH also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment rates. DMH annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, service areas, planning regions, and the state.

Substance abuse and mental health treatment admissions data are retrieved from the DMH Customer Information, Management, Outcomes, and Reporting (CIMOR) system, based on each consumer's county of residence. Information on demographics, substances abused, diagnoses, and treatment services are assembled by fiscal year into geographic profiles for the counties, planning regions, service areas, and state. These profiles are included in DMH's annual Status Report on Missouri's Substance Abuse and Mental Health Problems.

State Epidemiology Outcomes Workgroup

In 2010, Missouri was awarded a State Epidemiology Outcomes Workgroup (SEOW) contract, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The state used this funding to revitalize its SEOW workgroup that had been established under Strategic Prevention Framework State Incentive Grant (2004-2009) to address underage drinking. An expanded scope of the new SEOW includes mental health promotion. The mission of Missouri's current SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;

- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

The SEOW is chaired by a Research Assistance Professor at the Missouri Institute for Mental Health – University of Missouri, St. Louis. DMH's Director of Prevention, Research Coordinator, and Director of Quality Improvement are members of the SEOW. Social services, public safety, health, education, the judicial system, and academia are also represented on the workgroup:

Name	SEW Position	Title	Agency
Susan Depue	chairperson	Research Assistant Professor	Missouri Institute for Mental Health
Stacy Scott	Member	Research Assistant Professor	Missouri Institute for Mental Health
Angie Stuckenschneider	member	Prevention Director	Missouri Department of Mental Health
Christie Lundy	member	Research Coordinator	Missouri Department of Mental Health
Emilia Beckmann	member	Research Analyst	Missouri Department of Mental Health
Freddie Spraggs	member	Research Analyst	Missouri Department of Social Services, Research & Evaluation
Ron Beck	member	Director	Missouri State Highway Patrol, Statistical Analysis Center
Shumei Yun	member	State Epidemiologist	Missouri Department of Health and Senior Services, Division of Community and Public Health
Anne Janku	member	Research Manager	Office of State Courts Administrator
Liz Sale	member	Research Associate Professor	Missouri Institute for Mental Health
Tracy Greever Rice	member	Director	Office of Social and Economic Data Analysis , University of Missouri
Dan Reilly	member	Underage Drinking Prevention Coordinator	Partners in Prevention
Tom Schlimpert	member	Guidance and Counseling Services	Missouri Department Of Elementary And Secondary Education

As part of the SAMHSA-funded Partnership for Success Grant (2013-2015), the SEOW has been responsible for providing data expertise and support to Partnership coalitions in addressing underage drinking and to the college consortium, Partners in Prevention, in addressing misuse of prescription drugs among college students. As part of the broader behavioral health system, the SEOW workgroup continues to assess data gaps, enhance capacity to use behavioral health data, promote data driven decision-making, increase dissemination of data and analyses, promote common data standards, and increase data collaborations.

Overall Need

Serious Emotional Disturbance (Children) and Serious Mental Illness (Adults)

Substate Planning Area	2012 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2013	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	354,709	24,829	5,226	19,603	78.95%
Central	183,123	12,818	2,032	10,786	84.15%
Eastern	486,633	34,064	3,574	30,490	89.51%
Southwest	216,796	15,175	2,418	12,757	84.07%
Southeast	163,754	11,462	2,641	8,821	76.96%
State Total	1,405,015	98,348	15,891	82,457	83.84%

Table 1 FY 2013 Estimated prevalence of childhood serious emotional disorder.

Substate Planning Area	2012 Population Age 18+	Estimated Need (5.4%)	Received Treatment FY 2013	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	1,115,530	60,238	18,680	41,558	68.99%
Central	630,720	34,058	7,194	26,864	78.88%
Eastern	1,609,291	86,901	15,582	71,319	82.07%
Southwest	715,209	38,621	8,399	30,222	78.25%
Southeast	548,757	29,632	11,461	18,171	61.32%
State Total	4,619,507	249,450	61,316	188,134	75.42%

Table 2 FY 2013 Estimated prevalence of adult serious mental illness.

State estimates for serious mental illness (SMI) (adults) and serious emotional disturbances (SED) (children) are obtained from estimates published in the federal register (FR Doc. 98-19071; FR Doc. 99-15377). Based on these historically reported estimates required for use in the Block Grant State Plan, approximately 5.4 percent of the Missouri adult population has an SMI and 7 percent of Missouri children have an SED. Based on national NSDUH data, the

estimated number of adults with SMI in the past year who did not receive mental health treatment in the past year is about 32 percent or an estimated 85,146 Missouri adults with SMI (SAMHSA, 2015). For the remaining 180,936 Missouri adults with SMI who did received some level of mental health treatment, it is not known what portion of these received a sufficient level of care to address their SMI condition. A study by Mark and Buck (2006) examining characteristics of U.S. youth with SED found that about 44 percent were covered by private insurance, 31 percent were enrolled in Medicaid/Children's Health Insurance Program (CHIP), 11 percent were covered by another unspecified public program, and about 14 were uninsured. It is reasonable to assume that the majority if not the entire uninsured group represents unmet need. It is not, however, known what portion of the private insurance group did not have sufficient coverage for adequate care of the child's SED condition.

As of March 2015, it is not known if Missouri will expand its Medicaid program to 138 percent of the federal poverty level. The majority of Department of Mental Health consumers with SMI do not have private insurance.

Substance Use Disorder

Substate Planning Area	2012 Population Age 12-17	Estimated Need 5.76%	FY13 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	117,640	6,776	694	6,082	89.76%
Central	61,187	3,524	477	3,047	86.46%
Eastern	168,798	9,722	762	8,960	92.16%
Southwest	73,885	4,255	442	3,813	89.61%
Southeast	55,859	3,217	420	2,797	86.94%
State Total	477,369	27,494	2,795	24,699	89.83%

Table 3 FY 2013 Estimated prevalence of adolescent substance abuse disorder.

Substate Planning Area	2012 Population Age 18+	Estimated Need 8.66%	FY13 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	1,115,530	96,604	9,213	87,391	90.46%
Central	630,720	54,620	5,589	49,031	89.77%
Eastern	1,609,291	139,364	11,453	127,911	91.78%
Southwest	715,209	61,937	7,151	54,786	88.45%
Southeast	548,757	47,522	6,041	41,481	87.29%
State Total	4,619,507	400,047	39,447	360,600	90.14%

Table 4 FY 2013 Estimated prevalence of adult substance abuse disorder.

County-level population of persons age 12 or older was obtained from the Missouri Census Data Center and aggregated to the substate areas (Missouri Census Data Center, 2012). Statewide estimates for substance use disorder treatment need are obtained from the National

Household Survey (NSDUH) (SAMHSA, 2015). The difference between estimated need and number served yields the combination of estimated served outside of the state system and unmet need. As of March 2015, it is not known if Missouri will expand its Medicaid program to 138 percent of the federal poverty level. Less than five percent of DMH consumers receiving substance use disorder treatment in FY 2013 had private health insurance at the time of admission.

Coordination of Primary Care and Behavioral Health Services

Individuals with serious mental illness die 11 to 32 years prematurely from preventable chronic health conditions such as heart disease, diabetes, cancer, pulmonary disease, and stroke (National Institute on Mental Health, 2012). In addition, individuals with co-occurring mental illness and substance abuse disorders are at greater risk for relapse and tend to have poorer outcomes in comparison to individuals with only a substance abuse disorder (Compton, W.M., Cottler, L.B., Behn-Abdallah, A., & Spitnagel, E.L., 2003; Hser, Y.I., Evans, E., Teruva, C., Huang, D., & Anglin, M.D., 2007). Expenditures for co-occurring individuals on Medicaid tend to be higher because of not only the substance abuse and mental illness disorders but also accompanying physical disorders (Clark, R.E., Samnaliev, M., & McGovern, M.P., 2009). The Missouri Department of Mental Health (DMH) has implemented a Health Home model for its Community Mental Health Centers (CMHC) and disease management programs for both serious mental illness and substance use disorders. Under the Health Home model, individuals with serious mental illness served by the CMHC's have monitoring of their health status; coordination of their care including their physical health needs; individualized care planning; and promotion of self-management. For an individual to be eligible for enrollment in Missouri's Health Home, he/she must meet one of the following three conditions:

1) have a serious and persistent mental illness,
2) have a mental health condition and a substance abuse disorder, or
3) have a mental health condition or a substance abuse disorder and one other chronic health condition.

DMH's disease management programs target Medicaid-enrolled adults with serious mental illness or substance use disorders and high medical costs who are not currently engaged in behavioral health treatment.

Crisis Intervention

Individuals experiencing a crisis due to a behavioral health condition often visit the emergency room or have contact with law enforcement or other first responders. In 2012, Missouri had over 82,000 emergency room visits in which the primary diagnosis was for a mental illness. In addition, there were roughly 35,000 emergency room visits in which the primary diagnosis was for alcohol and/or drug use (Smith, R. *et al*, 2014). Research suggests that about 7 percent of all police contacts in urban settings involve a person experiencing mental illness (Deane, M. *et al*., 1999). In a random sample of 500 recent admissions to Missouri's penal institutions, about one-half (48 percent) were assessed with serious functional impairment due to a substance use disorder and 14 percent were under clinical care for a mental illness

(Missouri Department of Mental Health, 2015). DMH has implemented several projects: 1) Community Mental Health Liaisons, 2) Emergency Room Enhancements, 3) Crisis Intervention Team (CIT), and 4) Assess Crisis Intervention (ACI) hotlines with the goals of increasing access to treatment and improving individual outcomes.

Substance Abuse Traffic Offenders' Program

Substate Planning Area	FY 2013 Screened due to DWI/DUI
Northwest	5,512
Central	3,479
Eastern	8,716
Southwest	3,845
Southeast	2,954
State Total	24,506

Table 6 Number screened due to a DUI arrest.

Missouri's Substance Abuse Traffic Offender Program (SATOP) is a statewide network of community-based education and treatment options for consumers arrested in Missouri for alcohol- and drug-related driving offenses. Completion of SATOP is a requirement by state statute as a condition of license reinstatement resulting from DWI/DUI administrative action. The program incorporates a comprehensive assessment to determine the appropriate level of education and/or clinical treatment services. DMH continues to work to improve the program in order to reduce DWI/DUI recidivism.

Department of Corrections Community Supervised Offenders

Substance Abuse

Substate Planning Area	FY 2013 Probation and Parole Population	Probation and Parole Need (68%)	FY13 Served	Estimated Unmet Need	Penetration Gap
Northwest	17,909	12,178	3,340	8,838	72.57%
Central	11,501	7,820	2,487	5,333	68.20%
Eastern	35,429	24,091	6,897	17,194	71.37%
Southwest	13,524	9,196	2,601	6,595	71.72%
Southeast	17,835	12,127	3,697	8,430	69.51%
State Total	96,198	65,412	19,022	46,390	70.92%

Table 7 Estimated need for substance abuse treatment among parole and probation offenders.

The number of individuals on parole or probation for FY 2013 was obtained from the Missouri Department of Corrections (DOC). Estimated need for substance abuse treatment was determined from the DOC Substance Abuse Classification Assessment (SACA). Most

individuals receive an assessment when they enter prison and when they start community supervision. Number served in the publicly-funded system for FY 2013 was obtained from the Missouri Department of Mental Health billing system. Estimated unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment.

Mental Illness

Substate Planning Area	FY 2013 Probation and Parole Population	Probation and Parole Need (17%)	FY13 Served	Estimated Unmet Need	Penetration Gap
Northwest	17,909	3,044	1,661	1,383	45.43%
Central	11,501	1,955	897	1,058	54.12%
Eastern	35,429	6,022	1,784	4,238	70.38%
Southwest	13,524	2,299	840	1,459	63.46%
Southeast	17,835	3,031	1,743	1,288	42.49%
State Total	96,198	16,351	6,925	9,426	57.65%

Table 8 Estimated need for serious mental illness treatment among parole and probation offenders.

The number of individuals on parole or probation for FY 2013 was obtained from the Missouri Department of Corrections (DOC). Estimated need for mental illness treatment was determined from the mental health needs score. Number served in the publicly-funded system for FY 2013 was obtained from the Missouri Department of Mental Health billing system. Estimated unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment.

Tobacco Prevention / Cessation

Past Month Cigarette Use for Selected Groups	Missouri	U.S.
Individuals with Serious Mental Illness in Past Year	46.7%	44.9%
Individuals without a Serious Mental Illness in Past Year	32.8%	25.6%
Individuals with an Alcohol or Drug Abuse/Dependence Problem in Past Year	62.2%	55.3%
Individuals without an Alcohol or Drug Abuse/Dependence Problem in Past Year	26.4%	21.2%
Youth Age 12-17	14.4%	10.2%
Young Adults Age 18-25	43.1%	37.3%

Table 9 Prevalence of Current Cigarette Use (SAMHSA, 2013)

Estimates of past month cigarette use were obtained from the National Household Survey on Drug Use and Health (SAMHSA, 2013). Prevalence of cigarette use for Missouri tends to be

higher than that for the U.S. Cigarette use for individuals with a serious mental illness or an alcohol or drug problem tend to be much higher than those without a serious mental illness or an alcohol or drug problem.

Research has shown that higher merchant compliance with tobacco control laws predicts lower levels of youth smoking (DiFranza, Savageau, & Fletcher, 2009). The Missouri Department of Mental Health - Division of Behavioral Health (DBH) is the state agency that oversees the state's federal Synar requirements and partners with the Department of Public Safety – Division of Alcohol and Tobacco Control for tobacco control efforts. Federal Synar regulations require all states to maintain a retailer non-compliance rate of no more than 20 percent (42 U.S.C. 300x-26 and 45 C.F.R. 96.130). Since 1996, DBH is charged with overseeing the Synar requirements in Missouri, conducting the annual Synar survey, and implementing tobacco prevention activities as it relates to the sale of tobacco products to minors. A state that fails to comply with the federal Synar requirements is at risk for losing Substance Abuse Prevention and Treatment Block Grant funding.

Recovery Support Services

Substance Abuse

Substate Planning Area	Estimated Number with a Substance Use Disorder in Past Year (2011-2012)	Number that Received Recovery Support Services in the State System in FY 2013
Northwest	98,360	2,651
Central	54,382	454
Eastern	144,436	78
Southwest	55,975	1,645
Southeast	43,847	586
State Total	397,000	5,414

Table 10 Estimated Substance Abuse Prevalence and Number Served with Recovery Support Services

Research has shown that, for many individuals, recovery coaching, 12-step programs, spirituality, and social and community supports play an important role in maintaining long-term recovery from substance addiction (SAMHSA, 2009). While the Missouri Department of Mental Health (DMH) has sought additional state funding to support recovery support services in the past, serious state budget deficits and difficult economic conditions have precluded such funding. DMH has received three SAMHSA-funded Access to Recovery (ATR) Grants: ATR I which ended in 2007, ATR II which ended in 2010, and ATR III which ended in 2014. The state has been notified that it will receive an ATR IV grant sometime around April 2015. Under ATR I, DMH implemented a voucher system and created a network of recovery support providers including many faith-based providers. Under ATR II, the state increased focus on the implementation of evidence-based practices and added reentry coordination services to the menu

of recovery support services. Under ATR III, DMH has implemented a model to focus on local recovery-oriented systems of care and to provide outreach and priority to 1) Veterans and National Guard soldiers, 2) Treatment court participants, and 3) Department of Corrections offenders returning to the community. Under ATR IV, the state seeks to increase service coordination with priority given to 1) parole and probation offenders beginning community supervision, 2) African-Americans, and 3) women.

Serious Mental Illness

For the provision of behavioral healthcare to individuals with severe mental illness, research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to generate better outcomes in engaging the "difficult-to-engage" clients, reducing hospitalizations for clients, and in decreasing substance use among co-occurring clients (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Findings from the SAMHSA Consumer-Operated Service Program Multisite Research Initiative showed that adding peer support services or programs to traditional mental health programs was positively associated with increased personal empowerment among clients using those services (Rogers *et al*., 2007). DMH funds five drop-in centers: two in St. Louis, two in Kansas City, and one in Springfield. DMH's five Warm (non-crisis) Lines offer safe, confidential telephone support by peers when an individual with a mental illness or family member needs information, referral, or to talk to someone. In FY 2014, there were 9,177 visits to the drop-in centers. An estimated 266,802 adults in Missouri have a serious mental illness and an estimated 98,348 children have a serious emotional disturbance. It is likely that most of these individuals would benefit from and/or seek recovery support services if available.

Certified Missouri Peer Specialist training began in 2008 in Missouri. After researching peer support training curricula, the Comprehensive Psychiatric Services State Advisory Council (CPS/SAC) made the recommendation for the Appalachian Consulting Group "Georgia Model" which was subsequently adopted by the Division of Behavioral Health. The Department of Mental Health (DMH) is moving the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. One primary strategy in transforming the system is to recognize the power of consumer as providers. Recognizing consumers as providers is taking root in the mental health system. Emerging evidence supports the need for peer support services as a cost-effective and complementary adjunct to professional mental health services and supports. Peer support services can move the system to focus less on illness and disability and more on wellness. To accomplish this goal, Missouri has provided equal weight to expertise gained through the "lived experience" as is done with any other credential or knowledge base. A Peer Specialist can share lived experiences of recovery, share and support the use of recovery tools, and model successful recovery behaviors. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent

choices, and take a proactive role in their treatment. Additionally, Peer Specialists can help consumers connect with other consumers and with their community at large.

With oversight of the CPS/SAC, the week-long training has been conducted by trained individuals with lived experience of recovery. To date, 380 individuals have been trained and 241 have reached the goal of Certified Missouri Peer Specialist (CMPS) status. CMPSs are employed around the state providing services in community mental health centers, consumer operated service programs (Drop In Centers and Warm Lines), the Veteran's Administration, substance use residential and outpatient providers, as well as 5 of our state operated psychiatric facilities. The Medicaid reimbursement rate is comparable to that of a Community Support Worker and continues to be utilized among Missouri providers.

In 2014 a small group of stakeholders including the peer trainers began a curriculum update and added the following sessions: Transitional Age Youth Brain Development and Decision Making; Transitional Age Youth, Why the Focus on trauma?; Guiding Principles of Recovery; Self-Care; Building Resources; The Strengths Model; Providing Support and Planning for Crisis Situations; and Peer Specialists in the Workplace: Skills for Effective Teams. Also in 2014, Ike Powell of the Appalachian Consulting Group provided a series of regional peer supervision trainings to Certified Missouri Peer Specialists and their supervisors. The training was highly successful and will continue to be offered. Future training includes Darby Penney led Peer Trauma Informed Care Train the Trainer for ten certified Missouri peers working with adults, youth, and families in the areas of both substance use and mental health in May 2015. Five regional refresher trainings will be held in FY 2016 in addition to six Peer Specialist Basic trainings. DMH continues to contract with Wichita State University to provide the website support for the training and certification process. The website is www.peerspecialist.org.

Medication Assisted Treatment for Addiction

Substate Planning Area	FY 2013 Number Served who Had an Alcohol and/or Opiate Problem	FY 2013 Number who Received MAT Services	% Received MAT Services
Northwest	7,262	680	9.36%
Central	4,632	202	4.36%
Eastern	9,747	2,130	21.85%
Southwest	5,380	204	3.79%
Southeast	5,029	255	5.07%
State Total	32,050	3,471	10.83%

Table 11 Number served in state system with an Opioid or alcohol problem identified as the primary, secondary, or tertiary substance abuse problem and the number who received MAT services including methadone, Vivitrol, naltrexone, buprenorphine/Suboxone, Antabuse, and acamprosate.

Medication assisted treatment (MAT) is the use of medications, in combination with psychosocial counseling, to support treatment and recovery from substance abuse disorders. DMH fully supports the use of evidence-based practices in substance abuse treatment, which includes MAT. DMH funds four Opioid treatment programs (3 contracted and 1 state-operated) that are certified to provide methadone maintenance treatment. Two agencies are located in St. Louis, and two are located in Kansas City. In addition, DMH has been introducing new medications into its non-Opioid treatment programs since 2006 as part of a Robert Woods Johnson Advancing Recovery Grant. Medication services were added to treatment contracts in 2007. In 2010, Missouri began credentialing for a MAT specialty. DMH continues to work to integrate MAT into addition treatment where clinically appropriate. The National Quality Forum recommendations state that pharmacotherapy should be made available to all adult patients diagnosed with an alcohol or Opioid dependence if no medical contradictions are applicable (National Quality Forum, 2007).

DMH is working with the Vivitrol drug manufacturer, the Missouri Institute for Mental Health, and the St. Louis Drug Courts to conduct an Investigator Trial on the pre-release initiation of Vivitrol and continuation in the community. Vivitrol blocks opiate receptors in the brain thereby eliminating the euphoric effects and preventing cravings for alcohol and opiate drugs such as heroin. It is administered in the form of a shot once per month. These individuals will receive follow-up medication and substance abuse counseling through DMH contracted community agencies in St. Louis. It is anticipated that these individuals will be less likely to relapse to alcohol or opiate use upon their release from prison, thereby reducing the likelihood of re-arrest and re-incarceration. DMH is also conducting a two-year pilot on the use of Vivitrol for incarcerated women who are released into the community. The University of Missouri-St. Louis, Missouri Institute of Mental Health is conducting evaluation of these projects.

Community Advocacy and Education

Substance Abuse

Approximately 419,000 Missourians have a substance abuse problem (SAMHSA, 2015). Alcohol, tobacco, and other drug (ATOD) use are impacted by social acceptability including community laws and norms favorable toward use as well as by availability of the substances. Missouri's approximately 160 community coalitions; the 11 regional support centers; and Missouri's higher education substance abuse consortium, Partnerships in Prevention (PIP) work to change community norms, policy, and substance availability in support of creating healthy, safe communities. The Regional Support Centers, in collaboration with the community coalitions, develop, implement, and evaluate a comprehensive strategic plan with identified target outcomes based on community needs.

	Missouri	U.S.
Nonmedical Use of Pain Relievers in Past Year, Age 12+	4.71%	4.51%
Alcohol Use in Past Month, Age 12-17	12.40%	12.23%
Tobacco Use in Past Month, Age 12+	33.52%	26.10%

Table 12 Estimates of Substance Use/Abuse (SAMHSA, 2015)

Substate Planning Area	2012 Population Age 12-17	FY 2013 Heroin Admissions	Heroin Treatment Admissions per 10,000 Population
Northwest	1,226,698	156	1.3
Central	689,681	248	3.6
Eastern	1,769,177	2,669	15.1
Southwest	787,700	119	1.5
Southeast	604,906	299	4.9
State Total	5,078,162	3,491	6.9

Table 13 Rates of heroin-related admissions to substance abuse treatment in FY 2013 (Smith *et al*., 2014).

Some issues facing Missouri's communities include: 1) methamphetamine laboratories in rural parts of the state, particularly in Southeast and Southwest Missouri, as well as methamphetamine imported from Mexico; 2) a problem with prescription drug misuse; 3) underage drinking, and 4) continued availability and use of heroin in Eastern Missouri. In addition, the statewide use of tobacco products tends to be higher than that for the country as a whole. From January through December 2014, Missouri had 1,045 methamphetamine incident seizures – second highest in the country (Missouri Department of Public Safety, 2015). Approximately 4.71% of Missourians age 12 or older engage in nonmedical use of pain relievers in the past year (SAMHSA, 2015). In FY 2014, Eastern Missouri had a higher rate of heroin-related admissions to substance abuse treatment compared to that of other regions of the state (Smith *et al*., 2014). Current use of tobacco by Missourians age 12 or older is 33.52 percent – higher than that for the United States (26.10%) (SAMHSA, 2015).

Mental Illness

	Age 12-17		Age 18+	
	Missouri	U.S.	Missouri	U.S.
Serious Mental Illness in the Past Year			4.67%	4.14%
Had Serious Thoughts of Suicide in Past Year			4.05%	3.89%

	Age 12-17		Age 18+	
Had at Least One Major Depressive Episode in the Past Year	9.91%	9.86%	7.35%	6.77%

Table 14 Prevalence of Mental Illness (SAMHSA, 2015).

Behavioral health issues such as substance addiction and mental illness often carry a stigma that prevents individuals from seeking help and others from providing help. Of those Missourians who experience serious psychological distress in the past year, an estimated 50 percent do not receive any mental health treatment (SAMHSA, 2012f). Research has shown that Mental Health First Aid, a public education program designed for the general public in appropriately responding to behavioral health issues, is associated with increased knowledge of behavioral health disorders, less stigmatization, and greater confidence to provide assistance (Kitchener, J.A., 2004; Kitchener, B.A. & Jorm, A.F., 2004). The Missouri Department of Mental Health has partnered with the Maryland Department of Health and Mental Hygiene and the National Council for Community Behavioral Healthcare to implement Mental Health First Aid USA, modeled after a program developed in Australia. Missouri is piloting a second version of Mental Health First Aid for adults who work with young people – Mental Health First Aid for Youth.

School-Based Behavioral Health Education

	Missouri	United States
Past Month Marijuana Use	7.10%	7.15%
Past Year Nonmedical Pain Reliever Use	5.25%	5.00%
Past Month Alcohol Use	12.40%	12.23%
Past Month Tobacco Use	11.41%	8.24%
At Least One Major Depressive Episode	9.91%	9.86%

Table 15 Behavioral Health Measures: Age 12 - 17 (SAMHSA, 2015).

An estimated 12.40 percent of Missouri's youth in grades 6 through 12 report using alcohol in the past 30 days. In addition, 7.10 percent and 11.41 percent reported using marijuana and tobacco in the past month (Depue, S. & et al., 2015). Missouri's School-based Prevention Intervention and Resource Initiative (SPIRIT) implements evidence-based programming to delay the onset of substance use and decrease the use of substances, improve overall school performance, and reduce incidents of violence. Age- and grade-appropriate curricula are taught. Screening and referral services are provided as needed. The program receives an annual evaluation by the Missouri Institute for Mental Health, University of Missouri-St. Louis.

Evidence-based Behavioral Health Practices

The Department of Mental Health (DMH) supports implementation of programs and practices that have proven effectiveness in reducing the impact of behavioral health disorders on

individuals and families in Missouri. Missouri has implemented the following evidence-based practices in the treatment of serious mental illness (SMI):

- Integrated treatment for co-occurring mental illness and substance use disorders,
- Supported employment,
- Illness management and recovery,
- Assertive community treatment, and
- Consumer-operated services.

Individuals with co-occurring SMI and substance abuse disorders tend to have poorer outcomes when served in traditional treatment programs where each disorder is treated by a separate team of providers (McGovern, M.P., 2006). The evidence-based treatment model of care for persons with co-occurring disorders that is recommended by SAMHSA is the Integrated Treatment for Co-Occurring Disorders (ITCOD). In the ITDOC model persons receive coordinated, integrated treatment by a single multidisciplinary team including trained specialists in co-occurring disorders. Missouri has 20 ITCOD programs operating in 32 locations. Missouri has Medicaid approved billing codes for co-occurring individual counseling, group education, group counseling, and a supplemental individual assessment for substance abuse disorders. DMH monitors fidelity to the SAMHSA tool kit.

Supported employment programs have been shown to be more effective than traditional vocational programs in gaining competitive employment, earning more income, and working more days for individuals with SMI (Bond, G.R. *et al*., 2008; Crowther, R.E. *et al*., 2001). Missouri has seven supported employment programs. The State's programs have received technical assistance and fidelity training from the Dartmouth Psychiatric Research Center through a grant from Johnson & Johnson. Providers collaborate with the Division of Vocational Rehabilitation (VR) venders to offer supported employment services to ensure that:

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

Fidelity is monitored for the Individualized Placement Support (IPS) Supported Employment model.

Illness management recovery strategies have been shown to increase the individual's knowledge of their condition, aid in medication compliance, and reduce the occurrence and severity of symptom relapse (Mueser, K.T. *et al*., 2002). DMH, in collaboration with the State Medicaid authority, has established an enhanced rate for Psychosocial Rehabilitation. Twenty

community mental health centers provide these services that focus on health, wellness, and recovery. Fidelity to this evidence-based practice is not monitored.

Assertive Community Treatment (ACT) has been shown to reduce hospitalizations for individuals with severe mental illness (Phillips, S.D. *et al*., 2001). In Missouri, ACT services are made available to adults with serious and persistent mental illness who: 1) are high users of inpatient beds, 2) may have a co-occurring substance abuse disorder, 3) have involvement with the criminal justice system, and 4) are homeless. DMH funds six ACT programs. Missouri has obtained technical assistance from the ACT Center of Indiana and continues to monitor fidelity of its implementation.

Research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to generate better outcomes in engaging the "difficult-to-engage" clients, reducing hospitalizations for clients, and in decreasing substance use among co-occurring clients (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Findings from the SAMHSA Consumer-Operated Service Program (COSP) Multisite Research Initiative showed that adding peer support services or programs to traditional mental health programs was positively associated with increased personal empowerment among clients using those services (Rogers *et al*., 2007). DMH funds 10 COSP programs. Fidelity to the COSP is monitored using the SAMHSA tool kit.

In addition to the evidence based practices listed above, DMH also funds Dialectical Behavior Therapy (DBT), a cognitive-behavioral treatment initially developed to treat individuals with borderline personality disorder (BPD) but has also been found to be effective for persons with other diagnoses. Several studies have shown that DBT had better outcomes in the treatment of BPD compared to treatment as usual on measures of anger, parasuicidality, and mental health (Stoffers, J.M. *et al*., 2012). Introductory and advanced DBT training has been made available statewide. DMH has partnered with the University of Missouri Psychiatric Center to produce an online training in communication strategies. DMH also supports a DBT website (www.dbtmo.org) to provide information on DBT and the DBT certification process.

Substance Abuse-Related Services for IV Drug Users

Substate Planning Area	2012 Population Age 15+	Estimated IVDU Need	IVDU FY 2013 Served	Estimated IVDU Need but Not Receive	Penetration Gap
Northwest	1,173,689	5,634	1,390	4,244	75.33%
Central	661,483	3,175	927	2,248	70.80%
Eastern	1,694,462	10,506	3,040	7,466	71.06%
Southwest	751,974	3,609	1,654	1,955	54.18%
Southeast	576,708	2,768	1,325	1,443	52.13%
State Total	4,858,316	25,692	8,336	17,356	67.55%

Table 16 Estimates of prevalence and need for the treatment of IV drug use.

In the past, the number of intravenous drug users (IVDU) was estimated at 0.19 percent of the population aged 12 or older from NSDUH national-level data. Based on 1) the number of IV drug users served and the number on wait lists and given that 2) NSDUH excludes some populations with higher rates of drug use such as incarcerated individuals, homeless, hospitalized patients, and college dormitory students, the NSDUH estimate was believed to generate estimates for Missouri that seriously underestimates the number of IV drug users in the state. Research from Brady *et al*. estimated the prevalence of IV drug users in the U.S. and in 76 metropolitan statistical areas (MSA) (Brady, J.E. *et al*., 2008). Brady's estimates for IV drug users in the Kansas City and St. Louis MSA's exceeded that generated from the NSDUH data by a factor of 2.7 and 3.4, respectively. Brady's prevalence rate for Kansas City MSA and St. Louis MSA was applied to the populations of Northwest and Eastern regions. The remaining regions were assumed to have a similar rate as that of Northwest region and a corresponding estimate was generated for the remaining regions. The number of IVDU's served by substate region was obtained from the publicly-funded system (Missouri Department of Mental Health, 2012a). The estimated number for unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment. In Missouri, methamphetamine IV drug use is prevalent throughout the rural areas of the state but is particularly notable in Southwest, Southeast, and Northwest Regions. Heroin and other Opioid IV drug use are highly concentrated in Eastern Region impacting both urban and rural locations. Ninety percent of the state's heroin-related deaths are reported from Eastern Region (Missouri Department of Health and Senior Services, 2012).

Substance Abuse-Related Services for Pregnant Women and Women with Dependent Children

	Missouri	U.S.
Pregnant Females	7.7%	8.0%
Females with Children (Age <18) in the Household	7.7%	6.4%
Females without Children (Age <18) in the Household	6.7%	6.1%
All Females, Age 12+	7.2%	6.2%

Table 17 Prevalence of substance abuse problems among women (SAMHSA, 2012g).

An estimated 7.7 percent of females with children under the age of 18 in the household and 4.8 percent of pregnant females in Missouri have an illicit drug or alcohol problem (SAMSHA, 2012f). The prevalence of substance abuse problems is lower for Missouri's pregnant females (4.8%) in comparison to that for the United States (8.0%) but is higher for females with children in the household (7.7% vs. 6.4%).

Substate Planning Area	2012 Female Population Age 12+	Women Need (7.2%)	Women FY 2012 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	641,432	46,183	3,408	42,775	92.62%
Central	336,032	24,194	1,965	22,229	91.88%
Eastern	928,763	66,870	4,219	62,651	93.69%
Southwest	394,528	28,406	2,498	25,908	91.21%
Southeast	296,933	21,379	2,575	18,804	87.96%
State Total	2,597,688	187,032	14,665	172,367	92.16%

Table 18 Prevalence of substance abuse problems among women (SAMHSA, 2012g).

County-level population of females age 12 or older was obtained from the Missouri Census Data Center and aggregated to the substate areas (Missouri Census Data Center, 2012). The estimated percent in need of treatment (7.2%) is obtained from the 8-year National Household Survey on Drug Use and Health (NSDUH) dataset (2002-2009) for females in Missouri. The number served in the state system in FY 2012 was obtained from the Department of Mental Health information system. The difference between estimated need and number served is a combination of number served outside of the state system and unmet need. As of August 2013, it is not known if Missouri will expand its Medicaid program to 138 percent of the federal poverty level. Less than four percent of female consumers receiving substance abuse treatment in FY 2012 had private health insurance at the time of admission.

Infectious Disease Prevention and Treatment for Individuals with Substance Use Disorders

Substate Planning Area	TB Rate per 100,000 Persons
Central	0.74
Eastern	1.78
Northwest	1.65
Southeast	1.96
Southwest	0.86
State Total	1.49

Table 19 Incidence of TB disease in 2012 for the Missouri population.

The number of new cases of tuberculosis (TB) for the Missouri population are obtained from the Missouri Department of Health and Senior Services by county and aggregated to the planning region. The TB incidence rates for Missouri were 1.6 and 1.49 cases per 100,000 persons for 2011 and 2012, respectively. In comparison, the TB incidence rate for the United States in 2011 was 3.4 cases per 100,000 persons (Centers for Disease Control and Prevention, 2012). Risk factors associated with TB transmission include illicit drug use, excessive alcohol consumption, homelessness, previous incarceration, and HIV/AIDS (Nava-Aquilera, E. *et al*.,

2009). An important component of TB control is the screening and the testing or referral for TB testing, as appropriate, for individuals admitted to and continuing in substance abuse treatment.

Employment

Substance Abuse

Substate Planning Area	FY 2012 Adults Discharged with a Known Employment Status	Number Employed at Discharge	Percent Employed at Discharge
Northwest	7,137	2380	33.3%
Central	4,340	1704	39.3%
Eastern	8,024	2564	32.0%
Southwest	5,202	1843	35.4%
Southeast	5,726	1857	32.4%
State Total	30,429	10,348	34.0%

Table 20 Employment status for consumers discharged from substance abuse treatment in FY 2012.

Serious Mental Illness

Substate Planning Area	CY 2012 Adults in Community Mental Health Treatment with a Known Employment Status at Annual Review or Discharge	Number Employed at Annual Assessment or Discharge	Percent Employed at Annual Assessment or Discharge
Northwest	4,236	555	13.1%
Central	3,127	396	12.7%
Eastern	5,762	699	12.1%
Southwest	2,452	203	8.3%
Southeast	2,859	252	8.8%
State Total	18,436	2,105	11.4%

Table 21 Employment status for consumers in or discharged from community mental health treatment in calendar year 2012.

Traditional behavioral health treatment has focused on the behavioral health issues believing that once recovery is achieved that employment will naturally follow. Meaningful occupation has a powerful therapeutic impact for individuals recovering from substance abuse and/or mental illness. Identified barriers to employment for individuals with behavioral health issues often include low educational attainment, lack of developed job skills, low motivation, learned helplessness, and poor social supports (Jason, L.A. *et al*., 2001). SAMHSA's Treatment Improvement Protocol (TIP) Series 38 recommends that vocational services be an integral component of substance abuse treatment (SAMHSA, 2000). Research has also shown that

adding a vocational focus to mental health rehabilitation can help individuals with serious mental illness (SMI) develop skills and positive attitudes (Blankertz, L. & Robinson, S., 1996). Characteristics associated with obtaining and maintaining employment among people with SMI include having: 1) confidence and motivation to work, 2) work-related skills, 3) work-related opportunities, 4) ongoing access to mental health services in addition to 5) receiving social support (Dunn, E.C. *et al*., 2010). Supported employment programs have been shown to be more effective than traditional vocational programs in gaining competitive employment, earning more income, and working more days for individuals with SMI (Bond, G.R. *et al*., 2008; Crowther, R.E. *et al*., 2001). In 2012, the employment rates for individuals in substance abuse treatment (34%) and in treatment for SMI (11.4%) were considerably lower than that of the general population (59.6%) (Missouri Department of Mental Health, 2012a; U.S. Bureau of Labor Statistics, 2013).

Mental Health Services for Transition-Aged Youth and Young Adults

Substate Planning Area	2012 Population 16-17	2012 Population 18-25	Estimated Need, Age 16-17 (7%)	Estimated Need, Age 18-25 (5%)	Total Estimated Need
Northwest	38,876	158,696	2,721	7,935	10,656
Central	20,648	115,746	1,445	5,787	7,233
Eastern	57,151	217,753	4,001	10,888	14,888
Southwest	24,488	105,503	1,714	5,275	6,989
Southeast	18,771	75,372	1,314	3,769	5,083
State Total	159,934	673,070	11,195	33,654	44,849

Table 22 Estimated need for mental health services among transition age youth and young adults.

Individuals who are transitioning into adulthood and have or develop a serious mental illness face unique challenges. Compared to the general population, these individuals tend to have increased difficulty in reaching developmental milestones such as graduating from high school, gaining employment, securing stable housing, and developing and sustaining meaningful relationships. In a study by the U.S. Government Accounting Office (GAO) (2008), young adults age 18 to 26 with SMI graduated from high school at a lower rate compared to those without SMI (64% vs. 83%). For young adults who were receiving disability payments from SSI or DI, the high school graduation rate was even lower at 52%. Transition-age youth are more likely to become involved with the juvenile justice system and are at increased risk for substance abuse (Gilmer, T. P. *et al*., 2012). Although SMI may develop earlier than age 16, it is not uncommon for the diagnosis to be made during the late teens and early twenties. As such, individuals and their families may be inexperienced at navigating multiple systems of care and programs. Adult and youth programs often have differing eligibility requirements and service mix that can cause disruptions in continuity of care once an individual reaches age 18. In

looking at mental health service utilization in the U.S., Pottick *et al*. (2008) found that service utilization fell by almost 50 percent at the age of emancipation. Adult programs may be more tailored to the needs of older adults which may cause young adults to feel disenfranchised and result in treatment drop-out (GAO, 2008). In FY 2013, DMH provided community-based mental health services to 11,347 transition-aged youth and young adults.

Behavioral Healthcare Services for Children

Substate Planning Area	2012 Population 16-17	2012 Population 18-25	Estimated Need, Age 16-17 (7%)	Estimated Need, Age 18-25 (5%)	Total Estimated Need
Northwest	38,876	158,696	2,721	7,935	10,656
Central	20,648	115,746	1,445	5,787	7,233
Eastern	57,151	217,753	4,001	10,888	14,888
Southwest	24,488	105,503	1,714	5,275	6,989
Southeast	18,771	75,372	1,314	3,769	5,083
State Total	159,934	673,070	11,195	33,654	44,849

Table 23 FY 2013 Estimated prevalence of childhood serious emotional disorder.

Substate Planning Area	2012 Population Age 12-17	Estimated Need 5.76%	FY13 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	117,640	6,776	694	6,082	89.76%
Central	61,187	3,524	477	3,047	86.46%
Eastern	168,798	9,722	762	8,960	92.16%
Southwest	73,885	4,255	442	3,813	89.61%
Southeast	55,859	3,217	420	2,797	86.94%
State Total	477,369	27,494	2,795	24,699	89.83%

Table 24 FY 2013 Estimated prevalence of adolescent substance abuse disorder.

Children with behavioral health issues face challenges in many aspects of their daily lives. Missouri supports the systems of care approach that recognizes the importance of family, school, and community and in which services are provided through a comprehensive, seamless system. Both substance use disorder and mental health services for children are coordinated under the Division of Behavioral Health (DBH) Director of Children's Services. Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health services to children and youth with serious emotional disturbances. The Comprehensive Substance Treatment and Rehabilitation (CSTAR) Adolescent program offers a full continuum of services for youth age 12 to 17 with substance use disorders.

Behavioral Healthcare Services for Military Service Members and Veterans

Approximately 495,000 veterans reside in the state of Missouri (Missouri Department of Public Safety, 2015). Of these about 6.2 percent or 30,690 need treatment for substance use disorders and about 4.0 percent or 19,800 need treatment for a serious mental illness (SAMHSA, 2014). The stressors and dangerous activities related to military service can take its toll on this population: PTSD, depression, sexual trauma and substance use disorder to name a few. There are numerous barriers for the military community when seeking behavioral health services: service members and their families fear jeopardizing their military careers if they ask for help, inadequate insurance or cost of services, limited geographic access and some mistrust with the VA system of care.

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Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Coordination of Primary Care and Behavioral Health Services

Priority Type: SAT, MHS

Population(s): SMI, SED

Goal of the priority area:

Coordinate consumers' primary and behavioral healthcare in order to improve consumer health and reduce medical costs

Objective:

Increase participation in programs that coordinate consumers' primary and behavioral healthcare

Strategies to attain the objective:

1) Continue to coordinate preventive and primary care for Health Home participants
2) Conduct pilot of Children's Health Home project focusing on children with serious emotional disturbance and obesity
3) Continue outreach to Medicaid-enrolled adults who 1) have a substance use disorder or serious mental illness, 2) have high annual healthcare costs, and 3) are not currently enrolled in behavioral health treatment
4) Contract with the Missouri Institute for Mental Health for ongoing evaluation of Missouri's Health Homes and Disease Management programs

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of participants in Health Homes per fiscal year

Baseline Measurement: 25,278 (FY 2014)

First-year target/outcome measurement: 25,800

Second-year target/outcome measurement: 26,200

Data Source:

Number of Health Homes participants is determined from a Per Member Per Month (PMPM) data file submitted to DMH from the Missouri Medicaid agency MO Healthnet on a monthly basis. These are individuals who participated at any time during the specified fiscal year.

Description of Data:

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Number of participants in DM 3700 per fiscal year

Baseline Measurement: 2,584 (FY 2014)

First-year target/outcome measurement: 2,625

Second-year target/outcome measurement: 2,700

Data Source:

DMH information system

Description of Data:

These are individuals who participated at any time during the specified fiscal year. A participant in the DM 3700 is defined as a consumer who is listed on the DM 3700 master list and who has an open episode of care for CPS treatment during the specified fiscal year.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Number of participants in ADA Disease Management

Baseline Measurement: 187 (FY 2014)

First-year target/outcome measurement: 800

Second-year target/outcome measurement: 1,200

Data Source:

DMH Information System

Description of Data:

A participant in ADA DM is defined as a consumer who is listed on the ADA Disease Management master list and who has an open episode of care for ADA treatment during the specified fiscal year.

Data issues/caveats that affect outcome measures::

N/A

Priority #: 2

Priority Area: Crisis Intervention

Priority Type: SAT, MHS

Population(s): SMI, SED

Goal of the priority area:

Promote safety and emotional stability, minimize further deterioration in mental state, increase access to treatment and support services, and improve individual outcomes for individuals in behavioral health crisis; better utilize limited criminal justice and healthcare resources by linking individuals needing behavioral healthcare services to those services

Objective:

Increase linkage and coordination of care for individuals experiencing a behavioral health crisis

Strategies to attain the objective:

1) Identify and address structural barriers, miscommunications, and consistent patterns that reduce access to behavioral healthcare services
2) Provide behavioral health expertise to law enforcement, court personnel, and primary healthcare staff in order to more effectively respond to behavioral health crises
3) Advocate for and engage individuals in crisis in behavioral health treatment and support services
4) Provide immediate person-centered interventions to individuals in mental health crisis and facilitate timely access to services and supports

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of referrals to the Community Mental Health Liaisons

Baseline Measurement: 3,696 (FY 2014)

First-year target/outcome measurement: 5,000

Second-year target/outcome measurement: 5,000

Data Source:

Number tracked and reported by the Coalition of Community Behavioral Healthcare

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Number served in the Emergency Room Enhancement project

Baseline Measurement: 852 (FY 2014)

First-year target/outcome measurement: 1,000

Second-year target/outcome measurement: 1,200

Data Source:

Number served is tracked and reported by the Missouri Institute for Mental Health

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Number of new law enforcement officers trained in Crisis Intervention Team

Baseline Measurement: 681 (FY 2014)

First-year target/outcome measurement: at least 400

Second-year target/outcome measurement: at least 400

Data Source:

Number of law enforcement officers trained in CIT is tracked and reported by NAMI-St. Louis.

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 4

Indicator: Number of calls to the Access Crisis Intervention (ACI) hotlines

Baseline Measurement: 81,908 (FY 2014)

First-year target/outcome measurement: at least 80,000

Second-year target/outcome measurement: at least 80,000

Data Source:

Number of ACI calls is tracked and reported by the contracted agencies on a quarterly basis

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Priority #: 3

Priority Area: Substance Abuse Traffic Offenders' Program (SATOP)

Priority Type: SAT

Population(s): Other (DUI/DWI Offenders)

Goal of the priority area:

Reduce DWI recidivism and initiate treatment services for those with substance use disorder

Objective:

Improve screening and referral processes

Strategies to attain the objective:

1) Require additional interview questions outside of the Driver Risk Inventory (DRI-II) to ensure assessment consistency
2) Implement SATOP-specific continuing education training for SATOP Qualified Professionals
3) Evaluate the feasibility of lowering the Blood Alcohol Content (BAC) placement criteria for levels I and II
4) Continue to educate judiciary and prosecutors on SATOP screening and referral process

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Implement SATOP specific continuing education training for SATOP Qualified Professionals

Baseline Measurement: N/A

First-year target/outcome measurement: In progress

Second-year target/outcome measurement: Implemented

Data Source:

Implementation of SATOP training considered complete with the award of Continuing Education Units (CEU).

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Implement a standardized set of interview questions outside of the DRI-II

Baseline Measurement: N/A

First-year target/outcome measurement: In progress

Second-year target/outcome measurement: Implemented

Data Source:

Input from the subcommittee of SATOP administrators will be required to develop the interview questions. Required implementation is established in SATOP policy.

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Priority #: 4

Priority Area: Department of Corrections Community Supervised Offenders

Priority Type: SAT, MHS

Population(s): SMI, PP, Other (Criminal/Juvenile Justice)

Goal of the priority area:

Improve access to clinically appropriate services

Objective:

Coordinate with the Department of Corrections to improve access to treatment

Strategies to attain the objective:

1) Monitor and target technical assistance to Probation and Parole Officers and treatment providers on the prioritization process for offenders needing substance use disorder treatment in order to facilitate rapid assessment and treatment initiation
2) Maintain Memorandum of Understandings (MOU) with the Department of Corrections for coordination of behavioral health treatment services
3) Continue the CMHT – Community Mental Health Treatment (mental illness) and MH4 (severe mental illness) programs
4) In coordination with DOC, develop a prioritization process for offenders in the CMHT program
5) Continue to participate on the DOC Oversight Committee

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of High Priority referrals for substance use treatment

Baseline Measurement: 1,560 (FY 2014)

First-year target/outcome measurement: 1,700

Second-year target/outcome measurement: 1,800

Data Source:

DMH Information System

Description of Data:

Number of High Priority referrals for substance use disorder treatment is determined from admission data in the DMH information system.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Current MOU between DMH and DOC?

Baseline Measurement: yes (FY 2014)

First-year target/outcome measurement: yes

Second-year target/outcome measurement: yes

Data Source:

MOU documentation is maintained by the DMH contracts unit.

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Number served in CMHT and MH4 programs

Baseline Measurement: 2,214 (FY 2014)

First-year target/outcome measurement: at least 2,000

Second-year target/outcome measurement: at least 2,000

Data Source:

DMH Information System

Description of Data:

Number served in the CMHT and MH4 programs is determined from billing data in the DMH information system.

Data issues/caveats that affect outcome measures::

N/A

Priority #: 5

Priority Area: Tobacco Prevention / Cessation

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Reduce tobacco initiation and promote tobacco cessation among vulnerable populations

Objective:

Provide education and supports to vulnerable populations and Missouri tobacco retailers

Strategies to attain the objective:

1) Support provider training in tobacco cessation with proven effectiveness
2) Promote the inclusion of tobacco cessation in the consumer's behavioral health treatment plan
3) Track smoking prevalence in mental health and substance use disorder treatment populations
4) Support tobacco cessation on Missouri's college campuses
5) Ensure the provision of tobacco enforcement and merchant education:
a. Continue contracting with the Food and Drug Administration for the enforcement of federal tobacco control laws
b. Maintain a Memorandum of Agreement with the Division of Alcohol and Tobacco Control for state and federal enforcement of tobacco control laws
c. Conduct a merchant education visit to every tobacco retailer in the state

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Synar non-compliance rate is less than 20 percent?

Baseline Measurement: yes (FY 2014)

First-year target/outcome measurement: yes

Second-year target/outcome measurement: yes

Data Source:

Synar rate is determined from annual Synar survey. For FY 2016, this will be completed by October 1, 2016. For FY 2017, this will be completed by October 1, 2017.

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Number of tobacco retailers visited and provided with retailer educational materials per fiscal year

Baseline Measurement: 5,447 (FY 2014)

First-year target/outcome measurement: at least 5,000

Second-year target/outcome measurement: at least 5,000

Data Source:

Number of tobacco retailers visited and provided educational materials is documented by prevention agencies, entered into a database by DMH staff, and reported in the State's Annual Synar Report.

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Number of nicotine replacement quit kit items distributed on Missouri college campuses per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: 567

Second-year target/outcome measurement: 567

Data Source:

Number of nicotine/replacement quit kit items is tracked and reported to DMH by Partners in Prevention (Missouri's higher education substance abuse consortium)

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Priority #: 6

Priority Area: Recovery Support Services

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, IVDUs, Other (Adolescents w/SA and/or MH, Rural, Criminal/Juvenile Justice, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Provide support services to promote sustained recovery from behavioral health disorders

Objective:

Develop infrastructure to support recovery, wellness, and community inclusion

Strategies to attain the objective:

1) Continue the five Drop-In Centers and five Peer Support Phone Lines for persons with mental illness
2) Maintain a housing unit to administer the Shelter Plus Care grants to provide housing assistance to long-term DMH consumers
3) Promote use of IPS Supported Employment
4) Implement an enhanced training curriculum for Family Support Specialists
5) Implement the ATR IV grant

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of contracts for Consumer Operated Service Programs for persons with mental illness per fiscal year

Baseline Measurement: 10

First-year target/outcome measurement: 10

Second-year target/outcome measurement: 10

Data Source:

Contracts are maintained by the DMH Contracts Unit.

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Number of Supported Employment programs per fiscal year

Baseline Measurement: 11 (FY 2014)

First-year target/outcome measurement: 11

Second-year target/outcome measurement: 12

Data Source:

The number of IPS Supported Employment programs is tracked by DMH staff.

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Number of trainings using the enhanced curriculum for Family Support Specialists per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: 2

Second-year target/outcome measurement: 2

Data Source:

The number of Family Support trainings is tracked by the Children's Services Unit.

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 4

Indicator: Number served in ATR IV

Baseline Measurement: N/A

First-year target/outcome measurement: 1,428

Second-year target/outcome measurement: 1,428

Data Source:

DMH Information System

Description of Data:

Number served in ATR IV will be tracked in the DMH information system. These are consumers who receive a service funded through the ATR IV program.

Data issues/caveats that affect outcome measures::

N/A

Priority #: 7

Priority Area: Medication Assisted Treatment for Addiction

Priority Type: SAT

Population(s): PWWDC, PP, IVDUs

Goal of the priority area:

To further integrate medication therapy into the substance use disorder treatment service delivery system

Objective:

Promote use of MAT

Strategies to attain the objective:

1) Monitor utilization of MAT by provider and provide technical assistance as needed
2) Increase utilization of different addiction medications at a given treatment provider
3) In collaboration with the drug manufacturer, Missouri Institute for Mental Health (MIMH), and the St. Louis Drug Courts, conduct an Investigator Trial on Vivitrol initiated prior to jail release
4) In collaboration with the Department of Corrections and MIMH, conduct a pilot study on the use of Vivitrol among incarcerated women who are released to the community
5) Implement the MAT Grant

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of consumers receiving MAT

Baseline Measurement: 3,753 (FY 2014)

First-year target/outcome measurement: 4,000

Second-year target/outcome measurement: 4,200

Data Source:

DMH Information System

Description of Data:

Number of consumers receiving medication assisted treatment including use of methadone, Vivitrol, naltrexone, buprenorphine/Suboxone/Subsolv, Antabuse, and acamprosate is determined from medication billings to the DMH information system and Medicaid Claims, excluding billings occurring while in detox.

Data issues/caveats that affect outcome measures::

N/A

Priority #: 8

Priority Area: Community Advocacy and Education

Priority Type: SAP

Population(s): Other (Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Create positive community norms; policy change; promote mental wellness; and reduce alcohol, tobacco, and other drug availability in Missouri's communities

Objective:

Strengthen Missouri's prevention network

Strategies to attain the objective:

1) Build state and community capacity by fostering strong partnerships and identifying new opportunities for collaboration
2) Further data capacity in support of data-driven strategic planning to include the continuation of the Missouri Study Survey and the Behavioral Health web tool
3) Fund evidence-based programming to prevent substance use and bullying among high-risk youth
4) Continue the education initiative in Eastern Missouri to address heroin and other opiate drug use

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of heroin and other opiate drug use training and education activities per fiscal year

Baseline Measurement: 80

First-year target/outcome measurement: 80

Second-year target/outcome measurement: 80

Data Source:

Number of heroin education activities is tracked and reported by the Eastern Regional Support Center.

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Number of high-risk youth served in prevention programs per fiscal year

Baseline Measurement: 26,691

First-year target/outcome measurement: at least 26,000

Second-year target/outcome measurement: at least 26,000

Data Source:

Reported by contracted providers

Description of Data:

Numbers of high-risk youth served in prevention programs are tracked and reported by contracted providers.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Number of youth served in the Partnership for Success Grant

Baseline Measurement: N/A

First-year target/outcome measurement: at least 15,000

Second-year target/outcome measurement: at least 25,000

Data Source:

Reported by contracted providers

Description of Data:

Number served is tracked and reported by the participating providers

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 4

Indicator: Number of persons trained in Mental Health First Aid by the Regional Support Centers per fiscal year

Baseline Measurement: 1,519 (FY 2014)

First-year target/outcome measurement: 2,200

Second-year target/outcome measurement: 2,200

Data Source:

Regional Support Centers

Description of Data:

The number trained in MHFA are tracked and reported by the Regional Support Centers.

Data issues/caveats that affect outcome measures::

Priority #: 9

Priority Area: School-Based Prevention Education

Priority Type: SAP

Population(s): Other (Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

To delay onset of substance use, reduce use, improve overall school performance, and reduce incidents of violence

Objective:

Continue Missouri's School-based Prevention Intervention and Resource Initiative (SPIRIT) program

Strategies to attain the objective:

1) Enhance protective factors and reverse or reduce risk factors for substance use and violence
2) Improve academic and social-emotional learning to address risk factors
3) Employ interactive techniques that allow for active involvement in learning
4) Reinforce prevention skills over time with repeated interventions
5) Ensure programming is culturally competent and age appropriate
6) Conduct annual fidelity reviews

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of students participating in SPIRIT per fiscal year

Baseline Measurement: 7,801 (FY 2014)

First-year target/outcome measurement: at least 7,600

Second-year target/outcome measurement: at least 7,600

Data Source:

SPIRIT participation is tracked and reported by the program evaluator: Missouri Institute for Mental Health.

Description of Data:

SPIRIT participation is tracked and reported by the program evaluator: Missouri Institute for Mental Health.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Annual report generated?

Baseline Measurement: yes (FY 2014)

First-year target/outcome measurement: yes

Second-year target/outcome measurement: yes

Data Source:

Missouri Institute for Mental Health

Description of Data:

MIMH generates the annual report which is posted to the DMH public website.

Data issues/caveats that affect outcome measures::

N/A

Priority #: 10

Priority Area: Evidence-based Mental Health Practices

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Continue evidence-based practice to the same standards and fidelity as shown to be effective in research

Objective:

Encourage adoption and provide on-going support to EBP programs

Strategies to attain the objective:

1) Continue support for EBP programs
2) Provide on-going monitoring of fidelity in EBP programs

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number served in Integrated Treatment for Co-Occurring Disorders (ITCOD)

Baseline Measurement: 1,750 (FY 2014)

First-year target/outcome measurement: at least 1,600

Second-year target/outcome measurement: at least 1,600

Data Source:

DMH information system

Description of Data:

Number served based on billing data submitted via the DMH information system.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number served in Assertive Community Treatment (ACT)

Baseline Measurement: 654 (FY 2014)

First-year target/outcome measurement: at least 600

Second-year target/outcome measurement: at least 600

Data Source:

DMH information system

Description of Data:

Number served based on billing data submitted via the DMH information system.

Data issues/caveats that affect outcome measures::

Priority #: 11

Priority Area: IV Drug Users

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

Ensure the provision of services to IV drug users in accordance with Substance Abuse Prevention and Treatment Block Grant statutory requirements

Objective:

Provide ongoing support to programs serving IV drug users

Strategies to attain the objective:

1) Monitor contractual requirements pertaining to IV drug users
2) Continue collecting wait list and capacity management data from contracted providers
3) Generate reports for wait list data and interim services billings in support of monitoring efforts
4) Increase one-on-one discussions with key provider

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of IV drug users served in substance use treatment per fiscal year (assuming same level of funding)

Baseline Measurement: 9,288 (FY 2014)

First-year target/outcome measurement: at least 9,000

Second-year target/outcome measurement: at least 9,000

Data Source:

DMH information system

Description of Data:

Number served based on billing data submitted to the DMH information system. These are individuals for whom a paid claim on a substance use disorder treatment program was submitted to and paid by DMH. Injection drug use is determined from the TEDS data also captured in the DMH information system. The route of substance was IV injection or non-IV injection on the primary, secondary, or tertiary substances.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Percent of SAPT Block Grant funded providers reporting wait list and capacity management data

Baseline Measurement: 100% (FY 2014)

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

DBH Research staff monitor wait list and capacity management reporting and follow-up with providers if they do not meet submission deadlines.

Description of Data:

DBH Research staff monitor wait list and capacity management reporting and follow-up with providers if they do not meet submission deadlines.

Data issues/caveats that affect outcome measures::

N/A

Priority #: 12

Priority Area: Substance-Abusing Pregnant Women and Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Continue to provide services to pregnant women and women with dependent children

Objective:

Provide ongoing support to providers serving pregnant women and women with dependent children

Strategies to attain the objective:

1) Monitor contractual compliance with regard to admission of pregnant women to substance use disorder treatment
2) Continue collecting wait list and capacity management data from contracted providers
3) Engage TANF referred individuals in substance use disorder treatment at a clinically appropriate level of care

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: 1) Number of pregnant women and women with dependent children served in substance use disorder treatment per fiscal year (assuming the same level of funding)

Baseline Measurement: 6,307 (FY 2014)

First-year target/outcome measurement: at least 6,000

Second-year target/outcome measurement: at least 6,000

Data Source:

DMH information system

Description of Data:

The number of pregnant women and women with dependent children served is captured in the DMH information system. These are individuals for which a paid claim was submitted to and paid by DMH. Pregnancy status and number of dependent children are also captured.

Data issues/caveats that affect outcome measures::

N/A

Priority #: 13

Priority Area: Infectious Disease Prevention and Treatment

Priority Type: SAT

Population(s): HIV EIS, TB

Goal of the priority area:

Reduce the incidence of HIV/TB/STDs/Hepatitis among consumers in substance use disorder treatment and those in close contact with consumers; have all consumers get screened for HIV/TB/STDs/Hepatitis; and have consumers needing treatment for HIV/TB/STDs/Hepatitis get linked to the appropriate services

Objective:

Provide ongoing support to providers serving consumers in substance use treatment

Strategies to attain the objective:

1) Contractually require programs to
a. Have a working relationship with the local health department, physician, or other qualified healthcare provider in the community to provide any necessary testing services for HIV/TB/STDs/Hepatitis
Arrange for HIV/TB/STDs/Hepatitis testing to be available to the client at any time during the course of the client's treatment,
b. Provide post-testing counseling for clients testing positive for HIV or TB, and
c. Provide education to clients and family members on the risks of HIV/TB/STDs/Hepatitis

2) Continue to track TB-related expenditures as required by federal regulations §96.127
3) Provide infectious disease training to provider staff

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Conducted survey of providers and developed technical assistance plan?

Baseline Measurement: N/A

First-year target/outcome measurement: In progress

Second-year target/outcome measurement: Completed

Data Source:

Workgroup progress report

Description of Data:

Survey instrument will be developed by a workgroup consisting of DBH clinical treatment and research staff. Information from the survey as well as data from the DMH information system pertaining to HIV/TB/STDs/Hepatitis will be used to develop a plan for training and technical assistance.

Data issues/caveats that affect outcome measures::

N/A

Priority #: 14

Priority Area: Mental Health Services for Transition-Aged Youth and Young Adults

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

To increase knowledge of effective interventions and supports and enhance skills of individuals who work with transition age youth/young adults and their families

Objective:

Provide education and training to providers

Strategies to attain the objective:

1) Develop a Transitional Age Youth/Young Adult training presentation for community system of care providers that will
• Provide information on important developmental interventions
• Identify and individualize important learning objectives for audience members
• Identify and increase awareness of resources necessary for effective transition services and supports
2) Conduct “Transition Age Youth/Youth Adult” presentations at conferences or workshops
3) Develop a “template” training presentation for community system of care providers that can be customized by the Community System of Care teams
4) Develop a “Transition Age Youth/Young Adult” resource webpage

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of new communities that customize the “template” training presentation to their local system of care per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: 1

Second-year target/outcome measurement: 2

Data Source:

Tracked and reported by the Children's Unit.

Description of Data:

Tracked and reported by the Children's Unit.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Number of conference or workshop trainings on Transition Age Youth/Young Adult per fiscal year

Baseline Measurement: 6 (FY 2014)

First-year target/outcome measurement: at least 1

Second-year target/outcome measurement: at least 2

Data Source:

Tracked and reported by the Children's Unit.

Description of Data:

Tracked and reported by the Children's Unit.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Resource webpage for Transition Age Youth/Young Adult?

Baseline Measurement: N/A

First-year target/outcome measurement: In progress

Second-year target/outcome measurement: Implemented

Data Source:

Children's Unit will track and report progress on resource webpage.

Description of Data:

Webpage implementation defined as when page(s) are placed into production.

Data issues/caveats that affect outcome measures::

N/A

Priority #: 15

Priority Area: Behavioral Healthcare Services for Children

Priority Type: SAT, MHS

Population(s): SED, Other (Adolescents w/SA and/or MH)

Goal of the priority area:

To enhance Children’s Behavioral Health services by increasing the knowledge of effective services, supports and interventions, enhancing the skills of service providers and expanding services based on the needs of the children, youth and families served.

Objective:

Provide ongoing support to providers who serve children

Strategies to attain the objective:

1) Expand access to Treatment Family Homes (TFH), Parent Professional Homes (PPH) and Family Support Providers (FSP) to children, youth and their families receiving services through the Adolescent C-STAR Program.
• Revise MO State Plan to include TFH, PPH and FSP services for Adolescent C-STAR and propose to CMS. Continue to revise proposal as needed in response to CMS review and feedback.
• Develop training curriculum related to TFH, PPH and FSP services and the specific needs of children, youth and their families eligible for Adolescent C-STAR services
• Pending CMS approval of CSTAR revised MO State Plan proposal, provide training to DBH service providers using curriculum developed related to TFH, PPH and FSP services and the specific needs of children, youth and their families eligible for Adolescent C-STAR services.
2) Depending on the state of the economy as directed by state government, prepare to submit a budget request for increased funding to support additional ACT Teams for Transitional Age Youth.
3) Include a “monthly” news blast section in existing DBH Newsletter to distribute articles, research and stories specific to behavioral health and early childhood, children, youth and their families.
4) Develop a partnership with the Department of Elementary and Secondary Education (DESE) to improve transition planning and services from high school to post-secondary education and/or employment for children and youth receiving DBH services.
• DBH Staff from children’s services and employment services will participate on a state level transitions team with DESE to develop strategies for expanding and enhancing local school-based transition teams.
5) DBH service providers will actively participate on local school-based transition teams for the children and youth receiving DBH services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Submission of a revised state plan to Mo HealthNet (Medicaid) to add Treatment Family Home, Parent Professional Homes, and Family Support Provider services for the Adolescent CSTAR program

Baseline Measurement: N/A

First-year target/outcome measurement: In progress

Second-year target/outcome measurement: Submitted

Data Source:

The Division of Behavioral Health’s Children’s Team will collect information related to the progress of the proposal process for submitted revisions to the MO State Plan to CMS.

Description of Data:

The Division of Behavioral Health’s Children’s Team will collect information related to the progress of the proposal process for submitted revisions to the MO State Plan to CMS.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: “Monthly” electronic news blast in DBH Newsletter per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: 10

Second-year target/outcome measurement: 10

Data Source:

Children's Unit will track and report number of news blasts distributed.

Description of Data:

Children's Unit will track and report number of news blasts distributed.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Number of DBH staff members participating on state level team per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: 3

Second-year target/outcome measurement: 3

Data Source:

Children's Unit will track and report number of DBH staff participating on the state level transition teams.

Description of Data:

Children's Unit will track and report number of DBH staff participating on the state level transition teams.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 4

Indicator: Number of DBH providers participating on local school-based transition teams per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: at least 5

Second-year target/outcome measurement: at least 10

Data Source:

Children's Unit will track and report number of DBh providers participating on local school-based transition teams

Description of Data:

Children's Unit will track and report number of DBh providers participating on local school-based transition teams

Data issues/caveats that affect outcome measures::

N/A

Priority #: 16

Priority Area: Military Servicemembers and Veterans

Priority Type: SAT, MHS

Population(s): Other (Military Families)

Goal of the priority area:

Increase use of treatment services by servicemembers and veterans

Objective:

Reduce barriers to treatment

Strategies to attain the objective:

1) Enhance identifying military-connected clients during intake
2) Promote military cultural competency training with behavioral health professionals
3) Reduce stigma to seeking services through education
4) Raise awareness of services/programs offered in local communities

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of veterans receiving substance use treatment per fiscal year

Baseline Measurement: 2,987 (FY 2014)

First-year target/outcome measurement: 3,046

Second-year target/outcome measurement: 3,107

Data Source:

DMH information system

Description of Data:

Numbers of consumers with military service are determined by consumer military history and includes active, honorable discharged, medical discharged, less than honorable discharged, inactive reserve, active reserve, National Guard, and non-specified Veteran. A consumer is counted if a paid claim was incurred at a contracted provider or a non-deleted claim was submitted to CIMOR for a state facility.

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Number of veterans receiving mental health treatment per fiscal year

Baseline Measurement: 1,724 (FY 2014)

First-year target/outcome measurement: 1,758

Second-year target/outcome measurement: 1,793

Data Source:

DMH information system

Description of Data:

Numbers of consumers with military service are determined by consumer military history and includes active, honorable discharged, medical discharged, less than honorable discharged, inactive reserve, active reserve, National Guard, and non-specified Veteran. A consumer is counted if a paid claim was incurred at a contracted provider or a non-deleted claim was submitted to CIMOR for a state facility.

Data issues/caveats that affect outcome measures::

N/A

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$19,782,329		$80,105,965	$8,173,010	$71,680,079	$0	$0
a. Pregnant Women and Women with Dependent Children*	$2,125,572		$3,700,086	$118,914	$11,547,080	$0	$0
b. All Other	$17,656,757		$76,405,879	$8,054,096	$60,132,999	$0	$0
2. Substance Abuse Primary Prevention	$5,272,700		$0	$3,676,094	$2,229,813	$0	$0
3. Tuberculosis Services	$295		$1,638	$0	$245	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$1,318,174		$0	$2,230,058	$2,382,357	$0	$0
13. Total	$26,373,498	$0	$80,107,603	$14,079,162	$76,292,494	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:
Missouri is not an HIV-designated state.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$7,898,358	$175,834,688	$0	$0
6. Other 24 Hour Care		$0	$0	$4,243,217	$13,600,100	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$6,982,075	$257,753,866	$18,262,227	$66,624,399	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$236,425	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$387,893	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$387,893	$0	$1,961,161	$840,338	$0	$0
13. Total	$0	$7,757,861	$257,753,866	$32,601,388	$256,899,524	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	$	$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	$	$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	$	$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	$	$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	$	$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$	$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	$	$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	$	$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	$	$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	$	$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	$	$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	$	$
Total	$0	$0

Footnotes:
Missouri is opting out of this table.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$19,772,329
2 . Substance Abuse Primary Prevention	$5,272,700
3 . Tuberculosis Services	$295
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	$1,318,174
6. Total	$26,363,498

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Missouri is not an HIV designated state.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	$328,134
	Selective	$166,309
	Indicated	
	Unspecified	
	Total	$494,443
Education	Universal	$585,972
	Selective	$1,133,435
	Indicated	
	Unspecified	
	Total	$1,719,407
Alternatives	Universal	$36,229
	Selective	$292,048
	Indicated	
	Unspecified	
	Total	$328,277
Problem Identification and Referral	Universal	$38,504
	Selective	$37,853
	Indicated	
	Unspecified	
	Total	$76,357

Community-Based Process	Universal	$2,109,426
	Selective	$173,368
	Indicated	
	Unspecified	
	Total	$2,282,794
Environmental	Universal	$204,728
	Selective	$6,776
	Indicated	
	Unspecified	
	Total	$211,504
Section 1926 Tobacco	Universal	$40,913
	Selective	$1,721
	Indicated	
	Unspecified	
	Total	$42,634
Other	Universal	$105,094
	Selective	$12,190
	Indicated	
	Unspecified	
	Total	$117,284
Total Prevention Expenditures		$5,272,700
Total SABG Award*		$26,363,498
Planned Primary Prevention Percentage		20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$2,882,329	
Universal Indirect	$566,671	
Selective	$1,823,700	
Indicated		
Column Total	$5,272,700	
Total SABG Award*	$26,363,498	
Planned Primary Prevention Percentage	20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	þ
Tobacco	þ
Marijuana	þ
Prescription Drugs	þ
Cocaine	¢
Heroin	þ
Inhalants	¢
Methamphetamine	þ
Synthetic Drugs (i.e. Bath salts, Spice, K2)	¢
Targeted Populations	
Students in College	þ
Military Families	¢
LGBT	¢
American Indians/Alaska Natives	¢
African American	þ
Hispanic	¢
Homeless	¢
Native Hawaiian/Other Pacific Islanders	¢
Asian	¢
Rural	þ
Underserved Racial and Ethnic Minorities	þ

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$362,828	$0	$0	$362,828
2. Quality Assurance	$0	$0	$0	$0
3. Training (Post-Employment)	$26,250	$0	$0	$26,250
4. Education (Pre-Employment)	$0	$0	$0	$0
5. Program Development	$590,231	$16,597	$0	$606,828
6. Research and Evaluation	$265,786	$0	$0	$265,786
7. Information Systems	$0	$0	$0	$0
8. Total	$1,245,095	$16,597	$0	$1,261,692

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	$387,893
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$387893
Comments on Data:	

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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[35] TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671

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http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf;. Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges.* Baltimore, MD: The Hilltop Institute, UMBC.

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[39] Health homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

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[41] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html;Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

[42] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

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[50] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[51] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. **Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?**

Missouri has not expanded Medicaid. No changes are anticipated in terms of the State's Medicaid coverage of substance abuse or mental health services.

2. **Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?**

Missouri does not currently have plans to expand its Medicaid program nor is the state implementing a state health exchange. Provider staff have been trained on identifying and facilitating enrollment of individuals who meet basic categorical eligibility criteria for Medicaid benefits. In addition, consumers seeking services through the Department of Mental Health receive a Standard Means Test which includes questions regarding insurance.

3. **Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.**

Missouri does not currently have plans to expand its Medicaid program nor is the state implementing a state health exchange.

4. **Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?**

Missouri does not currently have plans to expand its Medicaid program nor is the state implementing a state health exchange.

5. **What specific changes will the state make in consideration of the coverage offered in the state's EHB package?**

Missouri does not currently have plans to expand its Medicaid program nor is the state implementing a state health exchange.

6. **Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?**

Yes, Missouri's initiatives are described below:

Health Homes:

The Health Home under the Affordable Care Act is an alternative approach to the delivery of health care services that promises better patient experience and better results than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home but is customized to meet the specific needs of individuals with serious mental illness who often have other co-occurring chronic illnesses. Missouri's initiative enhances the existing psychiatric rehabilitation program by adding nurse care managers and a primary care physician consultant to each community mental health center, and giving the enhanced psychiatric rehabilitation teams access to a wealth of care management reports designed to help them both identify treatment gaps and to assist individuals in developing healthy

lifestyles and managing their chronic illnesses. Goals of the CMHC health home initiative are to reduce unnecessary hospitalization and emergency room visits, while improving the health status of the individuals enrolled in the program. Missouri's plan was approved by the Centers for Medicare and Medicaid Services (CMS) in October 2011. Implementation began in January 2012. Under Missouri's plan, 27 Community Mental Health Centers (CMHC) are contracted as Healthcare Home providers. For an individual to be eligible for enrollment in Missouri's Healthcare Home, he/she must meet one of the following three conditions:

1) have a serious and persistent mental illness,
2) have a mental health condition and a substance use disorder, or
3) have a mental health condition or a substance use disorder and one other chronic health condition.

In FY 2014, Missouri began piloting a Children's Health Home program targeting children with co-occurring serious emotional disturbance and obesity.

Disease Management 3700 (DM 3700) & ADA Disease Management (ADA DM):
These programs are the result of collaboration between the Department of Mental Health (DMH) and the state Medicaid agency, MO HealthNet. DM 3700 started in November 2010 and targets Medicaid-enrolled adults with a serious mental illness and high medical costs who are currently not engaged in treatment at a Community Mental Health Center (CMHC). The ADA DM project started in February 2014 and targets Medicaid-enrolled adults with substance use disorders and high medical costs who are not currently engaged in treatment. DMH funds outreach efforts and the state Medicaid agency funds behavioral health treatment. Healthcare Home providers also participate in the DM 3700 program. Nineteen CSTAR providers (i.e. Missouri's only Medicaid-reimbursable substance use disorder program) participate in the ADA DM project. Each provider added a nurse liaison to assist with care coordination of complex physical health conditions of program participants.

7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

The SSA/SMHA has worked with the state hospital association on several initiatives including the Screening, Brief Intervention, Referral, and Treatment Grant. Several of the providers that contract with the SSA/SMHA are also FQHC's. Contracted providers also coordinate with local public health agencies for infectious disease testing and counseling.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

The Department of Mental Health (DMH) is working with mental health and substance use disorder providers to provide the American Lung Association's Freedom From Smoking (FFS) program to DMH consumers. Several DMH providers are conducting FFS groups. DMH has also supported Tobacco Treatment Specialist Certification training for providers. The training is accredited by the Council on Tobacco Treatment Training Programs and is

provided by the Mayo Clinic. Over 60 DMH provider staff have received TTS certification. Missouri's Health Homes project is also addressing smoking for participating consumers.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

Participants in Missouri's Health Home program are regularly screened and assessed for tobacco use.

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

- **Regular screening with a carbon monoxide (CO) monitor**
- **Smoking cessation classes**
- **Quit Helplines/Peer supports**
- **Others_____**

Some contracted providers provide smoking cessation classes. In Missouri, the Department of Health and Senior Services maintains the Missouri Tobacco Quitline through funding from the Centers for Disease Control and Prevention.

11. The behavioral health providers screen and refer for:

- **Prevention and wellness education;**
- **Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,**
- **Recovery supports**

Participants in the Health Homes program are screened for health risks such as heart disease, hypertension, high cholesterol, and diabetes. As part of the treatment planning process, providers screen and refer for recovery supports.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. **Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?**

Consumer demographics are captured by the Department of Mental Health's (DMH) Consumer Information Management Outcomes and Reporting (CIMOR) system. These demographic variables include preferred language, race, ethnicity, gender identity (ISO 5218), age, veteran status, and hearing status. CIMOR does not currently collect sexual preference information other than sexual history for the HIV/STD/TB risk assessment for individuals seeking substance abuse treatment.

2. **Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.**

Core standards require that services be delivered in a manner that is responsive "to each individual's age, cultural background, gender, language and communication skills, and other factors, as indicated" (9 CSR 10-7.010). In addition, programs that provide meals must have a written plan to ensure that menus are responsive "to cultural and religious beliefs of individuals" (9 CSR 10-7.080). The Division of Behavioral Health (DBH) requires through contract language that contractor staff be competent in the cultural, racial, and ethnic patterns of the geographic area being served. Interpreting services are provided to individuals in treatment whose preferred language is a language other than spoken English. The Department of Mental Health's Office of Deaf Services (ODS) is responsible for consultation and technical assistance to DMH facilities and contracted providers delivering behavioral health services to eligible individuals who are deaf, hard of hearing or from cultural minority groups. The ODS also establishes minimum competencies for behavioral health interpreters, consistent with the federal Culturally Linguistically Appropriate Services Standards. Client complaints and grievances received either by DMH's Office of Constituent Services or by the provider organization are reviewed by DMH clinical staff for issues with cultural competency. Cultural competency training is included in the DMH's annual Spring Training Institute which is attended by approximately 800 behavioral health and human service professionals.

About 27 percent of the consumers accessing behavioral health treatment funded through the DBH are of minority race and/or ethnicity. This is a higher percentage than compared to that of the general population in the State. About 19 percent of Missouri's general population is of a minority racial or ethnic group. DBH contracts with several prevention, treatment, and recovery support providers that specifically target minority populations and underserved populations. The state of Missouri contracts with Language Select which can provide written and spoken translation as needed. The Department's Director of Deaf Services also provides consultation and assistance to DMH facilities and providers delivering behavioral health services to eligible individuals who are Deaf, hard of hearing or from cultural minority groups.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

The state of Missouri contracts with Language Select which can provide written and spoken translation as needed. Language Select provides interpretations in 200 languages. Language Select monitors customer language requests to recruit additional languages as needed. The Department of Mental Health's (DMH) Office of Deaf Services (ODS) is responsible for consultation and technical assistance to DMH facilities and contracted providers delivering behavioral health services to eligible individuals who are deaf, hard of hearing or from cultural minority groups. The ODS also establishes minimum competencies for behavioral health interpreters, consistent with the federal Culturally Linguistically Appropriate Services Standards. Client complaints and grievances received either by DMH's Office of Constituent Services or by the provider organization are reviewed by DMH clinical staff for issues with cultural competency.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

See response to question #3.

5. Is there state support for cultural and linguistic competency training for providers?

Cultural competency training is included in DMH's annual Spring Training Institute which is attended by approximately 900 behavioral health and human service professionals. In recent years, Spring Training Institute workshops have included sessions: "Understanding the Military Culture" (2015), "Hearing Loss and Development" (2015), "Engage & Retain Military Clients" (2014), "Alcohol Addicted Women: Treatment is Still a Man's World" (2014), "Meet Me Where I Am: Working with Combat Trauma Veterans" (2014), "Behavioral Ethno-geriatrics" (2013), "Ethics and Cultural Competence" (2013), "Female Veterans in the Criminal Justice System" (2013), "Understanding Deaf Culture" (2013), "Elder Fraud: New Threats, Prevention, and Ethical Practice" (2013), "What It Feels Like to Go To Combat…and Its Aftermath" (2013), "Homelessness and Women – Research, Co-Occurring Disorders and Clinical Intervention" (2013), "One World, Many Cultures, Where Do I Start? Cultural Competency in Mental Health Care" (2012), "Becoming More Culturally Responsive in a Multi-Cultural Workplace" (2012), "Cultural Diversity in Counseling" (2012), "Clinical Consideration in the Treatment of PTSD in Military Veterans" (2012), "Connect. Accept. Respond. Empower. – How to Support LGBTQ Youth" (2011), "Substance Abuse Treatment for Lesbian, Gay Bisexual, and Transgender Individuals" (2011), "Cultural Competence: Working with Diverse Populations" (2010), and "Mental Health Needs of the Veterans Returning from Iraq" (2010).

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. **Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.**

Specific staff is designated to conduct fidelity reviews and to provide technical assistance and training on evidence-based practices. The evidence-based practices currently utilized are:

- Assertive Community Treatment (ACT)
- Integrated Treatment for Co-occurring Disorders
- Individualized Placement and Support Supported Employment
- Consumer Operated Service Programs (COSP)
- Dialectical Behavior Therapy
- Therapeutic Foster Care
- Medication Assisted Treatment (MAT)

The Division of Behavioral Health (DBH) currently has a service code in the state rehab model (CPR) that allows certain children's EBP's to be reimbursed through Medicaid. A clinical review committee composed of state children's personnel and Community Mental Health Center clinical personnel review EBP's for determining their feasibility to be billed to rehab model. In addition, it is an expectation that clinical treatment and prevention staff share evidence-based practices information as appropriate during other agency reviews and contacts.

2. **How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?**

Information regarding evidence-based or promising practices has been used in the implementation and evaluation of programs. DBH has used the SAMHSA EBP Toolkits and the Dartmouth models when available, e.g., Integrated Treatment for Co-Occurring Disorders and Consumer Operated Service Programs. For Supported Employment, DBH is following the Individualized Placement and Support model from Dartmouth. For Dialectical Behavior Therapy, DBH has remained faithful to the Marsha Linehan, Ph.D., model. DMH has used state and national outcome data for Assertive Community Treatment.

3. **Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?**

DBH, working closely with MO HealthNet, the state Medicaid agency, has created specific billing codes to support services for Integrated Treatment for Co-Occurring Disorders, Assertive Community Treatment and Dialectical Behavior Therapy. DBH has used best practice information in educating MO HealthNet on the provision of rehabilitation services for transitional age youth within the school setting.

4. **Does the state use a rigorous evaluation process to assess emerging and promising practices?**

DBH contracts with the Missouri Institute for Mental Health, University of Missouri – St. Louis for evaluation of many of its pilot programs including Health Homes, Emergency Room Enhancement, and use of medication assisted treatment among pre-release offenders.

5. Which value based purchasing strategies do you use in your state:

a. Leadership support, including investment of human and financial resources.

DBH secures staff with leadership and technical skills necessary to implement and maintain quality behavioral health programs. DBH leadership provides a consistent message that treatment is to be individualized based on the consumer's needs and that treatment is about treating the whole person. Leadership champions evidence-based practices to include:

- Assertive Community Treatment (ACT),
- Integrated Treatment for Co-occurring Disorders,
- Individualized Placement and Support Supported Employment,
- Consumer Operated Service Programs (COSP),
- Dialectical Behavior Therapy,
- Therapeutic Foster Care, and
- Medication Assisted Treatment (MAT).

b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

DBH monitors and tracks the performance of its initiatives via its state plans and continuous quality improvement plan as well as via program evaluation. DBH Researchers monitor data integrity

c. Use of financial incentives to drive quality.

In general, use of financial incentives has been limited to the collection of GPRA follow-ups in the Access to Recovery program.

d. Provider involvement in planning value-based purchasing.

DBH currently has a service code in the state rehab model (CPR) that allows certain children's EBP's to be reimbursed through Medicaid. A clinical review committee composed of state children's personnel and Community Mental Health Center clinical personnel review EBP's for determining their feasibility to be billed to rehab model.

e. Gained consensus on the use of accurate and reliable measures of quality.

DBH solicits input from its providers on report format and use of performance measures for provider-level reports. DBH solicits input from the State Advisory Councils on the use of performance measures for the state plans and continuous quality improvement plan.

f. Quality measures focus on consumer outcomes rather than care processes.

DBH uses national outcome measures (NOMS) in its provider-level reports used to guide technical assistance.

g. Development of strategies to educate consumers and empower them to select quality services.

DBH provides technical assistance to providers on educating consumers and their families on treatment planning and the recovery process. Peer Support Specialists share lived experiences of recovery, share and support use of recovery tools, help navigate the system, and model successful recovery behaviors. Peer support services are Medicaid-reimbursable for mental health treatment, and DMH has submitted a request to make them Medicaid-reimbursable for substance use disorder treatment.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

DBH does support a culture that makes quality a priority across the entire state infrastructure. DBH is consumer-focused. As such, quality is central to all activities across the state's behavioral health network. One strategy for ensuring a consumer focus is creating a stronger consumer voice in planning and program operation and greater opportunities for consumer employment in DBH service systems. State standards for psychiatric and substance use programs emphasize quality improvement. Programs are required to have a written plan for a "systematic quality assessment and improvement process" and that consumers are involved in the "planning, design, implementation, and review of the organization's quality improvement activities." Moreover, the process must be data-driven and include consumer satisfaction data. DBH, in collaboration with the State Advisory Councils, has a quality improvement plan which uses a data-driven process and is aligned with the NBHQF.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

DBH does not have a formal evaluation plan.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

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[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.

The evidence-based practice proposed by Missouri has not changed. Coordinated Specialty Care (CSC) services will include empirically-supported interventions including 1) cognitive/behavioral psychotherapy, 2) family education/supports, 3) case management, 4) supported employment/education, and 5) medication/primary care supports. Psychotherapy provides goal-oriented treatment designed to maximize the strengths and to reduce behavior problems and/or functional deficits stemming for the existence of a psychotic disorder that interferes with a consumer's personal, familial, vocational, and/or community adjustment. Family education and supports are designed to improve knowledge, coping skills, communication, problem solving, and goal setting for the family unit. Case management includes the arrangement and coordination of an individual's treatment and rehabilitation needs, as well as other medical, social, and educational services and supports to ensure continuity of services. The functional components of case management include assessment, care planning, referral/linkage, and monitoring/follow-up. With supported employment, direct job coaching/support services are provided to the consumer at the community work site with the goal of assisting the consumer in choosing, getting, and keeping competitive employment. Specific supported employment services include, but are not limited to, meeting at the work site with the employer for needed interventions; mediation between the individual and the employer, and helping the consumer learn specific job-related tasks. Medication services include the assessment of the need for medications, the prescription of medications, and ongoing management of a medication regimen. Management services include monitoring lab levels; coordination of medication needs with primary care, consumers, and their families; consumer and family education regarding medications; and monitoring physician orders for treatment modifications requiring consumer/family education.

The CSC program will provide a recovery-oriented approach that includes person-centered planning and shared decision-making. Program expectations are that CSC treatment will be time-limited (2-3 years) and linkages to community supports will be established to maintain recovery during and beyond treatment. Treatment may be extended in the CSC program, as clinically appropriate, using a step-down approach with eventual transition to traditional mental health services in the community.

The program will employ a multi-disciplinary team approach to provide flexible, individualized care in community settings of the consumer's choice. The team will include professionals with expertise in psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The team leader will be responsible for the consumer's overall treatment plan and programming. Team caseloads will be relatively small (25-35 consumers or less) to ensure that teams have sufficient time to adequately provide individualized wraparound. Teams will meet regularly and frequently to maintain focus on consumer recovery and support program fidelity. Ongoing training will be provided to CSC staff.

2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.

Implementation Status/Accomplishments: Missouri has established a CSC site in southwest Missouri. CSC staff at the southwest site has received both team training that focused on the using the team approach in serving transition age youth emphasis on early onset psychosis and specialty training focusing on the skills and interventions required by the CSC model. DBH has worked with Burrell Behavioral Health in Springfield, Missouri to implement the CSC program. As of August 7, 2015, 21 transition age youth have been served in the CSC program. Of these, 16 were served in FY 2015.

Proposed Changes: Missouri is proposing to add a CSC site in Cass County, Missouri. Located southeast of Kansas City, Cass County, Missouri is primarily a rural area with a total population of 100,889 (Missouri Census Data Center, 2015). The county is home to about 3,026 youth age 16 to 17 and 9,109 young adults age 18 to 25. The prevalence of serious emotional disturbance (SED) among U.S. teens age 16 to 17 is estimated at 10.4 percent (Mark, T.L. and Buck, J.A., 2006). The prevalence of serious mental illness (SMI) among U.S. young adults age 18 to 25 is estimated to be 4.2 percent (Substance Abuse and Mental Health Services Administration, 2013). Applied to the respective populations in Cass County, an estimated 314 youth have SED and 382 young adults have SMI. To estimate the number with psychosis, prevalence of psychotic disorders is determined for those populations in Cass County who were served by the Missouri Division of Behavioral Health (DBH). The grouping of ICD-9 codes for the psychosis group is taken from the Healthcare Cost and Utilization Project (H-CUP) (Agency for Healthcare Research and Quality, 2004). In Cass County, about 4.7 percent of SED youth age 16 to 17 and 22.4 percent of the SMI young adults age 18 to 25 served by DMH had a psychotic disorder. The estimated number of transition age youth/young adults with a psychotic disorder residing in Cass County is 99.

	Age 16-17		
Target Area	2014 Population	Estimated SED (10.4%)	Estimated Psychotic Disorder (59.2%)
Cass County	3,026	314	14

	Age 18-25		
Target Area	2014 Population	Estimated SMI (4.2%)	Estimated Psychotic Disorder (76.6%)
Cass County	9,109	382	85

The priority populations for the Block Grant five percent set-aside are youth age 16 to 17 with SED and a psychotic disorder and young adults age 18 to 25 with SMI and a psychotic disorder. The geographic area to be served is the Cass County in northwest Missouri. The estimated numbers of transition age youth with SED/SMI is 696. Of these, an estimated 99 have a psychotic disorder.

Missouri will contract with Compass Health-Pathways to implement the CSC program in Cass County. Compass Health is a community-based non-profit organization that provides a wide range of behavioral healthcare services and is contracted with the Missouri Department of Mental Health (DMH) for treatment of substance use disorders and mental illness. Compass Health is the administrative agent for the three-county region in northwest Missouri that includes Cass County. The agency has accreditation from CARF International.

3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.

Priority: Transition Age Youth with Emphasis on Early Psychosis

Goal: Improve access to and use of promising practices in the treatment of transition age youth with early onset serious mental illness including psychosis

Objective: Increase number served in the Coordinated Specialty Care model

Strategy 1: Identify individuals with early onset serious mental illness who could benefit from CSC

Strategy 2: Educate referral sources on the CSC model

Performance Indicator: Number Served with CSC

Baseline (FY 2015): 16
Target FY 2016: 25
Target FY 2017: 40

Objective: Increase the number of CSC teams statewide

Strategy 1: Provide education and training opportunities in the CSC model for providers

Strategy 2: Solicit proposals from providers on implementing a CSC team

Strategy 3: Provide ongoing technical assistance to CSC teams

Performance Indicator: Number of CSC Teams (cumulative)

Baseline (FY 2015): 1
Target FY 2016: 2
Target FY 2017: 3

4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.

FY 2016 Award:

Activity	**Budget for Block Grant 5% Set-Aside**
Coordinated Specialty Care Staff Development	$54,000
Coordinated Specialty Care Services for Transition Age Youth	$334,886
Total for FY 2016 Award	**$389,686**

FY 2017 Award:

Activity	Budget for Block Grant 5% Set-Aside
Coordinated Specialty Care Staff Development	$54,000
Coordinated Specialty Care Services for Transition Age Youth	$334,886
Total for FY 2017 Award	**$389,686**

5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Until SAMHSA standardizes the data collection for the 5 percent set-aside, the state plans to use existing data sources for reporting. The state collects consumer outcome data at intake, annual follow-up, and at discharge. Because the CSC program began admitting consumers in March 2015, there is not enough follow-up data to present data at one year post-admission.

i. Target Population (FY 2015)

a. Age groups

Age	#	%
<18	2	12.50%
18-19	2	12.50%
20-21	7	43.75%
22-24	5	31.25%
Total	**16**	100.00%

b. **Number served**: 16

c. **Diagnostic categories**:

Diagnostic Categories	# Occurrences
Anxiety Disorders	8
Developmental Disorders	1
Mood Disorders	13
Personality Disorders	2
Psychotic Disorders	1
Sexual Disorders	1
Total	**26**

*A consumer may have more than one diagnosis.

ii. Chosen model: Coordinated Specialty Care

iii. Number of service providers trained: 1

iv. Number and type of referrals:

Referrals	#	%
Family/Friends/Self	5	31.25%
Medical Facility	6	37.50%
Behavioral Health Professional	3	18.75%
School	1	6.25%
Other	1	6.25%
Total	**16**	100.00%

v. Program outcome of persons receiving services:

a. Home:

1. Number and percentage of individuals in stable housing:

Stable Housing at Admission	#	%
Stable Housing	10	62.50%
Homeless	1	6.25%
Unknown	5	31.25%
Total	**16**	100.00%

b. Health

1. **Number and percentage of individuals receiving coordinated Primary Care**: N/A
2. **Number of individuals who did not have repeated hospitalization**: N/A

c. Community:

1. **Number and percentage of individuals staying socially connected**: N/A
2. **Number and percentage of individuals who did not have repeated contact with the criminal justice system**:

Arrests in Past 30 Days at Admission	#	%
Arrests	1	6.25%
No Arrests	10	62.50%
Unknown	5	31.25%
Total	**16**	100.00%

d. Purpose:

1. Number and percentage of employed individuals.

Employment Status at Admission	#	%
Employed	1	6.25%
Unemployed/seeking work	6	37.50%
Not in Labor Force - Student	1	6.25%
Not in Labor Force - Disability	1	6.25%
Not in Labor Force - Other	2	12.50%
Unknown	5	31.25%
Total	**16**	100.00%

2. Number and percentage of individuals in school.

Attended School in Past 3 Months	#	%
Yes	2	12.50%
No	9	56.25%
Unknown	5	31.25%
Total	16	100.00%

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

The Division of Behavioral Health (DBH) uses a Billing and Services Review (BSR) team to monitor compliance of services billed to the Purchase of Services (POS) billing category which is composed of block grant dollars and state funding. The BSR team is comprised of six (6) mental health professionals who conduct chart reviews at 80 contracted providers from the DBH, to assess compliance with program and certification standards. A further purpose of the reviews is to verify that services paid for by the DBH were actually provided and that the services are of high quality and appropriate to the needs of the consumer receiving the services.

2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

The Division of Behavioral Health (DBH) has a Compliance and Systems Management Coordinator who supervises the Billing and Services Review (BSR) team.

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:

a. **Budget review;**

The block grant budgets are reviewed annually. Each set-aside (5% Administration, 20% Prevention, 70% Treatment and 5% Prevention/Treatment) is budgeted separately. These annual budget reviews include review of all contracts to determine what, if any, changes are needed for the renewal and what contracts will be renewed; review of prior year expenditures and any additional funding needs over that amount; and consideration of funding available to establish new budgets. Once all contracts and obligations against those set asides are reviewed, funds are allocated to the treatment & prevention providers accordingly. Administration personal service (payroll) and expense & equipment budgets are established and expenditures are monitored at least monthly.

b. Claims/payment adjudication;

Specific block grant reporting categories are assigned within the state wide accounting system (SAM II) for each Block Grant set asides. Each reporting category has a budget established within SAMII that prevents the set-aside from being overspent. These reporting categories used for tracking the SAPT block grant with the SAMII system are as follows: BAM-administration; BGP-prevention, BGT-treatment. In addition, the division has established certain project codes to further distinguish SAPT block grant set-asides as they relate to Women & Children services and primary prevention activities. Routine reports are generated to ensure project codes are used appropriately. Any project code inadvertently missed is corrected with a journal voucher to add the project code in SAMII. All block grant expenditures are tracked in the statewide accounting system.

c. Expenditure report analysis

Various reports have been established to monitor block grant expenditures, by the specific set asides, monthly or more often if needed.

d. Compliance reviews;

"Desk Audits" are completed throughout the year to monitor for compliance of selected services in scope of service delivery processes and documentation. A random selection of consumer charts is submitted by agencies for review. The Billing and Services Review (BSR) team reviews the charts for accuracy in service delivery, documentation and billing. Review findings are reported back to agencies along with technical assistance and training, if needed.

e. Client level encounter/use/performance analysis data; and

Payer determination rules have been established in our Customer Information Management & Outcome Reporting (CIMOR) provider billing system to ensure proper spending of block grant funding.

f. Audits.

The Billing and Services Review (BSR) team is responsible for completing reviews (also referred to as billing audits) on a statewide basis. In terms of scope, the BSR team conducts site visits and chart reviews at 80 provider agencies across the state. The impact of the BSR team is that it assures state money is being spent appropriately and insures documentation in clinical records meets applicable rules and requirements in the state code of regulations, division contracts, and division policies.

4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.

In order to determine service rates and package limits, the Division of Behavioral Health (DBH) seeks input from service providers and assesses current rates and package limits of comparable services and packages. In some grant programs such as Access to Recovery IV and Medication Assisted Treatment (MAT) where client targets are a requirement, those targets are also considered in the determination of service mix, rates, and packages.

5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

Through Billing and Service Reviews (BSR), Safety and Basic Assurance Reviews (SBARS), and Certification surveys, the Division of Behavioral Health (DBH) assesses compliance with program requirements and standards. Through these surveys, agencies receive feedback regarding deficiencies and/or recommendations. DBH has implemented a Monitoring Database to track the monitoring process including scheduling of site visits, findings and deficiencies,

action plan requirements, action plan approval, certification status, and related communications and reports. DBH uses the survey outcomes to target technical assistance.

6. How does the state ensure block grant funds and state dollars are used for the four purposes?

- **Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.**

Consumers seeking services through the Department of Mental Health receive a Standard Means Test which includes questions regarding insurance. For consumers with insurance, providers direct bill the insurance company. Billing and Services Reviews (BSR) check the appropriateness of service billing.

- **Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.**

DBH funds an array of programs and practices that have demonstrated success in improving outcomes. Performance data are routinely collected and analyzed. Provider staff have been trained on identifying and facilitating enrollment of individuals who meet basic categorical eligibility criteria for Medicaid benefits. In addition, consumers seeking services through the Department of Mental Health receive a Standard Means Test which includes questions regarding insurance. Billing and Services Reviews (BSR) check the appropriateness of service billing. The Department of Mental Health (DMH) information system links with the state Medicaid agency, MO Healthnet, to obtain the consumer's current Medicaid eligibility information. The system has an automatic sweep process that checks for the billing of Medicaid reimbursable services on Medicaid eligible consumers to ensure that such services are not billed to non-Medicaid funding sources including the Block Grant funds.

- **Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.**

Funding for primary prevention is tracked by the IOM Model of Universal, Selective, and Indicated interventions. DBH contracts with 10 Regional Support Centers (RSCs) to provide technical assistance to 160 community coalitions focused on substance abuse prevention. As a part of the Strategic Prevention Framework model, the RSCs conduct a needs assessment to identify the types of primary prevention services for each community. Missouri's School-based Prevention Intervention and Resource Initiative (SPIRIT) provides evidence-based prevention programs to four school districts in Missouri. Missouri funds a statewide consortium of 21 colleges and universities, Partners in Prevention (PIP) to address underage and binge drinking on Missouri campuses. High Risk Youth Programs in various parts of the state provide evidence-based prevention services to youth and families with high risk factors for substance use because of living in low-income and/or minority communities, family history of abuse, or because they are experiencing academic failure.

- **Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.**

DBH collects the National Outcome Measures (NOMS) for its behavioral health treatment programs and substance abuse prevention programs. For the Access to Recovery IV and Medication Assisted Treatment (MAT) grants, DBH collects the Government Performance and Reporting Act (GPRA) data. The Department's information system - Customer Information Management Outcomes and Reporting (CIMOR) system - provides for the intake and tracking of consumers (including admission, level changes, and discharge) collection of Treatment Episode Dataset (TEDS) data, state facility bed management, event tracking for incidents impacting consumer safety, clinical screening and assessments, recording of diagnostic information, tracking of court commitments, recording of clinical encounters, authorization request and approval processes, maintenance and tracking of department funding and program expenditures, claims adjunction and payment, voucher management and Government Performance and Reporting Act (GPRA) data collection, tracking of Medicaid benefit eligibility, consumer banking for management of consumer funds held in trust by state facilities, provider management, standard means test (SMT) application, outcomes reporting, and waiting lists. Encounters do capture type, amount, and cost of service provided, date provided, and location of service delivery. CIMOR captures reimbursable medications for non-Medicaid consumers but not for non-reimbursable medications. For Medicaid consumers, pharmacies direct bill the state Medicaid agency.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

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[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

Tribes

The state of Missouri does not have any federally recognized tribal governments or tribal lands within its borders.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. **Please indicate if the state has an active SEOW. If so, please describe:**

   - **The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);**
   - **The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and**
   - **The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).**

In 2010, Missouri was awarded a State Epidemiology Outcomes Workgroup (SEOW) contract, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The state used this funding to revitalize its SEOW workgroup that had been established under Strategic Prevention Framework State Incentive Grant (2004-2009) to address underage drinking. An expanded scope of the new SEOW includes mental health promotion. The mission of Missouri's current SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

The SEOW is chaired by a Research Assistance Professor at the Missouri Institute for Mental Health – University of Missouri, St. Louis. DMH's Director of Prevention, Research Coordinator, and Director of Quality Improvement are members of the SEOW. Social services, public safety, health, education, the judicial system, and academia are also represented on the workgroup.

Prevalence data, behavioral health indicators, treatment admissions data, population estimates, needs assessments, and outcomes data are collected. The SEOW assimilates behavioral health-related data from several national and state surveys. The SEOW acquires state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH), state estimates from the Youth Risk Behavior Survey (YRBS), state estimates from the Behavior Risk Factor Survey (BRFS), state and county-level data from the Missouri Student Survey (MSS) for grades 6 through 12, state-level data from the Pregnancy Risk Assessment Monitoring System (PRAMS) for pregnant women, state-level data from the Missouri GSA Network's Missouri School Climate Survey (MSCS), and state data collected from 21 of Missouri's universities and colleges using the Missouri College Health Behavior Survey (MCHBS). The SEOW annually updates prevalence estimates using the most current survey data. In addition to prevalence data, the MSS survey collects data on risk and protective factors related to a range of health and safety issues.

A report summarizing the results of the this survey is published on the DMH website: http://dmh.mo.gov/ada/rpts/docs/2014mssreport.pdf.

The SEOW collects an array of behavioral health indicator data, mostly from other state agencies. The indicators include traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements; methamphetamine lab confiscations; probation, parole, and prison admissions; and drug, DUI, and mental health court enrollments. The SEOW also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment rates. The SEOW annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, service areas, planning regions, and the state. The 2015 state profile includes information on individuals across the age continuum with a special focus on high risk groups such as LGBTQ and veterans. Substance abuse and mental health treatment admissions data are retrieved from the DMH Customer Information, Management, Outcomes, and Reporting (CIMOR) system, based on each consumer's county of residence. Information on demographics, substances abused, diagnoses, and treatment services are assembled by fiscal year into geographic profiles for the counties, planning regions, service areas, and state. These profiles are included in DMH's annual Status Report on Missouri's Substance Abuse and Mental Health Problems. SEOW data products such as community profiles and the web data querying tool can be found at: http://dmh.mo.gov/ada/mobhew/.

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds;

The Missouri Division of Behavioral Health (DBH) is supported by a Research and Statistics unit and also contracts with the Missouri Institute for Mental Health (MIMH) at the University of Missouri-St. Louis for data and research support. The DBH Research unit annually compiles and publishes behavioral health statistics in its Status Report on Missouri's Substance Use and Mental Health. In addition, the DBH Research unit tracks prevention outcomes for budget and grant reporting. MIMH provides expertise in behavioral health research, evaluation, and training and has provided management and/or evaluation support to grant projects: Strategic Prevention Framework State Incentive (SPF-SIG) Grant (2004-2009), Screening Brief Intervention Referral and Treatment Grant (SBIRT) (2008-2013), Mental Health Transformation Grant (2006-2011), the Partnership for Success Grant (2012-2015) as well as other ongoing projects including the Missouri Student Survey and the School-based Prevention Intervention and Resource Initiative (SPIRIT).

The DBH Research Coordinator and the Prevention Director are both represented on the State Epidemiology Outcomes Workgroup (SEOW). Missouri's SEOW, initially established under the SPF-SIG was revitalized under the SEOW contract and currently receives support from the Partnership for Success Grant.

Missouri's SEOW is chaired by a Research Assistant Professor at MIMH. Membership includes data experts from mental health, social services, public safety, health, education, and the judicial system. The SEOW workgroup continues to assess data gaps, enhance capacity to use

behavioral health data, promote data driven decision-making, increase dissemination of data and analyses, promote common data standards, and increase data collaborations. The SEOW generates regular work products including county-level epidemiology profiles and hot topic briefs. The SEOW with support from the DBH Research unit has developed and continues to maintain a web-based querying tool to facilitate use of behavioral health data.

DBH's priorities, goals, and performance measures are established in the Strategic Plan for Prevention (2010-2015):

http://dmh.mo.gov/docs/ada/Progs/Prevention/StrategicPlanforPrevention2010.pdf.

The state plan was drafted by the DBH Prevention Director under the guidance of the DBH Management Team and the State Advisory Council for Alcohol and Drug Abuse (SAC-ADA). The SAC-ADA serves as an advisory body to DBH. Performance measures established by the state plan are tracked via a dashboard report that is integrated into the web-based querying tool. The dashboard report is in the process of being retooled.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

The Missouri Division of Behavioral Health (DBH) works collaboratively with other state agencies and non-profit organizations to maximize prevention resources. Interagency workgroups with DBH representation include:

- Council for Adolescent School Health;
- Missouri Coordinated School Health Coalition;
- Missouri Alliance for Drug Endangered Children;
- Juvenile Crime Enforcement Coalition for Missouri School Violence Hotline;
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Missouri Behavioral Health Epidemiology Workgroup;
- Show Me Response (disaster & emergency coordination);
- Smoking Cessation Planning Workgroup;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Mental Health First Aid Advisory Council; and the
- Missouri Alliance to Curb Problem Gambling.

DBH prevention funds are used to leverage other prevention resources in the community. For example, SAPT Block Grant funds in addition to funds from other prevention providers including United Way have been used to implement a comprehensive campaign to stop the rising number of heroin-related deaths in Eastern Missouri. Missouri's higher education consortium, Partners in Prevention (PIP), receives funding from the SAPT Block Grant prevention set-aside with supplemental funding from the Missouri Division of Highway Safety, the Youth Suicide Prevention Grant, the Enforcing Underage Drinking Laws Grant, and the Garrett Lee Smith Memorial Act Campus Prevention Grant.

The Missouri Division of Behavioral Health (DBH) provides training, education, and technical assistance to prevention providers and community coalitions through the Missouri Statewide Training and Resource Network (STRC).

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce;

All funded prevention agencies must be certified by the Department of Mental Health. http://dmh.mo.gov/mentalillness/provider/certification.html. Prevention staff must maintain a minimum prevention credential, Missouri Substance Abuse Prevention Associate (MSAPA), through the Missouri Credentialing Board (MCB) http://www.missouricb.com/.

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and

The Missouri Division of Behavioral Health (DBH) provides training, education, and technical assistance through the Missouri Statewide Training and Resource Network (STRC). Training and technical assistance are provided to Regional Support Center staff and community leaders to promote community development, accountability, and targeted prevention initiatives based on the Center for Substance Abuse Prevention's (CSAP) best practices program recommendations. The STRC, with assistance from the Southwest Regional Expert Team, presents statewide and regional workshops throughout the year. The STRC plans and coordinates the annual Statewide Prevention Conference. The 2014 Conference included workshops on strategic planning, use of data products, care for drug endangered children, suicide prevention, building sustainable community partners, program evaluation, in addition to other topics. The conference was attended by about 200 prevention professionals and other interested parties. In addition, the Department of Mental Health's Annual Spring Training, attended by over 900 behavioral health and human service professionals, provides a prevention track.

c. A formal mechanism to assess community readiness to implement prevention strategies.

Each Regional Support Center (RSC) conducts a formal community readiness annually as part of their strategic planning process.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

DBH contracts with 10 RSCs to provide technical assistance to 160 community coalitions focused on substance abuse prevention. As a part of the Strategic Prevention Framework model, the RSCs conduct a needs assessment to identify the types of primary prevention services for each community. The needs assessment data sources include state, county and local data for

consumption patterns, consequences of use and risk and protective factors. The RSCs use multiple data sources for the assessment. Examples include but are not limited to the following:

- Missouri Behavioral Health Epidemiologic Workgroup (MO-BHEW) data querying website: http://dmh.mo.gov/seow,
- Missouri Status Report on Missouri's Substance Use and Mental Health: http://dmh.mo.gov/ada/rpts/status.htm,
- Missouri Information for Community Assessment (MICA): http://health.mo.gov/data/mica/MICA/,
- Annie Casey Foundation Kids Count: http://datacenter.kidscount.org/;
- Missouri Department of Elementary and Secondary Education School District Reports: http://mcds.dese.mo.gov/quickfacts/SitePages/DistrictInfo.aspx, and
- local data when available from schools and law enforcement sources.

The primary prevention programs for the community are identified through the community needs assessment.

The Missouri Student Survey (MSS) is a significant data source for prevention planning. The Division of Behavioral Health replicated the survey first conducted by Research Triangle Institute for the SAMHSA/CSAP funded Missouri State Prevention Needs Assessment Grant. Since 2000, the survey has been available for Missouri students in grades 6 through 9. The MSS collects data for substance use consumption patterns, consequences of use, and risk and protective factors. Participating schools and their communities review the survey results to assist program selection. The annual Missouri Student Survey Report is published at: http://dmh.mo.gov/ada/rpts/survey.htm

Missouri's School-based Prevention Intervention and Resource Initiative (SPIRIT) provides evidence-based prevention programs to four school districts in Missouri. Data has been used with the SPIRIT model since implementation in 2002. After meeting the risk factors of: 1) at least 60% of students receiving free/reduced lunch, 2) standardized tests scores below state average, 3) ATOD use above state average, 4) high drop-out rate, and 5) high number of referrals to juvenile authorities, the high-risk population schools were then matched to evidence-based substance abuse prevention programs. The SPIRIT model also includes an evaluation component. Each school's needs determine the evidence-based program and any supplemental lessons implemented. Missouri's SPIRIT program received the 2010 SAMHSA Science and Service Award. SPIRIT reports and related-information are published at: http://dmh.mo.gov/ada/progs/SPIRIT.htm.

Missouri funds a statewide consortium of 21 colleges and universities, Partners in Prevention (PIP) to address underage and binge drinking on Missouri campuses. Data from the Missouri College Health Behavior Survey (MCHBS): http://pip.missouri.edu/data.html and the Missouri College Student Veterans Assessment (MCSVA): http://pip.missouri.edu/research.html are reviewed by each campus to identify their specific needs. PIP also provides technical assistance to campus communities involving alcohol access laws.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

DBH's priorities, goals, and performance measures are established in the Strategic Plan for Prevention:

http://dmh.mo.gov/docs/ada/Progs/Prevention/StrategicPlanforPrevention2010.pdf.

The state plan was drafted by the DBH Prevention Director under the guidance of the DBH Management Team and the State Advisory Council for Alcohol and Drug Abuse (SAC-ADA). The SAC-ADA serves as an advisory body to DBH. Performance measures established by the state plan are tracked via a dashboard report that is integrated into the web-based querying tool. The dashboard report is in the process of being retooled.

DBH is currently in the process of updating the Strategic Plan for Prevention.

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

An evidence-based workgroup will soon be formed under the new Partnerships for Success grant program. The Division of Behavioral Health (DBH) is both the Single State Authority (SSA) for substance use and the State Mental Health Authority (SMHA). The DBH Director of Prevention oversees substance use prevention, Synar retailer education, suicide prevention, Mental Health First Aid training, and mental health promotion. Prevention efforts are coordinated through interagency workgroups represented by government agencies, nonprofit organizations, and academia. These groups include:

- Council for Adolescent School Health;
- Missouri Coordinated School Health Coalition;
- Missouri Alliance for Drug Endangered Children;
- Juvenile Crime Enforcement Coalition for Missouri School Violence Hotline;
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Missouri Behavioral Health Epidemiology Workgroup;
- Show Me Response (disaster & emergency coordination);
- Smoking Cessation Planning Workgroup;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Mental Health First Aid Advisory Council; and the
- Missouri Alliance to Curb Problem Gambling.

In addition, Missouri's higher education consortium, Partners in Prevention (PIP) coordinates prevention programming at 21 public and private college and university campuses across the state. PIP receives funding from the SAPT Block Grant prevention set-aside with supplemental funding from the Missouri Division of Highway Safety, the Youth Suicide Prevention Grant, the Enforcing Underage Drinking Laws Grant, and the Garrett Lee Smith Memorial Act Campus Prevention Grant.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

Statewide Substance Abuse Prevention Network – DMH has created a prevention network to address alcohol, tobacco, and other drug use in the community through advocacy and community education. Missouri's 160 **community coalitions** and the 10 **Regional Support Centers (RSCs)** work to change community norms, policy, and substance availability in support of creating healthy and safe communities across the state. The Regional Support Centers, in collaboration with the community coalitions, develop, implement, and evaluate a comprehensive strategic plan with identified target outcomes based on community needs. The RSC in Eastern Missouri is leveraging SAPT Block Grant prevention dollars with funding from United Way and other community partners to conduct a comprehensive campaign on heroin and other opiate drug use. The **Statewide Training and Resource Center** (STRC) provides resources, training, and technical assistance for the RSCs, coalitions, and other direct prevention providers. The STRC presents a number of statewide workshops throughout the year and also holds a statewide prevention conference.

The **School-based Prevention Intervention and Resources Initiative (SPIRIT)** program supports implementation of prevention curricula of proven effectiveness at reducing alcohol and other drug use and reducing incidences of violent behavior among children in grades Kindergarten through 12. Age- and grade-appropriate curricula are taught, screening and referral services are available, and support for prevention activities throughout the school are provided. SPIRIT currently operates in four sites and six school districts across the state: Carthage R-IX, Knox Co. R-I, Charleston R-I, Scotland Co. R-I, New Madrid Co. R-I, and Ritenour in St. Louis. Programs implemented include: PeaceBuilders, Second Step, Too Good for Drugs, and Project Towards No Drug Abuse. Specific program goals are to: 1) delay onset and decrease use of alcohol, tobacco and other drugs; 2) improve overall school performance; and 3) reduce incidents of violence, including bullying. All aspects of the SPIRIT project are evaluated by a professional prevention evaluation team. The school districts participating in SPIRIT were identified as high-risk districts based on the number of youth for each district, the number of referrals to juvenile authorities, school drop-out rates, and the number of students receiving reduced or free lunches.

Partners in Prevention (PIP) is Missouri's higher education substance abuse consortium comprised of 21 public and private college and university campuses across the state that work to reduce rates of harmful and dangerous drinking on campuses. The coalition also focuses on other problematic health behaviors such as high risk driving behaviors and problem gambling.

In addition, support and services are provided to campuses across the state to prevent suicide and support positive mental health among college students. Brief Alcohol Screening and Intervention for College Students (BASICS) is being implemented to reduce risky behaviors and harmful consequences of alcohol abuse, as well as t**he Student Alcohol Responsibility Training (START)** program which assists students in planning and hosting a successful, fun, and safe event of any kind. Members of the PIP coalition meet monthly for training and network opportunities and host a statewide prevention conference each spring called Meeting of the Minds. Each college and university involved with PIP is required to write and implement a strategic plan. To identify progress of their goals, and to obtain data for program planning and implementation, each campus conducts the Missouri College Health Behavior Survey (MCHBS), an annual, online survey implemented each spring semester since 2007.

High Risk Youth Programs in various parts of the state provide evidence-based prevention services to youth and families with high risk factors for substance use because of living in low-income and/or minority communities, family history of abuse, or because they are experiencing academic failure.

The programs and strategies implemented by these agencies include: After school mentoring programs for predominantly African-American 12-15 year old youth in urban St. Louis who are at risk for substance use due to poor social or economic factors; the How to Cope program for those ages 18 and up which offers education and support to individuals who are affected by another person's abuse of alcohol or drugs; and the Lincoln University Youth Development Kids' Beat program which enriches and empowers youth in geographically and economically depressed areas, focusing on substance abuse prevention through leadership skill development, conflict resolution, self-esteem, interpersonal relationships, application of knowledge and resources, and cultural experience. The Leadership Education and Advocacy for the Deaf (L.E.A.D.) Institute provides education and research for enhancing socio-emotional development, effective communication, and leadership skills to individuals who are deaf and hard of hearing. The Missouri Alliance of Boys and Girls Clubs, consisting of 14 sites across the state, serves high risk youth between the ages of 5 and 18. The sites implement SMART Moves, which helps young people learn to resist alcohol, tobacco and other drugs and avoid premature sexual activity, and MethSMART which is a program designed to help youth understand how to achieve life goals without succumbing to the threat of drugs, particularly methamphetamine.

The **Missouri Student Survey (MSS)**, jointly administered by the Departments of Mental Health and Elementary and Secondary Education, assesses substance use and related behaviors among 6^{th} – 12^{th} graders attending public schools across the state. The Regional Support Centers and coalitions use data from the MSS for their community needs assessment and planning.

Prevention Evaluation supports all prevention services through the provision of data for assessing prevention needs and program effectiveness. The Missouri Student Survey is included among the evaluation activities. The Behavioral Health Data Tool website provides users with the ability to access and analyze community-level data to support strategic planning and implementation of targeted interventions. The State Epidemiology Outcomes Workgroup (SEOW) ensures a data-driven process and helps increase data capacity.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

As part of the needs assessment in the Strategic Prevention Framework model, identification is made of available prevention resources so as not to duplicate programming. Where possible, resources are leveraged to ensure a coordinated and comprehensive approach to prevention programming. In past years, for example, SAPT Block Grant dollars have been used to fund a joint effort of state government, local governments, charitable foundations, and community agencies to address a growing heroin problem in the St. Louis area. At the state-level, prevention efforts are also coordinated through interagency workgroups represented by government agencies, nonprofit organizations, and academia. These groups include:

- Council for Adolescent School Health;
- Missouri Coordinated School Health Coalition;
- Missouri Alliance for Drug Endangered Children;
- Juvenile Crime Enforcement Coalition for Missouri School Violence Hotline;
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Missouri Behavioral Health Epidemiology Workgroup;
- Show Me Response (disaster & emergency coordination);
- Smoking Cessation Planning Workgroup;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Mental Health First Aid Advisory Council; and the
- Missouri Alliance to Curb Problem Gambling.

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

The RSCs submit monthly progress reports that provide numbers served, progress towards outcomes, and includes technical assistance provided to coalitions and partnerships, trainings provided to coalitions, summary of the training evaluations, community education events conducted, and direct prevention services provided. An annual report is also required which demonstrates that the RSCs and their coalitions have achieved their prevention outcomes.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

The outcome data collected by the state is determined by the Department of Mental Health's Strategic Plan for Prevention:

http://dmh.mo.gov/docs/ada/Progs/Prevention/StrategicPlanforPrevention2010.pdf

Statewide prevention goals include:

- Reduce binge drinking among Missouri's youth and young adults;
- Delay onset of first use of alcohol and marijuana;
- Reduce the use of alcohol and marijuana among youth in the past 30 days;
- Increase the number of youth who perceive risk/harm of alcohol, cigarettes, marijuana and other drugs;
- Reduce the prescription drug misuse among young and older adults;
- Reduce smoking and other tobacco use among Missouri's youth;
- Decrease methamphetamine labs;
- Reduce substance use among pregnant women; and
- Continue to meet the requirements of the Synar amendment for reducing sale and distribution of tobacco products to individuals under the age of 18.

Data measuring binge drinking among youth and young adults is obtained from the Missouri Student Survey and the National Household Survey on Drug Use and Health, state and sub-state estimates. The Missouri Student Survey also provides data on the onset of first use of alcohol and marijuana; current use of alcohol and marijuana; risk/harm perception of alcohol, cigarettes, marijuana, and other drugs; current use of cigarettes and other tobacco products; and non-medical use of prescription drugs. The Missouri Department of Public Safety provides data on methamphetamine laboratory incidents by county which can be aggregated up to the service area, regional, and state levels. Non-medical use of prescription drugs for adults age 26 and older is available from the National Household Survey on Drug Use and Health. DBH, in collaboration with the SEOW, continues to explore data sources to measure substance use among pregnant women. These data sources include the Pregnancy Risk Assessment Monitoring System (PRAMS) of which Missouri is a participating state: http://apps.nccd.cdc.gov/cPONDER/default.aspx?page=main. In addition, DBH obtains reportable incidents of maternal use of illicit drugs from the Missouri Patient Abstract System. DBH is the agency responsible for conducting Missouri's Synar survey and for reporting the state's non-compliance rate.

The outcome data are tracked in the state dashboard report which is currently being reworked and will be integrated into the web-based data querying tool. In addition, provider reports are being developed to be used as a tool to assess strategic planning at the provider level. These reports will show providers how their area's outcome data compares to that for the state. Providers will have flexibility to incorporate other initiatives into their plans provided it can be supported by a data-driven process rather than antidotal evidence.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

Missouri Department of Mental Health
Division of Behavioral Health

FY 2016 – FY 2017 Continuous Quality Improvement (CQI) Plan

Draft
5/22/2015

Introduction

The following Quality Improvement Plan serves as the foundation of the commitment of this agency to continuously improve the quality of treatment and services it provides.

Quality: Quality services are services that are provided in a safe, effective, person-centered, timely, equitable, and recovery-oriented manner.

The Missouri Division of Behavioral Health is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care. The organization continuously strives to ensure that:

- Consumer safety is a priority in the state-operated and contracted community programs.
- Consumers have a voice in system design, individualized service planning, and evaluation.
- Behavioral health treatment, medical treatment, and recovery supports are integrated and intensive care management services are targeted for high-risk consumers with co-occurring conditions.
- The Division effectively uses data to guide its program design and evaluation.
- The Division establishes and maintains strong partnerships with providers and referral sources to give consumers earlier access to individualized services that achieve desired consumer outcomes.
- Development of a highly skilled behavioral health workforce and leadership pool is supported.

Quality Improvement Principles: Quality improvement is a systematic approach to assessing services and improving them on a priority basis. The Division of Behavioral Health's approach to quality improvement is based on the following principles:

- **Customer Focus**. High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations.
- **Leadership Involvement**. Strong leadership, direction, and support of quality improvement activities are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with the mission, vision, and strategic plan.
- **Data Informed Practice**. Successful quality improvement processes create feedback loops, using data to inform practice and measure results.
- **Prevention Over Correction**. Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.

Continuous Quality Improvement Activities: Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the leadership, is understood, accepted, and utilized throughout the organization, as a result of continuous education and involvement of staff at all levels in performance improvement. Quality improvement involves two primary activities:

- Measuring and assessing the performance of services through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated.

Leadership and Organization

Leadership: The key to the success of the Continuous Quality Improvement process is leadership. The following describes how the leaders of the Division of Behavioral Health provide support to quality improvement activities.

The **Division of Behavioral Health Leadership Committee** provides ongoing operational leadership of continuous quality improvement activities at the agency. The responsibilities of the Committee include:

- As part of the Plan, establishing measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of services.
- Developing indicators of quality on a priority basis.
- Periodically assessing information based on the indicators, taking action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.
- Establishing and supporting specific quality improvement initiatives.

The **State Advisory Councils** also provide leadership for the Quality Improvement process as follows:

- Providing guidance on the implementation of quality improvement activities at the agency.
- Reviewing, evaluating, and approving the Quality Improvement Plan.

The Leaders support quality improvement activities through the planned coordination and communication of the results of measurement activities and overall efforts to continually improve the quality of care provided. Leaders, through a planned and shared communication approach, ensure the State Advisory Councils, consumers, and family members have knowledge of and input into ongoing quality improvement initiatives as a means of continually improving performance.

This planned communication may take place through the following methods:

- Director or section unit briefings during State Advisory Council meetings.
- Sharing of the Division's annual Quality Improvement Plan evaluation
- Presentations, reports, or handouts on specific programs and/or initiatives

Response to Emergencies, Critical Incidents, Complaints and Grievances

Emergencies: The Missouri Department of Mental Health - Office of Disaster Services is responsible for behavioral health emergency planning and continuity of operations planning. The Department's All-Hazards Disaster Mental Health Plan for behavioral health response represents the structure, communications, and resource utilization plants for the Department to perform its public mental health authority role to meet the mental health-related needs of Missourians affected by natural or human-caused disasters. The plan can be found at: http://dmh.mo.gov/docs/diroffice/disaster/ahp3.3.2011final.pdf.

Critical Incidents, Complaints and Grievances: The code of state regulations prescribes procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property in an agency that is licensed, certified, accredited, in possession of deemed status, and/or funded by the Department of Mental Health. The regulations also set forth due process procedures for persons who have been accused of abuse, neglect, and/or misuse of funds/property. In addition, certification standards require community programs to establish policies, procedures, and practices to ensure a prompt, responsive, impartial review of any grievance or alleged violation of rights (http://www.sos.mo.gov/adrules/csr/current/9csr/9csr.asp#9-10). The Missouri Department of Mental Health – Office of Constituent Services is responsible for ensuring that constituent rights are not being violated; reviewing reports of abuse or neglect; and providing useful information to constituents and family members about behavioral health issues.

Goal 1: Promote the most effective prevention, treatment, and recovery practices for behavioral health disorders (NBHQF Goal 1).

Objective 1: Increase utilization of medication assisted treatment (MAT) in the treatment of alcohol and opioid use disorders.

Significance: MAT is a National Quality Forum recommendation. MAT is use of medications approved by the FDA for treatment of substance use disorders in combination with counseling and behavioral therapies.

Performance Measure: Number of Adult Consumers with alcohol and/or opioid use disorders who receive FDA-approved MAT medications

Baseline: 3,753 (FY 2014)

Objective 2: Continue support of Individualized Placement Support (IPS) Supported Employment programs.

Significance: IPS-Supported Employment is based on the principle that people with behavioral health disorders can work in competitive employment. In addition, they have better outcomes.

Performance Measure: Number of IPS Supported Employment programs

Baseline: 11 (FY 2014)

Objective 3: Continue support of Assertive Community Treatment (ACT) programs for individuals with serious mental illness

Significance: ACT is a team-based model that has been shown to reduce hospitalizations.

Performance Measure: Number served in ACT

Baseline: 654 (FY 2014)

Objective 4: Promote use of peer support services

Significance: Research has shown that peer services tend to generate better outcomes in engaging the "difficult-to-engage" clients, reducing hospitalizations for clients, and in decreasing substance use among co-occurring clients.

Performance Measure 1: Number of Consumer-Operated Service Programs (e.g. Drop-In Centers and Peer Support Warm Lines)

Baseline: 10 (FY 2014)

Performance Measure 2: Number of consumers receiving peer support services while engaged in substance use treatment and/or recovery supports

Baseline: N/A (FY 2014)

Note: Peer support is a new service established on the treatment menu in FY 2015. Recovery support services funded through the Access to Recovery IV grant will begin in FY 2015.

Objective 5: Continue to provide Integrated Treatment for Co-Occurring Disorders (ITCOD) services

Significance: The ITCOD model is an evidence-based practice that improves the quality of life for people with co-occurring serious mental illness and substance use disorders.

Performance Measure 1: Number served in ITCOD

Baseline: 1,750 (FY 2014)

Objective 6: Continue evidence-based prevention programming in the School-Based Prevention Intervention and Resource Initiative (SPIRIT) program.

Significance: Prevention programming with proven success is used to delay the onset of substance use and decrease the use of substances, improve overall school performance, and reduce the incidents of violence.

Performance Measure 1: Number of students participating in SPIRIT

Baseline: 7,801 (FY 2014)

Objective 7: Promote policies and practices that keep consumers engaged in substance use treatment

Significance: Research indicates that most individuals with substance use disorders need at least three months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment (NIDA).

Performance Measure 1: Average length of engagement in substance use treatment

Baseline: 83 days (FY 2014)

Goal 2: Assure behavioral health care is person, family, and community centered (NBHQF Goal 2).

Objective 1: Promote community-based mental health services that meet or exceed consumer's expectations.

Significance: Patient satisfaction is a measure of quality of care.

Performance Measure 1: Percent of adult consumers satisfied with their services

Baseline: 90.7% (FY 2014)

Performance Measure 2: Percent of youth consumers satisfied with their services

Baseline: 86.7% (FY 2014)

Objective 2: Further train Family Support Specialists in providing one-on-one supports and services to the parents or caregivers of children, youth, and young adults with mental illness

Significance: Family Support is a peer support service designed to help the family better understand what is happening with their child

Performance Measure 1: Number of trainings using the enhanced curriculum for Family Support Specialists per fiscal year

Baseline: N/A

Objective 3: Expand access to Treatment Family Homes, Professional Parent Homes, and Family Support Providers to children, youth and their families receiving services through the Adolescent CSTAR program.

Significance: Children with behavioral health issues face challenges in many aspects of their daily lives. Missouri supports the systems of care approach that recognizes the importance of family, school, and community and in which services are provided through a comprehensive, seamless system.

Performance Measure 1: Revision of MO State Plan and training of service providers

Baseline: N/A

Goal 3: Encourage effective coordination within behavioral health care, and between behavioral health care and community-based primary care providers, and other health care, recovery, and social support services (NBHQF Goal 3).

Objective 1: Continue to coordinate preventive and primary care for Health Home participants

Significance: Individuals with serious mental illness die 11 to 32 years prematurely from preventable chronic health conditions such as heart disease, diabetes, cancer, pulmonary disease, and stroke (National Institute on Mental Health, 2012).The Health Home is customized to meet the specific needs of individuals with serious mental illness who have other co-occurring chronic illness.

Performance Measure 1: Number of participants in Health Homes per fiscal year

Baseline: 25,278 (FY 2014)

Performance Measure 2: Implementation of Kid's Health Home program

Baseline: pilot in progress (FY 2014)

Performance Measure 3: Percent of Health Home participants who received follow-up after hospitalization

Baseline: 72.9% (FY 2014)

Objective 2: Engage in behavioral health treatment Medicaid-enrolled adults who 1) have substance use disorders and/or serious mental health, 2) have high medical costs, and 3) are not currently engaged in behavioral health treatment.

Significance: In collaboration with the state Medicaid agency, the Disease Management (DM) programs provide outreach to Medicaid-enrolled adults with a behavioral health diagnosis and who have high medical costs.

Performance Measure 1: Number of participants in DM 3700 program (for individuals with serious mental illness) per fiscal year

Baseline: 2,584 (FY 2014)

Performance Measure 2: Number of participants in ADA DM program (for individuals with substance use disorders) per fiscal year

Baseline: 187 (FY 2014)

Objective 3: Provide coordination of care between detox and substance use treatment

Significance: "Detox alone with no follow-up is not treatment (NIDA). Transitioning from detox to treatment is key to reducing recidivism and ending the "revolving door" phenomenon.

Performance Measure 1: Percent transitioning from detox to substance use treatment

Baseline: 38% (FY 2014)

Goal 4: Assist communities to utilize best practices to enable healthy living (NBHQF Goal 4).

Objective 1: Ensure the provision of tobacco enforcement of youth access laws and merchant education

Significance: Research has shown that higher merchant compliance with tobacco control laws predicts lower levels of youth smoking (DiFanza, Savageau, & Fletcher, 2009)

Performance Measure 1: Number of tobacco retailers provided with education materials per fiscal year

Baseline: 5,447 (FY 2014)

Performance Measure 2: Annual Synar noncompliance rate less than 20 percent

Baseline: yes (7.2 percent) (FY 2014)

Objective 2: Continue to foster community coalition work to address alcohol, tobacco and other drug issues in their communities

Significance: Social policy is often shaped by grassroots, local efforts.

Performance Measure 1: Number of community coalitions as of the end of the fiscal year

Baseline: 156 (FY 2014)

Objective 3: Continue the education initiative in Eastern Missouri to address heroin and other opioid drug use

Significance: The heroin overdose death rate in Eastern Missouri is three times that for the state.

Performance Measure 1: 80 (FY 2014)

Baseline: 156 (FY 2014)

Objective 4: Train the general public to identify, understand, and respond to signs of mental illnesses and substance use disorders

Significance: Mental Health First Aid (MHFA) is on the National Registry of Evidence-based Programs and Practices (NREPP).

Performance Measure 1: Number of persons trained in MHFA by the Regional Support Centers per fiscal year

Baseline: 1,519 (FY 2014)

Objective 5: Promote policies and practices to ensure that individuals with driving-under-the-influence offenses get the appropriate level of care to prevent future offenses

Significance: Driving under the influence continues to be a serious public health concern. Missouri's Substance Abuse Traffic Offender Program (SATOP) is a statewide network of community-based education and treatment options for consumers arrested in Missouri for alcohol- and drug-related driving offenses.

Performance Measure 1: Percent of consumers screened who did not have a screening within the past 5 years

Baseline: 88.7% (FY 2014)

Goal 5: Make behavioral health care safer by reducing harm caused in the delivery of care (NBHQF Goal 5).

Objective 1: Prevent medication errors occurring for individuals in community mental health treatment

Significance: This is to prevent medication errors that result in the need for treatment and/or intervention beyond monitoring and observation (i.e. moderate to serious designation).

Performance Measure 1: Rate of medication errors in community-based treatment per 100,000 consumer-months

Baseline: 3.34 per 100,000 consumer-months (FY 2014)

Note: There were 5 moderate to serious medication errors in FY 2014.

Goal 6: Foster affordable high-quality behavioral health care for individuals, families, employers, and governments by developing and advancing new and recovery-oriented delivery models (NBHQF Goal 6).

Objective 1: Implement the Access to Recovery (ATR) IV program

Significance: Missouri has received a SAMHSA-funded ATR IV grant to fund recovery support services for individuals with substance use disorders. Recovery-oriented systems of care will be implemented in northwest, southwest, and southeast Missouri to provide an array of support services to support recovery.

Performance Measure 1: Number of participants served in ATR IV

Baseline: N/A (FY 2014)

Objective 2: Provide behavioral health expertise to law enforcement and court personnel in order to more effectively respond to behavioral health crises

Significance: Community Mental Health Liaisons provide consultation, education, training, and assistance in locating and accessing needed treatments and supports. The goals are to reduce unnecessary jail, prison, and hospital stays and to improve outcomes for individuals with behavioral health issues.

Performance Measure 1: Number of referrals to the Community Mental Health Liaisons per fiscal year

Baseline: 3,696 (FY 2014)

Objective 3: Provide immediate person-centered interventions to individuals in mental health crisis and facilitate timely access to services and supports

Significance: Individuals experiencing a crisis due to a behavioral health condition often seek help at the emergency room.

Performance Measure 1: Number of served in the Emergency Room Enhancement project per fiscal year

Baseline: 852 (FY 2014)

Objective 4: Monitor and target technical assistance to Probation and Parole Officers and treatment providers on the prioritization process for offenders needing behavioral healthcare

Significance: The Missouri Department of Corrections (DOC) is a major referral source. The provision of behavioral health services to the DOC supervised population is important in halting the cycling in and out of correctional institutions.

Performance Measure 1: Number of High Priority referrals for substance use treatment per fiscal year

Baseline: 1,560 (FY 2014)

Performance Measure 2: Number served in the Community Mental Health Treatment (CMHT) and MH4 programs

Baseline: 2,214 (FY 2014)

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

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75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

The Division of Behavioral Health requires contracted providers to adhere to certification standards. These standards are dated and the division is in the process of updating them. Thus, "trauma" is not specifically identified, but will be in the next iteration. That said, "co-occurring disorders" are specifically identified in standards and it is required that providers assess for the presence of such issues. In addition, they must either provide or arrange for co-occurring disorder services or refer to another resource where services can be obtained.

The majority of the division's contracted behavioral health treatment providers are CARF-accredited. The CARF Standards require its programs to screen for past trauma exposure and significant life events within the assessments and screenings. They require that continuum of care services address the needs of persona at risk or functionally limited due to trauma. CARF requires direct service or front line staff to receive continuous training in trauma informed services.

To assure clarity on expectations associated with the importance of our providers addressing trauma, the division includes such in contracts. For mental health treatment programs, the contractual language is as follows:

> **Trauma-Informed Emphasis**
> 3.8.1 The contractor shall incorporate trauma-informed approaches into service delivery that will actively consider the likelihood of consumer's experience of trauma.
>
> 3.8.2 Background: The psychological effects of violence and trauma are priority issues for the Department of Mental Health. The scope of psychological trauma is pervasive. When psychological trauma is not recognized or addressed, people may be unintentionally re-traumatized by the agencies and providers trying to serve them.
>
> 3.8.3 Trauma awareness and sensitivity is a key value of the Department, and accordingly, the contractor shall ensure that services delivered are guided by the Department's position statement on services and supports for trauma survivors.
>
> Guiding principles for trauma-informed services shall include:
> a. providing an environment that ensures physical, emotional and interpersonal safety;
> b. engaging the consumer as an equal partner;
> c. promoting consumer empowerment;
> d. utilizing staff that is knowledgeable and trained on trauma-related issues;
> e. providing services in a holistic, contextual, and strengths based manner;
> f. integrating services on an individual, system-wide, policy, and funding level; and
> g. educating stakeholders and the community at large about the needs of trauma survivors.

For Community Substance Treatment and Rehabilitation (CSTAR) programs, the contractual language is as follows:

Program Design

3.10.1 The contractor shall provide treatment that addresses multiple domains of the consumer's life, including substance use, mental illness, trauma, criminality, skill deficits, family conflict, employment or academic problems, and lack of social support for recovery.

a. The contractor's staff shall be trained in the delivery of any evidence-based practices used in the program.

3.10.2 In delivering the treatment program, the contractor shall:

a. engage families in treatment to the fullest extent possible;
b. provide substance use treatment at levels of intensity that meet individual and family needs;
c. provide for treatment of co-occurring behavioral health disorders;
d. assess for trauma-related issues and provide or arrange for trauma-specific services; and
e. provide effective care to people from different cultures in the communities it serves.

In addition, there are two billing codes in CSTAR programs for use by specially trained professionals, with enhanced reimbursement rates, that are specific to serving those with trauma histories: Individual Trauma Counseling and Group Trauma Education.

Through Missouri's Trauma Initiative, the Department of Mental Health (DMH) endorsed core trauma competencies, which promote trauma awareness, training and job standards. These competencies provide guidance to staff to screen for personal safety and trauma history. These competencies also provide guidelines for screening, which should include questions to consumers but also screen for behaviors that might indicate a current safety and/or trauma history. Missouri promotes these staff competencies in statewide trainings, inter-departmental initiatives, and makes them available by outlining them on the DMH website. DMH describes trauma informed clinical practices as flexible, individualized, client driven, and safety focused. Per the core competencies, trauma informed providers are knowledgeable and refer the client for trauma specialized treatment services.

2. Describe the state's policies that promote the provision of trauma-informed care.

In addition to the response provided in question #1, DMH has worked closely with MO Health Net Division, the Medicaid division for the Department of Social Services, to enhance the quality of both fee-for-service and managed care behavioral health. Specifically, DMH has worked with MO Health Net in planning for grant applications that increase access to training of evidence based practices and trauma-informed services and systems, which has improved access to screening of the early childhood population as well as shaped services towards best practice guidelines. DMH works to promote prevention and public awareness about risk and protective factors for trauma survivors, develop a cadre of mental health providers that support initiatives, encourage trainings, and work to develop a trauma responsive, and trauma informed workforce. Within Missouri's trauma initiative, Missouri's Trauma Competent model was developed. This model provides DMH service providers guidelines that promote trauma informed principles.

Trauma informed providers in Missouri provide an environment that ensures physical, emotional and interpersonal safety, engage the consumer as an equal partner, promote consumer empowerment, have staff that is knowledgeable and trained, provide services in a holistic, contextual, and strengths based manner, be integrated on an individual, system-wide, policy, and funding level, and educate stakeholders and the community at large about the needs of trauma survivors.

3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?

Missouri has supported multiple youth and adult initiatives using evidence based and trauma specific interventions. Trauma specific interventions include but are not limited to Seeking Safety, Trauma Recovery Empowerment Model (TREM), Sidran Institute: Traumatic Stress Education & Advocacy, Motivational Interviewing, Strengthening Families, and Trauma Focused Cognitive Behavioral Therapy. DMH's residential facility for children and the community mental health providers, for both children and adult, receive training on evidence based trauma interventions such as DBT. DMH's inpatient facility has instituted the Sanctuary Model of trauma-informed care to better care for the children and youth served. In addition, DMH's "Introduction to Trauma" training, provided by Dr. Patsy Carter, and resources, such as the National Child Traumatic Stress Network, which identify evidence informed practices and provide information on trauma specific evidence based interventions, are at the DMH website.

4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

In 2011, DMH received a grant for a trauma initiative where providers, AKA "early adopters", were trained on evidence informed trauma techniques. The initiative guided an agency through a self-assessment process to identify environmental and policy issues that may lead to "re-traumatizing" the youth. They reviewed and developed their own policies, procedures, and assessment tools making them trauma informed. DMH trauma trainer, Dr. Patsy Carter, also works with other State Departments to provide trainings on evidence informed practices and to help transform their services by making them trauma informed. It is part of DMH's strategic direction for 2013-2018 to expand Trauma Informed Care to all mental health service systems in Missouri.

In Fiscal Year 16, the Division of Behavioral Health, in coordination with the Coalition for Community Behavioral Healthcare, will offer the following training opportunities:

Trauma Informed Learning Collaborative – Five or more agencies will be selected to join the early adopters to begin their journey to become trauma informed. They will participate in a 2-day training at the coalition conference and will join the early adopters in consulting calls, webinars, assessments, etc over the next year and beyond depending on funding.

Nurse Care Manager Learning Collaborative – In the Healthcare Homes, the nurses will be receiving trauma training and information during their collaborative. In-state experts will be assisting with this.

Early childhood/Kids First Training – the Kids First initiative will include evidenced-based trauma training.

Integrated System of Care Workgroup - this workgroup has made trauma training for qualified mental health professionals and community support supervisors a priority this next year. The specific model has not yet been specified, nor has the training rollout plan.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. **Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?**

   The Missouri legislature has not pass legislation authorizing the expansion of Medicaid.

2. **Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?**

For individuals with mental disorders, in most cases a sentencing assessment report (SAR) is done if ordered by the sentencing judge. At the time of the SAR interview, all criminogenic needs and risks are discussed and evaluated including mental health and substance abuse. Tools used are the Interview and Assessment Worksheet, the SAR Risk Factor, and the Static 99R for sex offenders.

Substance abuse is assessed using the Screening for Alcohol and Chemical Abuse (SACA) score, criminal history, treatment history, file material, or other evidence of substance-abusing behavior. These assessments guide placement and treatment services within the Department of Corrections.

The Risk and Needs Assessment (RANT) is the assessment/screening tool used on all drug-involved offenders prior to placement in drug court. This assessment tool provides court personnel with a classification tool to determine the appropriate level and type of criminal justice supervision and treatment services to efficiently utilize treatment drug court funds. The RANT includes 19 questions related to empirically identified, criminogenic risks and clinical needs of drug-involved offenders. Offenders are assigned to one of four quadrants with two scales, one of risk and one of need, based upon their RANT score.

Missouri offers several types of specialized courts: adult drug court, juvenile drug court, family treatment court, mental health treatment court, DWI court, veteran's treatment court and re-entry treatment court.

The Missouri Juvenile Offender Classification System represents Missouri's effort to create an objective based decision-making strategy for managing youthful status and law violators referred to juvenile and family courts. The Office of State Courts Administrator (OSCA) developed the classification system pursuant to Subdivision 4 & 5 of Sections 211.326.1, 211.141.4, and 211.141.5 RSMo. Supp.1995 of the Missouri Juvenile Code.

The complete classification system includes an empirically validated risk assessment for estimating a youthful offender's relative likelihood of future delinquency, a classification matrix, which links the level of risk with offense severity to recommend graduated sanctions, and a needs assessment for identifying the underlying psychosocial needs of youth. The system also includes a method for assessing juvenile offender adjustment to supervision

through the use of a supervision reassessment form, and a set of web-based reports on the risk and needs characteristics of youthful offenders.

Thirty-five of Missouri's 45 judicial circuits are currently using the system for the purpose of case management decision-making and workload estimation, 20 of which utilize Missouri's automated case management system (JIS), which provides for an automated version of the classification system.

Specifically for youth, the DMH allocates a small amount of funds to designated community mental health centers to partner with juvenile courts to assess, identify and expand quality mental health services to children jointly served by the two entities. The goals are to improve access and coordination between the courts, mental health and schools; provide early intervention services to decrease risk of juvenile offending; improve the prognosis for recovery for our youth through earlier identification and intervention; address the special needs of children; and promote public safety. The impact can be extensive for the community, schools, and families and in addressing public safety issues. These projects also provide a model for partnerships within the community to meet the needs of youth and special needs populations.

The Missouri Crossover Youth Policy Team is assisting several communities interested in enhancing their ability to meet the needs of crossover youth by implementing a Crossover Youth Practice Model. For purposes of the pilot project, the term "crossover youth" is defined as youth who are adjudicated or receiving services from either the child welfare or juvenile justice system and who are at risk of becoming dually involved due to a subsequent delinquent offense or finding of child abuse/neglect, as well as youth who are dually adjudicated or simultaneously receiving services or supervision from both the child welfare and juvenile justice systems.

Crossover youth in Missouri are typically known and served by multiple state and local agencies, yet they continue to progress deeper into the juvenile justice system or cross back and forth between systems. To better meet the needs of crossover youth, the Center for Juvenile Justice Reform at the Georgetown University Public Policy Institute and Casey Family Programs developed a practice model to help agencies strengthen their organizational structures and implement or improve practices that directly affect the outcomes for crossover youth. Key elements include:

- creation of a process for identifying crossover youth at the point of risk for crossing over,
- ensuring that staff exchange information in a timely manner,
- including families in all decision-making aspects of the case,
- ensuring that foster care bias is not occurring at the point of detention or disposition, and
- maximizing the services utilized by each system to prevent crossover from occurring.

3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

The Department of Mental Health has been actively involved in prison reentry since partnering with the Department of Corrections in 2002 as part of a National Institute of Corrections (NIC) Transition from Prison to Community Initiative (TPCI) demonstration project. This partnership continued beyond the TCPI and is now known as the Missouri Reentry Process. The Department of Mental Health provides a representative on the statewide Missouri Reentry Process Steering Team that meets regularly to assist local and statewide agencies with prison reentry.

The Division of Behavioral Health (DBH) works closely with the Department of Corrections (DOC). Regular joint meetings that include staff from DOC's Offender Rehabilitation Unit, Probation and Parole, and DBH are held to address opportunities for system enhancement, ideas for addressing challenges, and the development of initiatives for offenders in reentry or diversion from prison. Specific initiatives that have been successfully implemented include referral processes that ensure individuals with serious mental illness and/or substance use disorders that are considered high risk for repeated criminal activity and/or relapse have immediate access to community-based services.

Staff of the Division of Behavioral Health regularly interacts with the Office of the State Courts Administrator (OSCA) to ensure that individuals involved in the various treatment courts have appropriate services available to them through the state's network of community-based providers. Treatment court participants are a target population and receive priority consideration for placement in services based upon their individual needs.

Additionally, the Department, through the Coalition of Community Mental Health Centers, partners with the Department of Corrections and the Division of Probation and Parole to provide mental health and substance abuse services to offenders under supervision in the community upon referral from a Parole Officer.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Cross trainings have been provided in the partnership described above between the providers in the Coalition of Community Mental Health Centers and the Division of Probation and Parole. These trainings have occurred primarily at the local level between the individuals working directly together and also at a summit hosted by the Division of Probation and Parole for the community providers and field officers. Additionally, the Missouri Department of Mental Health hosts a spring training conference that devotes an entire track

to those consumers involved with the criminal justice system and the conference is well-attended by DOC staff. Likewise, there is an annual drug court conference held in Missouri each spring that is sponsored by the National Association of Drug Court Professionals, that is well-attended by providers of behavioral health services.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. **What fiscal resources are used to develop communication plans to educate and raise awareness about parity?**

The Division of Behavioral Health (DBH) does not currently have a communication plan for parity education. However, communication goals regarding the importance of taking care of mental health needs are included in the Department's strategic plan.

2. **Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?**

The Department of Mental Health works with stakeholders to increase awareness regarding parity. Advocacy organizations like the Coalition for Community Mental Health Centers play an important role in educating providers. Individual community support specialists play a role in assisting the individuals served in the public mental health system to be educated about their benefits.

3. **Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?**

The Missouri Department of Insurance provides information to the health plans and health insurance issuers regarding the requirements of MHPAEA.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

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[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. **Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.**

The **Governor´s Council on Disability** (GCD) is committed to advancing Missouri´s compliance with the Supreme Court decision in Olmstead vs. L.C. The Council provides staff and resources to support this vital effort. The mission of the Council is to provide leadership and support so people with disabilities achieve inclusion and independence. The GCD Resource Director is available at: http://disability.mo.gov/resource_search/. The Division of Behavioral Health (DBH) keeps informed and current with the Governor's Council's actions.

DBH has numerous programs, services and evidence based practices that promote compliance with the Olmstead Decision. The Missouri DBH has encouraged the Community Mental Health provider system to reach beyond psychiatric diagnoses by developing Disease Management programs, outreach people with serious health/mental health/substance use disorders who are high utilizers of Medicaid, coordinate services with consumer's primary care physicians, do metabolic screenings for consumers and provide education about health and safety. The DBH has Individual Placement and Support (IPS) employment services sites, and works with the State Department of Elementary and Secondary Education (DESE) to provide vocational rehabilitation services to DBH consumers. DBH works with community providers to build, access and/or fund appropriate housing for each individual. Housing options across the state range from Housing First programs to Residential Care facilities with specialized Psychiatric Independent Supported Living homes, clustered apartments, safe havens, Intensive Residential Treatment Settings (IRTS), Assertive Community Treatment (ACT) teams for people living independently in the community who need additional supports or Supported Community Living dollars to help people live in the setting of their choice. Other funding options include Shelter + Care, Rent Assistance Program, Section 8 Housing and assistance with the application process.

2. **How are individuals transitioned from hospital to community settings?**

People leaving the care of long term State operated psychiatric hospitals are assisted with locating appropriate housing and care. The hospitals fund moves to the community and seek Psychiatric Independent Supported Living (PISL) or Intensive Residential Treatment Sites (IRTS) to help people transition to community life at their own pace. People who have experienced a need for an acute hospital stay are often able to transition back to their home or the community by living in an IRTS with time-limited services, treatment and discharge planning. These sites also provide coordination with ongoing care providers for good outcomes when the consumer returns home.

3. **What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?**

As noted above the DMH explores new services and supports to ensure people are able to live in accessible affordable homes of their choosing and receive services from providers who are knowledgeable about their needs. The DMH partners with the Governor's Council

on Disability. New services are thoughtfully implemented so the entire community can benefit.

4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

None are known.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[94] Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. **How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?**

Missouri supports the system of care approach that recognizes the importance of family, school and community and in which services are provided through a comprehensive, seamless system. The Comprehensive Children's Mental Health Plan and grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) have supported the development of local interagency teams to oversee children's services in the community. Missouri currently has 16 local System of Care (SOC) teams. SOC interagency teams collaborate and work towards reducing barriers for children and families seeking mental health services. The Department of Mental Health (DMH) has provided technical assistance to support sustainability of the local interagency teams on a range of issues including SOC principles, public policy issues, cross-agency protocols, community services options, and improving family and youth voice. In addition to working towards enhanced community-based services through our community mental health centers, DMH staff has worked across various state agencies to develop protocols to streamline processes and improve coordination and collaboration to improve behavioral health services for children and youth throughout Missouri. Feedback is gathered on local interagency efforts in a number of ways including networking opportunities, an annual Summit, conference calls, individual, direct communication and surveys. DMH's Office of Comprehensive Child Mental Health is currently enhancing a data tool for SOC teams to collect information and track outcomes for children, youth and families served.

2. **What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?**

In 2002, a steering committee at DMH developed practice guidelines to screen for indicators of substance use, developmental disabilities and emotional disturbance for children and youth. These guidelines are available and applicable to all service providers, independent of their specific expertise or area of work, and guide their assessment of children and youth to include broad indicators of deficits and/or needs in the areas of substance use, developmental disabilities and emotional functioning as part of a more in-depth assessment in a specific area. More specifically, by state regulation, each one of DMH's Administrative Agents providing services to children, youth, and families are required to provide prompt access to a screening in order to determine eligibility and to plan an initial course of action. The child and family will receive an assessment and Individual Care Plan where the client and family's needs are more fully identified. The Individual Care Plan details the specific and individualized goals of the client and family and if there are substance use or co-occurring issues identified they will receive specialized or integrated services which might include a referral to DMH's Comprehensive Substance Treatment and Rehabilitation (CSTAR)

program, a co-occurring specialist, group, family psycho-education, or specialized services. The participation of family and other collateral parties in assessment and individualized plan development is encouraged, as appropriate. A Care Coordinator will provide the arrangement and coordination of an individual's care and rehabilitation needs, as well as other medical, social, and educational services and supports. In addition to providing coordination of services, the Care Coordinator will assess the implementation of the client's Individual Care Plan and progress towards outcomes specified in the plan. In some cases, families have access to Family Support Professionals (FSP) who share lived experiences with the client's family. Through modeling, and support, the FSP assists the family in obtaining their identified goals.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

A custody diversion process was established for child-serving agencies to follow in those cases involving parents who are considering voluntarily relinquishing custody of their child for the sole purpose of accessing mental health care. For those children already in state custody solely for mental health services in the absence of child abuse or neglect, DMH and the Department of Social Services have facilitated an evaluation and review process. DSS' Children's Division has established Family Support Teams for children identified to determine future custody status. In conjunction with the diversion protocol, voluntary placement under Title IV-E allows a family to relinquish physical custody but retain legal custody so that these children become eligible for mental health services funded by Medicaid and Title IV-E funds for a period of up to 180 days. In 2014, DMH, DSS' Children's Division and the Office of State Court Administrators developed a workgroup to review and update the existing custody protocol. In July of 2015 five regional trainings were held across the state to train local Children's Divisions, Juvenile Offices, DBH Substance Use Treatment Providers, Division of Developmental Disabilities and Community Mental Health Centers on the updated protocol,

In 2012, DMH was awarded a SAMHSA-funded Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) Grant to create a coordinated system to support St. Louis City children, ages 0-8, in a supportive environment conducive to healthy development. The five-year grant will use a public health approach emphasizing prevention and promotion. The grant will implement screening and mental health assessment in a range of child-serving settings. The state team includes representation from DMH, the Department of Health and Senior Services, and the Missouri Institute for Mental Health. Grant partners include Vision for Children at Risk, the Council on Young Child Wellness, and the National Council on Alcoholism and Drug Abuse. Boone County (located in central Missouri) was

awarded a Project LAUNCH Grant in 2010 to improve coordination of children's services in that county. DMH is represented on the Boone County Project LAUNCH Wellness Council.

Missouri KidsFirst collaborated with the Missouri Coalition of Behavioral Health Centers to establish a mental health network of providers trained in evidence based trauma specific interventions. The Network will be managed through DMH. The Missouri state budget that passed this year included $500,000 for the development of the network and will also include a learning collaborative in the state for Child Advocacy Centers, Youth Residential Treatment Centers, and Community Mental Health Centers.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

DMH- Division of Behavioral Health works collaboratively with Missouri's Coalition for Community Behavioral Healthcare and the Statewide Training and Resource Center and Regional Support Centers (RSC) to train mental health, substance use, and co-occurring professionals to provide evidence based and promising practices for children with behavioral health concerns and their families.

Infrastructure including the Statewide Training and Resource Center and Regional Support Center (RSC) network, and Partners in Prevention program on state college campuses, positions Missouri to achieve population-level changes in substance use patterns locally and across the state. Among other requirements, these funded programs are required to implement evidence-based programs and strategies that address identified gaps and needs and implement strategies with fidelity. Additionally, these programs evaluate outcomes and address sustainability.

One of the goals of the Governor is Coordinating Board for Early Childhood, led by the DMH, is to build the capacity of mental health professionals to serve the social and emotional needs of young children (0-8) in the community and better connect the early childhood field with mental health. In 2014, the workgroup developed a 6-hour training targeted to mental health providers that introduced the essential components of social and emotional development of children ages 0-8, and the importance of early identification and intervention. In 2015, the Missouri Coalition for Community Behavioral Healthcare, with funding from the Department of Health and Senior Services and Department of Mental Health, will sponsor a second cohort of this training learning collaborative with capacity to train 30 more mental health professionals.

Another initiative strongly supported by the Governor and led by DMH is Mental Health First Aid. Mental Health First Aid training has expanded across the state and has targeted groups that are likely to encounter people in mental health crises – e.g., teachers, law

enforcement, clergy, and employers, so they can recognize the early warning signs of mental illness. Since 2008, over 20,000 "Mental Health First Aiders" have been trained in Missouri; over 3,500 of these have been added under the current initiative.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

After client contact has been established and they agree to receive DMH services, the Community Mental Health provider enroll them in the Customer Information Management Outcomes and Reporting system (CIMOR). This is the point where financial and other outcomes will begin to be tracked by DMH. The Daily Living Activities Functional Assessment (DLA20) is used to assess eligibility of services for children and youth behavioral health services as well as collect outcomes for children receiving services within the Division of Behavioral Health at DMH. The DLA20 is administered upon admission, in conjunction with quarterly treatment plan reviews, at the time of the annual assessment, and upon discharge. The Children's Global Assessment Score (CGAS) correlated from the DLA20 is entered into CIMOR by the Community Mental Health Centers. The CIMOR data system is currently being enhanced to include data collected from the entire DLA20 twenty-item functional assessment, which includes but is not limited to data addressing the child/youth's health practices, communication, housing, personal hygiene, alcohol and drug use, and coping skills. This allows DMH to track the functional progression of the child/youth. These outcomes are collected and provided to the Director of Children and Youth services and to the Coalition for Community Behavioral Healthcare.

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

DBH has expanded the availability and accessibility of treatment services by authorizing the delivery of designated CPR services in school settings. These designated CPR services are provided to children with an Individualized Education Plan (IEP), as well as those without an IEP. DBH providers partnering with schools is effective because it enables specialists to quickly identify student issues and immediately triage care based on the severity of circumstances. Besides the students getting immediate assistance, the school personnel benefit from having Community Support Specicalists and Therapist on school grounds as a place of contact and able to provide CPR services provided in the school setting.

In 2002, the Missouri Department of Mental Health (DMH), Division of Behavioral Health (DBH) launched the School-based Prevention Intervention and Resources Initiative (SPIRIT). This project proposes to delay the onset and decrease the use of substances, improve overall school performance, and reduce incidents of violence. To achieve these goals, prevention agencies are paired with participating school districts to provide technical assistance in implementing evidence-based substance use prevention programming, help to

identify and respond to additional needs of some students for selective and indicated services, provide screening and referral service upon request and offer resources as needed. SPIRIT currently operates in four sites serving six school districts across the state, including Carthage R-IX, Knox Co. R-1, New Madrid Co. R-1, Ritenour, Charleston R-1, and Scotland Co. R-1. Annual program evaluations are conducted by the Missouri Institute of Mental Health.

7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Age 18 is the cut-off age in the state for receiving behavioral health services; under age 18 for youth services and 18 and older for adult services. DBH recognized the need to bridge services between children and adult systems and implemented the Daily Living Activities Functional Assessment (DLA20). The DLA20 Youth Version is the standardized functional tool used for children ages 6-18 entering Community Psychiatric Rehabilitation (CPR) services. In the case of young adults that are 18 and over that continue to receive youth funded services, the provider is strongly encouraged to administer the Youth, or the Adult version of the DLA20 based on the young adult's functioning. The DLA20 is a Daily Living Activities functional scale used to assess eligibility of services for both youth and adult behavioral health services within DMH. This makes a young adult's transition from youth services to adult services a much smoother process since the same scale is already in place and providers in both systems use the same tool. Depending on individual needs, young adults can potentially remain in youth services up to the age of 25 and individuals enrolled in youth CPR programs will be automatically eligible for adult CPR when transfer to an adult program is determined to be clinically appropriate. This systems change to one assessment tool within DMH and the Mo Healthnet policy change in 2007 that make youth eligible for Medicaid up to age 21, have increased the likelihood that children aging out of foster care will remain in mental health services past their 18th birthday without losing benefits. This means a stronger safety net can be put in place during this time of transition.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. **The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.**

All Community Substance Treatment and Rehabilitation (CSTAR) contracts include language that specifies priority populations with pregnant, IVDU women being the first priority. The next highest priority population to be served is pregnant women. The language requires immediate assessment and admission. It also directs referrals of pregnant women to be made to Women and Children's CSTAR programs if at all possible. If, for whatever reason, pregnant women are not immediately admitted, the Division receives this information from the providers via weekly waiting list reports. On an approximate monthly basis, regional staff is requested to follow-up with agencies on waiting list issues. Any reference to a pregnant woman being placed on a waiting list MUST be followed up on by division staff. Normally, the circumstances are related to referral arrangements, consumer availability, etc. However, the follow-up by division staff serves as a regular reminder of the division's expectation that pregnant women receive top priority.

The specific contract language pertaining to pregnant women is as follows:

3.11 **Requirements for Admissions/Priority Populations**

3.11.1 The contractor shall provide services to consumers that meet admission criteria as defined in applicable certification standards.

3.11.2 In accordance with the requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959), Missouri state statute, and Departmental priorities, the contractor shall give preference for admission to identified priority populations.

3.11.3 The contractor shall ensure that all individuals requesting services are appropriately screened at the point of first contact with the agency to determine if a crisis situation exists and/or the individual's potential eligibility as a priority population.

3.11.4 The following populations require priority assessment by a qualified substance abuse professional and admission to an appropriate level of care:

a. Women who are pregnant intravenous (IV) drug users
b. Women who are pregnant
c. Intravenous (IV) drug users
d. …..

3.11.6 The contractor shall ensure that individuals identified as a priority population who request or are referred to treatment, including those identified high risk offenders being released from a correctional institution, are assessed and admitted to an appropriate level of care within 72 hours of initial contact or scheduled release date (including weekends and holidays) with the exception of civil involuntary detentions and pregnant women who must receive immediate admission. Women and Children CSTAR programs are not subject to civil involuntary detention requirements.

3.11.7 The contractor shall refer pregnant women to a Women and Children's CSTAR program unless the contractor's treatment team determines that the individual's needs are best met in the contractor's treatment program, and there is clear justification in the clinical record for such determination or the contractor cannot immediately make arrangements for admission to a Women and Children's CSTAR program. In the event that temporary admission into the contractor's program is needed, arrangements for transfer to a Women and Children's CSTAR program should be completed as soon as possible with efforts documented in the consumer's record.

3.11.8 If the contractor is unable to refer to a Women and Children's CSTAR program or immediately assess and admit a pregnant woman, the contractor shall contact the appropriate DBH regional staff to make arrangements for immediate admission to treatment with another provider.

2. **Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.**

As above, provider agencies are contractually required to immediately admit or refer for immediate admission women that are pregnant. In the event that a treatment facility cannot admit immediately, they are instructed to contact regional Division staff to facilitate admission at an appropriate facility. Data reports are generated to monitor admission dates, priority populations and wait lists. As noted above, if any reports reflect that pregnant women were not immediately admitted, division staff follows up directly with provider agencies to determine the circumstances of delayed admission.

3. **Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.**

Provider agencies are contractually required to immediately admit or refer for immediate admission women that are pregnant. In the event that a treatment facility cannot admit immediately, they are instructed to contact regional Division staff to facilitate admission to an appropriate facility. Pregnant women should not be in need of interim services. Data reports are generated to monitor priority populations and interim services. As noted above, if any reports reflect that pregnant women were not immediately admitted, division staff follows up directly with provider agencies to determine the circumstances of delayed admission.

4. **Discuss who within your state is responsible for monitoring the requirements in 1-3.**

Priority populations are monitored primarily through data reports. Regional division staffs conduct monitoring activities through Safety and Basic Assurance Reviews for agencies that are not nationally accredited. These visits include reviews and discussions with provider agencies regarding priority populations and the agency's admission processes. Contract compliance activities are planned for the Billing and Services unit staff for agencies that are nationally accredited. However, as noted above, if compliance with admission requirements for pregnant

women is not reflected in the waiting list reports, then division staff follow up directly with the provider following each provider report issued for every instance reported.

5. **How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)**

   DBH contracts with eleven agencies (12 programs) that provide women and children's-specific programming. All but one of these agencies provides residential support; all provide the full array of outpatient treatment services. For Missouri, this includes Community-Based Primary Treatment, Intensive Outpatient Rehabilitation, and Supported Recovery levels of care.

   Pregnant women may be served in any of the twenty other contracted or state operated general population programs that include opioid treatment programs. All but the three opioid programs offer all levels of care.

   a. **How many of the programs offer medication assisted treatment for the pregnant women in their care?** All programs are required to offer or arrange for MAT.

   b. **Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?** No. Our contracted providers are located across the state. There is not a Women and Children's CSTAR located in Northwestern Missouri, but again, all programs can serve pregnant women and all must offer and/or arrange for MAT.

6. **How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)**

   a. **How many of the programs offer medication assisted treatment for the pregnant women in their care?** See above.

   b. **Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?** There is not a Women and Children's CSTAR located in Northwestern Missouri. However, women with dependent children can be served at any of the general population programs where MAT is available. Or, their admission to a women and children's specific program can be facilitated through division staff if care and treatment of dependent children is needed.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

Please indicate areas of technical assistance needed related to this section.

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

Suicide Prevention

Missouri is in the process of updating its Suicide Plan. No technical assistance is requested at this time.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.

The Missouri Department of Mental Health (DMH) has strategic partnerships with its sister agencies including the Department of Social Services, the Department of Health and Senior Services, the Department of Elementary and Secondary Education, the Department of Corrections, the Department of Public Safety, the Office of State Court Administrators, and the Department of Insurance, and the Office of Administration. DMH has had formal written memorandums of understanding (MOU) with many of these agencies.

Department of Corrections

DMH and the Department of Corrections (DOC) maintain an MOU to coordinate monitoring and review of community-based addiction programs that serve offenders under community supervision. The agreement provides for the transfer of DOC substance abuse community services funding to DMH. DMH is required to monitor appropriation balances to assure funds are expended appropriately and provide DOC with quarterly reports on utilization of contract funds. The agreement also requires DMH and DOC to establish a process for referring offenders to treatment.

DMH and DOC maintain an MOU to efficiently provide, through existing community service contracts, comprehensive psychiatric services for DOC supervised offenders who have moderate to serious mental health conditions. Joint responsibilities include:

- Work together to provide input for contract amendments;
- Provide monitoring and technical assistance activities of community providers/contractors; and,
- Participate in oversight committee, which will include the designated management staff of contractor, P&P Contract Manager, and DMH staff members.

DMH and DOC maintain an MOU for collaboration and planning between the Departments should any disaster or emergency occur.

Department of Health and Senior Services

DMH and the Department of Health and Senior Services (DHSS) maintain an MOU to formalize the cooperative process for utilizing a statewide toll free phone number to receive reports of adult abuse and neglect, enhancing DHSS background checks by allowing DHSS access to certain investigated report information and the DMH Employment Disqualification Registry, and further sharing of information to assist each agency in fulfilling its statutory responsibilities.

DMH and DHSS maintain an MOU in coordinating the use of state resources to advance the work outlined in Missouri's Early Childhood State Plan. This agreement is in support of DMH's Project LAUNCH Grant.

Department of Public Safety

DMH maintains an MOU with the Department of Public Safety (DPS) for the enforcement of the federal Family Smoking Prevention and Tobacco Control Act. DMH has loaned DPS four full-time equivalent positions for the sole purpose of enforcing federal and state tobacco regulations to include federal advertising and labeling inspections and state and federal undercover buy inspections. This activity is in support of DMH's Synar program.

Department of Social Services

DBH works closely with three divisions of the Department of Social Services: Children's Division (child welfare); Division of Youth Services (youth adjudicated as delinquent and committed to state custody); and MO HealthNet (Medicaid agency).

DMH maintains an MOU with the Department of Social Services (DSS), Family Support Division for the referral and provision of substance abuse treatment services for identified applicants and recipients of Temporary Assistance (TA clients) who request referral to an appropriate substance abuse treatment program in lieu of a drug test or who test positive for the illegal use of a controlled substance under the provisions of section 208.027 RSMo.

DMH maintains an MOU with the DSS-Children's Division for voluntary placement so that parents do not have to give up custody of their child to get mental health services.

DMH maintains an MOU with the DSS-Children's Division for inpatient diversion for the provision of intensive programming that diverts the child from being placed in an inpatient setting.

DMH maintains an MOU with DSS-Division of Youth Services to hold slots at DMH's Cottonwood Residential facility for several DSS youth.

DMH maintains a Cooperative Agreement with DSS relating to the Medicaid State Plan for Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Program. This agreement covers the determination of Medicaid eligibility, Medicaid provider and Department/Division audit and compliance initiatives, and implementation and administration of the CSTAR program.

DMH maintains a Cooperative Agreement with DSS relating to the Medicaid State Plan for Community Psychiatric Rehabilitation (CPR) Program. This agreement covers the determination of Medicaid eligibility, Medicaid provider and Department/Division audit and compliance initiatives, and implementation and administration of the CPR program.

DMH maintains a Cooperative Agreement with DSS relating to the Medicaid State Plan for Targeted Case Management (TCM) for Severely Emotionally Disturbed Children and TCM for Chronically Mentally Ill Adults. This agreement covers the determination of Medicaid

eligibility, Medicaid provider and Department/Division audit and compliance initiatives, and implementation and administration of the TCM program.

Missouri Institute of Mental Health

DMH maintains an MOU with the Missouri Institute of Mental Health (MIMH), The Curators of the University of Missouri for the provision of Mental Health First Aid in Missouri (MHFA-MO). DMH's responsibilities include providing a Project Director and Project Manager to support the program; representing Missouri on the MHFA-USA Executive Committee. MIMH's responsibilities include training instructors, providing technical assistance, conducting courses, conducting instructor reviews, and providing CEUs.

In addition, to the formal agreements DMH collaborates with other state agencies on various initiatives and workgroups including the following:

- Council for Adolescent School Health;
- Missouri Coordinated School Health Coalition;
- Stakeholders Advisory Group;
- Child and Family Services Review Advisory Committee;
- Children's Division Recruitment and Retention Workgroup;
- Missouri Alliance for Drug Endangered Children;
- Juvenile Crime Enforcement Coalition for Missouri School Violence Hotline;
- Task Force on the Prevention of Sexual Abuse of Children;
- Comprehensive System Management Team (for state agencies providing services to children);
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Children in Nature Committee (to increase education about nature and positive experiences with the outdoors);
- Missouri Behavioral Health Epidemiology Workgroup;
- Show Me Response (disaster & emergency coordination);
- Missouri Reentry Process Steering Team;
- MO HealthNet (Medicaid) Managed Care Quality Assurance & Improvement Advisory Group;
- Mo HealthNet (Medicaid) Behavioral Health Committee for Health Care Reform
- Missouri Alliance to Curb Problem Gambling;
- Midwest Consortium on Problem Gambling and Substance Abuse Committee;
- Governor's Committee to End Homelessness;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Missouri Drug Court Coordinating Commission;
- Governor's Faith-based and Community Service Partnership for Disaster Recovery;
- Maternal, Infant and Early Childhood Home Visiting Program State Steering Committee;
- Missouri Injury and Violence Prevention Advisory Council;
- Sexual Violence Prevention Planning Stakeholders Committee;
- Paula J. Carter Center on Minority Health and Aging;
- Eating Disorders Council;

- Missouri Behavioral Health Alliance;
- State of Missouri Brain Injury Advisory Council;
- Corrections Oversight Committee for Behavioral Health Services;
- Early Childhood Comprehensive System Steering Committee; and the
- Missouri Prevention Partners Coalition.

2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

The SSA and SMHA are the same entity. Copies of MOUs are available upon request.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

No technical assistance is requested at this time.

Footnotes:

JEREMIAH W. (JAY) NIXON
GOVERNOR

KEITH SCHAFER, Ed.D.
DIRECTOR

MARK STRINGER
DIRECTOR
DIVISION OF
BEHAVIORAL HEALTH
(573) 751-8499
(573) 751-7814 FAX

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
1706 EAST ELM STREET
P.O. BOX 687
JEFFERSON CITY, MISSOURI 65102
(573) 751-4122
(573) 751-8224 FAX
www.dmh.mo.gov

June 25, 2015

Grants Management Officer
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Rd, Room 7-1091
Rockville, MO 20850

Dear Grants Management Officer:

The State Advisory Councils for the Missouri Department of Mental Health, Division of Behavioral Health (DBH), (formerly the Division of Comprehensive Psychiatric Services and the Division of Alcohol and Drug Abuse) have reviewed the FY2016 – 2017 Combined Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and Mental Health Block Grant (MHBG) Assessment and Plan. Both State Advisory Councils are committed to working with the DBH to create a recovery oriented system of care. In December 2014 the State Advisory Councils held a joint meeting to assist DBH in developing the SAPTBG/MHBG Assessment and Plan. Both Councils have reviewed and approve of Missouri's final State Plan, written under our guidance.

We will continue to work with the DBH in monitoring the implementation of the State Plan. We appreciate our involvement in the Block Grant planning development and would like to express appreciation to SAMHSA for making these funds available.

Sincerely,

Mickie McDowell, Chair
CPS State Advisory Council

Joseph Hahne, Chair
ADA State Advisory Council

An Equal Opportunity Employer; services provided on a nondiscriminatory basis.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Bruce Charles	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2715 Chestnut Hannibal, MO 63401 PH: 573-541-2715	Bruce.Charles28@yahoo.com
Eric Martin	State Employees	Department of Social Services/Medicaid	PO Box 6500 Jefferson City, MO 65102 PH: 573-522-8336	eric.d.martin@dss.mo.gov
Heather Cushing	Parents of children with SED		114 Distinction Lake St. Louis, MO 63367 PH: 314-608-1206	hjcushing@gmail.com
Sarah Earll	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	St. Louis Empowerment Center	1908 Olive St. Louis, MO 63103 PH: 314-652-6103	ssearll@sbcglobal.net
Liz Hagar-Mace	State Employees	State Housing Authority	1706 E Elm St Jefferson City, MO 65102 PH: 573-522-6519	liz.hagar-mace@dmh.mo.gov
John Harper	State Employees	Dept. of Elementary & Sec. Educ./Div. of Voc. Rehab.	3024 Dupont Circle Jefferson City, MO 65101 PH: 573-526-7049	john.harper@vr.dese.mo.gov
Toni Jordan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3640 Garfield Ave St. Louis, MO 63113 PH: 314-531-0511	jordan.toni@ymail.com
Gregory Markway	State Employees	Missouri Department of Mental Health	1706 E Elm St, PO Box 687 Jefferson City, MO 65102 PH: 573-522-1324	greg.markway@dmh.mo.gov
Mickie McDowell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3324 South Avenue Springfield, MO 65807 PH: 417-895-1332	mickie.mcdowell@gmail.com
Rene Murph	Parents of children with SED		9822 Edgefield Dr St. Louis, MO 63136 PH: 314-246-7774	murphr@webster.edu

Karah Waddle	Providers	Strategy & Business Development Behavioral Medicine	500 Medical Dr Ernyzville, MO 63385 PH: 636-327-1017	karah_waddle@ssmhc.com
John Czuba	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		28963 Westwood Dr Macon, MO 63552 PH: 660-651-6462	johnczuba@hotmail.com
Stephanie Washington	State Employees	Missouri Department of Health and Senior Services	930 Wildwood Dr, PO Box 570 Jefferson City, MO 65102 PH: 573-522-2550	stephanie.washington@health.mo.gov
Nancy Johnson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		13045 Tesson Ferry Rd St. Louis, MO 63128 PH: 660-988-2090	nkr323@gmail.com
Sandra Jackson	Others (Not State employees or providers)	John J Pershing Veteran's Administration	1500 N Westwood Blvd Poplar Bluff, MO 63901 PH: 573-778-4740	sandra.jackson@va.gov
Kelly McKerrow	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	McKerrow Consulting	2 Lakeside Dr. Perryville, MO 63775 PH: 573-513-9880	kellymckerrow@gmail.com
Edgar Hagens	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		413 N Boonville Springfield, MO 65806 PH: 417-866-9717	rocks-hiphip@att.net
Daniel Cayou	Providers	Missouri Protection & Advocacy	925 South Country Club Jefferson City, MO 65109	Daniel.Cayou@mo-pa.org
Scott O'Kelley	State Employees	Missouri Department of Corrections	PO Box 236 Jefferson City, MO 65102 PH: 573-751-5834	Scott.O'Kelley@doc.mo.gov
Liz Page	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Jefferson City, MO PH: 573-632-6646	adoptionsolutionsinc@gmail.com
Christine McDonald	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3642 Deerfield Dr St. Charles, MO 63301	christine.crypurple@gmail.com
Janet Worthy	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	St. Louis Valley Hope	12777 Olive Blvd, Ste. C St. Louis, MO 63141 PH: 314-514-9220	janetwvalleyhope@yahoo.com
Rosanna Metcalf	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Essex, MO PH: 573-625-1460	rosanna.metcalf@yahoo.com

Lisa Doyle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Addiction Awareness	PH: 816-749-4060	lisadoyle@addictionawarenessllc.com
Gloria Nepote	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Lee's Summit, MO PH: 816-616-3121	glorianepote@gmail.com
Joseph Hahne	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Archangel Outreach Ministries	PO Box 5151 Springfield, MO 65801 PH: 417-499-2628	joe@archangeloutreach.org
Kathileen Grose	Providers	Preferred Family Healthcare	4820 SW Leafwing Dr. Lee's Summit, MO 64082 PH: 816-416-9448	w-kgrose@pbhc.org
Malva Yocco	Family Members of Individuals in Recovery (to include family members of adults with SMI)		786 Redstart Ellisville, MO 63021 PH: 636-348-7198	malvayocco@hotmail.com
Sean Adams	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1505 Little Ave, Apt 4 Grandview, MO 64030 PH: 816-830-8943	adams.sean12@yahoo.com
Jean Harris-Sokora	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		801 Charlesgate Dr St. Louis, MO 63132 PH: 314-659-6580	iamamom23@gmail.com
Barb Scheideger	Providers	Families 4 Families	2623 Idelwood Rd Jefferson City, MO 65109 PH: 573-619-1322	Mof4f@mediacombb.net
Mindy Ulstad	State Employees	Missouri Department of Health and Senior Services	912 Wildwood Dr Jefferson City, MO 65109 PH: 573-526-8534	mindy.ulstad@health.mo.gov
Mary Horn	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1107 S First St El Dorado Springs, MO 64744 PH: 417-955-5020	mhorn@pbhc.org
Linda Myers	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1121 State Rt H Fayette, MO 65248 PH: 660-635-1647	Lhmyers.64@gmail.com
Stacey Gilkey	Providers	ReDiscover	211 SW Yost Ave Lee's Summit, MO 64081 PH: 816-651-9290	sgilkey@rediscovermh.org
Denise Mills	Family Members of Individuals in Recovery (to include family members of adults with SMI)		624 E Wayne Republic, MO 65738 PH: 417-988-5222	denise.mills@burrellcenter.com

Mark Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	548 Co Rd 510 Wappapello, MO 63966 PH: 573-722-2115	smithmarkerdr@gmail.com

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	47	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	20	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	27	57.45%
State Employees	7	
Providers	5	
Federally Recognized Tribe Representatives	0	
Vacancies	8	
Total State Employees & Providers	20	42.55%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	7	
Persons in recovery from or providing treatment for or advocating for substance abuse services	40	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

A joint meeting of the Alcohol and Drug Abuse State Advisory Council (ADA-SAC) and the Comprehensive Psychiatric Services State Advisory Council (CPS-SAC) was held in December 2014 to review a draft of Missouri's Behavioral Health State Plan. Recommendations from the SAC's were incorporated into a second draft which was distributed to SAC members for a second review.

Footnotes:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 7 2015

Mr. Mark Stringer
Missouri Department of Mental Health
1706 East Elm Street
Jefferson City, MO 65102

Dear Mr. Stringer:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Christie Lundy
Mickie McDowell

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory