Missouri

UNIFORM APPLICATION
FY2010

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

42 U.S.C.300x-21 through 300x-66

OMB - Approved 09/20/2007 - Expires 09/30/2010

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Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Center for Substance Abuse Prevention

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-66), as implemented by the Interim Final Rule (45 CFR Part 96, part XI). With regard to the requirements for Goal 8, the Annual Synar Report format provides the means for States to comply with the reporting provisions of the Synar Amendment (Section 1926 of the Public Health Service Act), as implemented by the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, part IV).

Public reporting burden for this collection of information is estimated to average 470 hours per respondent for Sections I-III, 40 hours per respondent for Section IV-A and 42.75 hours per respondent for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (OMB No. 0930-0080), 1 Choke Cherry Road, Room 7-1042, Rockville, Maryland 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is OMB No. 0930-0080.

Form 1

State: Missouri
DUNS Number: 780871430-

Uniform Application for FY 2010 Substance Abuse Prevention and Treatment Block Grant

1. State Agency to be the Grantee for the Block Grant:

Agency Name:	Missouri Department of Mental Health	
Organizational Unit:	Division of Alcohol and Drug Abuse	
Mailing Address:	1706 E. Elm Street, P.O. Box 687	
City:	Jefferson City	Zip Code: 65102-0687

2. Contact Person for the Grantee of the Block Grant:

Name:	Mark Stringer	
Agency Name:	Missouri Department of Mental Health Div. of Alcohol and Drug Abuse	
Mailing Address:	1706 E. Elm Street, P.O. Box 687	
City:	Jefferson City	Zip Code: 65102-0687
Telephone:	(573) 751-9499	FAX: (573) 751-7814
Email Address:	mark.stringer@dmh.mo.gov	

3. State Expenditure Period:

From: 7/1/2007 To: 6/30/2008

4. Date Submitted:

Date: Original: Revision:

5. Contact Person Responsible for Application Submission:

Name:	Mark Stringer	Telephone:	(573) 751-9499
Email Address:	mark.stringer@dmh.mo.gov	FAX:	(573) 751-7814

Form 2 (Table of Contents)

FORM 3: UNIFORM APPLICATION FOR FY 2010 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX of the Public Health Service (PHS) Act

Title XIX of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

FORM 3: UNIFORM APPLICATION FOR FY 2010 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications

As required by Title XIX of the PHS Act (continued)

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	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 Act, as amended, as summarized above, except for those Sections in the 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.

State: Missouri

Name of Chief Executive Officer or Designee:

Signature of CEO or Designee:

Title: **Date Signed:**

If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

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

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

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

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

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

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

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

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

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

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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

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

3. CERTIFICATION REGARDING LOBBYING

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

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

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

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

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

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

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

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that

his or her knowledge, and that he or she is aware

By signing the certification, the undersigned certifies

that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application. **5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE** Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.	that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly. The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.
SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

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

1. Type of Federal Action:

☐ a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

☐ a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

☐ a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____
date of last report

4. Name and Address of Reporting Entity:

☐ Prime ☐ Subawardee

Tier _____ , if known: _____

Congressional District, *if known:* _____

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:

7. Federal Program Name/Description:

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:
$

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No.: _____ **Date:** _____

Federal Use Only:

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

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

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

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

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

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

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

FY 2007 SAPT Block Grant

Your annual SAPT Block Grant Award for FY 2007 is reflected on line 8 of the Notice of Block Grant Award.

$26,067,598

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

During FY 2007, the Missouri Division of Alcohol and Drug Abuse (ADA) supported a strong continuum of substance abuse treatment services through contracts with private treatment providers. Treatment services are made available at locations throughout the state based on needs assessments and the availability of qualified care providers. Treatment and support services were delivered via 37 Primary Recovery contracts and 47 Comprehensive Substance Treatment and Rehabilitation (CSTAR) contracts, which includes three opioid treatment providers. There were 117 providers of recovery support services.

Detoxification

Often the first step towards recovery, detoxification services assist consumers in withdrawing from addictive substances in a safe, supportive, and closely monitored environment. At admission, trained staff assess a consumer's need for detoxification services utilizing physician-approved protocols. This assessment guides the individual's placement into an appropriate level of care given the consumer's physical and mental needs. The types of publicly-funded detoxification programs available in Missouri are modified medical and social setting. During the course of detoxification, consumers are assisted in making arrangements for continuing treatment.

CSTAR

Developed by ADA and funded by Missouri's Medicaid program and ADA's Purchase of Service system, the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program provides a continuum of care approach to substance abuse treatment. CSTAR offers a flexible combination of clinical and supportive services, to include temporary living arrangements when appropriate, that vary in duration and intensity depending on the needs of the consumer. Available services include assessment, individual and group counseling, group education, community support, residential or housing support as appropriate, trauma individual and group counseling, and family therapy. In addition, families can also participate in individual and group codependency counseling. Work began in FY 2007 to expand the service menu to include medication services to promote the implementation of medication-assisted treatment as well as individual counseling for co-occurring disorders. Contracts were amended and formally issued in mid-FY 2008.

In FY 2007, there were four different types of CSTAR programs available in Missouri: women and children, adolescent, general population, and opioid. All offer three graduated levels of care. The most intensive level offers a residential component for individuals needing that kind of structure and support. Consumers can enter the program at any level and move between levels depending on their assessed needs, problem severity and treatment progress.

CSTAR Women and Children's Treatment Programs

Substance abuse can affect women differently than men, both physically and psychologically. Specialized CSTAR programs are offered for women and their children

with programming that is relevant to this population. Pregnant women and women with children in their care are prioritized populations. The full array of services is available and is tailored to the consumer's unique needs. In addition, daycare is provided to ensure childcare is not an obstacle to treatment. Alternative Care (Alt Care) is a more specialized type of women and children's program that resulted from a joint effort through ADA and the Missouri Department of Corrections. Alt Care is designed specifically for female offenders being released from correctional institutions and those under probationary supervision. There is one program in each of Missouri's two metro areas, St Louis and Kansas City.

CSTAR Adolescent Programs
Adolescent CSTAR programs offer a full continuum of services provided by specially trained staff to consumers 12 to 17 years of age. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Consumers in residential settings are offered academic support services to minimize disruptions in their education.

CSTAR General Population Programs
CSTAR General Population programs offer the complete array of substance abuse treatment and supportive services to men and women receiving Medicaid.

CSTAR Opioid Programs
Opioid programs utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs while under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle. Missouri's opioid treatment programs comply with applicable federal guidelines.

Primary Recovery and Primary Recovery Plus (PR+)
Missouri's Primary Recovery programs offer a full continuum services within multiple levels of care, modeled after the CSTAR program. Detoxification services are available to any Missourian in need, but are accessed through the PR+ providers. Three of the providers offer modified medical detoxification services versus social setting detoxification. Missouri's receipt of the Access to Recovery (ATR) grant supported the implementation of the ATR goals into the PR+ programs. The goals of the grant were to promote consumer choice of treatment and recovery support providers, expand access to a comprehensive array of treatment and support options, to include faith-based and non-traditional programs, and increase substance abuse treatment capacity.

State regulations pertinent to substance abuse treatment and prevention can be found in the Code of State Regulations (CSR) 9 CSR 30-3 which are on file with the Missouri Secretary of State: http://www.sos.mo.gov/adrules/csr/current/9csr/9c30-3.pdf.

FY 2009 (Progress)

In FY 2009, the Division of Alcohol and Drug Abuse (ADA) continued to support and monitor a full continuum of substance abuse treatment services throughout the state of Missouri via contracts with private treatment providers. Treatment and support services were delivered via 37 Primary Recovery Plus contracts and 35 Comprehensive Substance Treatment and Rehabilitation (CSTAR) contracts. The decrease in the number of CSTAR contracts between FY 2007 and FY 2009 simply reflects a change in how contracts were drafted; there was no decrease in the number of available programs.

All primary recovery programs were converted to the Primary Recovery Plus (PR+) model in FY 2006 under the Access to Recovery (ATR) grant that was awarded to Missouri in FY 2005. The goals of the grant were to promote consumer choice of treatment and recovery support providers, expand access to a comprehensive array of treatment and support options, to include faith-based and non-traditional programs, and increase substance abuse treatment capacity. Recovery supports were intended to help keep consumers engaged in treatment for longer periods of time by addressing issues that may otherwise serve as barriers to treatment completion. As of June 30 2009, there were 100 contracted recovery support providers. An expanded menu of recovery support services was made available which includes re-entry coordination, care coordination, work preparation and pastoral counseling. Missouri was awarded a second ATR grant, which was largely implemented in FY 2008. This award allowed for the continuation of the program objectives, with an increased emphasis on the treatment of methamphetamine-dependent consumers. Missouri was one of seven states recognized in May 2009 during the annual meeting of the ATR II grantees. ADA received special recognition for exceeding two performance targets of the grant – number of people served and follow-up interviews with those individuals. A performance incentive payment will be awarded to ADA for exceeding the target for follow-up GPRA interviews.

Both the CSTAR programs and the PR+ programs continue to provide a multi-level system of care with a wide service menu that can be applied to meet consumers' individual needs. All services previously cited were continued in FY 2009, to include Individual Co-Occurring Disorder Counseling, Medication Services (delivered by physician, APN, or psychiatrist), Extended Day Treatment, and the Clinical Supervision of Counselors. In FY 2009, collaborative partnerships were developed between the Division of ADA, Alkermes Pharmaceuticals, and the Department of Corrections with the goal of increasing the appropriate use of Vivitrol for severe alcohol addiction. Research has shown that this form of the medication can be especially useful for individuals at high-risk for relapse and for whom daily medication administration is an obstacle to recovery. An increasing number of providers began making agency and practice changes to incorporate the use of Vivitrol in their clinical treatment of alcohol dependence. Monthly "Vivitrol Change Leaders" conference calls were held to disseminate information, discuss progress, and allow providers to share experiences, problems, and successes.

Early FY 2009 marked the formal end to the Robert Wood Johnson Foundation grant. The purpose of the grant was to study processes and practices within the state and provider systems that were barriers to the use of evidence-based practices (EBP), and consequently improve those practices to increase the utilization of EBP. The focus of the first project year was the development and implementation of medication-assisted services to treat alcohol dependence. Nearly all agencies, grant-participating or not, have made efforts to incorporate what was learned in year one to their current practices. The focus in the second year was increased utilization of motivational interviewing. Walk-through exercises were conducted at the provider and state levels during the implementation planning stage. The ability to provide brief motivational interviewing interventions before completion of the assessment was first started with the grant-participating agencies, but was later expanded to all Primary Recovery Plus providers.

The Division of ADA continues to collaborate with SAMHSA, CSAT, the Division of Pharmacological Therapies (DPT), and other opioid accrediting bodies to evaluate certified opioid treatment programs (OTP). Each accrediting body must provide DPT with timely reporting regarding the clinics that are accredited. Discussion topics during conference calls and meetings of accrediting bodies include: consumer safety; best practices and current issues in opioid treatment; disaster planning; methadone deaths; drug abuse patterns and trends; accreditation survey scope and practice; and accreditation standards and guidelines.

ADA has continued to pursue the establishment of Centers of Excellence for the comprehensive treatment and prevention of substance abuse disorders and compulsive gambling. In doing so, providers will embody the “13 Principles of Effective Treatment” developed by the National Institute on Drug Abuse. Prevention providers and coalitions will employ the Strategic Prevention Framework. In order to move forward with this initiative, ADA asked the State Advisory Council (SAC) to define and make recommendations for the development of Centers of Excellence. The SAC is comprised of many stakeholders to include the following: consumers, providers, Missouri Recovery Network, ACT Missouri, Missouri Institute of Mental Health, Committed Caring Faith Communities, and partnering state agencies. Recommendations for treatment services were received in the spring of 2009, while the prevention subcommittee is still working on recommendations for prevention services.

The Clinical Utilization Review Unit continues to function as a monitoring, consulting, and training unit within ADA to ensure the best consumer care is provided in an appropriate, efficient manner.

FY 2010 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to fund a continuum of treatment services but, in addition, will promote and support a wider utilization of evidenced-based practices by treatment providers.

As a continuation and expansion of work initiated under a grant from the Robert Wood Johnson Foundation that ended in FY 2009, ADA will continue work to identify and remove barriers to the implementation and integration of evidence-based practices (EBP) including medication-assisted services to treat alcohol dependence and motivational interviewing. Changes have been made to Primary Recovery Plus (PR+) contracts to allow billing for a brief motivational intervention prior to the completion of the comprehensive assessment. In FY 2010, the Division will be exploring how to implement this option on CSTAR contracts.

In FY 2009, collaborative partnerships were developed between the Division of ADA, Alkermes Pharmaceuticals, and the Department of Corrections with the goal of increasing the appropriate use of Vivitrol for severe alcohol addiction. ADA will continue to work with Alkermes to connect contracted providers with the training and informational resources this company offers. The Division of ADA and the Department of Corrections will continue to offer mutual consumers the benefit of Vivitrol when its use is determined to be clinically appropriate. "Vivitrol Change Leaders" conference calls will continue to be offered by the Division and participation by all treatment providers will be encouraged.

The Division of Alcohol and Drug Abuse will continue to administer funding and oversee all community-based substance abuse treatment services for offenders. A Memorandum of Understanding with the Department of Corrections delineates the terms of this collaborative working relationship. The community-based programs for offenders that are managed by ADA include outpatient services throughout the state, Alt-Care and Free and Clean programs in St. Louis and Kansas City, and a Partnership for Community Restoration program in St. Louis.

ADA will continue to pursue the establishment of Centers of Excellence for the comprehensive treatment and prevention of substance abuse disorders and compulsive gambling. In doing so, providers will embody the "13 Principles of Effective Treatment" developed by the National Institute on Drug Abuse. Prevention providers and coalitions will employ the Strategic Prevention Framework. In order to move forward with this initiative, ADA has asked the State Advisory Council (SAC) to define and make recommendations for the development of Centers of Excellence. The Division will be considering the Centers of Excellence recommendations made by the SAC in FY 2010.

The Division of ADA will continue to collaborate with SAMHSA, CSAT, and other opioid accrediting bodies to evaluate certified opioid treatment programs. Discussion topics during conference calls will include: current issues in opioid treatment; disaster

planning; methadone deaths; drug abuse patterns and trends; accreditation survey scope and practice and accreditation standards and guidelines.

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. 300x-22(a)(1) and 45 C.F.R. 96.124(b)(1)).

Institute of Medicine Classification: Universal, Selective and Indicated:

• ***Universal:*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

o ***Universal Direct. Row 1***—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

o ***Universal Indirect. Row 2***—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

• ***Selective:*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

• ***Indicated:*** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. *(Adapted from The Institute of Medicine Model of Prevention)*

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

FY 2007 (Compliance)

Universal

The Missouri Division of Alcohol and Drug Abuse (ADA) utilizes Universal prevention strategies to address Missouri's entire population (state, local community, school, neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Missouri's ADA Universal prevention programs continued to focus on the mission of universal prevention, to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. (NIDA 1997)

Universal Direct

During the year, ADA procured with 11 Regional Support Centers (RSCs) to provide ongoing technical assistance to 154 community coalitions comprised of a diverse representation of the community. The coalitions were located throughout the state and represented approximately 1,540 local volunteers present in most of Missouri's 114 counties plus the city of St Louis. The ongoing technical assistance to the community coalitions supported capacity building at the local level through community needs assessments, resource identification, development of community plans to address the identified needs, implementation of plans, and assistance with the evaluation of data for outcomes. In addition, the RSCs provided technical assistance to 18 of the 20 Strategic Prevention Framework State Incentive Grant (SPFSIG) coalitions. The technical assistance provided by the RSCs increased the coalitions' information and skills necessary to prevent substance abuse in their community.

One tool used by the RSCs for the community needs assessment was the Missouri Student Survey (MSS), supported with Safe and Drug Free School and Communities funds. The MSS was jointly administered by ADA and the Missouri Department of Elementary and Secondary Education (DESE) to assess substance use and related behaviors among 6^{th}-12^{th} graders attending public school across the state.

Partners in Prevention (PIP), Missouri's higher education substance abuse consortium, represented 12 public universities located throughout the state. During FY 2007, an estimated 130,000 students attended PIP campuses full-time. PIP administered the Missouri College Student Health Behavior Survey (MCHBS) to a total of 5,375 students. Results from the survey showed a reduction in the percentage of PIP students who engaged in binge drinking.

Universal Indirect

During FY 2007, ADA procured with multiple prevention providers for universal indirect services to support population-based prevention and environmental strategies. Three Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City, and St. Louis responded to requests for prevention materials throughout the state. In addition the eleven Regional Support Centers (RSC), the Statewide Training and Resource Center (STRC), the University of Missouri, and 154 local coalitions also provided universal indirect services. The broadcast media was utilized and reached four million individuals aged 5-64 years. KidsCast, a radio and web-based program was available for Missouri youth in 4^{th}-6^{th} grades to increase awareness of how tobacco, alcohol, drug use and unhealthy behaviors impact communities. The KidsCast web-site had over 5,000 page reviews. The 154 Missouri registered coalitions recognized national prevention awareness programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3D Month, and Alcohol Awareness Month.

ADA utilized the Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the substance abuse prevention workforce who included ADA and the contractual prevention staff. The STRC, a Community Anti-drug Coalitions of America (CADCA) member, represented Missouri at national conferences. Under the direction of ADA, the STRC administered training, development and consultant funds to the approximately 154 coalitions. These resources were supported with the Governor's Discretionary Fund of Safe and Drug Free School and Communities funds.

Merchant tobacco materials were developed and distributed to the RSCs during the annual merchant education campaign held from February through May, 2007. During the campaign, the RSCs informed retailers on the tobacco laws and on the availability of tobacco retailer training for employees. The campaign consisted of a phone call and two walk-in visits to the state's approximate 6,500 retailer outlets. More than 20,000 phone call and walk-in contacts were completed. Several support centers partnered with the Division of Alcohol & Tobacco Control to provide training to retailers in their region.

ADA continued to support the Missouri Youth/Adult Alliance (MYAA), a statewide coalition that provides resource materials and education to local community efforts focused on addressing underage drinking. MYAA addressed the topics of environmental and social policy change during the annual Speak Hard workshop for youth held in Jefferson City.

Selective

Selective prevention strategies targeted subsets of Missouri's population that were identified by ADA to be at risk for substance abuse. ADA's selective prevention programs were provided through subgroups which as a whole, had higher risk of substance abuse than the general population.

ADA implemented selective services through a school-based program, School-based Prevention, Intervention and Resources Initiative (SPIRIT). CSAP model programs were implemented in five school districts: Knox County, Carthage, Hickman Mills, New Madrid, and Jennings. 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. The programs included Peace Builders, Positive Action, Second Step, Project Towards No Drug Abuse, Life Skills and Too Good For Drugs. During 2007, the SPIRIT initiative provided CSAP model programs to over 5,500 students in grades K-9.

Selective prevention services were also provided through eight community-based agencies located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the Missouri Bootheel. The subgroups targeted by these community-based agencies include youth experiencing academic failure located in communities identified as low income. The evidence-based programs and strategies implemented by these agencies include Creating Lasting Connections, Creating Lasting Family Connections (ages 9-17), Passport to the Future: Urban Rhythms (ages 5-18), Too Good For Drugs (ages 11-14), after school mentoring emphasizing bullying prevention (ages 12-14), Life Skills (ages 12-14), faith-based programs specializing in youth substance abuse prevention (ages 12-18), Promoting Responsibility through Education and Preparation (PREP) mentoring program (ages 9-11), Lincoln University Youth Development Kid's Beat (ages 6-18), All Stars (ages 11-14), and How to Cope (ages 18+). Over 60,000 Missourians were served through these eight agencies.

Selective prevention services were provided through the Missouri Alliance of Boys and Girls Club, consisting of 12 Boys and Girls Club sites located throughout the state. The target subgroup for the Missouri Alliance of Boys and Girls Club was youth who may be academically failing and low-income. The sites implemented SMART Moves to over 60,000 youth ages 5-18.

ADA also provided selective prevention through the Leadership Education and Advocacy for the Deaf (L.E.A.D.), the statewide provider for Deaf and Hard of Hearing.

L.E.A.D. targets the subgroup of Deaf and Hard of Hearing youth in Missouri. L.E.A.D. provided The Teen Institute for the Deaf to over 900 youth ages 12-17.

Partners in Prevention (PIP) targets the subgroup of students at risk for underage and binge drinking on college campuses. PIP, consisting of 12 state universities, implemented Community Trials, Brief Alcohol Screening and Intervention for College Students (BASICS), and SMART to over 5,600 students ages 18-24.

Indicated

The SPIRIT initiative also implemented Reconnecting Youth to students in grades 10-12 at Carthage and Knox County serving over 45 students. The students served through SPIRIT's Reconnecting Youth exhibited risk factors such as conduct disorders, and alienation from parents, school, and positive peer groups.

References:

National Institute of Drug Abuse (1997). "Drug Abuse Prevention: What Works", pp. 10-15.

FY 2009 Progress

Universal

The Missouri Division of Alcohol and Drug Abuse (ADA) utilizes Universal prevention strategies to address Missouri's entire population (state, local community, school, neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Missouri's ADA Universal prevention programs continues to focus on the mission of universal prevention, to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. (NIDA 1997)

Universal Direct

The Missouri Division of Alcohol and Drug Abuse (ADA) continues to procure with 11 Regional Support Centers (RSCs) for ongoing technical assistance to 152 community coalitions comprised of a diverse representation of the community. The community coalitions are present in most of Missouri's 114 counties plus the city of St Louis and involve approximately 1,520 local volunteers. The RSCs also provide technical assistance to 18 of the 20 Strategic Prevention Framework State Incentive Grant (SPFSIG) coalitions. The ongoing technical assistance continues to support capacity building at the local level through community needs assessments, resource identification, development of community plans to address the identified needs, implementation of the plans, and the evaluation of data for outcomes. The technical assistance provided by the RSCs continues to increase the coalition's information and skills necessary to prevent substance abuse.

The RSC's ongoing technical assistance continues to be evident as one of Missouri's 152 coalitions, Ray County Coalition in Lawson, was selected as a recipient of the 2008 Community Anti-Drug Coalitions of America (CADCA) Got Outcomes! Coalition of Excellence Award. This award is given to coalitions that have successfully fought substance abuse in their communities through implementation of a strategy or set of comprehensive strategies resulting in measurable change.

The RSCs continue to use the Safe and Drug Free School and Communities funded Missouri Student Survey (MSS) as a tool for the community needs assessment. The biennial MSS is jointly administered by the Department of Mental Health – Division of Alcohol and Drug Abuse (ADA) and the Missouri Department of Elementary and Secondary Education (DESE) to assess substance use and related behaviors among 6^{th}-12^{th} graders attending public schools across the state. The RSC monthly progress with each coalition is monitored by ADA prevention specialists.

Partners in Prevention (PIP), Missouri's higher education substance abuse consortium, gained a new member when Harris –Stowe State University joined the consortium in

2009 bringing the total membership to 13 public universities. PIP continues to utilize the Strategic Prevention Framework and strives to create positive change on their college campuses. The technical assistance provided by PIP to the 13 college campuses continues to increase information and skills necessary to prevent substance abuse. Full-time enrollment for PIP schools is over 130,000 students. During the year, PIP administered the Missouri College Student Health Behavior Survey (MCHBS) at the 13 publically funded universities. An estimated 6,000 students participated in the survey designed to assist in determining the needs of the campuses and obtain aggregate statewide data.

Universal Indirect

ADA continues to provide Universal Indirect to support population-based prevention through multiple prevention providers. Three Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City, and St. Louis responds to requests for materials. In addition, the eleven Regional Support Centers (RSC), the Statewide Training and Resource Center (STRC), the University of Missouri, and 152 local coalitions provide universal indirect services. The broadcast media are utilized to reach about 4 million individuals aged 5-64 years. KidsCast, a radio and web-based program continues to be available for Missouri youth in 4^{th}-6^{th} grades to increase awareness of how tobacco, alcohol, drug use and unhealthy behaviors impact communities. The KidsCast website receives approximately 5,000 page reviews annually. The 152 volunteer coalitions recognizes national prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3D Month, and Alcohol Awareness Month.

Merchant tobacco materials continue to be developed and distributed to the RSCs during the annual merchant education campaign from February through May. During the campaign, the RSCs inform retailers on tobacco laws and the availability of tobacco retailer training for employees. The campaign consists of a phone call and two walk-in contacts with the state's approximate 6,500 retailer outlets. More than 20,000 contacts have been made during the FY 2009 campaign. Several RSCs partner with the Division of Alcohol & Tobacco Control to provide training to retailers in their region.

ADA uses the Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the substance abuse prevention workforce who includes ADA and the contractual prevention staff. The STRC, a member of Community Anti-Drug Coalitions of America (CADCA) represents Missouri at national conferences. Under the direction of ADA, the STRC continues to administer training, development and consultant resources to the 152 Missouri registered coalitions.

The STRC held a Missouri Statewide Prevention Conference on December 1-3, 2008, with 160 professionals from the substance abuse prevention field in attendance. National and local experts presented on a range of topics including: using social marketing to create policy change, substance use, problem behaviors and suicidal ideation among Missouri's youth, prescription and over-the-counter medications, modifying model programs to meet local needs, the future of public support for prevention, gang awareness and prevention, media literacy in prevention, bullying, as well as other current issues impacting the substance abuse field.

Partners in Prevention continues to provide on-going training opportunities for higher education professionals, law enforcement, judicial officers, and students on effective prevention efforts of alcohol and other drug abuse among Missouri college students through monthly meetings, a statewide conference, and one-day workshops/trainings. The statewide conference, Meeting of the Minds, was held April 2-4, 2009 in Kansas City.

ADA continues to support the Missouri Youth/Adult Alliance (MYAA), a statewide coalition that provides resource materials and educational opportunities to local community efforts focused on addressing underage drinking. MYAA addresses the topics of environmental and social policy change during the annual Speak Hard workshop for youth in Jefferson City. MYAA also distributes brochures, pamphlets, and other materials on underage drinking.

ADA supports the St. Louis Arc in delivering Fetal Alcohol Syndrome (FAS) information, education and promoting awareness to youth aged 12-21 in St Louis schools. Over 4,200 information and promotional materials have been distributed during the year. In addition, 945 informational and promotional materials have been distributed through health fairs, conferences, and a town hall meeting.

Selective

Selective prevention strategies targets subsets of Missouri's population that were identified by ADA to be at risk for substance abuse. ADA's selective prevention programs are provided through subgroups which as a whole had higher risk of substance abuse than the general population.

ADA continues to provide selective services through the school-based program, School-based Prevention Intervention and Resources Initiative (SPIRIT). CSAP model programs have been implemented in five school districts: Knox County, Carthage, Hickman Mills, New Madrid, and Jennings. 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. The programs include Peace Builders,

Positive Action, Second Step, Project Towards No Drug Abuse, Life Skills and Too Good For Drugs. During 2009, SPIRIT has served over 6,900 students in grades K-9.

Selective prevention services are being provided through eight community-based agencies located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the Missouri Bootheel. The subgroups targeted by these community-based agencies include youth who are experiencing academic failure located in communities identified as low income. The evidence-based programs and strategies implemented by these agencies include Creating Lasting Connections, Creating Lasting Family Connections (age 9-17), Passport to the Future: Urban Rhythms (age 5-18), Too Good For Drugs (age 11-14), after school mentoring emphasizing bullying prevention (age 12-14), Life Skills (age 12-14), faith-based programs specializing in youth substance abuse prevention (age 12-18), Promoting Responsibility through Education and Preparation (PREP) program (age 9-11), Lincoln University Youth Development Kid's Beat (age 6-18), All Stars (age 11-14), and How to Cope (age 18+). During the year, approximately 62,000 Missourians have been served with these programs.

Selective prevention services continue to be provided through the Missouri Alliance of Boys and Girls Club, consisting of 12 Boys and Girls Club sites located throughout the state. The target subgroup for the Missouri Alliance of Boys and Girls Club is youth who may be academically failing and low-income. During the year, the 12 Boys and Girls Club sites have provided SMART Moves to over 60,000 youth ages 5-18.

ADA continues to provide selective prevention through the Leadership Education and Advocacy for the Deaf (L.E.A.D.), the statewide provider for Deaf and Hard of Hearing. L.E.A.D. targets the subgroup of Deaf and Hard of Hearing youth in Missouri. During the year, L.E.A.D. has provided The Teen Institute for the Deaf to over 1,000 youth ages 12-17.

ADA continues to provide selective prevention to the subgroup of students at risk for underage and binge drinking on college campuses through Partners in Prevention (PIP). PIP, consisting of 13 state universities, has provided Community Trials, Brief Alcohol Screening and Intervention for College Students (BASICS), and SMART to over 6,000 students ages 18-24 during FY 2009.

ADA continues to strive for distinction in implementing prevention programs. Three of Missouri's prevention programs were awarded the National Exemplary Award for Innovative Substance Abuse Prevention Programs, Practices, and Policies! Those programs awarded were Partners in Prevention (PIP) at the University of Missouri-Columbia, Promoting Responsibility through Education and Preparation (PREP) at Discovering Options in St. Louis, and How to Cope at the National Council on

Alcoholism and Drug Dependence in Kansas City. Missouri's programs received the top three of six awards given across the United States. The Exemplary Awards, sponsored by SAMSHA/CSAP, highlight innovation and showcase evidence-based, state-of-the-art substance abuse prevention programs in the United States.

Indicated

The SPIRIT initiative continues to provide Reconnecting Youth to students in grades 10-12 at Carthage, Knox County, and Swope serving over 70 students. The students served through SPIRIT's Reconnecting Youth exhibited risk factors such as conduct disorders, and alienation from parents, school, and positive peer groups.

References:

National Institute of Drug Abuse (1997). "Drug Abuse Prevention: What Works", pp. 10-15.

Goal 2 FY2010 (Intended Use)

Universal Direct

The Missouri Division of Alcohol and Drug Abuse (ADA) will continue to procure with 11 Regional Support Centers (RSCs) for ongoing technical assistance to approximately 152 community coalitions comprised of a diverse representation of the state. The RSCs will provide technical assistance to 18 of the 20 Strategic Prevention Framework State Incentive Grant (SPFSIG) coalitions. The RSCs will provide technical assistance on utilization of the Strategic Prevention Framework to the approximately 152 coalitions and the 18 SPFSIG coalitions. The ongoing technical assistance provided during the state fiscal procurement cycle from July1-June 30 will continue to support capacity building at the local level through community needs assessments, resource identification, development of community plans to address the identified needs, implementation of plans, and the evaluation of data for outcomes.

The RSCs will continue to use the Safe and Drug Free School and Communities funded Missouri Student Survey (MSS) as a tool for the community needs assessment. The biennial MSS will be jointly administered by the Department of Mental Health – Division of Alcohol and Drug Abuse (ADA) and the Missouri Department of Elementary and Secondary Education (DESE) to assess substance use and related behaviors among 6^{th}-12^{th} graders attending public school across the state.

During 2010, under the direction of ADA, the Statewide Training and Resource Center (STRC) will assemble the Statewide Prevention Training and Resource Network (STRN) consisting of a representative from each of the 11 RSCs. The STRN will meet monthly to plan and coordinate statewide prevention efforts on behalf of ADA and the overall state prevention system.

Partners in Prevention (PIP), Missouri's higher education substance abuse consortium comprised of 13 public universities located throughout the state, will continue to utilize the Strategic Prevention Framework model and create positive change on their college campuses. It is anticipated that over 140,000 students will attend PIP campuses full-time and approximately 6,500 students will be served by PIP. PIP will continue to administer the Missouri College Student Health Behavior Survey (MCHBS) to assist in determining the needs of the campuses and to obtain aggregate statewide data during 2010.

Universal Indirect

During 2010, ADA will continue to provide universal indirect prevention through multiple prevention providers. Three Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City and St. Louis will respond to

requests for RADAR materials. In addition, the eleven Regional Support Centers (RSCs), the Statewide Training and Resource Center (STRC), the University of Missouri, and 152 local coalitions will provide universal indirect services. The broadcast media will be used to reach about four million individuals aged 5-64 years. KidsCast, a radio and web-based program, will be available for Missouri youth in 4^{th}-6^{th} grades to increase awareness of how tobacco, alcohol, drug use and unhealthy behaviors impact communities. The approximately 152 volunteer coalitions will continue to recognize national prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3D Month, and Alcohol Awareness Month.

Merchant tobacco materials will continue to be developed and distributed to tobacco retailers by the RSCs during the year. The RSCs will conduct one walk-in visit to the state's approximate 6,500 retailer outlets in the spring to distribute education materials and educate on tobacco laws. ADA plans on providing incentives to those RSCs whose coverage area has an 88% or higher non-compliance rate for tobacco sales to youth.

ADA intends to utilize the Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the substance abuse prevention workforce who includes ADA and the contractual prevention staff. The Statewide Resource Center will represent Missouri at national conferences. Under the direction of ADA, the STRC will continue to administer training, development and consultant funds (TDC) to the approximately 152 volunteer coalitions. The Statewide Training and Resource Center will plan for the Missouri Statewide Prevention Conference to be held in FY 2011.

Partners in Prevention will continue to provide on-going training opportunities for higher education professionals, law enforcement professionals, judicial officers, and students on the effective prevention of alcohol and other drug abuse among Missouri college students through monthly meetings, a statewide conference, and one-day workshops/trainings.

ADA will continue to support the Missouri Youth /Adult Alliance (MYAA), a statewide coalition that provides resource materials and education to local community efforts focused on addressing underage drinking. MYAA will continue to address the topics of environmental and social policy change during the annual Speak Hard workshop for youth in Jefferson City. MYAA will distribute brochures, pamphlets, and other materials on underage drinking.

ADA will continue to support the St. Louis Arc in delivering Fetal Alcohol Syndrome (FAS) information, education and promoting awareness to youth aged 12-21 in the St Louis schools. An anticipated 5,100 units of information and promotional materials will be distributed.

ADA will develop a web-based statewide data query system for county and state level data. The system will provide access to the datasets local coalitions utilize for community need assessments. ADA is partnering with the Missouri Institute of Mental Health for development of this analysis tool.

Selective

ADA will continue to provide selective services through the school-based initiative and community-based programming for direct services. CSAP model programs will be provided through the School-based Prevention and Intervention and Resources Initiative (SPIRIT) in five school districts: Knox County, Carthage, Hickman Mills, New Madrid, and Ritenour. The programs include Peace Builders, Second Step, Project Towards No Drug Abuse, Life Skills and Too Good For Drugs. During 2010 the SPIRIT initiative will serve approximately 6,800 students in grades K-9.

Selective prevention services will be provided through eight community-based agencies located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the Missouri Bootheel. The evidence-based programs and strategies provided by these agencies include Creating Lasting Connections, Creating Lasting Family Connections (age 9-17), Passport to the Future: Urban Rhythms (age 5-18), Too Good For Drugs (age 11-14), after school mentoring emphasizing bullying prevention (age 12-14), Life Skills (age 12-14), faith-based programs specializing in youth substance abuse prevention (age 12-18), Promoting Responsibility through Education and Preparation (PREP) mentoring program (age 9-11), Lincoln University Youth Development Kid's Beat (age 6-18), All Stars (age 11-14), and How to Cope (age 18+). It is anticipated that over 62,000 Missourians will be served with these programs.

Selective prevention services will continue to be provided through three statewide providers: the Missouri Alliance of Boys and Girls Club, Leadership Education and Advocacy for the Deaf (L.E.A.D.), and Partners in Prevention (PIP). The Missouri Alliance of Boys and Girls Club will continue to provide SMART Moves and Meth SMART to over 60,000 youth ages 5-18. In 2010, the Missouri Alliance of Boys and Girls Club will add another site bringing the total number of participant sites to thirteen. L.E.A.D., the statewide provider for deaf and hard of hearing, will continue to provide the Teen Institute for the Deaf to over 1,000 deaf and hard of hearing youth ages 12-17. PIP, consisting of 13 state universities, will continue to provide Community Trials, Brief Alcohol Screening and Intervention for College Students (BASICS), and SMART to over 6,000 students ages 18-24. During 2010, the RSCs may elect to provide direct delivery of prevention services in communities and schools. The evidence-based prevention services delivered by the RSCs will be based on the community needs assessment and follow the strategic framework model.

State: Missouri

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 (http://www.healthypeople.gov/) objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

(●) Yes ( ) No ( ) Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

( ) Yes (●) No ( ) Unknown

3. Does your State Alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT Block Grant	Other State Funds	Drug Free Schools
( ) Yes	( ) Yes	( ) Yes
(●) No	(●) No	(●) No
( ) Unknown	( ) Unknown	( ) Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

( ) Yes (●) No ( ) Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau?	(●) Yes	( ) No	( ) Unknown
Dissemination of materials?	(●) Yes	( ) No	( ) Unknown
Media campaigns?	(●) Yes	( ) No	( ) Unknown
Product pricing strategies?	(●) Yes	( ) No	( ) Unknown
Policy to limit access?	(●) Yes	( ) No	( ) Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

(●) Yes ( ) No ( ) Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as:

(HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:	○ Yes ◉ No ○ Unknown
New product pricing:	○ Yes ◉ No ○ Unknown
New taxes on alcoholic beverages:	○ Yes ◉ No ○ Unknown
New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:	○ Yes ◉ No ○ Unknown
Parental responsibility laws for a child's possession and use of alcoholic beverages:	○ Yes ◉ No ○ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

◉ Yes ○ No ○ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	○	○	◉	○
Alcohol	○	○	◉	○
Marijuana	○	○	◉	○

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older?	0.08
Motor vehicle drivers under age 21?	0.02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-23)

Communities: 153

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

○ Yes ◉ No ○ Unknown

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA) has maintained the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. CSTAR programs allow women and their children to receive multiple levels of care based upon their assessed needs. CSTAR programs are available in each region of the state, in both rural and urban settings. ADA maintained certification standards that prioritize the treatment of pregnant or postpartum women or women with dependent children. During FY 2007, 541 pregnant women entered treatment upon request and received prenatal care and referrals in accordance with the requirements in the CSTAR certification standards and contract requirements.

Nurses are available at each agency to assist with medical needs and referrals. Community support workers assist consumers with coordinating social service needs identified during the assessment process. Childcare is provided on-site or the program makes arrangements for child care at licensed facilities.

Contract monitoring occurs annually through Safety and Basic Assurance Reviews at each agency. The monitoring visit includes the Area Treatment Coordinator reviewing the program's practices and the Block Grant Requirement Checklist to ensure compliance with requirements. Certification surveys occur on a three-year cycle and include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care, and children are receiving safe and appropriate childcare. During FY 2007, monitoring schedules were maintained.

FY 2009 (Progress)

The Division of Alcohol and Drug Abuse continues to provide specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services for pregnant women and women with dependent children. There are 12 contracted providers of Women and Children's CSTAR services. In FY 2009 through 6/22/2009, 582 pregnant women have been admitted to any of the Division's contracted treatment programs. In FY 2008, 530 pregnant women were admitted to and served in substance abuse treatment. Evidence-based treatments, including trauma-informed care and services, and co-occurring services continue to be available in these programs.

The Division developed contract language to more specifically address expectations regarding the admission of priority populations. An amendment for Women and Children's CSTAR programs will also be issued that more clearly identifies the prenatal and supportive services that must be provided or arranged for to meet SAPT Block Grant requirements. The contract language and amendment are being finalized and will be added to contracts at the start of FY 2010.

FY 2010 (Intended Use)

The Division of Alcohol and Drug Abuse will continue to provide specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services for pregnant women and women with dependent children. The implementation of evidence-based practices will continue to be a priority, as well as, quality assurance monitoring of this treatment. The monitoring of programs will continue to be completed annually. An annual Safety and Basic Assurances Review that includes a review of contract, certification, and block grant requirements will be completed for each agency. The newly developed priority population language and special services amendment will be added to contracts in FY 2010 and compliance with this amendment will also be monitored. A certification survey of program practices and operations conducted by a team of treatment specialists will be completed every three years for each agency.

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children (See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2007) to the fiscal year for which the State is applying for funds: Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2007. In a narrative of **up to two pages**, describe these funded projects.

Attachment B (Part 1)

Treatment for women in the State of Missouri has been enhanced over the past nineteen years due in part to the Block Grant funds. The Missouri Department of Mental Health – Division of Alcohol and Drug Abuse (ADA) has moved from providing treatment for women in gender-integrated programs to creating programs designed specifically for women and their children. Twelve contracts have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children and offer multiple treatment site locations across the state. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. All of the programs provide for licensed daycare services for the children accompanying their mothers to treatment. The dependent children receive treatment for physical, emotional and behavioral conditions brought about by their mothers' addictions. In this manner, the mandate of Section 1922(c) in spending FY 2007 Block Grant funds for at least a 5% set aside has been exceeded.

Urban hospitals in St. Louis and Kansas City noted the increase in drug-affected children in the late 1980's. By 1988, the number of impaired infants brought about an organized request for ADA to begin treating pregnant and postpartum women and their children. Concurrently, the CSTAR program was being developed to meet the needs of this specific population. Women are defined as requiring treatment when their use of alcohol and other drugs has caused dysfunction in any area of their lives. By offering a continuum of care, CSTAR is suited to match the level of care to the assessed needs of the woman and her children. This continuum of care is described below.

Continuum of Care Provided

Community-based Primary Treatment:
This is the most structured, intensive treatment in the continuum of care, and is provided in a trauma-sensitive environment. Services are provided five to seven days per week. Services available include day treatment (group and individual counseling, group education, and structured recovery support activities), community support, family therapy, trauma counseling, co-occurring disorders counseling, medication services, residential support and day care for dependent children. Age-appropriate assessment and codependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Intensive Outpatient Rehabilitation:
This treatment is designed for women who have a home environment supportive of recovery or are living in approved housing and present less severe symptoms of substance abuse. Women who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities for them to interact within their families and community while continuing to receive an intermediate level of support and treatment. Services are provided on several occasions each week. A minimum of ten hours of therapeutic activities are offered each week. Treatment is provided in a trauma

sensitive environment and consists of a menu of services including group counseling and education, individual counseling, community support, family therapy, trauma counseling, co-occurring disorders counseling, medication services, and day care for dependent children. Age-appropriate assessment and codependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Supported Recovery:
This level of care provides service on a regularly scheduled basis, offering a minimum of three therapeutic activities weekly. Women who are assessed as not needing intensive or structured clinical services may begin substance abuse treatment at this level on the continuum of care. Women who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities to interact within their families and community while continuing to receive regular reinforcement of treatment principles. The frequency of services will be determined by the assessed clinical needs of the woman. Treatment is provided in a trauma-sensitive environment and consists of a menu of services including group counseling and education, individual counseling, community support, family therapy, trauma counseling, co-occurring disorders counseling, medication services, and day care for dependent children. Age-appropriate assessment and codependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Specialized Treatment

Women are offered group education on a wide array of topics such as drug education, communication skills, anger management, coping with trauma, mental health education, and relapse prevention. Group counseling is offered to allow consumers to explore emotional issues and work towards healthy self image, relationships, and lifestyles. Individual counseling allows for further exploration and working towards specified individualized treatment goals.

Child care is provided at all levels of CSTAR programming for women while they attend treatment sessions. State certification standards require each program to be licensed as a daycare facility for children. A child therapist must be on staff in each program to assess infants/children and either provide the necessary services or make appropriate referrals for infants/children with special needs. Codependency counseling and family therapy are provided for all persons identified with a need for these services.

Women who are homeless may receive housing assistance from ADA while participating actively in treatment. Supportive housing is intended as a bridge to other, long term housing arrangements. Two forms of housing support currently available through the treatment providers are community housing and transitional housing. Community Housing may be provided to consumers and their families who are in need of a living arrangement that supports ongoing recovery and community integration. Community Housing may be provided in an individual apartment or single-family home

of the consumer's choice that is inspected and approved by the Department. The stipend for community housing can be used to pay rent, initial deposits, utilities and local telephone service. Transitional Housing may be provided to consumers in need of a living arrangement that provides an intermediate level of supervision, structure and external support for their continued recovery. Transitional Housing is provided in a communal living setting limited to sixteen adult beds, inspected and approved by the Department. Transitional Housing funds provide for room and board and on-site supervision when consumers are present.

All women and children who enter treatment are provided health screenings to identify health deficits or needs for medical intervention. Within the CSTAR programs, registered nurses are on duty to assist mothers and their children to achieve health goals. The nurses offer medical services, referrals, and education for all children and families. Each child is required to have a current physical exam and current immunizations. The community support workers assist the consumers in arranging medical appointments and obtaining transportation. Close associations with local health clinics, hospitals and doctors enable the provision of prenatal care, immunizations and other preventive measures to increase the well being of mothers and their children. All CSTAR programs conduct a communicable diseases risk assessment for all consumers at admission. Pre- and post-test counseling for HIV/AIDS, sexually transmitted diseases and tuberculosis are available on site or by referral at all CSTAR women's programs. This innovative healthcare provision was a result of the FY 1997 mandate to increase and improve services for women.

In FY 2007, a specialized communication protocol was developed to facilitate communication between primary care physicians (PCP), case managers for the Medicaid managed care plans, Women and Children CSTAR providers, and ADA's Clinical Utilization Review Unit. Pregnant women entering the Medicaid managed care system at their physician's office will be asked to consent to sharing only clinically relevant and appropriate information to improve continuity of care when screened by a CSTAR Women and Children provider. The protocol also provides guidelines for the communication of all parties should the women enter the system from a different referral source. This will ensure pregnant women and their child will have access to all available treatment and support services that meet their specialized clinical needs. The protocol was continued in FY 2008 and expanded to include all Women and Children's CSTAR programs. Initially, only those within the MO HealthNet managed care service areas were included. It was soon realized that some women must seek services outside of their service network and the Division wanted to promote communication with all potential providers.

Dramatic results have occurred due to the provision of treatment services specifically designed for women. In FY 2007, 7,263 women and children were treated in the CSTAR women and children programs. In FY 2007, 84 out of 89 babies born to women in CSTAR programs were born drug-free. In addition, 91 children were returned to their mother's custody from the Children's Division because their mothers had regained their ability to manage healthy families and live productive lives. The emotional rewards and

cost savings from these program measures alone support the cost effectiveness of continuing specific substance abuse treatment for women and children. The State is moving towards a standardized, outcome-based system of monitoring consumer improvement on numerous domains. Implementation of evidence-based practices to treat this special needs population and quality improvement are on-going goals.

Attachment B: Programs for Women (contd.)

Title XIX, Part B, Subpart II, of the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2007 Block Grant and/or State funds?

3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2007 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Attachment B (Part 2)

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), type of care (refer to definitions in Section II.5), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

The capacity of Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs in all three levels are limited by the amount of General Revenue and Medicaid dollars available. However, the residential component at facilities is limited to 16 beds for the primary consumers and 10 beds for children. Housing can be made available for families that are homeless or alienated from their families of origin. All of the women's' facilities have access to supportive housing funds, and therefore can offer additional safe housing options.

Women and children served in FY 2007 at the women's programs are provided by level of care and agency:

Agency	collateral	non-collateral		
		short-term residential	intensive outpatient	non-intensive outpatient
Alternative Opportunities, Inc.	116	311	378	187
BASIC	64	0	256	56
Bridgeway Behavioral Health, Inc.	61	440	395	108
Comprehensive Mental Health Services	43	227	216	99
Family Counseling Center	27	468	345	107
Family Counseling Center of Missouri, Inc.	133	261	220	188
Family Self Help Center	133	261	233	99
Hannibal Council On Alcohol & Drug Abuse	59	268	117	43
New Beginnings Cstar	0	0	268	83
Queen Of Peace Center	183	416	503	259
ReDiscover	241	382	690	214

A list of all women and children's CSTAR programs in Missouri, including the sub-State Planning Area (SPA) and the Inventory of Substance Abuse Treatment Services (I-SATS) ID number, is as follows:

Black Alcohol/Drug Service Information Center (BASIC)
3026 Locust
St. Louis, MO 63103
Allocated funds FY 2007 $550,851
Number of beds: 0

SPA: Eastern Region
ISATS: MO903788

Bridgeway Behavioral Health, Inc.
1570 South Main Street
St. Charles, MO 63303
Allocated funds FY 2007 $907,990
SPA: Eastern Region
Number of beds: 36 for women and 10 for children
ISATS: MO100786

Family Counseling Center of Missouri, Inc.
McCambridge Center for Women
201 North Garth
Columbia, MO 65203
Allocated funds FY 2007 $765,443
SPA: Central Region
Number of beds: 16 for women and 5 for children
ISATS: MO902269

Family Counseling Center, Inc.
Cape Girardeau CSTAR
20 South Sprigg, Suite #2
Cape Girardeau, MO 63701
Allocated funds FY 2007 $784,508
SPA: Southeastern Region
Number of beds: 16 residential and 16 transitional
ISATS: MO101128

Family Self-Help Center
Lafayette House Serenity Program
PO Box 1765, 1809 Connor Avenue
Joplin, MO 64804
Allocated funds FY 2007 $648,813
SPA: Southwestern Region
Number of beds: 16 for women and 10 for children
ISATS: MO101029

Hannibal Council on Alcohol and Drug Abuse
146 Communications Drive
Hannibal, MO 63401
Allocated funds FY 2007 $681,692
SPA: Central Region
Number of beds: 16 for women and 10 for children
ISATS: MO750098

Alternative Opportunities
Carol Jones Recovery Center for Women
2411 West Catalpa Street
Springfield, MO 65801-1277
Allocated funds FY 2007 $664,383
SPA: Southwestern Region
Number of beds: 16 for women and 12 for children
ISATS: MO903879

New Beginnings Alt-Care
3901 N Union Blvd, Suite 101
St. Louis, MO 63115-1130
Allocated funds FY 2007 $900,101
SPA: Eastern Region
Number of beds: 0
ISATS: MO102092

Queen of Peace Center
325 North Newstead
St. Louis, MO 63108
Allocated funds FY 2007 $875,972
SPA: Eastern Region
Number of beds: 16 for women and 10 for children
ISATS: MO100591

Comprehensive Mental Health Services (CMHS)
5840 Swope Parkway
Kansas City, MO 64127
Allocated funds FY 2007 $820,581
SPA: Northwestern Region
Number of beds: 16 for women and 10 for children
NFR ID: MO301678

ReDiscover
(Two programs; Alt-Care women's Correctional and a Women and Children Program)
620 East 18th Street
Kansas City, MO 64108
Allocated funds FY 2007 Women and Children $800,876
Number of beds: 11 for women and 6 for children (age < 12)
Allocated funds FY 2007 Alt-Care Women's Correctional $900,101
Number of beds: 0
SPA: Northwestern Region
ISATS: MO101207

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY2007 Block Grant funds?

Treatment services for women in the State of Missouri have continued to expand due in part to the block grant funds. Missouri's Division of Alcohol and Drug Abuse (ADA) moved from providing treatment for women in gender integrated programs to developing programs designed specifically for women and their children. Twelve provider contracts with multiple treatment site locations have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children in Missouri. Two of the CSTAR programs were designed in collaboration with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. Dependent children were provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. In this manner, the mandate of Section 1922(c) in spending FY 2007 block grant funds for at least a 5% set aside has been exceeded.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

The specialized programs to meet the needs of pregnant women and women with dependent children are monitored on a regular basis. A site certification survey is conducted at all CSTAR treatment program every three years by a team of treatment certification specialists. The programs are reviewed for compliance with certification standards for CSTAR programs which reflect the accepted standard of care in substance abuse treatment. In addition, Area Treatment Coordinators perform annual Safety and Basic Assurances Reviews (SBARs) which include a review of compliance with Block Grant requirements. The Area Treatment Coordinators also provide technical assistance when necessary. Representatives from each women and children's program meet regularly to collaborate with ADA staff on developing issues and trends.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

The State uses data reported by the contract providers on a routine basis for monitoring the treatment capacity and utilization by women. The Department of Mental Health maintains a central data system that identifies, among other data, the services provided, the number of consumers, and consumer demographics (including pregnancy at admission). Requests for treatment by women have increased substantially over the past fifteen years. In 2000, a Placement of Expanded Treatment Services document was developed to assist ADA in placement of new CSTAR – Women and Children's programs as funds became available.

5. What did the State do with FY 2007 Block Grant funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

The State of Missouri has been a leader in providing quality substance abuse treatment services to women and their children. ADA has 12 contracts providing CSTAR

programs specifically for women at multiple locations. There are an increasing number of women served in state funded programs. The number of women and children treated in CSTAR Programs has increased from 2,548 in FY 1995 to 6,539 in FY 2007.

At the start of FY 2007, ADA expanded the service menu to include two new service codes related to treating trauma issues in the context of substance abuse issues. Trauma Individual Counseling and Trauma Group Education would be of immediate benefit to many of the women engaged in services at contracted substance abuse treatment providers, thereby enhancing the service array in existing programs. The service codes were made available on all ADA treatment contracts.

Also in FY2007, ADA implemented a protocol in coordination with the Division of Social Services (MO HealthNet) and the Women and Children CSTAR providers that focuses on facilitating substance abuse treatment referrals for pregnant women who are recipients of MO HealthNet Managed Care benefit. This protocol reinforced the prioritization of pregnant women into treatment.

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in certification standards. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires that each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.
(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.
1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.
2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.
3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.
(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.
(C) The screening—
1. Shall be conducted by trained staff;
2. Shall be responsive to the individual's request and needs; and
3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

The contracts for the Primary Recovery Plus (PR+) programs include specific language informing them that part of the program funding comes from the SAPT Block Grant and is therefore "subject to the federal rules and regulations associated with that grant." Opioid treatment providers were required to admit or refer individuals who abused intravenous drugs within the past thirty days or were in imminent danger of relapse. The Client Tracking Registration Admission and Commitment (CTRAC) information system, designed and maintained by the Missouri Department of Mental Health, had a registration screening/waiting option which could be used in lieu of program enrollment.

Once treatment became available, the consumer could then be transferred from the waiting list to a program admission. Since October 2006, the Division of Alcohol and Drug Abuse (ADA) has made available the waiting list monitoring option on the Customer Information Management, Outcomes and Reporting (CIMOR) system.

Provider contracts include provisions and requirements related to outreach activities. Additionally, ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim services, including linkage to other appropriate services and community resources, until treatment services at the appropriate intensity are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. ADA can also assist agencies in locating referral resources throughout the state. Compliance with block grant requirements has been consistently monitored through the certification survey process and annual Safety and Basic Assurance Reviews which includes the Block Grant Requirement Checklist.

FY 2009 (Progress)

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in certification standards. Standards require that each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed. Additionally, the contracts for the Primary Recovery Plus (PR+) programs include specific language informing them that part of the program funding comes from the SAPT Block Grant and is therefore "subject to the federal rules and regulations associated with that grant." To more specifically ensure the prompt evaluation and treatment of intravenous drug users (IVDUs), the Division developed new contract language at the end of FY 2009 that identifies IVDUs as a priority population. The language requires the immediate admission of individuals in this population.

Opioid treatment providers are required to admit or refer individuals who abuse intravenous drugs within the prior thirty days and are in imminent danger of relapse. The Customer Information Management, Outcomes and Reporting (CIMOR) system, designed and maintained by the Missouri Department of Mental Health, has a waiting list option which can be used in lieu of program enrollment. Once treatment becomes available, the consumer can then be transferred from the waiting list to a program admission. This allows ADA providers who choose to use this function to track priority population consumers who are waiting for treatment. Providers have been encouraged, but not required, to utilize the wait list function in CIMOR to assist with departmental monitoring of waiting lists for IVDUs. In FY 2009, 5,046 consumers identified as IVDUs were admitted to substance abuse treatment.

Provider contracts include provisions and requirements related to outreach activities. At the end of this fiscal year, ADA developed new language for contracts that clearly identifies IVDUs as a population to be targeted in outreach activities. This will be included in the FY 2010 contracts. Additionally, ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim services, including linkage to other appropriate services and community resources, until treatment services at the appropriate intensity are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. ADA can also assist agencies in locating referral resources throughout the state. Compliance with block grant requirements has been consistently monitored through the Certification Survey process and annual Safety and Basic Assurances Reviews which includes the Block Grant Requirement Checklist.

ADA continues to use certification surveys and annual Safety and Basic Assurances Reviews with the Block Grant Checklist to review provider compliance with priority treatment for IVDUs. Agencies found to be out of compliance are identified and are required to provide an action plan to achieve contract and standard compliance.

Technical assistance, consultation, and focused compliance reviews are applied to those treatment agencies serving IVDUs to ensure consistent compliance and the provision of high quality service to the high-risk IV drug abusing consumer.

FY 2010 (Intended Use)

The Division has developed a new contract amendment that more explicitly states requirements for serving priority populations. Intravenous drug users (IVDUs) are identified as a priority population for whom admission must be immediate. Given that requirement, the Division's expectations are more stringent than SAPT Block Grant requirements. Compliance with this new contractual requirement will be monitored during certification surveys that occur on a three-year cycle as well as during Safety and Basic Assurance Reviews (SBARs) that occur in the interim years. If there are significant issues related to compliance with the immediate admission requirement, the Division will, at a minimum, include in contracts the exact requirements for serving IVDUs as is outlined in the SAPT Block Grant.

Additionally, the Division has added language in contracts that specifically requires IVDUs to be included in agency outreach activities.

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))
For the fiscal year three years prior (FY 2007) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2007 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

Attachment C

1. Missouri defines intravenous (IV) drug abusers as those substance abusing persons whose primary, secondary or tertiary route of administration is by needle, whether intravenously, intramuscularly, or subcutaneous injection.

2. Throughout FY 2007, all providers operated at or near capacity. Agencies not at capacity were quickly filled with referrals from waiting lists from other treatment programs. Providers are contractually mandated to adhere to Block Grant requirements. While no official notification of reaching 90% capacity was formally sent to the Division of Alcohol and Drug Abuse (ADA), programs do communicate with staff at the Division's district offices via phone and/or email regarding their capacity when issues arise or when information or referral assistance is requested. At points during which capacity was reached, programs made referrals to other resources in the community, for example, to other contracted providers, private pay opioid, or detoxification programs. The Customer Information, Management, Outcomes and Reporting (CIMOR) information system for the Missouri Department of Mental Health (DMH) continues to have a registration option of screening/waiting which may be used. ADA has encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. This has proven to be an effective process. Compliance with these regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during certification surveys and Safety and Basic Assurance Reviews (SBARs). Agency admissions of priority populations, including IV drug users, and management of waiting lists are discussed and monitored during certification and SBAR visits, as well as, during technical assistance visits that might be conducted throughout the year. Regional staff conducting these reviews are knowledgeable about contract requirements and how to apply them to substance abuse treatment programs. Programs demonstrate compliance with capacity requirements by either conducting a brief screening by telephone or in person with the consumer. At that time, an assessment/admission date for individuals requesting service is scheduled or an appropriate referral for alternative or interim services is provided to the consumer.

   The agencies that provided treatment services to IVDUs in FY 2007 are listed as follows:

Organization Name	ISATS
Assessment & Counseling Solutions	MO100687
BASIC	MO903788
Bridgeway Behavioral Health, Inc.	MO100786
Burrell Behavioral Health Care Center	MO902004
Center For Life Solutions, Inc.	MO100761
Clark Community Mental Health Center	MO101631
Community Mental Health Consultants	MO100930
Community Services Of Missouri, Inc.	MO102035
Community Treatment, Inc.	MO901592
Comprehensive Mental Health Services	MO100518
Cox Health Systems, Inc.	MO903515
Family Counseling Center	MO903598
Family Counseling Center of Missouri, Inc.	MO750056
Family Guidance Center	MO101532
Family Self Help Center	MO101029
Gibson Recovery Center, Inc.	MO903911
Hannibal Council On Alcohol & Drug Abuse	MO750098
Kansas City Community Center	MO301785
Liberty Programs Inc., The	MO101490
Meramec Recovery Center, Inc.	MO102027
Midwest ADP, Inc.	MO102068
Missouri Alcohol Assessment Consultants	MO101987
New Beginnings Cstar	MO102928
Paseo Clinic	MO100667
Pathways Community Behavioral Healthcare, Inc.	MO901527
Phoenix Programs, Inc.	MO102159
Preferred Family Healthcare, Inc.	MO101797
Queen Of Peace Center	MO100591
RDC Group, Inc. dba Correction Services	MO101482
ReDiscover	MO100864
Salvation Army - Harbor Light Center	MO101033
Samuel U Rodgers Health Center	MO100716
Scott Greening Center For Youth Dependency	MO100922
Sigma House of Springfield	MO750593
Southeast Missouri Community Treatment Center	MO903259
St. Patrick Center	MO103967
Swope Health Services	MO106598
Tri-County Mental Health Services	MO105152
Westend Clinic	MO105087

In FY 2009, contract language was added to make IV drug users a priority I population for all treatment programs. As a priority I population, IV drug users who have injected drugs in the prior 30 days require immediate admission to detoxification or residential support unless clinically contraindicated. IV drug users may be referred for immediate admission to an Opioid treatment program if safe and clinically appropriate. Contracts were further modified to indicate:

a. For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.
b. In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.

In FY 2010, ADA will be requesting technical assistance from the Center for Substance Abuse Treatment (CSAT) on the issue of capacity management.

3. Opioid treatment providers were required to admit persons, within the Block Grant required time frames, who have used IV drugs within the prior 30 days, are pregnant, have HIV, or who were in imminent danger of relapse. If at capacity, programs were to make referrals to other resources in the community, for example, to private pay Opioid programs or detoxification programs. The information system designed and maintained by DMH has waiting list functionality. ADA has encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. This has proven to be an effective process. Compliance with Block Grant regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during certification surveys and Safety and Basic Assurances Reviews.

   In FY 2009, contract language was added to make IV drug users a priority I population for all treatment programs. As a priority I population, IV drug users who have injected drugs in the prior 30 days require immediate admission to detoxification or residential support unless clinically contraindicated. IV drug users may be referred for immediate admission to an Opioid treatment program if safe and clinically appropriate. Contracts were further modified to indicate:

   a. For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.
   b. In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.

In FY 2009, a new data field was added to the CIMOR information system to capture *Date of First Contact.* The Division is developing monitoring reports to identify any consumers that indicated IV drug use and were not admitted within the required timeframe.

In FY 2010, ADA will be requesting technical assistance from the Center for Substance Abuse Treatment (CSAT) on the issue of capacity management.

4. ADA has encouraged certified substance abuse treatment providers to conduct outreach services to consumers needing treatment to address intravenous (IV) drug use. Outreach requirements were specified in provider contracts. As outreach services are billable, documentation is required to reflect the description of the outreach activity. Contract language specifies:

    a. The contractor may provide clinical outreach services for certain persons including individuals using intravenous drugs.
    b. Clinical Outreach activities may include assessment, consultation, coordination, and referral.
    c. Clinical outreach services shall be provided on a face-to-face basis.
    d. The contractor shall maintain a log for clinical outreach service provided that includes, at a minimum, the following information:
        i. Date of service
        ii. Actual time
        iii. Name of consumer/person
        iv. Referral source
        v. Name and title of staff providing the services
        vi. Description of the outreach activity; and
        vii. Outcome or disposition.
    e. Contractor staff providing this service shall be qualified substance abuse professionals or community support workers, as defined in certification standards.

    Contract compliance is one of the areas monitored by regional staff during Safety and Basic Assurance Reviews (SBARs). Providers are encouraged during certification surveys to engage consumers' families in treatment and to address family IV drug use. During both the FY 2007 and FY 2008 DMH Spring Training Institutes, training sessions provided information relevant to IV drug use treatment protocols. ADA collaborates with treatment providers and the Missouri Department of Health and Senior Services (DHSS) to present blood-borne disease prevention information to consumers and to utilize appropriate HIV and Hepatitis screening tools during consumer admission to treatment. Additionally, ADA collaborates with treatment providers, DHSS and the Missouri Department of Corrections to educate consumers about treatment options for intravenous drug abuse. Individual providers offer presentations specific to IV drug use to local probation, parole, drug, and mental health courts personnel.

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2008) to the fiscal year for which the State is applying for funds:

In **up to three pages** provide the following:

• A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
• A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. 300x-23(a)
(See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. 300x-27(b)
(See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

Attachment D

1. Notification of Reaching Capacity

All contracted substance abuse treatment agencies in Missouri's publicly-funded system of care continue to remain at or near capacity. Regional monitoring procedures are in place to assist consumers in accessing treatment as quickly as possible. ADA has a toll-free number advertised to consumers for providing treatment referrals. Regional staff receive the calls and make referrals to treatment programs in the consumer's area. Agency activity levels are monitored at the regional level through the Regional District Administrators and Area Treatment Coordinators (ATCs). Regional District Administrators and ATCs meet with providers on an as-needed basis to discuss issues pertaining to access, capacity, referral processes, and other treatment issues. As noted, ATCs and District Administrators regularly take calls from consumers attempting to access care at local providers. As consumers are assisted with obtaining a referral, regional ADA staff obtain real-time feedback about capacity and access issues at the providers in their regions. ATCs also conduct yearly Safety and Basic Assurance Reviews at each provider in their respective regions. Every three years, the ADA Certification team conducts comprehensive surveys. Compliance with certification standards is assessed. While always an issue of importance, the Division of ADA is beginning to focus very specifically on how agencies provide a continuum of care to consumers. This includes how the agency provides for all levels of care needed and/or how the agency works with other agencies to provide a full range of services at varying intensities.

Agencies within close proximity of each other have also developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. In addition, ADA assists agencies in locating treatment services throughout the state. Again, assessing a provider's capacity to provide or arrange for a full continuum of care will assist in monitoring for access and capacity issues.

Prior to October 2006, the Client Tracking Registration Admission and Commitment (CTRAC) information system, designed and maintained by the Missouri Department of Mental Health (DMH), provided screening/waiting functionality. In October 2006, DMH implemented a new information system, Customer Information Management, Outcomes, and Reporting (CIMOR), which offers treatment providers a management tool for waiting lists. CIMOR is accessible to all the organizations that have contracts with the Division of Alcohol and Drug Abuse (ADA). ADA encourages each provider to maintain contact with those consumers on their waiting lists by providing interim treatment services until services at the appropriate level of care are available and/or providing referrals for adjunct or supportive services.

No problems were identified and thus, no corrective action was taken.

In FY 2010, ADA will be requesting technical assistance from the Center for Substance Abuse Treatment (CSAT) on the issue of capacity management.

2. Tuberculosis Services

ADA collaborates with the Missouri Department of Health and Senior Services (DHSS) to access current information and training information related to the prevention and treatment of tuberculosis in high risk groups. ADA requires contracted treatment providers to maintain referral relationships with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. The services provided include educational information about tuberculosis, related health risks and risks of transmission. Also, tuberculosis testing services are provided to determine whether the individual has been infected with mycobacterial tuberculosis. Those testing positive receive referral for appropriate medical evaluation and treatment.

All contacted substance abuse treatment facilities are required by contract to provide access to tuberculosis testing. Some facilities provide testing on site while others refer consumers to the county health department. The treatment facilities are required to maintain collaborative relationships with their county health departments. Consumers may have access to testing and health care services at any time during their treatment. Agencies may not deny access to treatment based on a positive tuberculosis test result providing the individual does not have active disease. Treatment providers are required by contract to make appropriate referrals for persons seeking services who are not admitted to their program. Treatment providers may request assistance from county health department staff to observe their consumers taking preventive medicine when a positive tuberculosis skin test is identified.

The Area Treatment Coordinator or a treatment specialist from ADA is available to assist if an agency has difficulty finding services or has concerns about referring someone with positive tuberculosis test results. ADA staff may assess the needs of the consumer, advise agency staff of procedures and protocols or, if necessary, seek assistance from the DHSS, Bureau of Tuberculosis Control, in determining appropriate services and available medical resources.

Training and education opportunities are available to provider staff through DMH and DHSS. The Division's treatment specialists, District Administrators, and Area Treatment Coordinators continue to work with treatment providers and county health departments to maintain and improve tuberculosis services. Through site certification surveys, Safety and Basic Assurances Reviews, and technical assistance visits, ADA monitors tuberculosis services including screening, referral, testing procedure, counseling, and consumer confidentiality. Certification surveys are conducted every three years. Safety and Basic Assurance Reviews are conducted during the years in which certification is not performed. Technical assistance visits are provided as needed. Providers' billings of pre- and post-test counseling services can be determined through CIMOR and associated reporting programs.

The infection control recommendations and protocols for substance abuse treatment providers include, but are not limited to, the following procedures:

- screening of patients,
- identifying those individuals who are at high risk of becoming infected, and
- complying with all state reporting requirements while adhering to federal and state confidentiality requirements.

No problems were identified and thus, no corrective action was taken.

3. Treatment Services for Pregnant Women

It has been a long-standing Division of Alcohol and Drug Abuse (ADA) policy that service providers must give priority to pregnant women seeking admission to treatment. Certification standards mandate this for programs specializing in women's treatment. ADA maintains the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. Missouri continues to offer these services to women and children suffering from the effects of substance abuse. CSTAR programs allow women and their children to receive multiple levels of care depending on assessed need. These programs are available in each region of the state. ADA has maintained certification standards which establish substance abusing pregnant or postpartum women or women with custody of children as a first priority population. CSTAR certification standards (9 CSR 30-3.190 Specialized Program for Women and Children) state that "[p]riority shall be given to women who are pregnant or postpartum" and, "[t]he program shall engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria." During FY 2008, 572 pregnant women entered treatment upon request and received prenatal care and referrals in accordance with the requirements in the CSTAR Certification Standards and contract requirements. In FY 2009 through 6/22/2009, 582 pregnant women were admitted to substance abuse treatment services.

Nursing services are available at the program site and a community support worker assists the consumer with necessary medical referrals and scheduling of appointments. At all CSTAR programs specializing in treatment of women and children, childcare is provided on-site or the program makes arrangements for childcare.

Contract monitoring occurs annually through Safety and Basic Assurances Reviews at the program site. This review includes the Area Treatment Coordinator reviewing the program's practices and Block Grant Requirement Checklist to ensure compliance. Certification surveys occur on a three-year cycle and include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care, and children are receiving safe and appropriate childcare. Monitoring schedules are current, and programs are in compliance.

As no problems were noted, no corrective actions were taken. However, to ensure all treatment programs understand the prioritization of pregnant women, new contracts in

FY 2010 clearly identify pregnant women as a treatment population for whom admission must be immediate. To further specify block grant requirements for those programs specializing in the treatment of women, a contract amendment will be issued that outlines the services that must be provided or arranged for pregnant women and women with dependent children.

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007(Compliance)

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Missouri Department of Health and Senior Services (DHSS) to access current information, trends, and training related to the prevention and treatment of tuberculosis in high risk groups. The DHSS serves as a repository for statistical data and as an information and training resource related to tuberculosis (TB) issues. There is a Memorandum of Understanding between ADA and DHSS with the purpose of combining "skills, experience, and expertise for the development of a collaborative educational effort designed to benefit the general public and those at high risk for health and mental health conditions." This collaborative effort is to provide for an integrated systems framework by which both entities will educate, through technical assistance, local providers contracted with ADA to provide substance abuse counseling services, in order to better serve the consumers. ADA has a representative attend Community Planning Group meetings that address a variety of issues related to communicable diseases. The ADA representative disseminates information to providers as it relates to TB services, information, and issues.

ADA requires contracted treatment providers to make TB skin testing available to all consumers in their programs. Health screening is a best practice utilized upon admission and thereafter during treatment, as needed, to identify those consumers who might be considered at risk for transmitting *M. tuberculosis* or who might be infected. Consumers may request TB testing and/or counseling. Treatment providers are also required to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. This requirement was and is formalized, along with requirements for other communicable diseases, in contract language as follows:

4.5 **Communicable Diseases Risk Assessment, Education, Testing and Counseling**

4.5.1 The contractor shall 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 Human Immunodeficiency Virus (HIV), tuberculosis (TB), sexually transmitted diseases (STDs), and Hepatitis.

a. The contractor shall arrange for HIV, TB, STDs and Hepatitis testing to be available to the consumer at any time during the course of the consumer's treatment.

1. The contractor shall make referrals and cooperate with appropriate entities to ensure coordinated treatment, as appropriate, is provided for any consumers with positive tests.

4.5.2 The contractor shall provide or arrange individual counseling for consumers prior to testing for HIV.

a. In the event the contractor elects to provide HIV pre-test counseling, counseling shall be provided in accordance with the State of Missouri Department of Health and Senior Services (DHSS) Rule (19 CSR 20-26.030), as mandated by state law. These requirements may be downloaded from the following site:

http://www.sos.mo.gov/adrules/csr/current/19csr/19c20-26.pdf

b. Contractor staff providing HIV pre-test counseling must be trained in accordance with DHSS requirements. The contractor shall be responsible for all costs associated with receiving any such training.

4.5.3 The contractor shall provide or arrange individual post-test counseling for consumers who test positive for HIV or TB.

a. Contractor staff providing post-test counseling must be knowledgeable about additional services and care coordination available through the DHSS.

4.5.4 The contractor shall arrange and coordinate, as necessary, post-test follow-up for consumers who test positive for STDs or Hepatitis.

4.5.5 The contractor shall provide group education with substance abusers and/or significant others of abusers to discuss risk reduction and the myths and facts about HIV/TB/STD/Hepatitis and the risk factors for contracting these disease.

Compliance with TB and other communicable disease-related requirements was and is assessed as part of annual Safety and Basic Assurance Reviews (SBARs), at certification surveys, and at accreditation surveys for Missouri's Opioid treatment programs. This requirement is specifically included on the tool used to conduct SBARs. The SBAR process involves interviewing provider staff about these requirements and discussing established community linkages. As screening for communicable diseases is a requirement of intake assessments, information about one's risk status can be found in chart reviews during both SBARs and certification visits. Chart reviews focus on how a consumer has been provided, or has had access arranged for, a full continuum of care, including medical and health-related services.

FY 2009 (Progress)

Contracted treatment providers are required to make tuberculosis (TB) skin testing available to all consumers in their programs. Consumers are assessed through the screening and/or assessment process to identify specific health concerns; such as outcomes of previous TB testing, exposure to TB, or if the consumer is asymptomatic because of latent tuberculosis infection (LTBI). Consumers who are considered to be at high risk (HIV infected or IV users) or have other risks identified above are offered testing. Consumers may also request testing. All substance abuse treatment programs provide TB and HIV services to consumers entering treatment by arranging with a nearby health clinic to provide consumers with TB testing and counseling. Testing and other services are provided by the local health clinic with a referral from the substance abuse treatment program. Providers are required by contract to maintain effective linkages with local health departments to assist treatment program staff with consumer testing and monitoring efforts. TB post-test counseling funding is available as part of the Access to Recovery grant.

Compliance with TB and other communicable disease-related requirements was and is assessed as part of annual Safety and Basic Assurance Reviews (SBARs), at certification surveys, and at accreditation surveys for Missouri's Opioid treatment programs. This requirement is specifically included on the tool used to conduct SBARs. The SBAR process involves interviewing provider staff about these requirements and discussing established community linkages. As screening for communicable diseases is a requirement of intake assessments, information about one's risk status can be found in chart reviews during both SBARs and certification visits. Chart reviews focus on how a consumer has been provided, or has had access arranged for, a full continuum of care, including medical and health-related services. ADA provides a linkage between providers and the Missouri Department of Health and Senior Services (DHSS) when referrals and training opportunities are needed, particularly in rural settings. The ADA representative has met with DHSS' TB Coordinator to discuss implementing TB protocols for substance abuse providers.

The Missouri DHSS, as part of a Memorandum of Understanding with the Division of Alcohol and Drug Abuse (ADA), offers technical assistance and direct intervention at the community level to contracted providers to procure TB testing supplies. ADA participation in Community Planning meetings continue. The DHSS continues to provide follow-up diagnostic services for consumers who do not have health care resources. The DHSS has demonstrated their commitment to the provision of consistent TB services at the community level. This state department serves as a repository for statistical data and as an information and training resource related to tuberculosis issues.

FY 2010 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to make tuberculosis (TB) risk assessment, testing, and risk reduction education available to all treatment consumers. All substance abuse treatment programs will continue to conduct general health screens upon admission to identify high risks consumers and to offer TB and HIV services to consumers entering treatment by arranging with a nearby health clinic to provide consumers with TB testing and counseling. Testing and services for TB may be arranged upon request from the consumer. Testing and other services will be provided by the local health clinic with a referral from the substance abuse treatment program. The provision of tuberculosis-specific services will continue to be monitored with annual Safety and Basic Assurances Reviews and certification site surveys. ADA will continue to require contracted treatment providers to maintain effective linkages with their community health departments to ensure that consumers will have access to and can participate in tuberculosis services. This requirement is established in contracts. Contracted providers will continue to receive ADA support, technical assistance, and direct intervention at the community level to access TB services. ADA will continue to offer technical assistance to encourage a successful partnership between ADA contracted providers and Department of Health and Senior Services (DHSS) community health departments. The DHSS will continue to serve as a repository for statistical data and as an information and training resource related to tuberculosis issues.

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).
FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

Missouri is not a designated state.

FY 2009 (Progress)

Missouri is not a designated state.

FY 2010 (Intended Use)

Missouri is not a designated state.

Attachment E: TB and Early Intervention Svcs for HIV

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV (See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2007) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2007 Uniform Application, Section III.4, FY 2007 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

Examples of **procedures** include, but are not limited to:

• development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
• the role of the Single State Agency (SSA) for substance abuse prevention and treatment; and
• the role of the Single State Agency for public health and communicable diseases.

Examples of **activities** include, but are not limited to:
• the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
• the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
• the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
• technical assistance.

Attachment E

Note: Missouri is not an HIV designated state.

The Division of Alcohol and Drug Abuse (ADA) has provided tuberculosis (TB) and human immunodeficiency virus (HIV) services in the four publicly-funded methadone programs and other selected treatment programs since 1989. Linkages between early intervention services for HIV and the Intravenous Drug Users (IVDU) Outreach Programs included methadone service providers as well as other identified efforts, particularly in St. Louis and Kansas City.

Since July 1, 1993, all substance abuse treatment programs have provided TB and HIV services to consumers entering treatment by arranging with a nearby health clinic to provide consumers with TB testing and counseling. Testing and other services are provided by the local health clinic with a referral from the substance abuse treatment program. In FY 2009 $39,298 of total state funds and $9,592 of federal funds were spent on TB services for clients who were in substance abuse treatment – for total TB expenditures of $48,890.

During FY 2009 $489 was spent on TB tests by Department of Health and Senior Services (DHSS). All consumers, whether admitted or not, are offered the service. Follow-up counseling and ongoing services are then provided collaboratively between the substance abuse provider and the health clinic. An ADA Treatment Specialist coordinates the HIV and TB services with the DHSS, local county health departments, and substance abuse programs to ensure services are available to all consumers.

In FY 2009 these services and local linkages between substance abuse programs and local clinics were evenly distributed statewide and involved all contracted program sites. All consumers received a HIV/STD/TB/Hepatitis Risk Assessment at admission to treatment and appropriate referrals were made. Pre-and post-test counseling, testing, and HIV education were available to consumers in substance abuse treatment. A total of $31,628 was spent on TB pre-and post-test counseling.

A Treatment Specialist from ADA maintained regular contact with contracted agencies and coordinated technical assistance education. A qualified contracted provider conducted regional trainings for treatment providers regarding HIV Prevention and Pre/Post Test Counseling. Additional services were provided by the Department of Mental Health in the form of technical assistance and consultation. ADA adhered to the protocols established by the Centers for Disease Control and Prevention (CDC) and DHSS.

All offenders receiving substance abuse treatment within the Missouri Department of Corrections (DOC) receive TB testing with a two-step test at intake. This is performed and read by licensed nurses. Patient education is also provided. Testing is performed annually in the birth month or if a consumer is symptomatic or is exposed to an active case. Those who are symptomatic or have positive tests/x-rays/sputum are isolated in

respiratory isolation. They remain there until TB is ruled out or until treatment is proven successful by negative sputum tests. Those with a positive test, indicating exposure, but without active disease, are given prophylactic treatment directly observed by nursing staff. Those with active disease are given medication and housed in respiratory isolation until no longer contagious. Those exposed to active cases are tested. All positive tests are reported to DHSS. If an active case is identified DOC works with the DHSS to develop an action plan. A total of $7,181 was spent by DOC on the above TB services.

The responsibility for public health and communicable diseases is a secondary role for the Division, but requires close coordination of policy and program priorities between DHSS and ADA. ADA has a current Memorandum of Understanding (MOU) with DHSS which identifies the on-going partnership related to the prevention of communicable disease. This MOU identifies that ADA will continue to collaborate with DHSS to strengthen community access to, and utilization of, HIV prevention and care services, sexually transmitted diseases (STD), Hepatitis, and TB educational, screening, and treatment services. Continued technical assistance and regional cross-training are available for delivery to all regions in the state as identified in the current MOU between DHSS and ADA.

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2007 (Compliance): (Reporting REQUIRED if State chose to participate)
FY 2009 (Progress): (Reporting REQUIRED if State chose to participate)
FY 2010 (Intended Use): (State participation is OPTIONAL)

FY 2007 (Compliance)

Since 2002, the state of Missouri contracts with Oxford House, Inc. to manage the Revolving Loan Fund to provide start-up costs for safe, stable housing for individuals in recovery. To be accepted in an Oxford House, the individual in recovery completes and submits an application to a House. Members of the House review the applications, interview applicants, and determine through a democratic vote who to accept into the House. House members must maintain sobriety. A return to substance use results in automatic expulsion. Individuals accepted into an Oxford House must attend self-help groups such as AA during the first 30 days of acceptance and are encouraged to attend on a regular basis thereafter. In addition, individuals accepted into an Oxford House must obtain employment within 30 days of acceptance if not already employed or on disability. If the individual is on disability, the individual must also be attending school or engaging in at least 20 hours of community service per week.

Each house elects officers that generally include a president, treasurer, secretary, comptroller, and coordinator. The treasurer and comptroller are responsible for the House's money management. Regular House meetings are held to discuss the House's financial status as well as other issues impacting the House and its members. Each House member is responsible for paying an equal share of the household expenses as well as contributing to the household chores. Household expenses include rent for the House and utilities. The lease for the House is established between the landlord and the House members. The Division of Alcohol and Drug Abuse (ADA) housing specialists work to educate landlords on the Oxford House program and to find landlords willing to rent their property as an Oxford House.

The Oxford Houses form chapters. The state's 55 Oxford Houses in operation in FY 2007 were represented by 8 chapters. The chapters engage in public relations activities to inform individuals and groups about the Oxford House program. This includes monthly presentations at substance abuse treatment centers to individuals who may be in need of stable housing once treatment has been completed. The chapters also meet to discuss issues faced by member Houses. ADA housing specialists provide consultation to chapters and individual houses on various issues including, but not limited to, financial management and relationship issues – making referrals as needed. In addition, ADA housing specialists work with Houses to attract new members to fill vacancies. It is not uncommon, however, for Houses to have waiting lists. ADA housing specialists receive and monitor regular loan payment reports from Oxford House, Inc. Technical assistance from the ADA Drug Free Group Home Specialist is provided to Houses falling behind in their financial commitments.

In FY 2007, Missouri had 55 Oxford Houses located in 15 cities. The 42 houses for men provided 353 beds. The 12 houses for women provided 90 beds. The one house for veterans provided 8 beds. No new houses were opened in FY 2007 but ten refinancing loans were made to existing houses. Most of the state's Oxford Houses are located in cities of sufficient size to support the needed membership. This included the Kansas City area in the Western part of the state, the St Louis area in the Eastern part

of the state, Columbia in the Central part of the state, and Springfield in the Southwestern part of the state. Some Houses were also located in smaller towns including Joplin, West Plains, Cape Girardeau, and St Joseph. In FY 2007, stable and affordable housing remained a significant need for many Missourians entering recovery.

FY 2009 (Progress)

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA), continues to support the Oxford House program within the state of Missouri. The Oxford House program offers a supportive way of living for individuals in recovery to learn and implement skills needed for long-term recovery in a clean, sober and safe environment. All Oxford Houses have three characteristics in common:

- Houses are democratically self-run;
- House membership is responsible for all household expenses; and
- Houses must immediately expel any member using alcohol or drugs.

Missouri has 61 Oxford Houses – 45 for men with a total of 397 beds, 14 for women with a total of 105 beds, and 1 house for veterans with a total of 15 beds. Houses have been established in every region of the state but with the greatest representation in the more heavily populated areas of Kansas City and St Louis.

At the start of FY 2009, there was $34,000 in the revolving loan account. Seven new loans totaling $28,000 and 4 stabilization loans totaling $8,000 have been given over the course of the fiscal year. As the loans are paid back, more loans are taken out to open new houses. As of September 2009, the revolving loan account was $26,202. This amount is lower than the $100,000 originally used to start the fund as loans had been written off in the past. In FY 2010, ADA will contact Oxford House, Inc. and develop a plan to increase the balance of the fund account.

Starting this year, payments from the houses to Oxford House, Inc. are electronically transferred and are no longer mailed. This action has helped reduce the frequency of late payments.

State budget cuts have reduced housing specialist positions and expense and expenditure funds for all travel. The Division currently has one housing specialist to provide technical assistance to the Oxford House program. This housing specialist provides

- consultation to Oxford House chapters on fundraising activities to replenish the revolving loan fund so that new Houses can be established,
- referrals for individuals seeking housing,
- guidance to House membership on financial management and inter-personal conflict resolution, and
- education on the Oxford House program for concerned parties.

Through careful selection of prospective house locations, the stabilization of the Oxford House program has been maintained.

FY 2010 (Intended Use)

The housing needs of individuals in recovery will continue to be a high priority in the future. The State of Missouri will continue to support the group home program to assure adequate housing for individuals completing substance abuse treatment and seeking safe and affordable housing. Oxford Houses are located in every region of the state. The Oxford House program seeks to establish and maintain housing for individuals in recovery. These Houses are democratically self-run. House members are responsible for household expenses including rent and utilities. In addition, House members must remain substance-use free if to remain in the Oxford House program.

State budget cuts have limited the number of housing specialists that can provide technical assistance to the Oxford House program. Due to limited resources restricting travel, most of this technical assistance will be provided off-site via telephone and e-mail communication. One housing specialist from the Division of Alcohol and Drug Abuse will act as a consultant to the program. This housing specialist will continue to assist in opening new houses and providing technical assistance to the existing 61 Houses and 8 chapters located throughout the state. In total, these Houses provide 397 beds for men, 105 beds for women, and 15 beds for veterans. In FY 2010, ADA will contact Oxford House, Inc. and develop a plan to increase the balance of the fund account.

Attachment F: Group Home Entities and Programs

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25)

If the State has chosen in FY 2007 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund, then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2007 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:
• the number and amount of loans made available during the applicable fiscal years;

• the amount available in the fund throughout the fiscal year ;
• the source of funds used to establish and maintain the revolving fund ;
• the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered ;
• the private, nonprofit entity selected to manage the fund ;
• any written agreement that may exist between the State and the managing entity ;
• how the State monitors fund and loan operations ; and
• any changes from previous years' operations.

Attachment F

The Anti-Drug Abuse Act of 1988 (Pub. I. 100-690, approved November 18, 1988) amended Subpart I of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x) by adding a new section 1916A establishing a program entitled Group Homes for Recovering Substance Abusers.

Under the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Missouri Department of Mental Health (DMH) established the Group Home Revolving Loan fund by contract with the Missouri Housing Development Commission (MHDC) effective August 11, 1989. In 2002, the DMH contracted with Oxford House, Inc. to manage the Revolving Loan Fund. States were required to establish the revolving fund in the amount of $100,000. States must establish, directly or through the provision of a grant or contract to a non-profit entity, a revolving loan fund.

By law, individual loans for the establishment of programs to provide housing may not exceed $4,000 each. The loans are to be repaid within a 2 year period. These funds are to be used to provide start-up loans to groups of recovering individuals.

As stipulated in accordance with the specifications in the Block Grant legislation, the loans have specific requirements. An application must be submitted to the DMH and signed by at least six recovering individuals who have completed alcohol and/or drug treatment. They must want to start a self-run, self-supported alcohol and drug free house. After reviewing the application, the DMH forwards the application to Oxford House World Services where a review is completed; a check is then forwarded to the applicant (borrower). Loan checks are not made payable to individuals but in the name of the house which is designated by the name of the street or town where it is located. Loan repayment schedules are in 12, 18, or 24 month installments. No loan payments are due for the first 30 days after the original loan is issued. No interest is charged to the borrower on the principal on the loan. Repayments are made to Oxford House World Services where they are deposited into the revolving loan fund. Late payments from the borrower are assessed a 20% or $25 penalty if not received as scheduled.

There were three (3) loans issued in FY 2007 totaling $8,080. The amount of funds available as of July 1, 2007 was $27,312. A monthly report is forwarded by Oxford House World Services giving details for each loan and payment schedule. Every house that has a loan receives a payment book and is contacted if scheduled payments are late or have not been received. There have been instances of late payments or loan defaults during the past year due to vacancies, unexpected increases in utility bills, house closings, or changes in the house such as switching from a women to men's houses. In FY 2007, 33 loans were outstanding totaling $68,606. Nine loans were in default totaling $23,303. When payment issues arise, a letter is sent to the house reminding them of their payment obligations. In cases where a house closes, the loan is reassigned to the Oxford House Chapter or another house until the loan is repaid.

On a monthly basis, the Oxford House Drug Free Group Home Specialist receives the loan report from Oxford House World Services detailing the activity of every house. Any house experiencing financial difficulty is contacted and counseled by the Drug Free Group Home Specialist who is employed by the Department of Mental Health, Division of Alcohol and Drug Abuse (ADA). Technical assistance is provided by the Drug Free Group Home Specialist and can be obtained through a toll-free phone number. Through publications, meetings, and workshops, ADA has made education of the Oxford House concept a priority for legislators, communities, and local government agencies throughout Missouri.

As of June 30, 2007, 109 loans have been committed in Missouri for drug-free group homes. These homes are located in 15 Missouri cities. More than $321,405 has been loaned to open Oxford Houses in Missouri since 1989. There are 55 houses in the state where 367 men and 106 women make their home.

Missouri was one of a few states that initially welcomed the Oxford House program when it was first offered. Since that time, Missouri has seen its share of successes and failures. Because it has been through the good and tough times, Missouri recognizes the value of continuing to provide safe and affordable housing programs for individuals after their completion of substance abuse treatment.

List of group homes:

Central Region			
Alhambra 107 E. Alhambra Columbia, MO 65203 M 573-443-0259	**Bicknell** 104 Bicknell Columbia, MO 65203 M 573-442-7084	**Calico** 2504 Calico St. Columbia, MO 65202 M 573-474-0035	**Cougar** 600 Rogers St. Columbia, MO 65203 M 573-442-2330
Countryside 2504 Quail Dr. Columbia, MO 6520 M 573-514-4797	**Elliott** 220 Elliott Ave. Columbia, MO 65201 W 573-256-8501	**Hubbell** 105 E. Hubbell Dr. Columbia, MO 65201 W 573-219-9597	**Leslie** 19 E. Leslie Columbia, MO 65202 M 573-256-5221
Nelwood 2501 Nelwood Dr. Columbia, MO 65202 M 573-814--0888	**Pinewood** 115 Pinewood Ave. Columbia, MO 65203 W 573-234-7220	**Pioneer** 3401 Pioneer Dr. Columbia, MO 65202 M 573-234-7986	**Proctor** 314 Proctor Dr. Columbia, MO 65202 M 573-874-9610
Quail 2614 Quail Dr. Columbia, MO 65202 M 573-814-3900	**Sondra** 921 Sondra Columbia, MO 65202 M 573-875-5721	**W. Broadway** 2402 W. Broadway Columbia, MO 65203 W 573-514-4310	**Willowbrook** 2501 Willowbrook Ct. Columbia, MO 65202 M 573-474-0741

Eastern Region

Allendale 3127 Meramec St. Louis, MO 63118 M 314-353-5823	**Chippewa** 6408 Chippewa St, Louis, MO 63109 V 314-353-2771	**Clayton** 6957 Clayton Rd. St. Louis, MO 63110 M 314-863-7669	**Fairview** 2171 Hwy. 61 Festus, MO 63028 M 636-937-2514
Gravois 3943 Gravois St. Louis, MO 63116 M 314-772-1303	**Humphrey** 3542 Humphrey St. Louis, MO 63118 M 314-762-9976 314-762-9794	**Jarman** 4506 S. Grand St. Louis, MO 63118 W 314-351-1567	**Kensington** 5058 Kensington St. Louis, MO 63108 M 314-367-7962
Lincoln-Midwest 1663 Lincoln Dr. St. Charles, MO 63303 M 636-493-1385	**Lynncove** 1751 Lynncove Lane St. Charles, MO 63303 M 636-724-4562	**Lusher** 11876 Lusher Rd. St. Louis, MO 63138 M 314-741-7536	**McCausland** 2017 McCausland St. Louis, MO 63143 M 314-644-0971
McDonough 527 McDonough St. Charles, MO 63301 M 636-947-6730	**Michigan** 7127 Michigan St. Louis, MO 63111 M 314-351-2712	**Monitor** 3633 Meramec St. Louis, MO 63116 W 314-752-1213	**Montana** 3655 Montana St. Louis, MO 63116 M 314-351-2064
Oak Lake 4004 Ashby Rd. St. Louis, MO 63047 W 314-432-5514	**Osage** 2715 Osage St. Louis, MO 63118 W 314-7726771	**Portis** 4430 Arsenal St. Louis, MO 63116 M 314-776-5825 314-776-7076	**S. Pacific** 540 S. Pacific Cape Girardeau, MO 63703 W 573-651-4646
Shenandoah 720 Shenandoah St. Louis, MO 63104 M 314-776-4883	**South Jefferson** 827 Jefferson Cape Girardeau, MO 63703 M 573-651-6066	**St. Charles** 225 N 5th Street St. Charles, MO 63301 M 636-493-1751	**Winfield** 60 Franke Dr. Winfield, MO 63389 M 636-566-6258

Western Region

Blue Hills 1832 E. 49th St. Kansas City, MO 64130 M 816-923-7696	**Chouteau** 4401 N Walrond Ave. Kansas City, MO 64117 M 816-453-9402	**Harrison** 26 E. Concord Kansas City, MO 64112 M 816-216-1883	**Hillcrest** 9615 Freemont Kansas City, MO 64134 M 816-761-3948
Holmes 2641 Holmes Kansas City, MO 64108 M 816-842-1634	**Karnes** 3734 Walnut Ave. Kansas City, MO 64111 W 816-232-4773	**Marlboro** 1410 W. 77th Terrace Kansas City, MO 64131 M 816-333-2267	**Raytown** 10905 E. 62nd Terrace Raytown, MO 64133 M 816-358-6495
Rockhill 5632 Charlotte Kansas City, MO 64110 M 816-833-0222			

Northwestern Region			
Felix 1419 Felix St. Joseph, MO 64501 M 417-232-4773	**Museum** 1210 Felix St. Joseph, MO 64501 W 816-689-3075	**St. Joseph** 507 S. 10th Street St. Joseph, MO 65401 M 816-232-8988	**Truman** 400 S. Hocker Independence, MO 64050 M 816-833-0222
Southwestern Region			
Catalina 1674 S. Catalina Springfield, MO 65804 M 417-887-7783	**Grant Street** 2555 N. Grant Ave. Springfield, MO 65803 M 417-863-0244	**Kerr** 953 W, Kerr Springfield, MO 65803 M 417-368-9199	**Moffett** 529 Moffet Joplin, MO 64801 M 417-623-4347
United 1558 W Cherokee Springfield, MO 65807 M 417-368-3686	**Wall** 1422 S. Wall Ave. Joplin, MO 64804 W 417-623-8984		
Technical Assistance Staff			
1-800-575-7480 ADA Toll Free Number			
Jacquie Lockett 5400 Arsenal MSA-419 St. Louis, MO 63139 (314) 877-0386 jacqueline.lockett@dmh.mo.gov	**Sherry Hill** 2600 East 12th Street Kansas City, MO 64127 (816) 482-5763 sherry.hill2@dmh.mo.gov		M = Men W = Women V=Veterans

Goal #8: Tobacco Products

GOAL # 8.

An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26, 45 C.F.R. 96.130 and 45 C.F.R. 96.122(d)).

- Is the State's FY 2010 Annual Synar Report included with the FY 2010 uniform application? (Yes/No)

- If No, please indicate when the State plans to submit the report: (mm/dd/2009)

Note: The statutory due date is December 31, 2009.

Missouri plans to submit the FFY 2010 Annual Synar Report with the FFY 2010 SAPT Block Grant application.

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) provides specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and children. ADA certification standards and provider contracts require that pregnant and postpartum women be given priority admission. Monitoring procedures were in place to assist pregnant women in accessing treatment as quickly as possible. Agency admission practices were monitored at the regional level through the District Administrators and Area Treatment Coordinators. The information system designed and maintained by DMH includes a registration option of screening/waiting in addition to the regular program admission function. ADA encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care were available. Agencies within close proximity of each other developed informal telephone communications to refer consumers to other programs when they were unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. In addition, ADA assisted agencies in locating treatment services throughout the state. ADA had a toll-free number advertised for consumers to call for referrals. Central office or regional staff received the calls and made referrals to treatment programs in the consumer's area. Compliance was monitored by certification surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

FY 2009 (Progress)

Pregnant women continue to receive admission priority as required by provider contacts and certification standards. Compliance continues to be monitored by certification surveys and annual Safety and Basic Assurances Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district office staff. The results of this monitoring activity demonstrate that pregnant women are being admitted to treatment and receiving services as required. At the end of FY 2009, the Division further outlined, in draft contract language, the clear expectations that pregnant women be immediately admitted to treatment when they present or are referred for services. This formalizes what has been a long-standing ADA policy. This language will be included in the FY 2010 contracts.

At the start of FY 2008 the Division of Alcohol and Drug Abuse (ADA) implemented a protocol to facilitate the referral of pregnant women in Medicaid Managed Care in need of substance abuse treatment to Women and Children's Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs. This protocol is formally known as the Substance Abuse Treatment Referral Protocol for Pregnant Women under MO HealthNet Managed Care. The protocol guides the collaboration and communication between the primary care providers, CSTAR providers, health plan case managers, and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services. The ADA Clinical Utilization Review Unit monitors referral to CSTAR treatment programs through the protocol and promotes communication between the primary care providers and health plan case managers. In FY 2009, reports were developed using data from the Customer Information Management, Outcomes and Reporting (CIMOR) system that allowed for the verification of reported admissions. These reports also enabled the Division to more proactively follow-up with providers who were not timely in their reporting of admissions per the protocol. There was more regular communication occurring between the Division and the Women and Children's CSTAR providers this fiscal year. Providers were more receptive to consultation and were provided education about the protocol expectations and benefits. One component of the protocol is the expectation that the CSTAR providers involve primary care providers and health plan case managers in the pregnant women's continuing care plans. This expectation was recently reinforced with the providers. Communication had been happening between providers and case managers primarily at the outset of an episode of care. There was less communication when the women neared level transfer or discharge. The Clinical Utilization Review Unit submits quarterly reports to the MO HealthNet Division. That division supports efforts to increase referrals made from the MO HealthNet managed care plans and assists in finding solutions for any protocol-related issues.

FY 2010 (Intended Use)

Pregnant women will continue to receive admission priority as required by provider contract and certification standards. New contract language will be incorporated at the start of FY 2010 that clearly relays the expectations for all contracted providers regarding the prioritization of pregnant women. Specifically, pregnant women are to be immediately admitted to substance abuse treatment services when they present or are referred for care. Compliance will continue to be monitored by certification surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

The Division of Alcohol and Drug Abuse (ADA) will continue its participation in and promotion of the Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. The protocol guides collaboration and communication between the primary care providers, CSTAR providers, health plan case managers, and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services. The ADA Clinical Utilization Review Unit will continue to monitor referrals to CSTAR treatment programs through the protocol and promote communication between the primary care providers and health plan case managers. The unit will continue to submit quarterly reports to the MO HealthNet Division on the progress of the protocol.

Attachment G: Capacity Management and Waiting List Systems

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2008) to the fiscal year for which the State is applying for funds:

In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:

• development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;

• the role of the Single State Agency (SSA) for substance abuse prevention and treatment;

• the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and

• the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

• how interim services are made available to individuals awaiting admission to treatment ;

• the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and

• technical assistance.

Attachment G

The Single State Agency for the State of Missouri addresses the requirements for developing capacity management and waiting list systems for intravenous drug users and pregnant women through several methods:

1. Certification Standards for Alcohol and Drug Abuse Programs

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in standards which guide providers of treatment services through the Certification Standards for ADA programs. These Certification Standards are codified as state regulations in the Code of State Regulations (CSR) and filed with the Missouri Secretary of State. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.

2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.

3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;

2. Shall be responsive to the individual's request and needs; and

3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

9 CSR 30-3.190 (1) (Specialized Program for Women and Children) requires that in programs that provide treatment solely to women and children, priority is given to women who are pregnant or postpartum.

9 CSR 10-7.010 (6) (Treatment Principles and Outcomes) requires *(A) Services and supports shall be provided in the most appropriate setting available, consistent with the individual's safety, protection from harm, and other designated utilization criteria and (7) Essential Treatment Principle—Array of Services.*

(A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.

2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.

3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.

4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.

5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

9 CSR 30-3.100 (14) (Services Delivery Process and Documentation) requires that the ADA conduct clinical review to "*promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definition."*

9 CSR 30-3.132 (5) (Opioid Treatment Program) requires *"the program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive."*

Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. Also, ADA assists agencies in locating referral resources throughout the state.

The certification standards are part of the ongoing operations of ADA. In addition, the statewide network of treatment providers offer an easy vehicle for communication across provider agencies on topics related to treatment capacity. No direct costs can

be attributed to complying with the capacity management and waiting list requirements of the block grant.

2. Information systems:

DMH implemented a new information system, Customer Information Management, Outcomes, and Reporting (CIMOR), at the beginning of October 2006, which offers all organizations the option of using a tool in this system to manage waiting lists. This is available for access to all the organizations that have contracts with ADA. Providers are encouraged by ADA to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care are available.

The CIMOR system is a component of the DMH's consumer information infrastructure. Costs for complying with block grant capacity management and waiting list requirements are part of the ongoing costs of this infrastructure and cannot be estimated.

3. Toll-free Telephone Number and ADA Website

ADA has a toll-free number advertised for consumers to call to obtain referral information. Either central office or regional staff receive the calls and offer referrals to treatment programs in the consumer's area. In addition, ADA maintains a website, which provides the public with information regarding substance use and links to treatment facilities.

A long standing policy of ADA has been to prioritize the admission and treatment of pregnant women and intravenous drug users (IVDUs). When members of these priority populations present for services, they are promptly screened, assessed, and engaged in the level and intensity of care that is commensurate with their clinical needs. While treatment services at any level and intensity can be immediately available to members of these populations, agencies offering the residential component do not always have beds available. In such situations, the ADA policy has required the agency to transition a clinically stable consumer who is not a member of a priority population from residential support to transitional or supportive housing or other appropriate housing plan, thereby ensuring room in the residence for the priority population consumer. Near the end of FY 2009, the Division developed formal contract language clearly identifying pregnant women and IVDUs as priority populations for whom admission must be immediate. The contract language will be in effect for FY 2010.

The prior policy had worked reasonably well in light of limited resources, but the contract language formalizes the Division's expectations. Compliance with this policy will be monitored by certification surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

ADA does not identify costs separately for capacity management and waiting list systems; these costs are included in our administrative costs.

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

The Addiction Severity Index (ASI) was the primary assessment tool used to determine level of care for consumers age eighteen years and older. The ASI is a structured clinical interview which is typically conducted in less than fifty minutes at the time of the consumer's admission. This assessment tool encompasses seven areas of life functioning: medical status; employment status; drug and alcohol use; family history; family and social relationships; legal status; and psychiatric status. For the first quarter of FY 2007, this assessment was accessible to contracted providers and the Division of Alcohol and Drug Abuse (ADA) via the web-based data collection interface "Outcomes Web." Data was transported over a Virtual Private Network for confidentiality. Starting in October 2006, the assessment was available on the Customer Information Management, Outcomes and Reporting (CIMOR) system.

Beginning FY 2007, adolescent Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs were required to utilize the Global Appraisal of Individual Needs (GAIN). The GAIN is an evidence-based full bio-psychosocial assessment that is valid in many different treatment settings. It integrates research and clinical assessment to complete diagnosis, placement, individualized treatment planning, program evaluation, and reporting requirements. The GAIN has eight core sections: Background, Substance Use, Physical Health, Risk Behaviors and Disease Prevention, Mental and Emotional Health, Environment and Living Situation, Legal and Vocational. The GAIN provides a comprehensive, standardized tool with which to ensure appropriate consumer placement and service referrals.

ADA staff reviewed assessment and utilization data on an agency-by-agency basis to identify major trends, problem areas, and successful outcomes. Providers utilized the computerized assessment tool to assure consumers were provided the most appropriate level of care. The tools used in the assessment process provided the ability to perform utilization review and outcome measurement.

Assessment results should help guide assignment to an appropriate level of care. In addition to Division guidelines on level assignment using assessment information, certification standards outline eligibility requirements for admission into each level of the continuum of care:

9 CSR 30-3.120 Detoxification
(3) Eligibility Criteria: In order to be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. A person qualifies for detoxification services on a residential basis if one or more of the following additional criteria are met:
(A) Demonstrates a current inability to minimally care for one self;
(B) Lacks a supportive, safe place to reside and demonstrates a likelihood of continued use of alcohol or other drugs;

(C) Requires ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal or the severity of current symptoms of intoxication, impairment or withdrawal; or

(D) Presents a likelihood of harm to self or others as a result of intoxication, impairment or withdrawal.

9 CSR 30-3.140 Residential Treatment

(2) Eligibility Criteria: In order to fully participate in and benefit from the intensive set of services offered in residential treatment, a person must meet the following admission and eligibility criteria:

(A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. A screening instrument, that includes vital signs, must be used with all prospective clients to identify symptoms of intoxication, impairment, or withdrawal and, when indicated, detoxification services must be provided or arranged;

(B) Needs an alternative, supervised living environment to ensure safety and protection from harm;

(C) Meets the general treatment eligibility requirement of a current diagnosis of substance abuse or dependence and, in addition, demonstrates one or more of the following:

1. Recent patterns of extensive or severe substance abuse;

2. Inability to establish a period of sobriety without continuous supervision and structure;

3. Presence of significant resistance or denial of an identified substance abuse problem; or

4. Limited recovery skills and/or support system; and

(D) A client may qualify for transfer from outpatient to residential treatment if the person:

1. Has been unable to establish a period of sobriety despite active participation in the most intensive set of services available on an outpatient basis; or

2. Presents imminent risk of serious consequences associated with substance abuse.

9 CSR 30-3.130 Outpatient Treatment

(4) Community-Based Primary Treatment: This level of care is the most structured, intensive, and short-term service delivery option. Structured services shall be offered at least five (5) days per week and should approximate the service intensity of residential treatment.

(A) Eligibility for primary treatment shall be based on:

1. Evidence that the person cannot achieve abstinence without close monitoring and structured support; and

2. Need for frequent, almost daily services and supervision.

(5) Intensive Outpatient Rehabilitation: This level of care offers an intermediate intensity and duration of treatment. Services should be offered on multiple occasions during each week.

(A) Eligibility for intensive outpatient rehabilitation shall be based on:

1. Ability to limit substance use and remain abstinent without close monitoring and structured support;

2. Absence of crisis that cannot be resolved by community support services;

3. Evidence of willingness to participate in the program, keep appointments, participate in self-help, etc.; and

4. Willingness, as clinically appropriate, to involve significant others in the treatment process, such as family, employer, probation officer, etc.

(6) Supported Recovery: This level of care offers treatment on a regularly scheduled basis, while allowing for a temporary increase in services to address a crisis, relapse, or imminent risk of relapse. Services should be offered on approximately a weekly basis, unless other scheduling is clinically indicated.

(A) Eligibility for supported recovery shall be based on:

1. Lack of need for structured or intensive treatment;

2. Presence of adequate resources to support oneself in the community;

3. Absence of crisis that cannot be resolved by community support services;

4. Willingness to participate in the program, keep appointments, participate in self-help, etc.

5. Evidence of a desire to maintain a drug-free lifestyle;

6. Involvement in the community, such as family, church, employer, etc.; and

7. Presence of recovery supports in the family and/or community.

9 CSR 30-3.132 Opioid Treatment Program

(5) Admission Criteria: The program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive. Persons who are not residents of the state of Missouri shall comprise no more than twenty percent (20%) of the clients of the program.

(A) In order to qualify for medically supervised withdrawal, the applicant must demonstrate physiologic dependence to narcotics. Documentation must indicate clinical signs of dependence, such as needle marks, constricted or dilated pupils, etc.

(B) In order to qualify for initial admission to ongoing opioid treatment, the applicant must demonstrate physiologic dependence and continuous or episodic addiction for the one (1)-year period immediately prior to application for admission. Documentation must indicate clinical signs of dependence, past use patterns and treatment history, etc. The following exceptions may be made to the minimum admission requirements for opioid treatment:

1. The program may place a pregnant applicant on a methadone treatment regimen, regardless of age, if the applicant has had a documented dependency on heroin or other morphine-like drugs in the past and may be in direct jeopardy of returning to such dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiologic dependence if a program physician certifies the pregnancy and, in his/her reasonable clinical judgment, justifies opioid treatment;

2. For an applicant who is under the age of eighteen (18), the program shall document two (2) unsuccessful attempts at drug-free treatment prior to admission to

ongoing opioid treatment. The program shall not admit any person under the age of sixteen (16) to a program without the prior approval of ADA; and

3. An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a program within fourteen (14) days before release or discharge or within six (6) months after release from such an institution without evidence of current physiologic dependence on narcotics provided that prior to institutionalization the client would have met the one (1)-year admission criteria.

(C) In order to qualify for readmission to opioid treatment, the applicant must demonstrate current physiologic dependence.

1. The program may waive this requirement if it documents prior opioid treatment of six (6) months or more and discharge within the past two (2) years.

2. At the discretion of its medical director, the program may require an applicant who has received administrative detoxification due to an infraction of program rules to wait a minimum of thirty (30) days prior to applying for readmission.

(D) The medical director may refuse the admission of an applicant and/or opioid treatment to a particular client if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

ADA's Clinical Utilization Review Unit monitored agencies' level assignments to the initial level of care given information provided via the CIMOR system and clinical information supplied by providers during the utilization review process. Any concerns related to the referral of individuals to the most appropriate treatment modality could then be followed up on with the providers and appropriate ADA staff. The certification standards outlining the clinical utilization review process are as follows:

(14) Clinical Utilization Review: Services are subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

(A) The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization, and limitations.

(B) Any service matrix or package that is developed by the department or its authorized representative shall include input from service providers.

(C) Clinical utilization review shall include, but is not limited to, the following situations regarding an individual client:

1. Length of stay beyond any specified maximum time period;

2. Service authorization beyond any specified maximum amount or cost;

3. Admission of adolescents into adult programs; and

4. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA.

(D) Clinical utilization review may be required of any client's situation and needs prior to initial or continued service authorization.

(E) The need for clinical utilization review may be identified and initiated by a provider, an individual client, or by the department.
(F) Clinical utilization review may include, but is not limited to, the following situations regarding a program:
1. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA regarding the utilization of particular services and total service costs; and
2. Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical review.
(15) Credentialed Staff: Clinical utilization review shall be conducted by credentialed staff with relevant professional experience.

Another important avenue to providing the most appropriate, individualized treatment modality to those seeking substance abuse treatment is access to specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs. The Division of ADA maintained contracts with CSTAR programs throughout the state to provide specialized services to populations including women and children, adolescents, and opioid-dependent consumers.

The CSTAR specialized programs for women and children provide treatment, rehabilitation, and other supports solely to women and their children. These programs focus on therapeutic issues relevant to women including parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality. The women's CSTAR programs also provide or arrange for daycare and therapeutic services for children who accompany their mothers in treatment. The CSTAR specialized programs for adolescents provide treatment, rehabilitation, and other services solely to consumers between the ages of twelve and seventeen inclusive, and their families. These programs focus on therapeutic issues relevant to adolescents including recovery issues such as peer relationships; use of leisure time; abuse and neglect; skill development, such as decision-making and study skills; and information and education regarding adolescent developmental issues and sexuality. The adolescent CSTAR programs also have an emphasis on family support and involvement, as appropriate. The opioid CSTAR programs are designed to utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle.

FY 2009 (Progress)

Eligibility criteria are defined in certification standards. Assessment Severity Index (ASI) assessment results (for adult programs) or Global Assessment of Individual Needs (GAIN) assessment results (for adolescent programs), and eligibility criteria are to be used when determining the most appropriate treatment modality and level of care assignment for consumers. Eligibility criteria are established in the certification standards.

While most providers of adult substance abuse services use the traditional version of the ASI, the Division of Alcohol and Drug Abuse (ADA) approved the use of the ASI-MV to contracted agencies in October, 2008. The ASI-MV is an interactive self-administered computer-based assessment that has shown strong reliability and validity. Starting in October 2008, Inflexxion, the ASI-MV vendor, provided training and technical assistance to five agencies piloting the use of the ASI-MV. The Division offered periodic conference calls to provide a forum to field questions and provide additional assistance during this initial trial period. During the first year of implementation, ADA purchased the administrations directly from Inflexxion and dispersed to agencies on an as needed basis to encourage the use of the instrument. Over the past year, the Division has continued to promote the ASI-MV as a useful and valid assessment to encourage additional agencies to implement its use. There have been two webinars provided for interested agencies to learn more about the ASI-MV and its applicability to their treatment programs. Feedback from service providers on the instrument has been largely positive, although some agencies did not find sufficient clinical or administrative efficiencies to continue use. Others, however, found the reporting capacity to be very comprehensive and useful in treatment planning. Additionally, the self-administered instrument does not require the time of a trained interviewer.

The Division of Alcohol and Drug Abuse (ADA) maintains contracts with Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs throughout the state to provide specialized services to populations including women and children, adolescents, and opiate-dependent consumers. During FY 2009, there were twelve (12) women and children's CSTAR programs (includes two Alt Care programs specializing in treatment for women released from correctional institutions), fourteen (14) adolescent CSTAR programs, and four (4) opioid CSTAR agencies providing these specialized services in Missouri. The general population CSTAR programs and the community-based Primary Recovery Plus (PR+) programs continue to offer an array of community-based clinical substance abuse treatment services within multiple levels of care, based on the consumer's assessed needs. These services are delivered according to the genuine, free, and independent choice of provider, appropriate for the consumer's assessed needs.

The original award of Access to Recovery (ATR) funds allowed the enhancement of all existing primary recovery programs to provide the full array of services including relapse prevention, vocational support, and trauma services. In some cases, services were expanded into areas that are underserved. In other areas, nontraditional and faith-

based organizations have been credentialed to provide recovery support services in their communities. Specific recovery support services available from credentialed nontraditional and faith-based organizations through the ATR grant include: re-entry coordination, care coordination, childcare, drop-in center, emergency/temporary housing, family engagement, pastoral counseling, individual and group recovery support, spiritual life skills, and transportation. As of June 30, 2009, there were 100 recovery support providers credentialed and contracted to provide these services. The Missouri Institute of Mental Health (MIMH) serves as the contractor for technical assistance on consumer tracking and follow-up data collection for the ATR project.

In an effort to better meet the needs of consumers with co-occurring mental health disorders, enhance the quality of care, and promote provider utilization of evidence-based practices, additional services were added to the service menus of all contracted providers in FY 2008. These services include the following: Individual Co-Occurring Disorder Counseling, Medication Services (delivered by physician, advanced practice nurse, or psychiatrist), Extended Day Treatment (nursing service), Medications and the Clinical Supervision of Counselors. FY 2009 saw these services being utilized by more providers.

The Clinical Utilization Review Unit continues to review authorization requests and assessments for compliance with certification standards, as well as, for appropriateness of placements in the continuum of care and specific clinical services made available to consumers. Significant exploration has been conducted on deriving meaningful utilization data from the Customer Information Management Outcomes and Reporting (CIMOR) system. Considerable data can be retrieved and ad hoc reports have been successfully developed (example: provider trends in level assignment). Some data must still be rendered by manual tracking. Several division staff members have attended and will attend further training on reporting in the CIMOR system using various tools and databases to maximize data analysis.

FY 2010 (Intended Use)

Contracted providers of substance abuse services will continue to use the Assessment Severity Index (ASI) for adults and the Global Assessment of Individual Needs (GAIN) for adolescents. Training and maintenance support of the GAIN assessment will be delivered by contracted treatment providers and the Division of Alcohol and Drug Abuse (ADA) GAIN-certified local trainers.

The Division continues to support providers who choose to use the ASI-MV, an interactive, self-administered, computer-based version of the ASI. In FY 2010, ADA arranged for agencies to directly purchase the administrations from the vendor, Inflexxion, with the ability to be reimbursed an administration fee from ADA via the development of a billable service code. Approval was also received from MO HealthNet (Medicaid) to make this a covered service for eligible recipients. At least two agencies from phase one of the pilot project have expanded use of this tool to their satellite offices.

ADA will continue to review utilization data to identify practices related to consumer level of care placement and patterns of success by provider. Several division staff members have attended and will attend further training on reporting in the Customer Information Management, Outcomes, and Reporting (CIMOR) system using various tools and databases. ADA will continue to implement the outcomes measurement plan and assure reliable outcomes data are being collected to meet the federal requirements.

All data collected to meet reporting requirements and conduct longitudinal outcome evaluation is incorporated into the CIMOR system. All clinical treatment providers are required to collect and enter Treatment Episode Dataset (TEDS) data into the CIMOR system at appropriate points through consumers' episodes of care. In addition, primary recovery programs collect Government Performance Reporting Act (GPRA) data at intake, 6-months post-admission, and discharge. Treatment effectiveness is measured using the National Outcomes Measures (NOMs) domains, including: 1) retention in treatment; 2) abstinence from alcohol and drug use; 3) no involvement with the criminal justice system; 4) attainment of employment or enrollment in school; 5) stable family and living conditions; 6) access and capacity to treatment; and, 7) involvement in the social supports of recovery.

The Missouri Institute of Mental Health will continue to serve as the contractor to provide technical assistance for consumer tracking and collection of follow-up data for the Access to Recovery project.

The clinical utilization review unit will continue to review authorization requests and associated assessments for compliance with certification standards, appropriateness of placements in the continuum of care, and acceptable standards of care. This unit will regularly collect provider-specific and service category-specific data on trends in authorization requests.

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

FY 2007 (Compliance)

The Missouri Department of Mental Health's (DMH) annual Spring Training Institute was held May 16-18, 2007 with 1,126 professionals from the substance abuse prevention and treatment fields in attendance. National and local experts presented on a range of topics including co-occurring disorders, trauma informed care, criminal justice, ethics, faith-based recovery support, effective models for prevention in the treatment setting as well as other current issues impacting the substance abuse field.

Regional Collaborative Model trainings provided subsequent cross-training opportunities for the Division of Alcohol and Drug Abuse (ADA) and the Department of Health and Senior Services (DHSS) contracted providers. Participating DHSS and ADA treatment staff were provided with updated regional epidemiological data and responsive risk reduction methods to address consumer health risk factors associated with HIV/AIDS, STDs, TB, and Hepatitis. Regional collaboration plans were revised and updated to reflect the current progression of this regional service delivery model. Through regional trainings, additional action steps were identified to increase collaboration, resource development, and regional responsiveness.

ADA worked collaboratively in partnership with DHSS to provide the HIV pre- and post-test counseling training to DMH contracted provider staff. The DHSS has made the commitment to ADA to make their HIV trainings open to all ADA provider staff at no cost to the providers. ADA provider staff has been encouraged to pursue this required training at the regional level with their DHSS and local Department of Health staff.

ADA provided training, education, and technical assistance through the Missouri Statewide Training and Resource Network (STRC). Training and technical assistance were 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 Southwest Center for the Application of Prevention Technology (SWCAPT) continued to provide technical assistance to ADA to support the implementation of Missouri's Strategic Prevention Framework State Incentive Grant (SPFSIG) as prevention providers and community coalitions respond to the requirements for data driven targeted prevention intervention strategies.

ADA regional prevention staff continued to provide technical assistance to providers of the School-based Prevention Intervention and Resources Initiative (SPIRIT) to encourage their utilization of best practices and science-based intervention services.

FY 2009 (Progress)

The Department of Mental Health (DMH)'s annual Spring Training Institute scheduled for May 27-29, 2009 was cancelled due to the poor economic situation. DMH is in the process of planning for a Spring Training Institute to be held in May 2010.

Collaboration with the Mid-America Addiction Technology Transfer Center, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention (CSAP) continues to ensure that employees of treatment and prevention agencies in Missouri receive training and education to promote the use of evidence-based practices. The Division of Alcohol and Drug Abuse (ADA) Access to Recovery (ATR) staff continues to provide training to the clinical treatment and recovery support providers throughout the state. Technical assistance trainings include ensuring proper documentation and educating on invoicing techniques as well as providing information on appropriate business practices. ADA/ATR staff continues to partner with Committed Caring Faith Communities (CCFC), an independent statewide 501(c)(3) interfaith corporation, in presenting the Addictions Academy which is designed to educate recovery support providers on best practices in the field of addiction counseling and the faith communities' role in helping consumers recover. Training on the Government Performance and Results Act (GPRA) and the ATR voucher management system are available to both clinical and recovery support providers upon request.

The Statewide Training and Resource Center (STRC) provides training and technical assistance to Regional Support Center staff and community leaders on behalf of the Division to support their capacity to respond to community level prevention efforts. The STRC, with assistance from our Southwest CAPT Liaison, have presented a number of statewide workshops throughout the year including: Strategic Prevention Framework, Prevention Across the Lifespan, Meth 360, Prevention Ethics, Substance Abuse Prevention Specialist Training (SAPST), and "The Odd Couple, When Prevention meets Treatment." The Statewide Training and Resource Center also held a Statewide Prevention Conference on December 1-3, 2008, with over 160 professionals from the substance abuse prevention field in attendance. National and local experts presented on a range of topics including: using social marketing to create policy change, substance use, problem behaviors and suicidal ideation among Missouri's youth, prescription and over the counter medications, modifying model programs to meet local needs, the future of public support for prevention, gang awareness and prevention, media literacy in prevention, bullying, as well as other current issues impacting the substance abuse field.

The Southwest Center for the Application of Prevention Technology (SWCAPT) also provides additional training and technical assistance to ADA to support Missouri's Strategic Prevention Framework State Incentive Grant (SPFSIG) as community coalitions continue to implement their evidence-based programs.

ADA regional prevention staff continue to provide technical assistance to the providers of the School-based Prevention Intervention and Resources Initiative (SPIRIT) to encourage their utilization of best practice and science-based intervention services.

The Division of Alcohol and Drug Abuse (ADA) continues its collaboration with the Department of Health and Senior Services (DHSS). DHSS provides HIV pre-and post-test counseling training to substance abuse providers in accordance with federal guidelines of the Centers for Disease Control and Prevention and at no cost to providers. In partnership with DHSS regional staff, technical assistance is provided to ADA staff and providers to reduce the incidence of sexually transmitted and blood borne diseases among the substance abusing population. Representatives from both DHSS and ADA provide cross collaboration to assist staff, professionals and consumers in finding resources and referrals for education, testing, treatment and training. ADA and DHSS representation continues to be present and actively involved with the State Advisory Council – Community Planning Group with ADA and DHSS providing guidance and insight on interrelated issues of mental health, infectious diseases, and substance abuse.

FY 2010 (Intended Use)

The Department of Mental Health (DMH)'s annual Spring Training Institute will be held May 27-29, 2009. In addition, the Division of Alcohol and Drug Abuse (ADA) Access to Recovery (ATR) staff will continue to provide training to the clinical treatment and recovery support providers throughout the state. ADA/ATR staff will continue to partner with Committed Caring Faith Communities (CCFC), an independent statewide 501(c)(3) interfaith corporation, in presenting the Addictions Academy which is designed to educate recovery support providers on best practices in the field of addiction counseling and the faith communities' role in helping consumers recover. Training on the Government Performance and Results Act (GPRA) and the ATR voucher management system will be available to both clinical and recovery support providers upon request.

The Statewide Training and Resource Center (STRC) will provide training and technical assistance to Regional Support Center staff and community leaders on behalf of the Division to support their capacity to respond to community level prevention efforts. The STRC, with assistance from our Southwest CAPT Liaison, will present statewide workshops throughout the year. Training and technical assistance will focus on implementing the strategic prevention framework in addressing regional substance abuse issues. The STRC will plan for the Missouri Statewide Prevention Conference to be held in FY 2011. The Prevention Conference will provide training on current issues and needs impacting the substance abuse field.

The Southwest Center for the Application of Prevention Technology (SWCAPT) will continue to provide training and technical assistance to ADA to support the final stages of Missouri's Strategic Prevention Framework State Incentive Grant (SPFSIG) as community coalitions continue to implement their evidence-based programs and work to sustain their programs.

ADA regional prevention staff will continue to provide technical assistance to the providers of the School-based Prevention Intervention and Resources Initiative (SPIRIT) to encourage their utilization of best practice and science-based intervention services. ADA will continue to identify web-based learning opportunities for prevention staff and providers.

ADA plans to continue their partnership with the Department of Health and Senior Services (DHSS) to provide HIV pre- and post-test counseling training to substance abuse provider staff. The training curriculum will be directly provided by DHSS regional training staff and will meet the federal guidelines of the Centers for Disease Control and Prevention. To ensure continuity of this collaboration, DHSS and DMH will sign a five-year Memo of Understanding (MOU) that outlines their respective responsibilities. Previous MOUs were renewed annually. DHSS and ADA will continue their representations at DHSS and ADA statewide meetings to guide and assist in the development of prevention and treatment activities and strategies as related to health, mental health, substance abuse and sexually transmitted disease and blood borne diseases. ADA will continue to disseminate statistical data collected by DHSS to ADA

providers and to encourage continued networking with regional DHSS health centers and staff for education and training assistance, referrals for testing and treatment, and development of policies and procedures to address these related issues.

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

In FY 2007, treatment services were coordinated with prevention activities and other appropriate services in the following manner:

The advisory council network continued to be an important link between the public and the Division of Alcohol and Drug Abuse (ADA). The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), is established by state statute and is an advisory body to the Director of ADA. The SAC is comprised of 25 members appointed by the ADA Director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services and no more than one-fourth can be ADA treatment or prevention contract providers. The SAC collaborates with ADA in developing a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol and other drug abuse. The SAC reviews current trends and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public treatment programs and other specialized services. The SAC recommends specific methods, means, and procedures that should be adopted to improve and upgrade the service delivery system and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding.

The following certification standards address the coordination of treatment services. Certification standard 9 CSR 10-7.010, Treatment Principles and Outcomes, states the following:

(7) (A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.

2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.

3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.

4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.

5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

Adolescent Comprehensive Substance Treatment and Rehabilitation (CSTAR) program certification standard 9 CSR 30-3.192 (3) (F) requires the following:

Cooperation with other youth-serving agencies shall be demonstrated in order to ensure that the needs of youth in treatment are met and that services are coordinated. Coordination of service needs is critical with youth due to their involvement with other community agencies and reliance on the family, as well as the fact that substance abuse affects multiple life areas.

Coordination of education for adolescent consumers during treatment is required by standards. All consumers in CSTAR programs are offered a community support worker whose responsibilities include "activities with or on behalf of a particular consumer in accordance with an individual rehabilitation plan to maximize the consumer's adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting consumer independence and responsibility." The community support worker arranges, refers, and monitors services external to the CSTAR program.

Each CSTAR Women and Children's program is required to provide a child care and development program for the children of women who are concurrently receiving treatment. Each center, as required in certification standards, must design appropriate services that address the following goals: build self esteem; learn to identify and express feelings; build positive family relationships; develop decision-making skills; understand chemical dependency as a family illness; and learn and practice non-violent ways to resolve conflict. Each child receives an individual assessment to determine his/her needs, and appropriate intervention or referral is arranged. Children can receive individual and family therapy and group codependency counseling from qualified personnel. The mothers receive extensive weekly training on parenting skills and supervised parent/child bonding time to practice the new skills. The women and their children receive residential support or supportive housing to assure a safe, drug-free environment.

All women and children who enter treatment are provided health screenings by registered nurses to identify health deficits or needs for medical intervention. Close association with local health clinics provides prenatal care, immunizations and other preventive techniques to increase the well-being of mothers and their children. For women receiving day treatment and outpatient services, transportation is available to and from the facility. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional, and behavioral conditions brought about by their mothers' addiction.

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Department of Health and Senior Services (DHSS) to access current information, trends

and training related to the prevention and treatment of tuberculosis (TB) in high-risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. ADA continued to work with the DHSS to maintain community linkages with contracted treatment providers to encourage effective utilization of state and community resources. Contracted treatment providers performed HIV, TB, STD, and hepatitis risk assessments for all consumers. High risk consumers were provided pre-test counseling, testing referral, and post-test counseling services. ADA designated staff continued to serve as liaisons with DHSS and ADA contracted treatment providers to respond to incidents or questions and to provide assistance with dissemination of infectious disease information.

ADA continued to work collaboratively with the DHSS on the Fetal Alcohol Syndrome (FAS) prevention initiative identified as the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP). ADA continued training the five participating Women and Children's CSTAR programs as needed. The training included fundamentals of Motivational Interviewing and instructions for providing the Healthy Balance Intervention Strategy to eligible women receiving treatment in the five CSTAR programs. Additional educational FAS curriculum continued to be used by the participating CSTAR sites for consumer education.

ADA continued support for the Missouri School-based Prevention and Intervention Initiative (SPIRIT) in the existing five school sites in Missouri, with one site located in each of the five ADA sub-state regions. The Missouri SPIRIT program continued to provide evidence-based prevention programs to students in grades K-12 using universal, selective, and indicated preventive interventions. The curriculums used in the SPIRIT initiative included Positive Action, Life Skills Training, Second Step, Too Good for Drugs, Project Towards No Drug Abuse, Peace Builders, and Reconnecting Youth. Outcome measurement included use of the Teacher Observation Checklist (K-3), the Fidelity and Quality of Program Implementation Report, a revised Healthy Kids Survey (grades 4-5), the SPIRIT Survey for (grades 6-12), and the Youth Satisfaction Survey.

FY 2009 (Progress)

Missouri was awarded an Access to Recovery (ATR) Grant, in 2004 that provided $7.6 million per year for three years to implement a statewide treatment voucher system. Missouri was awarded a second ATR grant in FY 2007, in the amount of $4.8 million that extended and expanded the voucher system. Funding from these grants improved coordination and available alternatives among an increased number of qualified service providers; provided recovery support services through traditional, non-traditional, and faith-based organizations; and, expanded the existing managed care system. Faith-based organizations and other nontraditional providers interested in providing recovery support services under the ATR project are required to become credentialed, with one of the requirements being participation in a 32-hour Addictions Academy. The Division of Alcohol and Drug Abuse (ADA) is in the final months of a no-cost extension of the Co-Occurring State Incentive Grant (COSIG) that assisted in reviewing and improving the system of care for individuals with co-occurring psychiatric and substance use.

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), was established by state statute and is an advisory body to the ADA Director. The SAC is comprised of 25 members appointed by the ADA Director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services, and no more than one-fourth can be ADA treatment or prevention vendors. The SAC collaborates with ADA in developing and administering a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol or drug abuse. The SAC studies current trends and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public residential facilities, day programs, and other specialized services. The SAC recommends specific methods, means, and procedures to be adopted to improve and upgrade the service delivery system and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding. During FY 2007, the SAC established a Treatment and a Prevention subcommittee to collaborate with appropriate ADA staff, provide feedback and provide suggestions into the planning and budget process for ADA activities. These subcommittees continue to meet regularly.

Comprehensive Substance Treatment and Rehabilitation (CSTAR) program certification standards continue to require ADA contracted treatment and prevention providers to maintain effective working relationships with other community resources to meet the emotional, mental, physical and spiritual needs of consumers. ADA has provided numerous technical assistance visits and sponsored statewide meetings of providers to facilitate creative collaborative relationships with community resources. Two CSTAR programs continue the joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. The

dependent children are provided child care and treatment for physical, emotional, and behavioral conditions brought about by their mothers' addiction. ADA continues to collaborate with DOC on their Missouri Reentry Program which was initiated with the Transition from Prison to Community Project. The primary objective of this program is to assist transitioning offenders with developing early and effective linkages to community treatment and mental health resources.

The Division of ADA and contracted providers continue to be actively involved in disease prevention activities in collaboration with the Department of Health and Senior Services (DHSS), which include screening, risk reduction assessment and education, and treatment of active diseases. DHSS maintains statistical data on trends of infectious diseases, and this data is disseminated to DMH prevention and treatment providers to assist providers in identifying high risk populations within geographical services areas. A collaborative agreement between DHSS and ADA continues to provide for the collection and transmission of data, cross training, and professional guidance on policy development, program development, and service referrals. DHSS seeks ADA guidance on mental health issues in the development of prevention and treatment programs for HIV/AIDS/STD community planning coalitions. Regional coalitions and health departments provide education, testing, treatment, and training to ADA providers and consumers.

The Division of ADA continues to partner with DHSS to coordinate the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP), a five-year prevention initiative funded by the Centers for Disease Control and Prevention (CDC) to focus Fetal Alcohol Syndrome Disorder prevention services in rural counties. Under the MOFASRAPP, selected women and children's CSTAR providers continue to receive training and technical assistance on the Fetal Alcohol Syndrom (FAS) model of risk reduction, "Healthy Balance." This is the final year of funding for this initiative.

The Division of ADA continues the Missouri School-based Prevention and Intervention Initiative (SPIRIT). The Missouri SPIRIT program provides evidence-based prevention programs to 6,588 students in grades K–12. The curricula used are Positive Action, Life Skills Training, Peace Builders, Two Good For Drugs, Second Step, Project Towards No Drug Abuse, and Reconnecting Youth. Prevention providers assist school personnel with identification and screening of students exhibiting problem behaviors. Missouri SPIRIT objectives are to delay onset of chemical use, decrease substance use, improve overall school performance, and reduce violence. The Missouri Institute of Mental Health has continued to provide program evaluation, collecting three types of data: individual, school or group, and program fidelity. In order to participate in the evaluation, both parental consent and student assent are required. A total of 3,938 students participated in the evaluation during FY 2008. The following measures continue to be used: Teacher Observation Checklist (K-3), SPIRIT Fidelity and Quality of Program Implementation Report, Healthy Kids Survey (grades 4-5), and the SPIRIT Survey (grades 6-12). Additional data collected on individual students includes grades, achievement test results, school attendance, suspensions, violent incidents, race, age,

and gender. School level data serve as indicators for each grade as a whole regardless of student participation in the evaluation.

In FY 2007, Missouri had its Strategic Prevention Framework State Incentive Grant (SPF SIG) Strategic Plan approved. All 18 coalitions are now in the implementation phase of their projects. SPF SIG staff continues to provide training and technical assistance to the SPF SIG recipients to help them with implementation, strategic planning and evaluation. State-level SPF SIG staff and Chuck Daugherty, Missouri's Southwest Center for Application of Prevention Technology (SWCAPT) representative, also provided individual technical assistance at the trainings and at follow-up site visits. Missouri's state priority under this grant is to reduce risky drinking for persons aged 12-25 years.

The State Epidemiological Outcome Workgroup (SEOW) began implementing a Learning Community website to assemble resources and links for training, technical assistance, consumption and consequences data, program strategies, and program outcomes. The SEOW developed a format for hosting presentations by data specialists, with attendance open to the SPF SIG Governor's Advisory Committee and staff of the SPF SIG Community Coalitions.

FY 2010 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to require coordination of substance abuse treatment with community resources to provide additional recovery support services to meet the needs of consumers. Housing, transportation, vocational rehabilitation, education, and family services will continue to be addressed in Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs. Specialized programs will continue to provide treatment for adolescents, those addicted to opiates, pregnant women, and women with dependent children. These programs provide additional programming and also maintain collaborative relationships with external community agencies to provide recovery support services to meet the special needs of these populations.

Missouri was awarded Access to Recovery (ATR) II grant funding to continue the system gains achieved under ATR I. ATR II will use faith-based and nontraditional recovery support providers to emphasize the use of recovery supports during pretreatment and in less intense levels of outpatient care. ATR support services were expanded to include consumers discharged from correctional facilities which serve to bridge the transition between institutional life and community-based substance abuse treatment.

The Office of Faith-Based and Community Partnerships was established in March 2007. This office will continue to coordinate the efforts of faith-based recovery support providers with those of the substance abuse treatment and prevention providers and ADA staff.

The Division of ADA and contracted providers will continue to be involved in collaborative disease prevention activities with the Department of Health and Senior Services (DHSS) including screening, risk reduction, assessment, education, and treatment of active diseases. Continued regional collaborative trainings will be planned to support the use of timely epidemiological data and to strengthen collaborative partnerships between ADA and DHSS providers.

The Division of ADA will continue to provide funding for program implementation and evaluation at the five School-based Prevention and Intervention Initiative (SPIRIT) sites. Evaluators will continue to track the number of referrals made through the project. Performance measures will include the Teacher Observation Checklist, the California Healthy Kids Survey, the Missouri Student Survey, the SPIRIT Fidelity and Quality of Program Implementation Report, the Youth Satisfaction Survey, and the teacher responses obtained from the SPIRIT Initiative Questionnaire. In collaboration with the Missouri Department of Elementary and Secondary Education, ADA will continue to support the Internet-based administration of the Missouri Student Survey in all Missouri school districts. Local districts and ADA will continue to use survey results for planning and program development.

The State Epidemiological Outcome Workgroup (SEOW) will continue to promote cooperation and coordination with other substance abuse data system gatekeepers and users to enhance data quality, specificity, and utilization. The SEOW will focus particular attention on Missouri data from the Behavioral Risk Factor Surveillance System (BRFSS), the Missouri Information for Community Assessment (MICA) system, Missouri pharmaceutical databases, and data submitted by the SPF SIG coalitions for inclusion in the Learning Community website. The SEOW plans to develop additional data products using national and state data from the National Survey on Drug Use and Health, the Youth Risk Behavior Survey, and the Behavioral Risk Factor Survey. The SEOW will explore new avenues for conveying substance abuse epidemiology information to policy makers, planners, prevention project implementers, and other stakeholders.

All of the Strategic Prevention Framework State Incentive Grant (SPF SIG) coalitions are in the implementation phase. The SPF SIG Governor's Advisory Committee will continue to review the goals contained within the state strategic plan.

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2007 (Compliance):

FY 2009 (Progress):

FY 2010 (Intended Use):

FY 2007 (Compliance)

In the development of the State's needs assessment, a combination of data sources were used including sub-state estimates from

1) the State Treatment Needs Assessment Program (STNAP-II) funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (CSAT), under the CSAT Grant No. 5H79 TI12229 and completed in 2003; and
2) the National Survey on Drug Use and Health (NSDUH) survey.

Three years of NSDUH survey data are combined to obtain sub-state planning estimates. The Division of Alcohol and Drug Abuse (ADA) used the estimated number of individuals with alcohol or illicit drug dependence or abuse as a proxy measure for treatment need. A more detailed demographic breakdown of need was obtained from the STNAP-II data.

The treatment needs estimates were used to estimate treatment penetration rates, plan and allocate treatment services, and develop the ADA portion of the Department of Mental Health's annual budget request. The estimates were also summarized in the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm). During FY 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) released national and state estimates from the combined 2005-2006 National Survey on Drug Use and Health (NSDUH). ADA developed tables to compare national and Missouri rates for several measures and indicators from the survey. These tables were included in the ADA status report.

NSDUH data was also used in assessing prevention needs by tracking trends in alcohol and other drug use rates across age groups. ADA, its prevention providers, and coalitions also used data from Missouri's Student Survey. This survey represents a collaborative effort between the Department of Elementary and Secondary Education (DESE) and ADA. The survey instrument collects data on substance abuse incidence and prevalence, delinquent behavior, and risk and protective factors related to a range of health and safety issues. ADA planned for the next biennial MSS survey to occur in 2008.

National outcome measures specific to local prevention projects were collected at the community level. Funds were allocated for program implementation under the Strategic Prevention Framework State Incentive Grant (SPF SIG). Sub-recipients funded through the SPF SIG worked on their strategic plans in which they assessed needs, resources, and readiness at the community level as part of their planning process. The state's priority issue of risky drinking among young people ages 12-25 was addressed through various evidence-based programs.

FY 2009 (Progress)

For treatment needs estimation, the Division of Alcohol and Drug Abuse (ADA) continues to use a combination of data sources including, but not necessarily limited to,

1) the State Treatment Needs Assessment Program (STNAP-II) funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (CSAT), under the CSAT Grant No. 5H79 TI12229 and completed in 2003; and
2) the National Survey on Drug Use and Health (NSDUH) survey.

ADA uses the estimated number of individuals with alcohol or illicit drug dependence or abuse as a proxy measure for treatment need. ADA continues to seek improvements and/or establishment of additional benchmarks in its treatment needs estimations.

Updated estimates of treatment need are used to calculate treatment penetration rates; plan and allocate treatment services; prepare presentation materials for the state legislature and other policy makers; and develop the ADA portion of the Department of Mental Health's annual budget request for FY 2011. The estimates are also summarized in the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm).

NSDUH data are also used in assessing prevention needs by tracking trends in alcohol and other drug use rates across age groups. ADA, its providers, and coalitions also utilize the Missouri Student Survey (MSS) for data analysis. This survey instrument collects data on substance abuse incidence and prevalence, delinquent behavior, and risk and protective factors related to a range of health and safety issues for 6th through 12th graders attending public schools. The final report of the 2008 MSS was published in FY 2009 (http://www.dmh.missouri.gov/ada/rpts/survey.htm). ADA is planning for the next biennial MSS which will be conducted in the spring of 2010. The survey will be available online to all of Missouri's school districts.

Missouri awarded Strategic Prevention Framework State Incentive Grant (SPF SIG) funding to 18 community-based coalitions in FY 2008, and extended funding to 2 statewide prevention coalitions -- Partners in Prevention and Missouri's Youth/Adult Alliance -- in FY 2009. Missouri's goal under this grant is to reduce risky drinking behavior, especially binge and underage alcohol use among the population 12-25 years of age. The 20 SPF SIG sub-recipient coalitions continued to develop their projects in FY 2009 by refining their assessments of resources, needs, and community readiness; implementing evidence-based programs and environmental strategies; and collecting, reviewing, and submitting data needed for program evaluations. The SPF SIG staff and the Regional Support Centers continue to provide training workshops and technical assistance to enhance the planning, program implementation, and evaluation capabilities of the SPF SIG coalitions. The Regional Support Centers also assist 152 other community coalitions to conduct prevention needs assessments.

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FY 2010 (Intended Use)

The state will use a combination of data sources to maintain and update its substance abuse treatment needs assessment. Included among these data sources are the National Survey on Drug Use and Health (NSDUH) state and sub-state estimates. This assessment will be used in policy development, budgeting, treatment planning, and reporting. The treatment needs data and the alcohol and drug abuse indicators will continue to be presented in charts and tables in the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm). Missouri is also exploring the possibility of collaborating with the Pacific Institute for Research and Evaluation (PIRE) to determine societal cost estimates based on an array of county-level substance abuse indicators.

In FY 2010, Division of Alcohol and Drug Abuse (ADA) will submit a formal request to the Substance Abuse and Mental Health Services' Office of Applied Studies for estimates to complete forms 8 and 9 for future Substance Abuse Prevention and Treatment Block Grant applications. ADA intends to use OAS generated estimates in lieu of the data from the State Treatment Needs Assessment Program (STNAP-II) as the STNAP-II data is nearly 7 years old. In recent years, the State has experienced declining revenues and budget cuts. As such, ADA does not have resources to conduct a separate household survey.

Missouri estimates from the NSDUH and the indicators from the *Status Report* will also be used for prevention needs assessment and services planning. The Division of ADA will supplement these data with estimates from the biennial Missouri Student Survey (MSS), the annual Missouri College Health Behavior Survey, the Youth Risk Behavior Survey, and the Behavioral Risk Factor Survey (BRFS). Collectively, data from these sources will identify trends in alcohol and drug use rates across age groups.

The MSS is administered to over 100,000 secondary school students and provides Missouri's largest set of data on alcohol and drug use, other behaviors, and risk factors among this population. The survey will be available online to all school districts in the spring of 2010. In FY 2010, ADA is partnering with the Missouri Institute for Mental Health to develop a web-based query system that will allow for customized data analysis and reporting and user-friendly access to sub-state level data. The system will be piloted with the MSS data but future plans are to integrate other data sources. In addition, ADA is exploring the possibility of working with the University of Missouri to analyze data from the BRFS by zip code cluster to compare trends in binge and underage alcohol use among young adults in the target areas of 18 coalitions funded by the Strategic Prevention Framework (SPF) State Incentive Grant (SIG) with use rates in areas not served by the SPF SIG.

ADA and its network of contracted Regional Support Centers will assist approximately 150 community coalitions to conduct or update prevention needs assessments, consistent with the SPF model when feasible. Ideally, each assessment will establish a foundation for a community to identify and prioritize its problems and needs based on

local data, identify or develop necessary resources, plan and implement appropriate strategies and programs, and evaluate results. Support for the SPF SIG funded coalitions will focus on sustainability and knowledge transfer. ADA will review the evidence-based programs and environmental strategies used by the coalitions to determine which are the most effective at decreasing risky drinking in the age group 12-25 and encourage their adoption by community coalitions with similar goals and target populations.

ADA will collect community-level National Outcome Measures data specific to its prevention projects. Among all of Missouri's substance abuse prevention programs, data collection and analysis will support data-driven needs assessment, planning, implementation, and evaluation.

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) continued the policy that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. Billing for such was not and is not possible in the Customer Information Management, Outcomes, and Reporting (CIMOR) system used by all contracted providers.

Policy adherence has been ensured through various monitoring mechanisms: three-year certification surveys; Annual Safety and Basic Assurance Reviews, which includes billing reviews; and, periodic site visits by the District Administrators and Area Treatment Coordinators.

FY 2009 (Progress)

The Division of Alcohol and Drug Abuse (ADA) continues the policy that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. Billing for such is not possible in the Customer Information Management, Outcomes, and Reporting (CIMOR) system used by all contracted providers.

Policy adherence continues to be ensured through various monitoring mechanisms: three-year certification surveys; Annual Safety and Basic Assurance Reviews, which include billing reviews; and, periodic site visits by the District Administrators and Area Treatment Coordinators.

FY 2010 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue the policy that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. Billing for such is not and will not be possible in the Customer Information Management, Outcomes, and Reporting (CIMOR) system used by all contracted providers.

Policy adherence will be ensured through various monitoring mechanisms: three-year certification surveys; Annual Safety and Basic Assurance Reviews, which includes billing reviews; and, periodic site visits by the District Administrators and Area Treatment Coordinators.

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) utilized independent peer review as one of several methods to encourage and assess the quality, appropriateness, and efficacy of substance abuse treatment and services provided. Seven (7) independent peer reviews were conducted in FY 2007. Contracts for treatment providers required that they make staff available to perform peer reviews of other agencies in the state.

The following is the language in contracts addressing peer review requirements:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and,

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

FY 2009 (Progress)

The Division of Alcohol and Drug Abuse (ADA) facilitated seven (7) peer reviews in FY 2009. Reviews are conducted in each region of the state and generally involve providers from different regions. Peer reviews are required of all providers contracting with the Division of ADA. The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting process is in place to ensure information collected through the review process is appropriately shared. Copies of the report are distributed to the respective District Administrator, the agency being reviewed, and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator may review the report with the appropriate agency staff if follow-up is necessary.

FY 2010 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to facilitate independent peer reviews to encourage and assess the quality, appropriateness, and efficacy of the substance abuse treatment being provided in the state. Peer reviews continue to be required in contracts. Such reviews will be scheduled annually in each region of the state. Area Treatment Coordinators will be responsible for initiating the peer review process. A reporting process is in place to ensure information collected through the review process will be appropriately shared. Copies of the report will continue to be distributed to the District Administrator, the agency reviewed, and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator will continue to review the report with the appropriate agency staff if follow-up is necessary.

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))
In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2008 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of **procedures** may include, but not be limited to:

• the role of the Single State Agency (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;

• the role of the State Medical Director for Substance Abuse Services in the development of such procedures;

• the role of the independent peer reviewers; and

• the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

• the number of entities reviewed during the applicable fiscal year ;

• technical assistance made available to the entity(ies) reviewed; and

• technical assistance made available to the reviewers, if applicable.

Attachment H

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness, and efficacy of substance abuse treatment services provided in the state of Missouri. ADA has been contractually requiring all treatment providers to participate in independent peer review since July 1993. Contracted providers have been cooperating with this requirement each year since that time. Seven (7) reviews were conducted in FY 2007, seven (7) were conducted in FY 2008, and seven (7) reviews were conducted in FY 2009.

The contract between ADA and the treatment provider includes language which requires each provider to participate in the peer review process. The contract states:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the respective ADA District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators, who work as Division of ADA regional staff and who report to the ADA District Administrators, are responsible for initiating the peer review process. A provider in the same region as the agency to be reviewed is contacted and asked to participate in this process. Peer reviewers are usually senior staff members of the contracted agency. Provider staff conducting the peer reviews are offered guidance from the ADA Area Treatment Coordinator. Expectations are relayed, optional tools for data collection are provided, and possible focus areas are suggested. Focus area suggestions may be based on prior survey

findings or areas of concern identified in other site visits, or if it is known that the peer reviewing agency has particular strengths in any given area of review.

A reporting process is in place to ensure information collected through the review process is appropriately shared. Copies of the report are distributed to the respective District Administrator, the agency being reviewed and ADA's treatment and fiscal staff. The ADA District Administrator and ADA Area Treatment Coordinator review the report with the appropriate agency staff if follow-up is necessary.

The agency being reviewed cooperates by providing access to consumer records, staff, and policy and procedure documents. The reviewer utilizes this information to establish the agency's compliance with certification standards, best practices, and efficiency in operations. Both the reviewer and the agency being reviewed have an opportunity to learn from one another, to the benefit of both programs. The information is also useful to ADA's certification specialists and other staff that provide monitoring and technical assistance to the agencies statewide. In addition to contract compliance, the role of the ADA Area Treatment Coordinator is to conduct safety and basic assurances monitoring, provide technical assistance, and/or arrange for technical assistance visits. Some of the feedback provided through the peer review process includes suggestions regarding treatment planning, documentation, cultural diversity, and agency systems improvement.

Federal confidentiality regulations are observed throughout the individual peer review process. All members of the peer review team are knowledgeable of, and agree to comply with, federal confidentiality regulations in carrying out their assigned duties.

In summary, the role of ADA in Peer Reviews is as follows:

1. Providers are contractually bound to participate in Peer Reviews by ADA contracts;
2. The ADA Area Treatment Coordinators initiate the Peer Review;
3. The ADA Area Treatment Coordinators assure that the peer reviewer is a knowledgeable and experienced Substance Abuse Treatment Professional;
4. The ADA Area Treatment Coordinators assure the findings and recommendations of the Peer Review visit are reported in a timely fashion;
5. The ADA Area Treatment Coordinators review the findings and recommendations report;
6. The respective ADA District Administrator reviews the findings and recommendations of the Peer Review report;
7. The ADA District Administrator and Area Treatment Coordinator may review the report with the appropriate staff from the agency being reviewed, and provide technical assistance, if necessary.
8. The ADA District Administrator reviews significant deviations from contractual requirements or certification standards with the Executive Director of the reviewed agency;
9. The ADA District Administrator may review recurring problems with the ADA Division Director and other ADA administrative personnel;

10. The ADA District Administrator and Area Treatment Coordinator share positive findings of innovative practices in technical assistance visits to all providers to help disseminate improvements in clinical practice;
11. Copies of Peer Review findings and recommendations are filed in the agency's certification file.

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. Part 2).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) has complied with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and, as of April 2003, the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complied with these federal regulations in the processing, storage, and appropriate release of consumer information. ADA also required contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance have been provided to contracted program staff to ensure compliance with the federal regulations. ADA monitored the compliance of providers with the above confidentiality regulations through certification surveys, Safety and Basic Assurances Reviews (SBAR) and periodic site visits by District Administrators and Area Treatment Coordinators.

FY 2009 (Progress)

The Division of Alcohol and Drug Abuse (ADA) continued to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complies with these federal regulations in the processing, storage, and appropriate release of consumer information. ADA also requires contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. All new ADA employees receive orientation and training to division policy and the above sited confidentiality laws. In April 2009, all Department of Mental Health (DMH) staff were reminded, by official memo, of the parameters and requirements related to the Notice of Privacy Practices for consumers of DMH-delivered services. Training and technical assistance continue to be provided to contracted program staff to ensure compliance with the federal regulations. ADA continues to monitor the compliance of providers with the above confidentiality regulations through certification surveys, Safety and Basic Assurance Reviews (SBAR) and periodic site visits by District Administrators and Area Treatment Coordinators.

FY 2010 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. All Department of Mental Health employees will continue to be required to adhere to HIPAA policies. ADA will continue to require contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance will continue to be provided to contracted program staff to ensure compliance with the federal confidentiality regulations. ADA will continue to monitor the compliance of providers with the above confidentiality regulations through certification surveys, Safety and Basic Assurances Reviews (SBAR) and periodic site visits by District Administrators and Area Treatment Coordinators.

Goal #17: Charitable Choice

GOAL # 17. An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(b) and 54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

FY 2007 (Compliance):
FY 2009 (Progress):
FY 2010 (Intended Use):

FY 2007 (Compliance)

The Missouri Code of State Regulations requires that creed not be used as criteria upon which to deny an individual admission to services. The right of consumers to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide Block Grant treatment services requires that those agencies comply with Block Grant Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Consumers are informed of their right to Charitable Choice and are provided written acknowledgement of their alternatives. Guidelines, training, and technical assistance have been made accessible to providers.

All recovery support services were authorized through a vouchering system as the result of the consumer's free and independent choice to receive such services from a recovery support provider selected by the consumer from a menu of credentialed providers.

FY 2009 (Progress)

The Missouri Code of State Regulations requires that creed not be used as criteria upon which to deny an individual admission to services. The right of consumers to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

Faith-based organizations that provide Block Grant treatment services via contract with ADA are required to comply with Block Grant Charitable Choice requirements by following the procedures listed below

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Contract language for all providers includes the following as it relates to charitable choice:

Charitable Choice Notification

2.10.1 In the event the contractor is a religious organization, the contractor shall:

a. comply with the requirements of 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (see 42 C.F.R. 54.8(c)(4) and 54.8(b)), Charitable Choice Provisions and Regulations;

b. provide consumers and prospective consumers with the “Notice to Individuals Receiving Substance Abuse Services”, attached hereto as Attachment I;

c. refer consumers to alternative services as requested if the consumer objects to the religious character or religious requirements of the organization and when alternative services are available;

d. maintain a log of requests for referral to alternative services based upon religious objection to which shall include the request date, consumer ID, disposition, and brief explanation; and

e. submit an annual report to the District Administrator, on or before July 31 of each year, containing the information required in subparagraph 2.10.1.d, above, for the prior fiscal year.

2.10.2 In the event the contractor utilizes subcontractors that are religious organizations, the contractor shall ensure that the Charitable Choice requirements stated in paragraph

2.10.1, above, are met by any subcontractors providing substance abuse treatment and prevention services.

2.10.3 If the contractor is a religious organization, the contractor shall declare as such, at the time of award, by way of written notification to the appropriate District Administrator.

a. If any subcontractor is a religious organization, the contractor shall require a written declaration from the subcontractor and shall submit the declaration to the District Administrator at the time of award.

b. For any subsequent subcontracts established with religious organizations, the contractor shall require a written declaration from the subcontractor and shall submit the declaration to the District Administrator prior to the subcontractor providing services.

Two religious-based programs are currently certified by ADA to provide clinical substance abuse treatment. Consumers are informed of their right to Charitable Choice and are provided written acknowledgement of their alternatives. Guidelines, training, and technical assistance have been made available to providers.

Faith-based and nontraditional service organizations desiring to provide recovery support services must be credentialed by Committed Caring Faith Communities, an independent statewide not-for-profit 501(c) (3) interfaith corporation. There are 101 credentialed and contracted recovery support providers in Missouri of which 87 report being faith-based programs. In Missouri, all recovery support services are vouchered with the consumer making the genuine and independent choice of service provider from a network of credentialed recovery support providers.

FY 2010 (Intended Use)

The Missouri Code of State Regulations maintains the requirement that individuals not be denied admission or services based on creed. The right of an individual to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

Religious organizations that provide Block Grant treatment services via contract with ADA will continue to be required to comply with Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Contract language for all providers includes the following as it relates to charitable choice:

Charitable Choice Notification

2.10.1 In the event the contractor is a religious organization, the contractor shall:

a. comply with the requirements of 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (see 42 C.F.R. 54.8(c)(4) and 54.8(b)), Charitable Choice Provisions and Regulations;

b. provide consumers and prospective consumers with the “Notice to Individuals Receiving Substance Abuse Services”, attached hereto as Attachment I;

c. refer consumers to alternative services as requested if the consumer objects to the religious character or religious requirements of the organization and when alternative services are available;

d. maintain a log of requests for referral to alternative services based upon religious objection to which shall include the request date, consumer ID, disposition, and brief explanation; and

e. submit an annual report to the District Administrator, on or before July 31 of each year, containing the information required in subparagraph 2.10.1.d, above, for the prior fiscal year.

2.10.2 In the event the contractor utilizes subcontractors that are religious organizations, the contractor shall ensure that the Charitable Choice requirements stated in paragraph

2.10.1, above, are met by any subcontractors providing substance abuse treatment and prevention services.

2.10.3 If the contractor is a religious organization, the contractor shall declare as such, at the time of award, by way of written notification to the appropriate District Administrator.

a. If any subcontractor is a religious organization, the contractor shall require a written declaration from the subcontractor and shall submit the declaration to the District Administrator at the time of award.

b. For any subsequent subcontracts established with religious organizations, the contractor shall require a written declaration from the subcontractor and shall submit the declaration to the District Administrator prior to the subcontractor providing services.

Continuing training, certification and monitoring will ensure the consumers have charitable choice and quality services.

All recovery support services will continue to be authorized through a vouchering system as the result of the consumer's free and independent choice to receive such services from a recovery support provider within a network of credentialed providers.

State: Missouri

Attachment I: Charitable Choice

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2009) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- [x] Used model notice provided in final regulations
- [ ] Used notice developed by State (Please attach a copy in Appendix A)
- [x] State has disseminated notice to religious organizations that are providers
- [x] State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- [ ] State has developed specific referral system for this requirement
- [x] State has incorporated this requirement into existing referral system(s)
- [x] SAMHSA's Treatment Facility Locator is used to help identify providers
- [x] Other networks and information systems are used to help identify providers
- [x] State maintains record of referrals made by religious organizations that are providers
- [x] 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

ADA included a Faith-Based track at Spring Training Institute in FY 2007 and FY 2008 that included Charitable Choice provisions in several of the course curriculum offered. Charitable choice requirements are included in all provider contracts.

State: Missouri

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).
- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128 (d))
- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

- Footnotes

Missouri does not plan to apply for any of the waivers.

Attachment J: Waivers

Attachment J: Waivers

If the State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to the SAMHSA Administrator following the submission of the application if not included as an attachment to the application.

Attachment J

Missouri is not requesting any waivers.

Form 4

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

Dates of State Expenditure Period: From: 7/1/2007 To: 6/30/2008

	Source of Funds					
Activity	**A.SAPT Block Grant FY 2007 Award (Spent)**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$18,745,526	$25,499,293	$6,990,842	$33,152,394	$0	$142,300
Primary Prevention	$6,009,530		$4,745,652	$648,118	$0	$0
Tuberculosis Services	$9,162	$20,885	$430	$10,743	$0	$0
HIV Early Intervention Services	$0	$0	$0	$0	$0	$0
Administration: Excluding Program/Provider	$1,303,380		$1,830,836	$1,517,949	$0	$41,645
Column Total	**$26,067,598**	**$25,520,178**	**$13,567,760**	**$35,329,204**	**$0**	**$183,945**

***Prevention other than Primary Prevention**

Missouri is not an HIV designated state. ";Other"; source of funds include the Robert Wood Johnson Foundation Advancing Recovery Grant.

Form 4ab

State: Missouri

Form 4a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2007	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 691,846	$ 270,856	$ 75,565	$ 0	$ 0
Education	$ 2,734,890	$ 414,162	$ 25,887	$ 0	$ 0
Alternatives	$ 224,869	$ 215,913	$ 1,708	$ 0	$ 0
Problem Identification & Referral	$ 27,392	$ 0	$ 963	$ 0	$ 0
Community Based Process	$ 930,388	$ 6,500	$ 169,922	$ 0	$ 0
Environmental	$ 479,892	$ 59,704	$ 11,314	$ 0	$ 0
Other	$ 436,803	$ 3,778,517	$ 61,225	$ 0	$ 0
Section 1926 - Tobacco	$ 483,450	$ 0	$ 301,534	$ 0	$ 0
Column Total	**$6,009,530**	**$4,745,652**	**$648,118**	**$0**	**$0**

Form 4b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2007	Other Federal	State Funds	Local Funds	Other
Universal Direct	$ 1,393,751	$ 1,845,268	$ 648,118	$ 0	$ 0
Universal Indirect	$ 2,708,825	$ 0	$ 0	$ 0	$ 0
Selective	$ 1,906,954	$ 2,900,384	$ 0	$ 0	$ 0
Indicated	$ 0	$ 0	$ 0	$ 0	$ 0
Column Total	**$6,009,530**	**$4,745,652**	**$648,118**	**$0**	**$0**

Form 4c

Resource Development Expenditure Checklist

Did your State fund resource development activities from the FY 2007 SAPT Block Grant?

(•) Yes ( ) No

Expenditures on Resource Development Activities are:

(•) Actual ( ) Estimated

Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 0	$ 269,767	$ 0	$ 269,767
Quality Assurance	$ 11,486	$ 0	$ 0	$ 11,486
Training (post-employment)	$ 1,545	$ 1,709	$ 0	$ 3,254
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 3,698	$ 605,360	$ 0	$ 609,058
Research and Evaluation	$ 0	$ 292,407	$ 0	$ 292,407
Information Systems	$ 0	$ 0	$ 0	$ 0
Column Total	**$16,729**	**$1,169,243**	**$0**	**$1,185,972**

Form 6

SUBSTANCE ABUSE ENTITY INVENTORY

State: Missouri

				FISCAL YEAR 2007			
1. Entity Number	**2. I-SATS ID** [X] if no I-SATS ID	**3. Area Served**	**4. State Funds** (Spent during State expenditure period)	**5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services (other than primary prevention)**	**5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children**	**6. SAPT Block Grant Funds for Primary Prevention**	**7. SAPT Block Grant Funds for Early Intervention Services for HIV** (if applicable)
002	X	Northwest Region	$0	$2,712	$0	$0	$0
008	X	Central Region	$479,769	$116,363	$0	$670,140	$0
009	MO901642	Eastern Region	$499,176	$0	$0	$0	$0
021	MO102084	Northwest Region	$400,510	$5,044	$0	$0	$0
037	MO750593	Southwest Region	$541,923	$400,347	$0	$0	$0
152	X	Eastern Region	$62,491	$0	$0	$665,754	$0
154	X	Northwest Region	$28,941	$0	$0	$0	$0
171	X	Northwest Region	$111,066	$0	$0	$259,392	$0
173	MO903788	Eastern Region	$506,475	$412,938	$101,932	$0	$0
174	MO103967	Eastern Region	$6,290	$734	$0	$0	$0
175	MO903515	Southwest Region	$280	$0	$0	$0	$0
183	MO100716	Northwest Region	$0	$485,371	$0	$0	$0
185	MO105152	Northwest Region	$18,029	$0	$0	$103,278	$0
189	MO100591	Eastern Region	$800,158	$254,633	$229,710	$0	$0
207	MO101031	Southwest Region	$22,585	$1,356	$0	$0	$0
208	X	Eastern Region	$53,135	$675	$0	$0	$0
209	X	Southwest Region	$95,067	$0	$0	$0	$0
210	X	Eastern Region	$126,525	$2,223	$0	$0	$0
211	X	Central Region	$94,089	$0	$0	$0	$0
216	X	Northwest Region	$17,117	$0	$0	$0	$0
217	X	Northwest Region	$79,610	$1,802	$0	$0	$0
220	X	Central Region	$5,338	$0	$0	$0	$0
226	MO101755	Northwest Region	$100,545	$10,950	$0	$0	$0
227	X	Eastern Region	$46,831	$3,129	$0	$0	$0
231	X	Central Region	$124,954	$1,867	$0	$0	$0
238	MO102027	Eastern Region	$78,736	$3,746	$0	$0	$0
239	MO101987	Eastern Region	$38,909	$2,256	$0	$0	$0
249	X	Eastern Region	$162,573	$2,477	$0	$0	$0
252	X	Southeast Region	$92,213	$0	$0	$0	$0
262	MO102928	Eastern Region	$1,138,996	$116,106	$0	$0	$0
264	X	Southwest Region	$47,514	$261	$0	$0	$0
267	X	Statewide	$0	$229,168	$0	$943,709	$0

269	MO105087	Eastern Region	$0	$509,399	$0	$0	$0
274	X	Southwest Region	$58,709	$0	$0	$0	$0
275	MO100711	Central Region	$45,991	$5,108	$0	$0	$0
276	MO100849	Southwest Region	$368,695	$301,099	$0	$0	$0
277	X	Southeast Region	$21,807	$0	$0	$0	$0
282	X	Northwest Region	$30,567	$0	$0	$0	$0
287	X	Northwest Region	$11,870	$0	$0	$0	$0
288	X	Central Region	$19,377	$1,045	$0	$0	$0
297	X	Northwest Region	$8,331	$0	$0	$0	$0
316	X	Eastern Region	$6,942	$784	$0	$0	$0
318	MO100761	Eastern Region	$0	$550,931	$0	$0	$0
401	X	Statewide	$0	$3,333	$0	$0	$0
402	X	Statewide	$0	$364	$0	$0	$0
403	X	Statewide	$0	$27,382	$0	$0	$0
405	X	Statewide	$0	$13,348	$0	$562,175	$0
406	X	Eastern Region	$0	$0	$0	$33,000	$0
408	X	Southwest Region	$0	$0	$0	$201,803	$0
411	X	Eastern Region	$0	$0	$0	$64,265	$0
412	X	Eastern Region	$0	$0	$0	$136,572	$0
413	X	Statewide	$0	$0	$0	$165,000	$0
414	X	Southeast Region	$0	$0	$0	$89,250	$0
416	X	Statewide	$0	$0	$0	$304,014	$0
417	X	Southeast Region	$22,791	$0	$0	$110,631	$0
418	X	Southeast Region	$26,309	$0	$0	$79,795	$0
420	X	Southwest Region	$48,699	$0	$0	$260,487	$0
421	X	Statewide	$0	$0	$0	$40,206	$0
423	X	Statewide	$112,438	$0	$0	$0	$0
430	X	Southwest Region	$6,586	$0	$0	$0	$0
431	X	Statewide	$53,403	$0	$0	$0	$0
638	MO100667	Northwest Region	$164,481	$512,581	$0	$0	$0
043a	MO902004	Southwest Region	$201,337	$120,373	$0	$89,126	$0
043b	MO101030	Southwest Region	$0	$1,923	$0	$1,423	$0
043c	MO101267	Southwest Region	$755	$270	$0	$200	$0
045a	MO105244	Northwest Region	$462,437	$201,474	$0	$0	$0
045c	MO902608	Northwest Region	$43,043	$26,546	$0	$0	$0
045d	MO902673	Northwest Region	$33,613	$12,404	$0	$0	$0
045e	MO101047	Northwest Region	$16,203	$8,921	$0	$0	$0
045f	MO101048	Northwest Region	$10,139	$4,435	$0	$0	$0
045g	MO101532	Northwest Region	$9,775	$23,578	$0	$0	$0
048a	MO101028	Southwest Region	$24,996	$9,188	$0	$0	$0
049b	MO106218	Southeast Region	$131,130	$58,083	$0	$4,147	$0
049c	MO103801	Southwest Region	$22,950	$21,258	$0	$1,518	$0
049d	MO106259	Southwest Region	$30,604	$12,168	$0	$869	$0
049e	MO901527	Southwest Region	$671,421	$428,213	$0	$30,567	$0
049g	MO106309	Southwest Region	$44,395	$9,435	$0	$674	$0
049h	MO103272	Northwest Region	$5,856	$2	$0	$0	$0
049i	MO106242	Southwest Region	$17,702	$138	$0	$10	$0
049j	MO100404	Southeast Region	$26,141	$20,854	$0	$1,489	$0
049k	MO103207	Central Region	$144,768	$33,161	$0	$2,368	$0
049l	MO105814	Central Region	$14,676	$4,271	$0	$305	$0

049m	MO103298	Central Region	$1,095	$1,553	$0	$111	$0
049n	MO105798	Central Region	$82,784	$24,645	$0	$1,760	$0
049o	MO103124	Northwest Region	$7,941	$137	$0	$10	$0
049p	MO103280	Northwest Region	$63,081	$10,291	$0	$735	$0
049q	MO901543	Northwest Region	$356,585	$401,686	$0	$28,679	$0
049r	MO103231	Northwest Region	$18,115	$226	$0	$16	$0
049s	MO103215	Northwest Region	$165	$0	$0	$0	$0
049t	MO100321	Central Region	$11,773	$6,747	$0	$482	$0
049w	MO103918	Southwest Region	$28,679	$14,162	$0	$1,011	$0
049x	MO100865	Northwest Region	$2,761	$0	$0	$0	$0
049z	MO100808	Northwest Region	$23,121	$1,151	$0	$82	$0
052a	MO103389	Southwest Region	$4,568	$1,092	$0	$0	$0
052d	MO901501	Southwest Region	$594,548	$396,545	$0	$0	$0
052f	MO100650	Southwest Region	$79,751	$35,258	$0	$0	$0
052g	MO100787	Southwest Region	$54,824	$0	$0	$0	$0
052h	MO100304	Southwest Region	$0	$146	$0	$0	$0
053a	MO102159	Central Region	$607,148	$475,918	$0	$0	$0
055a	MO903911	Southeast Region	$1,403,696	$553,563	$0	$0	$0
055aa	MO100774	Southeast Region	$20,428	$0	$0	$0	$0
055b	MO103785	Southeast Region	$160,784	$53,810	$0	$0	$0
055c	MO104593	Southeast Region	$287,328	$95,541	$0	$0	$0
055h	MO100859	Southeast Region	$28,060	$0	$0	$0	$0
055j	MO100860	Southeast Region	$5,580	$0	$0	$0	$0
055o	MO100770	Southeast Region	$34,287	$0	$0	$0	$0
055u	MO105913	Southeast Region	$52,129	$18,860	$0	$0	$0
055w	MO100772	Southeast Region	$68,213	$0	$0	$0	$0
056a	MO101128	Southeast Region	$525,969	$229,898	$199,844	$31,388	$0
056ac	MO101227	Southeast Region	$181,409	$201,550	$0	$27,518	$0
056b	MO301793	Southeast Region	$501,762	$324,367	$42,487	$44,286	$0
056c	MO101391	Southeast Region	$3,386	$3,930	$2,851	$537	$0
056e	MO100620	Southeast Region	$12,781	$28,808	$0	$3,933	$0
056f	MO000041	Southeast Region	$145,814	$103,567	$0	$14,140	$0
056g	MO903598	Southeast Region	$55,715	$50,660	$23,806	$6,916	$0
056h	MO105640	Southeast Region	$0	$13	$0	$2	$0
056i	MO100649	Southeast Region	$4,784	$0	$0	$0	$0
056j	MO100828	Southeast Region	$2,972	$2,985	$0	$408	$0
056k	MO101311	Southeast Region	$3,468	$2,046	$0	$279	$0
056l	MO105657	Southeast Region	$2,812	$1,353	$0	$185	$0
056m	MO105848	Southeast Region	$18,677	$23,857	$0	$3,257	$0
056n	MO750502	Southeast Region	$458,763	$268,220	$0	$36,620	$0
057a	MO100872	Northwest Region	$3,054	$1,524	$1,506	$0	$0
057b	MO106010	Northwest Region	$0	$170	$0	$0	$0
057d	MO100864	Northwest Region	$13,386	$26,770	$0	$0	$0
057e	MO101207	Northwest Region	$1,164,372	$135,893	$122,761	$0	$0
057f	MO104262	Northwest Region	$258	$0	$0	$0	$0
058a	MO100518	Northwest Region	$141,409	$179,846	$0	$0	$0
058b	MO301678	Northwest Region	$809,881	$709,893	$207,098	$0	$0
058d	MO100710	Northwest Region	$184	$653	$0	$0	$0
061a	MO101011	Central Region	$276,893	$282,790	$0	$0	$0
061c	MO106101	Central Region	$22,742	$30,124	$0	$0	$0

061d	MO750098	Central Region	$810,324	$709,733	$245,788	$0	$0
061e	MO106671	Central Region	$30,769	$30,757	$0	$0	$0
061i	MO100718	Central Region	$11,033	$12,282	$0	$0	$0
062a	MO902269	Central Region	$584,154	$272,698	$272,682	$77,571	$0
062b	MO100179	Central Region	$459,354	$349,880	$0	$99,526	$0
062c	MO105475	Central Region	$6,475	$495	$0	$141	$0
062d	MO750056	Central Region	$0	$84,040	$0	$23,906	$0
062e	MO100187	Central Region	$151,825	$71,554	$297	$20,354	$0
062i	MO105285	Central Region	$4,395	$0	$0	$0	$0
062j	MO100776	Central Region	$14,799	$162	$162	$46	$0
062l	MO102159	Central Region	$31,215	$0	$0	$0	$0
062n	MO103207	Central Region	$547	$0	$0	$0	$0
062o	MO100783	Central Region	$15,776	$0	$0	$0	$0
062p	MO100778	Central Region	$135	$0	$0	$0	$0
062q	MO100809	Central Region	$4,225	$4,941	$0	$1,405	$0
062r	MO100927	Central Region	$1,678	$0	$0	$0	$0
062s	MO106614	Central Region	$8,211	$0	$0	$0	$0
074a	MO103330	Northwest Region	$13,692	$2,680	$0	$0	$0
074b	MO103348	Southwest Region	$13,984	$723	$0	$0	$0
074c	MO100930	Southwest Region	$6,539	$0	$0	$0	$0
074d	MO103355	Southwest Region	$14,061	$293	$0	$0	$0
082a	MO901592	Eastern Region	$115,917	$107,677	$0	$0	$0
082b	MO103009	Eastern Region	$174,437	$70,866	$0	$0	$0
082d	MO102209	Eastern Region	$507,164	$363,729	$0	$0	$0
082e	MO101485	Eastern Region	$0	$321	$0	$0	$0
087a	MO106598	Northwest Region	$10,873	$37,359	$0	$21,353	$0
087b	MO903127	Northwest Region	$310,701	$483,046	$0	$280,833	$0
089a	MO750403	Eastern Region	$46	$1,111	$0	$0	$0
089b	MO101033	Eastern Region	$363,768	$442,267	$0	$0	$0
090a	MO101136	Eastern Region	$1,125,227	$754,827	$334,783	$0	$0
090b	MO101458	Eastern Region	$230,272	$89,769	$6,078	$0	$0
090c	MO106069	Eastern Region	$57,479	$5,549	$5,038	$0	$0
090d	MO100381	Eastern Region	$69	$2,151	$0	$0	$0
090e	MO102803	Eastern Region	$19,749	$1,383	$676	$0	$0
090g	MO100765	Eastern Region	$629,452	$285,051	$0	$0	$0
090h	MO100581	Eastern Region	$1,101	$2,095	$0	$0	$0
090i	MO100786	Eastern Region	$28,417	$8,326	$0	$0	$0
153aa	MO101389	Northwest Region	$58	$0	$0	$0	$0
153ab	MO101479	Northwest Region	$381	$0	$0	$0	$0
153ac	MO102019	Northwest Region	$441,456	$108,533	$0	$19,897	$0
153b	MO105723	Central Region	$55,551	$78,892	$0	$14,462	$0
153c	MO000024	Eastern Region	$939,912	$621,609	$0	$113,949	$0
153d	MO100567	Eastern Region	$41,442	$1,787	$0	$327	$0
153e	MO105715	Eastern Region	$233,928	$123,486	$0	$22,638	$0
153f	MO105046	Central Region	$43,902	$25,136	$0	$4,608	$0
153g	MO105780	Central Region	$23,698	$17,166	$0	$3,148	$0
153h	MO103942	Central Region	$35,914	$18,301	$0	$3,355	$0
153i	MO101797	Central Region	$1,061	$114,762	$0	$21,040	$0
153j	MO105038	Northwest Region	$59,603	$24,652	$0	$4,520	$0
153k	MO105210	Northwest Region	$36,868	$42,613	$0	$7,811	$0

153l	MO101169	Central Region	$526,695	$244,631	$0	$44,845	$0
153m	MO103892	Northwest Region	$31,392	$33,074	$0	$6,063	$0
153n	MO103900	Northwest Region	$344,452	$335,055	$0	$61,422	$0
153o	MO000025	Northwest Region	$227,038	$47,030	$0	$8,623	$0
153q	MO100668	Central Region	$574,171	$428,571	$0	$78,566	$0
153t	MO100768	Eastern Region	$46,149	$0	$0	$0	$0
153v	MO100714	Northwest Region	$84,718	$17,911	$0	$3,284	$0
153w	MO100503	Eastern Region	$5,245	$1,874	$0	$344	$0
153x	MO100608	Eastern Region	$0	$1,736	$0	$318	$0
153y	MO100871	Northwest Region	$212	$0	$0	$0	$0
153z	MO101388	Northwest Region	$47	$0	$0	$0	$0
154a	MO100526	Northwest Region	$500,957	$264,754	$0	$0	$0
154b	MO301785	Northwest Region	$407,369	$127,265	$0	$0	$0
154c	MO101441	Northwest Region	$672,480	$421,287	$0	$0	$0
154o	MO101067	Northwest Region	$79,412	$112,035	$0	$0	$0
156b	MO101029	Southwest Region	$509,286	$128,548	$92,464	$0	$0
156c	MO100287	Southwest Region	$17,125	$2,122	$2,122	$0	$0
156d	MO101032	Southwest Region	$5,344	$567	$567	$0	$0
158a	MO000022	Southeast Region	$229,291	$69,210	$0	$2,589	$0
158b	MO103157	Southeast Region	$74,598	$66,838	$0	$2,500	$0
158c	MO902319	Southeast Region	$263,949	$157,532	$0	$5,892	$0
158d	MO105095	Southeast Region	$55,095	$44,220	$0	$1,654	$0
158e	MO102571	Southeast Region	$61,848	$72,048	$0	$2,695	$0
158f	MO106705	Southeast Region	$109,236	$64,507	$0	$2,413	$0
158g	MO903853	Southeast Region	$180,424	$146,935	$0	$5,496	$0
158h	MO000021	Southeast Region	$103,513	$180,957	$0	$6,768	$0
158j	MO103165	Southeast Region	$24,597	$14,309	$0	$535	$0
158k	MO103140	Southeast Region	$70,553	$65,351	$0	$2,444	$0
158l	MO100928	Southeast Region	$21,404	$18,094	$0	$677	$0
158m	MO903259	Southeast Region	$0	$110,903	$0	$4,148	$0
158n	MO100730	Southeast Region	$92,392	$75,982	$0	$2,842	$0
188a	MO100922	Southwest Region	$154,134	$164,904	$0	$0	$0
201a	MO103587	Northwest Region	$1,497,122	$0	$0	$0	$0
207a	X	Southwest Region	$22,449	$0	$0	$0	$0
208a	MO103850	Eastern Region	$131,213	$316	$0	$0	$0
210a	MO101623	Eastern Region	$34,544	$0	$0	$0	$0
210b	MO103462	Eastern Region	$91,268	$5,283	$0	$0	$0
210c	MO106077	Eastern Region	$50,697	$2,498	$0	$0	$0
210d	MO103884	Eastern Region	$60,424	$2,873	$0	$0	$0
210e	MO100713	Eastern Region	$48,972	$2,121	$0	$0	$0
210f	MO100712	Eastern Region	$70,854	$4,248	$0	$0	$0
249a	MO105434	Southeast Region	$13,482	$1,400	$0	$0	$0
249b	MO105442	Southeast Region	$65	$0	$0	$0	$0
249c	MO105426	Eastern Region	$242,869	$14,432	$0	$0	$0
249e	MO105459	Eastern Region	$17,983	$3,238	$0	$0	$0
249f	MO100738	Southeast Region	$145	$0	$0	$0	$0
249g	MO100739	Southeast Region	$8,722	$1,793	$0	$0	$0
249h	MO100734	Eastern Region	$1,207	$0	$0	$0	$0
249i	MO100737	Eastern Region	$34	$0	$0	$0	$0
249j	MO101228	Eastern Region	$11,257	$968	$0	$0	$0

249k	MO101347	Eastern Region	$1,019	$0	$0	$0	$0
249l	MO105418	Eastern Region	$34,127	$2,775	$0	$0	$0
250a	MO100729	Northwest Region	$36,822	$3,933	$0	$0	$0
250b	MO102068	Northwest Region	$323,423	$10,110	$0	$0	$0
250c	MO103470	Northwest Region	$42,114	$3,824	$0	$0	$0
250d	MO105251	Northwest Region	$69,115	$3,753	$0	$0	$0
250e	MO105988	Northwest Region	$72,810	$6,624	$0	$0	$0
275a	MO103868	Central Region	$43,448	$2,890	$0	$0	$0
312a	MO903879	Southwest Region	$586,924	$208,537	$176,853	$0	$0
315a	MO100688	Eastern Region	$106,666	$5,645	$0	$0	$0
Totals:			**$33,811,255**	**$18,754,688**	**$2,069,505**	**$6,009,530**	**$0**

- Footnotes

Missouri is not a designated HIV state.

PROVIDER ADDRESS TABLE

State: Missouri

Provider ID	Description	Provider Address
002	NORTHWEST MO PSYCHIATRIC REHAB CENTER	3505 Frederick St. Joseph, MO 64506 816-387-2329
008	CENTRAL OFFICE	1706 E. Elm Street Jefferson City, MO 65101 573-751-4942
152	NATIONAL COUNCIL ON ALCOHOLISM & DRUG ABUSE - ST LOUIS AREA INC	8790 Manchester Road St. Louis, MO 63144 314-962-3456
154	KANSAS CITY COMMUNITY CENTER	1730 Prospect Avenue Kansas City, MO 64127 816-421-6670
171	NATIONAL COUNCIL OF GREATER KANSAS CITY	633 E. 63rd Street Kansas City, MO 64110 816-361-5900
208	LIBERTY PROGRAM INC.	929 Fee Fee Road Suite 203 Maryland Heights, MO 63043 314-434-9441
209	SAFETY COUNCIL OF THE OZARKS	1111 South Glenstone Springfield, MO 65804 417-869-2121
210	EASTERN MISSOURI ALTERNATIVE	2724 Draste Road St. Charles, MO 63301 636-946-2815
211	MARTY ENTERPRISES (DBA AFFILIATED COURT SERVICES)	800 North Providence Ste. 104 Columbia, MO 65203 573-499-3784
216	CAAREC	326 Cherry Street Chillicothe, MO 64601 660-646-1652
217	CENTRAL STATES MENTAL HEALTH CON	3217 S. Owens School Road Independence, MO 64057 816-224-4417
220	RASSE DAVID R & ASSOC	78 West Arrow Marshall, MO 65340 660-886-3373
227	SAFETY COUNCIL OF GREATER ST LOUIS	1015 Locust Street Suite 902 St. Louis, MO 63101 314-621-9200
231	TRAFFIC SAFETY AWARENESS	PO Box 575 Linn Creek, MO 65052 573-346-3829
249	COMMUNITY SERVICES OF MO INC.	1175 Cave Springs Estate Drive St. Peters, MO 63376 636-441-9002
252	ACCREDITED TRAFFIC OFFENDER SERV	1515 E. Malone Sikeston, MO 63801 573-471-7710
264	DOOR TO HOPE COUNSELING AND EDUCATION LLC	PO Box 1049 Nixa, MO 65714 417-724-9767
267	MISSOURI ASSOCIATION OF COMMUNITY TASK FORCES	428 E. Capitol Avenue Second Floor Jefferson City, MO 65101 573-635-6669
	ALCOHOL DRUG	1736 East Sunshine Suite 214

274	CONSULTANTS	Springfield, MO 65804 417-848-4565
277	HEARTLAND ALTERNATIVE SERVICE PROG	405 Poplar Street Poplar Bluff, MO 63901 573-686-5488
282	ST JOSEPH SAFETY & HEALTH COUNCIL	118 South Fifth Street (Lower Level) St. Joseph, MO 64501 816-233-3330
287	DEAF HOPE	PO Box 14441 Shawnee Mission, KS 66215 913-281-4875
288	SOUTH CENTRAL MO CITIZEN'S ADVISORY	1580 Imperial Center West Plains, MO 65775 417-257-7568
297	ABOUT FACE MENTAL HEALTH SERVICES LLC	6301 Rockhill Road Suite 105 Kansas City, MO 64131 816-444-6200
316	JONES TIMOTHY MA INC	309 West 4th Street Suite 101 Washington, MO 63090 636-239-2054
401	COMMUNITY HOUSING NETWORK INC	2600 East 12th Street Kansas City, MO 64127 816-482-5744
402	COVINGTON AND BURLING	1201 Pennsylvania Ave NW PO Box 7566 Washington, DC 20044 202-662-5410
403	OXFORD HOUSE INC.	1010 Wayne Avenue Suite 300 Silver Spring, MD 20910 301-587-2916
405	UNIVERSITY OF MO - COLUMBIA	Sponsored Programs Admin 310 Jesse Hall Columbia, MO 65211 573-882-9587
406	BIG BROTHERS BIG SISTERS	501 North Grand Blvd St. Louis, MO 63103 314-361-5900
408	COMMUNITY PARTNERSHIP OF OZARKS	330 N. Jefferson Springfield, MO 65806 417-888-2020
411	DISCOVERING OPTIONS	909 Purdue Avenue St. Louis, MO 63130 314-721-8116
412	FRIENDS WITH A BETTER PLAN	5622 Delmar Suite 102E St. Louis, MO 63112 314-361-2371
413	LEAD INSTITUTE THE	2502 West Ash Columbia, MO 65203 573-817-2400
414	LINCOLN UNIVERSITY	Business & Finance 306 Young Hall PO Box 29 Jefferson City, MO 65102 573-681-5058
416	MO ALLIANCE OF BOYS/GIRLS CLUB	1460 Bee Creek Road Branson, MO 65616 417-335-2089
417	PREVENTION CONSULTANTS OF MO	104 East 7th Street Rolla, MO 65401 573-368-4755
418	SOUTHEAST MO STATE UNIVERSITY	One University Plaza MS 3000 Cape Girardeau, MO 63701 573-651-2018
420	UNITED WAY OF THE OZARKS	320 N. Jefferson Springfield, MO 65806 417-863-7700
421	UNIVERSITY OF OKLAHOMA	Office of Proj & Compl Ass. 660 Parrington Oval 324 Norman, OK 73019 918-660-3700
		PO Box 45301

423	SAVE INC.	Kansas City, MO 64171 816-531-8340
430	OZARKS AREA COMMUNITY ACTION	215 South Barnes Avenue Springfield, MO 65802 417-864-3492
431	OFFICE OF STATE COURTS ADMINISTRATION	2112 Industrial Drive PO Box 104480 Jefferson City, MO 65110 573-751-4377
207a	CORRECTION SERVICES	2200 E. Sunshine Suite 320 Springfield, MO 65804 417-869-5161

Form 6a

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	4
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Drop-Outs [3]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7	22

	]	
	Information lines/Hot lines [8]	1
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Education programs for youth groups [14]	13
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	4
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18

	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	4
	Ongoing classroom and/or small group sessions [12]	8
	Mentors [15]	5
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	8
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	13
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Physically Disabled [7]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13

	Community team-building [44]	13
	Accessing services and funding [45]	13
Abuse Victims [8]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Already Using Substances [9]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Multi-agency coordination and collaboration/coalition [43]	13

Form 7a

TREATMENT UTILIZATION MATRIX

State: Missouri

Dates of State Expenditure Period: From: 7/1/2007 To: 6/30/2008

Level of Care	Number of Admissions ≥ Number of Persons		Costs per Person		
	A.Number of Admissions	B.Number of Persons	C.Mean Cost of Services	D.Median Cost of Services	E.Standard Deviation of Cost
Detoxification (24-Hour Care)					
Hospital Inpatient	258	247	$ 5761	$ 5438	$ 4931
Free-standing Residential	6711	5097	$ 337	$ 267	$ 293
Rehabilitation / Residential					
Hospital Inpatient			$	$	$
Short-term (up to 30 days)	16825	14607	$ 2587	$ 1869	$ 2563
Long-term (over 30 days)			$	$	$
Ambulatory (Outpatient)					
Outpatient	14240	13121	$ 556	$ 483	$ 568
Intensive Outpatient	17884	15747	$ 956	$ 581	$ 1131
Detoxification			$	$	$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	384	337	$ 1536	$ 1164	$ 1095

Form 7b

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	2459	1158	633	450	71	1	1	3	0	4	4	49	24	46	15	1661	732	50	16
2. 18-24	7779	4545	1900	745	269	4	1	10	4	9	7	109	48	95	33	5400	2215	117	47
3. 25-44	19408	10009	4776	2717	1235	11	1	34	6	29	21	204	102	202	61	12929	6106	277	96
4. 45-64	7587	3968	1372	1545	488	0	0	10	3	18	7	75	25	69	7	5585	1888	100	14
5. 65 and over	199	136	31	26	1	0	0	1	0	0	0	1	1	2	0	163	33	3	0
6. Total	37432	19816	8712	5483	2064	16	3	58	13	60	39	438	200	414	116	25738	10974	547	173
7. Pregnant Women	530		361		140		0		0		4		17		8		517		13

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? (•) Yes ( ) No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 9661

In FY 2008, another 4,613 persons were served with recovery services in lieu of clinical treatment.

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations

TB SERVICES

The Division of Alcohol and Drug Abuse (ADA) works in cooperation with the Missouri Department of Corrections, Missouri Department of Health and Senior Services, and the Missouri Department of Social Services, MO HealthNet Division (Medicaid) to collect the information required to report the statewide non-federal cost of Tuberculosis (TB) Services provided to citizens of Missouri, as well as to the substance abusers in treatment in Missouri. The statewide expenditures for TB services to substance abusers in treatment have been calculated with the following methodology:

The Department of Corrections provides aggregated costs of TB services to inmates in correctional facilities, and associated costs to those inmates in institutional substance abuse treatment programs.

The Department of Health and Senior Services provides aggregated costs of the number of clients treated for TB by local health departments. In addition, non-federal cost of the TB tests performed at local health departments is computed for clients referred from ADA funded treatment programs.

The Department of Social Services provides statewide expenditures for claims with TB diagnosis codes per the Missouri Medicaid Management Information System. The State Medicaid expenditures for TB treatment provided by ADA funded programs per the Department of Mental Health Customer Information Management, Outcomes, & Reporting (CIMOR) system are a subset of the information received from Medical Services and represent the percent of expenditures that were spent on substance abusers in treatment.

The final component of the TB cost determination is from the CIMOR system which captures services delivered to clients by service code. The payments for these non-Medicaid TB services were summed and segregated by funding source (Non-Federal or State Funds).

Table 1 Methodology for Determining the Cost of Tuberculosis Services Provided to Substance Abusers in Treatment.

A	B	C	D
Agency	**Total of All State funds spent on TB services**	**% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment**	**Total State Funds Spent on Clients who were Substance Abusers in Treatment**
ADA non-Medicaid	State non-Medicaid expenditures for TB treatment provided by ADA funded programs per the DMH (CIMOR) data system	Column D / Column B	State non-Medicaid expenditures for TB treatment provided by ADA funded programs per the DMH (CIMOR) data system
Medicaid	State Medicaid expenditures for claims with TB diagnosis codes per the Missouri Medicaid Management System (MMIS)	Column D / Column B	State Medicaid expenditures for TB treatment provided by ADA funded programs per the DMH (CIMOR) data system
Department of Corrections (DOC)	State expenditures for TB services provided in correctional facilities. Computed as the total number of inmates multiplied by the average TB treatment cost per day multiplied by average length of incarceration per inmate	Column D / Column B	The number of inmates receiving substance abuse treatment in correctional facilities multiplied by the average TB treatment cost per day multiplied by the average length of incarceration per inmate
Department of Health and Senior Services (DHSS)	Total State expenditures for TB services per DHSS	Column D / Column B	The number of clients referred from ADA funded treatment programs to local health departments for TB testing multiplied by average State expenditures for TB testing -plus- The number of clients treated for TB by local health departments multiplied by average State expenditures for TB treatment
Total	Sum of Rows Above	Sum of Rows Above	Sum of Rows Above

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

The Division used the following method to calculate the amounts for the base and subsequent years for services to pregnant women and women with dependent children:

For the base year 1992, all payments for services to women at programs meeting the requirements of Section 1922© and Section 96.124 (e) were summed and segregated by funding source (Federal Block Grant and Non-Federal or State Funds). The required base expenditures were calculated as $7,728,020.

The Department of Mental Health CIMOR fee-for-service payment system uses detailed coding to capture services delivered to pregnant women and women with dependent children by procedure code. The total expenditures on these qualified programs were $9,366,605 for SFY2008 and $10,238,872 for SFY2009. These amounts are exceed the required base expenditures.

With this application, we are changing the reporting period from a federal fiscal year to a state fiscal year and amending the information for 2008. This decision was discussed during our SAPT Core Technical Review conducted in October 2008 and approved by our Project Manager. This information differs minimally based on the reporting period. This change will facilitate our reporting as all our other reporting is done on the state fiscal year.

SSA (MOE TABLE I)

State: Missouri

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2007) + B2(2008) ---------- 2 (C)
SFY 2007 (1)	**$41,693,303**	**$43,223,212**
SFY 2008 (2)	**$44,753,120**	
SFY 2009 (3)	$ 48,801,203	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2007 (•) Yes ( ) No

FY 2008 (•) Yes ( ) No

FY 2009 (•) Yes ( ) No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2009 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

(•) Yes ( ) No If yes, specify the amount and the State fiscal year: $ 286477 , 2008(SFY)

Did the State include these funds in previous year MOE calculations?

( ) Yes (•) No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? (Date) 8/29/2008

- Footnotes

The State also had FY 2007 non-recurring expenditures of $613,700 for a specific purpose which were not included in the MOE calculation. The non-recurring expenditures of $286,477 in FY 2008 and $613,700 in FY 2007 were for implementation of the State's new information system at treatment provider agencies. These expenditures were not included in the previous year MOE calculations. The request to exclude the FY 2007 and FY 2008 non-recurring expenditures for the MOE calculations was submitted by the State on 8/29/2008. Approval was granted 12/17/2008.

TB (MOE TABLE II)

State: Missouri

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)	Average of Columns C1 and C2 C1 + C2 -------- 2 (D)
SFY 1991 (1)	**$ 421,670**	**0.06 %**	**$ 253**	**$ 1,265**
SFY 1992 (2)	**$ 455,117**	**0.50 %**	**$ 2,276**	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)
SFY 2009 (3)	**$ 534,181**	**7.35668240 %**	**$ 39,298**

HIV (MOE TABLE III)

State: Missouri

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 -------- 2 (B)
SFY 1993 (1)	$ 298,242	$ 301,434
SFY 1994 (2)	$ 304,625	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2009 (3)	$

* Provided to substance abusers at the site at which they receive substance abuse treatment

- Footnotes

Missouri is not an HIV designated state.

Womens (MOE TABLE IV)

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	**$7,728,020**	
2007		**$9,086,592**
2008		**$9,366,605**
2009		$ 10,238,872

Enter the amount the State plans to expend in FY 2010 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $ 10,238,872

Total expenditure amounts for 2007 have been updated from $9,362,319 to $9,086,592. Total expenditure amounts for 2008 have been updated from $9,135,883 to $9,366,605 to reflect a state reporting period. The request for these changes has been submitted to the state's CSAT project officer for approval on 9-15-09.

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29, 45 C.F. R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

In a narrative of **up to three pages**, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected and how it is used in making these decisions. If there is a State, regional or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. Describe the State's Epidemiological Outcomes Workgroup's composition and contribution to the planning process for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.
Describe how your State evaluates activities related to ongoing substance abuse prevention efforts, such as programs, policies and practices, and how this data is used for planning. For the prevention assessment, States should focus on the SEOW process. Provide a summary of how data/data indicators were chosen, as well as, key date construct and indicators for understanding State-level substance use patterns and related consequences and mechanisms for tracking data and reporting significant changes should be outlined.

- 42 U.S.C. 300x-51 and 45 C.F. R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2010 application for SAPT Block Grant funds.

Substate Area Planning

The Missouri Department of Mental Health (DMH) has five planning regions that are used by its Division of Alcohol and Drug Abuse (ADA) and Division of Comprehensive Psychiatric Services (CPS). The ADA planning regions are further divided into 20 service areas consisting of clusters of counties. The largest metropolitan service areas comprise one or two counties while some of the rural service areas cover up to nine counties (http://www.oas.samhsa.gov/subState2k5/secD.htm#MO).

ADA has developed planning models used in the past for expansion of treatment sites using a methodology to 1) rank treatment need based on substance abuse indicators, 2) identify service gaps, and 3) prioritize expansion of an array of youth and adult services in each service area. Data from the 2003 State Treatment Needs Assessment Program (STNAP-II) had been applied to the model. Since then, the state has been integrating state and sub-state data from the National Survey on Drug Use and Health (NSDUH) into its analysis. Of particular importance are the estimates for alcohol dependence and abuse, illicit drug dependence and abuse, and needing but not receiving treatment for alcohol abuse and illicit drug abuse by age group (NSDUH 2002-2004).

Prevalence is tracked through several different survey tools including 1) NSDUH, 2) the Missouri Student Survey (MSS), 3) the Youth Risk Behavior Survey (YRBS), and 4) the Behavioral Risk Factor Survey (BRFS). With the NSDUH survey, multiple years are combined to provide state and sub-state area planning prevalence data for individuals age 12 and older. In addition to NSDUH, the state is able to get prevalence data at the sub-state level for students in grades 8 through 12 via the MSS. In the 2008 MSS, about 115,000 students were surveyed. The MSS also captures data on risk and protective factors and antisocial behaviors in addition to substance use patterns.

Other substance abuse indicator data are tracked by sub-state planning area and county. These indicators include, but are not limited to, hospital and emergency room admissions, traffic crashes, deaths, new HIV/AIDS cases, arrests, methamphetamine laboratory incidents, school incidents, prison admissions, and drug court enrollments. The data are routinely collected from various other state and federal government agencies.

Substance abuse treatment admissions are also analyzed by sub-state planning area and county according to the consumer's county of residence. This data is retrieved from the DMH Customer Information, Management, Outcomes, and Reporting (CIMOR) system. Aggregate admission data are provided by age, race, gender, primary substance abuse problem, injection drug use, referral source, employment, co-occurring issues, and arrest history.

Prevalence data, indicator data, and treatment admission data are monitored, assessed, and documented in the ADA annual status report which is posted to the division's public website: http://www.dmh.missouri.gov/ada/rpts/status.htm. Statewide,

planning region and county levels of analysis are provided. County level data, in particular, are used by community coalitions for identifying needs and requesting DMH funding for local level mini-grants and other federal and private sources of funding for strategies and programming. The report also includes state and national comparisons and provides an overall assessment of the current conditions in the state as they relate to substance use and abuse. ADA is partnering with the Missouri Institute of Mental Health to develop a web-based querying system which will first be piloted with the MSS data but will be later expanded to include most if not all of the data elements tracked by the ADA annual status report. This querying system will be made available via the division's public website. This system will allow for more customized analysis and reporting than is available with a static report.

In addition to the status report data, ADA develops treatment and prevention program performance and outcome measures described and quantified in the annual budget requests. Measured performance is annually compared with projections, and new or revised decision items are developed to address emerging needs. During the processes of prioritizing and justifying these proposed programs and services, additional plan details such as consumer eligibility, treatment methods, program locations, and management issues are clarified and elaborated.

ADA also uses geographic information system (GIS) technology to map and analyze data geographically to identify service gaps. This technology was used in the Access to Recovery II (ATR II) grant by generating density maps of where methamphetamine consumers live in order to engage recovery support providers in these areas and target services to this population. Methamphetamine users have been identified as a special target group under the ATR II grant.

Missouri's Strategic Prevention Framework State Incentive Grant, awarded in 2006, addresses the prevention of risky (defined as binge and underage) drinking in the age group 12-25. Eighteen local coalitions, one statewide coalition, and one campus-based coalition offer evidenced based prevention programming to their communities, based upon a data-driven assessment of community needs. In addition, coalitions are implementing environmental strategies designed to decrease risky drinking by changing the environment in which the problem behavior occurs. Coalitions are also heavily involved in increasing the capacity of their communities to address alcohol use among youth and young adults. Capacity building efforts include acquiring additional data and resources and building community readiness, cultural responsiveness, and sustainability. In the coming year (FY 2010), the grant will focus on sustainability. Evidence-based programs and environmental strategies will be examined to determine which are the most effective at decreasing risky drinking in the age group 12-25. Those effective programs and strategies will then be transitioned into being housed with key stakeholders, ensuring that they will be continued after the grant funding has ended. Data collection and analysis will continue, allowing for the continuation of data based decision making in the communities.

The Strategic Prevention Framework State Incentive Grant (SPF SIG) has made a significant contribution to planning through the formation of the Governor's Substance Abuse Prevention Initiative Advisory Committee. The Governor's Substance Abuse Prevention Initiative Advisory Committee serves as an advisory body to ADA. With representation from state agencies impacted by substance abuse, other stakeholders, the State Advisory Council (SAC), and service providers--and with technical support from its subcommittees and the State Epidemiological Workgroup--the Advisory Committee has had an important role in making recommendations to ADA on direction of this grant. When the Advisory Committee was first established, it conducted Hispanic and Asian focus groups in each of the state's planning regions, piloted the Tri-Ethnic Institute's Community Readiness Assessment, developed an inventory of prevention resources and activities, and prepared a prevention needs assessment report. The Prevention Workforce Development Task Force had assessed workforce activities and training needs and made recommendations regarding standardized training and multi-tier certification program. The Missouri Substance Abuse Professional Credentialing Board now offers three levels of prevention credentials.

As a requirement of the SPF SIG, a State Epidemiology Workgroup (SEW) was established in April 2005. Membership of the SEW consists primarily of program managers in federal and state agencies that address substance abuse problems. These include the U.S. Drug Enforcement Administration, Missouri State Highway Patrol, Missouri Department of Health and Senior Services, Missouri Department of Corrections, Missouri Department of Social Services, Missouri Department of Mental Health, St. Louis Mental Health Board, and St. Louis Community Epidemiology Work Group. The SEW assembled and compared rates of Missouri and national substance abuse consumption and consequences data, including all data sets contained in the State Epidemiology Data System (SEDS). The SEW also used GIS to map county-level data for a variety of substance abuse consequences. These included alcohol and drug related traffic crashes, arrests, emergency room episodes, juvenile court referrals, out-of-home placements, and births compromised by maternal substance abuse. The data analysis, recommendations, and a comprehensive *SPF SIG Initial Needs Assessment* report developed by project staff at the Missouri Institute of Mental Health (MIMH) were presented to the Governor's Advisory Committee in December 2005. The MIMH issued the SPF SIG *Needs Assessment Update* in April 2009. That report examines trends in statewide data related to the SPF SIG Missouri goal of reducing risky drinking behavior. The updates include alcohol prevalence rates that comprise the primary measures and the proxy data that were used to select the project's target population of adolescents and young adults 12-25 years of age. The SEW is exploring the possibility of working with the Missouri Department of Health and Senior Services and the University of Missouri to analyze trends in the alcohol measures from the Behavioral Risk Factor Survey (BRFS). The analysis will examine the clusters of zip codes corresponding to the areas served by the 18 funded SPF SIG coalitions. Rates of current (past 30-day) alcohol use and binge alcohol use will be documented and compared for the three-year time periods prior to prevention program implementation (2004-2006) and during implementation (2007-2009). Funding will also be sought to conduct a follow-up analysis for the post-implementation period of 2010-2012.

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), was established by statute and is an advisory body to ADA and the ADA director. The SAC is comprised of 25 members appointed by the director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. According to statute, the SAC collaborates with ADA in developing and administering a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol or drug abuse. The SAC studies current technologies and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public residential facilities, day programs, and other specialized services. The SAC recommends specific methods, means, and procedures that should be adopted to improve and upgrade the service delivery system, and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding.

The SAC consults with ADA's District Administrators, Area Treatment Coordinators, and Prevention Specialists. The Treatment Coordinators monitor the ADA-funded treatment programs and their utilization rates. The Prevention Specialists monitor ADA-funded prevention programs and provide consultation on appropriate strategies. The District Administrators gather input from their staff, the advisory council members, and other sources to develop a thorough understanding of the service gaps in their districts with regard to locations, types of services, and populations to be served. The ADA Executive Staff utilize data from the needs assessment models, data analysis conducted by the ADA Research and Statistics unit, and consult with the District Administrators on decisions involving program expansions and reallocations. Information from these multiple sources helps ensure that ADA expends its funds to provide services in communities and for populations with the greatest needs.

Public Comment in Plan Development

The Missouri Advisory Council on Alcohol and Drug Abuse, commonly referred to as the State Advisory Council (SAC) constitutes the formal mechanism that ensures that Missouri citizens have an opportunity to participate in and express their views regarding the state's publicly funded substance abuse prevention and treatment system managed by the Missouri Division of Alcohol and Drug Abuse (ADA). The SAC's statutory mandate is to collaborate with ADA to disseminate public information about alcohol and drug abuse; review current social technologies and recommend improvements to substance abuse prevention and treatment programs based upon scientific evidence; recommend what should be changed and how to improve and update the substance abuse service delivery system; and participate in developing standards for prevention and treatment services.

The SAC has 25 members consisting of service providers, consumers (recipients of services or family members of recipients), and other interested citizens. Most SAC members have leadership roles as managers, advocates or volunteers in the substance abuse service delivery system. Current representation includes treatment, recovery support, and prevention service providers; the Missouri National Guard; the Department of Corrections; the Missouri Police Chiefs Association; drug court; the Department of Health and Senior Services; and the Department of Elementary and Secondary Education. The SAC meets regularly and holds conference calls to receive updates from ADA staff and provide feedback on budget-related matters, legislative initiatives, strategic planning, performance measurement development, and other aspects of service delivery system. The SAC chairperson appoints ad hoc committees as needed to address priority issues and make recommendations to ADA. SAC members continually seek input from individuals, agencies, and organizations impacted by substance abuse.

The content of the SAPT block grant application's state plan reflects recommendations originating from the SAC and other sources, including direct citizen input. The compressed time frame for preparing the SAPT Block Grant application generally precludes a review by the SAC and other interested persons prior to its submission to the Center for Substance Abuse Treatment (CSAT) in October of each year. To facilitate ongoing review, each application is posted to the ADA public website at http://www.dmh.missouri.gov/ada/blockgrant.htm. The array of links to current and past block grant applications is preceded by a narrative that explains the purpose of the block grant and solicits comments from any interested persons (http://www.dmh.missouri.gov/ada/reportsstatistics.htm#blockgrant.). The solicitation for comments is worded as:

The CSAT requires each state to have a process to facilitate public comment in developing the plan and the application for Block Grant funds. The Division encourages interested persons to review the application and submit comments and suggestions that can be considered for inclusion in the next Block Grant application submission. Please mail your comments to: Director, Division of Alcohol and Drug

Abuse; P.O. Box 687; Jefferson City, MO 65102. *You can also e-mail your comments to:* adamail@dmh.mo.gov.

ADA notifies the SAC members of the application submission, encourages them and their constituents to review it, and asks them to communicate their comments to ADA's central and district office staff for consideration in developing the next application. This process provides ongoing access to the SAPT applications and feedback from the advisory network and general public.

In October 2006, Missouri was awarded a Mental Health Transformation State Improvement Grant from the Center for Mental Health Services (CMHS). In addition to mental health, the State included substance abuse and developmental disabilities in its transformation planning process. As part of this grant, a needs assessment and resource inventory were conducted that included information gathering from 15 focus groups held with 191 consumers; online surveys conducted with 184 mental health, substance abuse, and developmental disabilities agencies; and 14 public hearings held across the state. This process delineated the needs as perceived by the various stakeholder groups and identified 21 themes clustered into six domains: Safety; Access to Care; Mental Health Wellness; Consumer-driven Care and Support; Quality Mental Health Care; and Mental Health System Fragmentation. Goals and strategies formulated in this process have helped guide the DMH strategic plan. This grant is a five-year grant.

Planning Checklist

State: Missouri

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2010 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

3 Population levels, Specify formula:

2007 population estimates of service areas

3 Incidence and prevalence levels

4 Problem levels as estimated by alcohol/drug-related crime statistics

4 Problem levels as estimated by alcohol/drug-related health statistics

5 Problem levels as estimated by social indicator data

5 Problem levels as estimated by expert opinion

1 Resource levels as determined by (specify method)

maintenance of existing services

2 Size of gaps between resources (as measured by)

number of consumers served in FY 2009

and needs (as estimated by)

prevalence estimatse based on the Missouri 2006-2007 NSDUH

Other (specify method)

Form 8

Treatment Needs Assessment Summary Matrix

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Northwest Region	1425141	112552	10979	4029	1581	45058	4269	8858	11743	24	10	12	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Central Region	778730	63387	4785	1217	170	25376	2230	5236	4492	153	5	3	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Eastern Region	2087945	171783	20278	3693	608	68770	7541	9529	14125	10	3	11	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southwest Region	895737	65917	5816	2103	147	26388	2276	6148	5598	21	3	4	1

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Operating Vessel Under the Influence	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southeast Region	690862	50361	2465	1249	130	20161	1284	5193	5567	5	6	5	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2007 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Number of DWI	B. Number of drug-	C. Other: Operating Vessel Under	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000

			treatment		treatment		treatment	arrests	related arrests	the Influence			
State Total	5878415	464000	44324	12291	2638	185756	17603	34964	41525	213	5	9	2

In FY 2010, Division of Alcohol and Drug Abuse (ADA) will submit a formal request to the Substance Abuse and Mental Health Services' Office of Applied Studies for estimates to complete forms 8 and 9 for future Substance Abuse Prevention and Treatment Block Grant applications. ADA intends to use OAS generated estimates in lieu of the data from the State Treatment Needs Assessment Program (STNAP-II) as the STNAP-II data is nearly 7 years old. In recent years, the State has experienced declining revenues and budget cuts. As such, ADA does not have resources to conduct a separate household survey.

Form 9

Substate Planning Area [95]: State Total

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	39,992	20,283	13,522	3,031	1,537	6	21	20	0	26	85	321	512	308	320	23,300	15,660	700	340
18 - 24 Years Old	126,541	64,170	42,780	9,044	5,846	48	21	120	86	108	151	1,278	996	1,157	736	74,319	49,614	1,611	1,005
25 - 44 Years Old	190,338	96,521	64,347	15,050	10,201	60	8	187	49	165	172	1,105	839	1,116	518	111,823	74,926	2,385	1,213
45 - 64 Years Old	80,924	41,038	27,358	6,775	4,615	0	0	43	28	74	66	319	236	306	66	47,720	32,133	838	239
65 and Over	25,166	12,764	8,509	2,026	779	0	0	77	0	0	0	77	779	155	0	14,830	10,069	273	0
Total	462,961	234,776	156,516	35,926	22,978	114	50	447	163	373	474	3,100	3,362	3,042	1,640	271,992	182,402	5,807	2,797

Total estimates for race and ethnicity do not equal due to rounding.

In FY 2010, Division of Alcohol and Drug Abuse (ADA) will submit a formal request to the Substance Abuse and Mental Health Services' Office of Applied Studies for estimates to complete forms 8 and 9 for future Substance Abuse Prevention and Treatment Block Grant applications. ADA intends to use OAS generated estimates in lieu of the data from the State Treatment Needs Assessment Program (STNAP-II) as the STNAP-II data is nearly 7 years old. In recent years, the State has experienced declining revenues and budget cuts. As such, ADA does not have resources to conduct a separate household survey.

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 8.

How your State determined the numbers for the matrix

Form 8:

Column 1: Substate planning area
The Division of Alcohol and Drug Abuse (ADA) configures Missouri into five large planning regions, each consisting of clusters of counties referred to as service areas. Missouri's three largest cities anchor three of these regions. Kansas City is located in the Northwest Region, St. Louis is in the Eastern Region, and Springfield is in the Southwest Region. Columbia, the fifth largest city, is in the Central Region. Cape Girardeau is the largest city in the Southeast Region.

Column 2: Total population
The population of each sub-state region listed on Form 8 is based on the 2007 population estimates prepared by the U.S. Census Bureau and the Missouri Census Data Center.

Column 3: Total population in need
The estimate for total population in need (464,000) was obtained from the National Survey on Drug Use and Health (NSDUH) 2006-2007. The number with alcohol or illicit drug dependence or abuse is used as a proxy for treatment need. Sub-state estimates were obtained by allocating the total in need (464,000) by the portion derived from the NSDUH 2004-2006 sub-state estimates.

For the number seeking but not receiving treatment, the State uses data from the Missouri State Treatment Needs Assessment Program (STNAP-II) study funded by CSAT and completed in 2003. The STNAP-II study estimates that 16% of household consumers would seek treatment and 50% of non-household residents would seek treatment. Therefore a rate of 20% was used to determine the number of consumers who would seek treatment. In FY 2007, ADA provided substance abuse treatment services to 48,476 Missouri residents whose county of residence (and therefore ADA planning region) is known. Subtracting the residents who accessed treatment services from the 92,800 who would seek treatment, an estimated 44,324 residents who would seek substance abuse treatment did not receive services. This unmet demand is reported by planning region in column 3B.

Column 4: Number of IVDUs in need
The State continued to apply the percent of those in need who were intravenous drug users (IVDUs) obtained from the STNAP-II study. For the sub-state planning regions, this ranged from 1.9% to 3.6%. Although the STNAP-II study did not estimate the number of IVDU who would seek treatment, it did estimate that 50% of high-risk non-household adults would seek treatment. During the last four years, ADA has actually provided services to more than 50% of the estimated IVDU in some of the planning regions, so a potential treatment seeking rate of 60% of prevalence was applied to the IVDU to yield an estimated 7,375 IVDU that would seek treatment.

Subtracting the 4,736 IVDU whose county of residence (and therefore ADA planning region) is known and who received treatment services in FY 2007 from the 7,375 who would seek services, an estimated 2,638 IVDU who would seek treatment did not receive services. This unmet demand is reported by planning region in column 4B.

Column 5: Number of women in need

In August 2008, the State obtained estimates of females dependent on or abusing alcohol or illicit drugs in the past year by planning region based on 2002-2007 NSDUH data. The percent of females in need of treatment was determined by comparing the estimate of women in need based on 2002-2007 NSDUH to the average total need for comparable years. About 40% of those in need are female and about 60% are male. These percentages were then applied to the estimate of total need (464,000) obtained from NSDUH 2006-2007 to obtain updated numbers of need by gender. The number of women in need of treatment was determined to be 185,756.

In determining the number of women seeking treatment, ADA applied the STNAP-II rate of women seeking treatment – roughly 17.5%. In FY 2007, ADA provided substance abuse treatment services to 14,904 Missouri women whose county of residence (and therefore ADA planning region) are known. By subtracting the women who accessed treatment services from the 32,507 who would seek treatment, an estimated 17,603 women have an unmet demand for treatment. This unmet demand is reported by planning region in column 5B.

Limitation of Data in Columns 3, 4, and 5

The STNAP-II study was conducted from 2000 to 2003. The household telephone interviews, which provided much of the core data for the prevalence estimates, were administered in 2001 and 2002. The STNAP-II data is seven years old or older. Some demographic breakouts can be obtained by combining multiple years of NSDUH surveys. Some demographic breakouts such as IVDUs cannot be obtained from NSDUH due to the insufficient sample size to obtain reliable estimates for such small population subgroups. ADA will continue to review the latest NSDUH estimates for the state and its planning regions as they become available and will integrate these survey results into the Missouri prevalence estimates.

Column 6: Prevalence of substance-related criminal activity

Driving while intoxicated (DWI) arrests, drug arrests, and 'operating vessel under the influence' (OVUI) arrests are included in the Uniform Crime Reporting system. Data is coded according to the county of arrest and aggregated to the ADA planning regions. OVUI was selected for reporting in the optional column because Missouri has a large number of lakes and navigable streams that are used for boating, skiing, canoeing, and other water recreation. Alcohol-related boat crashes, drowning, and injuries are a significant problem in the state.

Column 7: Incidence of communicable diseases

The 2007 data on acute and chronic hepatitis B, HIV&AIDS, and tuberculosis disease were provided by the Missouri Department of Health and Senior Services. The data are

aggregated to the ADA planning regions using the county of residence at time of diagnosis. The rates are based on the number of cases per 100,000 residents in accordance with 2007 population estimates.

Form 9:

The total number of youth age 12-17 dependent on or abusing alcohol or an illicit drug (40,000) was obtained from the 2006-2007 NSDUH. As the other age ranges from NSDUH do not match with that of form 9, percentages of need by age group were used from STNAP-II data. Gender percentages were estimated from combined NSDUH survey data – both published and unpublished estimates. Race percentages were obtained for groups "white" and "non-white" based on STNAP-II data. About 84.5% of those in need were white and 15.5% were of other race. The "non-white" group was further disaggregated based on demographics of the State's FY 2007 treatment admissions. The groups for non-Hispanic and Hispanic were generated by treatment rates as well.

Form 11

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

	(24 Month Projections)					
Activity	**A.SAPT Block Grant FY 2010 Award**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 19,677,298	$ 50,998,586	$ 13,981,684	$ 66,304,788	$ 0	$ 0
Primary Prevention	$ 5,249,723		$ 9,491,304	$ 1,296,236	$ 0	$ 0
Tuberculosis Services	$ 9,162	$ 41,770	$ 860	$ 21,486	$ 0	$ 0
HIV Early Intervention Services	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Administration: (Excluding Program/Provider Lvl)	$ 1,312,431		$ 3,661,672	$ 3,035,898	$ 0	$ 0
Column Total	**$26,248,614**	**$51,040,356**	**$27,135,520**	**$70,658,408**	**$0**	**$0**

Missouri is not an HIV designated state.

Form 11ab

Form 11a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2010	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 604,373	$ 541,712	$ 151,130	$ 0	$ 0
Education	$ 2,389,108	$ 828,324	$ 51,774	$ 0	$ 0
Alternatives	$ 196,438	$ 431,826	$ 3,416	$ 0	$ 0
Problem Identification & Referral	$ 23,929	$ 0	$ 1,926	$ 0	$ 0
Community Based Process	$ 812,756	$ 13,000	$ 339,844	$ 0	$ 0
Environmental	$ 419,217	$ 119,408	$ 22,628	$ 0	$ 0
Other	$ 381,576	$ 7,557,034	$ 122,450	$ 0	$ 0
Section 1926 - Tobacco	$ 422,326	$ 0	$ 603,068	$ 0	$ 0
Column Total	**$5,249,723**	**$9,491,304**	**$1,296,236**	**$0**	**$0**

Form 11b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2010	Other Federal	State Funds	Local Funds	Other
Universal Direct	$ 1,217,534	$ 3,690,536	$ 1,296,236	$ 0	$ 0
Universal Indirect	$ 2,366,338	$ 0	$ 0	$ 0	$ 0
Selective	$ 1,665,851	$ 5,800,768	$ 0	$ 0	$ 0
Indicated	$ 0	$ 0	$ 0	$ 0	$ 0
Column Total	**$5,249,723**	**$9,491,304**	**$1,296,236**	**$0**	**$0**

Form 11c

Resource Development Planned Expenditure Checklist

State: Missouri

Did your State plan to fund resource development activities with FY 2010 funds?

(•) **Yes** ( ) **No**

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 150,000	$ 321,360	$ 0	$ 471,360
Quality Assurance	$ 0	$ 0	$ 0	$ 0
Training (post-employment)	$ 42,500	$ 7,500	$ 0	$ 50,000
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 26,667	$ 620,224	$ 0	$ 646,891
Research and Evaluation	$ 75,000	$ 227,495	$ 0	$ 302,495
Information Systems	$ 0	$ 30,000	$ 0	$ 30,000
Column Total	**$294,167**	**$1,206,579**	**$0**	**$1,500,746**

Form 12

State: Missouri

TREATMENT CAPACITY MATRIX

This form contains data covering a 24- month projection for the period during which your principal agency of the State is permitted to spend the FY 2010 block grant award.

Level of Care	A.Number of Admissions	B.Number of Persons
Detoxification (24-Hour Care)		
Hospital Inpatient (Detox)	516	494
Free-standing Residential	13,422	10,194
Rehabilitation / Residential		
Hospital Inpatient (Rehabilitation)	0	0
Short-term (up to 30 days)	33,650	29,214
Long-term (over 30 days)	0	0
Ambulatory (Outpatient)		
Outpatient	28,480	26,242
Intensive Outpatient	35,768	31,494
Detoxification	0	0
Opioid Replacement Therapy (ORT)		
Opioid Replacement Therapy	768	674

State: Missouri

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2010 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐ Competitive grants	Percent of Expense: %
☑ Competitive contracts	Percent of Expense: 96 %
☐ Non-competitive grants	Percent of Expense: %
☑ Non-competitive contracts	Percent of Expense: 4 %
☐ Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐ Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐ According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. I n addressing a State's allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐ Line item program budget

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per slot

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $ Type of slot:
Rate: $ Type of slot:
Rate: $ Type of slot:

☑ Price per unit of service

Percent of Clients Served: 100 %
Percent of Expenditures: 100 %

Unit: quarter hour Rate: $ 13.70
Unit: daily Rate: $ 6.61

Unit: hourly

Rate: $ 9.73

☐ Per capita allocation (Formula:)

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $ Diagnostic Group:
Rate: $ Diagnostic Group:
Rate: $ Diagnostic Group:

State: Missouri

Program Performance Monitoring

☑ On-site inspections

Frequency for treatment: ANNUALLY

Frequency for prevention: ANNUALLY

☑ Activity Reports

Frequency for treatment: MONTHLY

Frequency for prevention: MONTHLY

☑ Management Information System

☑ Patient/participant data reporting system

Frequency for treatment: MONTHLY

Frequency for prevention: MONTHLY

☑ Performance Contracts

☑ Cost reports

☑ Independent Peer Review

☑ Licensure standards - programs and facilities

Frequency for treatment: OTHER every three years

Frequency for prevention: OTHER every three years

☑ Licensure standards - personnel

Frequency for treatment: OTHER every three years

Frequency for prevention: OTHER every three years

Other:

☐ Specify:

Form T1

Form T1 was pre-populated with the following Data Source: Discharges in CY 2008

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

Short-term Residential(SR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**3,383**	**3,270**
Total number of clients with non-missing values on employment\student status [denominator]	**14,816**	**14,816**
Percent of clients employed (full-time and part-time) or student	**22.8%**	**22.1%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**13,552**
Number of CY 2008 discharges submitted:	**15,482**
Number of CY 2008 discharges linked to an admission:	**15,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**15,197**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**14,816**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Long-term Residential(LR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]		
Total number of clients with non-missing values on employment\student status [denominator]		
Percent of clients employed (full-time and part-time) or student		

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**0**
Number of CY 2008 discharges submitted:	**0**
Number of CY 2008 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Intensive Outpatient (IO)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**4,221**	**4,557**
Total number of clients with non-missing values on employment\student status [denominator]	**11,558**	**11,558**

Percent of clients employed (full-time and part-time) or student	**36.5%**	**39.4%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**12,967**
Number of CY 2008 discharges submitted:	**13,188**
Number of CY 2008 discharges linked to an admission:	**12,917**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,502**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**11,558**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Outpatient (OP)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**7,820**	**8,613**
Total number of clients with non-missing values on employment\student status [denominator]	**14,528**	**14,528**
Percent of clients employed (full-time and part-time) or student	**53.8%**	**59.3%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**14,599**
Number of CY 2008 discharges submitted:	**17,138**
Number of CY 2008 discharges linked to an admission:	**16,852**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**16,388**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**14,528**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Form T2

Form T2 was pre-populated with the following Data Source: Discharges in CY 2008

STABLE HOUSING SITUATION (From Admission to Discharge)

Short-term Residential(SR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]	**11,244**	**11,626**
Total number of clients with non-missing values on living arrangements [denominator]	**12,478**	**12,478**
Percent of clients with stable housing	**90.1%**	**93.2%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**13,552**
Number of CY 2008 discharges submitted:	**15,482**
Number of CY 2008 discharges linked to an admission:	**15,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**15,197**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**12,478**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Long-term Residential(LR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]		
Total number of clients with non-missing values on living arrangements [denominator]		
Percent of clients with stable housing		

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**0**
Number of CY 2008 discharges submitted:	**0**
Number of CY 2008 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Intensive Outpatient (IO)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]	**9,169**	**9,166**
Total number of clients with non-missing values on living arrangements [denominator]	**9,576**	**9,576**
Percent of clients with stable housing	**95.7%**	**95.7%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**12,967**
Number of CY 2008 discharges submitted:	**13,188**
Number of CY 2008 discharges linked to an admission:	**12,917**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,502**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**9,576**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Outpatient (OP)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]	**11,794**	**11,809**
Total number of clients with non-missing values on living arrangements [denominator]	**11,910**	**11,910**
Percent of clients with stable housing	**99.0%**	**99.2%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**14,599**
Number of CY 2008 discharges submitted:	**17,138**
Number of CY 2008 discharges linked to an admission:	**16,852**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**16,388**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**11,910**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Form T3

Form T3 was pre-populated with the following Data Source: Discharges in CY 2008

CRIMINAL JUSTICE INVOLVEMENT - NO ARRESTS (From Admission to Discharge)

Short-term Residential(SR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]	**11,273**	**12,583**
Total number of clients with non-missing values on arrests [denominator]	**13,321**	**13,321**
Percent of clients with no arrests	**84.6%**	**94.5%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**13,552**
Number of CY 2008 discharges submitted:	**15,482**
Number of CY 2008 discharges linked to an admission:	**15,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**15,302**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**13,321**
Source:SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Long-term Residential(LR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients with no arrests		

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**0**
Number of CY 2008 discharges submitted:	**0**
Number of CY 2008 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**0**
Source:SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Intensive Outpatient (IO)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]	**9,411**	**9,535**
Total number of clients with non-missing values on arrests [denominator]	**10,207**	**10,207**
Percent of clients with no arrests	**92.2%**	**93.4%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**12,967**
Number of CY 2008 discharges submitted:	**13,188**
Number of CY 2008 discharges linked to an admission:	**12,917**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**12,792**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**10,207**
Source:SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Outpatient (OP)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]	**12,149**	**11,989**
Total number of clients with non-missing values on arrests [denominator]	**12,738**	**12,738**
Percent of clients with no arrests	**95.4%**	**94.1%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**14,599**
Number of CY 2008 discharges submitted:	**17,138**
Number of CY 2008 discharges linked to an admission:	**16,852**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**16,790**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**12,738**
Source:SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Form T4

Form T4 was pre-populated with the following Data Source: Discharges in CY 2008

ALCOHOL ABSTINENCE

Short-term Residential(SR)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol [numerator]	**7,431**	**11,403**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**13,699**	**13,699**
Percent of clients abstinent from alcohol	**54.2%**	**83.2%**
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**4,097**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**6,268**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**65.4%**
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**7,306**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**7,431**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**98.3%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**13,552**
Number of CY 2008 discharges submitted:	**15,482**
Number of CY 2008 discharges linked to an admission:	**15,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**15,302**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**13,699**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Long-term Residential(LR)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients	**At Admission**	**At**

(regardless of primary problem)	(T_1)	Discharge(T_2)
Number of clients abstinent from alcohol [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from alcohol		

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	0
Number of CY 2008 discharges submitted:	0
Number of CY 2008 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol [numerator]	8,171	9,450
All clients with non-missing values on at least one substance/frequency of use [denominator]	10,643	10,643
Percent of clients abstinent from alcohol	76.8%	88.8%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1,605
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and		

Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,472	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		64.9%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		7,845
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	8,171	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		96.0%

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	12,967
Number of CY 2008 discharges submitted:	13,188
Number of CY 2008 discharges linked to an admission:	12,917
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	12,792
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	10,643
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Outpatient (OP)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol [numerator]	11,079	13,331
All clients with non-missing values on at least one substance/frequency of use [denominator]	14,078	14,078
Percent of clients abstinent from alcohol	78.7%	94.7%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,567
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,999	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		85.6%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		10,764
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	11,079	

Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]	[redacted]	**97.2%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**14,599**
Number of CY 2008 discharges submitted:	**17,138**
Number of CY 2008 discharges linked to an admission:	**16,852**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**16,790**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**14,078**
Source: SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Form T5

Form T5 was pre-populated with the following Data Source: Discharges in CY 2008

DRUG ABSTINENCE

Short-term Residential(SR)		
A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs [numerator]	**4,678**	**10,215**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**13,699**	**13,699**
Percent of clients abstinent from drugs	**34.1%**	**74.6%**
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**5,667**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**9,021**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**62.8%**
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**4,548**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**4,678**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**97.2%**

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**13,552**
Number of CY 2008 discharges submitted:	**15,482**
Number of CY 2008 discharges linked to an admission:	**15,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**15,302**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**13,699**
Source:SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Long-term Residential(LR)		
A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission	**At Admission**	**At**

vs. discharge.	(T_1)	Discharge(T_2)
Number of clients abstinent from drugs [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from drugs		

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**0**
Number of CY 2008 discharges submitted:	**0**
Number of CY 2008 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**0**
Source:SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Intensive Outpatient (IO)		
A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs [numerator]	**6,893**	**8,710**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**10,643**	**10,643**
Percent of clients abstinent from drugs	**64.8%**	**81.8%**

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**2,328**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and	**3,750**	

discharge [denominator]	3,750	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		62.1%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		6,382
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,893	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		92.6%

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	12,967
Number of CY 2008 discharges submitted:	13,188
Number of CY 2008 discharges linked to an admission:	12,917
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	12,792
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	10,643
Source:SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs [numerator]	11,704	13,124
All clients with non-missing values on at least one substance/frequency of use [denominator]	14,078	14,078
Percent of clients abstinent from drugs	83.1%	93.2%

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		1,911
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,374	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		80.5%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		11,213
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	11,704	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		95.8%

Notes (for this level of care):	
Number of CY 2008 admissions submitted:	**14,599**
Number of CY 2008 discharges submitted:	**17,138**
Number of CY 2008 discharges linked to an admission:	**16,852**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**16,790**
Number of CY 2008 linked discharges eligible for this calculation (non-missing values):	**14,078**
Source:SAMHSA/OAS TEDS CY 2008 admissions file and CY 2008 linked discharge file [Records received through 4/30/2009]	

Form T6

Most recent year for which data are available	From: 1/1/2008 To: 12/31/2008

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	6033	8995
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	35447	35447
Percent of clients participating in social support activities	17.02%	25.38%

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

Since October 2006, a self-help indicator is collected in the State's information system at admission, at changes in levels of care, and at discharge. Prior to October 2006, this data was collected only at discharge. In May 2009, the State was notified of the plans to add a new self-help data item to TEDS. Upon notification, the State submitted an information system enhancement request to add a self-help data item that captures frequency of attendance. It is not known when such item will be added to the State's information system.

DATA SOURCE

What is the source of data for table T6? (Select all that apply)

- [x] Client Self Report
  - Client self-report confirmed by another source:
    - [ ] Collateral source
    - [ ] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T6? (Select one)

- (•) Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- ( ) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ( ) Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T6? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge
  Specify:
  - ( ) In-Treatment data ____ days post admission
  - ( ) Follow-up data ____ months post admission
  - ( ) Other, Specify:
- [x] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment
- [ ] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- [ ] Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T6? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
  Select type of UCID:
  - (•) Master Client Index or Master Patient Index, centrally assigned
  - ( ) Social Security Number (SSN)
  - ( ) Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
  - ( ) Some other Statewide unique ID

	Provider-entity-specific unique ID No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** Information is not collected at admission Information is not collected at discharge Information is not collected by the categories requested State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing social support of recovery data data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T7

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 1/1/2008 To: 12/31/2008

Length of Stay			
Level of Care	**Average**	**Median**	**Interquartile Range**
Detoxification (24-Hour Care)			
1. Hospital Inpatient	6.51	4	6
2. Free-standing Residential	2.90	3	1
Rehabilitation / Residential			
3. Hospital Inpatient			
4. Short-term (up to 30 days)	22.70	21	12
5. Long-term (over 30 days)			
Ambulatory (Outpatient)			
6. Outpatient	138.06	79	90
7. Intensive Outpatient	65.90	55	70
8. Detoxification			
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy	658	381	919

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

Treatment Performance Measures

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA), as the Single State Authority (SSA) has used data-driven decisions based on a limited number of performance measures in the past. Effective October 1, 2006 the SSA implemented a web-based information system Customer Information Management, Outcomes, and Reporting System (CIMOR). CIMOR replaced multiple legacy systems – integrating billing and client tracking. This system has been designed to capture the data elements needed for Treatment Episode Dataset / National Outcomes Measures (TEDS/NOMS) reporting at admission, at level changes, and at discharge.

Design flaws in the CIMOR data model, however, have impacted the data integrity of the State's outcome data. Initially, updates to the TEDS data resulted in overwriting of previously collected data. A fix was implemented in July 2007 but caused other difficulties in linking records in related tables. Work to re-design the tables began in spring 2008. Although not yet fixed, the new structure is expected to go into production during FY 2010.

In 2007, ADA sought State Outcomes Measures (SOMMS) Information Technology technical assistance. During the following year, ADA worked with the National Data Infrastructure Improvement Consortium (NDIIC) in reviewing reports used by other SSA's and with FEI.com in assessing CIMOR business rules and TEDS/NOMS data collection.

ADA continues to use data quality reporting to notify service providers of missing or inconsistent data. During the past year, ADA developed a process to identify duplicate ids assigned to the same consumer. When identified, these ids are forwarded to the help desk staff for consolidation. During spring 2009, ADA began requiring verified social security numbers which has helped reduce the number of duplicate ids assigned to the same consumer. ADA continues to maintain and distribute the ADA Data Guidance Document which provides definitions and instructions for much of its data including the TEDS/NOMS data.

With its Access to Recovery II (ATR II) program, ADA has implemented performance monitoring reports with regard to the GPRA follow-up collection. ATR II service providers are able to compare their follow-up rates with that of any other ATR II provider. Additional reports have been implemented for GPRA NOMS data – allowing providers to compare their data with statewide ATR II benchmarks. ADA requires providers to supply information about the intensity and number of services provided to consumers via the CIMOR system. During FY 2010, ADA will be developing and implementing process measure reports for all of its treatment programs. It is expected that these reports will be used for quality improvement efforts in various areas including data collection and reporting efforts; treatment planning, engagement, and retention; and business practices.

In terms of evidence-based practices, the State has added both motivational interviewing and medication assisted treatment (MAT) to its service menu. Outcome reports for those consumers receiving MAT and for a comparison group are generated and reviewed on a monthly basis.

In 2006, ADA, in conjunction with the Center for Substance Abuse Treatment (CSAT), provided training on the importance of the national outcome measures under the professional development track at the Spring Training Institute. At this time, ADA does not have a regular training program for provider staff or a workforce development plan but is in the discussion phase of both.

ADA continues to seek outside data linkages to be used to assess data quality in ADA's information infrastructure as well as to expand its information base. During 2009, ADA established linkage with the Department of Revenue driver's license records containing DWI administrative data. This data was used to assess the data quality and referral process for ADA's traffic offender program. Also, ADA has established linkage with the Department of Corrections (DOC) to monitor prison recidivism for those parolees and probationers who are receiving substance abuse treatment. In addition, ADA and DOC are collaborating on the development of a diversion program for nonviolent substance abusing female offenders. During FY 2010, ADA plans to explore developing linkages to access arrest data and hospital/emergency room admission data. The arrest data would be useful in quantifying the accuracy of ADA's self-reported NOMS arrest data. In addition, arrest patterns and health care utilization would be studied for ADA's consumer population in order to better understand the needs of these consumers and tailor services accordingly.

Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Form P1
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 21+ - FFY 2007	54.30	
		Ages 12–20 - FFY 2007	28.90	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having smoked a cigarette during the past 30 days.	Ages 12–17 - FFY 2007	11.10	
		Ages 18+ - FFY 2007	33.20	
3. 30-day Use of Other Tobacco Products	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).	Ages 12–17 - FFY 2007	5.80	
		Ages 18+ - FFY 2007	9.60	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - FFY 2007	6.70	
		Ages 18+ - FFY 2007	5.70	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 18+ - FFY 2007	4.20	
		Ages 12–17 - FFY 2007	5	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2007	75.60	
		Ages 18+ - FFY 2007	78.80	
2. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 18+ - FFY 2007	94	
		Ages 12–17 - FFY 2007	94.50	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 18+ - FFY 2007	77.20	
		Ages 12–17 - FFY 2007	82.80	

((s)) Suppressed due to insufficient or non-comparable data

Form P3
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - FFY 2007	13.20	
		Ages 18+ - FFY 2007	17	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 18+ - FFY 2007	15	
		Ages 12–17 - FFY 2007	12.80	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 12–17 - FFY 2007	13.40	
		Ages 18+ - FFY 2007	18.40	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish? " [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2007	13.50	
		Ages 18+ - FFY 2007	17.90	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 18+ - FFY 2007	19.50	
		Ages 12–17 - FFY 2007	13.10	

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2007	90.20	
2. Perception of Peer Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - FFY 2007	86.80	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2007	84.80	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2007	84	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2007	86.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P5
NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 18+ - FFY 2007	42.80	
		Ages 15–17 - FFY 2007	27.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P7
NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

State: Missouri

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	FFY 2007	93.70	

((s)) Suppressed due to insufficient or non-comparable data

Form P8
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

State: Missouri

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	FFY 2007	39.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P9
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

State: Missouri

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	FFY 2007	177.20	

((s)) Suppressed due to insufficient or non-comparable data

Form P10
NOMs Domain: Social Connectedness
Measure: Family Communications Around Drug and Alcohol Use

State: Missouri

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - FFY 2007	55.70	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - FFY 2007	90.80	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11
NOMs Domain: Retention
Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

State: Missouri

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - FFY 2007	91.10	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

Form P12a
Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

State: Missouri

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Missouri used the MDS and manual process data collection systems.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Missouri collects and records a participant's race through the MDS system and manual collection process. Participants who were more than one race were reported either under a single race or 'race not known or other' - the state does not use the 'more than one race' category.

Category	Description	Total Served
A. Age	1. 0-4	752
	2. 5-11	6788
	3. 12-14	8655
	4. 15-17	9862
	5. 18-20	2771
	6. 21-24	3463
	7.25-44	23172
	8. 45-64	17833
	9. 65 And Over	900
	10. Age Not Known	166579
B. Gender	Male	32719
	Female	41477
	Gender Unknown	166579

C. Race	White	55039
	Black or African American	18176
	Native Hawaiian/Other Pacific Islander	90
	Asian	630
	American indian/Alaska Native	261
	More Than One Race (not OMB required)	
	Race Not Known or Other (not OMB required)	166579
D. Ethnicity	Hispanic or Latino	2837
	Not Hispanic or Latino	237938

- Footnotes

Any unknown ethnicity was assumed to be not of Hispanic or Latino origin.

Form 12b
Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

State: Missouri

Category	Description	Total Served
A. Age	1. 0-4	
	2. 5-11	
	3. 12-14	
	4. 15-17	
	5. 18-20	
	6. 21-24	
	7.25-44	
	8. 45-64	
	9. 65 And Over	
	10. Age Not Known	19335129
B. Gender	Male	
	Female	
	Gender Unknown	19335129
C. Race	White	
	Black or African American	
	Native Hawaiian/Other Pacific Islander	
	Asian	
	American indian/Alaska Native	
	More Than One Race (not OMB required)	

	Race Not Known or Other (not OMB required)	19335129
D. Ethnicity	Hispanic or Latino	
	Not Hispanic or Latino	19335129

- Footnotes

Form P12B is based on media programs and is a duplicated count. Unknown ethnicity (n=19,335,129) was assumed to be not of Hispanic or Latino origin and is reported under that category.

Form P13 (Optional)
Number of Persons Served by Type of Intervention

State: Missouri

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total		

- Footnotes

The State is opting out of this form P13.

Form P14
Number of Evidence-Based Programs and Strategies by Type of Intervention

State: Missouri

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
  - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
  - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). "Informed experts" may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
Missouri uses the Strategic Prevention Framework process to implement the three guidelines. The process includes: assessment of the community needs and readiness; capacity building to mobilize and address the needs of the community; development of a prevention plan to identify the activities, programs, and strategies necessary to address the needs; implementation of the prevention plan; and, evaluation of the results to achieve sustainability and cultural competency. Missouri identifies appropriate strategies based on validated research, empirical evidence of effectiveness, and the use of local, state, and federal key community prevention leaders such as National Prevention Network, Southwest Center for Application of Prevention Technology and SAMHSA's Center for Substance Abuse Prevention. The Division of Alcohol and Drug Abuse ultimately determines whether or not a chosen intervention falls under the third definition.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
Missouri utilized a combination of the Minimum Data Set (MDS) and manual collection.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	320	336	656	102	2	760
2. Total number of Programs and Strategies Funded	320	336	656	102	2	760
3. Percent of Evidence-Based Programs and Strategies	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Form P15 - FY 2007 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

State: Missouri

IOM Categories	FY 2007 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2007 Total SAPT Block Grant $Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	320	$ 1393751
2. Universal Indirect	336	$ 2708825
3. Selective	102	$ 1906954
4. Indicated	2	$ 0
5. Totals	760	$6,009,530.00

Note: See definitions for types of interventions in the instructions for P-14 (Universal Direct, Universal Indirect, Selective, and Indicated)

Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D

FFY 2007 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2007 SAPT Block Grant Dollars Spent on Substance Abuse Prevention Worksheet . Note: Total EBPs and Total dollars spent on EBPs may be transferred to Form P-15.

Note: The Sub-totals for each IOM category and the Total FFY 2007 SAPT Block Grant Dollars spent on Evidence-based programs/strategies may be transferred to Form P-15.

See: The instructions for Form P-14 for the Definition, Criteria and Guidance for identifying and selecting Evidence-Based Programs and Strategies.

Form P15 Table 1: Program/Strategy Detail for Computing the Total Number of Evidence-based Programs and Strategies, and for Reporting Total FFY2007 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY2007 Program/Strategy Name Universal Direct	**FFY2007 Total Number of Evidence-based Programs and Strategies by Intervention**	**FFY2007 Total Costs of Evidence based Programs and Strategies for each IOM Category**	**FFY2007 Total SAPT Block Grant Funds Spent on Evidence-Based Programs/Strategies**
1.			
2.			
3.			
4.			
Subtotal			
Universal Indirect Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Selective Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Indicated Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Total Number of (EBPs)/Strategies and cost of these EBPs/Strategies	#	$	
Total FFY2007 SAPT Block Grant Dollars $ Spent on Evidence-Based Programs and Strategies			$

Description of Supplemental Data

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

This narrative response not included because it does not exist or has not yet been submitted.

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please combine them together in One Word file (or Excel, or other types) and attach here.

This narrative response not included because it does not exist or has not yet been submitted.