



**EASTERN REGION PUBLIC  
MENTAL HEALTH  
PLANNING PROJECT**

**BEHAVIORAL HEALTH  
CURRENT STATE  
ASSESSMENT**

**DECEMBER 2006**

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## 1.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: EXECUTIVE SUMMARY AND KEY FINDINGS

### EXECUTIVE SUMMARY

The Eastern Region of Missouri<sup>1</sup> has a long-standing commitment to provide healthcare services to individuals and families affected by substance abuse and mental illness. In April 2006, the Eastern Region Community Mental Health Centers, Missouri Department of Mental Health Division of Comprehensive Psychiatric Services and Division of Alcohol and Drug Abuse and the St. Louis Regional Health Commission partnered and began a first phase of strategic planning to improve access to and service delivery of behavioral health services.<sup>2,3</sup>

Regional stakeholders representing state government, mental, physical, and substance abuse service providers, clients and their advocates convened April through December 2006 to develop recommendations and an implementation plan that will guide the efforts of improving triage and case management functions and identifying best practice collaborative care models of physical and behavioral health integration.

The Eastern Region Public Mental Health Planning Project is being coordinated by the St. Louis Regional Health Commission (RHC), whose mission is to improve access to care for the medically underserved, reduce health disparities, and improve health outcomes for citizens in the region. The RHC is a collaborative partnership of health service providers, government and community leaders, community organizations and consumers.

Since its formation in 2001, the RHC has served as a lead body for regional planning and implementation of initiatives to strengthen the health care safety net system, and to improve health literacy, prevention and wellness services.<sup>4</sup> In 2003, the RHC issued recommendations calling for “improving coordination between mental and physical health systems.”

The implementation of the Eastern Region Public Mental Health Planning Project plan is scheduled to begin in 2007. The scope of phase two, to begin in early 2007, will be determined by stakeholders as a continuation of phase one’s work. Issues that may be addressed in phase two may include, but are not limited to, further collaboration of the Missouri Department of Mental Health Divisions of Alcohol and Drug Abuse,

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<sup>1</sup> The Eastern Region is defined by the Missouri Department of Mental Health Administrative Agents’ service delivery areas: St. Charles, Franklin, Jefferson, Lincoln, St. Louis and Warren Counties and St. Louis City.

<sup>2</sup> See **Appendix 1** for committee structure and steering committee composition.

<sup>3</sup> Throughout this document, the term “behavioral health” is used to indicate both mental health and substance abuse care. “Mental health” is defined as individuals with mental illness that is not necessarily substance abuse related. “Co-occurring” is used when speaking of the intersecting needs of mental health and substance abuse.

<sup>4</sup> For this document and project, safety net includes individuals on Medicaid and individuals who are uninsured.

Comprehensive Psychiatric Services, and Mental Retardation and Developmental Disabilities; long term funding; prevention/early intervention; and, children's services.

This analysis is the result of several months of activities, including:

- ∞ A review and description of the public behavioral health care system at the national, state and local level,
- ∞ An in-depth analysis of the continuum of care available in the Eastern region,
- ∞ A collection of provider service data information for 2005, and
- ∞ An analysis of behavioral health care funding for the Eastern region.

## **KEY FINDINGS**

As a result of the above activities and analysis, the following key findings emerged.

1. The behavioral health system in the Eastern Missouri region is fragmented and has gaps on many levels:
  - a. *Limited coordination of health care* – Stakeholders emphasized that the behavioral and physical health needs of an individual should not be separated – they are inextricably linked to the individual's overall health and well-being. However, there is limited coordination between the behavioral health care system and the physical health care system. The behavioral health system is separated from the physical health system in many ways.
  - b. *Limited coordination within the behavioral health system* – Within the behavioral health system, there is limited coordination between providers. For example, clients receive redundant assessments from each different provider/organization. Mental health and substance abuse providers have limited communication with each other and limited knowledge of each others' programs. And, although more than half of the adults with severe mental illness in the public mental health system are further impaired by co-occurring substance use disorders,<sup>5</sup> there is limited coordination of mental health and alcohol and drug abuse treatment.
  - c. *Limited coordination of community based behavioral health services with inpatient psychiatric services* – Stakeholders report that individuals often enter into inpatient psychiatric services without appropriate screening for community alternatives and come out of inpatient services without a seamless handoff to ongoing community treatment.
2. It is difficult for some people in need of behavioral health services to find adequate information regarding who can access services and what services are available. A large number and wide variety of formal and informal entry points are available for

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<sup>5</sup> Substance Abuse and Mental Health Services Administration, National Mental Health Information Center, Evidence-Based Practices, Co-Occurring Disorders: Integrated Dual Disorders Treatment, Implementation Resource Kit.

individuals to make an initial point of contact into the behavioral health system; however, stakeholders believe the general public does not understand the types or breadth of services provided, or the areas served by specific providers.

3. Clients and family members identify a combination of practical barriers and limited social supports that prevent them from accessing quality behavioral health services. Examples of practical barriers include limited transportation and limited ability to receive appropriate medications. Examples of limited social supports include the limited stable housing and employment, the stigma of mental illness and substance abuse, and the lack of respect from professionals, family and friends.
4. Accounting for dollars spent for behavioral health services in the region is challenging. Several measures highlight the limited funding for safety net behavioral health services in the Eastern region:
  - a. *Waiting Lists* – Because of limited funding and restrictions on how funding can be used, individuals with behavioral health needs in the safety net system are often unable to access care unless they are in a crisis situation. Existing capacity for community based mental health and alcohol and drug abuse services is not meeting service demand; many behavioral health organizations have a wait list for services. The current mental health system responds primarily to individuals in crisis, and has less emphasis on prevention and early intervention efforts.
  - b. *Serving a lower percentage of the population than other regions* – The money invested in the Eastern region public behavioral health system served a much lower percentage of the population than the percentage of people served in other regions of the state. For example, the state Comprehensive Psychiatric Services 2005 expenditures in the region served 7.5 citizens per 1,000 population (reported by the CPS Division) which is less than half the penetration rate of 15.9 per 1,000 observed in the Northwest Region (Kansas City region) and a statewide average of 12.4 people per 1,000. This finding may suggest the need for increasing community-based treatment options in the region.
  - c. *Decreasing state and federal funds* – Changes in the federal and state level have resulted in proportionately less funds available for behavioral health services; this has caused a noticeable erosion in services in safety net behavioral health services across the country.

## 2.0 PUBLIC BEHAVIORAL HEALTH SYSTEMS: BACKGROUND

### NATIONAL PUBLIC BEHAVIORAL HEALTH SYSTEM

The National Mental Health Act (P.L. 79-487) was passed by Congress in 1946, signaling the willingness of the federal government to address the plight of people with serious mental illness. This act eventually led to the creation of the National Institutes of Mental Health (NIMH) and promoted a lasting partnership between the states and the federal government.

In 1963, the Community Mental Health Centers Act was passed and laid the groundwork to establish more than 750 federally funded community mental health programs across the country. The first operating center funded under this act opened in 1966 as Mid-Missouri Mental Health Center in Columbia, Missouri. Mid-Missouri and the rest of the nation shared the goal of moving people out of state hospitals and into community care systems.<sup>6</sup>

The 1980s marked the end of an era of direct federal funding to community mental health center (CMHC) programs in America. Provisions of SB1122 created to expand the array of community based options for people with mental illness and/or substance addictions were rescinded. Federal support was re-directed to state governments in the form of “block grants” for behavioral health, working under the assumption that states could better coordinate care, meet the local needs of citizens, and operate more economically than the federal government. States in turn created their own administrative structures to pay these funds to community programs. Although these “block grants” were administered to the states, national funds for mental health were cut by 25 percent in the early 1980s.<sup>7</sup>

Missouri created an “administrative agent” structure within the Department of Mental Health (DMH) to ensure that every community in the state had access to a community program focused on the delivery of a continuum of care in each service area. The mental health centers were named as agents of the state DMH to provide locally managed and coordinated services for the safety net populations across the state. The integrated care systems were mandated and supported through a purchase-of-service (POS) contract system for psychiatric services.

In April 2002, President George W. Bush announced the “President’s New Freedom Commission on Mental Health Initiatives.” President Bush said in his address, “Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care.”<sup>8</sup> The New Freedom Commission identified stigma, unfair treatment limitations and financial requirements, and

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<sup>6</sup> Ahr, Paul R., Made in Missouri: The Community Mental Health Movement and Community Mental Health Centers 1963 – 2003, copyright 2003.

<sup>7</sup> Ahr, Paul R., Made in Missouri: The Community Mental Health Movement and Community Mental Health Centers 1963 – 2003, copyright 2003.

<sup>8</sup> President’s New Freedom Commission Report, 2003

fragmentation of the delivery system as areas of weakness in the current mental health care system. The New Freedom Commission recommended “complete transformation” of the mental health system in America. Six goals were identified to serve as the foundation for this transformation:

1. America understands that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

One of the main problems with the system was the observed fragmentation of mental health services. Many of these problems were traced to the process of deinstitutionalization that shifted care for people with mental illness from a hospital-based to a community-based system. According to the World Health Organization, deinstitutionalization was complex and should have led to “the implementation of a network of alternatives outside psychiatric institutions.” The report goes on to lament that these networks never developed due to a lack of appropriate community services and funding.<sup>9</sup> In addition to fragmentation, service delivery is also difficult because of changes to and limitations in funding for behavioral health services.

#### *FEDERAL CUTBACK IMPLICATIONS FOR LOW-INCOME PEOPLE WITH SERIOUS MENTAL ILLNESSES*

The Eastern Region Public Mental Health Planning Project seeks to address the specific needs of adult clients who are in crisis, who are unable to attain private insurance or do not qualify for Medicaid benefits. In the article, *The Struggle to Provide Community-Based Care To Low-Income People With Serious Mental Illness*,<sup>10</sup> the authors outline the challenges of service delivery to low-income people with serious mental illness as reported by mental health professionals, general medical care providers and policymakers in 12 U.S. communities.<sup>11</sup> Key findings from this report are:

- ∞ Medicaid has become the single largest payer of mental health services for low-income people accounting for about 40 percent of all public-sector spending on mental health services in 2001 compared with 21 percent in 1971.
- ∞ Due to tight state budgets and Medicaid cost increases, many states have attempted to contain costs through reductions in reimbursements and eligibility, greater restriction on prescription drug use, and increased cost sharing.
- ∞ State budgets for non-Medicaid mental health services have been cut or growth has not kept up with levels of inflation.

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<sup>9</sup> World Health Organization, 2001.

<sup>10</sup> Cunningham, Peter; McKenzie, Kelly; Taylor, Fries Erin. “The Struggle To Provide Community-Based Care To Low-Income People With Serious Mental Illnesses.” *Health Affairs* 25.3 (May/June 2006) 694-705.

<sup>11</sup> The 12 nationally representative markets are Boston, Cleveland, Greenville (South Carolina), Indianapolis, Lansing, Little Rock, Miami, northern New Jersey, Orange County (California), Phoenix, Seattle, and Syracuse.

- ∞ With states shifting an increasing proportion of their mental health budgets onto Medicaid, fewer state funds are available to provide services to lower-income uninsured people with serious mental illnesses who are not eligible for Medicaid.
- ∞ The impact of service gaps on the community includes homelessness, incarceration, and emergency department usage increase.

A noticeable erosion of services for the uninsured with serious mental illnesses was noted across the 12 U.S. communities including:

- ∞ Residential services are in short supply including transitional shelters, housing, and other support services.
- ∞ Lack of psychiatric inpatient beds for acute care.
- ∞ Shortage of key outpatient care staff, especially psychiatrists, resulting in longer waiting times. As with other physicians, psychiatrists are much more likely to limit Medicaid and uninsured patients in their practices than to limit privately insured or Medicare patients.
- ∞ Gaps in outpatient capacity for mental health services were most frequently attributed to low reimbursement from Medicaid.

The Eastern region differs from the trends listed above as related to the lack of psychiatric inpatient beds for acute care. The Eastern Region has a higher concentration of acute psychiatric hospital beds than other regions in Missouri.<sup>12</sup>

#### *FEDERAL IMPLICATIONS FOR CLIENTS WITH CO-OCCURRING DISORDERS*

Federal funding streams and structures also influence the ability for clients with co-occurring disorders to receive care. In the article *Substance Abuse with Mental Disorders: Specialized Public Systems and Integrated Care*, Audrey Burnam and Katherine Watkins indicate that although a separate administrative substance abuse structure preserves the distinctive treatment approaches and protects treatment priorities for the population with substance abuse disorders, administrative and funding divisions between mental health and substance abuse systems at both the federal and state levels create barriers that are difficult to remedy. This leaves clients without access to services across system lines.

Two consequences for clients with co-occurring disorders have been: 1) denied care in a single system because of the complexity of their disorder; or 2) obtaining treatment for one disorder while the other goes ignored. Substance Abuse and Mental Health Services Administration (SAMSHA) reports that clients who have co-occurring mental health and substance abuse needs have substantial difficulty receiving access to mental health services. Although public behavioral health treatment systems are the responsibility of each state, these systems are largely shaped by federal financing and different treatment philosophy traditions administered by distinctive domains of regulation and oversight at the state level.<sup>13</sup>

<sup>12</sup> Missouri Department of Mental Health 2003, Missouri Hospital Association 2003.

<sup>13</sup> Burnam, Audrey M.; Watkins, Katherine E. "Substance Abuse With Mental Disorders: Specialized Public Systems and Integrated Care" *Health Affairs* 25.3 (May/June 2006) 648-658.

## **MISSOURI PUBLIC BEHAVIORAL HEALTH SYSTEM**

### *PSYCHIATRIC SERVICES*

In 1974, Missouri recognized the opportunity to deliver the right care in the right place, and established a free-standing Department of Mental Health structure to manage, monitor and direct care. The Department includes a Division of Alcohol and Drug Abuse, Division of Comprehensive Psychiatric Services, and Division of Mental Retardation and Developmental Disabilities. (Prior to 1974, mental health programs were located in the Division of Mental Diseases – later called the Division of Mental Health – which was under the Missouri Department of Health and Welfare.)

The presence of an executive level department for mental health services offers important advantages for the state, service providers, individuals, and families. In recent years, the creation of the New Freedom Commission and their recommendations for transformation created an impetus on the federal level to transform the way the nation views and treats mental illness.

To meet the goals set out in the New Freedom Commission’s report, the Missouri Department of Mental Health Comprehensive Psychiatric Services has laid out five core strategic priorities for system transformation:

1. Prevention and Promotion
2. Science and Service
3. Access and Capacity
4. Consumer/Family Driven Services and System Accountability
5. Technology Supports

The Eastern Region Public Mental Health Planning Project is aligned with the science and service priority under “uniform screening and assessment” and with the access and capacity priority to “promoting early integrated screening, referral, and care coordination protocols between mental health/substance abuse and primary health care” and “regional planning/local community system of care infrastructure.”

### *ALCOHOL AND DRUG ABUSE SERVICES*

Statewide substance abuse services in Missouri were first established in April 1967 as an alcoholism section in the Division of Mental Health, at which time the five state mental hospitals and three mental health centers were ordered to develop inpatient alcoholism treatment programs. In 1972, a separate drug abuse section was created in the Division of Mental Diseases Central Office (as it was called then). The local programs were independently run by the state facilities with coordination and statewide education services provided by the Central Office section.

As noted above, when the Division of Mental Health was elevated to department status, it had the authority to establish necessary divisions for carrying out the work of the

department. The department established the Division of Alcohol and Drug Abuse in June 1975.

The Missouri Department of Mental Health Division of Alcohol and Drug Abuse has outlined their strategic priorities for 2006 as:

1. Access to Recovery
2. Prevention

See **Appendix 2** for an overview of DMH CPS and ADA core strategic priorities.

### **3.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: ACCESS TO CARE**

In 2003, the St. Louis Regional Health Commission published “Building a Healthier St. Louis” to inform the community about the healthcare safety net, including a section on psychiatric and alcohol and drug abuse services. This current state assessment builds on that report and includes updated information from mental health and alcohol and drug abuse safety net providers to understand the size and use of the safety net system for adult behavioral health services.

The behavioral health system is separated from the system of physical health care in many ways. Safety net treatment and service delivery for behavioral health are coordinated through separate state departments and networks of providers than physical health service delivery.

Individuals covered under Missouri’s traditional (non-managed care) Medicaid program receive behavioral health services through programs administered by the Missouri Department of Mental Health. Mental health services and alcohol and drug abuse services are coordinated through separate divisions of the department. Uninsured individuals also rely on the Department of Mental Health. Individuals eligible for managed Medicaid (MC+) receive mental health services through various behavioral health organizations.<sup>14</sup>

#### **BEHAVIORAL HEALTH PROVIDERS**

Individuals receive care for behavioral health issues from a variety of service providers. Providers can be divided into psychiatric care and alcohol and drug abuse treatment, though some providers do provide both and will be noted.

##### *PSYCHIATRIC CARE*<sup>15</sup>

Psychiatric care refers to the treatment of a range of psychiatric, psychological, emotional and behavior disorders. Treatment is provided by psychiatrists, psychologists, counselors, social workers and case managers.

The state Department of Mental Health divides Missouri into 25 service areas for the administration of psychiatric services to the safety net. For each service area, the state contracts with a service provider designated as an Administrative Agent.

Administrative Agents (also called Community Mental Health Centers) are responsible for public mental health assessments and services. They also provide follow-up services for people released from state-operated inpatient services. Four Administrative Agents coordinate outpatient and residential services for the Eastern region: BJC Behavioral

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<sup>14</sup> This section is taken from the St. Louis Regional Health Commission’s 2003 “Building a Healthier St. Louis” report.

<sup>15</sup> This section is updated from the St. Louis Regional Health Commission’s 2003 “Building a Healthier St. Louis” report.

Health Services, COMTREA Community Treatment, Inc., Crider Center for Mental Health and Hopewell Center.

In the Eastern region, three non-administrative agent agencies also provide community based mental health services for the Department of Mental Health. These organizations serve St. Louis City and County: Adapt of Missouri, Independence Center and Places for People.

Two public psychiatric hospitals provide adult inpatient safety net mental health care: Metropolitan St. Louis Psychiatric Center for acute inpatient care and St. Louis Psychiatric Rehabilitation Center for long-term inpatient care.<sup>16</sup> Numerous private hospitals also provide acute adult inpatient care.

Crisis services are provided by Behavioral Health Response (BHR), a 24-hour mental health crisis service center offering crisis intervention services, mobile community crisis assessments and crisis stabilization beds. The Administrative Agents contract with BHR to handle calls after hours, on weekends and holidays.

Many providers who do not contract with the state Department of Mental Health also provide important mental health services to safety net clients in the community, including services for episodic mental health problems. Providers include private for-profit and non-profit practitioners, community and faith-based providers, some Federally Qualified Health Center locations and the St. Louis County Family Mental Health Collaborative. However, as noted earlier in this report, national research indicates that private providers are much more likely to limit Medicaid and uninsured patients in their practices than to limit privately insured or Medicare patients.

The Family Mental Health Collaborative combines the expertise of five non-profit social service organizations<sup>17</sup> and St. Louis University to meet the mental health needs of children, adults and elderly living in St. Louis County who are unable to access adequate services due to the lack of insurance or geographic accessibility.

#### *SUBSTANCE ABUSE AND CO-OCCURRING CARE*<sup>18</sup>

Substance abuse is a maladaptive pattern of substance use leading to clinically significant impairment or distress.<sup>19</sup> The Division of Alcohol and Drug Abuse in the state Department of Mental Health provides services through a network of contractors who operate treatment and detoxification programs.

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<sup>16</sup> In addition, the John Cochran VA Medical Center, St. Louis VA Medical Center and St. Louis Veteran's Center provide services to veterans who meet eligibility based on military service, behavioral health issues and/or homelessness.

<sup>17</sup> The five organizations are BJC Behavioral Health, Catholic Family Services, Jewish Family & Children's Services, Lutheran Family & Children's Services and Provident Counseling.

<sup>18</sup> This section updated from the St. Louis Regional Health Commission's 2003 "Building a Healthier St. Louis" report.

<sup>19</sup> Diagnostic and Statistical Manual for Mental Disorders.

Four contractors provide detoxification services in the Eastern region: Bridgeway Counseling's St. Louis Center provides modified medical detoxification; Bridgeway Counseling's St. Charles Center, COMTREA Community Treatment, Inc., Preferred Family Healthcare and the Salvation Army provide social detoxification. Residential and outpatient treatment services are provided through BASIC, Bridgeway Counseling Services, Center for Life Solutions, COMTREA Community Treatment, Inc., New Beginnings, Preferred Family Healthcare, Queen of Peace Center, St. Patrick's Center and WestEnd Clinic. The recent addition of faith-based supportive services has enhanced the total array of services offered by the contract providers.

Additionally, many providers not contracted with the state Department of Mental Health provide important alcohol and drug abuse services to safety net clients in the community, including private practitioners and community providers; many of these organizations are certified by the Department of Mental Health, Alcohol and Drug Abuse Division. However, as noted earlier in this report, national research indicates that private providers are much more likely to limit Medicaid and uninsured patients in their practices than to limit privately insured or Medicare patients.

### **MULTIPLE ENTRY POINTS**

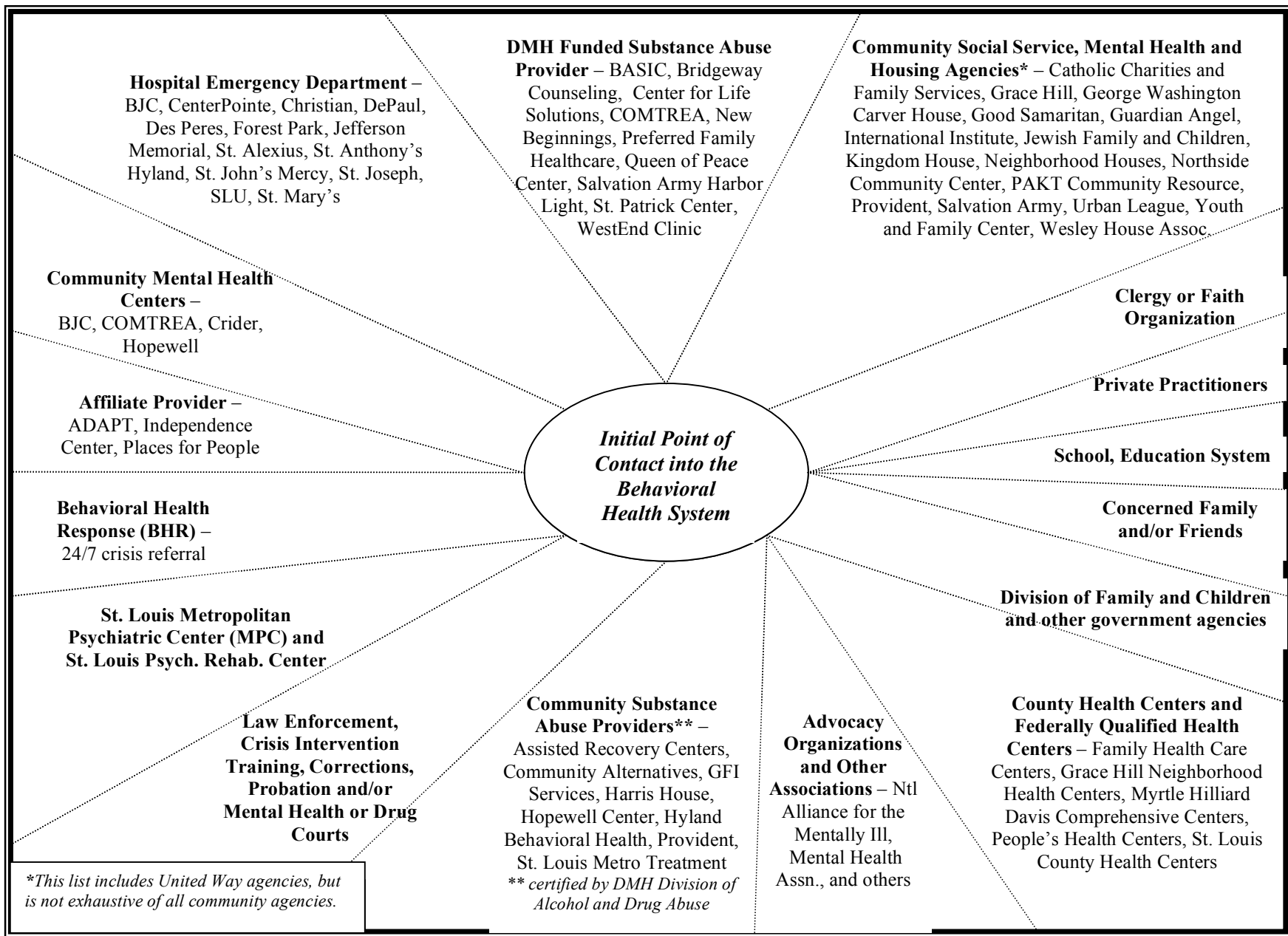
Stakeholders in the public behavioral health system believe that a significant strength of the system is the many and varied entry points that individuals can use as an initial point of contact about available care. Individuals may begin the process of receiving care after being referred either from formal channels, such as community mental health centers and private practitioners, or informal channels such as family members or clergy.

However, stakeholders also acknowledged that individuals who don't know where or how to start to receive care represent a significant challenge in the behavioral health system. While many starting points are available, people may not understand the services provided or areas served. Individuals or organizations who serve as informal entry points (e.g. family, clergy, friends) may be most at risk for not taking any action because they don't know where to begin.<sup>20</sup>

The following chart demonstrates the large number and wide variety of entry points for individuals who want to make an initial point of contact into the behavioral health system.

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<sup>20</sup> The Alcohol and Drug Abuse Division has a program to educate clergy and faith organizations on identifying substance abuse issues and referring individuals to appropriate care.

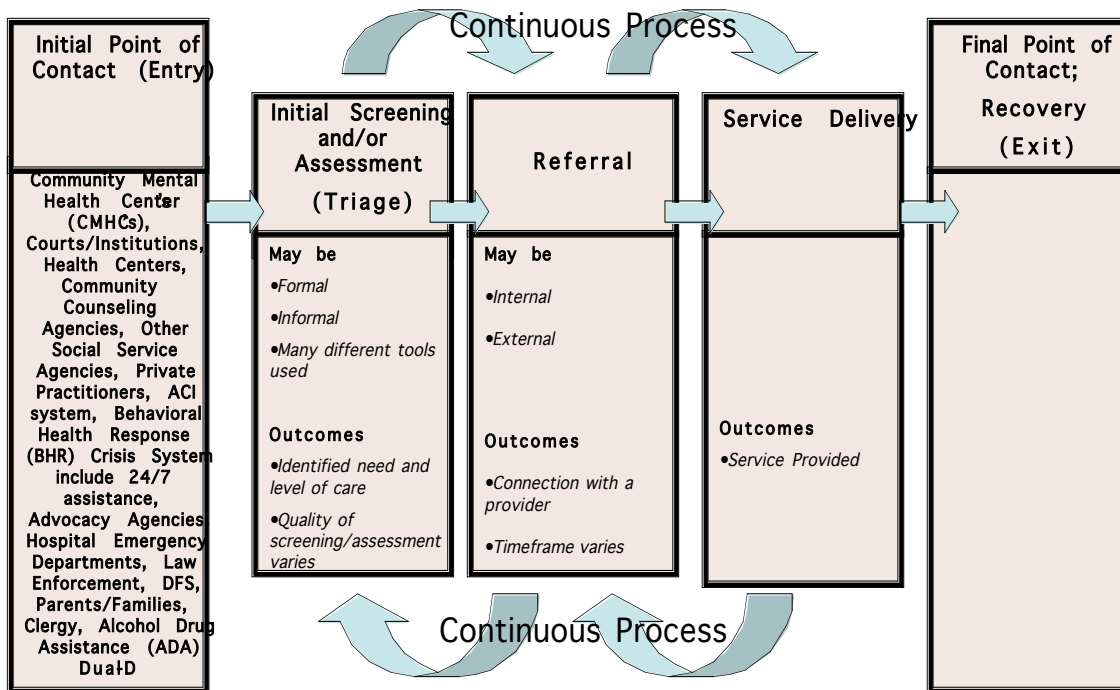


## MOVING THROUGH THE PUBLIC BEHAVIORAL HEALTH SYSTEM

### OVERVIEW

As noted earlier, a wide variety of organizations provide behavioral health services. To receive behavioral health services, individuals move from initial point of contact → initial assessment and/or screening → referral → service delivery → final point of contact or recovery (exit) (see map below).

## Eastern Region Public Mental Health Planning Project High Level Process Map



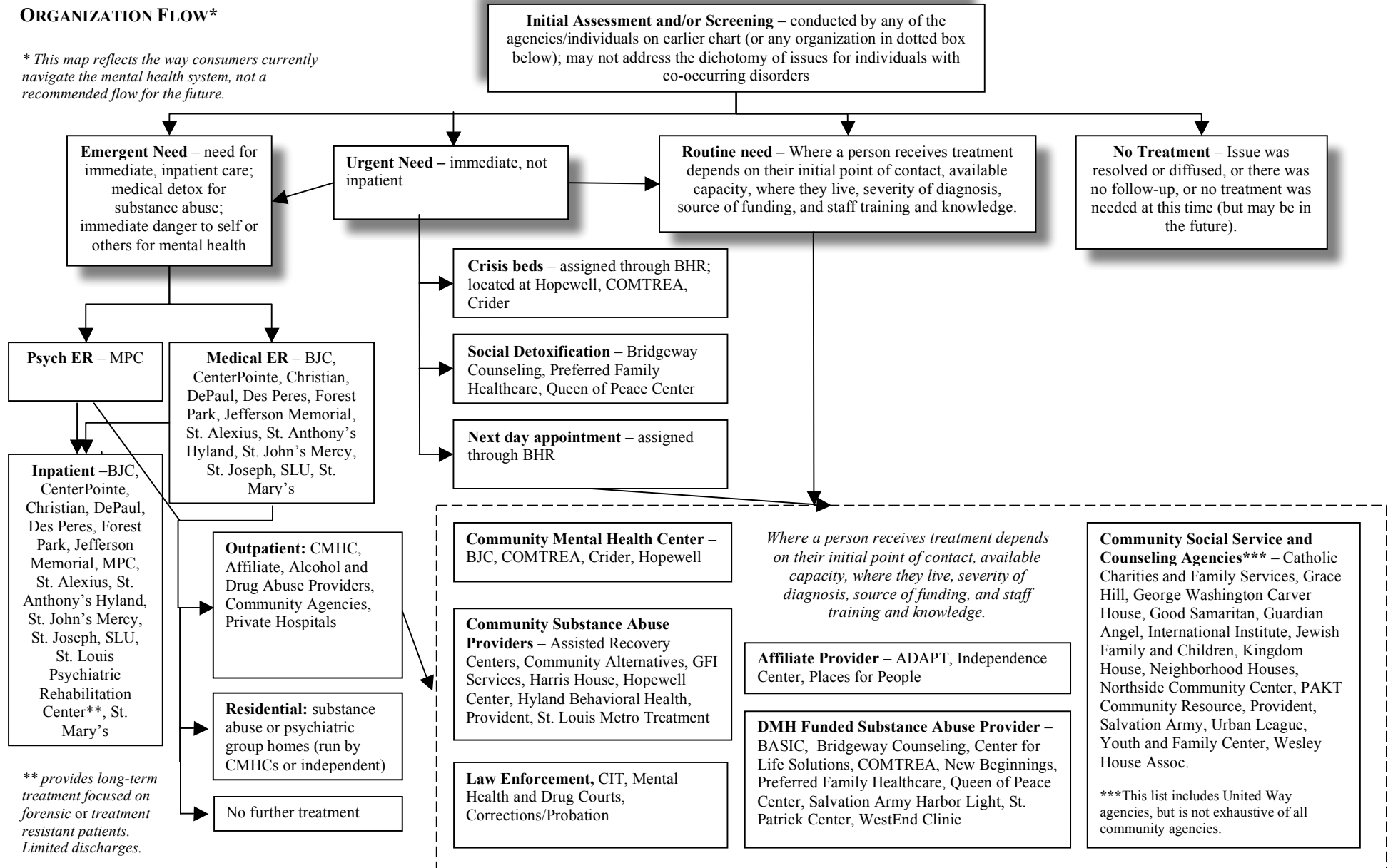
While the map depicts a simple, linear progression from one step to the next, the reality for individuals with behavioral health issues is much more complicated. As noted earlier in this report, the President's New Freedom Commission found that the fragmentation of the mental health system was an area of weakness in the system. Eastern region stakeholders report that after receiving a service or treatment, individuals may then have another assessment and continue a cycle of assessment, referral, service delivery, etc.<sup>21</sup> Individuals may never reach the final point of contact or exit from the system. Or, individuals may complete a service or treatment and exit the system, but return for care/treatment at a different point in time.

The following diagram provides an overview of the organizations providing behavioral health services and the way individuals currently navigate the system.

<sup>21</sup> Department of Mental Health Division of Alcohol and Drug Abuse has a standardized assessment tool and only pays for one assessment per client every six months.

**BEHAVIORAL HEALTH SYSTEM ORGANIZATION FLOW\***

*\* This map reflects the way consumers currently navigate the mental health system, not a recommended flow for the future.*



*\*\* provides long-term treatment focused on forensic or treatment resistant patients. Limited discharges.*

**Community Social Service and Counseling Agencies\*\*\*** – Catholic Charities and Family Services, Grace Hill, George Washington Carver House, Good Samaritan, Guardian Angel, International Institute, Jewish Family and Children, Kingdom House, Neighborhood Houses, Northside Community Center, PAKT Community Resource, Provident, Salvation Army, Urban League, Youth and Family Center, Wesley House Assoc.

*\*\*\*This list includes United Way agencies, but is not exhaustive of all community agencies.*



Limited data is available to report exactly how many individuals experience a continuous cycle of assessment, referral, service delivery, or to report how many individuals stay in the system, etc. Additional research may be warranted in this area in the future. Additional barriers and gaps that cause individuals to fail to receive effective treatment can be found in the “Barriers to Care” section of this document.

*INITIAL CONTACT*

All behavioral health care begins with an initial assessment and/or screening that determines whether or not an individual is in crisis, defined as someone who is an immediate danger to themselves or others.<sup>22 23</sup>

	<b>Initial</b>	
<b>Starts with:</b>	<b>Assessment/Screening</b>	<b>Ends with:</b>
∞ Person who identifies or questions own need	∞ Emergency Room	∞ Accurately identified needs of a person
∞ Concerned individual who questions or recognizes another’s need	∞ Phone screen	∞ Resources identified to best meet those needs
	∞ Face to face	

An individual who is in crisis is referred to the Metropolitan St. Louis Psychiatric Center or a hospital emergency room. After another screening, the individual may be admitted or discharged with a referral. An individual who is not in crisis is referred to one or more outpatient settings; the referral is based on several factors including the assessor’s training, knowledge and experience level, the individual’s initial point of contact, providers’ available capacity and/or where the individual lives. A diagram in **Appendix 3** provides more detailed information about how individuals move through the initial screening/assessment step.

*NEXT STEPS*

The initial assessment and/or screening also identifies individuals who are dealing with co-occurring issues of mental illness and substance abuse; however, both issues may not always be detected. These individuals may or may not be in crisis; regardless, treatment for substance abuse is usually provided first. After an individual receives treatment for substance abuse, s/he may resume the ongoing process of screening/assessment → referral → service delivery to treat mental health and other issues. A diagram in **Appendix 4** provides more detail about how individuals with co-occurring issues move through the system to receive care.

It is important to recognize that at any point in the process, an individual may not move to the next step, i.e. not receive treatment. Reasons an individual may not receive

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<sup>22</sup> For the purposes of this project, crisis for alcohol and drug abuse services is defined as “an individual needing medical or modified medical detoxification.”

<sup>23</sup> Out of the five steps in the process flow, workgroup members identified the screening/assessment as the most critical to create a more responsive behavioral health system.

treatment are many and varied; some are noted in the “Barriers to Care” section of this report.

## **INDIVIDUALS ELIGIBLE FOR PUBLIC BEHAVIORAL HEALTH SERVICES**

### *PSYCHIATRIC SERVICES*

The state Department of Mental Health serves four target populations for psychiatric services: persons with serious and persistent mental illness (SMI) (e.g. individuals who have been hospitalized more than once and/or have limited ability to function in key life areas, such as housing and employment, due to a mental illness); persons suffering from acute psychiatric conditions (e.g. individual in an acute psychiatric crisis); children and youth with serious emotional disturbances (SED) and forensic clients.

In addition, the state has identified four priority groups within the target populations: 1) individuals in crisis, 2) individuals who are homeless, 3) individuals recently discharged from inpatient care and 4) substantial users of public funds. These target populations currently constitute the majority of clients whom the Division serves both in inpatient and ambulatory settings.<sup>24</sup>

A standard means test is used to determine an individual’s ability to pay. Clients who are on Medicaid or below 150 percent of poverty level generally do not pay for services.

### *ALCOHOL AND DRUG ABUSE SERVICES*

Alcohol and drug abuse providers who contract with the Missouri Department of Mental Health use standardized assessment tools and guidelines to determine the level of care a client needs.

The state requires that individuals seeking alcohol and drug abuse treatment must present valid Missouri identification and verify their income and family size. A standard means test is used to determine an individual’s ability to pay. Clients who are on Medicaid or below 150 percent of poverty generally do not pay for services. Clients above 150 percent of the poverty level pay for services based on a sliding fee scale.

## **SERVICES AVAILABLE IN THE PUBLIC BEHAVIORAL HEALTH SYSTEM**

### *PSYCHIATRIC SERVICES*

Mental health providers offer a range of services – from intensive, inpatient care to care designed to help an individual remain in the community. Although individual providers may not offer the full array of services, following is a general list of services available to clients in the Eastern region.<sup>25</sup>

- ∞ Outpatient community-based services – Outpatient services provided in an individual’s community offer the least restrictive environment for treatment. An evaluation and treatment team provides services utilizing the resources of the

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<sup>24</sup> Missouri Department of Mental Health website.

<sup>25</sup> Missouri Department of Mental Health website.

individual, his/her family, and the community. Outpatient programs offer individual, group and family therapy, medication management, etc.

Outpatient programs may also include 1) targeted case management, which assists individuals in gaining access to psychiatric, medical, social and educational services and supports; and, 2) Community Psychiatric Rehabilitation (CPR), which is a client-centered approach that emphasizes individual choices and needs, features flexible community-based services and supports, uses existing community resources and natural support systems, and promotes independence and the pursuit of meaningful living, working, learning, and leisure-time activities in normal community settings. Both of these programs are Medicaid supported through the Rehabilitation Waiver.

- ∞ Day treatment/partial hospitalization – Day treatment offers the least restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than outpatient services can provide, but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services and educational services. The focus is on developing supportive medical, psychological and social work services.
- ∞ Residential care/community placement – Moderate-term placement in residential care provides services to persons with non-acute conditions who cannot be served in their own homes. A residential setting has more focused goals of providing a structured living environment in which to develop functional adaptive living skills, self-esteem, self-control of impulses, social skills, insight into personal issues, and enhanced family interactions.
- ∞ Inpatient (Hospitalization) – Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for persons who may be dangerous to themselves or others as a result of their mental disorder.

#### *SUBSTANCE ABUSE SERVICES*

Alcohol and drug abuse providers offer a range of services – from intensive, inpatient care, to care designed to help an individual stay in the community. Although providers may not offer every service, following is a general list of available services at alcohol and drug abuse providers.<sup>26</sup>

- ∞ Detoxification – Substance abuse treatment often begins with detoxification, during which an individual is assisted in withdrawing from alcohol or other drugs in a safe, supportive environment. Options include social setting detoxification, modified medical detoxification and medical detoxification.
- ∞ Residential Support – In a residential treatment program, a person receives round-the-clock care, seven days a week. Rehabilitation includes assessment, individual and

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<sup>26</sup> Missouri Department of Mental Health website.

group counseling, family counseling, participation in self-help groups and other supportive interventions.

- ∞ Outpatient Rehabilitation – Outpatient programs and services are designed for persons whose substance abuse is less severe or chronic and who do not require residential settings for treatment. They are also designed for persons who have completed residential programs and need follow-up counseling and support.
- ∞ CSTAR Program – CSTAR (Comprehensive Substance Treatment and Rehabilitation) focuses on serving people in their communities with individual and group counseling, skill building, family therapy, education, case management, and, where necessary, supportive housing. The CSTAR program serves as a funding source and encompasses the care provided through the Residential Support and Outpatient Rehabilitation programs.

## 4.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: UTILIZATION OF SERVICES

### OVERVIEW

As The President’s New Freedom Commission on Mental Health acknowledged in 2003, “mental illnesses are shockingly common; they affect almost every American family... No community is unaffected by mental illnesses; no school or workplace is untouched.”<sup>27</sup> That statement is compounded significantly when substance abuse and co-occurring disorders are included.

- ∞ Several national studies estimate that 5 – 7 percent of adults have a serious mental illness in any given year. *Applying this data to the Eastern Region, we can estimate that between 103,400 – 144,800 individuals are in serious need of psychiatric care at any given time, out of a population in the region of just more than 2 million.*<sup>28</sup>
- ∞ Assuming that the need for services is at least as high for the safety net population in our region, it can be estimated that *between 25,900 – 36,200 safety net individuals in the Eastern Region are in serious need of psychiatric care.*<sup>29</sup>
- ∞ The 2004 National Survey on Drug Use and Health estimates that 9.8 percent of the population is classified as needing substance abuse treatment.<sup>30</sup> Applying this data to the Eastern Region, *we can estimate that more than 202,000 individuals abuse or are dependent on substances, out of a population in the region of just more than 2 million.*<sup>31</sup>
- ∞ Assuming that the need for services is at least as high for the safety net population in our region, it can be estimated that *50,698 safety net individuals in the Eastern Region need treatment for substance abuse.*<sup>32</sup>

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<sup>27</sup> The President’s New Freedom Commission on Mental Health 2003.

<sup>28</sup> The President’s New Freedom Commission on Mental Health 2003. Eastern Region estimates based on 2005 census data. The Eastern Region includes Franklin, Jefferson, Lincoln, St. Charles, St. Louis and Warren counties and St. Louis city.

<sup>29</sup> Safety net is calculated by adding the number of individuals in the Eastern Region on Medicaid in 2005 (according to the Department of Health and Human Services website) and the number of uninsured individuals in the Eastern Region (according to Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), 2004). The population for the Eastern Region totals 2,068,000, which is 36 percent of the state population. Individuals receiving behavioral health care may also be part of the safety net because of the severity of their diagnosis or because they utilized all of their private health insurance benefits; these individuals are not represented in this safety net calculation.

<sup>30</sup> Needing treatment is defined in the survey as “persons dependent on or abusing a substance in the past 12 months or who received specialty treatment for a substance abuse problem within the past 12 months.”

<sup>31</sup> 2004 National Survey on Drug Use and Health, from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Eastern Region estimates based on 2005 census data.

<sup>32</sup> Safety net is calculated by adding the number of individuals in the Eastern Region on Medicaid in 2005 (according to the Department of Health and Human Services website) and the number of uninsured

## EASTERN REGION SURVEY RESULTS

For this current state assessment, a survey was sent to 19 community mental health centers<sup>33</sup>, affiliate providers<sup>34</sup> and alcohol and drug abuse providers in the Eastern region. All community mental health centers (four) and affiliate providers (four) in the region participated; seven of 11 alcohol and drug abuse providers participated.<sup>35</sup> A total of 15 surveys were returned for a 79 percent return rate.

The Missouri Department of Mental Health provided data about individuals served in the Eastern region. Data was also collected from hospitals and federally qualified health centers about the mental health and alcohol and drug abuse assessments and referrals they provide. The private hospital data includes information from 30 hospitals<sup>36</sup> in the Eastern region. One federally qualified health center in the region also provided information.

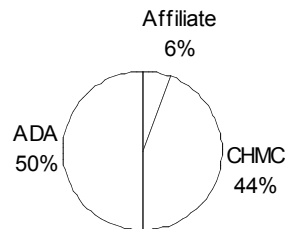
Additionally, Behavioral Health Response (BHR), who coordinates access and crisis intervention services in the region for the community mental health centers, provided information about the calls they receive.

The following data are aggregate totals about the services provided from January 1, 2005 – December 31, 2005, unless otherwise noted. This project and survey focused on behavioral health services provided to adults in the Eastern Region. Several pieces of information that would have been informative for this survey are not currently available across all providers, such as an individual's reasons for leaving or not seeking treatment, number of people attempting to access the system, services that are needed but not available, and number of times individuals access the system. Unless otherwise noted, the data was self-reported by each organization.

**Adult Clients Admitted -- 15,869 total**

### *CLIENTS SERVED AND NEW ADMISSIONS*

Together, the community mental health centers, alcohol and drug abuse providers and affiliate organizations in the Eastern region admitted 15,869 adults in 2005. Alcohol and drug abuse providers admitted half of those



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individuals in the Eastern Region (according to Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), 2004). The population for the Eastern Region totals 2,068,000, which is 36 percent of the state population.

<sup>33</sup> These organizations are also referred to as administrative agents.

<sup>34</sup> An affiliate provider is a non-administrative agent agency that receives funding from the Department of Mental Health to provide community based mental health services.

<sup>35</sup> Survey participants include all Department of Mental Health funded psychiatric services in the region. Survey participants did not include all of the community agencies, which may offer some form of behavioral health services, but are not funded by DMH. A complete list of survey participants is found in **Appendix 5**.

<sup>36</sup> In addition to hospitals in the Eastern region, the data includes one hospital from Washington County.

individuals (7,951), community mental health centers admitted 44 percent (6,973), and the affiliate providers admitted six percent (945).

The community mental health centers, affiliate organizations and alcohol and drug abuse providers serve a higher number of individuals in any given year than the number of admissions. Clients may be admitted one year and still be receiving services in the following year(s). The Department of Mental Health reports that community mental health centers served 12,175 clients in state fiscal year 2005. Affiliate organizations served 1,210 clients and alcohol and drug abuse providers served 13,559 clients.

### **Served vs. Admitted**

<b>TYPE OF PROVIDER</b>	<b>TOTAL SERVED</b>	<b>NEW ADMISSIONS</b>
Community Mental Health Centers	12,175	6,973
Affiliate Organizations	1,210	945
Alcohol and Drug Abuse Providers	13,559	7,951
<b>TOTALS</b>	<b>26,944</b>	<b>15,869</b>

### *REFERRAL SOURCES*

For all types of providers, most individuals refer themselves to these providers for service. Other significant referral sources changed for community mental health centers, affiliate organizations and alcohol and drug abuse providers.

### **Referral Sources**

<b>REFERRAL SOURCE</b>	<b>COMMUNITY MENTAL HEALTH CENTERS</b>	<b>AFFILIATE PROVIDERS</b>	<b>ALCOHOL AND DRUG ABUSE PROVIDERS</b>
BHR/Crisis Service	5%	--	1%
Courts	6%	3%	19%
DMH/MPC	8%	4%	1%
Family	9%	9%	7%
Hospital/Inpatient/Medical Doctor	13%	31%	3%
Law Enforcement	5%	<1%	17%
Other CMHCs	3%	21%	1%
Other Substance Abuse Program	1%	--	15%
Self	52%	31%	35%

### *SERVICES PROVIDED*

For community mental health centers, affiliate providers and alcohol and drug abuse providers, most individuals received outpatient services (47 percent for CMHCs/affiliates, 53 percent for alcohol and drug abuse providers).

### Services Provided – Community Mental Health Centers and Affiliate Providers

SERVICE	PERCENTAGE
Outpatient Office	47%
Community Support/Home Based	16%
Case Management	15%
Therapy/Counseling	9%
Medication Clinics	9%
Day Programs	3%
Residential	<1%
Crisis Beds	<1%

### Services Provided – Alcohol and Drug Abuse Providers<sup>37</sup>

SERVICE	PERCENTAGE
Outpatient	42%
CSTAR	18%
Residential Support	15%
Therapy/Counseling	15%
Community Support	7%
Detox	4%

#### *FUNDING SOURCES*

Most of the care provided by participating organizations was paid for through the Department of Mental Health (44 percent). Participating organizations also received supplemental funding from a variety of organizations, such as the Missouri Foundation for Health, drug courts, Missouri Division of Vocational Rehabilitation, St. Louis City Mental Health Board and the Jefferson County sales tax. Many organizations use supplemental funding to cover uninsured patients and costs above state reimbursement levels.

More information about funding is provided in Section 5.0 Eastern Region Public Behavioral Health System: Financing the System.

<sup>37</sup> Not included in this total are services provided by only one agency. Case management services (462 services) and day program services (1,696 services) were provided by only one alcohol and drug abuse provider.

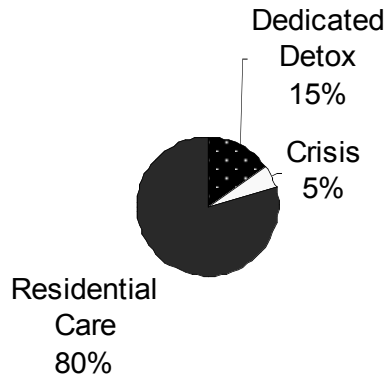
**Funding Sources – Community Mental Health Centers, Affiliates and Alcohol and Drug Abuse Providers**

<b>FUNDING SOURCE</b>	<b>PERCENTAGE OF INDIVIDUALS</b>
Department of Mental Health	44%
Traditional Missouri Medicaid	22%
Uninsured	15%
Commercial Insurance	4%
Medicare	6%
Missouri MC+ Medicaid	3%
Private Contracts	2%
Substance Abuse and Mental Health Services Admin. (SAMHSA) Grant	<1%
SAMSHA Federal Block Grant	<1%
Local Mental Health Tax Levy	<1%

*AVAILABLE STATE FUNDED COMMUNITY BASED BEDS*

Together, the mental health and alcohol and drug abuse providers had a total of 389 beds available. The average daily census for these beds indicates that nearly all were operating at highest occupancy.

**Alcohol and Drug Abuse Beds**



**Available Beds and Average Daily Census**

Type of Bed <sup>38</sup>	CMHCs AND AFFILIATES		ALCOHOL AND DRUG ABUSE	
	# of Beds	Avg Daily Census	# of Beds	Avg Daily Census
Residential Care	94	93	232	244
Crisis	3	0	15	14
Dedicated Detox	NA	NA	45	17

<sup>38</sup> These services are described in more detail on pages 18 - 20.

Information about inpatient beds located at Metropolitan St. Louis Psychiatric Center (MPC) and private hospitals is noted below. Additional types of available beds not counted in these totals include emergency, transitional and permanent housing.

## **OTHER SIGNIFICANT BEHAVIORAL HEALTH PROVIDERS**

### *PUBLIC HOSPITALS*

The Metropolitan St. Louis Psychiatric Center provides acute adult inpatient safety net mental health care, with a limited number of beds dedicated to substance abuse needs. Individuals from the Eastern region made 1,628 unduplicated and 2,141 duplicated visits to the Metropolitan St. Louis Psychiatric Center emergency room in 2005. Of the individuals from the Eastern region who visited the emergency room, 92 percent were from St. Louis city and county.

### **MPC Emergency Room Visits**

<b>LOCATION</b>	<b>UNDULICATED</b>	<b>DUPLICATED</b>	<b>% OF TOTAL ER VISITS UNDUP, DUP</b>
Eastern Region	1,628	2,141	94%, 95%
St. Louis City & County	1,513	2,008	88%, 89%

In addition to MPC, the St. Louis Psychiatric Rehabilitation Center (SLPRC) provides long-term inpatient mental health care for adults in the safety net. Together, MPC and the St. Louis Psychiatric Rehabilitation Center had 308 beds available;<sup>39</sup> MPC had an average occupancy of 81 percent.<sup>40</sup> MPC admitted 1,597 unduplicated individuals from the Eastern region in 2005. Of those admissions, most individuals were from St. Louis city and county (85 percent of Eastern region admissions).

### **MPC Admissions**

<b>LOCATION</b>	<b>UNDULICATED</b>	<b>DUPLICATED</b>	<b>% OF TOTAL ADMISSIONS UNDUP, DUP</b>
Eastern Region	1,597	2,000	85%, 87%
St. Louis City & County	1,369	1,737	73%, 75%

<sup>39</sup> Information from the Missouri Hospital Association, 2005 Annual Hospital Licensure Survey.

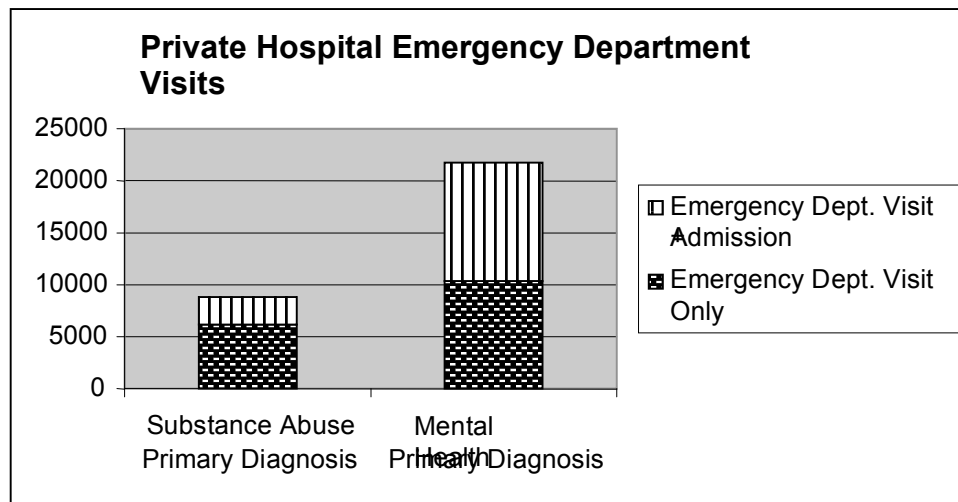
<sup>40</sup> St. Louis Psychiatric Rehab Center provides long-term treatment with limited discharges; therefore, the average occupancy is 100 percent.

*PRIVATE HOSPITALS*<sup>41</sup>

Hospitals in the Eastern region performed 30,625 emergency department assessments on individuals who had a primary diagnosis of mental health or substance abuse issues. Of those individuals, 14,042 were admitted to the hospital where they were evaluated. Individuals who visited the emergency department and received a primary or any secondary diagnosis of mental health or substance abuse issues totaled 100,925. Of those individuals, 59 percent were admitted to the hospital (59,806).

**Private Hospital Emergency Dept. Visits**

<b>PRIMARY DIAGNOSIS</b>	<b>ED VISIT ONLY</b>	<b>ED VISIT + ADMISSION</b>	<b>TOTAL</b>
Mental Health	10,378	11,384	21,762
Substance Abuse	6,205	2,658	8,863
<b>Totals</b>	<b>16,583</b>	<b>14,042</b>	<b>30,625</b>



**Private Hospital Emergency Dept. Visits**

<b>PRIMARY OR ANY SECONDARY DIAGNOSIS</b>	<b>ED VISIT ONLY</b>	<b>ED VISIT + ADMISSION</b>	<b>TOTAL</b>
Mental Health and/or Substance Abuse	41,119	59,806	100,925

Private hospitals<sup>42</sup> in the region had a total of 758 psychiatric beds available, with a weighted average occupancy of 78 percent.

<sup>41</sup> 2005 inpatient and outpatient administrative data from the Missouri Hospital Association's Hospital Information Data Institute. In addition to hospitals in the Eastern region, the data includes one hospital from Washington County (total of 30 hospitals). The data includes children. VA and DMH hospitals are excluded.

<sup>42</sup> Private hospitals included in this total: Barnes Jewish, CenterPointe, Christian, Forest Park, Jefferson Memorial, Missouri Baptist, SSM DePaul, SSM St. Joseph, SSM St. Mary's, St. Louis University, St.

### *FEDERALLY QUALIFIED HEALTH CENTERS*

One of the four federally qualified health centers (FQHC) in the region was able to provide information about mental health and substance abuse assessments. Family Care Health Centers conducted approximately 1,700 assessments during 2005, resulting in approximately 510 referrals for treatment. It should be noted that other FQHCs, including Grace Hill Neighborhood Health Centers, provide outpatient behavioral health services to the infant/adolescent populations.

### *BEHAVIORAL HEALTH RESPONSE*

BHR opened 19,200 cases during 2005.<sup>43</sup> The majority of callers were the clients themselves (73 percent) but significant amounts of calls were received from concerned others, law enforcement officers and staff of social service agencies. Forty-one percent of the cases were individuals who reported that they were already receiving services from a Department of Mental Health provider.

### **Behavioral Health Response Opened Cases**

<b>CALLER</b>	<b>PERCENTAGE OF TOTAL CASES</b>
Consumer/Self	73%
Concerned Other	20%
Other Agency or Professional	3%
Law Enforcement	2%
Medical Facility/Hospital	1%
Other	1%
Alcohol and Drug Staff	<1%

Slightly more than half of the BHR cases presented with non-acute mental health needs; 15 percent called in a crisis situation.<sup>44</sup> BHR was able to resolve the problem in the course of the telephone intervention for 44 percent of the cases;<sup>45</sup> just under 50 percent were referred to another provider; and, eight percent of the cases led to mobile outreach evaluations and/or immediate appointments or hospitalizations.

### **Behavioral Health Response Case Outcome**

<b>RESULT</b>	<b>PERCENTAGE OF TOTAL CASES</b>
Referred to another provider	47%
Problem resolved	44%
Mobile outreach/immediate appointment/hospitalization	8%

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Alexius, St. Anthony's, St. John's Mercy. Includes some children and adolescent psychiatric beds. Information from the Missouri Hospital Association, 2005 Annual Hospital Licensure Survey.

<sup>43</sup> A case documents all interventions provided for a given individual during a 24-hour period. As such, a case may incorporate multiple telephone calls.

<sup>44</sup> Crisis is defined as an individual in danger of immediate harm to themselves or others and/or unable to meet basic needs.

<sup>45</sup> "Resolve the problem" is defined as the client indicating satisfaction at the close of the call; therefore, no further action was planned.

## 5.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: FINANCING THE SYSTEM

### BACKGROUND

#### *FINANCIAL DATA ANALYSIS*

This financial analysis is intended to provide global estimates of the financial resources available to support clients who utilize public behavioral health services in the seven counties that make up the Eastern region. This includes crisis services, inpatient treatment, medical and social detoxification, social services and other wrap-around programs. In addition, area hospitals play a critical role in providing uncompensated care to safety net clients who require hospitalization. Further study of this issue is warranted in the future.

The methodologies employed in this analysis provide only “high-level” estimates of the need for care, the sources of funds to pay for this care, and the use of funds. More detailed study in this area may be warranted in the future. Much of the data used in this analysis has been voluntarily self-reported. In addition, funding information from a variety of state, federal, and local resources has been used. Public documents have been examined to verify information.

Categorization and allocation methods may vary from provider to provider. In some instances, existing data sources do not clearly identify uninsured patients or their cost of care, and payments received by providers are seldom explicitly earmarked as paying for the care of the uninsured.

Although the current focus for system improvements is oriented to adult care, the analysis includes funding available for children’s services. Children’s services funding is noted because these resources contribute substantially to overall program operations and support, including overhead for many local agencies.

Estimates of the true cost of behavioral health services in the region are speculative at best, considering the issues outlined above and additional variables such as multiple funding streams, levels of service intensity, duration of services and related costs of services, including housing and transportation. Accepting these limitations, a conservative estimate of \$87 million in additional funds would be needed to provide adequate behavioral health services to the adult safety net population in the Eastern region. More detailed analysis is available in **Appendix 6**.

#### *MISSOURI DEPARTMENT OF MENTAL HEALTH*

The Missouri Department of Mental Health is “charged with the delivery of services to persons with mental illness throughout the State of Missouri.”<sup>46</sup> There are eight adult inpatient hospitals, one children’s hospital, one children’s residential center and a number of group homes operated by the state and located throughout Missouri. DMH specifically

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<sup>46</sup> Missouri Department of Mental Health website, 2005.

targets four populations with special needs: (a) persons with severe/persistent mental illness, (b) persons with acute episodes of mental illness, (c) children and youth, and (d) forensic clients. To accomplish the goals of the DMH, the state is divided into 25 service areas, each with a Community Mental Health Center. In addition, the state funds an array of substance abuse services that are delivered by community based programs, including mental health centers. These programs focus on prevention, education, intervention and treatment for persons with abusing and addictions issues.

In FY 2006, the state appropriated \$971 million to fund all DMH services. Of that amount, \$103 million was available for ADA services while the CPS received approximately \$369.6 million for the year.<sup>47</sup> Federal funding makes up about 30 percent of that CPS total. Each Division, in turn, allocates expenditures to regions of the state and specifically to programs under contract or operated by the DMH.

#### *UNDERSTANDING MEDICAID*

Medicaid is a program managed by the states and funded jointly by the states and federal government to provide health insurance that pays for medical assistance for certain individuals and families with low incomes and few resources. Medicaid is the largest source of funding for medical and health-related services for people with limited incomes.<sup>48</sup>

The state of Missouri, like other states across the nation, has consistently made efforts to increase funding by billing Medicaid for services to disabled populations in our communities. Each new recipient in the program increases the number of “covered lives” for which matching funds may be used. Missouri currently has about 900,000 Medicaid eligible people who qualify for benefits. Based on income or covered conditions, the legislature can set eligibility criteria during each session. These changes in eligibility levels impact the service capacity of programs.

The matching formula for Medicaid funds requires states to provide approximately 40 percent of the funds needed for services, while the federal share makes up the balance, or about 60 percent. Approximately \$66.2 million of General Revenue (GR) Comprehensive Psychiatric Services funds were used in FY 2006 to earn \$108 million in Medicaid match. Some general revenue funds that are appropriated to CPS must be used to provide services for uninsured individuals who do not qualify for Medicaid, but need an array of safety net services to cope with their disabilities. As a result, Medicaid match totals just 30 percent of the 2006 CPS budget. As general revenue budgets are reduced, Medicaid funds will also necessarily go down. **Appendix 7** provides more information on the funding formula used to calculate payment levels to the state.

#### *PURCHASE OF SERVICE*

State psychiatric facilities are directly funded and managed by the Department of Mental Health. Community mental health centers, substance abuse and affiliate programs are operated under Purchase of Service (POS) contracts with DMH. POS contracts are

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<sup>47</sup> The remaining \$501.4 million funds the Division of Mental Retardation and Developmental Disabilities.

<sup>48</sup> See **Appendix 7** for additional information on state eligibility and funding sources.

reimbursed with a blend of state and federal dollars in a fee-for-service system. POS dollars (\$202 million in FY 2006) now make up 55 percent of the mental health CPS budget in Missouri. Each POS contractor receives an allocation at the start of the fiscal year. However, payment is made only after services are delivered and billed. Since there are no state operated substance abuse programs in the eastern region, Alcohol and Drug Abuse contracts have always been awarded to community programs.

There are a number of factors that influence the level of funding and pricing of services for specific ADA and CPS programs. Each service area receives a variable amount of funding based on their current contracts from ADA and CPS. Populations served and each agency's history in the federal funding cycle are important determinants of funding. ADA funds are primarily based on a competitive process, but the rates are set by the state. Mental health centers, however, usually receive a standard set price for any given service.

## **CURRENT FUNDING IN THE EASTERN REGION**

### *STATE FUNDING*

The formula for CPS allocations is largely driven by historical per capita rates that have been established with each service area/administrative agent. As implied by the name, "per capita" simply means that the service area population is multiplied by the specified rate as determined by the DMH. A service area of 100,000 people, for example, would receive \$850,000 if their rate were the regional average of \$8.50 per capita. Today, those rates (for adult services) range from \$8 to \$12 per capita in most service areas. The average per capita rate for the region is about \$8.50.<sup>49</sup> These funds are appropriated as general revenue.

In the past, per capita rates were driven by adjustments for poverty and the history of federal funding for a specific program. Today, rates continue to vary widely across the state. Funding to state hospitals remains the purview of the general assembly and does not take capitation into account. Each facility has a general revenue budget approved by the general assembly.

State funds for the CPS and ADA programs in the *Eastern Region* totaled \$98.1 million in FY 2005. The total CPS funding (general revenue and Medicaid) for the region during FY 2005 was \$80.8 million when all children's services were included. These funding levels include the cost of operating the 198 long-term beds at the St. Louis Psychiatric Rehabilitation Center (PRC), the acute care Metropolitan St. Louis Psychiatric Center (MPC) and the Hawthorn Children's Psychiatric Hospital. ADA contract funds for the region, including Medicaid, were approximately \$17,306,000 for FY 2005.

Resources not spent by year-end in any individual program may be shifted to other areas of high need. State funding levels for CPS and ADA programs in the Eastern region are shown on Table 1, on the next page.

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<sup>49</sup> Information from the Missouri Coalition of Mental Health Centers and Missouri Department of Mental Health, fall 2006.

**Table 1**  
**Eastern Region, State Funding - FY 2005**

Area	Agency	Adult	Child	Total
Region	Comp. Psych Services	\$20,955,029	\$16,105,475	\$37,060,504*
Region	Alcohol & Drug Abuse	14,912,488	2,393,512	17,306,000 *
State	St. Louis Psychiatric			
Inpatient	Rehab Center, St.			
Facilities	Louis Metro			
	Psychiatric Center & Hawthorn Ctr.	--	--	41,639,496
Region	Behavioral Health Response – Crisis			2,100,000
<b>Total:</b>				<b>\$98,106,000</b>

\*Includes administrative agents & affiliate agency funds

The break down of ADA, general revenue funding and Medicaid are shown in **Appendix 8**. Medicaid, 34 percent of total ADA funds in the region, provides significant support for services. As a result, many of the ADA services are targeted for Medicaid-eligible clients. **Appendix 9** illustrates the proportion of FY 2006 CPS funds statewide coming from federal (29 percent) and general revenue sources.

State general revenue funding is also available from the Office of State Court Administrators (OSCA), and is targeted to provide substance abuse treatment to offenders in drug court programs. The drug court commission administers funds to operating drug courts in 96 counties, which include 45 judicial districts statewide. The state general revenue appropriation for FY 2006 is approximately \$3.1 million. The Eastern region receives about \$1 million.

#### *LOCAL FUNDING*

##### 1. City and County Taxes

Local mental health/substance abuse agencies in the region have access to additional sources of public funds that are collected by city or county taxing authorities. These local funds are usually controlled by independent boards appointed by the taxing entity. In the Eastern region, St. Louis City, Jefferson County, and St. Charles County communities support behavioral health services through such a dedicated taxing source; St. Louis County, Lincoln County, Franklin County, Warren County do not. Funds supporting behavioral health services in St. Louis County are appropriated annually as a part of the budget of the Health Department.

In some instances, the tax board may serve as the governing board for the agency that receives the funds. County mental health levy (SB 652) funds may be administered in this manner. Some counties may also elect to use a portion of their money as “matching funds” in order to receive additional Medicaid support for clients. At least four counties in Missouri are using some form of local match (40 percent local to 60 percent federal) to increase Medicaid support for their treatment services.

## 2. Private Foundations/United Way

Depending on competitive applications for available grants, provider agencies in the region may receive Missouri Foundation for Health and United Way support, as well as local and national grants; all of these options have become an important source of funding for behavioral health services in the region. The amount of this support varies from year-to-year and among agencies. In general, these fund sources account for more than an estimated 10 percent of total dollars in the region supporting behavioral health care.

Table 2 provides a summary of local public and private funding sources for the Eastern region.

**Table 2**  
**Eastern Region, Local Funding Sources**

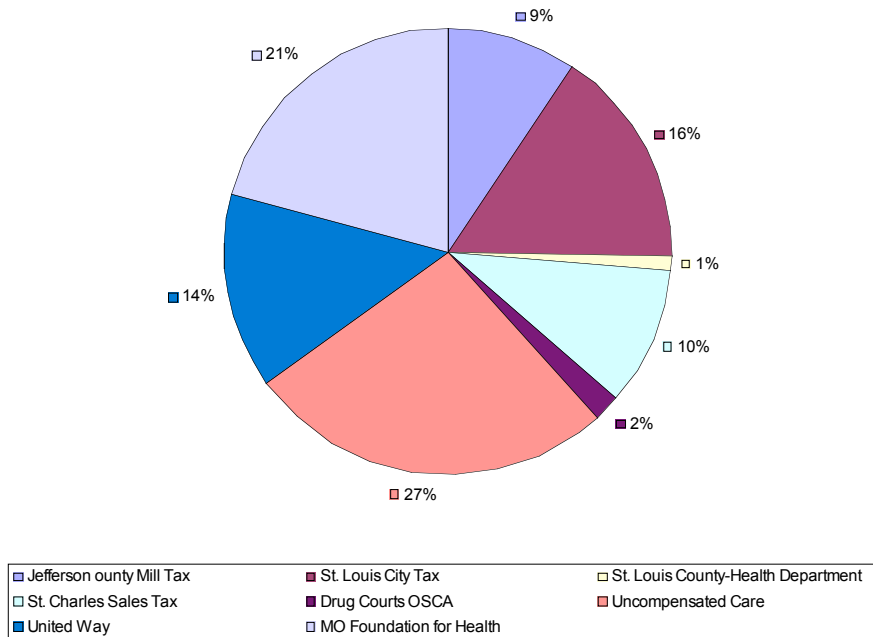
Source	Agency	Target Population	Amount
Jefferson County Mill & Sales Tax	Comtrea	Adult/Child	\$ 4,800,000
St. Louis City & Property Tax	Several	Adult/Child	8,000,000
St. Louis County Health Department	Several	Adult – Outpatient	600,000
St. Charles Sales Tax	Crider, Preferred Family, Bridgeway	Child only	5,000,000
Drug Courts OSCA	Several	Adult/Teen	995,000
Uncompensated Care <sup>50</sup>	Hospitals	All	13,566,250
United Way <sup>51</sup>	Several	All	7,200,000
MO Foundation for Health <sup>52</sup>	Many	All	10,500,000
<b>Total:</b>			<b>\$ 50,661,250</b>

<sup>50</sup> Uncompensated care is 1) care provided for patients who are unable to pay for their treatment, provided they meet charity care financial guidelines; 2) any shortfall in Medicaid reimbursement.

<sup>51</sup> Funding is a summary of grants awarded during the 2005 calendar year.

<sup>52</sup> Funding is a summary of grants awarded by MFH during the 2005 calendar year. Amount includes multi-year awards and may fluctuate annually based on dollars available and funding priorities.

Eastern Region, Local Funding Sources by Percentage



*OTHER FUNDING SOURCES*

1. Uncompensated Care by Community Hospitals

Community hospitals in the region often treat patients needing psychiatric care in the safety net system. The emergency rooms at these facilities routinely screen large numbers of clients needing acute care. The hospitals, regardless of whether they have dedicated psychiatric beds, may bill Medicaid for clients who qualify. Local hospitals in the region billed an estimated \$28.7 million for services to psychiatric patients in 2005.<sup>53</sup> Medicaid income totals nearly 30 percent of the revenues estimated for these patients. Self-pay amounts are usually minimal and result in “uncompensated care,” which generates a loss for the hospitals.

The amount spent on uncompensated care self-reported to the St. Louis Regional Health Commission by community hospitals in the region is estimated to be approximately \$13.5 million in 2005.

2. Disproportionate Share Funding

The mental health system in the Eastern region, like other areas in the state, benefits from disproportionate share (DSH) funds that are allocated to community hospitals that serve Medicaid populations. Federal payments are made to hospitals to compensate these facilities for the volume of uninsured services they provide. These DSH payments generate funding for hospitals that serve “disproportionately” large numbers of uninsured

<sup>53</sup> HIDI data, adults only.

recipients. Private psychiatric hospitals usually do not receive DSH payments. Facilities that are not “Institutes for Mental Disease” (IMD) qualify to receive these funds. The state hospital facilities usually earn the majority of these funds. However, DSH income received by state owned agencies returns to general revenue. The general revenue funds are then allocated by the state legislature to support various state needs, including mental health.

### 3. Federally Qualified Health Centers

The St. Louis region also benefits from the services of four federally qualified health centers (FQHC) which receive direct federal funding to deliver primary medical care. In addition, the St. Louis County Department of Health (DOH) also provides an array of services which includes primary care. Mental health interventions do occur in these health settings even in the absence of direct funding. This analysis includes a conservative estimated cost of these services at \$1.5 million based on the assumption that at least 10 percent of a primary care caseload may require assessment and/or referral to a mental health provider. Caseload information was provided by the health centers for FY 2005.

Table 3 presents a summary of funding data from all known sources of funding for behavioral health services. In addition to above mentioned state and local sources, it includes Disproportionate Share (DSH) payments received by the state facilities (and returned to general revenue) and community hospital uncompensated care. It also includes an estimate of Federally Qualified Health Centers (FQHC) and the St. Louis County Department of Health funds that are used to support behavioral health services.

**Table 3**  
**Eastern Region, All Funding Sources – FY 2005/2006**

<b>Source</b>	<b>ADA</b>	<b>CPS</b>	<b>Total</b>
State general revenue, Medicaid & DSH	\$17,306,000	\$80,800,000	\$ 98,106,000
General revenue – Office of State Court Administrators (OSCA-Drug Courts)	1,000,000	--	1,000,000
County & City taxes <sup>54</sup>	--	--	17,800,000
United Way Greater St. Louis	--	--	7,200,000
MO Foundation for Health – '05	--	--	10,500,000
Community Hospital- Medicaid	--	--	38,694,600
Fed. Qualified Health. Ctrs. and St. Louis County Health Department	--	--	1,500,000
Uncompensated Care	--	--	13,566,250
<b>Total All Categories</b>			<b>\$ 188,366,850</b>

<sup>54</sup> County taxes - \$9.8 million, city taxes - \$8 million

## 6.0 EASTERN REGION PUBLIC BEHAVIORAL HEALTH SYSTEM: BARRIERS TO CARE

### NEED FOR SERVICES

As noted earlier, an estimated *25,900 – 36,200 safety net individuals in the Eastern Region are in serious need of psychiatric care.*<sup>55</sup> The majority of mental health services for the adult safety net population are coordinated through Department of Mental Health providers, who serve 13,041 unduplicated clients in a given year, or *between 36 – 50 percent*<sup>56</sup> *of the safety net population estimated to be in serious need of services.*

For alcohol and drug abuse services, as noted earlier, an estimated *48,628 safety net individuals in the Eastern Region abuse or are dependent on substances.*<sup>57</sup> The state reports that state funded alcohol and drug abuse providers serve 13,559 unduplicated clients in a given year, or *28 percent*<sup>58</sup> *of the safety net population estimated to be in need of services.*

This is a conservative estimate which does not include an estimate for individuals who: 1) have private insurance but lack behavioral health care insurance, or 2) fully exhaust all of their behavioral health care benefits, or 3) have severe diagnosis or service needs and cannot find behavioral health care, or 4) are forensic clients.

### WAITING LISTS

Seventy-three percent of survey participants utilize a wait list for services, including two Community Mental Health Centers, four affiliates and five alcohol and drug abuse providers. During 2005, a total average of 458 individuals were on the wait lists on any given day, with most of those individuals on the wait lists for alcohol and drug abuse services.

Community mental health centers and affiliates averaged 106 individuals on their wait lists (average of 18 individuals per organization). This is a conservative estimate of the number of individuals waiting for care because of several factors: some individuals give up waiting until a crisis occurs, some organizations do not keep formal wait lists, some organizations cap their wait lists, and some organizations have a wait list but do not keep track of the number of individuals on it.

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<sup>55</sup> Safety net is calculated by adding the number of individuals in the Eastern Region on Medicaid in 2005 (according to the Department of Health and Human Services website) and the number of uninsured individuals in the Eastern Region (according to Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), 2004). The population for the Eastern Region totals 2,068,000, which is 36 percent of the state population.

<sup>56</sup> Equals 12,859 – 23,159 individuals. Average number of individuals is 18,009.

<sup>57</sup> Safety net is calculated by adding the number of individuals in the Eastern Region on Medicaid in 2005 (according to the Department of Health and Human Services website) and the number of uninsured individuals in the Eastern Region (according to Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), 2004). The population for the Eastern Region totals 2,068,000, which is 36 percent of the state population.

<sup>58</sup> Equals 35,069 individuals.

Alcohol and drug abuse providers averaged 352 individuals on their wait lists (average of 70 individuals per organization). Although individuals may be on the wait lists at multiple organizations, this is a conservative estimate of the number of individuals waiting for care because of the reasons noted above.

Nine organizations (60 percent of survey participants) kept data about the length of time individuals were on their wait list.

**Average Length of Time on Wait List**

LENGTH OF TIME	NUMBER OF ORGANIZATIONS
31+ days	4
15 – 30 days	3
8 – 14 days	1
0 – 7 days	1

**EXPERT OPINIONS ON BARRIERS TO CARE**

*CLIENT OPINIONS*

Stakeholders asked approximately 75 clients what prevented them from effectively accessing behavioral health services. The most common responses included lack of funds or insurance to pay for care and/or medicine, difficulty in getting the right medicine, limited transportation, wait lists to receive services (psychiatrists, ADA, etc.) and staff turnover.

Other challenges for clients included the stigma of mental illness, lack of support and respect from professionals and family, and difficult paperwork. Clients drew attention to the need for increased sensitivity to culture, race, ethnicity and language differences. Many clients and family members expressed an absolute frustration with the system. One individual commented that once you are in the system, you are in forever; another equated a mental illness diagnosis with a death sentence.

*STAKEHOLDER OPINIONS*

More than 40 individuals who are involved in behavioral health services participated in discussions<sup>59</sup> to identify barriers that prevent individuals from receiving behavioral health services or limit the care individuals receive. These statements were not quantified during this project; however, the following list notes stakeholders’ opinions on barriers that are systemic throughout the public behavioral health system.

- ∞ *Coordination of health care* – Stakeholders emphasized that the behavioral and physical health needs of an individual should not be separated – they are inextricably linked to the individual’s overall health and well-being. However, mental and physical health services are rarely coordinated and providers rarely have time to follow-up on referrals made for another service. A few pilot projects, such as the

<sup>59</sup> Discussions were held as part of Eastern Region Public Mental Health Planning Project steering committee, advisory board and workgroup meetings.

Medical Risk Management project with community mental health centers and the Family Mental Health Collaborative, are working to develop a more collaborative model of care.

- ∞ *Coordination of mental health and substance abuse* – National statistics estimate that more than half of the adults with severe mental illness in public mental health systems are further impaired by co-occurring substance use disorders (abuse or dependence related to alcohol or other drugs).<sup>60</sup> However, care is often fragmented because simultaneous treatment is limited, providers are unaware of available resources, and providers do not coordinate treatment.
- ∞ *Cultural awareness* – Racial, ethnic and economic differences between service providers and clients influence an individual’s health care encounter and affect whether or not individuals receive care. The U.S. Department of Health and Human Services reports that “race and ethnicity influence a patient’s chance of receiving many specific procedures and treatments. There is growing evidence that cultural expectations, assumptions and language are factors that affect the quality of care.”<sup>61</sup>
- ∞ *Funding and treatment options* – Stakeholders noted that individuals are not able to access care because of limited funding and restrictions on how funding can be used.

Individuals with mental illness in the safety net system are often unable to access care unless they are in a crisis situation. As a result, the system has been forced increasingly to rely more on inpatient care, instead of providing less restrictive care before individuals are in a crisis. Because of specific guidelines that dictate who qualifies for state funded services, individuals who suffer from non-chronic, non-crisis illness rarely receive treatment in the public mental health system. Stakeholders also related anecdotal examples of individuals who understand the criteria for entry into the mental health system, and claim to meet the criteria in order to receive care; however, on closer review, the individual may not actually meet the criteria.

Additionally, stakeholders recognized that individuals often receive care based on what services are available at the provider to which they are assigned. Individuals are designated to receive treatment from community mental health centers or affiliate providers based on the zip code they live in.<sup>62</sup> Service types and quality may vary among providers; however, client choice for mental health services is often limited by the individual’s home address.

- ∞ *Awareness of entry points and available resources* – Both providers and clients see it as advantageous that individuals can enter the behavioral health system through a

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<sup>60</sup> Substance Abuse and Mental Health Services Administration, National Mental Health Information Center, Evidence-Based Practices, Co-Occurring Disorders: Integrated Dual Disorders Treatment, Implementation Resource Kit.

<sup>61</sup> U.S. Department of Health and Human Services, “Addressing Racial and Ethnic Disparities in Health Care,” [www.ahr.gov/research/disparit.htm](http://www.ahr.gov/research/disparit.htm).

<sup>62</sup> It is important to note that substance abuse services are not administered on the basis of the individual’s zip code. Substance abuse services are available to individuals at any location in Missouri.

variety of formal and informal organizations and/or providers; however, there is a limited awareness in the community of the available entry points, treatment options and resources. Additionally, even within the system, providers make referrals based on their knowledge, training and experience, but may not be aware of the treatment options that are available.

- ∞ *Follow-up with clients* – Throughout the system, stakeholders recognized that most referrals involve giving an individual a name and phone number and relying on the individual to take the next step. These were identified as “cold” hand-offs, compared to a “warm” referral which would involve assisting the person with making contact with referral sources, overcoming any barriers to accessing the care and following-up to make sure the person was connected with the appropriate provider/organization. Additionally, clients who are receiving services who do not follow through with treatment recommendations have limited follow-up.
- ∞ *Communication among providers* – As one stakeholder noted, “We really don’t know each other.” Another stakeholder recognized that providers set one another and clients up for failure by referring clients inappropriately (for services that aren’t provided, etc.). Organizations and service providers have limited communication among themselves about clients or services. Communication is made more difficult because of staff turnover. Organizations change the treatment options and services delivered, and many times other providers are not aware of the changes. Privacy restrictions of HIPAA are often cited as a barrier to communicating about clients. Limited communication results in a system that does not maximize efficiencies, including repetitive screenings/assessments, no services, duplicate services, etc.
- ∞ *On-going regional planning* – Stakeholders recognized that many of the challenges noted above are the result of the lack of on-going regional planning efforts. Although some planning efforts have been undertaken in the past, the accomplishment of expected outcomes was limited. Stakeholders recommend increased buy-in and focus on implementation of recommendations with achievable results.

In addition to the systemic barriers noted above, which happen throughout the delivery of behavioral health services, stakeholders identified specific barriers an individual may experience during the initial assessment/screening, referral and service delivery steps of the process.

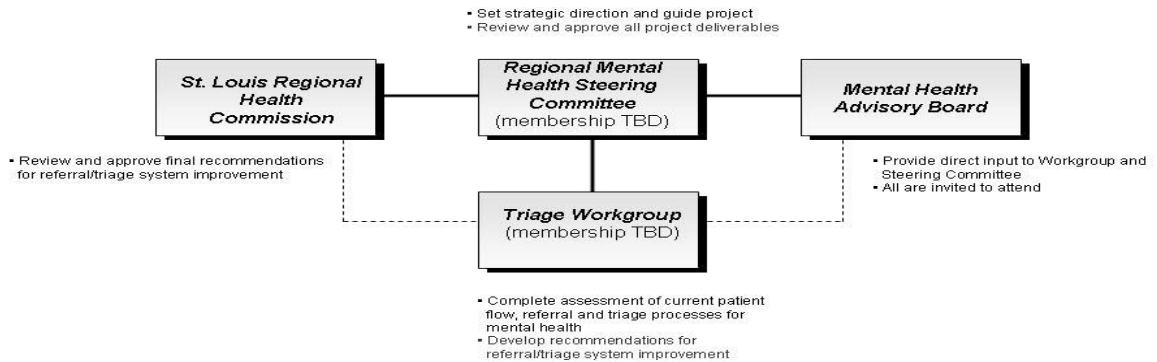
- ∞ *Social Supports* – Clients often lack adequate resources and supports necessary for treatment to be effective. Clients need safe and stable housing, stable employment, reliable transportation, child care and family/network support to attain their highest level of quality of life.
- ∞ *Transportation* – Stakeholders noted that transportation can be difficult for individuals in the public behavioral health system because of a lack of available public transportation, concerns about safety for mental health clients, etc.

- ∞ *Staff Training* – Staff members who work in the safety net system are very committed to clients; however, staff members are frequently “burned out,” resulting in high turnover. Entry level staff, who handle some of the most difficult and confusing situations, often have limited training. All levels of staff would benefit from more cross-training to help them recognize multiple diagnoses, identify appropriate referral sources, etc.
- ∞ *Treatment Options* – Other barriers identified related to the actual treatment options. Stakeholders highlighted limited evidence based models of care, limited research on how to help clients maintain gains and limits to the medications (and accessing and paying for the medications).

A list of stakeholder identified barriers and gaps can be found in **Appendix 10** at the end of this report.

## APPENDIX 1

### Eastern Region Public Mental Health Planning Project Committee Structure



#### Eastern Region Public Mental Health Planning Project Steering Committee:

**Dr. Karl Wilson**, President/CEO, Crider Center for Mental Health, Chair  
**Francie Broderick**, Executive Director, Places for People  
**John Eiler**, Executive Vice-President, SSM Healthcare  
**Dr. Dolores Gunn**, Director of Health, St. Louis County  
**Mary Ann Hampton**, Chief Nursing Officer, Forest Park Hospital  
**Jim House**, Executive Director, Mental Health Association of Greater St. Louis  
**Dr. Steve Huss**, President/CEO, COMTREA Community Treatment  
**Laurent Javois**, CEO, Public Psychiatric Hospitals of Eastern Missouri  
**Barbara Keehn**, District Administrator, MO DMH Division of Alcohol and Drug Abuse  
**Betty Jean Kerr**, CEO, People's Health Centers  
**Jackie Lukitsch**, Executive Director, NAMI St. Louis  
**Dr. Amanda Murphy**, President/CEO (represented by Regina Trotter, Vice-President), Hopewell Center  
**Connie Neumann**, Executive Director, Queen of Peace Center  
**Mark Stansberry**, Executive Director, BJC Behavioral Health  
**Janet Woodburn**, President/CEO, Bridgeway Counseling Services  
**Joe Yancey**, Community Mental Health Manager, MO DMH Comprehensive Psychiatric Services

## APPENDIX 2

### Missouri Department of Mental Health Comprehensive Psychiatric Services Division Core Strategic Priorities for System Transformation

#### **1. Prevention & Promotion**

##### **From a Disability to a Public Health Model of Service**

**New Freedom Commission Goal:** Missourians understand that Mental Health is Essential to Overall Health

- ∞ Integrated Prevention Effort with DHSS
- ∞ Expanded Strategic Prevention Framework
- ∞ Suicide Prevention, Relapse Prevention & Early Detection
- ∞ Mental Health Disaster Preparedness
- ∞ Mental Health Literacy and Anti-stigma Campaign
- ∞ Early Childhood Mental Health Promotion

#### **2. Science & Service**

##### **Toward Evidence-Based Practice and a Culturally Competent System of Care**

**New Freedom Commission Goal:** Excellent Mental Health Care is Delivered and Research is Accelerated

- ∞ EBP Steering Committee
  - Uniform Screening and Assessment
  - Integrated Dual Diagnosis Treatment (IDDT)
  - Supported Employment
  - Consumer Operated Service Programs (COSP)
  - Assertive Community Treatment (ACT)
- ∞ Research Consortium
- ∞ Coordinating Centers of Excellence
- ∞ Workforce Development
- ∞ Procovery Foundation with Trauma-Informed and Culturally Competent Care

#### **3. Access & Capacity**

##### **From Fragmentation to Appropriate Consultation, Collaboration and Integration; Toward Equal Access with Balanced Public-Private Capacity and State-Local Ownership and Investment**

**New Freedom Commission Goals:** Disparities are Eliminated, Early Mental Health Screening, Assessment and Referral to Local Services are Common Practice

- ∞ Early Integrated Screening, Referral and Care Coordination Protocols
  - Statewide Crisis Intervention Team Planning & Justice Grant
  - Statewide Mental Health/ED Task Force
- ∞ System Capacity Development
  - Home and Community-based Services Expansion
  - Housing Task Force
  - Special Populations (e.g. Deaf & Hard of Hearing)

- Public-Private Partnership Expansion
- Regional Planning/Local Community System of Care Infrastructure
- Mental Health Board Development

#### **4. Consumer/Family Driven Services & System Accountability**

##### **Toward a State-Wide Consumer and Family Voice that Drives Decision-making and Services at all levels of the System**

**New Freedom Commission Goal:** Mental Health Care is Consumer and Family Driven

- ∞ Procovery
- ∞ Individual Plans of Care
- ∞ Comprehensive State Plan with Active Consumer & Family Involvement in Planning and Evaluation
- ∞ Consumer & Family Mentors
- ∞ Quality Infrastructure with Integrated Consumer & Family Monitoring
  - System Integrity & Risk Management – Safety & Basic Assurances
  - Fidelity Assessment & Quality Service Review (QSR)
  - Outcomes
  - Shared “System” Scorecards
  - Performance Improvement
- ∞ Expansion of Consumer and Family Organizations and Service Programs

#### **5. Technology Supports**

##### **Toward the use of Technology to Support and Sustain Transformation**

**New Freedom Commission Goal:** Technology is Used to Support Access to Services and Information

- ∞ Data Warehouse
- ∞ Network of Care
- ∞ Tele-services
- ∞ Technology Transfer
- ∞ Electronic Medical Records

## APPENDIX 2 CONTINUED

### Missouri Department of Mental Health Division of Alcohol and Drug Abuse Core Strategic Priorities

#### 1. Access to Recovery

- ∞ Expanding consumer choice by **implementing a voucher system** that allows consumers to select the services and providers that best meet their personal needs.
- ∞ **Increasing the involvement of the faith community** in addressing the problems of alcohol and drug dependence and in providing support services.
- ∞ **Measuring results** through the collection of outcome measures including abstinence from drugs and alcohol, no involvement with the criminal justice system, and acquiring employment and stable housing.
- ∞ **Increasing treatment capacity** by adding treatment programs in underserved areas, and expanding the availability of treatment options, such as trauma counseling, relapse prevention, and peer support services.

**Goal 1: Recruit, enroll and train eligible faith-based agencies to provide recovery supports.**

**Goal 2: Assess the effectiveness of the Access to Recovery initiative in improving consumer outcomes.**

#### 2. Prevention

- ∞ Assist local community coalitions in developing programs, practices and policies to promote substance abuse prevention, using the five steps of the strategic prevention framework:
- ∞ Profiling needs, resources, and readiness to address problems and gaps
- ∞ Mobilizing and/or building capacity to address needs
- ∞ Developing a comprehensive strategic plan
- ∞ Implementing evidence-based prevention programs
- ∞ Evaluating effectiveness, and sustaining effective programs

**Goal 1: Promote development of local prevention initiatives utilizing the Strategic Prevention Framework.**

#### **Statewide Prevention Framework State Incentive Grant**

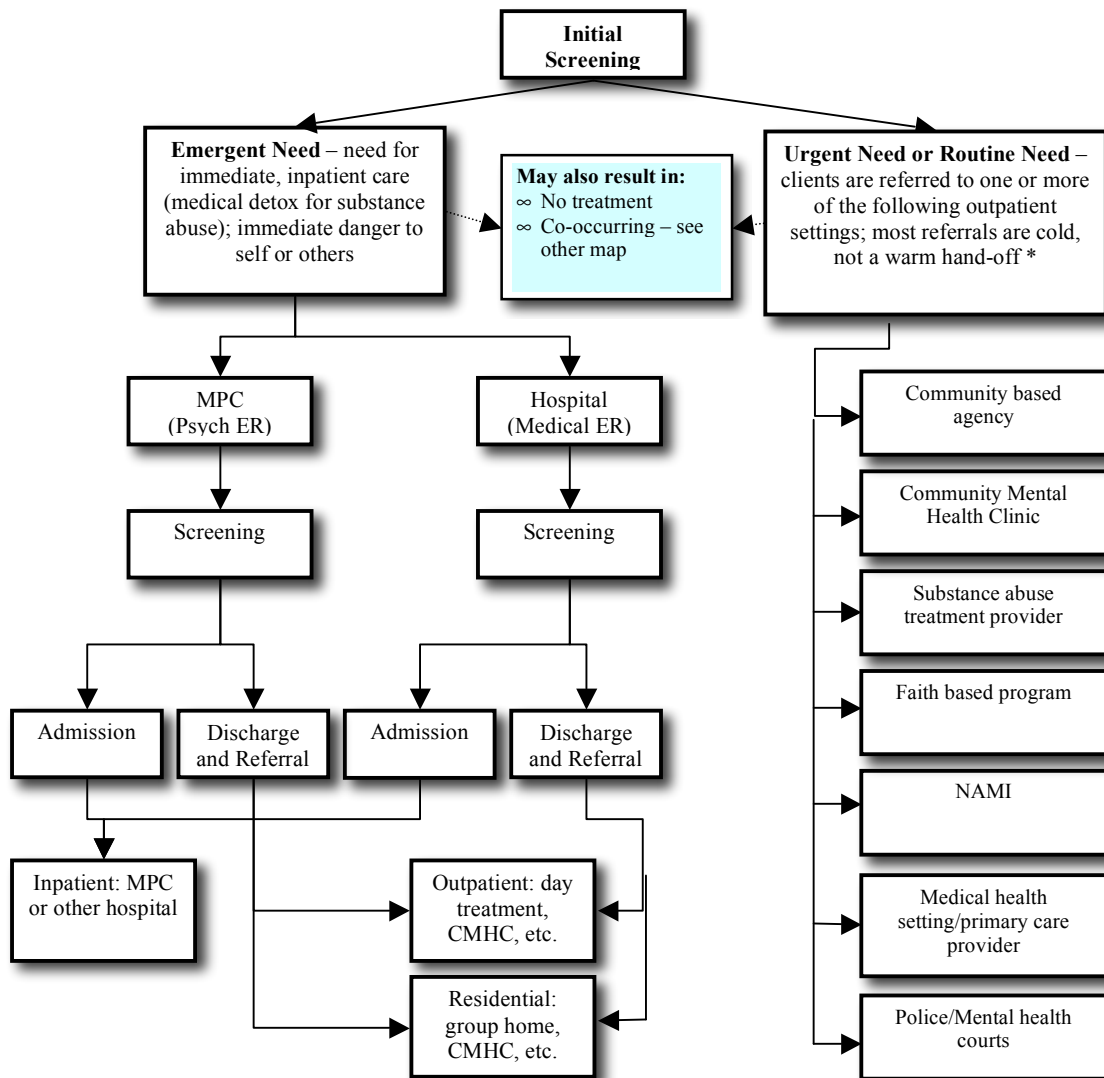
Missouri's Strategic Prevention Framework State Incentive Grant (SPF SIG) priority is to reduce risky drinking (binge and underage) among Missouri residents ages 12 through 25.

## **Strategies**

- ∞ Implementation of the Strategic Prevention Framework and its five steps at state and community levels.
- ∞ Support of the statewide epidemiological work group in collection, analysis and use of consequence and consumption data.
- ∞ Mobilization and capacity building for increased collaboration and partnership development among all substance abuse prevention stakeholders.
- ∞ Funding and promotion of the use of data-driven, culturally-competent, evidence-based programs, practices and policies that that can be adapted at the community level to capture targeted outcomes sensitive to geographic and population diversity.

### APPENDIX 3

#### EASTERN REGION PUBLIC MENTAL HEALTH PLANNING PROJECT INITIAL SCREENING AND/OR ASSESSMENT MAP<sup>63</sup>

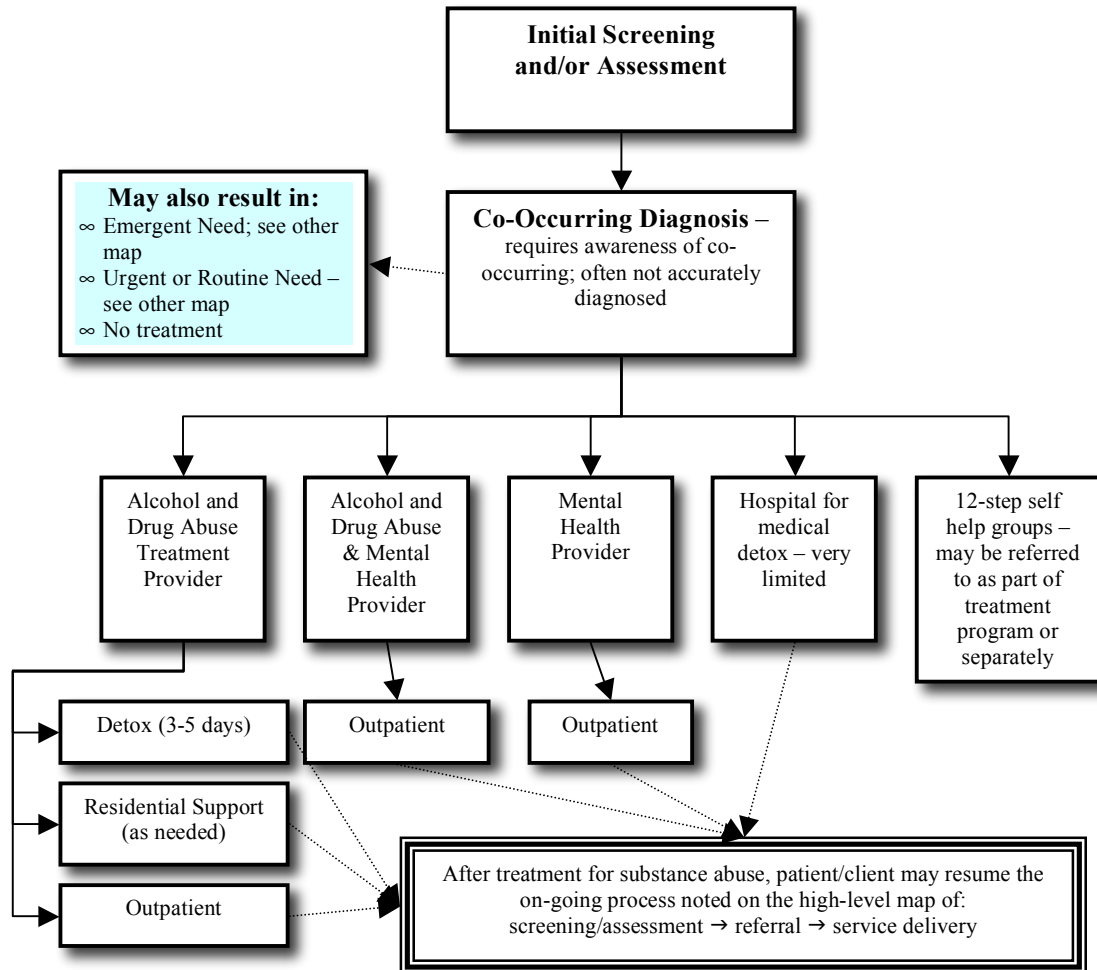


\* A “cold hand-off” is described as giving an individual contact or referral information and relying on the individual to take the next step. A “warm hand-off” is described as relying on the referral and receiving providers/agencies to ensure the client receives service at the next step – such as scheduling an appointment and arranging transportation, etc.

<sup>63</sup> This map reflects the way clients currently navigate the mental health system, not a recommended flow for the future.

## APPENDIX 4

### EASTERN REGION PUBLIC MENTAL HEALTH PLANNING PROJECT CO-OCCURRING DIAGNOSIS MAP – MENTAL HEALTH AND SUBSTANCE ABUSE<sup>64</sup>



<sup>64</sup> This map reflects the way clients currently navigate the mental health system, not a recommended flow for the future.

**APPENDIX 5**

**Eastern Region Public Mental Health Planning Project  
Survey Participants**

<b>Type</b>	<b>Organization</b>	<b>Completed Survey?</b>
Affiliate	Adapt of Missouri	Yes
Affiliate	Places for People	Yes
Affiliate	Independence Center	Yes
	Community Alternatives*	Yes
CMHC	BJC Behavioral Health	Yes
CMHC	COMTREA	Yes
CMHC	Crider Center	Yes
CMHC	Hopewell Center	Yes
ADA	BASIC	No
ADA	Bridgeway Counseling Services	Yes
ADA	Center for Life Solutions	Yes
ADA	COMTREA	Yes
ADA	Harris House Foundation	No
ADA	New Beginnings –CSTAR, Inc.	Yes
ADA	Preferred Family Healthcare, Inc.	Yes
ADA	Provident	No
ADA	Queen of Peace Center	Yes
ADA	St. Patrick Center	Yes
ADA	Salvation Army Harbor Light	Yes
ADA	WestEnd Clinic	No

\* Provides affiliate-type services, but is not officially an “affiliate provider” with the Missouri Department of Mental Health. Also provides alcohol and drug abuse services.

## APPENDIX 6

### **Behavioral Health Services Estimates of Funding Need**

Estimates of the true cost of behavioral health services in the region are speculative at best, given multiple funding streams, levels of service intensity, duration of services given and related costs of service including housing and transportation (which many agencies provide or contract for). Accepting those limitations, several global estimates of aggregated per patient costs are given below. The rationale or calculations for each number are also reported. The dollar amounts, number of individuals served and number of individuals in need of service are reported in earlier sections of this assessment.

These estimates do not assume any changes in system efficiency, cost structures or cost offsets.

#### **Summary of estimated new money needed**

Estimate 1	\$ 86,949,932
Estimate 2	\$194,106,246
Estimate 3	\$289,062,788
Estimate 4	\$111,251,488

### Estimate 1

This estimate breaks down the number of individuals in need of services based on ADA services and different types of CPS services.

Estimated number of individuals in need of ADA services:	35,069 <sup>65</sup>
Multiplied by the estimated cost per person:	<u>\$1,357<sup>66</sup></u>
New money needed to serve ADA safety net population:	\$47,588,633

For CPS services, an estimated 18,009 individuals in the safety net need psychiatric services. However, not all of the individuals would need the same level of service. Providers estimate about 20 percent of the individuals would need more in-depth, comprehensive community support services, and about 80 percent would need outpatient only psychiatric services. Providers estimate the cost of providing the in-depth community support services to be \$5,500 and the cost of providing outpatient only services to be \$1,357 (based on the ADA per person cost).<sup>67</sup> These numbers are estimates and require more study and analysis.

Number of individuals in need of CPS services:	18,009 <sup>68</sup>
20 percent <sup>69</sup> of individuals needing more in-depth community services:	3,602
Multiplied by the estimated cost per person:	<u>\$5,500</u>
New money needed to serve 20% of CPS safety net population:	\$19,811,000

80 percent <sup>70</sup> of individuals needing outpatient services:	14,407
Multiplied by the estimated cost per person:	<u>\$1,357</u>
New money needed to serve 80% of CPS safety net population:	\$19,550,299

Total of ADA and CPS:	
New money needed to serve ADA safety net population:	\$47,588,633
New money needed to serve 20% of CPS safety net population:	\$19,811,000
New money needed to serve 80% of CPS safety net population:	<u>\$19,550,299</u>

*Total new money needed to serve ADA and CPS safety net population: \$86,949,932*

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<sup>65</sup> Taken from page 37 of the Barriers to Care section. Number of individuals in need of ADA services is estimated by subtracting the number of individuals served from the estimated number of individuals in need of services.

<sup>66</sup> Reported by the Missouri Department of Mental Health Division of Alcohol and Drug Abuse.

<sup>67</sup> This is a best-guess estimate based on the ADA per person cost for similar types of services.

<sup>68</sup> Taken from page 37 of the Barriers to Care section. Number of individuals in need of CPS services is estimated by taking the average of the estimated need and subtracting the number of individuals served.

<sup>69</sup> Estimated percentage of individuals who would need more in-depth, comprehensive community support services.

<sup>70</sup> Estimated percentage of individuals who would need outpatient only psychiatric services.

## Estimate 2

This estimate separates the costs per person for Alcohol and Drug Abuse Services and Comprehensive Psychiatric Services.

$$\begin{array}{l} \text{Documented costs of state funded ADA services:} \\ \text{Reported individuals receiving ADA services:} \end{array} \quad \frac{\$17,306,000^{71}}{13,559^{72}} =$$

*\$1,276 cost per person*<sup>73</sup>

$$\begin{array}{l} \text{Documented costs of state funded CPS services:} \\ \text{Reported individuals receiving CPS services:} \end{array} \quad \frac{\$80,800,000^{74}}{13,385^{75}} =$$

*\$6,037 cost per person*

If we average or “blend” the ADA and CPS costs, we have a *per person cost of \$3,657*.

$$\begin{array}{l} \text{Estimated number of individuals in need of services:} \\ \text{Multiplied by the averaged cost per person:} \end{array} \quad \begin{array}{l} 53,078^{76} \\ \underline{\$3,657} \end{array}$$

$$\text{Total new money needed to serve safety net population:} \quad \$194,106,246$$

- ∞ This estimate includes costs of state-funded inpatient facilities, but it does not include individuals served in those facilities.
- ∞ Several ADA providers report that this estimate of cost per person is lower than their actual average costs; they estimate their average cost to be approximately \$2,500 per person. The Missouri Department of Mental Health Division of Alcohol and Drug Abuse estimates the average cost to be \$1,357 per person.

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<sup>71</sup> Reported in table 1 of the Financing the Safety Net section.

<sup>72</sup> Reported on page 23 of the Utilization of Services section.

<sup>73</sup> Substance abuse providers report their average costs are actually higher – averaging \$2,500 per person.

<sup>74</sup> Reported on table 1 of the Financing the Safety Net section.

<sup>75</sup> Reported on page 23 of the Utilization of Services section; individuals served by CMHCs and affiliate organizations.

<sup>76</sup> Taken from page 37 of the Barriers to Care section. Number of individuals in need of CPS services is estimated by taking the average of the estimated need and subtracting the number of individuals served. Number of individuals in need of ADA services is estimated by subtracting the number of individuals served from the estimated number of individuals in need of services. Then, the CPS and ADA numbers were added together to equal 53,078.

### Estimate 3

This estimate subtracts the costs of state-funded inpatient facilities from the total dollars funding service delivery in the region. Then, the number is divided by the number of individuals served by state contracted providers. ADA and CPS funds and clients are all included in the totals.

Total documented costs of service delivery in the region:	\$188,366,850 <sup>77</sup>	
Subtract DMH facility budgets (state inpatient costs):	<u>- 41,639,496<sup>78</sup></u>	
	\$146,727,354	
	<u>\$146,727,354</u>	
Reported number of people served (ADA and CPS):	26,944 <sup>79</sup>	=
		\$5,446 cost per person

Estimated number of individuals in need of services:	53,078 <sup>80</sup>
Multiplied by the estimated cost per person	<u>\$5,446</u>

*Total new money needed to serve safety net population:*     \$289,062,788

- ∞ This estimate does not include funding for state inpatient facilities.
- ∞ This estimate includes funding from United Way and the Missouri Foundation for Health, but it does not necessarily include an estimate of individuals served with those funds.
- ∞ The number of people served only includes individuals served by state contracted alcohol and drug abuse and community-based comprehensive psychiatric providers.

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<sup>77</sup> Reported in table 3 of the Financing the Safety Net section.

<sup>78</sup> Reported in table 3 of the Financing the Safety Net section.

<sup>79</sup> Reported on page 23 of the Utilization of Services section.

<sup>80</sup> Taken from page 37 of the Barriers to Care section. Number of individuals in need of CPS services is estimated by taking the average of the estimated need and subtracting the number of individuals served. Number of individuals in need of ADA services is estimated by subtracting the number of individuals served from the estimated number of individuals in need of services. Then, the CPS and ADA numbers were added together to equal 53,078.

**Estimate 4**

This estimate only includes the costs of state funded ADA services and community-based CPS services in the region. It does not include regional funding sources or state inpatient facility funding. ADA and CPS funds and clients are all included in the totals.

Documented costs of state funded ADA and community-based CPS services in the region:  $\frac{\$56,466,504^{81}}{26,944^{82}} =$   
Reported number of people served (ADA and CPS):

*\$2,096 cost per person*

Estimated number of individuals in need of services: 53,078<sup>83</sup>  
Multiplied by the estimated cost per person \$2,096

*Total new money needed to serve safety net population: \$111,251,488*

∞ This estimate does not include funding for or individuals served by state inpatient facilities, United Way, or the Missouri Foundation for Health.

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<sup>81</sup> Reported in table 1 of the Financing the Safety Net section.

<sup>82</sup> Reported on page 23 of the Utilization of Services section.

<sup>83</sup> Taken from page 37 of the Barriers to Care section. Number of individuals in need of CPS services is estimated by taking the average of the estimated need and subtracting the number of individuals served. Number of individuals in need of ADA services is estimated by subtracting the number of individuals served from the estimated number of individuals in need of services. Then, the CPS and ADA numbers were added together to equal 53,078.

## APPENDIX 7

### Explanation of Medicaid

#### Medicaid Defined

The Medicaid program provides medical benefits to groups of low-income people, some who may have no medical insurance or inadequate medical insurance. Although the federal government establishes general guidelines for the program, the Medicaid program requirements are established by each state. Whether or not a person is eligible for Medicaid depends on the state where he or she lives.

#### Eligibility

States are required to include certain types of individuals or eligibility groups under their Medicaid plans, and may elect to include additional groups. State eligibility groups are considered one of the following: categorically needy, medically need, or special groups. Some of the key eligibility groups may include the following:

- ∞ Families who meet states' Aid to Families with Dependent Children (AFDC) eligibility requirements.
- ∞ Pregnant women and children under age six whose family income is at or below 133 percent of the Federal poverty level.
- ∞ Children ages 6 to 19 with family income up to 100 percent of the Federal poverty level.
- ∞ Caretakers (relatives or legal guardians who take care of children under age 18).
- ∞ Supplemental Security Income (SSI) recipients.
- ∞ Individuals and couples who are living in medical institutions and who have monthly income up to 300 percent of the SSI income standard.<sup>84</sup>

#### Funding Sources

The State of Missouri and federal government provide funding for Medicaid programs. The amount of Medicaid funding provided by the government is based on the Federal Medical Assistance Percentage (FMAP), and is based on a three-year average of the state per-capita personal income. That level is then compared to the national average. For a wealthy state, the federal contribution might be limited to 50 percent of every dollar the state pays out; the maximum federal contribution, no matter how poor the state, is 83 percent.<sup>85</sup>

Missouri's state Medicaid funds generate federal matching funds at a 61.60 percent rate for most individuals and 73.13 percent for the State Children's Health Insurance Program (SCHIP) in federal FY 2007.<sup>86</sup> Currently, Missouri Medicaid spending generates \$1.574 in federal matching funds for every state dollar spent; SCHIP spending generates \$2.678 in matching funds.<sup>87</sup>

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<sup>84</sup> Information from "Medicaid At A Glance," Centers for Medicare & Medicaid Services.

<sup>85</sup> Information from [www.stateline.org](http://www.stateline.org), 2006.

<sup>86</sup> Federal Register: November 30, 2005.

<sup>87</sup> Ferber, Bednarek, Islam, "The County Level Impact of Medicaid and SCHIP in Missouri," February 2, 2005.

**APPENDIX 8**

**Eastern Region, ADA - Expenditures by Fund Source  
Medicaid versus Non-Medicaid  
FY 2005**

<b>Category</b>	<b>General Revenue</b>	<b>Health Initiatives Fund(1)</b>	<b>Healthy Family Trust(2)</b>	<b>Non Medicaid Federal(3)</b>	<b>Adult and Child, TOTAL</b>
Medicaid	\$1,136,702	\$ 649,544	\$ 533,554	\$3,651,370	\$ 5,971,170
Non-Medicaid	4,461,285	1,452,383	-	5,421,729	11,335,397
<b>TOTAL</b>	<b>\$5,597,987</b>	<b>\$2,1101,927</b>	<b>\$ 533,554</b>	<b>\$9,073,099</b>	<b>\$17,306,567</b>

- (1) Funding from tax on cigarettes that is dedicated to substance abuse Treatment
- (2) Funding from tobacco settlement funds
- (3) Funding from various grants

**Medicaid and Non-Medicaid Funding**

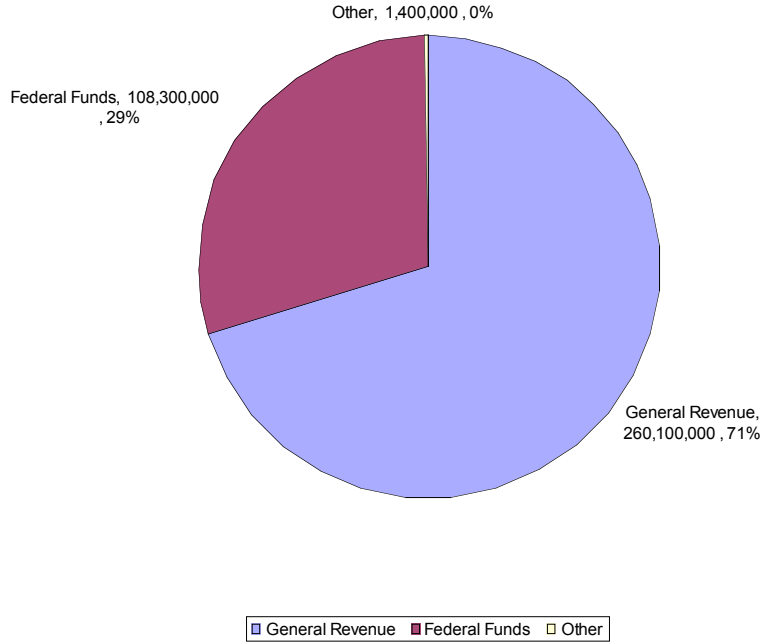
- ∞ The Medicaid line item represents dollars expended for Medicaid eligible services.
- ∞ The non-Medicaid line item represents two types of services/clients:
  - Non-Medicaid eligible services to Medicaid eligible clients (examples include adult residential services, child care, or academic education for adolescents); and,
  - Service to non-Medicaid clients

## APPENDIX 9

### CPS FY 2006 BUDGET (in millions)

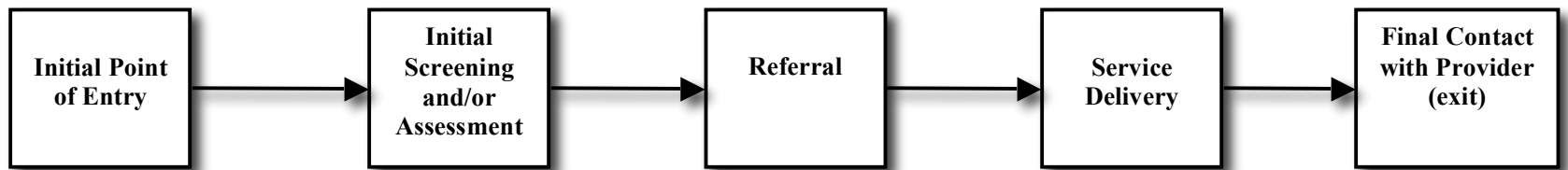
Source	Amount	Percentage
General Revenue	\$260.1 M	70.3
Federal Funds	\$108.3 M	29.3
Other	\$1.4 M	.4
<b>Total:</b>	<b>\$369.8M</b>	<b>100.0</b>

CPS FY 2006 Budget



## APPENDIX 10

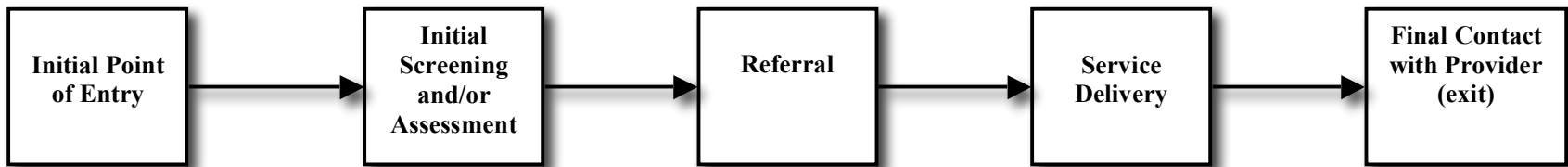
### Eastern Region Public Mental Health Planning Project High-Level Map of Service Delivery Stakeholder Identified Strengths and Gaps – 3 pages



<b>STRENGTHS – WHAT IS WORKING WELL IN THE SYSTEM?</b>	<ul style="list-style-type: none"> <li>∞ Lots of points of entry</li> <li>∞ Expertise and diversity of providers</li> <li>∞ Consumer survivor skills</li> <li>∞ ACI system provides timely, 24/7 MH assessments via phone and/or face to face</li> </ul>		<ul style="list-style-type: none"> <li>∞ Good psych assessment tools/instruments</li> <li>∞ Experienced, committed staff</li> <li>∞ Formal and informal collaborations</li> <li>∞ Many available programs</li> <li>∞ State, county and city funded programs</li> <li>∞ MH courts</li> <li>∞ CIT policing</li> </ul>				<ul style="list-style-type: none"> <li>∞ Staff commitment</li> <li>∞ Community very interested in this area?</li> </ul>			
<b>BARRIERS – WHAT WALLS ARE SO HIGH PEOPLE CAN'T GET OVER THEM? (→ = problem throughout the</b>	<ul style="list-style-type: none"> <li>∞ Transportation not available</li> <li>∞ Transportation not safe for MH clients</li> <li>∞ Stigma associated with mental illness</li> </ul>	<ul style="list-style-type: none"> <li>∞ Rigid system eligibility</li> </ul>	<ul style="list-style-type: none"> <li>∞ Transportation</li> <li>∞ Wrong diagnosis</li> <li>∞ Criteria of each program</li> <li>∞ Not enough time to</li> </ul>				<ul style="list-style-type: none"> <li>∞ Affiliates not well integrated</li> <li>∞ Services/programs not even among catchment areas</li> </ul>		<ul style="list-style-type: none"> <li>∞ Capacity/funding</li> <li>∞ Access for medications for co-occurring</li> <li>∞ Limitations of programs</li> <li>∞ Lack of staff</li> </ul>	<ul style="list-style-type: none"> <li>∞ Transportation</li> </ul>

<p>system, not just during one step)</p>	<ul style="list-style-type: none"> <li>∞ Lack of standardized quality</li> <li>∞ Some populations better served? →</li> <li>∞ Fragmented system; don't treat whole person →</li> <li>∞ Limited funding across providers and services? →</li> <li>∞ Discrimination →</li> <li>∞ Not enough staff to respond to calls →</li> <li>∞ Rigid criteria of programs/ services →</li> <li>∞ Lack of individual literacy →</li> <li>∞ Individual fear →</li> </ul>		<p>screen/assess adequately</p>		<ul style="list-style-type: none"> <li>∞ Lack of communication between referral source and provider; fragmented referral system</li> </ul>		<p>development, esp. for entry level</p> <ul style="list-style-type: none"> <li>∞ High staff turnover; burned-out professionals</li> <li>∞ Clients lack family/network support</li> <li>∞ Clients are labeled with DSM diagnostic system</li> <li>∞ Cost of medication</li> <li>∞ Access to medication</li> <li>∞ Limited research on how to maintain client gains</li> <li>∞ No uniform clinical evidenced based model of care</li> </ul>		
<p><b>GAPS – WHAT ARE GAPS PEOPLE FALL THROUGH?</b> (→ = problem throughout the system, not just during one step)</p>	<ul style="list-style-type: none"> <li>∞ Entry level criteria differs</li> <li>∞ Mis-diagnosis</li> <li>∞ Lack of community knowledge about available resources</li> <li>∞ Transportation</li> <li>∞ Services don't exist</li> <li>∞ Limited staff knowledge about what options are available</li> <li>∞ Limited technology →</li> <li>∞ Limited staff training in evidence based interventions →</li> <li>∞ Lack of</li> </ul>	<ul style="list-style-type: none"> <li>∞ Client not aware of available resources</li> </ul>	<ul style="list-style-type: none"> <li>∞ Lack of follow up</li> <li>∞ No standardized screening/assessment tool</li> <li>∞ Limited preventive services available</li> </ul>	<ul style="list-style-type: none"> <li>∞ Specific services don't exist</li> <li>∞ Treatment options</li> </ul>	<ul style="list-style-type: none"> <li>∞ Transportation</li> <li>∞ Lack of follow up</li> <li>∞ Limited communication within the system</li> <li>∞ Identified levels of care don't exist</li> <li>∞ Many are cold referrals – lack of staff time to ensure a warm hand-off</li> <li>∞ Mental health and substance abuse not well integrated into social service system</li> </ul>		<ul style="list-style-type: none"> <li>∞ Types of services available (limited if you don't meet SMI criteria)</li> <li>∞ Housing, housing, housing – specialized and affordable</li> <li>∞ Co-occurring offenders with terminal illness</li> <li>∞ Childcare</li> <li>∞ Funds not available</li> <li>∞ Lack of intensive community support to keep housing</li> </ul>		<ul style="list-style-type: none"> <li>∞ Co-occurring relapse prevention</li> <li>∞ Short follow-ups</li> <li>∞ Limited outcome measurement to know what works</li> <li>∞ Limited support services (such as job training)</li> <li>∞ Few consumer led support groups</li> </ul>

	<ul style="list-style-type: none"> <li>awareness of cultural issues? →</li> <li>∞ Lack of resources available for care? →</li> <li>∞ Limited family/network support →</li> </ul>						<ul style="list-style-type: none"> <li>∞ Staff isn't prepared to treat multiple diagnosis (need cross-training?)</li> <li>∞ Family not integrated into treatment</li> <li>∞ Lack of communication within agencies and between agencies</li> <li>∞ Lack of effective psychotropic drugs</li> <li>∞ Difficulty of managing medications</li> <li>∞ Limited preventive services available</li> </ul>		
<b>OBSERVATIONS – NOTES THAT DON'T FIT ANYWHERE ELSE</b>	<ul style="list-style-type: none"> <li>∞ Lack of general awareness of services</li> <li>∞ Limited public awareness of entry points</li> </ul>	<ul style="list-style-type: none"> <li>∞ Assessments are redundant</li> </ul>		<ul style="list-style-type: none"> <li>∞ Assessments are redundant</li> </ul>	<ul style="list-style-type: none"> <li>∞ We don't know each other's organizations</li> <li>∞ Second assessment for alcohol and drug abuse services</li> </ul>	<ul style="list-style-type: none"> <li>∞ Assessments are redundant</li> <li>∞ Disproportionate funding</li> </ul>			<ul style="list-style-type: none"> <li>∞ Lack of uniform discharge criteria</li> </ul>



## ACRONYMS USED

ADA	Alcohol and Drug Abuse
BHR	Behavioral Health Response
CMHC	community mental health centers
CPS	Comprehensive Psychiatric Services
DMH	Missouri Department of Mental Health
DSH	Disproportionate Share
FQHC	Federally Qualified Health Center
MPC	Metropolitan St. Louis Psychiatric Center
POS	Point of Service
RHC	St. Louis Regional Health Commission
SAMHSA	Substance Abuse and Mental Health Services Administration