JOURNAL OF THE HOUSE

Second Regular Session, 102nd General Assembly

FOURTEENTH DAY, THURSDAY, JANUARY 25, 2024

The House met pursuant to adjournment.

Representative Billington in the Chair.

There was a moment of silent prayer.

The Pledge of Allegiance to the flag was recited.

HOUSE RESOLUTIONS

Representative Davidson offered House Resolution No. 4050.

INTRODUCTION OF HOUSE BILLS

The following House Bills were read the first time and copies ordered printed:

HB 2543, introduced by Representative Voss, relating to the homestead property tax credit.

HB 2544, introduced by Representative Morse, relating to political advertisements, with penalty provisions.

HB 2545, introduced by Representative Dinkins, relating to allegations of sexual misconduct against private school employees.

HB 2546, introduced by Representative Taylor (48), relating to fireworks protections, with penalty provisions.

HB 2547, introduced by Representative Christ, relating to adoption.

HB 2548, introduced by Representative Christ, relating to hospitals with emergency departments.

HB 2549, introduced by Representative Christ, relating to small wireless facilities.

HB 2550, introduced by Representative Fountain Henderson, relating to speed humps.

HB 2551, introduced by Representative Schulte, relating to the certification of a juvenile for trial as an adult.

HB 2552, introduced by Representative Schulte, relating to allergies in child care facilities.

HB 2553, introduced by Representative Oehlerking, relating to annual property tax reporting requirements.

HB 2554, introduced by Representative Keathley, relating to administrative rules.

HB 2555, introduced by Representative Hicks, relating to expungement.

HB 2556, introduced by Representative Hicks, relating to health care workers.

HB 2557, introduced by Representative Lonsdale, relating to personal flotation devices, with penalty provisions.

HB 2558, introduced by Representative Sparks, relating to reimbursements to jails.

HB 2559, introduced by Representative Sparks, relating to the use of self-defense.

HB 2560, introduced by Representative Byrnes, relating to electrical corporation rates.

HB 2561, introduced by Representative Gregory, relating to water contamination.

HB 2562, introduced by Representative Gregory, relating to compensation of student athletes.

SECOND READING OF HOUSE CONCURRENT RESOLUTIONS

The following House Concurrent Resolution was read the second time:

HCR 39, relating to motorcycle profiling awareness.

SECOND READING OF HOUSE REVISION BILLS

The following House Revision Bill was read the second time:

HRB 1, for the sole purpose of repealing expired, terminated, sunset, and obsolete statutes.

SECOND READING OF HOUSE BILLS

The following House Bills were read the second time:

HB 2523, relating to the offense of trespass by an illegal alien, with a penalty provision.

HB 2524, relating to regulating insurance companies.

HB 2525, relating to the administration of medications in long-term care facilities.

HB 2526, relating to financial transactions involving public funds.

HB 2527, relating to animal micro shelters.

HB 2528, relating to boards of equalization.

HB 2529, relating to child care, with penalty provisions.

HB 2530, relating to conversion therapy for minors.

HB 2531, relating to submetering of utilities.

HB 2532, relating to paid family and medical leave.

HB 2533, relating to operating hours of businesses.

HB 2534, relating to fraudulent misrepresentations in advertisements of health care practitioners.

HB 2535, relating to school compulsory attendance, with penalty provisions.

HB 2536, relating to school board elections, with an effective date.

HB 2537, relating to the career development and teacher excellence plan.

HB 2538, relating to elections, with penalty provisions.

HB 2539, relating to the offense of possession of an open alcoholic beverage container in a motor vehicle, with a penalty provision.

HB 2540, relating to renewable energy contracts.

HB 2541, relating to electric utilities.

HB 2542, relating to the appointment of deputies.

REFERRAL OF HOUSE RESOLUTIONS

The following House Resolutions were referred to the Committee indicated:

HR 3931 - Consent and House Procedure
HR 3955 - Consent and House Procedure
HR 3959 - Consent and House Procedure
HR 3960 - Consent and House Procedure
HR 3963 - Consent and House Procedure
HR 4008 - Consent and House Procedure
HR 4009 - Consent and House Procedure

REFERRAL OF HOUSE JOINT RESOLUTIONS

The following House Joint Resolutions were referred to the Committee indicated:

HJR 98 - Transportation Accountability
HJR 109 - Transportation Accountability
HJR 116 - Special Committee on Property Tax Reform
HJR 120 - Special Committee on Property Tax Reform

REFERRAL OF HOUSE REVISION BILLS

The following House Revision Bill was referred to the Committee indicated:

HRB 1 - Government Efficiency and Downsizing

REFERRAL OF HOUSE BILLS

The following House Bills were referred to the Committee indicated:

HB 1413 - Special Committee on Homeland Security
HB 1421 - Health and Mental Health Policy
HB 1423 - Ways and Means
HB 1426 - General Laws
HB 1436 - Local Government
HB 1471 - Government Efficiency and Downsizing
HB 1478 - Financial Institutions
HB 1484 - General Laws
HB 1490 - Veterans
HB 1496 - Veterans
HB 1532 - Healthcare Reform
HB 1533 - Higher Education
HB 1562 - Special Committee on Tourism
HB 1577 - Crime Prevention and Public Safety
HB 1607 - Government Efficiency and Downsizing
HB 1664 - Healthcare Reform
HB 1666 - Professional Registration and Licensing
HB 1707 - Crime Prevention and Public Safety
HB 1709 - Children and Families
HB 1721 - Emerging Issues
HB 1725 - Financial Institutions
HB 1726 - Financial Institutions
HB 1728 - Utilities
HB 1746 - Utilities
HB 1777 - Corrections and Public Institutions
HB 1797 - Government Efficiency and Downsizing
HB 1811 - Transportation Accountability

HB 1812 - Ways and Means
HB 1814 - Government Efficiency and Downsizing
HB 1815 - Government Efficiency and Downsizing
HB 1818 - General Laws
HB 1825 - Professional Registration and Licensing
HB 1834 - Economic Development
HB 1837 - General Laws
HB 1855 - General Laws
HB 1869 - Pensions
HB 1870 - Conservation and Natural Resources
HB 1873 - Health and Mental Health Policy
HB 1880 - Insurance Policy
HB 1942 - Judiciary
HB 1954 - Judiciary
HB 1955 - Financial Institutions
HB 1987 - Financial Institutions
HB 1993 - General Laws
HB 2056 - General Laws
HB 2058 - Government Efficiency and Downsizing
HB 2059 - Corrections and Public Institutions
HB 2063 - Financial Institutions
HB 2136 - Elections and Elected Officials
HB 2142 - Special Committee on Tax Reform
HB 2143 - Pensions
HB 2148 - Emerging Issues
HB 2156 - Special Committee on Education Reform
HB 2157 - General Laws
HB 2184 - Elementary and Secondary Education
HB 2211 - Crime Prevention and Public Safety
HB 2276 - Emerging Issues
HB 2282 - Government Efficiency and Downsizing
HB 2289 - Transportation Accountability
HB 2292 - General Laws
HB 2319 - Government Efficiency and Downsizing
HB 2320 - Special Committee on Tourism
HB 2326 - Higher Education
HB 2345 - General Laws
HB 2352 - Transportation Infrastructure
HB 2385 - General Laws
HB 2402 - Emerging Issues
HB 2407 - Rural Community Development
HB 2413 - Healthcare Reform
HB 2414 - Transportation Accountability
HB 2418 - Agriculture Policy
HB 2448 - General Laws

HB 2457 - Special Committee on Tax Reform
HB 2460 - Economic Development
HB 2464 - Economic Development
HB 2470 - Special Committee on Homeland Security
HB 2489 - Special Committee on Innovation and Technology
HB 2491 - Special Committee on Tourism
HB 2496 - Local Government
HB 2498 - Government Efficiency and Downsizing
HB 2499 - Emerging Issues
HB 2502 - Corrections and Public Institutions

RE-REFERRAL OF HOUSE BILLS

The following House Bills were re-referred to the Committee indicated:

HB 1622 - Utilities
HB 2491 - Conservation and Natural Resources

COMMITTEE REPORTS

Committee on Agriculture Policy, Chairman Haffner reporting:

Mr. Speaker: Your Committee on Agriculture Policy, to which was referred **HB 2082**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (14): Brown (149), Busick, Christensen, Diehl, Farnan, Gregory, Haden, Haffner, Haley, Justus, Knight, Parker, Pollitt and Van Schoiack

Noes (3): Fountain Henderson, Weber and Woods

Present (2): Clemens and Plank

Absent (1): Young

*The following ex officio member was present: Aune

Committee on Conservation and Natural Resources, Chairman Sassmann reporting:

Mr. Speaker: Your Committee on Conservation and Natural Resources, to which was referred **HB 2134** and **HB 1956**, begs leave to report it has examined the same and recommends that it **Do Pass with House Committee Substitute** by the following vote:

Ayes (13): Bonacker, Brown (87), Diehl, Farnan, Haley, Justus, Knight, Mayhew, Sassmann, Stephens, Taylor (48), Walsh Moore and Woods

Noes (0)

Present (1): Burton

Absent (0)

Committee on Crime Prevention and Public Safety, Chairman Roberts reporting:

Mr. Speaker: Your Committee on Crime Prevention and Public Safety, to which was referred **HB 1659**, begs leave to report it has examined the same and recommends that it **Do Pass with House Committee Substitute** by the following vote:

Ayes (24): Allen, Anderson, Banderman, Brown (16), Collins, Cook, Hardwick, Hicks, Hovis, Jones, Kelley (127), Lavender, Mackey, Marquart, Myers, Perkins, Riley, Roberts, Sauls, Seitz, Sharp (37), Sparks, Thomas and West

Noes (0)

Absent (2): Bosley and Doll

Committee on Government Efficiency and Downsizing, Chairman Murphy reporting:

Mr. Speaker: Your Committee on Government Efficiency and Downsizing, to which was referred **HB 2111**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (8): Bangert, Chappell, Clemens, Lovasco, Murphy, Schulte, Schwadron and Van Schoiack

Noes (0)

Absent (6): Baker, Boggs, Burton, Davis, Nickson-Clark and Riggs

Committee on Utilities, Chairman Bromley reporting:

Mr. Speaker: Your Committee on Utilities, to which was referred **HB 1995**, begs leave to report it has examined the same and recommends that it **Do Pass - Consent**, and pursuant to Rule 24(5) be referred to the Committee on Consent and House Procedure by the following vote:

Ayes (13): Atchison, Banderman, Black, Bromley, Byrnes, Crossley, Falkner, Ingle, Keathley, Lonsdale, McMullen, Taylor (84) and Weber

Noes (0)

Absent (1): Schulte

Mr. Speaker: Your Committee on Utilities, to which was referred **HB 2057**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (13): Atchison, Banderman, Black, Bromley, Byrnes, Crossley, Ingle, Keathley, Lonsdale, McMullen, Schulte, Taylor (84) and Weber

Noes (1): Falkner

Absent (0)

Committee on Ways and Means, Chairman McGirl reporting:

Mr. Speaker: Your Committee on Ways and Means, to which was referred **HB 1912**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (10): Casteel, Chappell, Hicks, Lovasco, McGirl, Phifer, Smith (155), Taylor (84), Thompson and Titus

Noes (0)

Absent (4): Bland Manlove, Gray, Hudson and Wright

Committee on Rules - Legislative Oversight, Chairman Knight reporting:

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HB 1488**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (7): Bosley, Buchheit-Courtway, Burger, Knight, Lavender, Mann and McGirl

Noes (1): Schnelting

Absent (2): Hudson and Owen

REFERRAL OF HOUSE BILLS - RULES

The following House Bills were referred to the Committee indicated:

HCS HB 1511 - Rules - Administrative Oversight
HCS HB 1708 - Rules - Legislative Oversight
HCS HB 1720 - Rules - Legislative Oversight
HCS HB 1886 - Rules - Regulatory Oversight
HB 1960 - Rules - Administrative Oversight
HB 2062 - Rules - Regulatory Oversight
HB 2380 - Rules - Regulatory Oversight
HB 2381 - Rules - Legislative Oversight

COMMITTEE CHANGES

January 25, 2024

Ms. Dana Rademan Miller
Chief Clerk
Missouri House of Representatives
State Capitol, Room 310
Jefferson City, MO 65101

Dear Ms. Miller:

I hereby make the following changes to the Special Committee on Innovation and Technology:

I hereby appoint the following members to the committee:

Representative Jeff Farnan
Representative Bridget Walsh Moore

If you have any questions, please feel free to contact my office.

Sincerely,

/s/ Dean Plocher
Speaker of the House

REPORT OF THE SUBSTANCE ABUSE PREVENTION AND TREATMENT TASK FORCE

January 17, 2024

Dean Plocher, Speaker
House of Representatives
State Capitol Building
Jefferson City, MO 65101

Caleb Rowden, President Pro Tempore
Missouri Senate
State Capitol Building
Jefferson City, MO 65101

Dear Mister Speaker and Mister President Pro Tempore:

The Task Force on Substance Abuse Prevention and Treatment authorized in Section 21.790 of the Revised Statutes of Missouri, has met held hearings and taken testimony. The attached Task Force report addresses the subjects set forth in Section 21.790.3, and includes recommendations for current and future legislation sessions with regard to funding and legislation. The below listed committee members are pleased to submit the attached report:

/s/ Chairman Representative John Black
/s/ Representative LaDonna Appelbaum
/s/ Representative Dave Griffith
/s/ Representative Melanie Stinnett
/s/ Representative Del Taylor
/s/ Representative Dale Wright
/s/ Rodney Hummer
/s/ Greg White

/s/ Vice Chairman Nick Schroer
/s/ Senator Rusty Black
Senator Tony Luetkemeyer
/s/ Senator Karla May
/s/ Senator Angela Mosley
/s/ Senator Brian Williams
/s/ Phillip Ohlms
/s/ Rachel Winograd

AUTHORS

Representative John Black, SATP Task Force Member
Representative Del Taylor, SATP Task Force Member
Sarah Anderson, Ph.D., MOST Policy Initiative Legislative Policy Fellow
Madeleine Roberts, Ph.D., MOST Policy Initiative Legislative Policy Fellow
Isabel Warner, Ph.D., MOST Policy Initiative Legislative Policy Fellow
Rieka Yu, Ph.D., MOST Policy Initiative Legislative Policy Fellow

FOREWORD

This is the first report of the Missouri statutorily authorized Substance Abuse Prevention and Treatment Task Force. The goal of this first report is to provide an overview of the efforts of the state of Missouri to address the tragedy of substance use, both from a financial and programmatic perspective, and to summarize our findings and recommendations.

In five evidentiary hearings, the task force heard hours of expert testimony from 7 state departments and multiple organizations that implement multiple programs to combat substance misuse. Details of programs were compiled and used to generate charts, tables and the budget overview. Hearing testimony is summarized and formed the basis for recommended next steps. The appendix contains over 80 pages of programmatic and budgetary information provided by the state departments, and over 20 pages of additional descriptive information from the departments as well as organizations receiving state funding.

This first report of the Substance Abuse Prevention and Treatment Task Force would have been impossible without the significant cooperation of the state departments, analysis provided by the Missouri MOST Policy Initiative, participation of task force members, and support from the House Research team.

Special thanks to task force member Del Taylor (District 84) who actively participated in all hearings, designed this report's templates, guided MOST Fellow efforts and contributed to the content and final editing of this document.

MOST Fellows Drs. Sarah Anderson, Madeleine Roberts, Isabel Warner and Rieka Yu contributed hours organizing department data into a useful document without cost to the state (see note regarding MOST on page 152). The assistance of the House Research staff, and particularly Colin Zentmeyer, is most appreciated.

Undoubtedly there are errors in attempting to assemble such a volume of information. Those have been minimized by offering review of the product to the state departments prior to issuing the final report. Any remaining will be addressed in subsequent reports.

This is intended to be only the first in the efforts of this task force. Requirements of the traditional session limit hearings primarily to the period after the General Assembly has adjourned. The Recommendations provided in this report identify important and plentiful subjects for future investigation. The plan is to continue that investigation in 2024.

John Black, Task Force Chair, 102nd General Assembly, State of Missouri.

TASK FORCE MEMBERS

- Senate Members
    - Rusty Black, Senate District 12
    - Tony Luetkemeyer, Senate District 34
    - Karla May, Senate District 4
    - Angela Mosley, Senate District 13
    - Nick Schroer, Task Force Vice Chair, Senate District 2
    - Brian Williams, Senate District 14
- House of Representatives Members
    - LaDonna Appelbaum, House District 71
    - John Black, Task Force Chairman, House District 129
    - Dave Griffith, House District 60
    - Melanie Stinnett, House District 133
    - Del Taylor, House District 84
    - Dale Wright, House District 116
- Governor Appointees
    - Rodney Hummer, Vice President of Strategy, Missouri Primary Care Association
    - Philip Ohlms, Associate Judge (Ret.), 11th Judicial Circuit Court of Missouri
    - Greg White, Sheriff (Ret.), Cole County
    - Dr. Rachel Winograd, Associate Professor, University of Missouri - St. Louis

AUTHORIZING STATUTE

Title III LEGISLATIVE BRANCH
Chapter 21 Effective – 28 Aug 2019

21.790. Task force established, members — duties — report. — 1. There is hereby established the "Task Force on Substance Abuse Prevention and Treatment". The task force shall be composed of six members from the house of representatives, six members from the senate, and four members appointed by the governor. The senate members of the task force shall be appointed by the president pro tempore of the senate and the house members by the speaker of the house of representatives. There shall be at least two members from the minority party of the senate and at least two members from the minority party of the house of representatives. The members appointed by the governor shall include one member from the health care industry, one member who is a first responder or law enforcement officer, one member who is a member of the judiciary or a prosecuting attorney, and one member representing a substance abuse prevention advocacy group.

2. The task force shall select a chairperson and a vice-chairperson, one of whom shall be a member of the senate and one a member of the house of representatives. A majority of the members shall constitute a quorum. The task force shall meet at least once during each legislative session and at all other times as the chairperson may designate.

3. The task force shall:

(1) Conduct hearings on current and estimated future drug and substance use and abuse within the state;

(2) Explore solutions to substance abuse issues; and

(3) Draft or modify legislation as necessary to effectuate the goals of finding and funding education and treatment solutions to curb drug and substance use and abuse.

4. The task force may make reasonable requests for staff assistance from the research and appropriations staffs of the senate and house of representatives and the joint committee on legislative research. In the performance of its duties, the task force may request assistance or information from all branches of government and state departments, agencies, boards, commissions, and offices.

5. The task force shall report annually to the general assembly and the governor. The report shall include recommendations for legislation pertaining to substance abuse prevention and treatment.

(L. 2019 S.B. 514)

EXECUTIVE SUMMARY

Illicit drug overdose deaths in the United States have doubled from 2015 to 2021. The total number of all drug overdose deaths in 2021 was 106,699.[1] By comparison, 58,220 American soldiers were killed in the Vietnam War.[2] Opioids caused the largest number of deaths with 80,411 fatal overdoses in 2021. Cocaine, stimulants (including methamphetamine), psychostimulants, benzodiazepine, and antidepressants contributed to over 55,000 overdose deaths in 2021. In addition to drug overdoses, alcohol and tobacco use has greatly contributed to deaths in the United States. Between 2015 and 2019, more than 140,000 people per year died from excessive alcohol use.[3] Between 1965 and 2014, there have been more than 425,000 tobacco related deaths per year. These deaths were due to cancer and other diseases as well as secondhand smoke inhalation and residential fires.[4]

[1] National Institutes of Health. (2023). *Drug Overdose Death Rates*. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates.
[2] National Archives. (n.d.). *Vietnam War U.S. Military Fatal Casualty Statistics*. https://www.archives.gov/research/military/vietnam-war/casualty-statistics#:~:text=April%2029%2C%202008.-,The%20Vietnam%20Conflict%20Extract%20Data%20File%20of%20the%20Defense%20Casualty,and%20Records%20Administration%20in%202008
[3] Centers for Disease Control and Prevention. (2022). *Alcohol-Related Disease Impact (ARDI) Application*. https://nccd.cdc.gov/DPH_ARDI/default/default.aspx.
[4] U.S. Department of Health and Human Services (2014). *The Health Consequences of Smoking – 50 Years of Progress*. https://www.hhs.gov/sites/default/files/consequences-smoking-exec-summary.pdf.

In Missouri, the most used substances are alcohol, tobacco, and marijuana. Frequency of tobacco use in Missouri is higher than the national average with 27.93% of Missourians having used tobacco within the last month compared to 19.55% nationally.[5] In 2021, about 18% of Missourians had a substance use disorder (SUD).[6] In 2022, more than 2,000 Missourians died from a drug overdose. Most of these deaths were due to non-heroin opioid overdoses. In addition to drug-related deaths, more than 910 Missourians died due to alcohol use and almost 10,000 Missourians died from smoking-attributable causes in 2022 (Figure 1, Table 1).[7, 8]

Deaths in Missouri from substance use range from approximately 10,000 smoking-related; to more than 1500 opioid-involved; over 700 methamphetamine-involved; and 910 alcohol induced in 2022. (Table 1 page 10). It should be noted that the deaths related to alcohol is contradicted in the testimony. The Department Mental Health testified that 6% of overall deaths are related to the use of alcohol, which would result in a number for Missouri greater than 910. That being the case, alcohol would join tobacco in resulting in more deaths in Missouri than opioids or methamphetamine.

By accumulating the information provided by Missouri departments, the amount spent in Missouri in FY 2023 on SUD is estimated at approximately $244 million, with the appropriation for FY 24 to be approximately $350 million (Figure 9). This compares to the state budgets of $47.1 billion, and $51.8 billion for the fiscal years, or percentage of expenditure of 0.52% and 0.68%, if all the FY 24 appropriation is spent. (All figures include both federal and state funds) The first and obvious question is whether approximately 0.5% to 0.7% of the state budget spent on substance use is an adequate expenditure.

Table 2 summarizes information provided by the departments and compares the amounts spent & appropriated on the various addictive substances. Not all substances are explicitly budgeted separately. For example, all the expenditures specifically identifying opioids is in the range of $68 million. Funds explicitly spent on tobacco in FY 23 was $725,000, and there was no specifically identified funding for alcohol misuse. To be fair, many more millions are not specifically identified and could include alcohol and tobacco, but the testimony indicated the bulk of that money is spent on opioids and stimulants. Table 2 provides that approximately $30 million is spent for a combination of opioids and alcohol.

The next question might be how much is spent on prevention versus treatment. Table 4 attempts to address that question by identifying FY24 Appropriations and FY23 Spending for Treatment only, Prevention Only, Recovery Only and combinations of these three. The bulk of moneys went to Treatment Only programs with FY23 Spending exceeding $153 million and FY24 appropriation exceeding 224 million.

What is Missouri doing with the money provided? A lot. Table 6 breaks down the spending between the state departments, with the Department of Mental Health (DMH) receiving over 70% of the funding. DMH is the state authority for coordinating a statewide response to substance use disorders. The Department of Health and Senior Services (DHSS) received approximately 13% and the Department of Corrections (DOC) about 8% in FY 23. Figure 3 charts the number of programs per department, with DMH at 31 of a total of 61. It may or may not be surprising that the largest source of funding for substance use disorders is ultimately MOHealthNet (Medicaid) as a result of the percentage of participants that are Medicaid eligible.

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[5] Substance Abuse and Mental Health Services Administration (2021). *National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)*. https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf.

[6] Missouri Department of Health and Senior Services. (n.d.). *Drug Overdose Dashboard – Fatal Overdoses*. https://health.mo.gov/data/opioids/. Accessed December 7th, 2023.

[7] Data provided directly by Missouri Department of Health and Senior Services.

[8] For additional information relating to substance use frequency, please see the summary of testimony for the Department of Health and Senior Services from the July 2023 hearing, beginning on page 27.

Of course, ultimately, a most significant question is the effectiveness of these programs. With a few exceptions, the testimony did not provide clear answers to that question, which should be a major issue in future task force hearings. Some testimony was offered with regard to the number of persons served and percentage expenditure of appropriations allotted, which provides some basis for recommendation. There was testimony that participation in federal programs requires data collection, and a strong preference for evidence-based practices. Again, more detail on program effectiveness is needed in the future.

As required by statute, this report will offer recommendations, like the need for statistics on program effectiveness. Without these details we cannot make budgetary recommendations about some programs. In other cases, the Missouri treatment court statistics demonstrate high rates of effectiveness. This was attributed to the value of a broad-based treatment methodology which involves medication and community supports. Programs such as Recovery Services providers were identified. Similarly, the need for reduced time for service was recognized. The value of a recovery "coach", who can help a person identify and stay in treatment, was repeated. Programs such as those offered by Engaging Patients in the Care Coordination (EP ICC), the Federally Qualified Health Centers (FQHC) comprehensive model, and services offered by the state public defender's office are examples. The need for qualified personnel to provide the services, known as Certified Peer Specialist and Community Behavioral Health Liaisons, working with both youth and adult populations, was identified as extremely valuable.

The connection between mental health and substance use is apparent. The fact that many persons suffering from substance use disorders utilize many addictive substances makes simple categorization impossible. The impact of substance use on maternal and infant health, on young people served for example by the DSS Divisions of Children and Youth Services, the need for early intervention in primary settings and schools, the essential coordination with community organizations such as Certified Community Behavioral Health Organizations (CCBHO), and the ten DMH Prevention Resource Centers around the state, were all repeated themes.

There are positive indications. The emphasis on evidence-based practices in many cases appear to be achieving results and create the ability for better metrics and analysis. The reports of coordination and cooperation between the departments of the state of Missouri, spearheaded by the Department of Mental Health were virtually universal. Yet, the concept of a substance use prevention and treatment coordinator between the departments, perhaps located in the Department of Mental Health or the Governor's office, was acknowledged as worthy of consideration.

Table 9 lists recommendations including subjects for further investigation, in addition to those subjects previously mentioned. Among those are analysis of the societal cost for the state of Missouri from substance use/misuse; the impact of recreational marijuana based on experiences of other states; and to date controversial subjects in the state of Missouri such as needle exchange programs. The issue of whether the state would well be served by a substance use "Czar" to coordinate programs of various departments is to be further discussed, even in view of the often-reported cooperation between the departments tasked with the major efforts to address substance abuse. The Table follows the report details and summaries of witness testimony, in the hope the reader will review at least those portions of the report. Certainly, the department summaries and supplemental information in the appendices are recommended.

REPORT DETAILS

Deaths by Substance

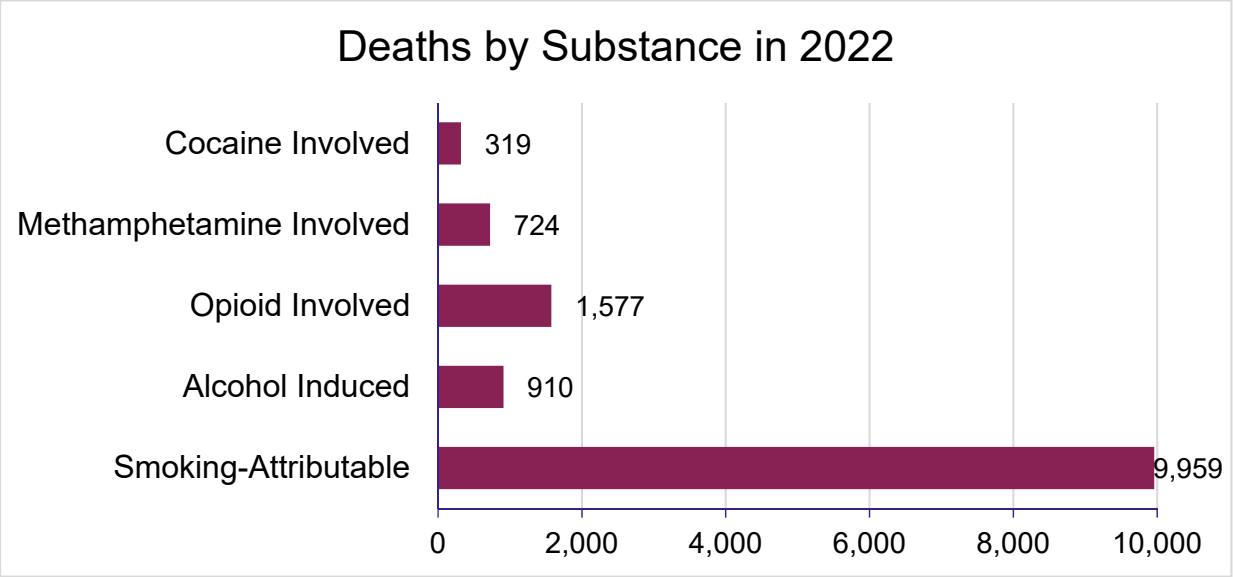

Figure 1. Number of deaths in Missouri per addictive substance. Data provided by DHSS for 2022.

Table 1. Number of deaths in Missouri per addictive substance. Data provided by DHSS for 2022. (See Figure 1).

Cause***	Deaths (2022)
Smoking-Attributable*	9,959
Alcohol Induced**	910
Opioid Involved	1,577
Methamphetamine Involved	724
Cocaine Involved	319

*Derived from a formula that assigns a certain percentage of various causes of death to tobacco smoking. Smoking also attributes to heart disease, cancer, and chronic lower respiratory disease, all of which are the three highest leading causes of death in Missouri. Secondhand smoke is also a significant cause.
** A broad definition that includes: alcohol induced pseudo-Cushing's syndrome; mental and behavioral disorders due to use of alcohol; degeneration of nervous system due to alcohol; alcoholic polyneuropathy; alcoholic myopathy; alcoholic cardiomyopathy; alcoholic gastritis; alcoholic liver disease; alcohol induced pancreatitis (chronic and acute); fetal induced alcohol syndrome (dysmorphic); excess alcohol blood levels; accidental poisoning by and exposure to alcohol (intentional, accidental, or undetermined intent); fetal alcohol syndrome.
***Drug types are not mutually exclusive, meaning a death record may have more than one drug listed, and would therefore be counted in both categories.

Funding

To assess these deaths and related substance use disorders (SUDs), the state of Missouri has appropriated funds to programs aimed at treatment, recovery, and prevention, as well as to support the associated administrative costs to run these programs. Per substance, Missouri spends the most on programs addressing all substances ($115,630,624.16) and programs where substances were unspecified ($109,384,816) (Table 2, Figure 2). The highest number of programs are dedicated to these two groups, and they constitute the highest and second highest increases in budget from FY23 to FY24. By contrast, no money has been appropriated to programs that deal specifically with either alcohol or stimulants only. Despite smoking attributable deaths constituting the majority of SUD related deaths in Missouri, there are only three tobacco related programs*, and they are only appropriated $833,145. A new FY24 program focused on cannabis SUDs includes a $955,000 budget, however, this program is not solely focused on smoking. The third highest budget increase ($11,552,022.78) is explicitly for programs excluding those that work with alcohol-related SUDs.

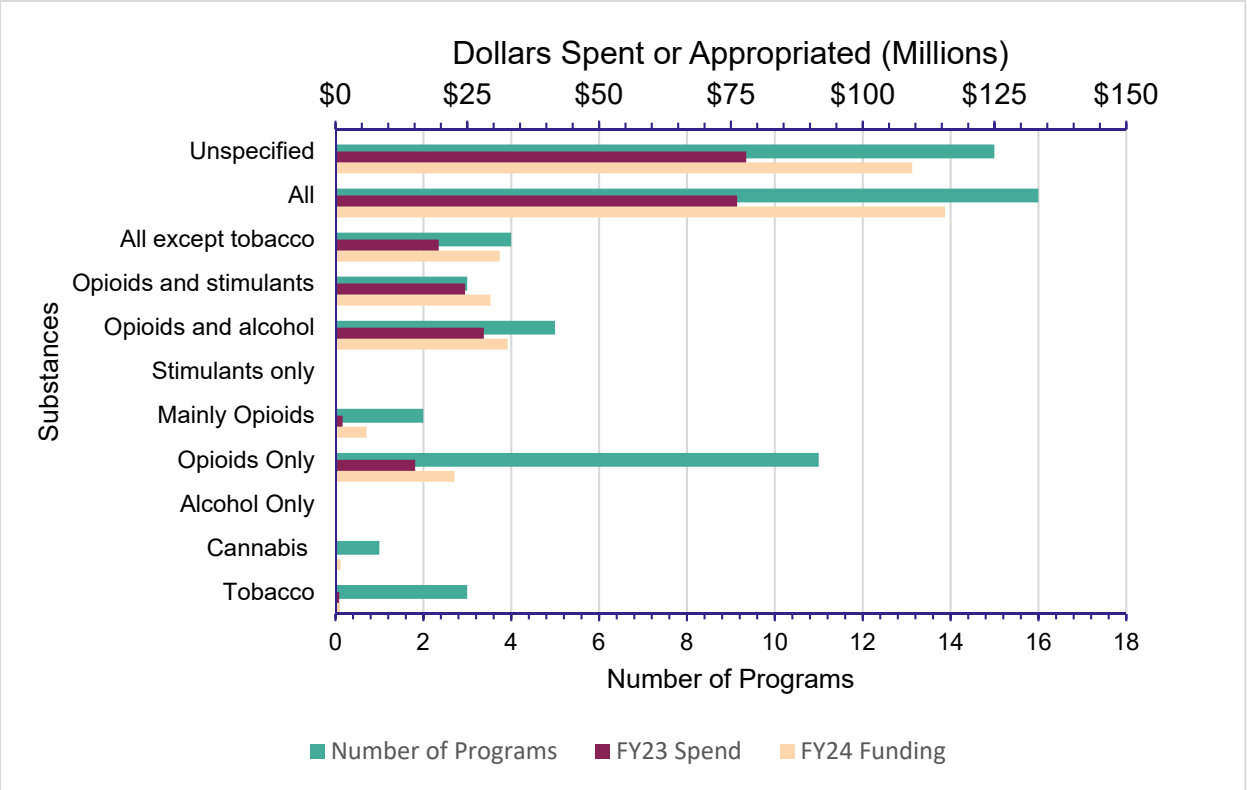

Figure 2. State funding dedicated to each addictive substance based on the number of programs dedicated to specific substances.

Table 2. State funding dedicated to programs working with SUDs related to each addictive substance. (See Figure 2)

Substance	Number of Programs	Amount Appropriated for FY24	Amount Spent for FY23	Additional Amount Appropriated in FY24
Tobacco	3	$833,145.00	$725,705.00	$107,440.00
Cannabis	1	$955,000.00	$0	$955,000.00
Alcohol Only	0	$0	$0	$0
Opioids Only	11	$22,602,198.66	$15,125,425.69	$7,467,772.97
Mainly Opioids	2	$5,899,877.00	$1,357,881.00	$4,541,996.00
Stimulants Only	0	$0	$0	$0
Opioids and Alcohol	5	$32,664,144.00	$28,159,694.00	$4,504,450.00
Opioids and Stimulants	3	$29,433,021.00	$24,604,520.37	$4,828,500.63
All Except Tobacco	4	$31,159,194.00	$19,607,171.22	$11,552,022.78
All	16	$115,630,624.16	$76,181,297.68	$39,449,326.00
Unspecified	15	$109,384,816.00	$77,918,685.00	$31,466,131.00

The Missouri Department of Mental Health (DMH) is the state authority for coordinating a statewide response to substance use disorders. In addition to DMH, the Department of Health and Senior Services (DHSS), Department of Corrections (DOC), Department of Social Services (DSS), Department of Elementary and Secondary Education (DESE), Office of State Courts Administrator (OSCA), and Office of Administration (OA) all have programs supporting the prevention and treatment of substance use disorders in Missouri.

The Task Force held hearings during the 2023 interim session. The Missouri state departments provided the bulk of the testimony. (The cooperation of the departments throughout this process has been invaluable and exceptional.) As a first report as required by statute, the goals are seemingly modest: to identify the amount spent by Missouri departments on substance use/misuse, the major programs; the number of persons suffering from the various addictions; the number of persons receiving care as a result of the expenditures; the source of the funding, whether state or federal; the amount spent on prevention versus treatment; all to establish basic findings and recommendations. Even those modest goals have not been fully met. This report will include recommendations for further Task Force areas of investigation.

Programs

The majority of programs related to SUDs are housed in the DMH (Figure 3), and where the data were provided, the majority of programs are between 1-10 years old (Figure 4). The oldest programs are housed within DMH and DOC, and DHSS is mainly comprised of younger programs (Figure 5). The ages of programs were not provided by the OA.

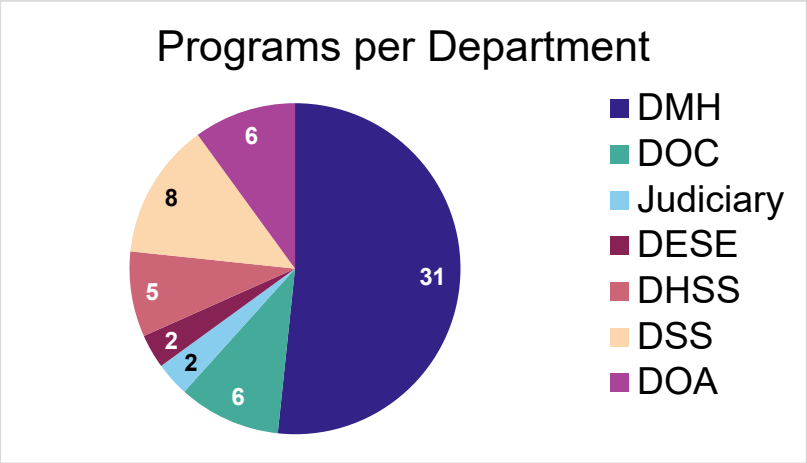

Figure 3. Total SUD programs in FY24 by department.

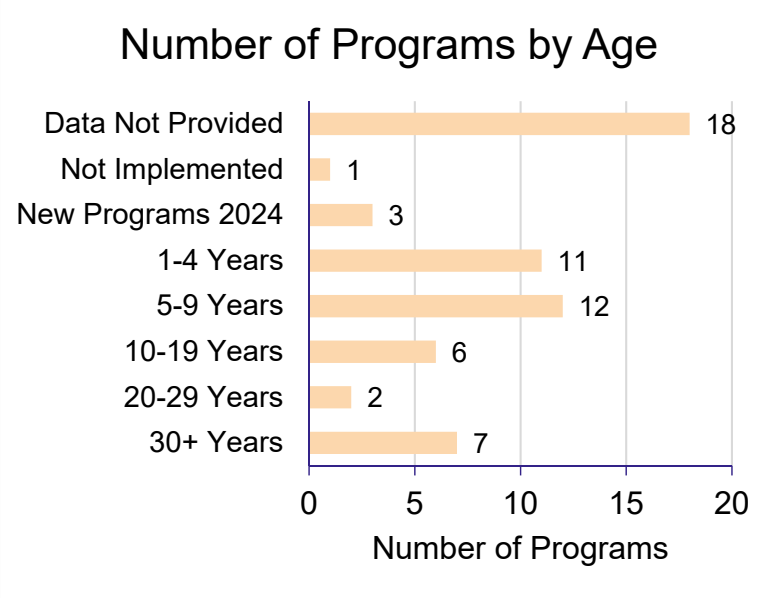

Figure 4. The number of programs addressing SUDs by age of the program.

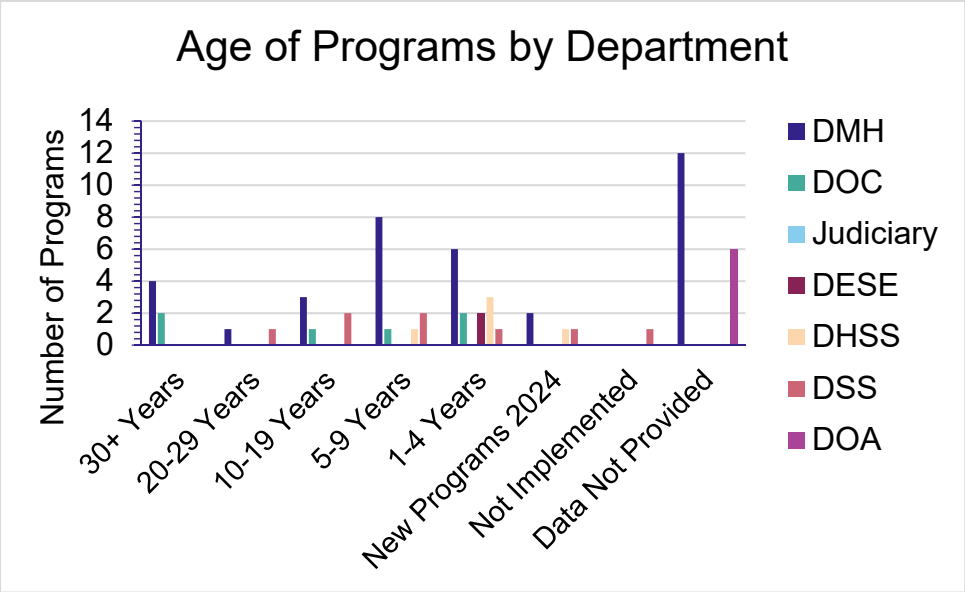

Figure 5. The number of programs addressing SUDs in each department by age of the program.

Newly initiated programs in FY24 and FY23 are separately listed in Table 3; examples include medication assisted treatment expansion in the DOC and marijuana substance use prevention in the DESE.

Table 3. Information on new SUD programs for FY2024 and FY2023

Program Name	Year Start	Department	Target Substance	Program Focus	FY24 Appropriation
Recovery Lighthouse	2024 (one time fund)	DBH	Unknown	Recovery	$1,138,212
Adult Use – SUD Grants	2024	DHSS	Not specified	Community grant opportunity	$1,278,973
Substance Abuse Prevention Network	2024	DSS	Mainly opioids, excluding tobacco	Prevention	$4,500,000
Reducing Recidivism	2023	DOC	All substances except tobacco	Prevention and Treatment	$4,680,250
Medication Assisted Treatment Expansion	2023	DOC	Opioids and Alcohol	Treatment	$4,000,000
Substance Use Prevention	2023	DESE	Cannabis	Prevention	$955,000

Prevention vs. Treatment

As mentioned above, programs may have specific focuses with respect to substances targeted. They also have specific focuses on the type of services offered, including whether these focus on prevention, treatment, and/or recovery, or are used for administration costs. In FY24, the greatest amount was appropriated to programs that only focused on treatment (Table 4, Figure 6). The largest number of programs focused on prevention only, and constituted the second highest spend for FY24, however this was still $51.7 million less than treatment programs.

Two programs focused on treatment and recovery receive the third highest budget, and the six programs focused on treatment and prevention received the fourth highest amount of money in FY24 (Table 4).

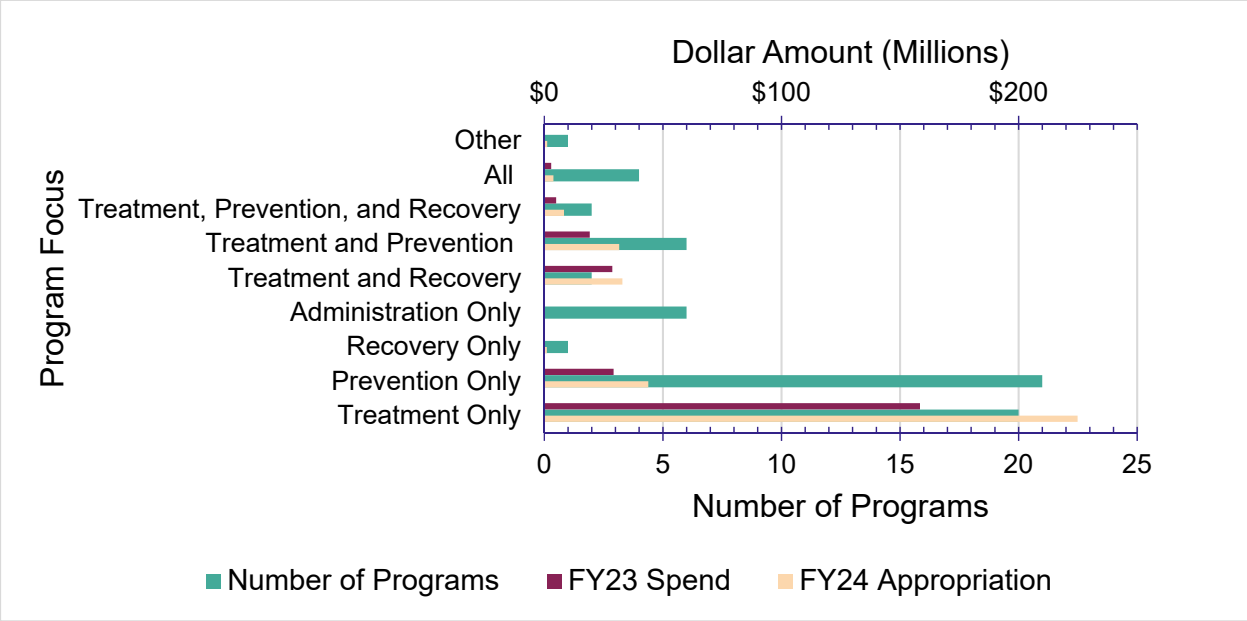

Figure 6. Amount spent on program priorities (prevention, treatment, etc.).

Table 4. Amount spent on program priorities (prevention, treatment, etc.)

Program Priority	Number of Programs	FY24 Appropriation	FY23 Spending	Additional Amount Appropriated in FY24
Treatment Only	20	$224,901,660.66	$158,477,770.66	$66,423,890
Prevention Only	21	$43,919,663	$29,213,276.40	$14,706,386.60
Recovery Only	1**	$1,138,212	$0	$1,138,212
Administration Only	6	$246,969	$127,676	$119,293
Treatment and Recovery	2	$32,962,826.16	$28,716,409	$4,246,417.16
Treatment and Prevention	6	$31,605,831	$19,196,028.90	$12,409,802.10
Treatment, Prevention, Recovery	2	$8,299,877	$4,997,359	$3,302,518
All (Treatment, Prevention, Recovery, Administration)	4	$3,905,319	$2,951,860	$953,459
Other*	1**	$1,278,973	$0	$1,278,973

* Community grant program
** New program in FY2024

The types of programs vary across departments. The DMH houses the greatest number of total programs, and the majority of most program focus types (prevention, treatment, recovery etc.) (Figure 7). DMH includes most programs focused on treatment only, with the second most housed within the DSS. The DMH also houses the majority of programs focused on prevention only, with DHSS housing most of the remaining prevention programs. The DOC houses all programs pertaining to treatment and prevention, which receives the fourth highest budgetary appropriation in FY24 (Table 4, Figure 8). The DOA houses all programs explicitly handling administration.

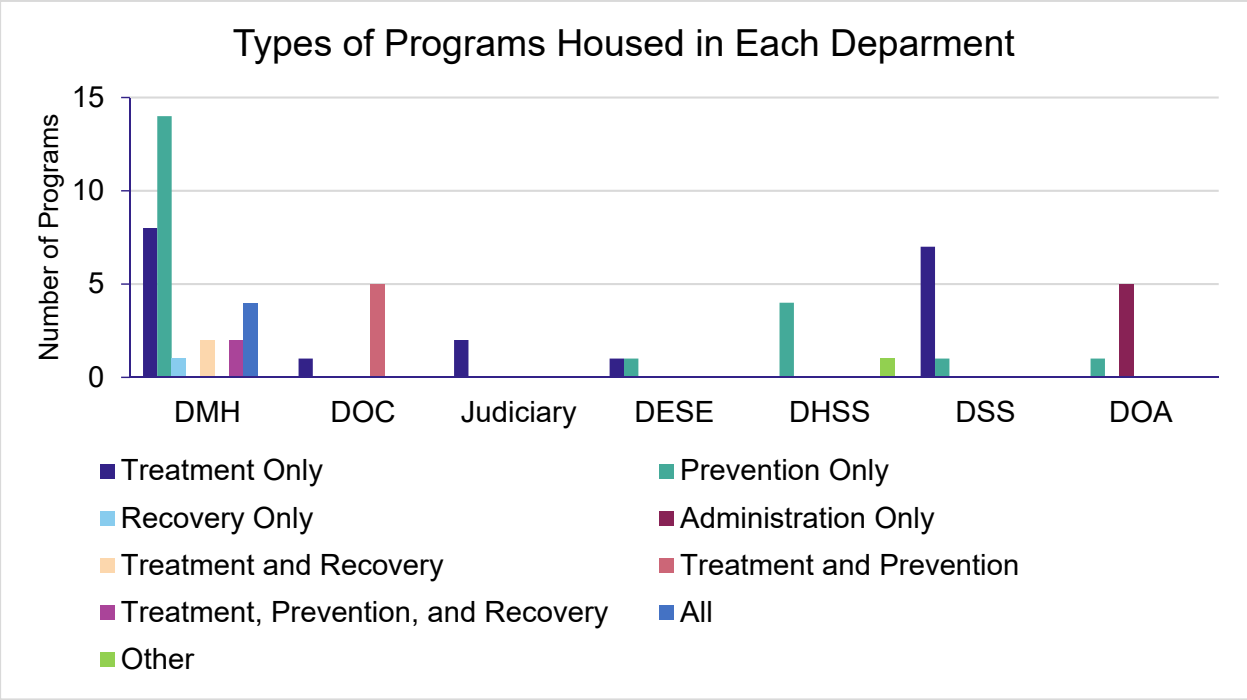

Figure 7. The focus of SUD programs housed in each department. "Other" includes a community grant program administered by DHSS.

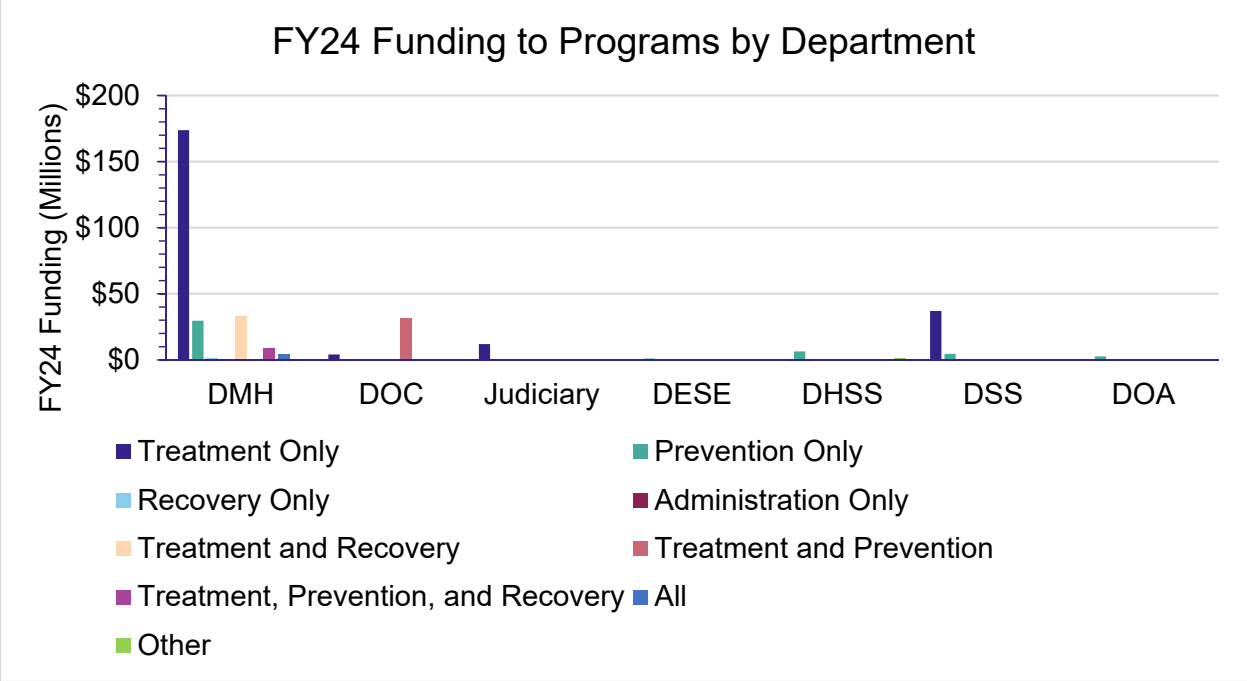

Figure 8. FY24 appropriation for SUD programs by program service focus and department.

BUDGET OVERVIEW

Fiscal year 2024 (FY24) appropriations for substance use disorders were calculated to be $350,259,330.82, an increase from FY23 spending of $243,837,833.90 (Figure 9). This number is approximate. Some programs are appropriated billions of dollars, only a portion of which is spent on substance use disorders. Because the amount spent is discretionary, the FY24 appropriations in this report represents the FY23 dollar amount spent for these programs, plus an additional $3,000,000 to approximate undetermined budget increases, increased costs, and anticipated additional spending on substance use disorders in FY24. A breakdown of this approximation is available in Table 5.

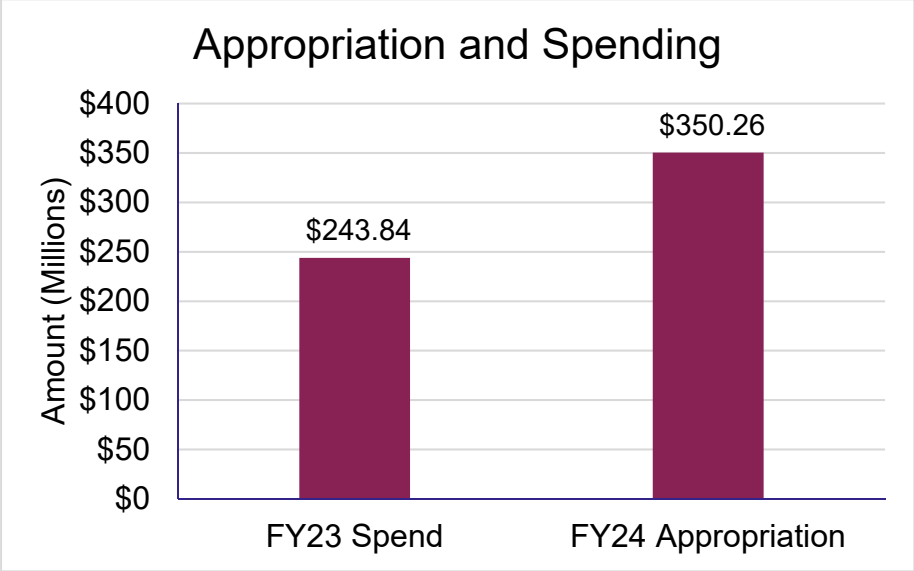

Figure 9. Differences in appropriation and spending between fiscal years 23 (FY23) and FY24 in millions of dollars.

Table 5. The Department of Social Services (DSS) includes the MOHealthNet Medicaid program. Funding for programs in other departments are generally contained in those department budgets, and Medicaid spending then accessed for Medicaid eligible participants. DSS has provided some direct funding for SUD, the bulk within their pharmacy medication assisted treatment. Table 5 describes the FY 23 funding for SUD maintained within the DSS budget.

Program	FY23 Spend
Medicaid Assisted Treatment – Drugs	$13,079,852
Medicaid Assisted Treatment – Drugs (AEG Population)	$11,874,908
Naloxone	$3,384,061.66
Assessment/Testing/Screening/Referral for SUD Treatment	$1,088,196
Treatment for Therapy (Family/Group/Individual)	$1,754,283

Of the FY23 spending on substance use disorders, 73% was spent by the Department of Mental Health (Figure 10), which administers major programs funded by Medicaid, and the majority of programs focused on SUDs generally (Figure 3). DMH accounted for more than $179 million of the dollars spent on SUDs in FY23. By contrast, DESE spent only $9,999 in FY23 on SUDs, less than a hundredth of a percent of the total spending on SUDs.

All budgets for programs dealing with SUDs increased in FY24 appropriations (Table 6, Figure 12). This caused a change in the proportions of SUD funding for each department (Figure 11). For example, the addition of a program and its appropriation administered by DESE caused its share of SUD funding to increase from 0.004% to 0.3%. While some departments such as DMH saw decreases in the percentage of total SUD funding to support their programming, they are still the recipients of increased funding overall (Table 6, Figure 12). The decrease in percentage of SUD funding for some departments is the result of additional programs in other departments introduced and funded in FY24 (Table 3) rather than any decrease in the actual amount of funding.

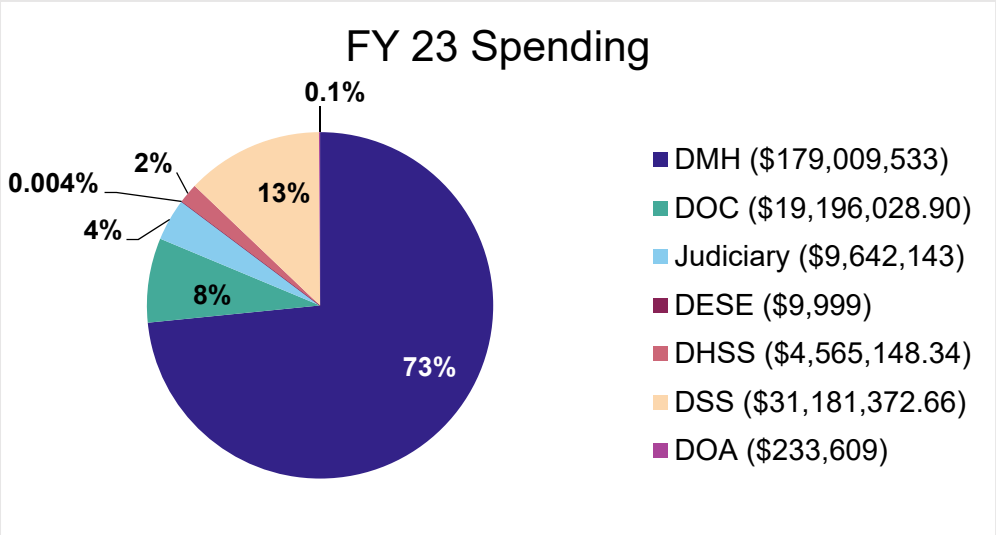

Figure 10. The percentage of FY23 spending on substance use disorders across departments. The amount spent is listed in the figure legend.

Table 6. FY23 spending and FY24 appropriation by department

Department	FY23 Spend	Percentage of FY23 Spend on SUDs	FY24 Appropriation	Percentage of FY24 Appropriations on SUDs
DMH	$179,009,533	73%	$249,613,637.16	71%
DOC	$19,196,028.90	8%	$35,605,831	10%
Judiciary	$9,642,143	4%	$11,953,607	4%
DESE	$9,999	0.004%	$1,210,600	0.3%
DHSS	$4,565,148.34	2%	$7,557,418	2%
DSS	$31,181,372.66	13%	$41,485,714.66	12%
DOA	$233,609	0.1%	$2,832,523	1%

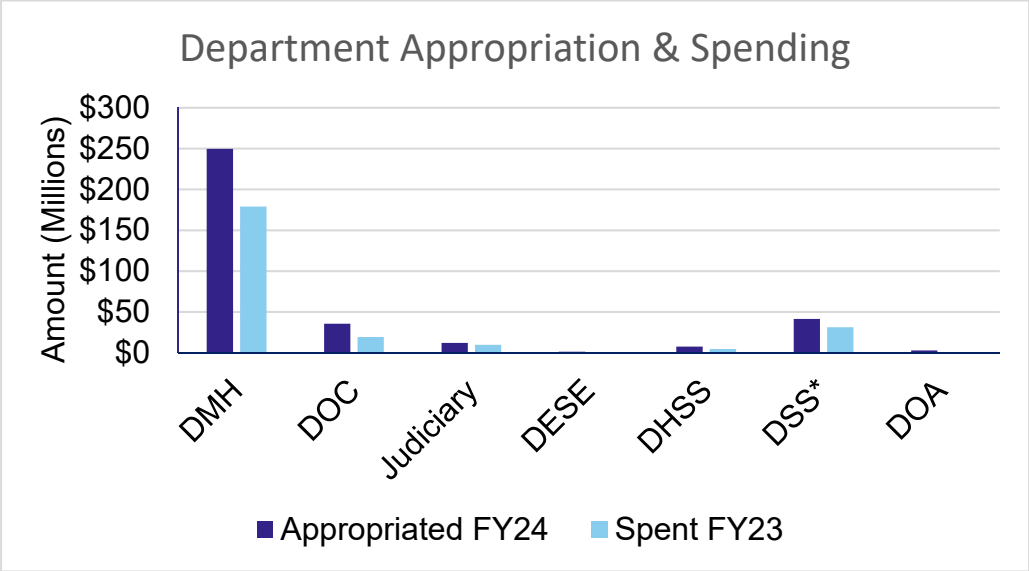

Figure 11. Appropriation and spending differences across the different Missouri state departments containing programs related to substance use disorders.

An additional $106 million was appropriated for programs related to SUDs in FY24 (Figure 13). Of this additional funding, the majority (66%) was allocated to DMH (Table 7, Figure 14). This was the result of budget increases for existing programs and a single, one-time payment to a new program (Table 3, Table 7). The DOC similarly saw increased funding but is introducing two additional programs in FY24. DSS was the third largest dollar increase, and similarly has a single new program (Table 7).

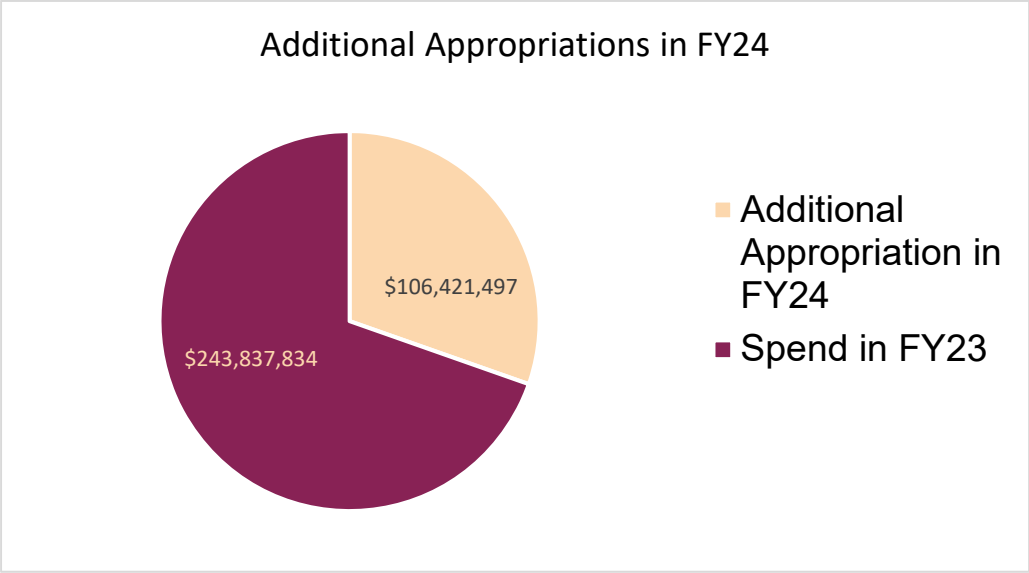

Figure 12. Additional moneys appropriated in FY24

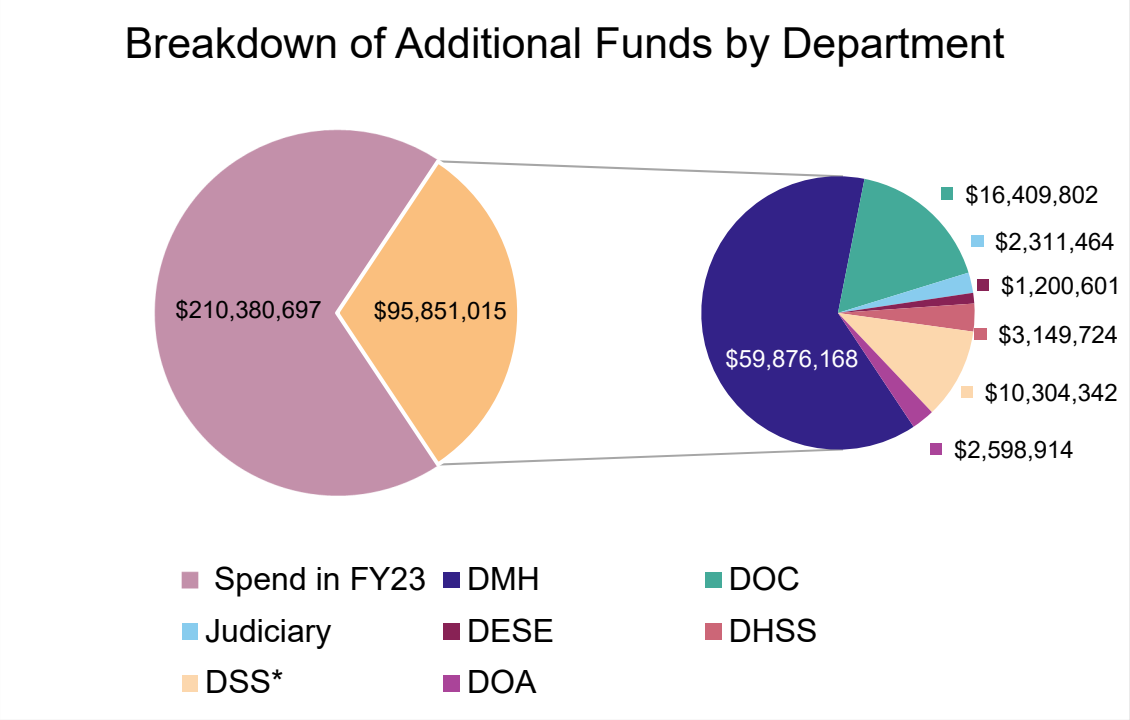

Figure 13. Breakdown of the additional moneys appropriated in FY24 by the additional money received by each department.

Table 7. Additional money appropriated to each department in FY24 and the percentage of the additional appropriation allocated to each department. *One-time payment, not an ongoing program

Department	FY24 Additional Funds	Percentage of Total FY24 Additional Funds for SUD Programs	Number of New Programs in FY24
DMH	$70,604,104.16	66%	1*
DOC	$16,409,802.10	15%	0
Judiciary	$2,311,464	2%	0
DESE	$1,200,601	1%	0
DHSS	$2,992,269.66	3%	1
DSS*	$10,304,342	10%	1
DOA	$2,598,914	2%	0

Finally, the total number of SUD programs in each department is compared to the FY24 appropriations to that department for SUD programming (Figure 15). As demonstrated with previous figures, the DMH contains the most programs and receives the highest budgeted amount for SUD programming. The DSS and DOC follow in both program number and funding amounts, and the DHSS and DOA administer several programs with relatively little funding in comparison.

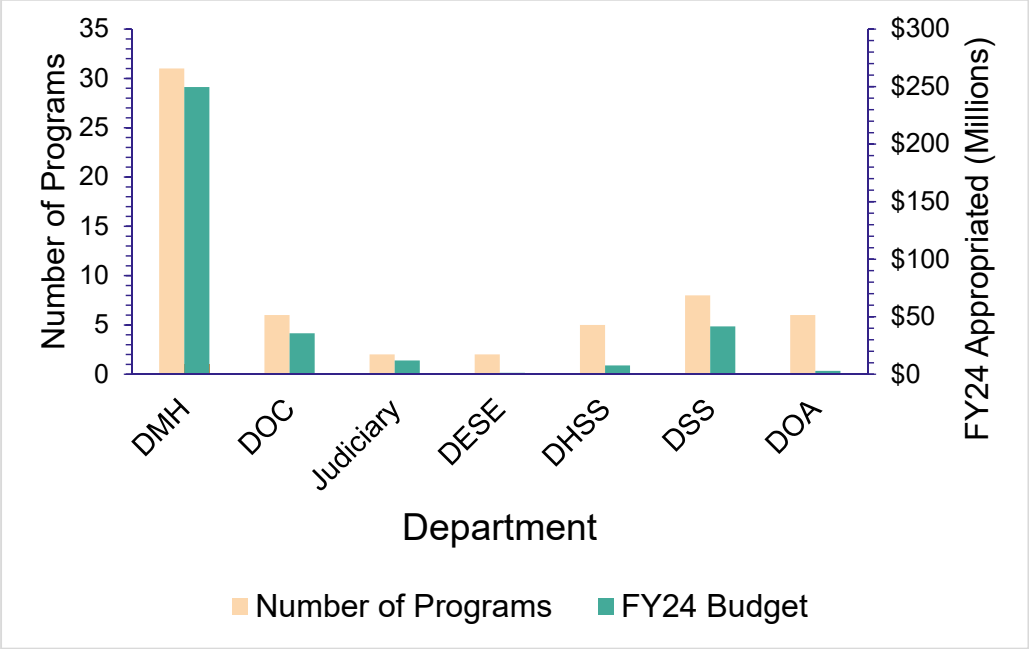

Figure 14. The number of SUD programs in each department compared to the FY24 total appropriated to that department for SUD programs.

SUMMARY OF TESTIMONY

I. June 22, 2023 Hearing

Department of Social Services

At the June 22, 2023, hearing in Jefferson City, testimony was offered by the Department of Social Services and the Office of Administration.

The Pharmacy Director of the MO HealthNet Division within the Department testified that the shift from prior-authorization implementation towards a risk-based model has been demonstrated to be successful. Previously, DSS used to only allow treatment to occur for a certain duration; when compared to examples of the provision of insulin to manage diabetes, the model was not sensible. Rather, the allowance of providers and patients to determine the duration of their treatment, even if it is for the patient's lifetime, is paramount. The stated goal during the hearing was to increase the number of patients treated for opioid use disorder (hereinafter "OUD").

Member Dr. Winograd commented that as overdose crises continue to worsen, there has been an overcorrection in pulling back on prescription opioids, and advised caution to the Department as there is danger in cutting off patients still in need of certain prescriptions. The Director reported increases in patient participants receiving Narcan, an increase of about 19,000. Chairman Black highlighted a discrepancy between the amounts appropriated versus spent; questioned the possibility of double-reporting; and inquired whether current appropriations would be sufficient for spending on new treatment programs, as well as available funding. The CFO of MO HealthNet testified that discrepancies do not necessarily mean a lapse in funding, and that these moneys go to total Medicaid expenditures; that federal reporting requirements separate the expenditures for addiction treatments and naloxone, and therefore actual expenditure amounts for each item are reported differently; and that DSS policy is open-access, that misinformation can result from the confusion on what is and is not permitted at the provider level, and that the intention is not for the Department to be an additional barrier to receiving treatment.

Beyond opioids, the Director testified that the Department offers informational materials to providers and referred to treatment products that are available without prior authorizations; and that there is not currently a proven methodology for appropriately treating methamphetamine use.

The Director of Behavioral Health Services within the Department's MO HealthNet Division testified that specialized services for substance use largely fall under programs in the Department of Mental Health (DMH) and the Comprehensive Substance Treatment and Rehabilitation (CSTAR) program. He stated that providers offering care through MO HealthNet are for general mental and behavioral health disorders. Mental health services for substance use generally go through the CSTAR program, and are reported through DMH. Medicaid eligible persons in the CSTAR program are funded by MO HealthNet. The MO HealthNet program offers complementary or alternative therapies for chronic pains, and that is intended to prevent opioid dependence; coverage for these services, moreover, is another approach to reduce unnecessary reliance on opioids.

Member Dr. Winograd commented that clinical programs are tools to help with treatment, which can include continuing to prescribe certain medications.

Office of Administration

The Executive Director for the state Prescription Drug Monitoring Program (hereinafter PDMP) testified that the Office is currently around a third of the way done with its implementation stage, and is working closely with a third-party service contractor. He stated that the program's goal is to provide more information for providers in considering which care may be most appropriate, and which will result in the best practice of care for their patients. The Office was in the process of conducting a "communication campaign" with providers and dispensers; there was a deadline of August 1 for all counties to agree and submit information, and the Executive Director estimated that the rollout for the program would be between 4-6 weeks if all counties had agreed and submitted materials – up to 120 weeks if not.

Closing Remarks

Chairman Black closed the hearing by offering the following remarks:
- MO HealthNet has significant funding that may not be utilized to the extent possible – why? What can the Task Force do to support increased treatment and access to treatment?
- It is counterproductive to implement prescription coverage cutoffs;
- Effective treatment for alcohol abuse disorder is not well utilized among the MO HealthNet population;
- Metrics and benchmarks to measure success are complex – however, it is important to move forward benchmarking results and to do comparative reports with other jurisdictions;

- While requiring counseling may not save lives, treatment courts show that medication alone does not necessarily resolve a person's addiction, and that it is important to try to motivate patient participants to consider alternative treatment methods;
- There need to be different measures of success for different quadrants of patients; and
- There is still a large population that is not seeking treatment – this is the portion of the population that is at the highest risk and is seeing the highest death rates.

II. July 26, 2023 Hearing

Department of Health and Senior Services

At the July 26, 2023, hearing in Jefferson City, testimony was offered by the Department of Health and Senior Services and the Office of State Courts Administrator.

Perinatal Quality Collaborative

The Chief of the Office of Women's Health and the Assistant Deputy Director of the Division of Community and Public Health testified to the Perinatal Quality Collaborative and their efforts on identifying causes of and preventing pregnancy-related deaths, of which SUDs are potential factors. The Perinatal Quality Collaborative has increased data transparency and access for both public and private stakeholders, with one of the involved committees assisting hospitals in implementation. About one-third of Missouri's birthing hospitals are working on implementing groups of evidence-based practice, giving strategies that will offer additional support for the state.

Tobacco Cessation

The Tobacco Control Program Manager testified to the state's smoking rate, and associated issues and health consequences. As the leading cause of preventable disease and death nationwide, smoking causes more deaths per year than HIV, illicit drug use, alcohol use, motor vehicle injuries, and firearm injuries combined. $3.5 billion is spent annually in treating tobacco usage and its health consequences. In Missouri 11,000 people die per year, and an additional 1,100 people die from complications associated with secondhand smoke exposure.

Missouri's rate for adults is 17.3%, or about one in six who smoke, placing Missouri tenth in the country for adult smokers; and for teenagers is 19.3%, or about one in five high school-age children who are vaping. More students are vaping than adults smoking, and the Program Manager testified that there has not been a noticeable reduction in use from the student population. The Department focused on a number of prevention and control efforts, as well as reducing secondhand smoke exposure, including:

1) Price and taxation increases;
2) Access to cessation services;
3) Smoke-free policies; and
4) Hard-hitting media campaigns.

Funding goals are primarily to prevent youth initiation into smoking; increasing access for individuals to smoke-free environments; offering programs to encourage cessation; and eliminating disparities that exist among marginalized groups, including people living in poverty, people who are suffering from mental illnesses, and people with lower educational attainment levels.[9]

Adult-Use Cannabis

The Bureau Chief for Community Health and Wellness testified to changes for the state since the passage of adult-use recreational cannabis. Part of what was passed included language to develop community grants with very specific categories; and to increase access to treatment, housing, employment, and overdose prevention assistance.

[9] For additional information and testimony on tobacco usage, please see the summary of testimony from the American Cancer Society on the October 2023 hearing, beginning on page 40.

Internally, Department stakeholders examined possible impacts to public health: increased impaired driving, injuries among children, and lung and respiratory issues were among concerns raised. The Department does not have any dedicated funding or staff.

To the Bureau Chief, members of the Task Force inquired about methods to test impairment; implementation of "cannabis-free" zones observed in other states; expanding educational materials through forums or community partnerships; possible statutory or regulatory updates; and what impacts are being observed in other states with legal recreational cannabis.

Office of State Courts Administrator

The Deputy State Courts Administrator and the Director of Court Business Services offered testimony relating to treatment court programs. They centered their efforts as collaborative engagement with treatment services for drug and alcohol use, while also protecting due process rights for participants. While remarking that, at its core, the treatment court program is designed as a means of prison and/or jail diversion for those persons with high criminogenic risk as well as high need for treatment services, in addition to other impacts, treatment courts:

1) Are a proven cost-effective way to avoid incarceration;
2) Help to lower recidivism rates of offenders, as compared the rate of recidivism relative to incarceration or probation;
3) Allow offenders the opportunity to remain connected to their communities, including to work, support their families, and pay taxes;
4) Contribute to reduced instances of babies born either prenatally exposed, or already physically dependent on drugs or alcohol, which saves millions of dollars in lifetime costs;
5) Reduce crime, as well as family separation and the need for foster care; and
6) Help ensure that child support payments are made on time.

Eligible offenders are selected through a process by which an assessment is conducted to ensure appropriate offenders are involved in programs. The key indicator to success for participants in the treatment court programs is ongoing judicial interaction and regular engagement.

Members of the Task Force inquired about funding sources, full-time employees, commissioners, and administrative staff; the decentralized nature of the treatment courts described in testimony as opposed to other state agencies; whether all counties throughout the state have access to treatment courts; if moneys from the Opioid Settlement Fund are being utilized; various performance metrics, including additional information on the relationship to recidivism; juvenile participation; sharing of best practices; and recommendations for possible statutory changes that could encourage early intervention.

There is currently no statutory authorization for Mental Health Courts to work as part of treatment courts.

III. August 22, 2023 Hearing

On August 22nd, the Director of the Department of Mental Health and the Director of the Division of Behavioral Health offered testimony on the Department of Mental Health's efforts addressing substance use.

The overarching goals of the Division of Behavioral Health center on treatment, prevention, and recovery, all in alignment with the Substance Abuse and Mental Health Services Administration (SAMHSA). Specifically, the Division's intent is to:

1) Prevent or delay substance use, misuse, and/or death;
2) Intervene when necessary to reduce negative impacts of substance use;
3) Develop illness management plans;
4) Coordinate with other systems, state agencies, and stakeholders to enhance impact; and
5) Obtain the highest possible level of functioning for participants in the least restrictive settings.

Specific functions from community programs and leveraged by the Division include:

1) Prevention programming;
2) Driver's license restoration;
3) Clinical treatment;

4) Crisis intervention;
5) Diversion programs;
6) Evidence-based practice implementation;
7) Recovery support; and
8) Improving access to communities and other stakeholders.

The Behavioral Health Division Director described alcohol as the most-used intoxicant in the world, and the repercussions of unhealthy use are of corresponding magnitude. 6% of overall deaths, as well as a six-fold increase in all-cause mortality, are related to the use of alcohol. Intoxication from alcohol is strongly tied to serious trauma; suicide; domestic abuse and sexual assault; crime; and deaths from alcohol poisoning, which can particularly impact young people. Moreover, alcohol addiction, which is estimated to impact over 14 million Americans, leads to the destruction of relationships, families, and social function, including unemployment, homelessness, or justice involvement.

Mortality among patients with alcohol use disorder increased during the beginning of the COVID-19 pandemic by over 20% in 2020 and 2021, and as with other conditions that result in medical, psychological, and/or social deterioration, patients who have alcohol use disorder present frequently to the emergency room for care. These visits are rapidly escalating, and the patients themselves are at higher risk for poorer health outcomes, especially those who frequently present for care, with nearly 10% of them expected to die within one year. The routine nature of these visits, the gradual pace of their decline, and their occurrence within the broader context of alcohol's social ubiquity and acceptance all help to conceal the reality: every harm that is caused by alcohol is preventable.

There is currently no FDA-approved medication to treat methamphetamine addiction, and instead, contingency management is an evidence-based practice utilized to promote positive changes in behavior. The State Opioid Response (SOR) grant allows the use of moneys for contingency management, but at a rate of about $75 per person, the scope of such support is limited. At the time of the hearing, the DBH Director testified that there were eight Missouri providers working in the field of methamphetamine addiction, but that there is a substantial need for further technical assistance.

Prevention Resource Centers

The realm of prevention work is primarily conducted through the ten Prevention Resource Centers (PRCs), which are allocated a set budget and utilize data to determine community-specific needs, as well as what the community is able to provide in order to meet those needs. Each PRC is able to provide all levels of service, but due to community need and staff expertise, as well as capacity, what is provided by each center may vary. Because this is data-based, implementation varies from year to year, and the Division of Behavioral Health accordingly requires each PRC to submit an annual plan that describes the center's focus for the upcoming year. In addition to these, other prevention providers include:

1) Big Brothers and Big Sisters of Eastern Missouri;
2) Missouri Alliance of Boys and Girls Clubs;
3) Burrell Behavioral Health;
4) DeafLEAD;
5) Lincoln University;
6) Missouri Police Chiefs; and
7) Partners in Prevention.

Each of these programs is allocated a set budget to provide specific programming targeting high-risk populations identified in the community. All PRCs, the Missouri Alliance of Boys and Girls Clubs, Partners in Prevention, and DeafLEAD, are highly skilled in primary prevention, and have contacts within the community to help disseminate the work to wider targets. Some PRCs, Big Brothers Big Sisters of Eastern Missouri, and Burrell Behavioral Health work on secondary prevention.

Crisis Intervention and Diversion Programs

Crisis intervention is split up primarily into three different segments: someone to talk to, someone to respond, and somewhere to go.

The 988 suicide and crisis hotline, launched in July 2022, has features for calling, texting, and chatting; has six call centers, and one text/chat center; has received over 5,000 calls in July of 2023, with a 95% in-state answer rate; and offers follow-ups and other support services.

Behavioral Health Crisis centers serve as alternatives to emergency rooms or jails for individuals who are experiencing crises, and offer interventions by multidisciplinary teams, including peer support specialists. There are current 18 open across the state, with four additional centers planned for FY25.

Engaging Patients in Care Coordination (EPICC) is a 24/7 referral and linkage service for those residing in targeted regions, primarily for individuals post overdose, but who also may present to hospitals with issues relating to opioid, stimulant, and/or alcohol use disorders. The goal is to establish immediate connections to recovery support services, and substance use treatment.

Community Behavioral Health Liaisons help divert individuals from unnecessary stays in jails, prisons, emergency departments, and hospitals; support working towards improved outcomes for those with behavioral health needs; assist law enforcement, jails, and courts with linking individuals with behavioral health needs to treatment; and provide law enforcement training, support, and referral to care to assist with stress and trauma, as well as promote officer wellbeing.

Treatment

The Division Director testified that most admissions involve more than one substance, and these substances may vary among age groups – the top three substances consistently encountered are alcohol, methamphetamine, and opioids.

The Substance Use Block Grant prioritize the following populations:

1) Pregnant women injecting drugs;
2) Pregnant women
3) Women with dependent children; and
4) People who inject drugs.

Further priority is given to individuals in crisis; MO HealthNet recipients; and referrals received from the Department of Corrections.

Approaches and interventions for treatment:

1) Are individualized;
2) Incorporate medication-assisted treatment, when clinically appropriate;
3) Use peer support specialists;
4) Involve motivational interviewing and other evidence-based treatments;
5) Feature integrated treatment for co-occurring disorders; and
6) Are trauma-sensitive, trauma-informed, and trauma-capable.

Comprehensive Substance Treatment and Rehabilitation (CSTAR) is the only comprehensive substance use disorder program that is covered by MO HealthNet, and provides counseling, medications, education, case management, and peer services, as well as a variety of subspecialty programs for adolescents, women and children, and individuals with OUD. CSTAR features an updated clinical treatment approach, and features an enhanced payment methodology to incentivize quality treatment and the use of evidence-based practices. CSTAR also requires that their providers must meet specific criteria related to clinical staffing.

Certified Community Behavioral Health Organizations (CCBHOs) are eligible providers for Medicaid reimbursement if CSTAR or component services are utilized, and feature a cost-based reimbursement method as well as performance incentives. These organizations have helped proliferate the usage of medication-assisted treatment (MAT).

The Substance Awareness Traffic Offender Program (SATOP) is a statewide system of comprehensive, accessible, community-based education and treatment programs designed for individuals who have pled guilty or were found guilty of an impaired driving offense with administrative action. SATOP is also required for offenses for individuals

under the age of 21, charged as a Minor in Possession, an Abuse and Lose, or Zero Tolerance offense. Completion of a SATOP is a statutory condition of license reinstatement, and incorporates a comprehensive assessment to determine placement in any one of the four levels of educational- and/or treatment-based interventions.

Recovery Support Services include faith-based organizations and community-based organizations that focus on behavioral health, and most organizations are represented by the Missouri Coalition of Recovery Support Providers (MCRSP).[10] Recovery support includes, but is not necessarily limited to:

1) Services available before, during, and after treatment and in coordination with substance use disorder providers;
2) Care coordination;
3) Recovery coaching;
4) Spiritual counseling;
5) Group support;
6) Recovery housing; and
7) Transportation services.

DBH collaborates with MCRSP, which is a network of faith-based, peer, and community organizations that work to restore and rebuild lives and families seeking recovery from substance use disorders, both through immediate access and with long-term relationships.

Certified peer specialists are credentialed by the Missouri Credentialing Board, with a total at the time of the hearing of 1,517 actively credentialed specialists. Peer- driven organizations called Recovery Community Centers are responsible for the following:

1) 6,307 social activities offered;
2) 6,084 individuals reached through street outreach;
3) Provided 15,923 telephone support calls;
4) Distributed over 8,800 boxes of Narcan; and
5) Though underreported, saved at least 680 lives through Narcan intervention.

MO HealthNet (Medicaid) covers mental health, which could include substance use, and that can be done through their behavioral health program. However, participants are then limited to the services of psychiatrists or licensed behavioral health professionals, not a broad array of services. Medicaid managed care flows through that program, but MOHealthNet also covers the CSTAR program as a payer for Medicaid recipients, including the adult expansion funds.

The Division Director drew a parallel to SUD and other chronic disorders such as high blood pressure, and compared usage of those medications intended to treat such chronic disorders, which may be for a lifetime, with the use of MAT for SUD. If an individual takes medication that helps encourage them to further their recovery, the Behavioral Health Division Director asserted that should be considered a net positive. Patients on MAT differ vastly from patients who are actively using; patients are being provided a stabilizing effect, which can have benefits such as improving their social relationships, access to housing, or employment, and cravings of the substance may be reduced through the administration of medication.

Effectiveness as it relates to recovery and the achievement of specific goals can be categorized within five domains that could signify efficacy by means of noted improvement in patients:

1) Decrease in symptoms;
2) Improved social connectedness;
3) Stable housing;
4) Employment; and
5) Cessation of illegal activity.

[10] For additional testimony from representatives of the Missouri Coalition of Recovery Support Providers, please see the summary of testimony from the October 2023 hearing, beginning on page 43.

The Director and Member Dr. Winograd addressed fentanyl test strips by clarifying the process and usage of a test strip before the consumption of an illicit substance. These can be particularly beneficial for users of stimulants such as methamphetamine or cocaine, or for pills.

Challenges

Challenges were identified as stigma and misinformation around behavioral health and substance use; temporary funding resources coming to an end without replacement funding; workforce shortages across the board; and barriers to housing and employment.

IV. September 14, 2023 Hearing

Department of Social Services

The Department continued its testimony from June 22 regarding primarily non-Medicaid concerns, with testimony offered by the Director. Regarding MO HealthNet, the Director described the department's role as serving other state departments with funding for Medicaid-eligible recipients, in addition to the department's standalone pharmacy program. The Director stated that communication between the state agencies is stronger than it has ever been.

The Department of Social Services' other three program divisions – Children's, Family Support, and Youth Services – are confronted with the downstream impacts of untreated substance use. The Director described those impacts as traumatic, especially for children, and at tremendous cost to the state. Some children have died in Missouri from fentanyl poisoning and some have tested positive for meth. Success will be determined by capacity, capability, and the speed at which treatment can be provided. Recidivism is linked to whether there are available avenues for treatment.

Reducing time to care and bridging coordinated services are vital components in getting someone out of the cycle of substance use. Between 2019 and 2021, Missouri experienced a 45% increase in opioid related deaths, with 90% of those being fentanyl-related. Coordination between state departments, local and state law enforcement, emergency management training, and additional resources are required. The cyclical nature of substance use and the related trauma on children, workers and communities is, in the Director's description, shocking.

The Director provided the following recommendations:

1) Build treatment capacity across the state;
2) Work on tools to remove barriers to downstream treatment services;
3) Engage community, social and faith – based groups;
4) Reduce time to service; and
5) Bring certified substance use counselors back into the Youth Services Division.

When asked by Member Wright regarding the possibility of a "quarterback" or oversight position, the Director indicated that was a concept meriting further consideration.

Department of Corrections

In recent years, more resources have been directed to incarcerated people with SUD. About 40% of all entrants into DOC are referred to treatment, and 25% require psychotropic medication, many with co–occurring disorders. The traditional institutional–based treatment is being reassessed to incorporate community based-resources, particularly upon release. An external assessment has identified that a contract-based model is more effective, and has been implemented since November 2022. Certification and licensure rates for staff have also improved. The data indicate that residential-based care is only effective when coupled with aftercare in the community. Recent funding increases have allowed for medication assisted treatment in all DOC facilities. The emphasis of the department is to rely on evidence-based practices, rather than traditional programs.

V. October 17, 2023 Hearing

During the October 17 Hearing in Jefferson City, testimony was offered by several organizations relating to the programs and services provided to clients.

University Health, Kansas City

The Medical Director for Addiction Services at University Hospital in Kansas City described the hospital as the largest Level 1 Trauma Center in western Missouri, with two hospitals (one downtown and one in Lee's Summit), and also connected to a large mental health system, as well as the University of Missouri–Kansas City (UMKC). Most funding comes from government sources, receiving money from Medicare, Medicaid, Jackson County, and the City of Kansas City.

University Health's addiction programs serve between 800-900 unique patients and 10-12,000 visits each year. Services includes intensive case management; telehealth mental health services; psychiatry residents offering care; group and individual counseling; and working alongside community providers. Federal grant funding has allowed for every UMKC medical student to receive training in SUD treatment through both online modules and real-world practical experience with patients experiencing SUD in their clinics, regardless if the student eventually goes into practice as a psychiatrist.

The federal State Opioid Response (SOR) funding has been helpful, according to the Medical Director, but is distributed through community behavioral health sources and other programs statewide. Certified Community Behavioral Health Organizations (CCBHOs) have set standards for organizations working in the state that want to be certified as such, and part of those standards include the requirement to provide evidence-based treatment for SUDs. The Medical Director said that it can be difficult for providers to let go of older models. Additionally, the Department of Mental Health has adapted a medication-first approach for Opioid Use Disorder (OUD). Because individuals with this disorder require medical stabilization, they can be so ill that they are unable to participate in certain interventions.

The Medical Director outlined several challenges to their work:

1) Addressing SUD in pregnancy;
2) The dearth of evidence-based resources in the legal system;
3) Expanding access to nontraditional settings;
4) Funding sources;
5) Rural community access and engagement;
6) Prevention and screening; and
7) Workforce shortages.

Missouri Association of Counties

The Boone County Commissioner, appearing on behalf of the Missouri Association, provided testimony relating to the Sequential Intercept Model, which is a tool to help map and identify how people with mental illnesses and substance use disorders interact with the legal system and further identify resources and gaps in services. Diversion happens, if possible, but a lot of their work comes down to reducing recidivism. From a local government perspective, people in communities throughout the state with SUD or mental illnesses are ending up in county jails (which are the largest mental health providers nationwide), emergency rooms, and with public administrators.

The Commissioner testified to a need for a "quarterback" type of role, either as a jail navigator or a health and justice coordinating council. Both of these positions have been identified as critical, supported by best practices, and are in use across counties throughout the country. A jail navigator is a person that would be able to support individuals leaving jails by connecting them to resources that the offender may require upon exit. A health and justice coordinating council would allow for collaboration across disciplines, connect people among resources, and identify any barriers or opportunities before taking action.

County jails are also contending with the dearth of placements at DMH for people who have been determined incompetent. There are over 300 people detained in county jails who have been adjudicated incompetent, but are still sitting in county jails awaiting competency restoration. An individual had waited seven months for an evaluation, was at nine months post-evaluation at the time of the hearing, and waiting for a court order. Despite the situation in this country that our jails act as our largest mental health facilities, they are not mental health facilities. The Commissioner identified a key sticking point as the effects of the Community Mental Health Act. When institutions were closed, that reduced the supply of appropriate placements for individuals that are now in communities with few resources. The public administrators have clients, but because there is no placement, they're being placed in nursing homes. That may go along for a while, but were that individual to become justice-involved, then the cycle continues.

PreventEd

Representatives from PreventEd testified to the "dramatic change" in how prevention efforts are addressed. Strategies were implemented in decades past that were thought to work well, but there was not confirmation that improvements were made until 25 years ago, when a new body of research was developed around the science of prevention. This body of work identifying risk and protective factors, developed strategies for implementation in communities.

The organization receives funding from the SAMHSA block grant, which mandates that 20% of funds support prevention efforts. For PreventEd, that translates to about $5.8 million divided among ten providers. PreventEd also leverages local grants to expand their work, and in looking to the future, the representatives argued that 20% is a low threshold for prevention efforts.

The representatives testified to the data that addiction is a disease that usually begins in childhood, with 90% of individuals who have SUD using an addictive substance before the age of 18. Early initiation of use is the strongest risk factor for SUD.

Return on investment is paramount, but one study cited stated that for every dollar spent on prevention, $18 is saved. When engaging in SUD prevention, it is not just alcohol and other drug use that requires attention, but factors like stressors, costs relating to healthcare and employment; and connections between mental health, violence, and teen pregnancy. The representatives pointed to school-based curriculums as an example of effective prevention programs – about 65,000 young people are served daily, only about 20% of whom the organization is in front of. Some of the best evidence gleaned from schools are peer to peer programs, teaching students to teach other students.

As prevention resource centers are structured, there are ten in the state that are funded by DMH, and they serve 166 community coalitions. Knowing that needs differ in areas across the state, these centers coordinate and educate, as well as work to raise public awareness and increase access to relevant information.

Missouri Primary Care Association

Representatives from the Missouri Primary Care Association offered testimony relating to funding, challenges, and services.

In 2022, Missouri Federally Qualified Health Centers (FQHCs) reported having over 230,000 visits for substance use. The need is great, so too must be the capacity to respond. Addiction is a chronic disease that can be managed with preventive and primary care.

State funding that goes to FQHCs include just under $2 million from DMH, which goes to medication-assisted treatment, and only to three centers. The other funding goes to ten collaborative efforts or CSTAR facilities to provide whole-person care. The organization has recently received an appropriation of $4.5 million dollars to support same day or next day care and immediate coordination with coaches (a "Network"), a combination of general revenue, opioid settlement funds and Medicaid, but issues in receiving approval from Medicaid have interrupted some of that funding. Early reports of effectiveness are favorable. The funding for FQHCs are limited to some extent to identified locations and expansion to other areas in the state is needed.

A key challenge that was identified was the earmarking of certain funds for very specific uses. As FQHCs are community-driven, and each community has different needs, funding that can only be applied to certain services can place restrictive burdens on the ability to provide care. Moreover, there are services like peer support and wraparound services that there is not a code for FQHCs receive reimbursement.

When someone comes to receive services, there are typically outstanding needs beyond medical treatment. Transportation, food stability, housing, all need provided alongside clinical care. At an FQHC, that is built into the systems as a whole. The organization worked with MO HealthNet for emergency approval for those dealing with substance use disorder. The other portion of wraparound services is that the connection to care, those pathways and community connections engaging patients in care coordination, peer support, medication-assisted treatment, and community health support exist in the EPICC program. Patient referrals work two ways. They can be referred out to the same individuals the organization is in network with. Another integral part is what services are provided in jails, and provided in treatment court services, behavioral health, peer support, and clinical care to people in treatment court as well as at the courthouse for that person, due to the existing challenges facing them.

State Public Defenders

Representatives of the State Public Defenders Office testified to their collaboration efforts with courts and community actors. They are not in need of clients, but there are individuals with SUD that require support. They do not force services with clients, and work to build trusting, voluntary relationships.

The Office obtained grant funding from the Missouri Foundation for Health to ensure appropriate training, and also to create a resource guide to identify what is available, in every county, and how to access it. It is updated daily. The Office has also obtained 22 advocates through grant funding, with the goal for an advocate in all 33 trial offices statewide; many offices will require more than one advocate due to intake. The Office wants to accomplish these goals in ways that will save the state money.

A lot of their work is done at the request of the Court, or on needs expressed by the Court. Oftentimes, attorneys are in front of judges trying to get individuals out on bond, but either they do not have home plans, or struggle with SUD or another mental illness and may be considered a flight risk. Without the unique role between courts and service providers, the Office would not be able to overcome concerns and community issues, but those of courts, jails, and prosecutors looking for solutions.

A large misconception about public defenders is that they mainly deal with violent crime, which is not true – the representatives testified that so much of their work is an "addiction docket", either for possession, probation violations, or possession while on probation. The representatives also testified that the public defenders contending with out-of-control caseloads is directly correlated to the introduction and widespread use of methamphetamines in the state.

The American Cancer Society

A representative from the American Cancer Society testified to the importance of public policy in affecting cancer in the country. The organization does not receive state funding, and are advocating for funding to address tobacco cessation efforts.

11,000 Missourians die every year of smoking related causes, and nationally the number is closer to one in five deaths. This substance has become so normalized to so many people that it is not considered a SUD issue. 34.3% of cancer deaths in the state are caused by smoking, the fifth highest in the country. The adult smoking rate, at 17.3%, makes Missouri the ninth highest in the US. This data, based in 2021, may lag a bit, but is still notably higher than the national average. 5,716 new lung cancer cases have been estimated, and 3,200 lung cancer deaths have occurred this year. 80% of lung cancer deaths are caused by smoking. The group heard partners in PreventEd mention there has been improvement in the teen smoking rate, but the overall rate is 21.3%; while teens are not using traditional cigarettes as much, they continue to use e-cigarettes and other tobacco products. That is a significant problem, as when kids start using at a young age, they go on to have a lifelong addiction. Estimates of direct healthcare costs are around $3.52 billion, almost $700 million in Medicaid, and $7 billion in lost productivity. On the financial side, the state receives $139 million from the tobacco makers settlement. Compare that to how much of the overall budget

($2.9 million) was for tobacco cessation. In looking at the scope of the amount of revenue brought by the state, not even counting the scope of revenue from tobacco tax, it's a drop in the bucket. For comparison's sake, $359 million is spent annually on marketing by the tobacco industry in the state.

There has been an observable impact of media campaigns, including one that spanned nationwide from 2012-2018 and featured "tips" from former smokers, which resulted in 1 million people successfully quitting. The challenge, much of the time, is that the state can run these campaigns, but they tend not to spend very much to do so.

Another area for additional investment is the "Quit Now" line; when that number is called, it is routed to the state, and they can provide the individual with cessation resources and certain counseling assistance. There were substantial restrictions, and costs prevent the full utilization of this measure. The Department had once expanded to 8-12 weeks of support, but that has been cut down to 4 weeks. There are specific populations that the organization intends to provide support for, but if people want to quit and stay quitting, they require the support to successfully do so.

The state also has an issue with pregnant and postpartum smokers, having the fourth-highest pregnant smoking rate in the nation, and more investment would work to address the needs of these individuals.

Engaging Patients in Care Coordination (EPICC)

The Vice President of Substance Use Programming with the Missouri Hospital Association testified to the increase of almost 40% of opioid overdose deaths pre- and post-pandemic. The majority of these Missourians are dying in their own homes. The organization coordinates the services provided by certified peer specialists (recovery coaches) available to meet people where they are, at emergency departments or police stations or in their homes, 24 hours per day, to connect people with community resources and treatment.

The organization received a bio-surveillance grant, which allowed them to beef up infrastructure in targeted hospitals in order to get a better reading of what is making its way into individuals' systems. This also allows for the analysis and screening of over 30 substances, and is kicked up to national partners for informed decision making. The organization recognizes that the cyclical behavior must stop, that people will make poor decisions at all hours, and in order to be responsive to that, must be able to meet people where they are, no matter the time of day or location.

EPICC has been integrated in the eastern region and has replicated it in Columbia, Springfield, and Kansas City, all in 2019. In 2023, another program was launched in South-Central, Lake of the Ozarks, Lebanon area. MHA-led EPICC, as of 2021, expanded eligibility criteria for treatment of opioid, alcohol, and stimulant use disorder. One of the frames built is recovery-oriented systems of care, which is an evidence-based model, something Missouri has tried to engrain in development, as well as SBIRT. Screening to discern need, then embedding and using evidence-based brief interventions, such as overdose education and naloxone distribution. The referral to treatment is where SUD providers come into play, but this goes beyond the use disorder. To set community members up for success, the state must address social determinants of health. Getting community members to engage in their own recovery, and addressing barriers and gaps that persist, is vital.

Aspire Advocates

A representative from Aspire Advocates offered testimony to the amount of young people engaged in substance misuse. Between 60-70% of students who have addiction problems relapse upon their return to high schools. For most youth, SUD and other mental health concerns are closely connected. Treatment is not one size fits all, and with that in mind, the organization advances two priorities: the establishment of a public recovery high school in partnership with St. Louis area school districts offering free recovery services, and the expansion of dialectical behavioral therapy (DBT).

Up to four pilot recovery high schools have been authorized, and all are trying to garner partnerships. An important component is to offer recovery services and other support avenues after school years are completed, as healthy peer support and influences can have a positive impact on recovering teens even beyond their educational setting. Recovery high schools and services can strengthen family relationships as they manage substance use, and could be replicated throughout the state, although dedicated funding would be required.

Dialectical behavioral therapy is delivered with fidelity to the treatment model and is eligible for partial reimbursement under Medicaid rules. DBT allows students to see their individual therapist, attend group skills training, retain access to 24/7 therapy coaching, and engage in counseling team meetings on a weekly basis. Because there is no reimbursement for the full model, the initiatives proposed by the Aspire Advocates representatives are intended to help youth and their families thrive, as well as expand access to this evidence-based treatment.

Missouri Association of Public Administrators

The Webster County Public Administrator, speaking on behalf of the Missouri Association of Public Administrators, testified that public administrators are essentially public guardians of last resort at the county level, only becoming appointed in cases where family, friends, or other possible guardians are unwilling or unable to undertake the task. They are also guardians for individuals unable to meet their own needs. The lack of availability for effective treatment for persons with mental health and substance use disorders, particularly in rural areas, results in Public Administrators serving as guardians for persons not well-suited for the Public Administrator system.

The Administrator testified that family members or loved ones who may be seeking assistance look to guardianship as a solution, but that is not necessarily an accurate representation of what guardianship is, or what it can achieve for those experiencing SUD. Administrators have no resources outside of those already available to those people not under guardianship. That population can be difficult to treat, as they cannot be mandated into care, and cannot be mandated into not using. The most possible that an administrator can do is a temporary placement or restriction. However, substance use should not be used as justification to strip people of their rights.

About 5% of the Administrator's caseload were individuals for whom substance misuse was the only (or primary) diagnosis, but around 33% of the population are those who struggle with mental illness, and the majority of these individuals also suffer from substance use issues. As a county office, the Administrator does not receive state funding; they manage their wards on county budgets, and differences emerge across the state depending on what funding or other resources may be available. The Administrator, at the time of their testimony, stated that they have 110 people under their care, and is unable to ensure that all of those people do not engage in substance use.

As public administrators, they have varying caseloads and resources with which to treat people. They want to focus on vulnerable individuals unable to help themselves, rather than those choosing to make decisions related to substance use. As public administrators, a lot of times they are viewed as an alternative to the criminal legal system, but they are not an extension of probation or parole. They do their best with what they have to provide oversight and utilize support, but cannot mandate care or force people to be drug-free. Restoration is the ultimate goal, without a guardian.

Recovery Services Providers

Two representatives of the Missouri Coalition of Recovery Support Providers, one of whom is also the owner of Healing House KC, offered testimony relating to recovery support services, which are person-centered and self-directed and involve care coordination, coaching, spiritual counseling, and support with housing and transportation, all before, during, after, and in coordination with other substance use disorder service providers.

Recovery support service providers received $3.1 million from the Missouri Department of Mental Health, and $700,000 from the Opioid Settlement Fund, through FY2025. According to testimony, most of that funding had already been expended, but they continue to provide support services to clients, allocated around $2,000 per person, though they are in effect out of funding. The organization represents recovery support agencies that have 192 accredited houses, 109 men's and 85 women's, a total of 2,192 accredited beds, and 1,600 certified peer support specialists. Emphasizing the importance of medication-assisted and direct treatment, the witnesses underscored the necessity of peer-supported treatment and lived experience in serving individuals experiencing substance use disorder.

Of clients supported with recovery support services:

1) 98% have not experienced a new arrest;
2) 90% of clients under her care are in stable housing;
3) 88% are abstaining from alcohol or improper drug use;

4) 71% are employed;
5) 91% demonstrate improved social connectivity; and
6) 97% are satisfied or very satisfied.

One of the witnesses described the process by which many individuals arrive to her: many come out of prison with no ID, Social Security Card, or medication, and few have anything beyond the clothing garments they are wearing. She additionally testified that some of the services provided for individuals include, but are not limited to, signing people up for Medicaid; meeting with physicians; offering employment support through their employment specialist; and securing additional resources such as temporary housing, phones, feminine hygiene products, and diapers.

The witness emphasized to the Task Force that she sees nothing short of miracles each day. There are 60 contract recovery support operations statewide, and the inherent strength in these programs revolves around the peer-based support from those who share a lived experience of substance use.

RECOMMENDATIONS

Table 9: Recommendations

Part 1: Recommendations for Fiscal Year 2025 and Following:

1) Review whether the current level of funding for substance use prevention and treatment is adequate to continue to build treatment capacity across the state;
2) Provide additional funding for the programs identified as particularly effective:
    a. Recovery support service providers;
    b. Programs offering comprehensive and reduced time to treatment, including EPICC and FQHCs;
    c. Judicial treatment courts, including mental health courts;
    d. State Public Defenders;
    e. Community and Youth Services liaisons; and
    f. Improve Medicaid coding to better track expenditures and services.
3) Continue current levels of funding in the short term, emphasizing prevention;
4) Utilize cannabis tax and opioid settlement funds for prevention efforts like: mentoring, school based supports, youth crisis centers, etc
5) Increase prevention funding for tobacco and alcohol addiction prevention, and for tobacco, increase the use of the tobacco settlement funding.

Part 2: Recommendations for Subjects for Future Task Force Investigation:

1) Determine measures and metrics for effectiveness, to include SUD incarceration and over-dose rates and returns on investments in other states;
2) Address subjects, which may have been previously controversial among the General Assembly, that have demonstrated effectiveness in other states, including:
    a. Raising the tobacco tax;
    b. Ensuring compliance with federal and state tobacco laws;
    c. Optimizing the use of tobacco settlement funds; and
    d. Implementing needle exchange programs;
3) Examine the need for and methods of providing wraparound services, including housing, expansion of rental assistance and community re-entry from incarceration/federal Medicaid re-establishment/exclusion waiver, and application of the sequential intercept model;
4) Continue to encourage departments to engage in evidence-based practices, with continued reporting and recommendations to the General Assembly, such as evidence based prevention education and evolving/cutting edge evidence based treatment methodologies linking mental health and substance use;
5) Examine the long-term impacts of recreational cannabis use in Missouri; and
6) Request from the departments additional data on the social costs of SUD to the state and national best practices

To see hyperlinks and appendices, please visit www.house.mo.gov/CommitteeReports.aspx.

The following members' presence was noted: Adams, Allen, Amato, Anderson, Aune, Baker, Banderman, Bangert, Barnes, Billington, Black, Bland Manlove, Bonacker, Bosley, Bromley, Brown (16), Brown (149), Brown (87), Brown (27), Buchheit-Courtway, Burger, Burton, Busick, Byrnes, Casteel, Chappell, Christ, Christensen, Clemens, Coleman, Collins, Cook, Copeland, Crossley, Davidson, Davis, Deaton, Diehl, Dinkins, Doll, Ealy, Evans, Falkner, Farnan, Fogle, Fountain Henderson, Francis, Gallick, Gragg, Gray, Gregory, Griffith, Haden, Haffner, Haley, Hardwick, Hausman, Hein, Henderson, Hicks, Hinman, Houx, Hovis, Ingle, Johnson (12), Johnson (23), Jones, Justus, Kalberloh, Keathley, Kelley (127), Knight, Lavender, Lewis (6), Lonsdale, Lovasco, Mackey, Mann, Marquart, Matthiesen, Mayhew, McGaugh, McGirl, McMullen, Merideth, Morse, Mosley, Murphy, Myers, Nurrenbern, O'Donnell, Oehlerking, Parker, Patterson, Perkins, Peters, Phifer, Plank, Plocher, Pollitt, Pouche, Proudie, Quade, Reedy, Reuter, Richey, Riggs, Riley, Roberts, Sassmann, Sauls, Schnelting, Schulte, Schwadron, Seitz, Sharp (37), Sharpe (4), Shields, Smith (46), Smith (155), Stacy, Stinnett, Strickler, Taylor (84), Taylor (48), Terry, Thomas, Thompson, Titus, Toalson Reisch, Unsicker, Van Schoiack, Veit, Voss, Walsh Moore, Weber, West, Wilson, Windham, Woods, and Wright.

ADJOURNMENT

On motion of Representative Billington, the House adjourned until 4:00 p.m., Monday, January 29, 2024.

COMMITTEE HEARINGS

BUDGET
Monday, January 29, 2024, 12:00 PM, House Hearing Room 3.
Budget presentations from the Office of Administration and Departments: Supplemental (HB 2015), Coronavirus State Fiscal Recovery Fund - ARPA (HB 2020). No public testimony will be taken.

BUDGET
Tuesday, January 30, 2024, 8:00 AM, House Hearing Room 3.
Budget presentations from Elementary and Secondary Education (HB 2002) and Higher Education and Workforce Development (HB 2003). No public testimony will be taken.

CONSENT AND HOUSE PROCEDURE
Tuesday, January 30, 2024, 4:00 PM, House Hearing Room 5.
Public hearing will be held: HR 3946, HR 3947
Executive session will be held: HR 3946, HR 3947

CONSERVATION AND NATURAL RESOURCES
Monday, January 29, 2024, 5:00 PM or upon adjournment (whichever is later), House Hearing Room 6.
Public hearing will be held: HB 1870, HB 2491

ECONOMIC DEVELOPMENT
Wednesday, January 31, 2024, 8:15 AM, House Hearing Room 1.
Public hearing will be held: HB 2460, HB 2106, HB 2464

ELECTIONS AND ELECTED OFFICIALS
Tuesday, January 30, 2024, 12:00 PM or upon adjournment (whichever is later), House Hearing Room 6.
Public hearing will be held: HJR 86, HJR 76, HJR 119
Executive session will be held: HB 1604, HB 1749, HB 2140

ELEMENTARY AND SECONDARY EDUCATION
Wednesday, January 31, 2024, 8:00 AM, House Hearing Room 7.
Public hearing will be held: HB 1727, HB 2184, HB 1851
Executive session will be held: HB 1486

FINANCIAL INSTITUTIONS
Tuesday, January 30, 2024, 12:00 PM or upon adjournment (whichever is later), House Hearing Room 5.
Public hearing will be held: HB 1478, HB 2063
Executive session will be held: HB 1803

GENERAL LAWS
Tuesday, January 30, 2024, 2:00 PM, House Hearing Room 7.
Public hearing will be held: HB 2056, HB 2385, HB 1818, HB 2345, HB 1837
Executive session will be held: HB 1563, HB 2291

GOVERNMENT EFFICIENCY AND DOWNSIZING
Wednesday, January 31, 2024, 8:00 AM, House Hearing Room 6.
Public hearing will be held: HB 2319, HB 2373, HB 2282
Executive session will be held: HB 2084, HB 1630

HIGHER EDUCATION
Wednesday, January 31, 2024, 2:00 PM, House Hearing Room 5.
Public hearing will be held: HB 1533, HB 2326

JOINT COMMITTEE ON TRANSPORTATION OVERSIGHT
Thursday, February 15, 2024, 8:00 AM, Joint Hearing Room (117).
MoDOT's presentation of annual report.
Pending applications for memorial highway and bridge designations.
Pending applications for specialty license plates.

LOCAL GOVERNMENT
Tuesday, January 30, 2024, 8:00 AM, House Hearing Room 7.
Public hearing will be held: HB 1751, HB 1438

PENSIONS
Tuesday, January 30, 2024, 8:30 AM, House Hearing Room 5.
Public hearing will be held: HB 2288, HB 2431

RULES - ADMINISTRATIVE OVERSIGHT
Monday, January 29, 2024, 2:00 PM, House Hearing Room 4.
Executive session will be held: HCS HB 1511, HB 1960
Executive session may be held on any matter referred to the committee.

RULES - LEGISLATIVE OVERSIGHT
Monday, January 29, 2024, 2:15 PM, House Hearing Room 4.
Executive session will be held: HCS HB 1708, HCS HB 1720, HB 2381
Executive session may be held on any matter referred to the committee.

RULES - REGULATORY OVERSIGHT
Monday, January 29, 2024, 2:30 PM, House Hearing Room 4.
Executive session will be held: HCS HB 1886, HB 2062, HB 2380
Executive session may be held on any matter referred to the committee.

RURAL COMMUNITY DEVELOPMENT
Monday, January 29, 2024, 12:00 PM, House Hearing Room 1.
Public hearing will be held: HB 2069, HB 2170

SPECIAL COMMITTEE ON EDUCATION REFORM
Monday, January 29, 2024, 4:30 PM or upon adjournment (whichever is later),
House Hearing Room 7.
Executive session will be held: HB 1485, HB 1764, HB 1941

SPECIAL COMMITTEE ON HOMELAND SECURITY
Monday, January 29, 2024, 12:00 PM, House Hearing Room 5.
Public hearing will be held: HB 1515, HB 1413
Added HB 1413.
AMENDED

SPECIAL COMMITTEE ON POLICY REVIEW
Tuesday, January 30, 2024, 2:00 PM, House Hearing Room 4.
Discussion and review regarding the Administration and Accounts Chair's policies in the House Policy Handbook.
Room change.
CORRECTED

SPECIAL COMMITTEE ON TAX REFORM
Tuesday, January 30, 2024, 12:00 PM or upon adjournment (whichever is later),
House Hearing Room 7.
Public hearing will be held: HB 2142

SPECIAL COMMITTEE ON TOURISM
Tuesday, January 30, 2024, 4:30 PM, House Hearing Room 6.
Public hearing will be held: HB 1624, HB 2320

SPECIAL COMMITTEE ON URBAN ISSUES
Monday, January 29, 2024, 4:30 PM or upon adjournment (whichever is later),
House Hearing Room 1.
Executive session will be held: HB 1477, HB 1437

SUBCOMMITTEE ON APPROPRIATIONS - EDUCATION
Tuesday, January 30, 2024, 8:00 AM, House Hearing Room 3.
Budget presentations from Elementary and Secondary Education (HB 2002) and Higher Education and Workforce Development (HB 2003). No public testimony will be taken.

TRANSPORTATION ACCOUNTABILITY
Thursday, February 1, 2024, 8:30 AM or upon adjournment (whichever is later),
House Hearing Room 1.
Public hearing will be held: HJR 98, HJR 109, HB 2414

UTILITIES
Wednesday, January 31, 2024, 12:00 PM or upon adjournment (whichever is later),
House Hearing Room 5.
Public hearing will be held: HB 1728, HB 1746

VETERANS
Tuesday, January 30, 2024, 8:00 AM, House Hearing Room 1.
Public hearing will be held: HB 1490, HB 1496, HB 1830
Presentation by the Missouri Department of Health and Senior Services regarding marijuana information and other general information.

HOUSE CALENDAR

FIFTEENTH DAY, MONDAY, JANUARY 29, 2024

HOUSE BILLS FOR SECOND READING

HB 2543 through HB 2562

HOUSE BILLS FOR PERFECTION

HCS HB 1989 - Pollitt

ACTIONS PURSUANT TO ARTICLE IV, SECTION 27

HCS HB 1 - Smith (163)
CCS SS SCS HCS HB 2 - Smith (163)
CCS SCS HCS HB 3 - Smith (163)
CCS SCS HCS HB 4 - Smith (163)

CCS SS SCS HCS HB 5 - Smith (163)
CCS SCS HCS HB 6 - Smith (163)
CCS SCS HCS HB 7 - Smith (163)
CCS SS SCS HCS HB 8 - Smith (163)
CCS SCS HCS HB 9 - Smith (163)
CCS SCS HCS HB 10 - Smith (163)
CCS SCS HCS HB 11 - Smith (163)
CCS SS SCS HCS HB 12 - Smith (163)
CCS SCS HCS HB 13 - Smith (163)
HCS HB 17 - Smith (163)
SCS HCS HB 18 - Smith (163)
SS SCS HCS HB 19 - Smith (163)
SS SCS HCS HB 20 - Smith (163)

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