



INSTITUTE *of* PUBLIC POLICY

*Harry S Truman School of Public Affairs*  
University of Missouri

# COMMUNITY INPUT REPORT

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## ***Prepared for***

*Boone County Children's Services Board*

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## **INTRODUCTION**

Missouri State Statute 67.1775 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children's Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6.5 million dollars annually. According to Missouri Statute 210.861, the Children's Services Fund may be expensed to purchase the following services for children age 0-19 residing within Boone County:

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
2. Respite care services
3. Services to unwed mothers and unmarried parent services
4. Outpatient chemical dependency and psychiatric treatment programs
5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

In an effort to better understand children's services in Boone County and make wise use of the Children's Services Fund, the Boone County Children's Services Board (BCCSB) contracted with the Institute of Public Policy (IPP) in the Truman School of Public Affairs at the University of Missouri. The following is a list of four IPP contracted services which aim to inform, align, and operationalize BCCSB's initiatives:

- #1: Create an inventory of Boone County providers and services eligible for funding
- #2: Construct a synthesizing document which draws from multiple county and local-level reports on children's services
- #3: Organize, moderate, and analyze five Community Input Sessions and supply five feedback briefing documents
- #4: Conduct ten key informant interviews

***A note on this report's organization:*** This document is a comprehensive report of the above listed contracted services. Therefore, this report has four main sections. Under each section there is a general overview of the contracted service followed by a brief methodology. The methodology explains the steps for conducting the task at hand and explains various nuances of the information gathering process. The findings section for each contracted service is where IPP explains and synthesizes the information gathered. Finally, where, appropriate, a conclusion is provided. The conclusions contained within the contract deliverables simply tie the information together. A larger and more comprehensive conclusion is found at the end of the report.



## **Inventory of Boone County Service Providers**

**Overview:** Using the twelve categories, the following inventory outlines Boone County providers whose services align with the statute funding parameters. The inventory is organized by applying two methods. The first is based upon category and will place all providers into one or multiple categories depending on their services. The second method is based on provider and will list the statute eligible services they currently provide to Boone County residents.

**Methodology:** The Heart of Missouri United Way 211 database is a tool designed to assist community members in locating local social service agencies. This database serves as the starting point for this provider inventory. Three Boone County organizations (*Putting Kids First in Boone County Coalition, The Youth Community Coalition, and Voluntary Action Center*) shared their lists of partnering agencies. The lists were cross referenced to identify Boone County service providers who were not listed as part of the 211 database. The City of Columbia, Boone County, Heart of Missouri United Way's social service funding allocations (FY2013), and Heart of Missouri United Way certified partner agencies identified additional social service agencies not yet included in the inventory. Finally, the Missouri Department of Mental Health's Division of Comprehensive Psychiatric Services publishes an annual list of providers in Missouri's Central Region. This list was canvassed for Boone County providers not yet included in the inventory. Thorough review of service provider websites determined the agencies' service classification within the 12 categories. Phone calls were made to some provider agencies to ensure inventory accuracy. It is important to note that agency categorization is not mutually exclusive; this means many agencies are classified within multiple funding categories. Furthermore, this inventory does not serve as an exclusionary list of fundable agencies; its purpose is to establish a starting point for the Board's understanding of the breadth and depth of services within Boone County.

**Findings:** Table 1 is an inventory summary which identifies 60 Boone County agencies that have one or more services/programs which fit into the statutes' service areas. In total, these agencies provide 128 services/programs to the local community. Figure 1 depicts the distribution of services by category type and it is clear that the majority of services (37 percent) fall under Category #9: *Prevention programs which promote healthy lifestyles among children and youth and strengthen families*. This finding is expected due to the broad nature of the category.

**Table 1: INVENTORY OF BOONE COUNTY SERVICES BY CATEGORY**

	<i>By Service</i>		<i>By Agency</i>	
	<i>#</i>	<i>%</i>	<i>#</i>	<i>%</i>
Category #1: Temporary shelter	10	7.8	10	16.6
Category #2: Respite care	5	3.9	5	8.3
Category #3: Unwed mothers/parents	15	11.7	8	13.3
Category #4: Outpatient (chemical & psychiatric) treatment	6	3.9	6	10.0
Category #5: Counseling and related services for transitional living counseling	2	1.5	2	3.3
Category #6: Home-based treatment	8	5.4	8	13.3
Category #7: Community-based treatment	6	4.6	6	10.0
Category #8: Crisis intervention	11	7.8	11	18.3
Category #9: Prevention (children, youth, families)	48	37.5	42	70.0
Category #10: Counseling and therapy	10	7.8	10	16.6
Category #11: Psychological evaluations	4	3.1	4	6.6
Category #12: Mental health screenings	7	5.4	7	11.6
Total	128	100	60	100

**Figure 1: NUMBER OF CHILDREN'S SERVICES BY CATEGORY  
 BOONE COUNTY, MO**

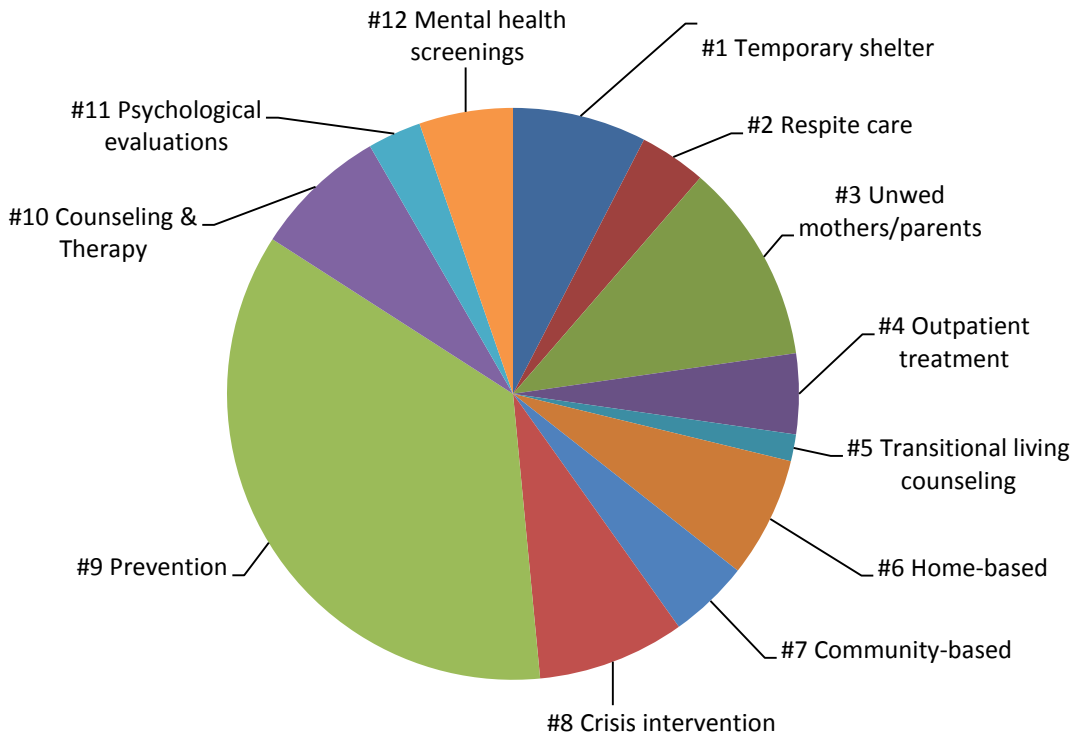






Table 2 contains the inventory of Boone County agencies and services by category classification. The agency, service, and category descriptions are provided:

**Table 2: INVENTORY OF BOONE COUNTY AGENCIES AND SERVICES BY CATEGORY CLASSIFICATION**

TABLE 2: INVENTORY OF BOONE COUNTY AGENCIES AND SERVICES BY CATEGORY CLASSIFICATION		
<i>Agency</i>	<i>Service and/or Program</i>	
<b>Category #1</b>	<b><i>Category #1: Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth</i></b>	
	13th Circuit Family Court	Temporary shelter
	Job Point	Affordable housing
	New Life Evangelistic Center	Shelter services
	Presbyterian Children’s Homes and Services	Transitional living
	Rainbow House	Emergency housing
	Salvation Army Harbor House	Emergency housing
	St. Francis House	Shelter services
	True North	Shelter services
	Voluntary Action Center	Shelter services
Z. Lois Bryant House	Shelter services	
<b>Category #2</b>	<b><i>Category #2: Respite care services</i></b>	
	American Home Care Columbia Office	Children's in-home respite care
	Coyote Hill Christian Children's Home	Children's in-home respite care
	Great Circle/Boys and Girls Town	Children's in-home respite care
	Lutheran Family and Children's Services	Children's out-of-home respite care
Rainbow House	Crisis nurseries/child care	
<b>Category #3</b>	<b><i>Category #3: Services to unwed mothers and/or unmarried parents</i></b>	
	Central Missouri Community Action	Fathers First Program
	Columbia/Boone County Public Health and Human Services	Healthy Babies Home Visiting Program
		Pregnancy counseling
	CoMo Cares	Diaper bank
	First Chance for Children	Baby bags
		Education classes
		Home visits
	Love, Inc.	Extra-mile coaching for unwed mothers
	Lutheran Family and Children's Services	Case management
		Childbirth preparation
Help accessing prenatal care		
Parenting skills		
Parents as Teachers program (All Boone County School Districts)	Supportive counseling	
	Training	
Rainbow House	Parenting classes	

Continued →



TABLE 2: INVENTORY OF BOONE COUNTY AGENCIES AND SERVICES BY CATEGORY CLASSIFICATION		
<i>Agency</i>	<i>Service and/or Program</i>	
<b>Category #4</b>	<b><i>Category #4: Outpatient chemical dependency programs and outpatient psychiatric treatment programs</i></b>	
	Burrell Behavioral Health	Outpatient care for chemical dependency
	Family Counseling Center of Missouri, Inc.	Outpatient care for chemical dependency
	McCambridge Center	Outpatient care for chemical dependency
	New Life Evangelistic Center	Outpatient care for chemical dependency
Phoenix Programs, Inc.	Outpatient care for chemical dependency	
<b>Category #5</b>	<b><i>Category #5: Counseling and related services as part of transitional living programs</i></b>	
	Rainbow House	Counseling for transitional living
	Salvation Army Harbor House	Caseworkers for transitional living
<b>Category #6</b>	<b><i>Category #6: Home-based family intervention programs</i></b>	
	13th Circuit Family Court	Home-based intervention
	Burrell Behavioral Health	In-home visits as part of outpatient Comprehensive Psychiatric Rehabilitation
	Presbyterian Children’s Homes and Services	In-home family therapy, therapeutic mentoring, transitional living
	Columbia/Boone County Public Health and Human Services	Home visiting program as part of Healthy Babies program
	Family Counseling Center of Missouri, Inc.	In-home visits as part of outpatient Comprehensive Psychiatric Rehabilitation
	First Chance for Children	Home visits
Love, Inc.	Home-based family interventions with MSW	
<b>Category #7</b>	<b><i>Category #7: Community-based family intervention programs</i></b>	
	Big Brothers Big Sisters of Central Missouri	Counseling
	Columbia/Boone County Public Health and Human Services	Counseling, Healthy Babies Program
	Family Health Center	Counseling
	Great Circle/Boys and Girls Town	Counseling
	Lutheran Family and Children's Services	Counseling, School-based
Rainbow House	Counseling	

Continued →



TABLE 2: INVENTORY OF BOONE COUNTY AGENCIES AND SERVICES BY CATEGORY CLASSIFICATION		
<i>Agency</i>	<i>Service and/or Program</i>	
<b>Category #8</b>	<b><i>Category #8: Crisis intervention services (inclusive of telephone services)</i></b>	
	13th Circuit Family Court	Crisis intervention
	Burrell Behavioral Health	Crisis intervention
	Family Counseling Center of Missouri, Inc.	Crisis intervention
	Great Circle/Boys and Girls Town	Crisis intervention
	Heart of Missouri CASA	Crisis intervention
	New Life Evangelistic Center	Crisis intervention
	Phoenix Programs, Inc.	Crisis addiction intervention
	Rainbow House	Crisis intervention
	Salvation Army Harbor House	Crisis intervention
True North	Crisis intervention	
<b>Category #9</b>	<b><i>Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families</i></b>	
	ACT Missouri	Prevention, drug use prevention programming
	Adventure Club	Prevention, mentoring, healthy development
	Big Brothers Big Sisters of Central Missouri	Prevention, mentoring, healthy development
	Boy Scouts of America	Prevention, youth programming
	Boys & Girls Club of Columbia	Prevention (gang prevention, Be Great-Graduate)
	Central Missouri Community Action	Prevention, family support programming for low-income
		Prevention, Fathers First programming
		Prevention, Head Start
	Centralia R-VI School District	Prevention, Parents as Teachers program
	Centro Latino de Salud	Prevention, family empowerment programming
	Child Care Aware of Missouri	Prevention, childcare/early childhood education
	Children's House Montessori	Prevention, early childhood education
	Columbia Center for Urban Agriculture	Prevention, healthy lifestyle promotion
	Columbia Housing Authority	Prevention, family self-sufficiency programming
		Prevention, Money Smart Program
		Prevention, Moving Ahead Youth Program
		Prevention, Teen Outreach Program
	Columbia Community Montessori	Prevention, early childhood education
	Columbia School District	Prevention, Parents as Teachers program
First Chance for Children	Prevention, parent education classes	
Food Bank of Central and Northeast MO	Prevention, nutrition	
For His Glory, Inc.	Prevention, Boys 2 Godly Men Mentoring program	

Continued →



TABLE 2: INVENTORY OF BOONE COUNTY AGENCIES AND SERVICES BY CATEGORY CLASSIFICATION		
	<i>Agency</i>	<i>Service and/or Program</i>
<b>Category #9 (continued)</b>	Fun City Youth Academy of Columbia	Prevention, parent empowerment/training, youth programming
	Girl Scouts of America	Prevention, youth programming
	Granny's House	Prevention, programming for at risk-youth
	Hallsville R-IV School District	Prevention, Parents as Teachers program
	Harrisburg Early Learning Center	Prevention, early childhood education
	Harrisburg R-VIII School District	Prevention, Parents as Teachers program
	Heart of Missouri Girls on the Run	Prevention, youth programming
	Job Point	Prevention, youth programming
	Nora Stewart Early Learning Center	Prevention, early childhood education
	Love, Inc.	Prevention, life-skills and living large program
	Lutheran Family and Children's Services	Prevention, parenting skills
	MADD of Mid-Missouri	Prevention, underage drinking
	Mary Lee Johnston Community Learning Center	Prevention, early childhood education
	Missouri Highsteppers	Prevention, youth programming
	One Hope United	Prevention, early childhood education
	Project LAUNCH	Prevention, substance abuse, parenting skills
	Rainbow House	Prevention, child abuse
		Prevention, internet safety
	Southern Boone County R-I School District	Prevention, Parents as Teachers program
	Sturgeon R-V School District	Prevention, Parents as Teachers program
	UCP Heartland Child Development Center	Prevention, childcare & early childhood education
	United Community Builders	Prevention, mentoring, youth programming
	University YMCA	Prevention, youth programming
	Voluntary Action Center	Prevention, family assistance for low-income
Youth Community Coalition	Prevention, Healthy Start Program	
Youth Empowerment Zone	Prevention, youth employment counseling	
<b>Category #10</b>	<b><i>Category #10: Professional counseling and therapy services for individuals, groups, or families</i></b>	
	Burrell Behavioral Health	Counseling/Therapy
	Family Counseling Center of Missouri, Inc.	Counseling
	Family Health Center	Counseling
	Great Circle/Boys and Girls Town	Counseling
	Lutheran Family and Children's Services	Counseling
	New Life Evangelistic Center	Counseling
	One Hope United	Counseling
	Phoenix Programs, Inc.	Counseling
Rainbow House	Counseling	

Continued →



TABLE 2: INVENTORY OF BOONE COUNTY AGENCIES AND SERVICES BY CATEGORY CLASSIFICATION	
<i>Agency</i>	<i>Service and/or Program</i>
<b>Category #11</b>	<b>Category #11: Psychological evaluations</b>
	Burrell Behavioral Health   Psychological evaluations
	Family Counseling Center   Psychological evaluations
	Family Health Center   Psychological evaluations
<b>Category #12</b>	<b>Category #12: Mental health screenings</b>
	Burrell Behavioral Health   Mental health screenings
	Family Counseling Center of Missouri, Inc.   Mental health screenings
	Family Health Center   Mental health screenings
	Lutheran Family and Children's Services   Mental health screenings
	Project LAUNCH   Mental health consultation
	Rainbow House   Mental health screenings

Table 3 contains the same information as Table 2, but is organized by agency. It also contains the service and category descriptions:

**Table 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY**

TABLE 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY	
<i>Service and/or Program</i>	<i>Category</i>
<b>13<sup>th</sup> Circuit Family Court</b>	<b>13<sup>th</sup> Circuit Family Court</b>
	Temporary shelter   Category #1: Temporary housing
	Home-based intervention   Category #6: Home-based intervention
	Crisis intervention   Category #8: Crisis intervention
<b>ACT Missouri</b>	<b>ACT Missouri</b>
	Drug prevention programming   Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b>Adventure Club</b>	<b>Adventure Club</b>
	Mentoring   Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
	Healthy development   Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b>American Home Care</b>	<b>American Home Care</b>
	Children's in-home respite care   Category #2: Respite Care

Continued →



TABLE 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY		
	<i>Service and/or Program</i>	<i>Category</i>
<b><i>Big Brothers Big Sisters of Central Missouri</i></b>	<b><i>Big Brothers Big Sisters</i></b>	
	Counseling	Category #7: Community-based family interventions
	Mentoring	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
Healthy development		
<b><i>Boys and Girls Clubs of Columbia</i></b>	<b><i>Boys and Girls Club</i></b>	
	Gang prevention	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
Be Great: Graduate		
<b><i>Boy Scouts of America</i></b>	<b><i>Boy Scouts of America</i></b>	
	Youth Programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b><i>Burrell Behavioral Health</i></b>	<b><i>Burrell Behavioral Health</i></b>	
	Counseling/Therapy	Category #10: Professional counseling and therapy services for individuals, groups, or families
	Crisis intervention	Category #8: Crisis intervention services
	Home visits as part of Comprehensive Psychiatric Rehabilitation	Category #6: Home-based family interventions
	Mental health screenings	Category #12: Mental health screenings
	Outpatient care for chemical dependency	Category #4: Outpatient chemical dependency programs and outpatient psychiatric treatment programs
	Psychological evaluations	Category #11: Psychological evaluations
<b><i>Central Missouri Community Action</i></b>	<b><i>Central Missouri Community Action</i></b>	
	Fathers First programming	Category #3: Services to unwed mothers and/or unmarried parents
	Family support programming for low-income families	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
	Head Start	
<b><i>Centralia R-VI School District</i></b>	<b><i>Centralia R-VI School District</i></b>	
	Parents as Teachers program	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b><i>Centro Latino de Salud</i></b>	<b><i>Centro Latino</i></b>	
	Family empowerment	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b><i>Child Care Aware of Missouri</i></b>	<b><i>Child Care Aware of Missouri</i></b>	
	Childcare/early childhood education	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families

Continued →



TABLE 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY		
	<i>Service and/or Program</i>	<i>Category</i>
<b>Columbia Center for Urban Agriculture</b>	<b>Columbia Center for Urban Agriculture</b>	
	Nutrition education programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b>Columbia Community Montessori</b>	<b>Columbia Community Montessori</b>	
	Early childhood education	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b>Children’s House Montessori</b>	<b>Children’s House Montessori</b>	
	Early childhood education	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b>Columbia Housing Authority</b>	<b>Columbia Housing Authority</b>	
	Family self-sufficiency program	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
	Moving Ahead Youth Program	
	Money Smart program	
Teen Outreach Program		
<b>Columbia/Boone County Public Health and Human Services</b>	<b>Columbia Public Health and Department of Human Services</b>	
	Pregnancy counseling	Category #3: Services to unwed mothers and/or unmarried parents
	Healthy Babies Home Visiting Program	Category #3: Services to unwed mothers and/or unmarried parents
		Category #6: Home-based family interventions
	Category #7: Community-based family intervention programs	
<b>Columbia School District</b>	<b>Columbia School District</b>	
	Parents as Teachers program	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b>CoMo Cares</b>	<b>CoMo Cares</b>	
	Diaper bank	Category #3: Services to unwed mothers and/or unmarried parents
<b>Coyote Hill Christian Children’s Home</b>	<b>Coyote Hill Christian Children’s Home</b>	
	Children’s in-home respite care	Category #2: Respite care

Continued →





TABLE 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY		
	<i>Service and/or Program</i>	<i>Category</i>
<i>Family Counseling Center of Missouri, Inc.</i>	<b><i>Family Counseling Center</i></b>	
	Counseling/Therapy	Category #10: Professional counseling and therapy services for individuals, groups, or families
	Crisis intervention	Category #8: Crisis intervention services
	Home visits as part of Comprehensive Psychiatric Rehabilitation	Category #6: Home-based family interventions
	Mental health screenings	Category #12: Mental health screenings
	Outpatient care for chemical dependency	Category #4: Outpatient chemical dependency programs and outpatient psychiatric treatment programs
	Psychological evaluations	Category #11: Psychological evaluations
<i>Family Health Center</i>	<b><i>Family Health Center</i></b>	
	Counseling	Category #7: Community-based family intervention programs
	Family Counseling	Category #10: Professional counseling and therapy services for individuals, groups, or families
	Psychological evaluations	Category #11: Psychological evaluations
	Mental health screenings	Category #12: Mental health screenings
<i>First Chance for Children</i>	<b><i>First Chance for Children</i></b>	
	Baby bags	Category #3: Services to unwed mothers and/or unmarried parents
	Home visits	Category #6: Home-based family interventions
		Category #3: Services to unwed mothers and/or unmarried parents
	Education classes	Category #3: Services to unwed mothers and/or unmarried parents
		Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>For His Glory, Inc.</i>	<b><i>For His Glory, Inc.</i></b>	
	Boys 2 Godly Men Mentoring program	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Food Bank of Central and Northeast MO</i>	<b><i>Food Bank of Central and Northeast MO</i></b>	
	Nutrition	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Fun City Youth Academy of Columbia</i>	<b><i>Fun City Youth Academy of Columbia</i></b>	
	Parent empowerment training, youth programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families

Continued →





TABLE 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY		
	<i>Service and/or Program</i>	<i>Category</i>
<i>Girl Scouts of America</i>	<b><i>Girl Scouts of America</i></b>	
	Youth Programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Granny's House</i>	<b><i>Granny's House</i></b>	
	Early childhood education, youth programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Great Circle / Boys and Girls Town</i>	<b><i>Great Circle/Boys and Girls Town</i></b>	
	Children's in-home respite care	Category #2: Respite care
	Counseling	Category #7: Community-based family intervention programs
		Category #10: Professional counseling and therapy services for individuals, groups, or families
Crisis intervention	Category #8: Crisis intervention	
<i>Hallsville R-IV School District</i>	<b><i>Hallsville R-VIII School District</i></b>	
	Parents as Teachers program	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Harrisburg Early Learning Center</i>	<b><i>Harrisburg Early Learning Center</i></b>	
	Early childhood education	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Harrisburg R-VIII School District</i>	<b><i>Harrisburg R-VIII School District</i></b>	
	Parents as Teachers program	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Heart of Missouri CASA</i>	<b><i>Heart of Missouri CASA</i></b>	
	Crisis Intervention	Category #8: Crisis Interventions
<i>Heart of Missouri Girls on the Run</i>	<b><i>Heart of Missouri Girls on the Run</i></b>	
	Youth Programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Job Point</i>	<b><i>Job Point</i></b>	
	Affordable Housing	Category #1: Temporary housing
	Youth Services	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families

Continued →



TABLE 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY		
	<i>Service and/or Program</i>	<i>Category</i>
<i>Love, Inc.</i>	<b><i>Love, Inc.</i></b>	
	Extra-mile coaching for unwed mothers	Category #3: Services to unwed mothers and/or unmarried parents
	Home-based family interventions with MSW	Category #6: Home-based family interventions
	Prevention, life-skills and living large program	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Lutheran Family and Children's Services</i>	<b><i>Lutheran Family and Children's Services</i></b>	
	Children's out of home respite care	Category #2: Respite care services
	Pregnancy support counseling	Category #3: Services to unwed mothers and/or unmarried parents
	Case management	
	Childbirth preparation	
	Help accessing prenatal care	
	Counseling	Category #7: Community-based family intervention programs
		Category #10: Professional counseling and therapy services for individuals, groups, or families
	Parenting skills	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
		Category #3: Services to unwed mothers and/or unmarried parents
Mental health screenings	Category #12: Mental health screenings	
<i>McCambridge Center</i>	<b><i>McCambridge Center</i></b>	
	Counseling	Category #4: Outpatient chemical dependency programs and outpatient psychiatric treatment programs
<i>MADD of Mid-Missouri</i>	<b><i>MADD of Mid-Missouri</i></b>	
	Underage drinking prevention	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Mary Lee Johnston Community Learning Center</i>	<b><i>Mary Lee Johnston Learning Center</i></b>	
	Early childhood education	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Missouri Highsteppers</i>	<b><i>Missouri Highsteppers</i></b>	
	Youth Programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families

Continued →



TABLE 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY		
	<i>Service and/or Program</i>	<i>Category</i>
<i>New Life Evangelistic Center</i>	<b><i>New Life Evangelistic Center</i></b>	
	Emergency/Temporary housing	Category #1: Temporary housing
	Outpatient care for chemical dependency	Category #4: Outpatient chemical dependency programs and outpatient psychiatric treatment programs
	Addiction crisis intervention	Category #8: Crisis intervention services
	Counseling/Therapy	Category #10: Professional counseling and therapy services for individuals, groups, or families
<i>Nora Stewart Early Learning Center</i>	<b><i>Nora Stewart Nursery</i></b>	
	Early childhood education	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>One Hope United</i>	<b><i>One Hope United</i></b>	
	Early childhood education	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
	In-home counseling	Category #10: Professional counseling and therapy services for individuals, groups, or families
<i>Phoenix Programs, Inc.</i>	<b><i>Phoenix Programs</i></b>	
	Outpatient care for chemical dependency	Category #4: Outpatient chemical dependency programs and outpatient psychiatric treatment programs
	Crisis intervention	Category #8: Crisis intervention services
	Counseling/Therapy	Category #10: Professional counseling and therapy services for individuals, groups, or families
<i>Presbyterian Children's Home and Services Network</i>	<b><i>Presbyterian Children's Home and Services Network</i></b>	
	In-home therapy	Category #6: Home-based family interventions
	Therapeutic mentoring	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
	Transitional Living	Category #1: Transitional Living
<i>Project LAUNCH</i>	<b><i>Project LAUNCH</i></b>	
	Substance abuse prevention	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
	Parenting skills	
	Mental health consultation	Category #12: Mental health screenings

Continued →



TABLE 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY		
	<i>Service and/or Program</i>	<i>Category</i>
<b>Rainbow House</b>	<b>Rainbow House</b>	
	Emergency housing Crisis nurseries/child care	Category #1: Temporary housing Category #2: Respite care services
	Parenting classes	Category #3: Services to unwed mothers and/or unmarried parents
	Counseling for transitional living	Category #5: Counseling and related services as part of transitional living programs
	Counseling	Category #7: Community-based family intervention programs
		Category #10: Professional counseling and therapy services for individuals, groups, or families
	Crisis intervention	Category #8: Crisis intervention services
	Child abuse prevention programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
	Internet safety programming	
	Mental health screenings	Category #12: Mental health screenings
<b>Salvation Army Harbor House</b>	<b>Salvation Army Harbor House</b>	
	Emergency housing	Category #1: Temporary housing
	Counseling for transitional living	Category #5: Counseling and related services as part of transitional living programs
	Crisis intervention	Category #8: Crisis intervention services
<b>Southern Boone County R-I School District</b>	<b>Southern Boone County R-I School District</b>	
	Parents as Teachers program	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b>St. Francis House</b>	<b>St. Francis House</b>	
	Shelter services	Category #1: Temporary housing
<b>Sturgeon R-V School District</b>	<b>Sturgeon R-V School District</b>	
	Parents as Teachers program	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b>True North</b>	<b>True North</b>	
	Shelter services	Category #1: Temporary housing
	Crisis intervention	Category #8: Crisis intervention services
<b>UCP Heartland Child Development Center</b>	<b>UCP Heartland Child Development Center</b>	
	Childcare and early childhood education	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<b>United Community Builders</b>	<b>United Community Builders</b>	
	Mentoring, youth programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families

Continued →



TABLE 3: INVENTORY OF SERVICES AND CATEGORY CLASSIFICATIONS BY BOONE COUNTY AGENCY		
	<i>Service and/or Program</i>	<i>Category</i>
<i>University YMCA</i>	<b><i>University YMCA</i></b>	
	Youth programming	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Voluntary Action Center</i>	<b><i>Voluntary Action Center</i></b>	
	Shelter services	Category #1: Temporary housing
	Assistance for low-income families	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Youth Community Coalition</i>	<b><i>Youth Community Coalition</i></b>	
	Healthy Start Initiative	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Youth Empowerment Zone</i>	<b><i>Youth Empowerment Zone</i></b>	
	Youth employment counseling	Category #9: Prevention programs which promote healthy lifestyles among children and youth and strengthen families
<i>Z. Lois Bryant House</i>	<b><i>Z. Lois Bryan House</i></b>	
	Shelter services	Category #1: Temporary housing

End



## Synthesis of Existing Boone County Reports

**Overview:** Previous efforts have been made to assess and analyze the need for services in Boone County. In an attempt to capitalize on this previously collected information, BCCSB requested that IPP conduct a synthesis of five publicly available Boone County reports published since 2011. The Board selected reports commissioned by the Heart of Missouri United Way, the Putting Kids First Coalition, the City of Columbia, Boone County, and the Columbia Public School District. Together, the reports offer a county-level understanding of the community at-large and its children, youth, and families.

**Method:** The five reports selected by the Board examine the current state of social service need in the community, attempt to measure gaps, gauge community perspective, and point toward findings that may guide new resource allocations. Despite differences in report-level methodology, audience, and purpose, IPP has attempted to synthesize the reports by creating two types of tables to supply the reader with important details of each report. The first series of tables are housed in the body of this synthesis and serve as a quick reference of each report’s purpose, methods, and findings. A second, more detailed group of tables are found in the appendix. There, table details include: the report’s author, funder, purpose, methodology, findings, and an itemized list of the data points, which serves as a quick reference guide to determine where specific data of interest are housed.

Finally, while the majority of the reports included in this synthesis focus on children, youth, and families, the Missouri Statutes allow the Children Services Fund to expend funds for programs serving Boone County residents up to the age of 20 years and their families. Therefore some of the data and reports also include references to adults.

### **Findings**

**TABLE 4: HEART OF MISSOURI UNITED WAY COMMUNITY NEED ASSESSMENT (2011)**

Purpose	Method
Evaluate perceptions of need in Mid-Missouri	1) 24 community leader interviews 2) 300 residential phone surveys (random digit dial) in Audrain, Boone, Callaway, Cole, Cooper, Howard, Moniteau and Randolph counties
Findings	
<ul style="list-style-type: none"> <li>• Weak economy</li> <li>• High unemployment</li> <li>• Address poverty by way of education</li> </ul>	

In April 2011, the Heart of Missouri United Way partnered with Pure, LLC, a Columbia, Missouri based marketing and communications firm, to evaluate the perceptions of need in mid-Missouri. In total, 24 community leaders were interviewed in person and 300 residents were



surveyed via random digit dial phone calls. They provided feedback on the strengths and weaknesses of social service providers in mid-Missouri, as well as the type of services that are under-resourced in the region. The most pressing issues of concern reported by all respondents (both community leaders and residents) are the weak economy and high unemployment rate, both of which are feared to be challenges for at least a few decades. Residents also perceived that growing needs of senior citizens, the need for a trained and skilled workforce, and the need to address poverty through education would form the core of social need in the future. These concerns are also shared by community leaders, who said it’s crucial to address the root causes of poverty (access to education, and development of job and life skills) as opposed to only the symptoms (hunger, lack of housing, etc.). A detailed table of the data used in the Heart of Missouri United Way Community Need Assessment can be found in Appendix A, Table A.

**TABLE 5: SCHOOL-BASED MENTAL HEALTH REPORT (2013)**

Purpose	Method
Describe the work of the CPS’s School Based Mental Health Committee and to analyze current practices and processes within the school district related to school mental health.	1) Examine current mental health services in CPS 2) Research best practices in schools 3) Compare with results of five surveys (parents, teachers, counselors, etc.)
Findings	
<ul style="list-style-type: none"> <li>• Lack of shared understanding and knowledge of appropriate emotional development and mental health for children/ teens</li> <li>• Lack of communication between parents and teachers</li> <li>• Need for universal promotion of skills building and mental health awareness</li> <li>• Need for targeted prevention by way of services to students who are at risk</li> <li>• Intense, individualized support for students</li> </ul>	

In June 2013, the Columbia Public Schools (CPS) released a report entitled, “Report of the School-Based Mental Health Committee”. The Committee evaluated the then-current mental health services available in CPS, researched best practices in school-based mental health services, and compared the results from five surveys sources which included: *Columbia Public Schools Elementary and Secondary Guidance Needs Assessment, Missouri School Improvement Program Advance Questionnaire, ACT Engage, Columbia Public Schools School-Based Mental Health Committee Surveys, Survey of Student Strengths and Differences* and *Survey of School Mental Health Systems*.

Through the analysis of the Columbia Public School-Based Mental Health Committee Surveys, it was discovered that there was a high level of disagreement between the perceptions of parents and faculty, and between grade school and secondary school teachers, in regards to the mental health wellness of the students in the CPS system. The committee cited a lack of a shared understanding and knowledge of appropriate emotional development and mental health, as well as a lack of communication between teachers and parents as the reasons behind their diverging perceptions. As a result, the Committee encouraged the use of a Multi-tiered System of Support,





with tier one providing universal promotion of skill building and mental wellness for all students, tier two providing targeted prevention through the provision of services to students who are at risk for additional academic difficulties, and tier three providing intense, individualized support for students.

The Committee acknowledges that mental illness and unusual emotional development can create barriers to learning and leading a successful, positive life. In order to best support their student body, schools must educate their students, faculty and parents on the appropriate emotional development for youth, the best ways to cope with life stress in a positive way, and the importance of early detection and treatment of mental illness. Overall, the Committee argues for the development of a comprehensive mental wellness program that incorporates different community partners. They caution that steps must be taken to assess the needs of the individual student, services must be provided strategically, and an inventory of resources available through different providers must be compiled in order to avoid service redundancy. Without these steps, there is the risk for: overlap in services, the needs of the individuals may not be met, and some individuals may fall through the cracks. A detailed matrix of the data used in the School-Based Mental Health Report can be found in Appendix A, Table B.

**TABLE 6: PUTTING KIDS FIRST IN BOONE COUNTY: CHILDREN’S MENTAL HEALTH SERVICES ASSESSMENT (2011)**

Purpose	Method
Children’s mental health assessment	1) Boone County provider survey 2) Secondary data analysis
<b>Findings</b>	
<ul style="list-style-type: none"> <li>• Need for more transitional housing</li> <li>• Need for mental health services</li> <li>• Need for substance abuse treatment for teens</li> </ul>	

The Putting Kids First Coalition contracted with the Institute of Public Policy (IPP) to research the accessibility and shortfalls of social services in Boone County. In the August 2011 report titled, “Putting Kids First in Boone County: Children’s Mental Health Services Assessment”, IPP worked with a steering committee to identify and recruit 48 representatives from 38 local agencies. Each representative received an online survey where he or she answered questions regarding the scope of need and availability of social services in Boone County. The survey revealed the following findings from 2010:

- 64 youth turned away from full shelters
- 65 older youth turned away from transitional living services
- 20 children turned away from respite care services
- 2,138 parents and children turned away from services for unwed teen parents
- 1,189 adolescents were suspected as turned away from substance abuse treatment services





- 245 children and youth were unable to receive school-based prevention services at the time of request
- 357 children and families were unable to receive counseling services at the time of request

In addition to provider surveys, this report included a significant amount of data from publicly available sources. This list of data can be found in a detailed matrix of the data used in the Putting Kids First report in Appendix A, Table C. Here are a few highlighted findings from the report:

- The greatest need for social service growth was in transitional housing, mental health services, and substance abuse treatment for teens.
- In 2010 alone, two transitional housing providers (Rainbow House and Boys and Girls Town) provided shelter to 43 youth and at the same time turned away 65 youth due to a lack of capacity.
- When comparing the 2008 Missouri Student survey and 2007 National Survey on Drug Use and Health, Boone County teens were found to be two times more likely to use alcohol and marijuana, while one and a half times more likely to use cigarettes in the past 30 days than the national average.

The report revealed that Boone County has many social service organizations which provide similar services. They often work together through a referral process to ensure a safety net for residents. However, with greater state and federal budget cuts, community organizations are forced to solicit private sector organizations and individuals for donations in order to maintain operations. Unpredictable funding sources may result in inconsistent social services.

**TABLE 7: BOONE COUNTY ISSUES ANALYSIS OF CHILDREN, YOUTH, AND FAMILIES (2011)**

Purpose	Method
Boone County Issues Analysis- help direct funding decisions	Examination of secondary data at the local level
Findings	
<ul style="list-style-type: none"> <li>• Significant increases in number of children in poverty between 2000 and 2008</li> <li>• Only one organization provides local support to homeless teens</li> <li>• African-Americans and other minorities in Boone County were shown to be at an overall disadvantage when compared to Caucasians</li> </ul>	

The City of Columbia/Boone County Department of Public Health and Human Services contracted with IPP to take a detailed look at the challenges faced by children, youth and families in Boone County. As a result, the report “Boone County Issues Analysis: Children, Youth and Families”, published in October 2012, compares community-level data on teen pregnancy, academic achievement, mental health, child welfare and safety, child and youth homelessness and school readiness rates. Through data analysis, the report identifies disparities



in at-risk populations. African-Americans and other minorities were shown to be at an overall disadvantage when compared to Caucasians in the same region. According to the Missouri Information for Community Assessment data from 2005-2011, Boone County’s teen pregnancy rate among 15-19 year old Caucasians is lower than the state rate. However, the rate of teen pregnancies for that same age range amongst African-Americans is higher in Boone County than the state of Missouri.

Additionally, the low birth weight amongst African-Americans in Boone County is higher than the national rate. When looking at the number of children living in poverty, the state of Missouri and Boone County saw an increase from 2000 to 2008, though Boone County has a lower percentage than the state as a whole. Even though there has been an increase in the number of reported homeless youth and number of children receiving free and reduced lunch, there is only one organization providing support to homeless teens in Boone County. When youth are left to fend for resources on their own, they may engage in illegal activities. Data from the Missouri State Highway Patrol Uniform Crime Reporting Program showed that juvenile arrests for violent crimes, property, and Part II crimes (which include simple assaults, vandalism, and drug abuse violations) in Boone County constituted a larger percentage of total arrests compared to the state of Missouri. Overall, Columbia had the highest percentage of juvenile arrests in Boone County. Please see Appendix A, Table D for detailed information on the data used in this report.

**TABLE 8: BOONE ISSUES ANALYSIS OF MENTAL HEALTH (2012)**

Purpose	Method
Boone County Issues Analysis- help direct funding decisions	Examination of secondary data
Findings	
<ul style="list-style-type: none"> <li>• Co-occurring psychological disorders are very common</li> <li>• Boone County has a higher rate of suicides than Missouri</li> <li>• Primary reasons for lack of treatment (12+ years old) is no health coverage and no means to afford treatment (National Data)</li> </ul>	

The City of Columbia/Boone County Department of Public Health and Human Services contracted with IPP to examine the status of mental health in Boone County. Their October 2012 report titled, “*Boone County Issue Analysis on Mental Health*”, examines secondary data sources to understand the community-level prevalence of mental health diagnoses, the prevalence of substance abuse, and access to treatment. The report and its findings are targeted at adult mental health, which is classified as those 18 years of age and older.

This report highlights the persistence of co-occurring psychological disorders and substance abuse disorders. These two conditions often occur at the same time and are not easily separated. The primary findings from the report show Boone County’s alcohol-related arrests and convictions are rising faster than drug-related arrests and convictions and that half of all Boone County admissions to treatment cite alcohol as the primary substance of abuse. Historically,



Boone County has had a higher rate of suicides than the state of Missouri and between 2008 and 2009, the number of suicides in Boone County increased to 133.

Access to treatment is a unique indicator examined in this report. IPP used the National Survey on Drug Use and Health (NSDUH) to examine specific reasons why a person in need of mental health treatment does not receive treatment. IPP found that among persons 12 years of age and older, the lack of health coverage and means to afford treatment are primary reasons substance abuse treatment is not received. Please reference to Appendix A, Table E for detailed information on the data used in this report.

**Conclusion:** The five reports included in this synthesis demonstrate the complex challenges facing Boone County children, youth, and families. Local social services agencies are continually challenged to stretch funding dollars further and, alongside the clients they serve, are at times faced with the reality of service shortfalls and gaps in services areas. This synthesis describes each report's purpose, method, finding, and data used to reach conclusions. Above all, this synthesis captures Boone County's diverse approaches to communicating the needs of children, youth, and families. Further examination of (1) community need, (2) community-level trends, and (3) agency impact are needed. Together, these three components describe the current state of social services in the community and may help support funding priorities.



## Community Input Sessions

**Overview:** The BCCSB hosted a series of Community Input Session between February 27, 2014 and April 24, 2014. While the input sessions were open to the public, a number of representatives from a variety of Boone County social services agencies were invited to participate in the meeting. The input session topic areas, listed below, grouped related funding categories from the original statutes.

- *Shelter & At-risk Populations*
- *Community-Based Program & Family Intervention Services*
- *Clinical & Mental Health Services*
- *Primary Prevention*
- *Open Forum*

The purpose of the sessions was to gather information from providers on a variety of topics including their perception of need, their description of obstacles, and their hopes for collaborative opportunities.

**Methodology:** Boone County agencies were invited to attend BCCSB meetings when the topic of discussion related to the service they provided. When an agency confirmed their desire to participate in the meeting they were provided with a worksheet containing five pre-established questions, which were developed by the Board, and given two directives. First, agency representatives were encouraged to submit their written responses to the questions in advance of the meeting by using the provided worksheet. Second, agency representatives were instructed to use their meeting participation time to answer the pre-established questions. Each participant was given five minutes to present their answers to the board.

The Board's pre-established questions for this input session were:

Question #1: *What are the top two issues you feel need to be addressed in your service area?*

Question #2: *Are there systemic obstacles to your success when working with your target population?*

Question #3: *Where is the gap in your services?*

Question #4: *What is a quantitative measure of success in your service area?*

Question #5: *Please describe potential collaborations you envision for addressing challenges in your service area.*



Written responses and notes gathered during input sessions were then analyzed for common themes and topics. In the analysis, responses were organized by the input session topic and then by question (responses were de-identified at this point as well). This allowed the aggregated responses to point toward common themes and topics rather than agency-level information and opinions.

All material pertaining to each input session is housed in Appendices B-F. Materials include lists of invited participants, invitation letters, a blank copy of each session's worksheet, meeting agendas, and copies of all completed agency worksheets. Most importantly, the appendices contain the finalized feedback reports. These reports were submitted to BCCSB within two weeks of the session's completion. The purpose of the feedback briefing documents was to inform BCCSB's knowledge as they moved toward crafting their request for proposal documents. All supporting community input session documents are organized by session number and name.

**Findings:** The following are highlights from each of the five community input sessions. Common themes are described for each. Following the discussion of all five sessions, a final conclusion is provided that pulls together all themes and concepts which will be most helpful for BCCSB.

### **Session #1 – Shelter & At-Risk Populations**

BCCSB's process of hearing input from agencies that provide temporary shelter services and services to unwed teens/unmarried parents proved to be useful in identifying common themes. Simply stated, transportation for rural and non-rural clients is a topic of great importance. Struggles with employment and job readiness circle back to the ever-present demand for basic needs, and access to mental health services/screenings were commonly mentioned items that apply to both temporary shelter populations and unwed teens/unmarried parents. Finally, agencies expressed the need for more shelter options for teens both within and outside of Columbia. Based on responses from participants, the lack of shelter options appeared to be more problematic in rural areas of the county.

### **Session #2 – Community-Based Programs & Family Intervention Services**

Community-based programs and home-based interventions facilitate service providers to meet families outside of clinical settings and to link them to services. The range of services can identify needs, offer primary prevention, and, if needed, make the connection to mental health or medical professionals. Furthermore, community-based and home-based approaches can ease the client's burden of transportation.

While Boone County providers see the value in meeting clients in the community, many are faced with a volume of demand that they are incapable of meeting. At times, service gaps can be mended with agency-level coordination, collaboration, and referrals; but, more often than not,



the shortage of service professionals in the field sustains the scarcity of community-based and family-based services. Nevertheless, there is a continued need for further education, training, and knowledge transfer from providers to parents/caregivers during the process of community and home-based services. The common thread throughout was the issue of access as it relates to shortages in services, bottlenecks in care, and a lack of agency capacity to meet the demand.

### **Session #3 – Clinical & Mental Health Services**

The most apparent concern during this session continued to be that of access. Agencies are to the point of frustration and desperation as they observe long delays and the persistent gap in services due to shortages in services, bottlenecks in care, and limited agency capacity. These sorts of access issues are evident not only for Columbia residents but may be magnified for families in rural parts of Boone County. The need for professional development among providers, the use of trauma informed care, and expanded substance abuse education were also acknowledged as deficiencies in the community.

According to feedback received during the session, the access challenge can begin to be addressed through the communicated desire for increased prevention methods, partnering with schools, and debunking the stigma associated with mental health issues. Together, these approaches may encourage a culture of prevention and help in identifying hidden mental health diagnoses in need of clinical interventions. However, structure/systems dilemmas such as insurance barriers, complex billing, and state-level issues fall squarely outside of direct agency control and may require broader efforts to resolve.

One such systemic obstacle is the eligibility requirements for clients to receive case management services. This was a service mentioned several times as being vital to a client's success. Another theme that emerged around community wide systems was that of school-based interventions. It appears that clinical/mental health providers feel a coordinated system with schools is needed to accurately screen and efficiently serve Boone County children and families. A third systemic issue identified was the gap in services for families and children who fall outside of the economic range for state-established care. In these BCCSB input sessions, this population has often been referred to as the working poor, or the underinsured. Economically challenged populations such as these also likely have transportation problems, a topic mentioned multiple times throughout the input sessions.

### **Session #4 – Primary Prevention**

Top emerging themes from the primary prevention session include: educating and training parents, thorough preparation of teachers, and shared collaboration in data, referrals, and agency coordination. The concept of community initiatives emerged and pointed toward the desire for community-level approaches to prevention. Providers with these sentiments expressed that a community approach to prevention cannot be conducted in "*name only*," but rather a community



approach must be supported by agreed upon goals which are specific, measureable, attainable, realistic, and timely.

Some clarification is needed in regard to the emerging theme of teacher preparedness and training. During the course of the primary prevention community input session, participant comments and worksheets indicated that teacher preparedness was lacking. However, it was not made clear whether the issue lies with (a) the nuanced characteristics of teachers (such as accreditation levels), (b) their specific shortcoming with regards to mental health, or (c) both. To the first point, it appears the accreditation for the early learning centers needs further examination to ensure basic teacher competency, which is largely a systems/structure issue. To the second point, comments made in this session, and in previous sessions, point toward a lack of skills/training/knowledge among all teacher groups as to appropriate mental health development and classroom management of children, youth, and adolescents. The need for greater knowledge of children's mental health also extends to parents.

### **Session #5 – Open Forum**

The open forum input session resulted in five community member participants. They spoke on topics ranging from access to healthy foods, the stigma associated with mental health, the need for parent education with regards to substance abuse, and the need for more agency collaboration. One community member noted his assessment of apprehension in the community regarding the funds' ability to actually impact the city and county. While it should be noted that out county schools and agencies were invited to attend and did participate in some of the community input sessions, this community member found it disheartening that the Board did not travel to the outer areas of the county to hear direct input.

A representative from the Missouri Department of Social Services Children's Division noted a number of concerns: lack of funding for services which can reunite families, lack of providers willing to accept services at a state-established rate, and transportation of families to services. The representative noted systemic obstacles including: a decreasing number of foster homes, increasing number of children entering foster care, and high staff turnover among Children's Division staff.

Representatives from the Columbia Police Department voiced concerns pertaining to youth who have not yet broken the law but are at high risk of engaging in criminal activity due to lack of supervision. It was suggested that police have an option to detain and transport a minor to a non-criminal assessment center where they could be housed temporarily and then directed to family services.

**Conclusion:** Three themes emerged as points of consensus from the five community input sessions. The first theme is the issue of access. Access is defined here as: shortages, bottlenecks, and limited agency capacity to meet the current demand in the community for





services. Considering the community input received across the five sessions, the access issue came down to provider shortages and the need for home-based and family based services. The former speaks to the long wait times to receive services, the perceived lack of emergency services, absence of night and weekend appointment times with providers, and the rural disparity of providers available outside of Columbia. The latter highlights the need for services that meet clients in the community and in their home. In addition, home-based interventions may facilitate increased opportunities for parental training in proper child development.

The second theme focuses around the issues of structure/systems. Structure/systems are defined here as: collaboration, billing, and state-level issues. Considering the community level input across the five sessions, the following issues fell under the theme of structure/systems:

- Lack of insurance
- Complexity of health insurance systems
- Need for family-based service coordination between agencies
- Chronically working in silos
- Lack of integration between mental and physical health systems
- Limited billable services for non-clinical settings (i.e., home-based services)
- Lack of insurance coverage for prevention services

The third theme is the issue of education. Education is defined here as number of separate concepts. Education as it applies to professional development, mental health stigma among parents and the community-at-large and parenting skills in general. When raised in the Community Input Sessions, the concept of professional development took on a number forms and came to include: continued professional development of mental health providers to ensure use and fidelity of evidence-based practices, teachers need more training in identifying and managing students with mental health issues, early childcare providers lack qualifications and appropriate training, and social workers/case managers need to be better-trained in home-based and family-based services. Also expressed during all input sessions was the need for parenting skills and it took on a number of forms including, disciplinary strategies, general knowledge of child development, parents' lack of coping skills, and parents of obese/overweight children lack understanding of nutrition.





## Key Informant Interviews

**Overview:** Key informant interviews consist of in-depth conversations with individuals who actively contribute to the community and who have knowledge of community-level issues. The purpose of conducting interviews is to ensure an array of perspectives from a variety of sectors as well as to collect additional information about the issues raised during the community input sessions. When questioned about children’s services in Boone County, the key informant responses circled back to a handful of core topic areas. These topic areas give BCCSB a guide for where well-informed professionals in Boone County feel the Children’s Services Fund should target resources.

**Methodology:** The BCCSB Community Input Sub-Committee held a meeting to discuss the selection of ten potential key informants who would be contacted for more in-depth information. The committee discussed the goal of the informant interviews, potential question topics, and established five sectors by which to organize the key informants. To facilitate the key informant nominations by the committee members, the lists of participants from the five previously held community input sessions were reviewed. Some new community members were suggested as well. By the end of the committee meeting, ten key informants were approved by the Community Input Sub-Committee and were later approved by the full Board at their scheduled meeting on April 10, 2014. Each key informant was placed into one of the five sectors shown below in Table 9.

**TABLE 9: KEY INFORMANT INTERVIEW ORGANIZATION**

Sector	Number of Interviews
Local School	2
Academic Research	2
Provider	1
Community/ Primary Prevention	2
Medical	3
	<i>Total: 10</i>

The sectors not only facilitated organization of the interviewees, but also provided structure for sector specific questions. Key informants who did not participate in the community input sessions were given the five questions posed during the input sessions. These questions were: *What are the top two issues you feel need to be addressed? Are their systemic obstacles to your success? Where is the gap in your services? What is a quantitative measure of your success?* In addition, a handful of sector specific questions were posed to interviewees. These questions were developed using the information garnered during the five community input sessions and the 56 submitted provider worksheets. Interviewers strategically left all questions open-ended to



facilitate a flexible and comfortable interview process. The purpose of the key informant interviews was to expand the scope and depth of the information shared throughout the Community Input Sessions.

Finally, the names of the interviewees are not listed because anonymity often facilitates open, honest and descriptive answers during the interview process. Interviews were conducted during the week of June 3, 2014 and were approximately 60-minutes in length.

**Findings:** The results of the key informant interviews are reported below by sector. Each section attempts to summarize the insight shared by the interviewees and points out agreements and disagreements within and across sectors. Information that either confirms or rejects statements made during input sessions is highlighted. Finally, in the conclusion, common themes across all interviews are identified and reported.

### **Local Schools**

Two representatives from local schools were interviewed to give the perspective of schools in addressing children's needs. The representatives had similar views as to what the issues were that schools faced and what the priorities in Boone County should be.

The first point of agreement was the shortage of child psychiatrists in the area. They reported that it was difficult to get children in to see a psychiatrist and often there was a long delay before appointments could be made. They both went on to say there is little to no follow-up by providers that informs the school about what steps were taken. This lack of communication can lead to further problems for the child and teachers. For example, it would be beneficial to both the teacher and student if teachers are aware of the issues the child is facing (to some degree) so that they can make classroom level adjustments when necessary. A suggested remedy to this gap in communication and follow-up is the use of case managers. These individuals would assist in bridging the gap between schools and providers as well as provide guidance to families.

During the input sessions, one critique of local public schools was that teachers seemed to lack appropriate classroom management skills. Both representatives were asked about this issue during their interview and both agreed that classroom management skills need improvement. It was their opinion that this needs to be addressed through both professional development and better training at the university level. It was also pointed out that teachers need to have better awareness and ability to identify mental health issues in order to make the necessary referral and ultimately make classroom adjustments where possible.

A second critique of public schools during the community input sessions was the apparent lack of a formalized system at the district level for dealing with mental health issues. It was reported that this creates challenges in working with schools because each principal is allowed to create their own process for addressing mental health/behavioral issues. Both key informants



acknowledged that schools do have a lot of autonomy in how they decide to handle the mental health needs of their students.

One of the key informants suggested the need for more outreach counselors at all levels (elementary and high school) who then could make use of case managers to help families navigate the provider system. An underlying understanding here is that the family/home environment needs attention if the child is to be successful in the classroom. This family-based approach is consistent with the views held by key informants in other sectors.

Both representatives supported the idea of universal screenings but one raised concerns about the difficulty in identifying what exactly should be screened for and the possibility of opposition by parents who are concerned about how the data would be used.

### **Academic Research**

Two representatives from the academic research community were selected as key informants. These individuals have some involvement with community programming and well as significant research experience related to child and family services.

A point of agreement between the two was the need for family-based care. The opinion of these two key informants was that therapy focusing solely on the child is simply not nearly as effective as an approach that includes the family/home environment. One informant went a little further in suggesting the most ideal model is one that addresses the child's school environment as well. One informant felt there was a shortage of psychiatrists, therapists, and a big need for case managers.

One of the key informants agreed with previous statements about teachers' apparent lack of skills and knowledge of how to identify children with mental health needs. They suggested that it was because mental health issues are often masked simply as behavioral issues. In their opinion, this lack of training/knowledge is seen in teachers' inability to (a) connect children to services and (b) have the necessary classroom management skills. On a related note, it was one individual's opinion that school counselors are undertrained and overworked. A potential contributing factor to school counselor workload may be teachers' inability to manage behaviors at the classroom level. Often a phone call or referral to the school counselor is an easier option than handling a student's problematic behavior within the classroom. Also related to schools' role, one of the informants discussed the need for better social and behavioral skill development being taught for all children, regardless of risk level. Finally, both informants supported the idea of mandatory screenings, although one informant raised the issue of deciding what exactly to screen for.

An issue raised during the input sessions was the belief, by some, that local mental health providers are not using evidence-based practices in their delivery of services. One of the informants in this sector reemphasized this point. It is their belief that providers need ongoing



professional development to ensure the treatment models being used are consistent with what current research says is most effective.

### **Provider**

One representative from the mental health provider sector was selected for a follow-up key informant interview. From their perspective, home-based services are most effective and very much needed. However, these services are very expensive to provide because they are often not reimbursed. They also stressed the need for more case-management services. Simple case-management can often be the linchpin in a clients' success. From this key informant's perspective, collaboration among mental health providers is simply not an issue. They acknowledge that collaboration is hard to quantify and/or describe, but believe it is a natural byproduct of their work.

This provider key informant disagreed with the critique by others that area providers are not using evidence-based practices. They argued that providers do employ evidence-based practices, but pointed out the difficulty in implementing a therapy model with complete fidelity given the challenging population with whom they work. Based on conversations with representatives from the provider sector and those in the university setting, there is clearly disagreement on this issue. It has been said that the academic community are far more concerned with program fidelity given much of their work is used to inform academic research. On the other hand, providers appear to be employing evidence-based practices but are less concerned with fidelity. Instead, they may be more willing to make adjustments (or even forced to make adjustments) based on the client/family's unique situation.

### **Community/Primary Prevention**

Two key informants were interviewed for the Community Intervention/Primary Prevention sector. Both key informants believed parenting skills are vital to early intervention and prevention services. In addition to parenting skills, they went on to say that a better understanding of basic child development is needed not just at home but also in the classroom. One suggested parent interventions in combination with youth programming at the agency-level. This may help with parent participation and buy-in. Another suggestion was the use of parent support groups rather than formal skills development classes. This may help parents feel less stigmatized and therefore aid in program participation rates.

Both key informants in this sector were asked whether they thought the target populations lacked awareness of the services available. One believed that those who were already linked into services had a good understanding of what was available, but those who slide in and out of hard times are less aware of the services and therefore go un-served. The other informant thought that generally the at-risk population has a good awareness of services that address basic needs (food,



clothing, and housing) but are much less aware of secondary services such as mental health services.

Both informants stressed the importance of a larger strategic plan for the fund that would include the community's agreed upon vision and indicators. This would ensure all community groups are working toward the same set of goals. However, common goals and approaches to achieving those objectives can vary dramatically. The two informants interviewed here had not only different community goals, but would employ different strategies. For example, one informant reported that there seemed to be a variety of activities for elementary children, but expressed the lack of teen programming. They also described a need for activities that assist in the preparation of teens for careers. This informant also felt the community's view on substance abuse depended on the substance. That is to say, alcohol is more widely problematic and yet parents seem more ambivalent about its use among their teens and adolescents.

Alternatively, the second informant voiced the community's need for more case management services and noted how these services work best when they are family-based. Outside of the family setting, the informant noted that teachers need to be better equipped to deal with mental health issues and behaviors in the classroom. This informant went on to also say that the community's expressed need for more temporary shelter beds is overstated. In his opinion, the true gap is in affordable long-term housing. He feels this should be included in the community's approach to addressing homelessness.

The varied responses of these two informants exemplify the challenges that BCCSB may face in aligning the community around a set of community-level indicators.

## **Medical**

Three key informants were interviewed from the medical sector. There were a couple issues that all three unanimously agreed on. The first is the shortage of child psychiatrists in the area, which often has negative consequences for the patients. It is also problematic for other medical providers who are left with expending their own resources to stabilize the patient and address the secondary medical issues that come from an untreated mental health problem. A second issue all three informants agreed on was the need for better prevention and early intervention services. Two of the informants specifically cited the need for better parenting skills and understanding of child development. One suggested that this service might be best implemented in the home. Another suggested the receipt of social services be tied to participation in parenting classes.

Two of the three informants pointed out that services need to be family-based, while the third hinted at the same idea by suggesting that parenting skills be provided in the home. Two informants believed case managers are needed to assist families with making and keeping appointments. The follow-up provided by case managers also helps medical and mental health providers stay better connected. The lack of connection and collaboration between the physical



health and mental health providers was identified as a problem during the community input sessions. The key informants explained that this was in part due to the communication difficulties presented by the nature of their work and also the patient privacy restrictions that must be adhered to. Medical partnerships, which include mental health providers, are rare but effective in addressing this communication gap.

More immediate interventions are needed for children who are “brewing”. In other words, they are not in an immediate crisis, but they are on the brink of one. The delay in seeing a professional is especially problematic for this population.

The design and management of classrooms can go a long way in managing behaviors and building skills in children. Also discussed by one of the informants in this sector was the difficulty in providing mental health services to the more rural areas of the county. It was their opinion that this is due to (a) the travel costs not being reimbursable and (b) the stigma of receiving mental health services, which is especially acute in rural areas.

**Conclusion:** In total, 10 interviews were conducted with key informants in the areas of local schools, academic research community, mental health service providers, medical professionals, and community/primary prevention. The intent of the interviews was to gather additional information on the common themes and other important issues which rose during the community input sessions. Over the course of the interviews, several concepts emerged; some of which were new and others reemphasized ideas presented during the input sessions. The following are the five most commonly agreed upon priorities for Boone County.

- Family-based care
- Classroom management skills and mental health awareness (social skill development)
- Case management services
- Psychiatrists
- Parenting skills and child development education



## CONCLUSION

In an attempt to tie together the information from each data collection strategy, the three general themes established from the input sessions (access, systems/structures, and education) will be used to frame the final conclusion.

### *Access*

The issue of access can be understood as community members not being able to acquire the following three priorities identified through the research process: mental health services, home and family-based services, and case management.

The perceived shortage in mental health service providers is consistent with the results of the *Putting Kids First Assessment*, which identified mental health services as the area that is most underfunded. Key informants also supported this finding by pointing to long wait times in getting appointments scheduled. More specifically, the difficulty in accessing child *psychiatrists* was mentioned by multiple interviewees.

Home-based and family-based services were discussed during the community input sessions and then reemphasized by multiple key informants. While there appears to be broad consensus that the ideal child therapy model would include the family and home environment, there do not seem to be enough providers willing and/or able to deliver this service. In addition, it was the belief of some that home and family-based services may provide an opportunity to deliver another priority service, that of parenting skills and child development education.

Another access problem, for which there appears to be broad consensus, is that of case management. Across the different sectors (schools, academic research community, medical, community/primary prevention, and providers), case management was seen as a necessary service for addressing the needs of the target population. As families seek services from providers many need hands on help with navigating the often complex medical and social service systems, finding transportation, maintaining a schedule, understanding what services are covered, securing and paying for child care, and communicating with employers to express the need for a flexible work schedule. It is the belief of many community members that case managers should fill this role and that it is an essential element to families' long-term success.

### *Structures/Systems*

While access to services quickly became the mantra among community input participants, it was also evident that access issues were often a result of systemic barriers. Over the course of the Community Input Sessions the phrase "lack of health insurance" became synonymous with families who are underinsured or carry extremely high deductibles. This finding is consistent with results of the *Boone Issues Analysis of Mental Health* (Institute of Public Policy, 2012),





which cited the primary reason for not receiving treatment among 12+ year olds is lack of health insurance. A medical sector key informant noted some effects of the Affordable Care Act (ACA). On one hand ACA increased access to medical treatment, but many are misinformed when it comes to the types of services that are and are not covered. In addition, those who select less expensive coverage options often fail to understand the impact of extremely high deductibles. For some, ACA coverage parameters and deductibles serve as a deterrent of care.

Providers face systemic barriers as well. While case management and home/family-based services are considered vital, Medicaid requirements make it very difficult, even impossible, to bill for such services. From a provider perspective, services like case management and family-based therapy may be more effective, but they are also more resource intensive in both time and money. Therefore, it is very difficult to implement them when resources are already stretched in trying to meet the need for services that are billable.

Systemic issues such as individuals being un/underinsured, billing difficulties for vital services (i.e., family-based services and case management), or navigating the complex Medicaid system will eventually lead to access issues as well. Consequently, efforts should be made to address these systemic inefficiencies rather than continually funding remedies for the symptoms of larger issues.

### ***Education***

In order to properly serve the children of Boone County it is evident there needs to be significant improvement in the education of mental health providers, school staff, and parents.

In regard to schools, the general observation was that because children spend such a significant amount of time at school, it is a critical environment for primary preventive measures. It is important that schools, and more specifically classrooms, teach social skills to all children as well as allow for and support children dealing with mental health/behavioral issues. It was the belief of several in the community input sessions, and confirmed by key informants, that teachers lack the classroom management skills needed to provide an environment that supports the development of appropriate social skills. This finding is consistent with the *School Based Mental Health Report* (Columbia Public Schools, 2013) that found – (1) a lack of shared understanding and knowledge of appropriate emotional development and mental health for children and teens, (2) a lack of communication between parents and teachers, and (3) the need for universal promotion of mental health awareness. In addition, a critique raised during the input sessions around the lack of a formalized system among schools in dealing with mental health issues seems to have been confirmed during key informant interviews.

The need for parenting skills was expressed in each community input session and reinforced during several of the key informant interviews. It came to include general parental knowledge of child development, effective disciplinary strategies, parents' lack of coping skills, and parents' lack of knowledge around nutrition. While the need for parenting skills was widely agreed upon,





opinions on how to best implement this service differed. Some of the suggestions included parent support groups, connecting it to the child's intervention, home-based interventions, and linking it to the receipt of social services.

In regard to the mental health stigma issue, there appeared to be some disagreement on how problematic this actually is. It was the opinion of several providers that they have techniques for reframing the idea of therapy that de-stigmatizes it and allows parents to feel comfortable permitting assistance for their child and for themselves. However, it may be the case that many referral sources do not make use of the same reframing techniques and therefore have difficulty convincing clients to accept services.



APPENDICES

Appendix A: Detailed Tables

Heart of Missouri United Way Community Needs Assessment

TABLE A: HEART OF MISSOURI UNITED WAY COMMUNITY NEEDS ASSESSMENT

Report	Year	Purpose	Method	Data
<p><b>Heart of Missouri United Way Community Needs Assessment</b></p> <p><i>Written by:</i> Pure Marketing, LLC</p> <p><i>Funded by:</i> Heart of Missouri United Way</p>	2011	Evaluate perceptions of need in Mid-Missouri	<p>1) 24 community leader interviews</p> <p>2) 300 residential phone survey (random digit dial) in Audrain, Boone, Callaway, Cole, Cooper, Howard, Moniteau, and Randolph Counties</p>	<ul style="list-style-type: none"> <li>• <i>Qualitative interviews with 24 Mid-Missouri community leaders:</i> <ul style="list-style-type: none"> <li>--Understanding perceived strengths and satisfaction with the Unites Way's current operations model</li> <li>--Understanding perceived challenges and weaknesses in meeting the region's social service needs</li> <li>--Understanding perceived opportunities for meeting the region's social service needs</li> <li>--Describing the future of community service need in Mid-Missouri over the next 10-20 years</li> </ul> </li> <li>• <i>Quantitative phone interviews with 300 Mid-Missouri residents:</i> <ul style="list-style-type: none"> <li>--Measuring poverty awareness</li> <li>--Identifying of non-profit and charitable organizations</li> <li>--Perception of social need</li> <li>--Perception the future of community service need in Mid-Missouri over the next 10-20 years</li> </ul> </li> </ul>
		<b>Findings</b>		
		Weak economy		
		High unemployment		
Address poverty by way of education				



### School Based Mental Health Report

TABLE B: SCHOOL-BASED MENTAL HEALTH REPORT					
Report	Year	Purpose	Method	Data	
<p><b>School-Based Mental Health Report</b></p> <p><i>Written by:</i> Columbia Public Schools' School-Based Mental Health Committee</p> <p><i>Funded by:</i> Columbia Public Schools</p>	2013	Describe the work of the CPS's School Based Mental Health Committee and to analyze current practices and processes within the school district related to school mental health.	<ol style="list-style-type: none"> <li>1) Evaluate current mental health services in CPS</li> <li>2) Research best practices in schools</li> <li>3) Compare with five survey results (parents, teachers, counselors, etc.)</li> </ol>	<ul style="list-style-type: none"> <li>• <i>Self-Regulation (Thinking before acting):</i> Perceptions of students "not thinking things out" before acting. --Respondents: 6<sup>th</sup> grade students, K-12 parents, and K-12 faculty</li> <li>• <i>Self-Regulation (Thinking before acting):</i> Perceptions of students in regards to emotions of anger, fear, sadness, and nervousness --Respondents: 6<sup>th</sup> grade students, K-12 parents, and K-12 faculty</li> <li>• <i>Motivation and Skills (Optimism):</i> Perceptions of students' personal characteristics that help students succeed academically. Optimism is characterized by having a hopeful outlook about the future in spite of difficulties or challenges --Respondents: 6<sup>th</sup> grade students, K-12 parents, and K-12 faculty</li> <li>• <i>Social Engagement (Bullying):</i> Perceptions of frequency and expression of need for help handling teasing or bullying. --Respondents: 6-12 grade students, K-12 parents, and K-12 faculty</li> <li>• <i>Systems and Practices (Utilization of Mental Health Referral Procedures):</i> Measure of faculty's knowledge of mental health referrals procedures and perception of utilization by school staff. --Respondents: K-12 faculty</li> <li>• <i>Systems and Practices (Systematic Provision of Preventive and Supportive Services):</i> Measure of faculty's awareness of school-wide, small group and classroom level preventative and supportive services --Respondents: K-12 faculty</li> <li>• <i>Systems and Practices (Provision of Training and Educational Activities on Mental Health and Appropriate Services):</i> Measure of faculty's knowledge of educational opportunities regarding mental health barriers to learning. --Respondents: K-12 faculty</li> <li>• <i>Systems and Practices (Utilization of Evidence-Based Practices and Program Monitoring):</i> Measure of faculty's knowledge of the school usage and monitoring of such programs. --Respondents: K-12 faculty</li> <li>• <i>Systems and Practices (Collaboration to Provide Flexible and Rapid Services Matched to Need):</i> Measure of faculty's knowledge of the decision process incorporated in the provision of services, the nature, and appropriate use of services. --Respondents: K-12 faculty</li> <li>• <i>Counseling Services and School Safety:</i> Measure of the perception of counseling services availability. Measure of "I feel safe at school." --Respondents: 3th-12<sup>th</sup> grade students, K-12 faculty</li> </ul>	
		<b>Findings</b>			
		Discord of shared understanding and knowledge of appropriate emotional development and mental health for children/teens			
		Lack of communication between parents and teachers			
		Need for universal promotion of skills building and mental awareness			
		Need for targeted prevention by way of services to students who are at risk			
Intense, individualized, support for students					



**Putting Kids First in Boone County: Children’s Mental Health Services Assessment**

TABLE C: PUTTING KIDS FIRST PUTTING KIDS FIRST IN BOONE COUNTY: CHILDREN’S MENTAL HEALTH SERVICES ASSESSMENT					
Report	Year	Purpose	Method	Data	
<p><b>Putting Kids First</b></p> <p><i>Written by:</i> The Institute of Public Policy</p> <p><i>Funded by:</i> Putting Kids First Coalition</p>	2011	Children’s mental health assessment	1) Boone provider survey  2) Secondary data analysis	<ul style="list-style-type: none"> <li>• <i>Missing juveniles</i></li> <li>• <i>Runaways</i></li> <li>• <i>Juvenile arrests</i></li> <li>• <i>Domestic violence</i></li> <li>• <i>Child abuse</i></li> <li>• <i>Teen births</i></li> <li>• <i>Past 30-day use</i></li> <li>• <i>Past 2-week binge drinking</i></li> <li>• <i>Children on Medicaid</i></li> <li>• <i>Youth suffering from serious emotional disturbance</i></li> <li>• <i>Homeless youth in public schools</i></li> <li>• <i>Suicides</i></li> <li>• <i>Dropouts</i></li> <li>• <i>Children in foster care</i></li> </ul> <ul style="list-style-type: none"> <li>• <b>Service gaps &amp; number of clients reached in each of the following categories:</b></li> <li>--Temporary shelter services, respite care services</li> <li>--Services to unwed and teen mothers/fathers</li> <li>--Substance abuse treatment services</li> <li>--Outpatient psychiatric services</li> <li>--Transitional living services</li> <li>--Crisis intervention services</li> <li>--School-based prevention services</li> <li>--Home- and community based intervention services</li> <li>--Individual/group/family counseling services</li> </ul>	
		<b>Findings</b>			
		Need for more transitional housing			
		Need for mental health services			
Need for substance abuse treatment for teens					



**Boone Issues Analysis of Children, Youth and Families**

TABLE D: BOONE ISSUES ANALYSIS OF CHILDREN, YOUTH, AND FAMILY				
Report	Year	Purpose	Method	Data
<p><b>Children Youth Family</b></p> <p><i>Written by:</i> The Institute of Public Policy</p> <p><i>Funded by:</i> City of Columbia Boone County Heart of Missouri United Way</p>	2011	Boone County Issues Analysis – help direct funding decisions	1) Examination of secondary data at the local level	<ul style="list-style-type: none"> <li>• <i>Teen pregnancy rates</i></li> <li>• <i>Life births among 15-19 year olds by race</i></li> <li>• <i>Dropout rates</i></li> <li>• <i>High school graduation rates by race</i></li> <li>• <i>Missouri Assessment Program Results by grade</i></li> <li>• <i>Missouri Assessment Program Results by race</i></li> <li>• <i>Emergency room use by mental health diagnosis and age</i></li> <li>• <i>Risk behaviors: 30-day use, perception of wrongness to use alcohol/cigarettes/marijuana</i></li> <li>• <i>Out-of-home placement entries</i></li> <li>• <i>Rate of homeless students</i></li> <li>• <i>Rate of students receiving free and reduced lunch by school district</i></li> <li>• <i>Rate of discipline incidents by school district</i></li> <li>• <i>Juvenile arrests</i></li> <li>• <i>Referrals on minors for “runaway” offenses</i></li> <li>• <i>Poverty rates for children five years old and younger by race</i></li> <li>• <i>Rate of births to mothers with less than 12 years of education</i></li> <li>• <i>Rate of low birth weight babies by race</i></li> <li>• <i>Number of families with children enrolled in Columbia Public School District’s Parents as Teachers program</i></li> <li>• <i>Number of children receiving subsidized childcare</i></li> <li>• <i>Number of spaces in licensed family childcare homes, group childcare homes, and childcare centers</i></li> <li>• <i>Number of accredited child care centers</i></li> <li>• <i>Early childhood special education participation rate</i></li> <li>• <i>Head Start enrollment</i></li> <li>• <i>Head Start waiting list</i></li> <li>• <i>Title I enrollment</i></li> <li>• <i>Title I waiting list</i></li> </ul>
		<b>Findings</b>		
		Significant increases of number of children in poverty between 2000 and 2008		
		Only one organization provides local support to homeless teens		
African-Americans and other minorities in Boone county were shown to be at an overall disadvantage in comparison to Caucasians				



### Boone Issues Analysis of Mental Health

TABLE E: BOONE ISSUES ANALYSIS OF MENTAL HEALTH						
Report	Year	Purpose	Method	Data		
<p><b>Mental Health</b></p> <p><i>Written by:</i> The Institute of Public Policy</p> <p><i>Funded by:</i> City of Columbia Boone County Heart of Missouri United Way</p>	2012	Boone County Issues Analysis – help direct funding decisions	1) Examination of secondary data	<ul style="list-style-type: none"> <li>• <i>Homelessness</i> <ul style="list-style-type: none"> <li>--Point in time count of sheltered and unsheltered individuals by mentally ill status, chronic substance abuse status, and Veteran status</li> <li>--Section 8 Housing voucher wait list</li> <li>--Public Housing wait list</li> </ul> </li> <li>• <i>Affordable Housing</i> <ul style="list-style-type: none"> <li>--Rate of cost burdened families (renters and homeowners)</li> <li>--Median annual housing costs</li> <li>--Median household income</li> </ul> </li> <li>• <i>Domestic violence</i></li> <li>• <i>Food Security</i> <ul style="list-style-type: none"> <li>--Rate of families eligible for SNAP</li> <li>--Rate of families receiving SNAP</li> <li>--WIC participation numbers</li> </ul> </li> </ul>		
		<b>Findings</b>				
		Co-occurring psychological disorders are very common	Boone has higher rate of suicides than Missouri			
		Primary reasons for lack of treatment ( 12+ year olds) is no health coverage and no means to afford treatment (National data)				



## Appendix B: Community Input Session Components

### Session #1 – Shelter & At-Risk Populations

#### *Invitation to Participate*

TO:

February 14, 2014

Barbara Hodges, Executive Director, True North  
 Belinda Masters, Parents as Teachers Coordinator, Columbia School District  
 Katie Harris-Smith, Corps Office, Salvation Army Harbor House  
 Christine Corcoran, Director, Lutheran Family and Children’s Services  
 Darin Preis, Executive Director, Central Missouri Community Action  
 Emma Benham, Program Director, St. Raymond Center  
 Jack Jensen, Executive Director, First Chance for Children  
 Jan Stock, Executive Director, Rainbow House  
 Jane Williams, Program Director, Love Inc.  
 Jessica Burbridge, Parents as Teachers Educator, Harrisburg R-VIII School District  
 Karen Smith, Parents as Teachers Educator, Hallsville R-VIII School District  
 Mary Ann Sander, Parents as Teachers Coordinator, Centralia R-VI School District  
 Nick Foster, Executive Director, Voluntary Action Center  
 Rev. Larry Rise, President, New Life Evangelistic Center  
 Shawn Schultz, Parents as Teacher Educator, Sturgeon R-V School District  
 Stephanie Browning, Administrator, Columbia Public Health and Department of Human Services  
 Steve Jacobs, Catholic Worker Community Member, Lois Bryant House and St. Francis House  
 Suzanne Haugen, Parents as Teachers Educator, Southern Boone County R-I School District

**FROM:** Jacqueline Schumacher, Consultant, Boone County Children’s Services Fund

**RE:** Invitation to the February 27, 2014 Community Input Session

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Dear Service Provider,

The Boone County Children’s Services Board (BCCSB) is taking steps to gather information about children’s services in Boone County. The Chairman, Mr. Les Wagner, and his eight-member board seek targeted information from the perspective of local providers whose services and programming align with Missouri Statutes 67 & 210. With assistance from the Institute of Public Policy in the Truman School of Public Affairs at the University of Missouri, the Board is organizing a series of five community input sessions, one of which you are specifically invited to attend.

The organization and variety of community input sessions are driven exclusively by the funding statutes. For clarification, Missouri Statute 67 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children’s Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6 million dollars annually. According to Missouri Statute 210, the Children’s Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

#### **Service Funding Categories**

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth



2. Respite care services
3. Services to unwed mothers and unmarried parent services
4. Outpatient chemical dependency and psychiatric treatment programs
5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

You have been identified as a service provider whose services apply to funding Category #1 (shelter services) and/or Category #3 (unwed mothers and unwed parent services). You, or a representative from your agency, are invited to participate in the Boone County Children Services Board meeting at **4:30 PM on February 27, 2014** in the Boone County Commission Chambers (RM 110) at 811 East Walnut, Columbia, Missouri 65201. This input session will address the topic of *Shelter and At-Risk Populations* as it applies to Category #1 and Category #3.

During the input session, you will be asked five questions (described below). Your answers should be thoughtful, although brief. It is important the Board understands your service area's collective perspective and not simply agency-specific information. Please keep in mind, **your invitation to address the Board is not an opportunity to express your agency's need for funding**. Rather, the focus of the input session will center on the five questions listed below.

Your individual response time to these questions will range between a total of three and eight minutes. This time frame depends on the number of input session attendees. Therefore, please **RSVP** to [schumacherja@missouri.edu](mailto:schumacherja@missouri.edu) by Friday, February 21, 2014. If possible, I will be in touch with you before the input session to confirm the amount of time you will have to answer the five questions below.

BOONE COUNTY CHILDREN'S SERVICE BOARD COMMUNITY INPUT SCHEDULE			
DATE	Service Area	Funding Categories	Questions





BOONE COUNTY CHILDREN’S SERVICE BOARD COMMUNITY INPUT SCHEDULE			
DATE	Service Area	Funding Categories	Questions
Feb 27	Shelter & At-Risk Populations	<ul style="list-style-type: none"> <li>• <i>Category #1:</i> Temporary shelter</li> <li>• <i>Category #3:</i> Unwed mothers/parents</li> </ul>	<ol style="list-style-type: none"> <li>1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?</li> <li>2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?</li> <li>3) Where is the gap in your shelter and/or at-risk population services?</li> <li>4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?</li> <li>5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?</li> </ol>

We look forward to hearing from your agency later this month. Do not hesitate to reach out to me for further information.

***Please RSVP by February 21, 2014***

Sincerely,

JACQUELINE SCHUMACHER, MPA  
 Consultant, Boone County Children’s Services Fund  
 INSTITUTE of PUBLIC POLICY  
 Truman School of Public Affairs- University of Missouri  
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*Meeting Agenda*

**AGENDA**  
**COMMUNITY INPUT SESSION #1**

**Boone County Children’s Services Board**

February 27, 2014 starting at 4:30

**Overview:** This input session will address the topic of *Shelter and At-Risk Populations* as it applies to Category #1(shelter services) and/or Category #3 (unwed mothers and unwed parent services).

**Agenda:**

- 1) *Welcome & Overview:* Jacqueline Schumacher, consultant to the Board
- 2) *Input Session Moderation:* Christian Arment, consultant to the Board

<b>SCHEDULE OF PARTICIPANTS FEBRUARY 27, 2014</b>		
<b>Funding Category</b>	<b>Participant Name</b>	<b>Agency</b>
1: Temporary shelter	Nick Foster	Voluntary Action Center
1: Temporary shelter 3: Parenting/unwed...	Jan Stock	Rainbow House
3: Parenting/unwed...	Jack Jensen	First Chance for Children
3: Parenting/unwed...	Kelly Hill	Love, Inc.
3: Parenting/unwed...	Emma Benham	St. Raymond Center
3: Parenting/unwed...	Scott Clardy	Columbia Public Health and Department of Human Services
3: Parenting/unwed...	Kim Lewis	Parents as Teachers, Southern Boone County R-I School District
3: Parenting/unwed...	Mary Ann Sander	Parents as Teachers, Centralia R-VI School District
3: Parenting/unwed...	Shawn C. Schultz	Parents as Teachers, Sturgeon R-V School District
3: Parenting/unwed...	Karen Smith	Parents as Teachers, Hallsville R-IV School District
3: Parenting/unwed...	Claycie Gerlt	Lutheran Family and Children's Services

- 3) *Follow-up and Clarification Questions:* Board Members
- 4) *General Input:* Audience & non-scheduled participants
- 5) *Closing Remarks:* Kelly Wallis, Boone County Director of Community Services



## **Feedback Report**

### *Community Input Session on Shelter and At-risk Populations*

The Boone County Children’s Services Board (BCCSB) is taking steps to understand more about children’s services in Boone County. BCCSB contracted with the Institute of Public Policy (IPP) in the Truman School of Public Affairs at the University of Missouri to organize and moderate five Community Input Sessions. BCCSB wishes to make wise expenditures of the Children’s Services Fund and seeks targeted information from local services aligning with the Missouri Statutes 67 & 210. This feedback document provides an overview of the information shared with the Board during the first input session and will help guide BCCSB’s future funding strategies.

Missouri State Statute 67.1775 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children’s Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6 million dollars annually. According to Missouri Statute 210.861, the Children’s Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
2. Respite care services
3. Services to unwed mothers and unmarried parent services
4. Outpatient chemical dependency and psychiatric treatment programs
5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

**Overview:** The BCCSB hosted a Community Input Session on February 27, 2014 and invited Boone County social services agencies to attend. The topic of this session was *Shelter & At-risk Populations* which centered on temporary shelter services and services for unwed mothers and unmarried parents. A total of 19 agencies were invited to participate, of which 12 were able to attend. A total of 13 agencies prepared and submitted formal comments on worksheets in response to the Board’s predetermined questions. Table F is a reference guide to Community Input Session #1 and quantifies the number of agencies engaged in the convening.



<b>Table F: Community Input Session #1 By the Numbers</b>	
Session #1	Date: February 27, 2014
	Topic: Shelter & At-risk populations
	Funding categories: 1 & 3
	Number of invited participants: 19
	Number of scheduled participants: 12
	Number of worksheets received : 13
	Number of individuals in attendance: 18

**Methodology:** Boone County agencies that provide services which apply to Category #1 and #3 were invited to attend the BCCSB meeting on February 27, 2014. When an agency confirmed their desire to participate in the meeting they were provided with a worksheet containing five pre-established questions developed by the Board. A copy of the agency worksheet may be found in Appendix A. Invited agencies were given two directives: first, agency representatives were encouraged to submit their written responses to the Board’s five questions in advance of the meeting by using the provided worksheet. These responses may be found in Appendix B, and are organized by agency name. Second, agency representatives were instructed to use their meeting participation time to answer these questions. Each respondent was given a total of five minutes.

The Board’s pre-established questions for this input session are:

Question #1: *What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?*

Question #2: *Are there systemic obstacles to your success when working with shelter and/or at-risk populations?*

Question #3: *Where is the gap in your shelter and/or at-risk population services?*

Question #4: *What is a quantitative measure of your success when working with shelter and/or at-risk populations?*

Question #5: *Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area.*

**Findings:** The following responses are organized by question and have been de-identified. This allows the aggregated responses to point toward themes and topics rather than agency-level information shared as a byproduct of the participant’s responses during the input session. When possible, responses in bulleted lists are organized by funding topic: Shelter, mental health, transportation, basic needs, and education. The “other” category is catchall for items that do not readily fit into the aforementioned groups.



### Top Two Issues – Shelter & At-Risk Populations

During the community input session, the following were mentioned in response to the question: *What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

#### Shelter

- Limited low-cost housing options outside of Columbia, MO\*
- Limited number of beds for youth under 18 years old
- Shortage of shelter rooms\*
- Transient and homeless populations lack supports
- Unmarried parents cannot stay together

#### Mental Health

- Lack of social services and support relationships means no sources of advice or role modeling\*
- Need immediate access to mental health evaluations and treatment\*
- At-risk populations have mental health issues which they cannot handle on their own, specifically postpartum depression, toxic stress syndrome for children
- Families need emotional support because they have no support mechanisms
- Free and adequate mental health services (including residential care) regardless of whether the need stems from trauma-induced illness or other

#### Transportation

- Transportation for those clients outside of Columbia, MO\*\*

#### Basic Needs

- A more holistic approach to poverty
- Families struggle with meeting basic needs, this is rooted in lack of job, and causes stress
- Need for low-cost medical and dental services in our community (outside of Columbia, MO)
- There is a lack of basic life skills among our clients

#### Education

- Generating adequate income to support one’s self and family
- Families struggle with meeting basic needs, this is rooted in lack of job, and causes stress

#### Other

- Our funds only go so far\*
- Children exiting foster care
- No local services for clients outside of Columbia, MO
- Overcoming generational perspectives on family support
- Parallel developmental needs of parents and children\*
- Parents seek help (via shelter) once they have “lost it all” and it takes a family a very long time to come back from that
- Teens have limited time to meet with parent educator

*Summary:* These responses point toward a need for basic services aimed at keeping families intact. Many providers mentioned a lack of familial or social support structures which may serve as protective factors aimed to help families during crisis. At-risk populations, particularly those



living in generational poverty, often to do not have strong role models or informal safety nets in place to prevent homelessness or to seek out self-help mechanisms to combat mental distress. The needs for transportation and access to timely mental health screenings/services are two of the most often mentioned topics for this question. Finally, the top issues facing rural areas of Boone County are access into the network of Columbia-based agencies and transportation into Columbia for services.

**Systemic Obstacles to Success – Shelter & At-Risk Populations**

During the community input session, the following were mentioned in response to the question: *Are there systemic obstacles to your success when working with shelter and/or at-risk populations?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Shelter**

- Lack of affordable housing\*\*

**Transportation**

- Lack of transportation\*\*
- Limited transportation to and from shelters\*\*
- Struggle to maintain a working relationship with clients due to transportation and trust issues\*

**Basic Needs**

- Getting identification is difficult\*
- Quality infant care
- Wait times at Family Division limits SNAP flow\*\*

**Education**

- Developing marketable skills
- Lack of sustainable wage employment
- Under employment

**Other**

- Educating the community as to the dynamics involved in domestic violence
- Family trust in our program so they can see they have the ability to be successful
- In communities outside of Columbia, there is a collective lack of knowledge about services available in Columbia, MO
- Influx of people coming from St. Louis and Kansas City because getting services take longer in other regions
- No local services for clients outside of Columbia, MO\*
- Not connected or invited to collaborate with Columbia, MO
- Services offices are not open after 5PM
- Systematic exclusion of fathers
- Teen parent services – limited because not adults

*Summary:* These responses call to mind systemic obstacles which hinder agency-level successes. Because of their very nature, these obstacles are outside the control of agencies and call to mind the need for larger, or systematic, solutions to problems which hinder social services. Inadequate transportation, long waiting time for services from Missouri Family Support Division, shortage of affordable/safe housing, and lack of employment (or opportunities for skills development) are



some of the most commonly mentioned systemic obstacles to success. In addition, living outside of Columbia proves to be an obstacle for access to services and thwarts agency-level collaboration.

**Gap in Services – Shelter & At-Risk Populations**

During the community input session, the following were mentioned in response to the question: *Where is the gap in your shelter and/or at-risk population services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Shelter**

- Kids with developmental issues have no shelter
- Pregnant teens have no shelter, they are referred out of the county
- Rental deposits
- We have no shelter for homeless youth (outside of Columbia) and have a large couch-surfing problem\*
- Demand for healthy babies program is larger than supply
- Lack of affordable daycare facilities outside of Columbia, MO
- No WIC office outside of Columbia, MO
- Requests for money
- There is no “safety net” because resources are too slim

**Mental Health**

- Lack of adequate services for women’s mental health
- Long wait lists – demand outweighs the supply of services
- Need for mental health services
- When youth turn 18 years old they no longer have Medicaid for treatment or therapy\*

**Education**

- Employment support
- Youth with bad credit, felony convictions, limited education have limited job options

**Other**

- 13-16 year olds often need parental consent to participate, but this violates their confidentiality
- Confusing funding streams
- Gap in case management services
- Lack of agency funding
- No quiet place for our kids in shelter to have homework time
- Not enough staff to service all families in the areas outside of Columbia, MO
- Pregnant teens unwilling to participate in services

**Transportation**

- Transportation\*\*\*
- Getting children to school on-time from shelters

**Basic Needs**

- Child furniture \*\*
- Affordable childcare\*
- Generational poverty\*

*Summary:* Boone County service providers acutely understand the demand for services made on their agency and the resulting service shortfalls, or gaps, generated due to limited resources. In





light of efforts to develop ways to make funding dollars stretch, agency representatives mentioned chronic funding/economic constraints. Bottlenecks in services and long-wait times are common. When asked to describe these gaps, agencies responded with specific shortfalls applicable to their programming. Many centered on common themes such as: transportation, limited mental health services, affordable childcare, shelter for children and youth outside of Columbia, MO, and the ever present need for children’s furniture and bedding.

**Quantitative Measures of Success – Shelter & At-Risk Populations**

During the community input session, the following were mentioned in response to the question: *What is a quantitative measure of your success when working with shelter and/or at-risk populations?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

- Annual performance review
- Birth outcomes
- Birth spacing
- Early entry into prenatal care
- Evidence-based programming measures
- Look at high school graduation rates
- Measurement of goals
- Mental health screenings
- Performance measures
- Research-based curricula
- Screenings happen as part of our services
- Survey of knowledge and skills gained
- Three, six, and 12-month follow up intervals
- Vehicle voucher redemption rate
- We know the children we serve are evaluated systematically
- We measure increased savings in savings accounts
- WIC appointment show-rate

*Summary:* Many respondents testified to tracking some measure of performance; however, the majority did not offer specific quantitative examples and/or did not indicate specific data they are currently collecting. The majority of the respondents answered the question by referring to tools used to measure knowledge gained over time, evidence-based programming measures, and annual performance reviews.

**Potential Collaboration – Shelter & At-Risk Populations**

During the community input session, the following were mentioned in response to the question: *Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area.* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:



Appendix B: Community Input Session Components
Session #1 – Shelter & At-Risk Populations

- A physical presence of larger agencies in areas outside of Columbia, MO would make collaboration easier
• Collaborate with our local churches for basic needs
• Collaborate with churches, we need to pool our resources together
• Our collaboration hopes to eliminate redundancy
• We are always looking for more
• We collaborate and work together to make sure our services do not overlap
• We collaborate with many agencies
• We don't collaborate with Columbia due to transportation issues of our clients\*
• We have applied for joint grants in the past, but we were not awarded
• We have capacity to collaborate, but no time
• We would like to collaborate to obtain timely mental health screenings
• Yes, we hope to collaborate with another local agency for a grant

Summary: Agencies appear to have the intuitive nature to pool resources and eliminate redundancy through collaboration. Many participants expressed the desire for more collaboration and hope the BCCSC can be a conduit for collaboration initiatives. Service providers outside of Columbia, MO mentioned the lack of collaboration and expressed their hope for being part of collaborative efforts in the future. More than one representative noted their agency's experience co-grant writing with other local agencies as a source of collaboration.

Conclusion:

BCCSB's process of hearing input from agencies that provide temporary shelter services and services to unwed teens/unmarried parents proves to be useful in identifying common themes. Simply stated, transportation for rural and non-rural clients is a topic of great importance. Struggles with employment and job readiness circle back to the ever-present demand for basic needs and access to mental health services/screenings were commonly mentioned items that apply to both temporary shelter populations and unwed teens/unmarried parents. Finally, agencies expressed the need for more shelter options for teens both within and outside of Columbia, MO. The "other" categories in the previous bulleted lists should by no means be overlooked. While they do not fit directly into categories or groups, they offer useful and anecdotal perspectives from agencies and the populations they serve.

Agency Worksheets

Table with 2 columns: Agency (Centralia Parents As Teachers) and Respondent (Ms. Mary Ann Sander)

1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?



- There is a huge need for low cost medical, dental, counseling other services to be offered directly in our local community. We find that many of our ‘at-risk’ single and two parent families not only do not have insurance but they either a) don’t have access to a car, or b) don’t have the money for gas to travel to Columbia to access these services. At today’s gas prices it could easily cost a family \$8.00 in gas just to drive once to Columbia and back. When there are required appointments on different days of the month, this necessitates several trips to Columbia each month.
- The free or low cost services that are available to families such as WIC, Health Department immunizations, and all Family Support Division services also require families to travel to Columbia, which is either difficult or impossible for our most vulnerable families. The need also exists for additional low cost or Section 8 housing and for licensed child care providers who will accept state-assistance pay.

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- There are currently 37 single parent families being served by the Centralia Parents as Teachers staff. Of these, 33 have multiple at-risk factors. Seven of them are teen parents—all with multiple at-risk factors. The over-all lack of resources in our small community makes serving these families with the family supports they need extremely challenging. Centralia PAT serves as the ‘child find’ resource for others in our community such as Head Start. Because of a lack of local resources, PAT staff often end up serving as “listening ears” when the family really would benefit from professional counseling and/or other support. There is also a general lack of “collective knowledge” about what services are available to families in Columbia/Boone County to which they could be referred. It would be desirable if many/most of the services located in Columbia could be offered in each of the smaller communities at least once a month. It is our belief that these would be best offered in a neutral, centrally located site that would be within walking distance for most families since public transportation is not available. It is critical that someone within the local community stay in touch with families because they move often and change cell phone numbers frequently.

**3) Where is the gap in your shelter and/or at-risk population services?**

- Being able to have the time and financial resources to seek out and identify at-risk families is huge. If the services at-risk families needed were offered in a shared location in our local community, PAT staff could recruit/meet the families at there and begin providing them with PAT services as well as link them with other community services. Social services provided in the local community would allow PAT staff members to accompany at-risk families on appointments to service delivery agencies when needed. We also do not have enough current staff to serve all at-risk families with the intensity of services suggested by the Parents as Teachers national office and the Missouri Department of Elementary and Secondary Education. This means families are either ‘under-served’ or not served at all. Housing for homeless youth is unavailable in Centralia except from family, friends and neighbors.



**4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?**

- For many years we have worked closely with our high school guidance counselors and staff at our alternative high school to identify and serve all pregnant and parenting teens with personal visits and/or group connections especially designed for teens. Our high teen parent population greatly fluctuates from none to as many as seven with a typical number being one to three. All five current staff members are trained to serve teens. With our most at-risk families we continue monthly home visits until the child enters kindergarten or the family declines visits. We have some current at-risk families that we have been providing PAT services to for five to eight years. Our program is working toward meeting model fidelity requirements with an increasing number of families as funding allows. Last program year we served three families who had two or more high needs characteristics with model fidelity services. We are striving to increase this number as funding permits and families agree to twice monthly service frequency.
- We use a computerized record keeping system to keep track of referrals made and resources suggested as well as following up with families to see if they accessed the referral or resource. The follow-up is also recorded. We can track the frequency and type of Pat services a family receives, the duration of each contact as well as documenting the content of the contact. Our computerized record keeping system also summarizes the services we have provided to provide year end statistical data to both the Parents as Teachers national office and the Missouri Department of Elementary and Secondary Education about the services we have provided. Our program is currently in the middle of a research grant in collaboration with Project LAUNCH to assess the effectiveness of Parents as Teachers with 30-50 newly enrolled families.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- We have and will continue to collaborate with our elementary and intermediate school counselors and teachers as well as Centralia Head Start to identify at-risk families for PAT services. We also work with Centralia City Hall staff in identifying new residents with young children. Plans are being made to connect with local doctors' offices to encourage their referrals. We currently work with First Chance for Children and Project LAUNCH to provide services to at-risk families. Those collaborations are in place and will continue into the future.
- It is hoped that if agencies and services would have a physical presence in Centralia and the other small communities in Boone County that we would have the opportunity to get to know each other and the services that each provides. Our belief is that this would provide better and more coordinated services for all at-risk families that live in the out-county area.

<b>Agency:</b> Columbia Public Schools Parents As Teachers	<b>Respondent:</b> Ms. Belinda Masters
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***What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?***

- Of the 277 single parents we serve, 230 of them have multiple risk factors from poverty to mental health issues to low education level. We have found that they lack many supports and are often very transient and experience homelessness. This year we have 99 teen parents enrolled in our program. They are either visited in their homes and/or in one of our high schools (Battle, Rock Bridge or Hickman) where Parent Educators/Teen Specialists hold bi-weekly parent groups. We have found that our teens often have insecure housing. Some move often. It can be very difficult to keep them active in the program...particularly home visits. Teen parents often struggle with managing work, home, school and parenthood...leaving little time to meet with a parent educator.

***2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?***

- The PAT staff spends a significant amount of time and resources trying to keep up with our families who are transient and lead lives that are crisis- filled. Additionally, many of our families do not have reliable phones, transportation or other resources that make it a challenge to keep in touch with them for scheduled appointments, screenings, etc. Because we've not been allowed to hire additional staff, caseloads are too large to devote the time and resources needed to provide the intensity of contact that many of our families require.
- While we are proud of our teen parent program in each of the 3 high schools, attendance to our meetings is optional. We have seen our attendance decrease over the past year with the change to block scheduling. Some PAT teen programs in other areas offer students educational credit for attendance that comes from structuring a curriculum that teaches child development and parent education.

***3) Where is the gap in your shelter and/or at-risk population services?***

- Our wait list continues to grow because we lack the staff to serve all of the at-risk parents who are requesting services. The majority of our families are low income. Research and our experience shows that the longer an at-risk family has to wait for services to begin, the greater the chance that we will not be able to retain them in our program. Our large caseloads limit our ability to offer the recommended intensity of services (24 home visits per year) for our most vulnerable families.

***4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?***

- We complete an annual performance report for the Parents as Teachers National Office that measures our service outputs as they relate to meeting the 22 essential requirements and quality standards for successful home visitation programming. We submit regular reports to our primary funder, the Department of Elementary and Secondary Education



that measure outputs in terms of services completed (home visits, screening) as well as demographic information regarding high need factors, race, ethnicity, etc.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- Columbia Parents as Teachers and the other home visitation programs in Columbia (First Chance for Children, Lutheran Children and Family Services, The Health Department and Head Start) make referrals to each other, meet on a regular basis to discuss gaps, new initiatives and projects that we feel would provide a positive impact on our clients, families, and children.

<b>Agency:</b> City of Columbia/Boone County Department of Public Health and Human Services	<b>Respondent:</b> Mr. Scott Clardy
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

- The Columbia/Boone County Department of Public Health and Human Services (PHHS) provides multiple services to shelter and/or at-risk service populations, including managing City of Columbia social services funding, Healthy Babies Home Visiting program, Special Supplemental Nutrition Program for *Women, Infants, and Children (WIC)*, and *nutrition classes*. *While there are several issues that need to be addressed in these populations, including issues as basic as transportation, we feel the top two issues are:*
  - 1) Addressing mental health issues which these populations are not equipped to handle (e.g., maternal depression and toxic stress in children), and;
  - 2) A lack of protective factors. Protective factors are conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities and that, when present, increase the health and well-being of children and families. Protective factors help parents find resources, supports, or coping strategies that allow them to parent effectively, even under stress. Examples include nurturing and attachment between the parent and child, social connections, parental resilience, and knowledge of parenting skills and of child and youth development.

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- There are systematic obstacles in PHHS’ work with these populations. Overall, obstacles include quality infant care and early child education; safe, healthy and affordable housing; underemployment; and systematic exclusions of fathers from impoverished families.





- Our shelter and/or at-risk populations who participate in WIC specifically deal with complicated forms and required attendance at appointments, in order to maintain benefits. As stated above, transportation can be a barrier for these populations.

**3) Where is the gap in your shelter and/or at-risk population services?**

- The gaps tend to be more dependent on the particular service being offered. In the Healthy Babies Home Visiting program, the primary gap is that the demand/need for services greatly exceeds capacity.
- As for WIC services, PHHS serves several prenatal mothers living in shelters, but very few children living in shelters participate in WIC.

**4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?**

- As in question # 3, quantitative measures are service-dependent. For the Healthy Babies Home Visiting program, many short-term, intermediate, and long-term outcomes are measured. Examples of outcome measurement categories include:
  - Single parent households,
  - Domestic violence,
  - Early entry into prenatal care,
  - Health insurance coverage,
  - Tobacco use,
  - Birth outcomes,
  - Birth spacing,
  - Depression screenings,
  - Scores from the Ages and Stages Questionnaire (ASQ) for physical and social/emotional development, and;
  - Child harm (hospitalizations/abuse/neglect).
- WIC performance measures include:
  - Appointment show-rate, and;
  - WIC check redemption rate.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- The administration of Parents as Teachers, Lutheran Family Children's Services, First Chance for Children and the PHHS Division of Human Services currently meet monthly regarding home visitation. These organizations are planning a potential collaborative system of intake, coordination, and performance measurement for the home visitation programming in Boone County. We have also envisioned a multi-agency card or form with basic information such as full name, address, phone, email, and other pertinent information (Mo HealthNet information, income, other household members, etc.). These collaborations could eliminate the need for some of the most common and redundant forms which can be complicated to complete for families.
  - For the Board's information, we are currently participating in the following collaborations:



- Collaboration with the State of Missouri Department of Social Services to provide presumptive eligibility for pregnant women (temporary Medicaid) and serve as the "front door" to services for low-income pregnant women. In this role, we coordinate with numerous community, state, and federal agencies in providing prenatal services with the common goal of healthy pregnancies and positive birth outcomes, and;
- Collaboration with in the Networking Early Childhood Team (NET) which serves as a networking and resource opportunity for front-line home visitors.

<b>Agency:</b> First Chance for Children	<b>Respondent:</b> Mr. Jack Jensen
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

- Our families struggle to meet the basic needs all people have, including food, safe housing, medical care, transportation, etc. This is basically caused by financial insecurity and leads to the families living their lives in poverty and crisis. The stress they live under makes it difficult for them to plan for the future as they are just struggling to survive.
- Our families also struggle to find emotional support from family, friends and community agencies. In most cases our families are single parent households so they do not have the support of a partner as they struggle to meet the needs of their children. Also, their family and friends are in the same crisis situations the parents we are working with live in and can provide little support. Community agencies have limited resources and often cannot supply the degree of services that allow the families to overcome these crisis situations.

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- The majority of our families live in poverty leading to numerous obstacles in providing and maintaining a reliable service model. They are often homeless, or lose stable safe housing. Communication is difficult when they lose phone or internet services because they lack money. When you are able to connect them with services, transportation and child care are often barriers.
- Building trust with the families so they are willing to accept the support we can offer is an ongoing process. They have been let down by so many people and institutions in their lives they are hesitant to accept the help that is available.

**3) Where is the gap in your shelter and/or at-risk population services?**

- There is not a safety net in place that gives families the support they need to make progress in moving out of poverty. They are so busy surviving they cannot pursue education or training that might improve their lives. Limited financial resources, childcare, transportation are also barriers. Because they are in crisis mode so much of





the time they look for escapes through alcohol, drugs and emotionally unhealthy relationships.

**4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?**

- First Chance for Children’s programs are audited yearly to evaluate if we are meeting the requirements of our funding grants. Our home visitation programs use the research based Parents as Teachers Foundational curriculum. Our child abuse and prevention programs were created with input from the Women and Children’s Hospital Staff and The Children’s Trust Fund. We conduct numerous screenings to evaluate if developmental milestones are being met by the children we serve. If there are concerns we provide support for the family. We monitor family goals that they establish. Our families have a low incident rate of child abuse or neglect.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- First Chance for Children works in collaboration with all PAT programs in Boone County to supply additional resources for working with at risk families. We also meet and collaborate with Lutheran Children and Family Services, Head Start, Columbia Public Schools PAT and the City County Health Department to share resources and to make sure families are being best served. These organizations have worked in the past on a joint grant application to help families with mental health needs, the grant was not funded. We currently are looking for ways to help families deal with pre and postnatal stress in a collaborative manner.

<b>Agency:</b> Hallsville Parents As Teachers	<b>Respondent:</b> Ms. Karen Smith
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

- The two issues we would like to address in this population are the need for education (either high school or continuing), and the inability to contact our participants, due to transiency, which also causes inconsistency and a lack of longevity in the services we provide.

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- The funding cut that our Parents As Teachers program sustained in the last few years has greatly impacted our ability to provide needed services to this population. There are many mothers and fathers we are unable to assist because of the lack of available funds. The Hallsville P.A.T. program is over 60% dependent on state funding, and our community has no business or corporate base that can contribute to supporting our program, as some other districts have.



**3) Where is the gap in your shelter and/or at-risk population services?**

- The primary service needed for this population is in the area of daycare facilities/Title 1 Pre-School availability to these families in our community. Parents are unable to afford most of the daycare facilities in our area, and no parent co-op exists here. Our district provides Special Education Pre-School, but nothing else at this time, so the majority of children are not able to take advantage of its' services.

**4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?**

- Over the past 3 years, about 20-25% of the families we serve are part of this at-risk population. Of that number, each child is assessed by the Ages and Stages Questionnaire or the DIAL -4 screening tool to determine their developmental progress. We also administer the Life Skills Progression assessment to identify areas that these families are at-risk. Each of these measure the progress the parent/child make during their participation in the P.A.T. program, and, in the last 3 years, all have shown improvement in their prospective areas. In this same time period, 30% of the children enrolled in our pre-school program have been former enrollees in our program. They each had at least 1 developmental delay, and all showed significant progress when screened at the end of each year.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- The collaborations we are working towards include partnering with area churches to provide basic necessities to families at-risk, including food, clothing and shelter. We're also working towards opening a parent co-op in this area to provide low cost childcare for interested families. Another vision we have is to help those needing educational resources find the schools/training they desire.

<b>Agency:</b> Love, INC	<b>Respondent:</b> Ms. Jane Williams
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

1. Limited social support and relationships (e.g. persons or organizations to turn to in time of crisis, employment networking, emotional support, practical advice, role modeling)
2. Lack of personal life-skills (e.g. money management and other practical living skills, interpersonal/soft skills necessary to find/keep a job and maintain healthy relationships)

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- The two issues that most impact our client population are lack of affordable housing and lack of sustainable wage employment. This is particularly true for those who have barriers to overcome such as poor work, rental, or criminal history. +



**3) Where is the gap in your shelter and/or at-risk population services?**

- Our organization continually seeks to identify gaps in services in our community and find ways to fill them. In some cases we have begun to respond to the gap but do not have the capacity to provide all that is needed. Examples include:
  1. Reliable transportation – Helping clients procure affordable/reliable cars, gasoline, car repairs, bus passes
  2. Rental deposits/assistance for those identified as being able to sustain housing.
  3. Professional counseling services for those who don't qualify for Medicaid/ACA
  4. Basic needs furniture – Shortage of donated beds and dressers

**4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?**

- Our organization counts “needs met” per client to measure provision of basic needs area. We use client surveys to measure increased knowledge and applied knowledge.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- At its core, our organization is a network of local churches and volunteers that seeks to pool resources and strategize together to work more effectively with individuals/families in need and address complex issues that would be beyond the scope of individuals or single organizations. By uniting the faith community through a clearinghouse we are more able to partner with community agencies and enhance the outcomes of all. For example, Love INC is collaborating with two organizations to expand transitional housing for families with children. We are providing oversight and case management for a transitional living house that Compass Evangelical Free church will open in May 2014 and administrative office space and social work support for Saint Raymond’s Society’s new maternity home.

<b>Agency:</b> Lutheran Family and Children Services	<b>Respondent:</b> Ms. Christine Corcoran
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

- The top two issues we experience when working with teen parents are:
  1. Lack of support services: Stability-housing, employment, transportation, parenting, and education. We utilize case management to address the obstacles that these issues bring consistently through their individualized treatment plans. Our youth often do not have the coping mechanisms and problem solving skills to overcome the obstacles that they incur that inhibits their overall well-being. Last year LFCS turned away at least 50 youth that would have benefited from case management intervention services.



2. Mental health needs/ issues. Counseling is a key service to decreasing stress, anxiety, overcoming childhood and familial patterns for the youth and increasing stability. Prevention of abuse and neglect. In 2013, LFCS was able to provide counseling to 20 pregnant and/ or parenting youth through a Children's Trust Fund grant. We have approximately 30 additional youth that could benefit from this service.
3. Our staff maintains full caseloads, in 2013 we served 119 youth. With additional social workers we could accept more referrals for case management and counseling services

**2) *Are there systemic obstacles to your success when working with shelter and/or at-risk populations?***

- Pregnant and parenting teens face a variety of obstacles including a lack of housing, child care, transportation, and employment opportunities. That the majority of the youth we serve have grown up in generational poverty. We are able to help youth break the cycle of poverty through increasing their employment opportunities, parenting skills, overall mental health and relationships

**3) *Where is the gap in your shelter and/or at-risk population services?***

- There is a huge gap in counseling services for pregnant and parenting youth who don't have health insurance. In our current caseloads we have identified at least 30 youth who would benefit from and are open to receiving counseling.
- There is also a gap in case management services (assisting youth with resources, providing counseling and support on an ongoing basis). Our staff maintains full caseloads and routinely has to turn referrals away.
- Our demonstrated outcomes affirm that the services offered are crucial to the success of our young parents and their children.

**4) *What is a quantitative measure of your success when working with shelter and/or at-risk populations?***

- Currently we measure the following:
  1. Healthy pregnancies- teens are at higher risk of having an unhealthy pregnancy. The state average for healthy pregnancies is 73%, our rate for 2013 was 93% of babies born were healthy.
  2. Depression, stress and anxiety- we utilize the Burns depression inventory and our youth have shown a 80-90% decrease in depression, stress and anxiety after our intervention
  3. Parenting skills- LFCS utilizes the Nurturing Parents curriculum which is an evidenced based model. We provide pre and post tests after parenting sessions. Our teens have consistently shown a 100% increase in parenting knowledge
  4. Education- Only 30% of pregnant and parenting youth complete their high school education, approximately 85% of our youth complete or continue their education.



5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?

- The agencies providing home visiting services (Parents as Teachers, Boone County Health Department, First Chance for Children and Central Missouri Community Action) in the community meet monthly to discuss ways to work together and meet the demands of referrals.
- LFCS collaborates with many community partners, such as schools, health clinics, Parents as Teachers and First Chance for Children. We would continue to partner with these agencies to ensure that our youth are getting the most comprehensive services possible.

<b>Agency:</b>	<b>Respondent:</b>
Rainbow House	Ms. Jane Stock

1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?

- More immediate access to mental health evaluation and treatment
- More holistic approach needs to be taken in dealing with issues of poverty including substance abuse, child abuse, domestic violence, crime, hunger, homelessness, etc.

2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?

- **Youth** who are ready to graduate the Homeless Youth Program and/or **parents in crisis** whose children are staying at the Children’s Emergency Shelter who have **felony convictions, bad credit or lack of education** have **limited options available to them when they are seeking employment or permanent housing.**
- **Youth above the age of 18 do not have insurance** that will cover the cost of mental health treatment and/or medication
- **Lack of funding and/or complicated funding stream**

3) Where is the gap in your shelter and/or at-risk population services?

- **Limited number of beds available** for children and homeless youth below the age of 18
- **Pregnant and Parenting homeless teens have no options** available to them for residential services where the child and the parent can reside together
- Youth who are **not** appropriate for our Children’s Emergency Shelter or Homeless Youth Programs because of **severe mental health or developmental issues have no other immediate options for shelter.**

4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?

- Rainbow House strives to make sure that every single child, youth, family that seeks help from Rainbow House is given a resource or service that provides them immediate relief.



- Long term success would be for 100% of the children, youth and families who seek help from Rainbow House (or the other organizations in our community) to have options immediately available to them within the community to ensure that their safety and basic needs are met, at least for one more day.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- Rainbow House Collaborative agencies include: Phoenix Programs, Youth Empowerment Zone, Job Point, Columbia Builds Youth, Youth Community Coalition, Basic Needs Coalition, Wilkes Boulevard Church, Columbia Public Schools, Dept. of Probation & Parole, 13<sup>th</sup> Judicial Circuit Juvenile Office, Central Missouri Community Action, Columbia Housing Authority, Boone County Drug Court, University of Missouri Adolescent Clinic, Children’s Division, Central Missouri Food Bank, Red Cross, Burrell Behavioral Health, MUPC, Boone County Family Resources.

<b>Agency:</b> Salvation Army Harbor House	<b>Respondent:</b> Ms. Cynthia Chapman
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

- The Salvation Army Harbor House is the only shelter that accommodates parents with children, as well as single men and women. Three meals a day are served for Harbor House residents. Unfortunately, there is a stigma related to being homeless and too often, people do not seek the services of Harbor House until they have lost everything. This makes it a longer, more arduous road to start over and re-build lives.
- Faster access is needed for medical and dental services. Even with some funding for co-pays, services for new patients are hard to schedule at Family Health Center.

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- People move into the Columbia area from other metropolitan areas because they can obtain social services much faster in Columbia. This means that there is a constant supply of people seeking services in our area.
- Sometimes Harbor House clients are taken advantage of financially, by their family or other people, when they leave the security of Harbor House. Consequently, some parents with children fall victim to other peoples’ request for money, causing the victims to again need shelter.
- Some people come to Harbor House without documentation they need to obtain other services in the community. Also, the time to obtain SNAP and/or SSDI can be an obstacle.

**3) Where is the gap in your shelter and/or at-risk population services?**





- The Salvation Army Harbor House has a need for a quiet space for study time AND mentors to get children to grade level on important subjects like reading and math.

**4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?**

- Some components of success are:
  - families who obtain housing, and who increase their income, either through employment or through obtaining government assistance,
  - getting children enrolled in school quickly and daily, and
  - increased savings for Harbor House clients.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- We would like to see collaborations that provide for mental health evaluations and beginning treatment within three days of request.
- Also, we would like a collaborative effort that provides mentors to help get children to grade level.

<b>Agency:</b> St. Raymond’s Society	<b>Respondent:</b> Ms. Emma Benham
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

- Our mission is to support mothers who have chosen life for their child, taking particular care to continue support after the baby is born. We provide resources mothers need to become self-reliant and we prepare them to give their child the security of a stable home. The top two issues our clients face are generating adequate income to support an independent lifestyle and overcoming generational perspectives on family support.

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- The obstacles we encounter include difficulty finding affordable childcare, lack of means of transportation, health issues and developing marketable skills.

**3) Where is the gap in your shelter and/or at-risk population services?**

- The current gap we face at St. Raymond’s Society is largely due to generational poverty. We at St. Raymond’s Society are working toward breaking the cycle of generational poverty through empowering mothers to become self-sufficient. Trying to break the cycle of generational poverty comes with many challenges. Our shelter home in Columbia is not on a bus route and transportation is an issue for many of our residents. Many of our residents do not have their own vehicles. Without reliable transportation, it is difficult for our clients to attend appointments for job interviews or take their children to school or day care. While many of the women we serve qualify for state assistance with childcare,



our clients still have difficulty finding childcare they can afford. Many of our clients face challenges receiving adequate services for physical health and mental health due to financial difficulties. Without the basic resources of transportation, adequate childcare or appropriate health services, our clients face challenges in the job market. Many of our clients are unable to continue their education or receive further job training due to the aforementioned obstacles.

**4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?**

- The following are the 2013 statistics for St. Raymond’s Society:
  - 16 women resided at the St. Raymond’s House in Jefferson City
  - All but two of these women had one major accomplishment during their stay at St. Raymond’s Society
  - Last year, six of our residents got full-time jobs; six residents got their own apartments, five residents purchased vehicles, four residents got part-time jobs; four residents earned their GED; one resident earned her driver’s license; one resident earned her Associate degree
  - 14 children resided at St. Raymond’s House in Jefferson City
  - 6 babies were born to clients of St. Raymond’s Society
  - 4 prior house guests spoke publicly on behalf of St. Raymond’s Society
- Our shelter home in Jefferson City can house five families at a time. The average length of stay for our residents in Jefferson City is four months.
- In December of 2013 we purchased a second shelter home in Columbia. St. Raymond’s Society House in Columbia will function in the same manner as that of the St. Raymond’s Society House in Jefferson City. One Board resides over both shelter homes.
- The House in Columbia is a duplex. We will be able to provide shelter for up to six mothers and their children when both sides of the duplex are open. We anticipate that both sides of the duplex will be fully functioning by the end of March 2014.
- Currently there are three mothers, four children and one full-time House Mother residing in the Columbia home. One of our residents is expecting a baby due in June 2014. One more resident is scheduled to move in this Saturday March 1, 2014.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- St. Raymond’s Society currently partners with crisis pregnancy centers, Children’s Division, Lutheran Family and Children’s Services, Love INC, and other local agencies in Jefferson City and Columbia to meet the needs of our clients. We would like to partner with a local childcare center to establish quality care for the children of St. Raymond’s Society. We also need to establish an effective, reliable mode of transportation for the women we serve. Our ultimate goal is to promote self-sufficiency for mothers so that they may provide a safe, loving environment for their children for years to come.

<b>Agency:</b> Sturgeon Parents As Teachers	<b>Respondent:</b> Mr. Shawn Schultz
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

- Parallel developmental needs of parents and their children. Examples: Nutrition, Clothing, Medical Needs, and other resources. Strategies to address the families.

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- The success in knowing they have resources to go to. The trust that they have in our program. Knowing they have the confidence to be successful in the community and with employment and education.

**3) Where is the gap in your shelter and/or at-risk population services?**

- The gap is the lack of willingness to participate in the program.

**4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?**

- 35%

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- To work jointly with programs. To work with contractors through the children services board. Essentially, we would be willing to work with anybody that could provide resources to aid in the success of our young students.

<b>Agency:</b> True North	<b>Respondent:</b> Ms. Jennifer Graves
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

1. Finding safe, affordable housing for our residents remains both our greatest challenge and our top priority.
2. Finding affordable (i.e., “free”) and adequate mental health services – including residential care -- for those with severe mental health needs (regardless of whether the need stems from trauma-induced illness or other).

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- Yes. Although we work hard to educate our community about the dynamics involved in domestic violence, the average citizen does not always understand – the first question



remains “Why does she stay?” – Also, like most non-profits, we struggle to succeed in our mission with fewer dollars awarded through governmental funding each year.

**3) Where is the gap in your shelter and/or at-risk population services?**

- Primarily in our teen population – young teens (13-16 year olds) are at increasing risk of dating violence and sexual assault and, at present, there is no agency in our community that provides direct victim services for this population. When the abuse is peer-related (Rainbow House does provide services for those victimized by adults), no agency is currently able to provide advocacy, counseling or other face-to-face services without parental permission – this violates confidentiality issues and often prohibits teens from seeking services. True North can and does provide hotline crisis intervention and information services to victims regardless of age and is currently seeking funding for a collaborative project with the Youth Empowerment Zone to provide services to this population gap.

**4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?**

- We track the number of shelter residents who leave the shelter for safer environments (i.e., without the abuser) and conduct phone surveys at 3, 6, and 12 month intervals to ensure continued safety and stability in their new environments.

**5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?**

- As briefly mentioned in #3, we are currently seeking funding for a collaborative project with the Youth Empowerment Zone and Centro Latino to both address the gap in service provision and ensure more members of our community understand the dynamics of domestic violence. We also work with the Columbia Housing Authority on resident housing issues (although the need is greater than either agency can currently meet) and work with Phoenix Programs on some mental health issues and McCambridge Center on substance abuse issues. We would like to one day establish collaboration with Burrell Mental Health Services to better address the sometimes severe mental health challenges our residents face.

<b>Agency:</b> Voluntary Action Center	<b>Respondent:</b> Mr. Nick Foster
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**1) What are the top two issues you feel need to be addressed in your shelter and/or at-risk service populations?**

- Shortage of shelter rooms available for families with children.
- Unmarried parents are unable to stay together at some shelters.

**2) Are there systemic obstacles to your success when working with shelter and/or at-risk populations?**

- Limited transportation options to and from shelters or other agencies.



- The following are obstacles in helping to make families stable:
  - Wait time at Family Support Division slows access to SNAP (food stamps).
  - Obtaining identification has become more difficult; one needs identification to obtain identification.
  - Teen parents that are not over age 18 are unable to obtain services because they are not considered adults.
  - Limited resources for parents seeking furniture for their children.
  - Expense of day care.
  - The need for employment supports.

***3) Where is the gap in your shelter and/or at-risk population services?***

- Inability to provide long term housing assistance and only able to provide short term housing assistance if client has a permanent place to stay afterwards. VAC has limited resources and so is limited in provision of emergency shelter (motel). There is a need for more transitional housing.

***4) What is a quantitative measure of your success when working with shelter and/or at-risk populations?***

- Surveys to measure the impact our services had on clients

***5) Please describe potential collaborations you envision for addressing challenges in the shelter and/or at-risk populations service area?***

- VAC provides a broad range of services that enhance the services of many other community agencies. VAC seeks ways to strengthen these connections and improve awareness of shared and unique resources for meeting needs.



## Appendix C: Community Input Session Components

### Session #2 – Community-Based Programs & Family Intervention Services

#### *Invitation to Participate*

**TO:**

February 19, 2014

Anna Drake, Executive Director, Heart of Missouri CASA  
 Annie Jensen, Vice President of Operations, Burrell Behavioral Health  
 Carmelita White, Executive Director, American Home Care  
 Christine Corcoran, Regional Director, Lutheran Family and Children’s Services  
 Heather Dimitt, Executive Director, Big Brother Big Sisters  
 Jack Jensen, Executive Director, First Chance for Children  
 Jan Stock, Executive Director, Rainbow House  
 Jane Williams, Program Director, Love Inc.  
 Jim Wallis, Vice President, Preferred Family Healthcare  
 Karen Cade, Director, Family Counseling Center  
 Larry McDaniel, Executive Director, Coyote Hill Christian Children’s Home  
 Marissa Peterson, Resident Director, Great Circle/Boys and Girls Town  
 Mel Fetter, Chief Executive Officer, Pathways Community Behavioral Health  
 Stephanie Browning, Administrator, Columbia Public Health and Department of Human Services  
 Tara Lusby, Director, Columbia Community Counseling (Presbyterian Children’s Home)

**FROM:** Jacqueline Schumacher, Consultant, Boone County Children’s Services Board

**RE:** Invitation to the March 13, 2014 Community Input Session

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Dear Service Provider,

The Boone County Children’s Services Board (BCCSB) is taking steps to gather information about children’s services in Boone County. The Chairman, Mr. Les Wagner, and his eight-member board seek targeted information from the perspective of local providers whose services and programming align with Missouri Statutes 67 & 210. With assistance from the Institute of Public Policy in the Truman School of Public Affairs at the University of Missouri, the Board is organizing a series of five community input sessions, one of which you are specifically invited to attend.

The organization and variety of community input sessions are driven exclusively by the funding statutes. For clarification, Missouri Statute 67 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children’s Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6 million dollars annually. According to Missouri Statute 210, the Children’s Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

#### **Service Funding Categories**

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
2. Respite care services
3. Services to unwed mothers and unmarried parent services



4. Outpatient chemical dependency and psychiatric treatment programs
5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

You have been identified as a service provider whose services apply to funding Category #2 (respite care), Category #6 (home-based treatment), and/or Category #7 (community-based treatment). You, or a representative from your agency, are invited to participate in the Boone County Children Services Board meeting at **4:30 PM on March 13, 2014** in the Boone County Commission Chambers (RM 110) at 811 East Walnut, Columbia, Missouri 65201. This input session will address the topic of ***Community-Based Programs & Family Intervention Services*** as it applies to Category #2, Category #6, and Category #7.

During the input session, you will be asked five questions (described below). Your answers should be thoughtful, although brief. It is important the Board understands your service area's collective perspective and not simply agency-specific information. Please keep in mind, **your invitation to address the Board is not an opportunity to express your agency's need for funding**. Rather, the focus of the input session will center on the five questions listed below.

Your individual response time to these questions will range between a total of three and eight minutes. This time frame depends on the number of input session attendees. Therefore, please **RSVP** to [schumacherja@missouri.edu](mailto:schumacherja@missouri.edu) by Friday, March 7, 2014. If possible, I will be in touch with you before the input session to confirm the amount of time you will have to answer the five questions below.



BOONE COUNTY CHILDREN’S SERVICE BOARD COMMUNITY INPUT SCHEDULE			
DATE	Service Area	Funding Categories	Questions
Mar 13	Community-Based Programs & Family Intervention Services	<ul style="list-style-type: none"> <li>• <i>Category #2: Respite Care</i></li> <li>• <i>Category #6: Home-based treatment</i></li> <li>• <i>Category #7: Community-based treatment</i></li> </ul>	<ol style="list-style-type: none"> <li>1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?</li> <li>2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?</li> <li>3) Where is the gap in your community-based programs and/or family intervention services?</li> <li>4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?</li> <li>5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention service area.</li> </ol>

We look forward to hearing from your agency next month. Do not hesitate to reach out to me for further information.

*Please RSPV by March 7, 2014*

Sincerely,

JACQUELINE SCHUMACHER, MPA  
 Consultant, Boone County Children’s Services Board  
 INSTITUTE of PUBLIC POLICY  
 Truman School of Public Affairs- University of Missouri  
 137 Middlebush Hall  
 Columbia, Missouri 65211  
 (573) 882-6207(phone)  
[schumacherja@missouri.edu](mailto:schumacherja@missouri.edu)



## Worksheet



INSTITUTE of PUBLIC POLICY

Harry S Truman School of Public Affairs

Dear Service Provider,

You will have between three and eight minutes to address the Children’s Services Board. They will expect you to answer the following five questions. If you would like to submit your answers in advance (or in lieu of attending) please use this worksheet. Email completed worksheets to Jacqueline Schumacher ([schumacherja@missouri.edu](mailto:schumacherja@missouri.edu)).

**Boone County Children’s Services Board  
Community Input Session Worksheet  
March 13, 2014**

- 1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?*
  
  
  
  
  
  
  
  
  
  
- 2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?*
  
  
  
  
  
  
  
  
  
  
- 3) Where is the gap in your community-based programs and/or family intervention services?*
  
  
  
  
  
  
  
  
  
  
- 4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?*
  
  
  
  
  
  
  
  
  
  
- 5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area.*



**Meeting Agenda**

**AGENDA**  
**COMMUNITY INPUT SESSION #2**

**Boone County Children’s Services Board**  
March 13, 2014 starting at 4:30

**Overview:** This input session will address the topic of *Community-based Programs & Family-Intervention Services* as it applies to Category #2 (respite care), Category #6 (home-based treatment), and/or Category #7 (community-based treatment).

**Agenda:**

- 1) *Welcome & Overview:* Jacqueline Schumacher, consultant to the Board
- 2) *Input Session Moderation:* Christian Arment, consultant to the Board

SCHEDULE OF PARTICIPANTS MARCH 13, 2014		
Funding Category	Participant Name	Agency
2: Respite care	Carmelita White	American Home Care
6: Home-based...	Anna Drake & Candice Iveson	Heart of Missouri CASA
6: Home-based...	Julie Arment Marlene Howser	Burrell Behavioral Health
6: Home-based...	Kelly Hill	Love INC.
6: Home-based...	Karen Cade & Libby Brockman-Knight	Family Counseling Center
6: Home-based... 7: Community-based...	Chuck Borduin	University of Missouri, Department of Psychological Sciences
7: Community-based...	Heather Dimitt	Big Brothers Big Sisters of Central Missouri
7: Community-based...	Julia Adami	Great Circle/Boys and Girls Town
2: Respite care 7: Community-based...	Christine Corcoran	Lutheran Family and Children’s Services
6: Home-based... 7: Community-based...	Vinta Khanna & Drew Moffett	Preferred Family Healthcare
6: Home-based... 7: Community-based...	Steve Hollis	Columbia/Boone County Public Health and Human Services

- 3) *Follow-up and Clarification Questions:* Board Members
- 4) *General Input:* Audience & Non-scheduled participants
- 5) *Closing Remarks:* Kelly Wallis, Boone County Director of Community Services





## Feedback Report

### *Community Input Session on Community-based Programs & Family-intervention Services*

The Boone County Children’s Services Board (BCCSB) is taking steps to understand more about children’s services in Boone County. BCCSB contracted with the Institute of Public Policy (IPP) in the Truman School of Public Affairs at the University of Missouri to organize and moderate five Community Input Sessions. BCCSB wishes to make wise expenditures of the Children’s Services Fund and seeks targeted information from local services aligning with the Missouri Statutes 67 & 210. This feedback document provides an overview of the information shared with the Board during the second input session and will help guide BCCSB’s future funding strategies.

Missouri State Statute 67.1775 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children’s Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6.5 million dollars annually. According to Missouri Statute 210.861, the Children’s Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
2. Respite care services
3. Services to unwed mothers and unmarried parent services
4. Outpatient chemical dependency and psychiatric treatment programs
5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

**Overview:** The BCCSB hosted Boone County social services agencies at their bi-monthly board meeting on March 13, 2014. The topic of this session was *Community-based Programs & Family-intervention Services* which centered on respite care, home-based treatment, and community-based treatment. A total of 16 agencies were invited to participate, of which 11 were able to attend. A total of 11 agencies prepared and submitted formal comments on worksheets which addressed the Board members’ predetermined questions. Table G is a reference guide to



the Community Input Session #2 and quantifies the number of agencies engaged in the convening.

Table G: Community Input Session #2 By the Numbers	
Session #2	Date: March 13, 2014
	Community-based Programs & Family-intervention Services
	Topic: Services
	Funding categories: 2, 6, & 7
	Number of invited participants: 16
	Number of scheduled participants: 11
	Number of worksheets received : 11
Number of individuals in attendance: 25	

**Methodology:** Boone County agencies having services which apply to Category #2, #6 and #7 were invited to attend the BCCSB meeting on March 13, 2014. When an agency confirmed their desire to participate in the meeting they were provided with a worksheet containing five pre-established questions developed by the Board. A copy of the agency worksheet may be found in Appendix A. Invited agencies were given two directives: first, agency representatives were encouraged to submit their written responses to the Board’s five questions in advance of the meeting. These responses may be found in Appendix B, and are organized by agency name. Second, agency representatives were instructed to use their meeting participation time to answer these questions. Each respondent was given a total of five minutes.

The Board’s pre-established questions are as follows:

Question #1: *What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?*

Question #2: *Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?*

Question #3: *Where is the gap in your community-based programs and/or family intervention services?*

Question #4: *What is a quantitative measure of your success when working with community-based programs and/or family intervention services?*

Question #5: *Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services area.*

**Findings:** The following responses are organized by question and have been de-identified. This allows the aggregated responses to point toward themes and topics rather than agency-level



information shared as a byproduct of the participant’s responses during the input session. When possible, responses in bulleted lists are categorized by topic: *Shelter, mental health, transportation, basic needs, education, access* (meaning shortages, bottlenecks, agency capacity), *structure/systems* (meaning collaboration, billing, state-level issues), and *early intervention*. The “other” category is catchall for items that do not readily fit into the aforementioned groups.

**Top Two Issues – Community-Based Program & Family Intervention Services**

During the community input session, the following were mentioned in response to the question: *What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Mental Health**

- Behavior health needs (maternal depression, toxic stress in children, substance abuse, and chronic mental illness)
- Mental health services specialized in child welfare
- Trauma Informed Care\* is child-specific

**Basic Needs**

- Basic needs furniture and housewares

**Education**

- Education for the families that inspire change in the social beliefs and norms
- In-home service providing parent aid/education
- Parents are not able to adequately gather information about services available to them or how to access services
- Parents have little to no knowledge about basic child development
- Provide training to parents and teachers to help identify, respond to, and manage behavioral health needs

**Access (shortages, bottlenecks, agency capacity)**

- Access to services quickly
- Huge lack of services for older youth
- Securing access to services that are tailored to a child’s specific need

**Early Intervention**

- Prevention\*\* and early intervention that is integrated in schools and the community
- Utilization of the school system to reach adolescents and families with valuable behavioral health education, prevention, and treatment
- A sheer lack of protective factors that, if present, could mitigate or eliminate risk in families

**Structure/Systems (collaboration, billing, state-level issues)**

- Comprehensive in-home family services coordination with other agencies
- Mental health issues/needs is extensive for our clients, but lack of insurance limits access to therapy
- Services must be delivered in home, school, neighborhoods, i.e. not a clinical setting

**Other**

- Actions to address dangerous/hazardous environment to the kids (we engage in hotlines, but we have no follow-back for hotline results). Additional information sharing is need this regard
- Lack of personal life-skills
- Limited social support
- Lack of support services for our clients, they need specifically case management
- Services must be evidence-based

*Summary:* Education, training, and knowledge sharing appears to be an inherent part of the community- and home-based intervention process and can have a positive impact on parents and caregivers. Agencies often struggle with working though the dilemma of serving with clients



who lack insurance. The most commonly mentioned issue among agency representatives is the need for prevention and early intervention services. Follow-up comments noted that an integrated prevention system in the schools and community would allow for access to adolescents and families.

**Systematic Obstacles to Success – Community-Based Program & Family Intervention Services**

During the community input session, the following were mentioned in response to the question: *Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Transportation**

- Lack of transportation for clients to participate in community-based programs

**Basic Needs**

- Lack of basic needs (employment, housing, transportation)
- Lack of quality infant care and early child education
- Lack of safe, healthy, affordable housing
- Underemployment

**Education**

- Stigma around mental health and lack of knowledge

**Access (shortages, bottlenecks, agency capacity)**

- Difficulty accessing entry into services for smaller communities in Boone County (i.e. transportation, and awareness of services)\*\*
- Delays in service provisions can extend a child’s time in state custody
- Lack of agency capacity to provide more in-home services
- Therapy and psychiatry services are not readily available after hours due to a lack of availability of licensed providers.

**Early Intervention**

- Early identification of children and families in need
- Early screening

**Structure/Systems (coordination, billing, state-level issues)**

- Collaboration – there is a tendency to work in silos
- Eligibility criteria related to the qualifying diagnosis and insurance
- Lack of affordable services for the un/underinsured
- Eligibility expiration and timely execution of services when funding is slow
- Kids are involved in multiple systems that don’t always talk to one another
- Lack of healthcare coverage including behavioral health and oral health
- Lack of integration between agencies

**Other**

- Consensus of the community in identifying areas of collaboration
- Expense for on-going professional development for mental health providers in evidence-based practices
- Funding
- Generational poverty
- Lack of funding in the field
- Systematic exclusion of fathers from impoverished families

*Summary:* Systematic obstacles to success in community- and home-based interventions circle back to two themes – the first is access and the second is the structure/systems in place. In this categorization scheme, access refers to shortages, bottlenecks in care, and a lack of agency capacity to serve more clients. Here, access issues range from the limited availability of services outside of Columbia, MO to agencies’ lack of capacity to meet the demand for more in-home



services. Client awareness of services, followed by transportation for Boone County residents living outside of Columbia, MO proves to be problematic. Structure/system issues point toward agency integration and coordination, client eligibility, and billing issues.

**Gap in Services – Community-Based Program & Family Intervention Services**

During the community input session, the following were mentioned in response to the question: *Where is the gap in your community-based programs and/or family intervention services?*

Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Shelter**

- Shelter provisions for homeless
- Transitional living slots

**Mental Health**

- Mental health services for parents
- We lack the opportunity to screen the individual, identify the need, and connect them to services

**Transportation**

- Reliable transportation

**Basic Needs**

- Basic needs furniture
- Need for additional foster homes at all levels

**Access (shortages, bottlenecks, agency capacity)**

- Shortage of licensed therapists and psychiatrists\* (outside of Columbia, MO)
- Children often need services immediately and they cannot be seen due to lack of available services in the area and/or long wait time for admissions into treatment
- Demand/need exceeds capacity
- In-home services are provided only to a limited number of our clients, we would like to serve more and increase staff and volunteer capacity
- Lack of case management services (we are operating at capacity all the time and have to turn away clients)
- There is a tremendous need for programs and services that are not only family-based, but community-based and evidence based

- We know we are not serving all the kids we could, but if we were to increase our referrals, we would meet with limitations in the supply of services

**Early Intervention**

- We fall short of identifying families and kids at an early stage of need

**Structure/Systems (coordination, billing, state-level issues)**

- Counseling services for people without health insurance
- Collaboration to create ongoing communication and network opportunities with other agencies who can supplement our services
- Current billing practices limit the availability of types of specialized therapists
- Limited menu of community and home-based services that are billable through Department of Mental Health
- More collaboration among agencies may prevent kids from falling in the gap
- We don't have a structured relationship outside of the schools and housing authority – we have a gap in forming relationships with other agency caseworkers or therapists who may already be working with our families

**Other**

- Autism evaluation and services

*Summary:* The gap in community- and home-based care is consistently described as a gap in access. Here, access is described as shortages in services, bottlenecks in care, and limited agency capacity. One agency representative astutely described her situation as the following – *My community-based organization is aware of the vast number of kids who we do not reach. We*



*have the ability and desire to serve more youth – But, if we increase the number of youth served in our program we know that means sending more kids onto the waiting lists to receive counseling and mental health services from our partnering agencies. By us doing more of our work, we simply continue to flood the already strapped system for mental health treatment services. We are not a mental health agency, we do community-based work and we see firsthand the need of families but we cannot always help them get expedited mental health services. A different respondent mentioned – We can usually get a child in to see a mental health provider for a first-time appointment or in a crisis situation. The problem is with follow-up visits. The child's second visit with a care provider is often pushed out 2 or 3 months.*

### **Quantitative Measures of Success – Community-Based Program & Family Intervention Services**

During the community input session, the following were mentioned in response to the question: *What is a quantitative measure of your success when working with community-based programs and/or family intervention services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

- Birth outcomes
- Birth spacing
- Change of attitudes
- Child harm (hospitalizations, abuse, neglect)
- Client surveys
- DECA
- Decreased incidents
- Depression, stress, anxiety measurements
- Domestic violence incidents
- Each program goal is associated with a quantitative measure
- Early entry into prenatal care
- Early entry into WIC
- Establishing permanency for a child
- Expediting permanency for children, length of time to achieve permanency, number of placements, re-entry rate in to foster care
- Health insurance coverage
- Improved resiliency
- Improved quality of life
- Increased medication compliance
- Measurement of needs met and knowledge gained
- Multiple assessments
- Number of healthy pregnancies
- Number of single parent households
- Our measures are research and evidence-based tools
- Parenting skills curriculum with pre and post tests
- Pre and post measurements prescribed by evidence-based programs
- Success based on surveys, performance, desired level of performance and action items for their achievement
- Surveys
- Tobacco use
- Tracking if family remains intact at 3-6-12 month intervals
- Youth Outcome Survey (YOS)





*Summary:* Responses to the question asking about quantitative measures of success indicate that all participating agencies have some method in place for tracking performance. However, there is no clear theme represented here. Responses vary by sophistication level of data collection. Inherent to the topic of this input session, it should be noted that community-based “programs” are measured differently from family-based “interventions.” The theoretical differences in prevention vs. intervention approaches should be taken into consideration when examining measurements of success.

**Potential Collaboration – Community-Based Program & Family Intervention Services**

During the community input session, the following were mentioned in response to the question: *Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services area.* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

- Brokering case plans with all agents involved in new client care
- Coordination, and performance measurement for the home visitation programming in Boone County
- Promote and welcome networking opportunities among community agencies
- There is a monthly meeting of local agencies on the topic of home visitation – these organization are planning a potential collaborative systems of intake,
- We are looking to create partnerships with local treatment centers, therapists, and counselors
- We see the opportunity for increased collaboration outside of Columbia, MO
- Work with Columbia Transit Authority to allow discounted bus passes
- Yes, as part of our CPR, we collaborate with multiple community agencies
- Yes, we collaborate by design
- Yes, through public awareness campaigns
- Yes, we collaborate with many partners to ensure our clients are getting the most comprehensive services possible
- Yes, we offer joint life skills classes
- Yes, we work with others and will continue to do so

*Summary:* The apparent theme from providers is that, “yes”, many do actively collaborate and place value on the joint process of serving youth and families. Through the community input process, agencies appear to have the intuitive nature to pool resources and eliminate redundancy through collaboration. However, an interesting and perplexing note revealed itself during the input session. Some agency representatives mentioned a lack of collaboration as a shortcoming and expressed a desire for better agency coordination. In addition to the critique that agencies work is silos, the example was given – *At times we are serving a family in our home-based program and we are unaware that a second agency is also working with that family. If we had known this and had better information sharing among agencies, we could have coordinated a joint approach.* A different respondent said – *We just cannot send one of our clients down the street to the next agency for specialized services. Often we need to escort them there. Better yet would be to have a representative from the agency come our offices to meet our client for whom we are establishing a bridge of services.*



**Conclusion:**

Community-based programs and home-based interventions facilitate service providers to meet families outside of clinical settings and to link them into services. The range of services can identify needs, offer primary prevention, and, if needed, make the connection to mental health or medical professionals. Most importantly, community-based and home-based approaches can ease the client’s burden of transportation.

While Boone County providers see the value in meeting clients in the community, many are faced with a volume of demand that they are incapable of meeting. At times, service gaps can be mended with agency-level coordination, collaboration, and referrals; but, more often than not, the shortage of service professional in the field sustains the dearth of community-based and family-based services. In the meantime, continued education, training, and knowledge transfer from providers to parents/caregivers during the process of community- and home-based services may serve as a protective factor among families.

At the close of the meeting, Board members asked informal questions of participants. Questions surrounded a variety of topics, but most notably were themes of Medicaid reimbursements, match funding, un/underinsured clients, and Boone County’s shortage of mental health professionals. These questions, and responses, circle back to the theme of access as it relates to shortages in services, bottlenecks in care, and a lack of agency capacity to meet the demand.

**Agency Worksheets**

<b>Agency:</b> American Home Care Management	<b>Respondent:</b> Ms. Carmelita White
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**1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- Limitations in actions that could be taken with families in respect to addressing environments that could be a potential endangerment.
- Education for families that would inspire a change in attitudes, beliefs, and social norms.

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- Eligibility and requirements being rendered in a timely manner

**3) Where is the gap in your community-based programs and/or family intervention services?**

- Collaborations to create ongoing communication between the funders and the community based agencies





- Initiatives for networking that will open access to additional resources for families

**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- Surveys/research that provided reflections of current level of performance, desired performance, and how goals will be achieved.

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area.**

- Promote/welcome networking and collaboration opportunities amongst community agents to ensure that advantage is taken with any opportunity where two or more agencies work could complement one another.
- Institutes new programs that will educate families
- Brokering case plans with all agents involved in clients care

<b>Agency:</b> Big Brothers Big Sisters of Central Missouri	<b>Respondent:</b> Ms. Heather Dimitt
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**1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- One of the biggest needs we see on our caseloads is parents who have little to no knowledge about basic child development (physical, psychological and educational), how to provide a safe and structured home environment for a child and a very limited to non-existent support system.
- Another concern we have is that parents are not able to adequately gather information about the services available to them or how to access those services.

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- As we go into homes for parent and child interviews, a part of our screening process is asking questions that identify child abuse, domestic violence and substance abuse. When we detect those concerns, we don't know to where we should refer families for treatment and/or counseling.

**3) Where is the gap in your community-based programs and/or family intervention services?**

- We don't have a structured relationship outside of the schools and housing authority with any other agency caseworkers or therapists who may be working with our families to help us identify additional areas where our children need help building resiliency.



**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- Our primary focus is on increasing a child’s developmental assets and resiliency. We use a measure called the Youth Outcomes Survey (YOS). The YOS is a researched based survey developed by Big Brothers Big Sisters of America to measure the child's developmental assets. It is given at the child's intake interview and then again at the yearly anniversary of the match. We also track educational progress, out of school suspensions and juvenile referrals for many of our children.

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area.**

- Since our organization matches children with caring adults in the community for a minimum of one year, we can help provide the community support that is a crucial part of a treatment, therapeutic or counseling plan. We are looking to create partnerships with local treatment centers, therapists and counselors to help create a community support system for higher needs children. (All of our children now are from single parents, children of prisoners, in long-term foster care or referred by their teacher or school counselor.) The higher needs children would fit our base criteria but will also have additional risks such as child/parent is in therapy for a substance abuse problem, mental health issue, child abuse/domestic violence, etc.; child is a pregnant teen; child is receiving services for a learning disability or behavior disorder. All of these children will be assigned to one Match Support Specialist (our caseworkers) who will have some therapeutic training and/or experience. This Match Support Specialist will work closely with the current child/family therapist to identify the resiliency skills most likely to help the child. The Match Support Specialist will then communicate these necessary skills to the mentor and help him or her generate a plan of action to help the child start building those skills. Mentors matched with children on this caseload will need special guidance and training beyond the standard training and support all of our mentors receive.
- These partnerships would also help us develop a relationship with treatment services in the community which would then help us make appropriate referrals for problems that we identify during our screening process.

<b>Agency:</b> Burrell Behavioral Health	<b>Respondent:</b> Ms. Julie Arment
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Burrell’s Comprehensive Psychiatric Rehabilitation Program is a community and home based program that serves children and adolescents with a mental health diagnosis and their families’. A Community Support Specialist visits the family (at least once a week) to assist the family with various aspects of treatment, including, but not limited to the following:

- Communication skills training
- Family conflict resolution
- Anger management
- Stress management
- Socialization skill building



Accessing and coordinating other needed services  
Monitoring behavioral progress (classroom and home)  
Consultation with schools  
Parenting skills training  
Re-establishing family roles  
Liaison with other agencies providing services to the child

**1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- **Prevention & Early Interventions** are foundational to a tiered system of support. Prevention provides education and support to the community-at-large. Schools have a major role in providing this foundational information to students in school through their counseling program for example, bullying, being safe and healthy choices.
- There is a role for community providers to educate stakeholders (including medical doctors, pediatricians, school staff, community agencies, families, etc.) about issues related to mental health and wellness. Prevention also includes early interventions to address at-risk signs and prevent future, more severe types of social-emotional-behavioral concerns. This work is done most effectively in an integrated system with schools.
- Another issue is that of **Trauma-Informed Care**. Given all we know about trauma today, how traumatized children experience themselves, their environment, ourselves as practitioners and how they experience the world must guide us in our assessment, care of and treatment of traumatized children.
- The primary philosophy of trauma-informed care is to “do no harm,” by not making assumptions that children must be traumatized by what they have been exposed to, or if traumatized, that all children need the same intervention.

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- Our community and home-based services are provided through our case management program which has **eligibility criteria** determined by the state. One of the systemic obstacles is related to the qualifying diagnosis and insurance. Families who are private pay are not able to access these services because the insurance won't cover it and they can't afford it. There are many children and families in need of this level of support who we cannot serve due to the criteria we are required to follow.
- Another obstacle is the **difficulty accessing** entry into services **for smaller communities** in Boone County (such as transportation and awareness of services available).
- Also, adjunct mental health services such as **therapy and psychiatry are not readily available** after hours due to lack of availability of licensed providers.
- In addition, **the lack of integration between** agencies and divisions is an obstacle. Each has different eligibility criteria and there is no unified system to get families into services.



Some families do not have the resources to navigate these services. (For example, Intellectual Disability, Substance Abuse, Mental Health.)

- Lastly, **the expense for on-going professional development** for mental health providers in evidenced-based practices can make these necessary treatment modalities prohibitive to agencies.

**3) Where is the gap in your community-based programs and/or family intervention services?**

- We believe there are two primary gaps in community and home-based services. One is a **shortage of licensed therapists and psychiatrists.**
- Another is a **limited menu of community and home-based services that are billable** through the Department of Mental Health. In particular, home-based family therapy is non-billable. Funds not tied to Medicaid restriction would allow us to access and serve children and families where, when and how it’s best for the consumer.

**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- The quantitative measure we use is a research and evidenced-based tool that looks at 20 areas of functioning that has been normed within the general population from ages 6 to 80 years old. It assesses if people are within normal limits of functioning.
- This tool is accepted by CMS (Center for Medicaid & Medicare Services), CARF (Commission on Accreditation of Rehabilitation Facilities), JCAHO (Joint Commission on Accreditation of Healthcare Organizations).
- This tool provides scales in the areas of mental health, substance abuse and intellectual disabilities.
- We also are currently using the **DECA** for youth under age 6.
- These tools are used to monitor progress and as outcome data measures.
- Additional information guides treatment planning for example, in school/out of school suspensions, office referrals, grades, teacher, parent student surveys, behavior plans, treatment goal progress.

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area.**

- We presently collaborate with multiple community agencies on a regular basis as part of the treatment provided through CPR.
- However we see increased potential for collaboration with outlying communities and providers that serve those youth and families.
- Also ensuring collaboration between divisions for youth who are dual-diagnosed.

<b>Agency:</b> City of Columbia/Boone County, Missouri	<b>Respondent:</b> Mr. Steve Hollis
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Department of Public Health and Human Services
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**1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- The Columbia/Boone County Department of Public Health and Human Services (PHHS) provides multiple services in this domain including managing City of Columbia social services funding, prenatal case management services, and the Healthy Families home visiting program. *Based on our decades of experience in providing these services, the top two issues are:*
  - Behavioral health issues (e.g., maternal depression, toxic stress in children, substance abuse, and chronic mental illness)
  - A lack of protective factors. Protective factors are conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities and that, when present, increase the health and well-being of children and families. Protective factors help parents find resources, supports, or coping strategies that allow them to parent effectively, even under stress. Examples include nurturing and attachment between the parent and child, social connections, parental resilience, and knowledge of parenting skills and of child and youth development.

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- Overall, obstacles include a lack of quality infant care and early child education; lack of safe, healthy and affordable housing; lack of healthcare coverage including behavioral health and oral health; underemployment; and systematic exclusions of fathers from impoverished families.

**3) Where is the gap in your community-based programs and/or family intervention services?**

- The primary gap is that the demand/need for services greatly exceeds capacity.

**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- The Healthy Families home visiting program utilizes a performance measurement logic model comprised of twenty four (24) short-term, intermediate, and long-term outcomes. Examples of outcomes measured include:
  - Single parent households,
  - Domestic violence,
  - Early entry into prenatal care,
  - Health insurance coverage,
  - Tobacco use,



- Birth outcomes,
- Birth spacing,
- Depression,
- Physical and social/emotional development (Ages and Stages Questionnaire (ASQ and ASQSE)
- Child harm (hospitalizations/abuse/neglect)
- The prenatal case management program utilizes a standardized risk assessment tool to identify risks among pregnant women. The desired program outcomes are:
  - Early entry into prenatal care
  - Access to health insurance coverage for the pregnancy
  - Early entry in WIC

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area?**

- The administration of Parents as Teachers, Lutheran Family Children’s Services, First Chance for Children and the PHHS Division of Human Services currently meet monthly regarding home visitation. These organizations are planning a potential collaborative system of intake, coordination, and performance measurement for the home visitation programming in Boone County. As part of this planning, a common web-based database is being considered. A common database would reduce barriers for families, avoid duplication of service, and facilitate performance measurement at the individual level.
- Our department is currently participating in the following collaborations:
  - Collaboration with the State of Missouri Department of Social Services to provide presumptive eligibility for pregnant women (temporary Medicaid) and serve as the "front door" to services for low-income pregnant women. In this role, we coordinate with numerous community, state, and federal agencies in providing prenatal services with the common goal of healthy pregnancies and positive birth outcomes, and;
  - Member of the Networking Early Childhood Team (NET) which serves as a networking and resource opportunity for front-line home visitors.

<b>Agency:</b> Family Counseling Center of Missouri Pathways Community Behavioral Health	<b>Respondent:</b> Ms. Karen Cade Ms. Libby Brockman-Knight
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**1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- Pathways and Family Counseling Center in the Boone County area provide services for children of all ages – from birth through adolescence. The first top issues that we feel need to be addressed in our service population are prevention services specifically targeting the identification of mental health issues and connection to and coordination of services (through programs like MHFA) and Bullying prevention. Our second issues that





we feel needs to be addressed within our community is Targeted in-home family services to include parenting skills training, in-home family therapy and wraparound community support services for at risk families in order to Break the cycle of vulnerability and repetition for high-risk children and families ,Support children and their caregivers in forming strong, functional and resilient attachments, Provide an enriched environment to support all domains of child development and Support parents in their own emotional development and in developing parenting skills in a supportive setting

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- Some systemic obstacles in providing these services include
  - Identification of families and children in need
  - Early screenings for at risk youth – especially in early childhood – from birth until school age
  - Consensus from community and community agencies of the need and support of programs through community collaboration
  - Funding

**3) Where is the gap in your community-based programs and/or family intervention services?**

- In addition to the gaps just mentioned, one particularly exists for at risk children from the ages of birth until school age due to the lack of opportunities to screen and identify children and connect them with the appropriate services.

**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- Through prevention and Family based services, Pathways and Family Counseling Center measures success by completion of community trainings and awareness of issues, decreased incidents of bullying and violence, attitudinal changes measured by assessment tools and surveys, decreased hospitalizations, satisfaction surveys, improvement in family functioning and resiliency, completion of treatment goals and improvement in quality of life.

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area?**

- Pathways envisions that through Collaborations with our schools, United Way, Juvenile office, Division of Family services, Housing Authority, University Hospital Center and High risk OBGYN Clinic as well as many other community agencies that we can increase identification for at risk children and families and help bridge the gaps in services.

<b>Agency:</b>	<b>Respondent:</b>
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Great Circle/Boys and Girls Town

Ms. Susan Reeves & Ms. Julia Adami

**1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- Increased commitment to both primary and secondary prevention focused on stabilizing families is essential. For those who come into contact with our foster care program or intensive in home program, maltreatment is only one of a multitude of adverse experiences. Other experiences often seen are: family dysfunction, drug & alcohol abuse, involvement with criminal justice system, mental health for children and adults, homelessness and educational issues.
- Thus,
  1. In-home services providing parent aide/education, supervised visitation in homes.
  2. Mental health services specializing in child welfare oriented issues along with a trauma informed care focus within schools and homes.

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- Collaboration - tendency to work in silos which may be due to the intensity and demands of the work. Greater collaboration improves the continuum of care. For example, a streamlined referral process that focuses on early identification of at-risk families across the board or that recognizes early signs of trauma.

**3) Where is the gap in your community-based programs and/or family intervention services?**

**Respite/Placement options:**

- An increase in shelter provisions for homeless youth or youth in crisis would be beneficial.
- Great need for additional foster homes at all levels; including, Therapeutic Foster Care-offers less restrictive environment than residential.
- Transitional Living slots need to be increased. Great Circle has 8 beds currently.
- Mental health services for parents - both therapy and psychological evaluations.
- Autism Evaluations & Services, the waiting list at the Thompson Center is approximately 6 to 8 months out.

**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**





- For foster care, we measure success by establishing permanency for a child. That could be reunification with their parents, an adoption or guardianship but ultimately moving the child out of the foster system.
- For Intensive In-Home Services we track whether or not the family remains intact at the 3, 6 and 12 month mark.
- Grant funded programs we use pre and post measures from evidence based evaluations such as the Parenting Stress Index or the Eyeburg.
- For Older Youth we track where and how they are doing every two years up through age 21.

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area.**

- Public Awareness & Educational Campaigns
- School-based programs
- Respite Services/Therapeutic Foster Care
- Transitional Living Programming

<b>Agency:</b> Heart of Missouri CASA	<b>Respondent:</b> Ms. Anna Drake
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**1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- CASA’s service population is very clearly defined. We only serve children who are already involved in the child welfare system and in custody of the 13<sup>th</sup> judicial circuit, which includes Boone and Callaway counties. There are currently 483 children in custody in Boone County, approximately 3/4ths of the total for the circuit. These children have multiple needs, including services in other service areas and categories defined by MO Statute 67. i.e. transitional living services, professional counseling and therapy, etc. To meet our overarching outcomes of expedited permanency for these children, our volunteers must be able to access multiple services that are tailored to client need. And they must be able to access those services quickly. Our main concern is the rising number of abuse and neglect cases in Boone County that are straining already overburdened resources (see below) and a lack of services for older youth.

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- Yes and No. Yes, in the sense that these children are involved in multiple complex systems, including the courts and the Children’s Division (CD) that are beyond the scope of this group, or any one service area to address. There are two DJOs in Boone County who handle most child abuse and neglect cases. GAL’s represent up to 75



cases, and CD staff carry 30 – 35 cases. Only the volunteer CASA is able to focus on these child's best interest—that often includes their family as almost half of these children return home. No, in the sense that we are generally able to access services because funding for those services is available, though our partners' limited capacity can sometime delay entry. Delays in service provision can extend a child's time in state custody and delay permanent placement.

**3) *Where is the gap in your community-based programs and/or family intervention services?***

- We have our own gap in service provision, currently serving less than 20 percent of our 13 Judicial Circuit's cases. Were we to serve a higher percentage of cases, it is likely that our volunteers would encounter more difficulty in securing necessary services. Overall, the rise in cases is partially attributable to lack of prevention services and delays or limitations in providing substance abuse treatment to their families. Current billing practices limit the availability of therapists trained in dialectical behavior therapy (DBT) with children, a technique that has been proved effective in some cases.

**4) *What is a quantitative measure of your success when working with community-based programs and/or family intervention services?***

- CASA has a proven record of shifting children from being system-dependent to being system contributors. Like Children's Division and the Court, we use Length of Time until Permanency is Achieved as a primary quantitative measure of success. Children with a CASA are more likely to reach permanency (a safe, stable home) sooner than those children without a CASA. Furthermore, children with a CASA are less likely to re-enter foster care and less likely to bounce from home to home. Children with a CASA volunteer also will receive more targeted services while in foster care than those children without a CASA volunteer. (Visit [www.casaforchildren.org](http://www.casaforchildren.org) for more information about this and other metrics.) Our measure of success in working with our partners is whether their intervention contributes to achieving these goals.

**5) *Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area.***

- CASA is collaborative by design. Because we do not deliver therapeutic services, our success depends on good relationships with other service providers. Our staff builds those relationships through active participation in many community collaborations so that we know the array of services available to our volunteers. Our volunteers benefit from provider presentations at our trainings and monthly in-service meetings. Each volunteer is also a collaborator, attending Family Support Team meetings, and working with the team to ensure the child's best interests. Finally, because they establish one-on-one connections with the children and families involved in their case,



the CASA is a collaborator in establishing the child’s best interests and becomes a unique and integral part of the team as an advocate for those interests. Our program design is built upon and depends upon ALL these collaborative relationships to improve outcomes for these children. Our most formal collaborative relationship is with the Boone County courts, with whom we have a Memorandum of Understanding for the provision of services. While we are an independent agency, our staff and volunteers are sworn in as Officers of the Court and as such we abide by the parameters set forth by that court.

<b>Agency:</b> Love INC.	<b>Respondent:</b> Ms. Jane Williams
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***1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?***

1. Limited social support (persons or organizations to turn to in time of crisis emotional support, employment networking) and lack of personal life-skills (money management, interpersonal skills needed for successful employment and healthy relationships)
2. Basic needs furniture and house wares.

***2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?***

- The two factors that most hinder our provision of services are lack of transportation for clients to participate in community based programs and lack of agency capacity to provide in-home services.

***3) Where is the gap in your community-based programs and/or family intervention services?***

- Our organization continually seeks to identify gaps in services in our community and find ways to fill them. In some cases we have begun to respond to the gap but do not have the capacity to provide all that is needed. Examples include:
  1. Reliable transportation – Love INC provides a limited number of clients with gasoline, car repairs and bus passes. We are developing a program to help clients shop for and maintain affordable cars. An average of 6 donated cars per year are awarded to families participating in our programs. We would like to expand all of these areas.
  2. Basic needs furniture – In 2013, Love INC provided furniture/houseware to 257 families but frequently had a waiting list for beds and dressers and in some cases were not able to fulfill the need.
  3. In-home services are provided to a limited number of clients through our professional social work staff and community volunteers. We would like to serve more families but are limited by staff capacity to provide direct services and recruit/train volunteers.



**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- Our organization counts “needs met” per client to measure provision of basic needs area. We use client surveys to measure increased knowledge/applied knowledge and improvement in life situation, and goals met. Specific measurement tools we use are Social Occupational Function Assessment (SOFA) and the Readiness for Change stages which are used in conjunction with our own psychosocial assessment.

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area?**

- At its core, our organization is a network of local churches and volunteers that seeks to pool resources and strategize together to work more effectively with individuals/families in need and address complex issues that would be beyond the scope of individuals or single organizations. By uniting the faith community through a clearinghouse we are better able to partner with community agencies and enhance the outcomes of all.
- For example, Love INC collaborates:
  - To provide life skills classes to the community. Partnerships include: Memorial Baptist Church (facility), Christian Fellowship Church (bus/drivers), MU Service Learning (childcare workers), and multiple churches/agencies (instructors/refreshments).
  - To provide support for single mothers. Love INC brought to Columbia The Caring People (nonprofit that assists communities to a establish a support group network), provides free office space for their regional director and facilitated establishment of a Latino group in conjunction with our life skills program.
  - To facilitate city bus travel. Columbia Transit Authority allows Love INC to distribute half price bus passes to those identified as low income. Love INC offers classes/individual lessons to teach clients how to ride the city bus.
  - To create church “gap” ministries to fill voids in local services. Examples include: Job Club, hygiene products closet, tots clothing closet, bunk bed frames, sewing center, home bound food delivery, transitional housing.

<b>Agency:</b> Lutheran Family & Children’s Services	<b>Respondent:</b> Ms. Christine Corcoran
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**2) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- Nurturing Kids offers services to children at risk for abuse and neglect. Child abuse and neglect is a serious issue in Missouri with more than 93,000 children involved in hotline calls and over 11,000 children (monthly average) in the custody of the Children's Division due to child abuse and neglect in 2012. Our target population is Boone County children, generally from birth through age six, who are at risk of child abuse and neglect and their families.
- The top two issues we experience when working with the parents we serve are:



1. Lack of support services: Stability-housing, employment, transportation, parenting, and education. We utilize case management to address the obstacles that these issues bring consistently through their individualized treatment plans. Our clients often do not have the coping mechanisms and problem solving skills to overcome the obstacles that they incur that inhibits their overall wellbeing. Last year LFCS turned away at least 60 clients that would have benefited from case management intervention services. Those 60 potential clients were just clients that were referred but turned away due to high case loads. Many referral resources didn't refer to us because they knew our case loads were at capacity. We believe that the need for services is much greater than what was documented.
2. Mental health needs/ issues. Counseling is a key service to decreasing stress, anxiety, overcoming childhood and familial patterns for the clients and increasing stability. Prevention of abuse and neglect. The majority of our clients are uninsured which greatly limits their access to therapy. With additional therapists we could provide counseling services to meet the needs of our clients.
  - With additional clinical social workers we could accept more referrals for case management and counseling services.

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- Our clients face a variety of obstacles including a lack of housing, child care, transportation, and employment opportunities. The majority of the clients we serve have grown up in generational poverty and in households where there was domestic violence and child abuse and neglect. We are able to help clients break the cycle of poverty through increasing their employment opportunities, parenting skills, overall mental health and relationships

**3) Where is the gap in your community-based programs and/or family intervention services?**

- There is a huge gap in counseling services for people who don't have health insurance. In our current caseloads, unless a client is pregnant they are uninsured.
- There is also a gap in case management services (assisting clients with resources, providing counseling and support on an ongoing basis). Our staff maintains full caseloads and routinely has to turn referrals away.
- Our demonstrated outcomes affirm that the services offered are crucial to the success of our parents and their children.

**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- Currently we measure the following:
  1. Healthy pregnancies- Our clients are at higher risk of having an unhealthy pregnancy due to their lack of resources and isolation. The state average for



healthy pregnancies is 73%; our rate for 2013 was 93% of babies born were healthy.

2. Depression, stress and anxiety- we utilize the Burns depression inventory and our clients have shown a 80-90% decrease in depression, stress and anxiety after our intervention
3. Parenting skills- LFCS utilizes the Nurturing Parents curriculum which is an evidenced based model. We provide pre and post tests after parenting sessions and case management/ counseling intervention. Our clients have consistently shown a 100% increase in parenting knowledge

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area?**

- The agencies providing home visiting services (Parents as Teachers, Boone County Health Department, First Chance for Children and Central Missouri Community Action) in the community meet monthly to discuss ways to work together and meet the demands of referrals.
- LFCS collaborates with many community partners, such as schools, health clinics, Parents as Teachers and First Chance for Children. We would continue to partner with these agencies to ensure that our clients are getting the most comprehensive services possible and that LFCS is being a responsive service provider in the community.

<b>Agency:</b> Preferred Family Healthcare	<b>Respondent:</b> Ms. Paula Brawner
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**1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- Preferred Family Healthcare (PFH) has over 33 years’ experience providing treatment for substance use disorders and mental health services, while also operating as the largest provider of adolescent substance use disorder treatment services in Missouri. Through this experience, PFH has found that some of the most effective services are those which are devised in response to the community’s identified needs, and which can prevent further problems in a given area. Accordingly, we have examined county needs assessments and listened to adolescents, adults, families, schools, and providers to learn what areas PFH can most effectively deliver its behavioral health services. From this information, PFH identified the following two areas of great need for the target population:
  1. Utilizing the school system to reach adolescents and their families with valuable behavioral health education, prevention, and treatment services for at-risk youth and youth suffering from substance use disorders and/or mental health issues.





2. Provide training, guidance, and opportunities for increased involvement of parents, teachers, and other supports to help identify, respond to, and manage social, emotional, and behavioral needs of our youth

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- PFH sees one of the largest obstacles to success as “need versus resources.” According to a 2012 assessment conducted by the Missouri Department of Mental Health, an astonishing 39,000 of Missouri’s youth were identified as needing substance abuse treatment, but did not receive services. Factors only complicating this need include:
  - a) Limited resources to respond to adolescent needs in behavioral health care.
  - b) Lack of affordable services for uninsured or underinsured.
  - c) Limited transportation.

**3) Where is the gap in your community-based programs and/or family intervention services?**

- PFH understands this gap to be the availability of services at the time of need. In many cases, a child needs behavioral health services *immediately*, instead of when the next appointment is available. The lack of available services in the area may cause wait time for admissions. Also complicating a child’s need for immediate services is the necessity of working around the child’s school and family schedule, which can further delay care. The current children’s services have the potential to bridge this gap by increasing the increase the supply of services in the community.

**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- PFH has a significant presence in the school systems in St. Charles, St. Louis, Lincoln, and Franklin Counties, providing prevention, early intervention, and treatment services for adolescents. Quantitative measures demonstrate that this service is making a positive impact on youth. For example, 89% of youth served demonstrated gaining knowledge of substance abuse and/or mental health issues; 81% of youth reported development of risk management skills; and 85% of youth reported improvement in school engagement and/or performance. Additionally, in our tax based outpatient services 82% of youth reported an improvement in school engagement and/or performance and 84% of youth reported an improvement in relationships with family members/caregivers.

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area.**





- PFH will continue to work with the many strong community resources, such as Boone County Coalition of Providers, as well as other healthcare and community service providers that may enhance our consumer’s care and/or their potential for success in the community.

<b>Agency:</b>	<b>Respondent:</b>
University of Missouri	Dr. Chuck Borduin

***1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?***

- Youths in the juvenile justice system need services that are (1) evidence-based and (2) delivered directly in their natural ecology (home, school, and neighborhood). To qualify as "evidence-based," services should be informed by the research literature on the causes and correlates of youth antisocial behavior and should be supported by randomized clinical trials. Delivery of services in the natural environment of the youth and family reduces barriers to service access, promotes family cooperation and collaboration, and provides ecologically valid assessment and clinical outcome data.

***2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?***

- No. The treatment model that we have developed (Multisystemic Therapy) delivers family- and community-based interventions directly in the settings in which problems occur. This requires flexibility in scheduling and intervention delivery, but it promotes positive outcomes for youths and their families.

***3) Where is the gap in your community-based programs and/or family intervention services?***

- There is a tremendous need for juvenile justice programs and services that are not only (a) family-based and (b) community-based but also (c) evidence-based. Research has shown which interventions are most effective, but those interventions are seldom the ones being funded or provided in our community.

***4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?***

- Multi-systemic Therapy is designed to help youths (a) live at home, (b) be successful in school and/or at work, and (c) have no new arrests. Each of these goals also represents quantitative measures of success. In addition, we use a comprehensive set of assessment tools (based on self-report, other-report, and observational instruments) to measure changes from pretreatment to post-treatment in youth, family, peer, and academic functioning.



***5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area.***

- We have successfully collaborated with the Juvenile Office in Boone County to deliver Multi-systemic Therapy to youths and their families since 1983. We have also enjoyed excellent cooperation from school systems in Boone County with interventions designed to help youths achieve academic success.



**Appendix D: Community Input Session Components**

**Session #3 – Clinical & Mental Health Services**

***Invitation to Participate***

**TO:**

February 28, 2014

- Annie Jensen, Vice President of Operations, Burrell Behavioral Health
- Barbara Hodges, Executive Director, True North
- Cynthia Chapman, Director of Development, Salvation Army Harbor House
- Christine Corcoran, Regional Director, Lutheran Family and Children’s Services
- Deborah Beste, Director, Phoenix Programs
- Isabel Rife, Project Director, Project LAUNCH
- Jan Stock, Executive Director, Rainbow House
- Jim Wallis, Vice President, Preferred Family Healthcare
- Karen Cade, Director, Family Counseling Center
- Marissa Peterson, Resident Director, Great Circle/Boys and Girls Town
- Matthew Gooch, Programs Director, McCambridge Center
- Mel Fetter, Chief Executive Officer, Pathways Community Behavioral Health
- Stephanie Browning, Administrator, Columbia Public Health and Department of Human Services

**FROM:** Jacqueline Schumacher, Consultant to the Boone County Children’s Services Board

**RE:** Invitation to the March 27, 2014 Community Input Session

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Dear Service Provider,

The Boone County Children’s Services Board (BCCSB) is taking steps to gather information about children’s services in Boone County. The Chairman, Mr. Les Wagner, and his eight-member board seek targeted information from the perspective of local providers whose services and programming align with Missouri Statutes 67 & 210. With assistance from the Institute of Public Policy in the Truman School of Public Affairs at the University of Missouri, the Board is organizing a series of five community input sessions, one of which you are specifically invited to attend.

The organization and variety of community input sessions are driven exclusively by the funding statutes. For clarification, Missouri Statute 67 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children’s Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6 million dollars annually. According to Missouri Statute 210, the Children’s Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

**Service Funding Categories**

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
2. Respite care services
3. Services to unwed mothers and unmarried parent services
4. Outpatient chemical dependency and psychiatric treatment programs



5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

You have been identified as a service provider whose services apply to funding Category #4 (outpatient chemical and psychiatric treatment), Category #5 (counseling and related services for transitional living), Category #8 (crisis intervention inclusive of telephone hotlines), Category #10 (professional counseling and therapy), Category #11 (psychological evaluations), and/or Category #12 (mental health screenings). You, or a representative from your agency, are invited to participate in the Boone County Children Services Board meeting at **4:30 PM on March 27, 2014** in the Boone County Commission Chambers (RM 110) at 811 East Walnut, Columbia, Missouri 65201. This input session will address the topic of ***Clinical & Mental Health Services*** as it applies to Category #4, Category #5, Category #8, Category #10, Category #11, and Category #12.

During the input session, you will be asked five questions (described below). Your answers should be thoughtful, although brief. It is important the Board understands your service area's collective perspective and not simply agency-specific information. Please keep in mind, **your invitation to address the Board is not an opportunity to express your agency's need for funding**. Rather, the focus of the input session will center on the five questions listed below.

Your individual response time to these questions will range between a total of three and eight minutes. This time frame depends on the number of input session attendees. Therefore, please **RSVP** to [schumacherja@missouri.edu](mailto:schumacherja@missouri.edu) by Friday, March 21, 2014. If possible, I will be in touch with you before the input session to confirm the amount of time you will have to answer the five questions below.



BOONE COUNTY CHILDREN’S SERVICE BOARD COMMUNITY INPUT SCHEDULE			
DATE	Service Area	Funding Categories	Questions
Mar 27	Clinical & Mental Health Services	<ul style="list-style-type: none"> <li>• <i>Category #4:</i> Outpatient (chemical &amp; psychiatric) treatment</li> <li>• <i>Category #5:</i> Counseling and related services for transitional living</li> <li>• <i>Category #8:</i> Crisis intervention</li> <li>• <i>Category #10:</i> Professional counseling and therapy</li> <li>• <i>Category #11:</i> Psychological evaluations</li> <li>• <i>Category #12:</i> Mental health screenings</li> </ul>	<ol style="list-style-type: none"> <li>1) What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?</li> <li>2) Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?</li> <li>3) Where is the gap in your clinical and/or mental health services?</li> <li>4) What is a quantitative measure of your success when working with clinical and/or mental health services?</li> <li>5) Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.</li> </ol>

We look forward to hearing from your agency next month. Do not hesitate to reach out to me for further information.

***Please RSPV by March 21, 2014***

Sincerely,

JACQUELINE SCHUMACHER, MPA  
 Consultant, Boone County Children’s Services Board  
 INSTITUTE of PUBLIC POLICY  
 Truman School of Public Affairs- University of Missouri  
 137 Middlebush Hall  
 Columbia, Missouri 65211  
 (573) 882-6207(phone)  
[schumacherja@missouri.edu](mailto:schumacherja@missouri.edu)



**Worksheet**



Dear Service Provider,

You will have between three and eight minutes to address the Children’s Services Board. They will expect you to answer the following five questions. If you would like to submit your answers in advance (or in lieu of attending) please use this worksheet. Email completed worksheets to Jacqueline Schumacher ([schumacherja@missouri.edu](mailto:schumacherja@missouri.edu)).

**Boone County Children’s Services Board  
Community Input Session Worksheet  
March 27, 2014**

- 1) *What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?*
  
- 2) *Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?*
  
- 3) *Where is the gap in your clinical and/or mental health services?*
  
- 4) *What is a quantitative measure of your success when working with clinical and/or mental health services?*
  
- 5) *Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.*



**Meeting Agenda**

**AGENDA**  
**COMMUNITY INPUT SESSION #3**  
**Boone County Children Services Board**  
March 27, 2014 starting at 4:30

**Overview:** This input session will address the topic of *Clinical & Mental Health Services* as it applies to any of the following:

- Category #4 (outpatient chemical and psychiatric treatment)
- Category #5 (counseling and related services for transitional living)
- Category #8 (crisis intervention inclusive of telephone hotlines)
- Category #10 (professional counseling and therapy)
- Category #11 (psychological evaluations)
- Category #12 (mental health screenings)

**Agenda:**

- 1) *Welcome & Overview:* Jacqueline Schumacher, consultant to the Board
- 2) *Input Session Moderation:* Christian Arment, consultant to the Board

SCHEDULE OF PARTICIPANTS MARCH 27, 2014		
Funding Category	Participant Name	Agency
4: Outpatient chemical and psychiatric treatment 8: Crisis intervention... 10: Professional counseling and therapy 11: Psychological evaluations 12: Mental health screenings	Marlene Howser & Julie Arment	Burrell Behavioral Health
	Karen Cade & Libby Brockman-Knight Matthew Gooch	Family Counseling Center
	Una Bennett & Vinita Khanna	Preferred Family Healthcare
	Rebecca Nowlin & Marissa Peterson	Great Circle
10: Professional counseling and therapy 11: Psychological evaluations 12: Mental health screenings	Dr. Deborah Bell	University of Missouri, Department of Psychological Sciences
12: Mental health screenings	Scott Clardy	Columbia Public Health and Department of Human Services
8: Crisis intervention... 10: Professional counseling and therapy	Dr. Laine Young-Walker	Project LAUNCH

- 3) *Follow-up and Clarification Questions:* Board Members
- 4) *General Input:* Audience & Non-scheduled participants
- 5) *Closing Remarks:* Kelly Wallis, Boone County Director of Community Services





## **Feedback Report**

### *Community Input Session on Clinical & Mental Health Services*

The Boone County Children’s Services Board (BCCSB) is taking steps to understand more about children’s services in Boone County. BCCSB contracted with the Institute of Public Policy (IPP) in the Truman School of Public Affairs at the University of Missouri to organize and moderate five Community Input Sessions. BCCSB wishes to make wise expenditures of the Children’s Services Fund and seeks targeted information from local services aligning with the Missouri Statutes 67 & 210. This feedback document provides an overview of the information shared with the Board during the third input session and will help guide BCCSB’s future funding strategies.

Missouri State Statute 67.1775 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children’s Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6.5 million dollars annually. According to Missouri Statute 210.861, the Children’s Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
2. Respite care services
3. Services to unwed mothers and unmarried parent services
4. Outpatient chemical dependency and psychiatric treatment programs
5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

**Overview:** The BCCSB hosted Boone County social services agencies at their bi-monthly board meeting on March 27, 2014. The topic of this session was Clinical & Mental Health Services which centered on outpatient chemical and psychiatric services, counseling and related services for transitional living, crisis intervention, professional counseling and therapy, psychological evaluations, and mental health screenings. A total of 14 agencies were invited to participate, of which seven were able to attend. A total of seven agencies prepared and submitted formal comments on worksheets which addressed the Board members’ predetermined questions. Table



H is a reference guide to the Community Input Session #3 and quantifies the number of agencies engaged in the convening.

Table H: Community Input Session #3 By the Numbers	
Session #3	Date: March 27, 2014
	Clinical & Mental Health
	Topic: Services
	Funding categories: 4, 5, 8, 10, 11 & 12
	Number of invited participants: 14
	Number of scheduled participants: 7
Number of worksheets received : 7	
Number of individuals in attendance: 21	

**Methodology:** Boone County agencies having services which apply to Category #4, #5, #8, #10, #11 & #12 were invited to attend the BCCSB meeting on March 27, 2014. When an agency confirmed their desire to participate in the meeting they were provided with a worksheet containing five pre-established questions developed by the Board. A copy of the agency worksheet may be found in Appendix A. Invited agencies were given two directives: first, agency representatives were encouraged to submit their written responses to the Board’s five questions in advance of the meeting. These responses may be found in Appendix B, and are organized by agency name. Second, agency representatives were instructed to use their meeting participation time to answer these questions. Each respondent was given a total of five minutes.

The Board’s pre-established questions are as follows:

Question #1: What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?

Question #2: Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?

Question #3: Where is the gap in your clinical and/or mental health services?

Question #4: What is a quantitative measure of your success when working with clinical and/or mental health services?

Question #5: Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.

**Findings:** The following responses are organized by question and have been de-identified. This allows the aggregated responses to point toward themes and topics rather than agency-level information shared as a byproduct of the participant’s responses during the input session. When possible, responses in bulleted lists are categorized by topic: Shelter, mental health, transportation, basic needs, education, access (meaning shortages, bottlenecks, agency capacity),



structure/systems (meaning collaboration, billings, state-level issues), early intervention, provider skills/development, substance abuse, case management, and school-based interventions. The “other” category is catchall for items that do not readily fit into the aforementioned groups.

**Top Two Issues – Clinical & Mental Health Services**

During the community input session, the following were mentioned in response to the question: *What are the top two issues you feel need to be addressed in your service population for clinical and/or mental health services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Mental Health**

- Maternal depression
- Toxic stress

**Transportation**

- Transportation

**Basic Needs**

- Child care
- Foster care youth are ill prepared for adulthood

**Education**

- Misperception that residential care is a final destination rather than a proactive treatment intervention
- Parent education on prescription drug abuse

**Access**

- Long wait times to be seen
- Not enough children’s mental health providers

**Early Intervention**

- Primary prevention\*\*
- Coordination of services for children 0-6
- Early identification of services for children 0-6

**Structure/Systems**

- Collaboration with agencies is needed to treat families from a systemic approach

- Insurance does not cover prevention services
- Lack of integration between physical health and mental health systems

**Provider Skills/Development**

- Lack of evidence based interventions in the community
- Need for professional development/education of providers to continue to offer evidence based practices
- Need for trauma-informed care

**Substance Abuse**

- Substance abuse for teens

**Case Management**

- Foster care youth aging out of care have a need for caseworkers to offer skills training, mentoring, and therapeutic services

**School-based Interventions**

- Formalized systems between schools and mental health providers to provide timely treatment for students with needs

**Other**

- Violence related to substance abuse and mental health issues
- Based upon level of trauma exposure, there is a need for more intensive treatment services than just once a week

*Summary:* Clinical and mental health service providers present at this community input session feel that primary prevention and early intervention are top issues to be considered by BCCSB. While early identification of mental health issues relies partially on parent and guardian knowledge of appropriate child development, many providers referenced the stigma attached to mental health services which deter treatment. Both the need for prevention-based actions and



de-stigmatization of mental health issues are topics that have been reinforced throughout many of the Board’s community input sessions and remain areas for future examination.

Finally, a new theme emerged during this session and, as a result, the Provider Skills/Development topic was established. It appears that clinical/mental health providers need education on trauma informed care practices, evidence-based approaches, and continuing training/skills development for evidence-based practices.

**Systemic Obstacles to Success – Clinical & Mental Health Services**

During the community input session, the following were mentioned in response to the question: *Are there systemic obstacles to your success when working with clinical and/or mental health services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Transportation**

- Lack of transportation\*

**Education**

- Lack of awareness of services
- Limited understanding of how to access services by patients and their families
- Not enough resources to provide outreach training/education to the community-at-large
- Reluctance to seek services due to stigma of mental illness\*

**Access**

- Difficulty in access for non-Columbia residents
- Finding professional staff to work evenings and weekends
- Lack of trained psychologists trained to work with children and adolescents
- We are operating at capacity, we cannot grow

**Early Intervention**

- Early identification for systems interventions
- Early screenings for children 0-6 and adolescents

**Structure/Systems**

- Inability for families to get services when un/underinsured\*\*
- Lack of health care coverage including behavioral and oral health

- Qualifying diagnosis and insurance criteria for needed treatment programs

**Provider Skills/Development**

- Need for on-going skills development at the staff-level to provided evidence base approaches
- Professional development funding for mental health providers of evidence based programs

**Case Management**

- Case management services have strict eligibility requirements
- Many patients need assistance with follow-up treatment and care coordination for their child

**Other**

- Generational family problems
- Lack of funding
- Limited resources
- Need for community consensus identifying need



*Summary:* It remains difficult for un/underinsured populations of Boone County to receive mental health services. Economically challenged populations such as these likely have transportation problems, a topic mentioned twice as a systemic issue. Clinical and mental health service providers at this community input session feel issues of access, such as limited services outside of Columbia, the lack of professionals willing to work after hours, limited capacity to grow, and a shortage of child psychologists, feed into the broader systemic obstacles to their agency’s success.

Finally, a new theme emerged during this session and, as a result, the Case Management topic area was established. It appears that clinical/mental health providers have identified case management eligibility requirements as a systemic obstacle. In addition, it has been made clear that providers find some parents simply need extra support (in the form of case management) in order to sustain their child’s treatment plan.

**Gap in Services – Clinical & Mental Health Services**

During the community input session, the following were mentioned in response to the question: *Where is the gap in your clinical and/or mental health services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Mental Health**

- Need for services to treat issues that are non-life threatening self-injury behaviors

**Basic Needs**

- Parenting skills training

**Education**

- Stigma attached to mental health

**Access (shortages, bottlenecks, agency capacity)**

- Shortage of licensed psychiatrists and therapists\*\*
- Access to treatment for those not in state care
- Availability of services at the time of need
- Inability to provide services in remote areas of the county
- Lack of immediate clinical response services
- Long wait times

**Structure/Systems (collaboration, billing, state-level issues)**

- Case coordination with collaborating entities
- Lack of ability to bill for case coordination among agencies

**Case Management**

- Lack of case management

**School-based Interventions**

- Needs are identified by schools, but there is a failure for parents to follow through with school’s recommendation and there are no means for follow-up
- There is no school-based mental health system in place providing psychiatric treatment

*Summary:* Boone County service providers at this input session describe the gap in clinical and mental health services as a shortage of licensed psychiatrists and therapists. This directly points toward the issue of access – defined as shortages in services, bottlenecks in care, and limited agency capacity. Access issues are evident not only for Columbia residents and may be magnified for families in remote parts of Boone County.



In addition, providers illuminated the gap in services for families and children who fall outside of the economic range for state-established care. In these BCCSB input sessions, this population has often been referred to as the working poor, or the un/underinsured. In short, this population draws an annual income which makes them ineligible for Medicaid. However, their self- or employer-insured plans come with extremely high insurance deductibles for mental health services making necessary care, and at times crisis-based care, cost prohibitive.

Finally, a new theme emerged during this session and, as a result, the School-Based Interventions topic area was established. It appears that clinical/mental health providers feel a coordinated system with schools is needed to accurately screen and efficiently serve Boone children and families.

**Quantitative Measures of Success – Clinical & Mental Health Services**

During the community input session, the following were mentioned in response to the question: *What is a quantitative measure of your success when working with clinical and/or mental health services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

- Decreased hospitalizations\*\*\*
- Academic performance\*\*
- Satisfaction surveys\*\*
- Abstinence and decreased use
- Decreased juvenile office referrals
- DECA (Devereux Early Childhood Assessment)
- Depression measures
- Development of risk management skills
- Evaluation of clinician competencies
- Evidence based tool accepted by Center for Medicaid and Medicare Services
- Health insurance
- Improved reunification
- Knowledge gained measures
- Living alone
- Office referrals
- Outcome studies
- Reduction in suicide attempts
- School performance
- School suspensions
- Substance use/abuse
- Treatment goal progress data

*Summary:* Responses to the question asking about quantitative measures of success indicate that all participating agencies have some performance tracking method in place. Multiple agency responses cluster around the clinical measure of decreased hospitalizations, academic performance, and satisfaction surveys. As observed here, and in previous sessions, numerous measures appear to be part of broader evidence-based programs employed by providers. For the first time during BCCSB community input sessions, the concept of clinician competencies was raised as a quantitative measure. This idea goes beyond “patient-centered” success to “agency-centered” success by way of competency. This may circle back to the need for provider skills/development.





**Potential Collaboration – Clinical & Mental Health Services**

During the community input session, the following were mentioned in response to the question: Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health services area. Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

- Collaboration must start with the schools\*\*, daycares, etc. The goal must be early identification
- Services should be complementary, not redundant
- To address access and quality, we need a larger, more connected network of evidence based providers
- We are looking into a coordinated referral system for therapeutic services
- We are planning an internal collaboration in which all WIC moms are screened for prenatal and postnatal depression
- We collaborate with multiple community agencies on a regular basis
- We will build new collaborations with programs that are established in the future
- We see increased potential for collaboration with outlying communities and providers

*Summary:* Participating agency representatives not only confirm collaboration in a basic sense, but also express a desire for real and measureable joint initiatives. This implies that optimum collaboration may not yet be occurring among clinical and mental health providers in Boone County. A number of the comments focused on expected and future coordination opportunities.

**Conclusion:**

BCCSB’s process of hearing input from the clinical and mental health agency perspective proves to be useful in identifying common themes. Issues of access appear to lead agencies to the point of frustration and desperation as they observe the persistent gap in services due to shortages in services, bottlenecks in care, and limited agency capacity. The access conundrum may be solved through the communicated desire for increased prevention methods, partnering with schools, and debunking the stigma associated with mental health issues. Together, these approaches may embolden a culture of prevention and deter latent mental health diagnoses in need of clinical interventions. However, structure/systems dilemmas such as insurance, billing, and state-level issues fall squarely outside of direct agency control and may require broader efforts to resolve.

As a result of this session, four new categories were developed: professional skills development, case management, school-based interventions, and substance abuse. While some of the categories did not surface as resounding themes, their inclusion is nonetheless important. In the future the board will begin to analyze the collective input across all community sessions wherein these additional topics may hold surprising results.

***Agency Worksheets***

<b>Agency:</b>	<b>Respondent:</b>
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Burrell Behavioral Health

Ms. Marlene Howser

Ms. Julie Arment

Burrell's mental health services are specifically tailored to meet the mental health needs of children and families. Burrell has psychiatry, therapy (both individual and family), Parent Child Interaction Therapy (research based intervention), crisis intervention, no cost mental health screens at a walk in clinic, transitional age youth program, a psychiatric community based case management program and healthcare home program which provides the integration of the physical and mental health needs of a child.

**1) What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?**

- There is a lack of funding for prevention and early intervention services. Prevention services can provide education and support for the community at large in the areas of mental health and wellness. For example, educating stakeholders (including medical doctors, pediatricians, students, schools, community agencies, etc.) about issues related to mental health and wellness.
- Prevention also includes early interventions to address at-risk signs and prevent future, more severe types of social-emotional-behavioral concerns.
- There is also a lack of integration of physical health and mental health systems. Currently there is a tendency to look at physical health and mental health as two separate entities. We have a program that integrates the systems (Healthcare Home) however there are strict Medicaid requirements for children to have access to this integrative program.
- Another issue is that of Trauma-Informed Care. Given all we know about trauma today, how traumatized children experience themselves, their environment, ourselves as practitioners and how they experience the world must guide us in our assessment, care of and treatment of traumatized children.
- The primary philosophy of trauma-informed care is to “do no harm,” by not making assumptions that children must be traumatized by what they have been exposed to, or if traumatized, that all children need the same intervention.

**2) Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?**

- There is a significant difficulty accessing services for children and families living in smaller communities in Boone County (such as transportation and awareness of services available).
- Another obstacle is the inability of families who are underinsured or uninsured to afford psychiatric and therapy services that are essential to their child's mental health and wellness, success in school, in the community and within the family.
- Additionally, our psychiatric case management services program has strict eligibility criteria determined by the state. One of the systemic obstacles to providing this care is related to the qualifying diagnosis and insurance criteria for this program. Families who are private pay are not able to access these services because the insurance won't cover it and they can't afford it. There are many children and families in need of this level of support who we cannot serve due to the criteria we are required to follow.



- Lastly, the expense for on-going professional development for mental health providers in evidenced-based practices can make these necessary treatment modalities prohibitive to agencies.

**3) Where is the gap in your clinical and/or mental health services?**

- We believe there are two primary gaps in clinical and mental health services:
  - One is a shortage of licensed therapists and psychiatrists.
  - Secondly the ability within the present system to provide case coordination with other collaborating entities due to the lack of ability to bill for this coordination.

**4) What is a quantitative measure of your success when working with clinical and/or mental health services?**

- This tool provides scales in the areas of mental health, substance abuse and intellectual disabilities.
  - The quantitative measure we use is a research and evidenced-based tool that looks at 20 areas of functioning that has been normed within the general population from ages 6 to 80 years old. It assesses if people are within normal limits of functioning. This tool is accepted by CMS (Center for Medicaid & Medicare Services), CARF (Commission on Accreditation of Rehabilitation Facilities), JCAHO (Joint Commission on Accreditation of Healthcare Organizations).
- These tools are used to monitor progress and as outcome data measures.
  - Vanderbilt Teacher Behavior Evaluation Scale
  - Vanderbilt ADHD Diagnostic Parent Rating Scale
  - Connors Short Form – Parent and Teacher
- We also are currently using the DECA (Devereux Early Childhood Assessment) for youth under age 6.
- Additionally, the following information also guides treatment planning for example, in school/out of school suspensions, office referrals, grades, teacher, parent student surveys, behavior plans, and treatment goal progress data.

**5) Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.**

- We presently collaborate with multiple community agencies on a regular basis including Schools, Children’s Division, Juvenile Office, Boone County Family Resources, Police Dept. Sheriff’s Office, Other mental health providers, and MU.
- However we see increased potential for collaboration with outlying communities and providers who serve those youth and families.

<p><b>Agency:</b>          City of Columbia/Boone County, Missouri          Department of Public Health and Human          Services</p>	<p><b>Respondent:</b>          Ms. Stephanie Browning</p>
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**1) What are the top two issues you feel need to be addressed in your service population for clinical and/or mental health services?**

- The Columbia/Boone County Department of Public Health and Human Services (PHHS) provides multiple services in this domain including managing City of Columbia social services funding, prenatal case management services, and the Healthy Families home visiting program. *Based on our experience in providing these services, the top two issues are:*
  - Maternal depression
  - Toxic Stress

**2) Are there systemic obstacles to your success when working with clinical and/or mental health services?**

- Obstacles include lack of healthcare coverage including behavioral health and oral health; lack of affordable mental health services for uninsured and underinsured persons; unemployment and underemployment; and lack of transportation.

**3) Where is the gap in your clinical and/or mental health services?**

- The literature and our experience indicate a lack of systematic maternal depression screening in the United States. For women identified as experiencing maternal depression and other forms of mental illness, there is a lack of immediate clinical response services and subsequent case management.

**4) What is a quantitative measure of your success when working with clinical and/or mental health services?**

- The Healthy Families home visiting program and the prenatal case management program utilize a performance measurement logic model comprised of multiple short-term, intermediate, and long-term outcomes. Applicable outcomes measured include:
  - Living alone
  - Health insurance coverage
  - Tobacco use
  - Alcohol abuse
  - Substance abuse
  - Depression
  - History of mental illness
  - Physical and social/emotional development (Ages and Stages Questionnaire (ASQ and ASQSE)
  - Child harm (hospitalizations/abuse/neglect)
  - Domestic violence
  - History of violence
- Here is an inventory of screening tools utilized in our prenatal case management and home visiting programming:



- **Healthy Families America**
  - *Edinburgh Depression Scale*
    - Screen for prenatal and postpartum depression
    - Screen upon enrollment into program and within 4-8 weeks postpartum; follow-up depression screen as needed
  - *Ages and Stages Questionnaire 3<sup>rd</sup> Edition (ASQ 3)*
    - Screen for mental illness and developmental delays
    - Screened at 6, 12, 18, 24 & 36 mos. minimum
  - *Ages and Stages Social Emotional (ASQSE)*
    - Screen for emotional regulation and emotional well being
    - Screened at 6, 12, 18, 24 & 36 mos. minimum
  - *Domestic Violence Enhanced Visitation Intervention Program (DOVE)*
    - Screen for domestic violence occurring in the home
    - Screen every trimester during pregnancy; postpartum every other month for at least three months
  - *Home Observation for Measurement of the Environment Infant Toddler Inventory 3<sup>rd</sup> Edition (H.O.M.E. Inventory)*
    - Used to identify environments that do not stimulate cognitive development of children & assist with developing interventions
    - Screened at 6, 18 & 36 months
  - *Life Skills Progression*
    - Plan to improve clinical interventions to improve parenting behaviors and develop supports for family
    - Screened at 6, 18 & 36 months
- **Pregnancy Counseling**
  - *Risk Appraisal for Pregnant Women*
    - Screen for 34 risks
    - Applicable risks include:
      - Teen pregnancy
      - Single parent
      - Alcohol abuse by participant and/or partner
      - Substance abuse by participant and/or partner
      - Physical abuse of participant
      - Physical abuse/neglect of children in home
      - Partner with a history of violence
      - Chronic mental illness

**5) Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health services service area?**



- We are planning an internal collaboration in which all WIC customers will be screened for prenatal and postnatal depression. The screenings will be scored and follow up will be provided by Division of Human Services social services staff.
- The PHHS Division of Human Services has also been meeting with the administrators of Parents as Teachers, Lutheran Family Children’s Services, and First Chance for Children to better coordinate home visitation programming. One of the collaborative concepts being discussed is a systematic screening process for prenatal and postpartum depression screenings among the programs and a coordinated referral system for therapeutic services. In addition, a joint proposal was submitted to Project LAUNCH to fund a licensed clinical social worker position to provide immediate clinical response to women identified as experiencing maternal depression. The project was not funded, but the collaborative is planning to proceed with implementing a coordinated system of maternal depression screening and referral. We also hope to collect data about maternal depression in Boone County which we would then share with the Children’s Services Board.

<b>Agency:</b> Family Counseling Center of Missouri & Pathways Community Behavioral Health	<b>Respondent:</b> Ms. Karen Cade Ms. Libby Brockman-Knight
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***1) What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?***

- Family Counseling center has a long history of providing services to children and families in this community, from the newborns and children we serve at our Women’s and Children’s program at McCambridge, to the school age children served in our in school services and at FCC’s Outpatient Clinic, to the adolescents that we serve in our outpatient and residential Adolescent Substance abuse program.
- Working with kids throughout the age continuum, we believe that the two main issues that need to be addressed in our service population are early identification and coordination of services for at risk youth. In particular, for at risk children from the ages of birth until school age due to the lack of opportunities to screen and identify children and connect them with the appropriate services and also for high risk adolescents and pre-adolescent prone to substance use, violence, and juvenile office involvement.
- Family Counseling Center strongly believes that we need increased collaboration and coordination between service providers and community partners to identify these at risk youth earlier and to provide early intervention and treatment services that can improve outcomes.

***2) Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?***



- Within any system, there are obstacles in outreaching and providing these services within our community.
  - Early Identification of families and children in need before negative consequences/ system intervention
  - Early screenings for at risk youth – especially in early childhood – from birth until school age and in adolescence
  - Stigma associated with mental health and substance use disorders and stigma related to treatment which may lead to parental reluctance to seek needed treatment
  - Generational systemic issues for high risk families at risk for substance use, violence and legal system involvement
  - Consensus from community and community agencies of the need and support of programs through community collaboration
  - Funding – including high co-pays, deductibles

**3) *Where is the gap in your clinical and/or mental health services?***

- Several gaps exist in our mental health services. First is the ability to provide services in the remote and rural areas of our counties due to lack of transportation and opportunities to outreach. Secondly, there is a lack of Lack of Child psychiatry available and licensed therapists with advanced child training. While although we are able to perform some limited in home services, there is a substantial need to provide targeted in-home family services to include parenting skills training, in-home family therapy and wraparound community support services for at risk families in order to Break the cycle of vulnerability and repetition for high-risk children and families ,Support children and their caregivers in forming strong, functional and resilient attachments, Provide an enriched environment to support all domains of child development and Support parents in their own emotional development and in developing parenting skills in a supportive setting

**4) *What is a quantitative measure of your success when working with clinical and/or mental health services?***

- Quantitative Measures of our clinical success include:
  - Abstinence and decreased use of substances
  - Improved school performance and reduction of safe school violations – disciplinary referrals
  - Reduction in school drop out rates
  - Decreased incidents of violence, bullying and juvenile office referrals
  - Decreased hospitalizations and suicide attempts
  - Improvement in family functioning and resiliency
  - Increased rates of reunification with families
  - Improvement in functioning and mental health of our kids served





**5) Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.**

- Pathways envisions that through Collaborations with our schools, day cares, head start, United Way, Juvenile office, Division of Family services, Housing Authority, University Hospital pediatric Clinics as well as many other community agencies that we can increase identification for at risk children and families and help bridge the gaps in services.

<b>Agency:</b> Great Circle/Boys and Girls Town	<b>Respondent:</b> Ms. Melissa Peterson
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**1) What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?**

- Older youth currently or previously in the foster care system are ill prepared for adulthood and are in need of additional skills training, mentoring, therapeutic services, and other support services.
- Given the level of trauma exposure in children, adolescents, and families, there is a need for more intensive services than weekly individual and family therapy sessions to address related emotions, behaviors, and self-injury.

**2) Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?**

- Collaboration with agencies to fully understand and treat families from a systemic approach and to have greater understanding of the effects of trauma.
- Perception that residential care (and the community programs under the residential umbrella, such as day treatment) is a final destination for children and adolescents rather than a proactive, treatment intervention.

**3) Where is the gap in your clinical and/or mental health services?**

- Respite and day treatment services for children and adolescents not in state custody.
- Intensive outpatient services are not easily accessible for children, adolescents, and families not in Children’s Division custody. These families have to either private pay for services or use insurance which may not fund needed services if a client is not a current threat to self or others. Intensive outpatient services have been highly successful when used as prevention for inpatient/residential placements and is helping children more successfully reintegrate back into home and community following inpatient/residential placements.
- Feedback has consistently indicated a need for intensive services to treat issues of (non-life threatening) self-injury behaviors for youth in the community.





**4) What is a quantitative measure of your success when working with clinical and/or mental health services?**

- Prevent the need for acute care and/or long term residential care
- Self-report surveys for children, families, and referral sources measuring perceived success of treatment
- Managing self-injurious behaviors
- Educational success
- Clients are discharged to less restrictive environments
- Currently exploring implementation of a measure that measures therapeutic alliance

**5) Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.**

- Boone County school districts
- Inpatient hospitals
- Qualified Mental Health Professionals in Boone County
- Burrell Behavioral Health
- Local Dialectical Behavior Therapy consultation teams
- Physicians and other medical professionals

<b>Agency:</b> NAVIG8 Adolescent Treatment Program	<b>Respondent:</b> Mr. Matthew Gooch
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**1) What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?**

1. Synthetic drug abuse (K2, K3, spice, bath salts, potpourri, etc.)
2. Continued support and structure from referral sources (i.e. family, juvenile officer, GAL, caseworkers, etc.) – Adolescents are often not motivated to participate in treatment. It often takes the continued support of these people to ensure they get the help that they need.

**2) Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?**

1. Client access to synthetic drug purchases (its still being sold in stores, not on the street)
2. High cost in detecting synthetic via UA and requiring a diagnosis
  - a. Example – Client chronically smokes marijuana comes to treatment for it and then switches to synthetic cannabinoid without detection

**3) Where is the gap in your clinical and/or mental health services?**



1. Research and education on the effects of synthetic drug abuse
2. The continued change in manufacturing and types of synthetic cannabinoid result in multiple variables, side effects, and results.
  - a. For example, client A has a seizure when using only a certain type of K2

**4) What is a quantitative measure of your success when working with clinical and/or mental health services?**

- The Global Assessment of Functioning Score (GAF) and Daily Living Activities – Youth Assessment (DLA-20)

**5) Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.**

- Outreach into the community – getting into the schools, fundraising, and public speaking. Collaboration with referral sources on continued care (Children’s Division, Missouri Alliance, Division of Youth Services, Juvenile Office, etc.)

<b>Agency:</b> Preferred Family Healthcare	<b>Respondent:</b> Ms. Paula Brawner
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**1) What are the top two issues you feel need to be addressed in your service population for community-based programs and/or family intervention services?**

- Parent education on prescription medications. The abuse of synthetics and high rate of prescription med abuse is a major issue. We would like to focus on providing early intervention/identification and smooth transition into more intensive services either directly to families or through the school system.
- Violence is the second issue that should be addressed. Violence in our youth is continuously increasing and is related in part to substance abuse and behavioral health issues.

**2) Are there systemic obstacles to your success when working with community-based programs and/or family intervention services?**

- Finding professional staff to work evenings and weekends (outside of typical business hours) when the children are not in school and family members are not at work and hence available for desired services.
- If we work with adolescent in school setting that interferes with their school curricula/attendance/grades. PFH has worked for past 9 years in the Team of Concern (TOC) program spread over 45 school districts and has the experience to mesh treatment and intervention with the academic demands of the individual school districts.

**3) Where is the gap in your community-based programs and/or family intervention services?**



- A major gap, we feel, is the availability of services at the time of need. In many cases the child needs services *immediately* and not based on the next possible appointment with the professional. Because, as we explained above, the lack of services in the area may cause wait time for admissions. Furthermore, we would need to work around the school schedule of children and the schedule of their family.

**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- Our measures include satisfaction surveys, outcome studies, suggestion boxes, monthly quality improvement meetings.
- Our current experience working with youth in schools (St. Charles, St. Louis, Lincoln and Franklin Counties) shows impact of this intervention with 89% of youth served gaining knowledge of substance abuse and/or mental health issues; 81% of youth reported development of risk management skills; 85% of youth reported improvement in school engagement and/or performance. Additionally, in our tax based outpatient services 82% of youth reported an improvement in school engagement and/or performance, and 84% of youth reported an improvement in relationships with family members/caregivers.

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area.**

- We will continue to work, as we have in the past with the many community resources such as Boone County Coalition of Providers, and will build new collaborations with any programs that are established in the future.

<b>Agency:</b> Project LAUNCH	<b>Respondent:</b> Dr. Laine Young-Walker
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**1) What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?**

- Access to child psychiatric services for children and adolescents
  - Typically, there is an immediate need when families and referring providers are seeking the services of child and adolescent psychiatrists. Unfortunately, the wait to see a child and adolescent psychiatrist can range from 6 to 8 weeks. Such a delay in treatment can increase a child’s suffering and disrupt his/her family and school settings. Often, an exacerbation of symptoms follows leading to crises that necessitate trips to emergency rooms to assess and hospitalizations that might have been avoided.



- A formal system between the schools and mental health providers to provide timely and seamless psychiatric treatment for students with behavioral/emotional needs who have been unable to access care.

**2) Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?**

- Yes there are systemic obstacles.
  - There is a lack of psychiatrists trained to work with children and adolescents.
  - Often there is limited understanding of how to access services by patients and their families
  - Many parents need assistance with follow-up treatment and care coordination for their child.
  - Children and their families are sometimes reluctant to access mental health services due to the stigma of mental illness, lack of prior experience and/or frustrating experiences they have had with prior attempts to access care

**3) Where is the gap in your clinical and/or mental health services?**

- Due to the shortage of child and adolescent psychiatrists, there is often an inability for children in need of treatment to access care with a psychiatrist in less than 6-8 weeks.
- Children's psychiatric needs are often first identified by their school teachers and counselors. Even when these professionals provide strong encouragement to students and parents to seek treatment, there is a failure to follow through with recommendations.
- Currently there is no school based mental health system to providing psychiatric treatment. Such a system would allow children to be assessed and treated by a child psychiatrist quickly and within the school setting.

**4) What is a quantitative measure of your success when working with clinical and/or mental health services?**

- Quantitative measures of success in working with clinical and/or mental health services include:
  - Reduction in wait to see child and adolescent psychiatrist
  - Decreased use of the emergency room for mental health treatment
  - Reduction in suicide attempts due to successful treatment of depression
  - Improved academic function by the student due to improved mental health
  - Early psychiatric intervention has been shown to reduce the progression of chronic psychiatric conditions.

**5) Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.**



- Currently the Department of Psychiatry is working with the Columbia Public Schools to address the issues of access to Child Psychiatric Services through a Demonstration Project.
- The goal of the Demonstration Project is to identify students with untreated psychiatric needs, provide timely evaluations and treatment, and then refer the students to community providers without a delay in treatment. This is accomplished through collaboration between the child psychiatric team, the school, and the parent/guardian using a case-management model. The psychiatric team includes a child psychiatrist and a Registered Nurse (RN). The RN works closely with school professionals and the parents/guardians to gather information about students and to coordinate services. The RN is also available during, and outside of, clinic time to address concerns. Children are seen at school for an initial assessment and up to 3 follow-up appointments. At the time of the initial assessment, the RN works to schedule appointments for continuation of treatment in the community. As a result of this program, children are able to access child psychiatric services immediately in the school and avoid the 6-8 week wait for a community provider.
- We are measuring outcomes for this project and expect to show:
  - Parental satisfaction with the program to be high
  - School satisfaction with the program to be high
  - Reduction in symptoms (ADHD, depression, anxiety and aggression)
  - Improvement in academic performance and attendance of students
- In the first month of this project we have identified that there are many students who have not been able to access mental health services and are on the brink of crises. We are early in the project but have already seen that one student has not missed any days at school since her initial evaluation; previously this student was only attending school an average of two days per week. Another student has been noted by their teacher to have an improved ability to concentrate since being treated.
- This program has provided a wonderful opportunity to address children’s mental health needs quickly and in their normal setting (school). The stigma associated with going to a psychiatrist’s office has been removed. Our expectation is that this will help normalize the experience and promote greater compliance and acceptance as the children transition to community providers. Ultimately, we would be to expand the program to include all the schools in Boone County

<b>Agency:</b> University of Missouri Psychological Services Clinic	<b>Respondent:</b> Dr. Deborah Bell & Dr. Kristen Hawley
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***1) What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?***



- **Access to Youth MH Care:** Current estimates are that **50-75% of youth in need never receive any MH services** (e.g., Achenbach et al., 2003; Burns et al., 1995, 1999; IOM, 1989; NAMHC, 2001; Ringel & Sturm, 2001; Sturm et al., 2000).
  - a. Biggest issue here: **Not enough child providers** in Boone County willing and able to provide **low-cost services**, especially in out-county locations (i.e., **outside of Columbia**).
  - b. Other issues include transportation, parent work schedule, cost of services, lack of child care, etc. all prevent access to care even when family can identify a provider willing to work with them.
- **Quality of Youth MH Care:** For those that do manage to access MH care, that **MH care is rarely evidence-based** (e.g., Hawley, 2005, 2008; Weisz et al., 2006, 2013)
  - a. Biggest issue here: **Very few providers are trained in evidence-based assessment (EBA) and treatment (EBT)** (e.g., Cook & Hawley, 2007, 2008; Jensen-Doss & Hawley, 2010, 2011; Taylor et al., 2013). This may be especially true for those providers who work with low income families (e.g., Jensen-Doss, Hawley et al., 2009; Kearns et al., 2009).
  - b. Why are so few providers trained in evidence-based practice? Current data suggest that these providers have very little ability to access the kind of **training and supervision needed to support efforts to provide EBA and EBT** (Hawley, 2011; Powell et al., 2013). For the most part, these are dedicated providers working hard to provide care for their clients. In other words, the issue here seems to be lack of access to the kinds of training and supervision needed, not lack of interest from providers.

*2) Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?*

- **Not enough trained child providers:** The Psychological Services Clinic (PSC) is a small, university department-based clinic. We currently have only a small handful of providers who see youth and families – 3 licensed psychologists supervise youth services provided by 3-10 doctoral students (usually MA level) in clinical psychology. So our obstacle is not being able to hire or train enough child service providers to handle our wait-list. Removing this obstacle would require funding to support hiring additional licensed providers who can provide evidence-based youth services. Of note is that **cost to clients is generally not an obstacle** at the PSC, as we have a generous fee assistance schedule.
- **Not enough support for training:** We are fortunate to have and provide excellent training in evidence-based services. This is inherent in our nature as a training clinic in a doctoral clinical psychology program that emphasizes science-based practice. Part of what allows us to provide high-quality evidence-based service is the **ongoing supervision and skill-development** we provide for our doctoral trainee clinicians. One obstacle we face is limited funding for our supervision and training; it is sufficient for our needs but there is little room for expansion of our services.

*3) Where is the gap in your clinical and/or mental health services?*





- **For the community** as a whole, there is a need for **provider training in EBA and EBT**. Very few providers are trained in evidence-based assessment and treatment, particularly in the following critical areas:
  - a. Quality Evidence-Based Assessment (EBA) for youths before, during and after treatment (e.g., standardized diagnostic interview; symptom/functioning checklists) to facilitate appropriate treatment planning and referral and to monitor outcomes of treatment.
  - b. Behavioral Parent Training (BPT) for child disruptive behavior problems and disorders (e.g., ADHD, ODD, CD) and child abuse prevention,
  - c. Exposure-Based Cognitive Behavioral Therapy (CBT) for anxiety, depression, trauma, OCD, tics and related disorders.
- **For the PSC**, we do some things very well, but our small size limits what we can offer. Some of the services we could provide with additional resources include:
  - a. Clinician Training in EBA and EBT – We could provide training for many more community MH providers (both licensed and pre-licensure).
  - b. Behavioral Parent Training Groups – We could provide ongoing evidence-based groups for parents from surrounding areas.
  - c. CBT Skills Groups for Youths – We could provide ongoing evidence-based groups for youths with a range of MH problems (e.g., anxiety, depression, disruptive behavior).
  - d. Expanded EBA services – although evidence-based assessment is an integral part of our youth intervention clients, we currently refer most “assessment only” referrals out. However, wait lists are long and costs are high for these services. Expanded resources would allow us to provide more EBA, for our clients and others’ clients, to facilitate appropriate screening/triage/diagnosis, treatment planning/referral, and to monitor outcomes.

**4) What is a quantitative measure of your success when working with clinical and/or mental health services?**

- Ongoing **evidence-based assessment of client outcomes** is very important. It is the backbone of evidence-based practice. We use assessment in an ongoing manner with each case, to evaluate treatment progress and outcomes. To evaluate both individual client and broad clinic outcomes, we evaluate the number of youths who
  - (1) no longer meet diagnostic criteria (i.e., no longer have a MH disorder), and
  - (2) are now in the normal range in standardized symptom/functioning checklists (i.e., no longer have a significant MH problem).
- We also **evaluate clinician training competencies**.
  - (1) As part of our training mission, we regularly evaluate clinical trainees in several competency areas outlined by the APA.
  - (2) In addition, the department has expertise in evaluating the success of clinician training and implementation of evidence-based practice. Dr. Hawley has presented and published widely in this area (see above citations). She has developed and evaluated low-cost, web-based training and currently has grant funding to develop and test a low-cost web-based clinician feedback system to help clinicians deliver EBA and EBT (Hawley NIMH R21). This protocol





would be available to help clinicians county-wide in their efforts to become evidence-based providers.

*5) Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.*

- To address both ACCESS and QUALITY, we need a larger, more connected **network of evidence-based providers** to whom we, and others, can make appropriate referrals for youths in need. Dr. Hawley is co-director of the **Missouri Therapy Network**, a network of providers from across Missouri who provide low-cost services and who are interested in ongoing training and practice-based research/evaluation to continually evaluate and improve their practice (see [MOtherapynetwork.wustl.edu](http://MOtherapynetwork.wustl.edu)). This network could serve as a starting point for the development of an **evidence-based provider network** for Boone County.



## Appendix E: Community Input Session Components

### Session #4 – Primary Prevention

#### *Invitation to Participate*

TO:

March 11, 2014

Annie Jensen, Vice President of Operations, Burrell Behavioral Health  
 Becky Markt, Director, Youth Community Coalition  
 Belinda Masters, Parents as Teachers Coordinator, Columbia School District  
 Cheryl Howard, Director, Nora Stewart  
 Christine Corcoran, Regional Director, Lutheran Family and Children’s Services  
 Chuck Daugherty, Executive Director, ACT Missouri  
 Crystal Perkins, Boone County Chapter Coordinator, MADD of Mid-Missouri  
 Darin Preis, Executive Director, Central Missouri Community Action  
 Eduardo Crespi, Director, Centro Latino  
 Erika Buford, Executive Director, For His Glory, Inc.  
 Gloria Crull, CEO, Family Health Center  
 Heather Dimitt, Executive Director, Big Brothers Big Sisters  
 Isabel Rife, Project Director, Project LAUNCH  
 Jack Jensen, Executive Director, First Chance for Children  
 Jan Stock, Executive Director, Rainbow House  
 Jane Williams, Program Director, Love INC.  
 Jessica Burbridge, Parents as Teachers Educator, Harrisburg R-VIII School District  
 Jim Wallis, Vice President, Preferred Family Healthcare  
 Joanne Nelson, Director of Central Region, Child Care Aware  
 Karen Smith, Parents as Teachers Educator, Hallsville R-VIII School District  
 Laurie Waint, Program Director, Project REACH  
 Lorenzo Lawson, Executive Director, Youth Empowerment Zone  
 Paula Fleming, Great Circle/Boys and Girls Town  
 Mary Ann Sander, Parents as Teachers Coordinator, Centralia R-VI School District  
 Mary Windmiller, Administrator, Children’s House Montessori  
 Meg Bartlett, Executive Director, Mary Lee Johnston Learning Center  
 Mel Fetter, Chief Executive Officer, Pathways Community Behavioral Health  
 Nick Foster, Executive Director, Voluntary Action Center  
 Pam Ingram, Director, Granny’s House  
 Pam Osman, Director, Adventure Club  
 Phil Peters, Director, Cradle to Career  
 Phil Steinhaus, Executive Director, Columbia Housing Authority  
 Shawn Schultz, Parents as Teacher Educator, Sturgeon R-V School District  
 Stephanie Browning, Administrator, Columbia Public Health and Department of Human Services  
 Suzanne Haugen, Parents as Teachers Educator, Southern Boone County R-I School District  
 Valorie Livingstone, Executive Director, Boys and Girls Club

**FROM:** Jacqueline Schumacher, Consultant, Boone County Children’s Services Board

**RE:** Invitation to the April 10, 2014 Community Input Session

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Dear Service Provider,

The Boone County Children’s Services Board (BCCSB) is taking steps to gather information about children’s services in Boone County. The Chairman, Mr. Les Wagner, and his eight-member board seek targeted information from the perspective of local providers whose services and programming align with



Missouri Statutes 67 & 210. With assistance from the Institute of Public Policy in the Truman School of Public Affairs at the University of Missouri, the Board is organizing a series of five community input sessions, one of which you are specifically invited to attend.

The organization and variety of community input sessions are driven exclusively by the funding statutes. For clarification, Missouri Statute 67 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children's Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6 million dollars annually. According to Missouri Statute 210, the Children's Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

### Service Funding Categories

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
2. Respite care services
3. Services to unwed mothers and unmarried parent services
4. Outpatient chemical dependency and psychiatric treatment programs
5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

You have been identified as a service provider whose services apply to funding Category #9 (prevention programs which promote healthy lifestyles for individuals, groups, or families). You, or a representative from your agency, are invited to participate in the Boone County Children Services Board meeting at **4:30 PM on April 10, 2014** in the Boone County Commission Chambers (RM 110) at 811 East Walnut, Columbia, Missouri 65201. This input session will address the topic of **Primary Prevention** as it applies to Category #9.

During the input session, you will be asked five questions (described in the table on the following page). Your answers should be thoughtful, although brief. It is important the Board understands your service area's collective perspective and not simply agency-specific information. Please keep in mind, **your invitation to address the Board is not an opportunity to express your agency's need for funding**. Rather, the focus of your time addressing the board should center on your answers to the five pre-established questions.

Your individual response time to these questions will range between a total of three and eight minutes. This time frame depends on the number of input session attendees. Therefore, please **RSVP** to



[schumacherja@missouri.edu](mailto:schumacherja@missouri.edu) by Friday, April 4, 2014. If possible, I will be in touch with you before the input session to confirm the amount of time you will have to answer the five questions listed on the following table.

BOONE COUNTY CHILDREN’S SERVICE BOARD COMMUNITY INPUT SCHEDULE			
DATE	Service Area	Funding Category	Questions
April 10	Primary Prevention	<ul style="list-style-type: none"> <li>Category #9: Prevention programs which promote healthy lifestyles for individuals, groups, or families</li> </ul>	<ol style="list-style-type: none"> <li>1) What are the top two issues you feel need to be addressed in your service population for primary prevention?</li> <li>2) Are there systemic obstacles to your success when working with primary prevention services?</li> <li>3) Where is the gap in your primary prevention services?</li> <li>4) What is a quantitative measure of your success when working with primary prevention services?</li> <li>5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.</li> </ol>

We look forward to hearing from your agency next month. Do not hesitate to reach out to me for further information.

***Please RSPV by April 4, 2014***

Sincerely,

JACQUELINE SCHUMACHER, MPA  
Consultant, Boone County Children’s Services Board  
INSTITUTE of PUBLIC POLICY  
Truman School of Public Affairs- University of Missouri  
137 Middlebush Hall  
Columbia, Missouri 65211  
(573) 882-6207(phone)  
[schumacherja@missouri.edu](mailto:schumacherja@missouri.edu)





**Meeting Agenda**

**AGENDA**  
**COMMUNITY INPUT SESSION #4**

**Boone County Children Services Board**

April 10, 2014 starting at 4:30

**Overview:** This input session will address the topic of *Primary Prevention* as it applies to Category #9 (prevention programs which promote healthy lifestyles for individuals, groups, or families).

**Agenda:**

- 1) *Welcome & Overview:* Jacqueline Schumacher, consultant to the Board
- 2) *Input Session Moderation:* Christian Arment, consultant to the Board

SCHEDULE OF PARTICIPANTS APRIL 10, 2014		
Funding Category	Participant Name	Agency
9: Prevention...	Heather Dimitt	Big Brothers Big Sisters
9: Prevention...	Cheryl Howard	Nora Stewart Early Learning Center
9: Prevention...	Dr. L. Carol Scott	Child Care Aware of Missouri
9: Prevention...	Ryan Worley	Youth Community Coalition
9: Prevention...	Darin Preis & Ryan White	Central Missouri Community Action
9: Prevention...	Jerri Sites	Rainbow House
9: Prevention...	Kelly Hill	Love INC.
9: Prevention...	Nick Foster	Voluntary Action Center
9: Prevention...	Isabel Rife	Project LAUNCH
9: Prevention...	Phil Peters	Cradle to Career
9: Prevention...	Stacia Reilly	Columbia/Boone County Public Health & Human Services
9: Prevention...	Gloria Crull	Family Health Center
9: Prevention...	Becky Markt & Phil Steinhaus	Columbia Housing Authority – Low-Income Services
9: Prevention...	Mary Ann Sander	Parents as Teachers Centralia School District
9: Prevention...	Linda Frost & Karen Wallace	Family Counseling Center of Missouri
9: Prevention...	Drew Moffett & Vinita Khanna	Preferred Family Healthcare

- 3) *Follow-up and Clarification Questions:* Board Members
- 4) *General Input:* Audience & Non-scheduled participants
- 5) *Closing Remarks:* Kelly Wallis, Boone County Director of Community Services



## **Feedback Report**

### *Community Input Session on Primary Prevention*

The Boone County Children’s Services Board (BCCSB) is taking steps to understand more about children’s services in Boone County. BCCSB contracted with the Institute of Public Policy (IPP) in the Truman School of Public Affairs at the University of Missouri to organize and moderate five Community Input Sessions. BCCSB wishes to make wise expenditures of the Children’s Services Fund and seeks targeted information from local services aligning with the Missouri Statutes 67 & 210. This feedback document provides an overview of the information shared with the Board during the fourth input session and will help guide BCCSB’s future funding strategies.

Missouri State Statute 67.1775 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children’s Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6.5 million dollars annually. According to Missouri Statute 210.861, the Children’s Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
2. Respite care services
3. Services to unwed mothers and unmarried parent services
4. Outpatient chemical dependency and psychiatric treatment programs
5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

**Overview:** The BCCSB hosted Boone County social services agencies at their bi-monthly board meeting on April 10, 2014. The topic of this session was *Primary Prevention* which centered on prevention programs which promote healthy lifestyles for individuals, groups, or families. A total of 38 agencies were invited to participate, of which 17 were able to attend. A total of 19 agencies prepared and submitted formal comments on worksheets which addressed the Board members’ predetermined questions. Table I is a reference guide to the Community Input Session #4 and quantifies the number of agencies engaged in the convening.





Table I: Community Input Session #4 By the Numbers	
Session #4	Date: April 10, 2014
	Topic: Primary Prevention
	Funding categories: 9
	Number of invited participants: 38
	Number of scheduled participants: 17
	Number of worksheets received : 19
	Number of individuals in attendance: 31

**Methodology:** Boone County agencies having services which apply to Category #9 were invited to attend the BCCSB meeting on April 10, 2014. When an agency confirmed their desire to participate in the meeting they were provided with a worksheet containing five pre-established questions developed by the Board. A copy of the agency worksheet may be found in Appendix A. Invited agencies were given two directives: first, agency representatives were encouraged to submit their written responses to the Board’s five questions in advance of the meeting. These responses may be found in Appendix B, and are organized by agency name. Second, agency representatives were instructed to use their meeting participation time to answer these questions. Each respondent was given a total of five minutes.

The Board’s pre-established questions are as follows:

Question #1: *What are the top two issues you feel need to be addressed in your service population for primary prevention?*

Question #2: *Are there systemic obstacles to your success when working with primary prevention services?*

Question #3: *Where is the gap in your primary prevention services?*

Question #4: *What is a quantitative measure of your success when working with primary prevention services?*

Question #5: *Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.*

**Findings:** The following responses are organized by question and have been de-identified. This allows the aggregated responses to point toward themes and topics rather than agency-level information shared as a byproduct of the participant’s responses during the input session. When possible, responses in bulleted lists are categorized by topic: *Shelter, mental health, transportation, basic needs, education, access, structure/systems, early intervention, provider skills/development, substance abuse, case management, school-based interventions, community*



*initiatives, and parenting skills.* The “other” category is catchall for items that do not readily fit into the aforementioned groups.

**Top Two Issues – Primary Prevention**

During the community input session, the following were mentioned in response to the question: *What are the top two issues you feel need to be addressed in your service population for primary prevention services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Transportation**

- Transportation both in and out of Columbia

**Basic Needs**

- Access to stable housing
- Affordable housing
- Long-term effects of poverty on mental health of children
- Poor adult skills means inability to keep a job, finish school, respond appropriately to authority
- Poverty in general

**Education**

- Mental health education
- Negative stigmas of mental health

**Access**

- Accessibility to mental health services in the home
- Need for additional home-visitation services
- Services are not in out-county areas
- We have a long wait for our home-based prevention services

**Provider Skills/Development**

- Lack of applied classroom-based coaching for teachers
- Lack of teacher training in early learning centers

**Substance Abuse**

- Mental health in regards to substance abuse
- Substance abuse in general

**Community Initiatives**

- Reserve funding dollars for collaboration efforts which represent a good portion of the market share so you can see community level change

- The community must be aligned around positive outcomes for kids
- The community must establish a shared target to move toward and take steps, like data sharing, to overcome barriers and traditional rivalries
- The community should promote positive youth development

**Parenting Skills**

- Parent knowledge of child development is limited\*\*\*
- Increasing numbers of children entering kindergarten are not emotionally or socially ready to do so\*\*
- Parents of ADHD children lack knowledge of management of this issue (they need in-home counseling, training, educating)
- Education, training, parenting skills are needed to prevent problems from arising
- Keeping parents engaged as a way to continue to educate them and serve as a resource
- Lack of coping skills seen among the parents of our service population
- Parenting education in general
- Parents of obese/overweight children lack knowledge and training

**Other**

- Obesity
- Targeted evidence-based programming
- Violence prevention (bullies, gangs, domestic violence)



*Summary:* The top two issues identified by providers at this community input session on primary prevention focused on the need for more knowledge. A lack of knowledge was expressed at both the teacher-level and at the parental-level. Looking first at teachers, the argument for more education is twofold. First, there appears to be a less than adequate accreditation process by the State of Missouri for daycare providers. This is then compounded by a lack of training and coaching of early childhood care givers in the field. Second, child care providers/teachers often lack the specific training necessary to identify and address red flag mental health issues in young children. In regards to parental knowledge, an overwhelming number of providers participating in this community input session noted the need for parent education in the form of training. Parents appear to lack knowledge of basic child development and many children are entering kindergarten emotionally and socially not ready to do so. One provider said, “*Education, training, and parenting skills are needed to prevent problems from arising in children.*” The theme of parenting skills is a separate category while the teacher skills are grouped under *Professional Skills/Development*.

The issue of *Community Initiatives* was raised by a number of providers participating in this community input session. The sentiment they expressed focused on the concept that prevention is indeed a community-level issue and therefore community-level approaches are necessary. These approaches could include: data sharing, common measures, authentic collaboration, and community-wide agreement on prioritization of issues.

**Systemic Obstacles to Success – Primary Prevention**

During the community input session, the following were mentioned in response to the question: *Are there systemic obstacles to your success when working with primary prevention services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Shelter**

- Homelessness in general

**Transportation**

- Limited transportation options\*\*

**Basic Needs**

- Unemployment

**Education**

- Mental health stigmas\*
- Due to stigma of mental health, we see a denial of substance abuse as a problem and a disregard for warning signs
- Lack of funding for low-literacy engagement with a focus on mental/emotional well-being

**Access**

- The workforce is ill-equipped to handle mental health needs of families; there is a shortage of professionals to address intervention needs
- Lack of care for the un/underinsured
- Long wait times at agencies
- Shortage of mental health professionals

**Early Intervention**

- Intervention needs to happen birth to 3-years

**Structure/Systems**

- No shared data systems across agencies\*\*
- Agency referrals only happen intra-Columbia



- Fragmented services across agencies mean most at-risk families fall through the cracks
- Fragmented, uncoordinated, redundant services with poor referrals and follow-up outcomes
- Health insurance maze
- Insurance eligibility requirements means kids have to be in really great risk
- Lack of county-wide practices and policies
- Lapse in funding from the state
- Medicaid cut point is age 17 means kids lose medication coverage

**Provider Skills/Development**

- Lack of training and inexperienced teaching staff to identify and respond to mental health red flags presented by parents
- Limited teacher training hours
- Little sustained government financing for teacher training and coaching
- Teachers lack knowledge on the indicators of mental health and early childhood development

*Summary:* Providers participating at this community input session on primary prevention expressed their systemic obstacles to success as they relate to the overarching structure and systems problems present in the county. These problems include no shared data systems across agencies, fragmented services across agencies, and uncoordinated services in general. Access issues often prevent services from being obtained, while low-literacy of mental/emotional wellbeing, and a general stigma associated with mental health, perpetuates the systemic obstacles of primary prevention.

Teacher preparedness is classified here under the *Professional Skills/Development* theme. This theme gained momentum throughout the community input session on primary prevention and as seen here, “...a lack of early learning teacher training, limited coaching hours, and non-sustainable government funding continue to educate teachers,” were identified as systemic obstacles. It may be worth examining if teacher preparedness ought to be a subcategory of the *Professional Skills/Development* category.

**Gap in Services – Primary Prevention**

During the community input session, the following were mentioned in response to the question: *Where is the gap in your primary prevention services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

**Case Management**

- One-on-one coordination of services does not happened until the first intervention

**Community Initiatives**

- Community-level indicators of success need to be selected
- Lack of community-wide vision
- Safe and affordable recreation

**Parenting Skills**

- Low awareness/education among parents

**Other**

- Funding process encourages silos
- Lack of funding for prevention programs
- Lack of prioritization from agencies on the issues of healthy lifestyles
- Limited access to healthy foods
- Population is often distrustful of providers
- Transient nature of the population



**Shelter**

- No shelter options for children with mental, physical, or extreme aggression issues

**Basic Needs**

- Access to stable low income housing

**Mental Health**

- Group therapy for autism
- Mental health services for parents are needed

**Education**

- Lack of funding to support community education (nutrition, child development, time management)

**Access**

- Lack of family therapy services
- Shortage of professionals willing to serve children and families
- Supply vs. demand of in-home programming services

**Structure/Systems**

- Difficulty in accessing Medicaid, daycare assistance, TANIF
- Due to legal constraint, we do not have a complete picture of the family and are unaware of other services they are receiving
- There is no county-wide coordination to foster collaboration or to build capacity

aimed at addressing mental health and substance abuse issues

**Provider Skills/Development**

- Increased promotion of evidence based programming
- Non-existent funds for evidence based program training

**Case Management**

- Case managements services\*\*\*

**School-based Interventions**

- Coordination in schools and healthcare community sectors
- Difficult to coordinate prevention services with schools because of time constraints

**Community Initiatives**

- Lack of alternative activities for youth outside of Columbia
- No coordinated county-wide program to promote healthy lifestyles

**Parenting Skills**

- Parent education on all factors from child development to time management to nutrition

**Other**

- Need for more funding
- We could do more if we had more

*Summary:* Case management was identified multiple times as a gap in primary prevention services by providers at this community input session. Issues surrounding the theme of access, structure/systems, school coordination, need for evidence based programming, and the desire for meaningful collaboration are defined as a gap in services in this and previous community input sessions.

**Quantitative Measures of Success – Primary Prevention**

During the community input session, the following were mentioned in response to the question: *What is a quantitative measure of your success when working with primary prevention services?* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

- Knowledge gained\*\*
- Academic course failures
- Assessments of cognitive and socio-emotional kindergarten readiness
- Community level indicators



- Comprehensive data systems for tracking outcomes
- Conducting a comprehensive agency-level study
- Consumer level indicators
- Decreased dependency on TANF or other social services
- Healthy People 20/20
- Increased immunization rates
- Juvenile referrals
- Many measures address immediacy of need
- Missouri Student Survey of Behaviors
- Number of children screened
- Number of referrals to services
- Number of WIC checks redeemed
- Pounds of food grown in community gardens
- Pre/post surveys
- Provider and patient satisfaction surveys
- Reduced child maltreatment
- School dropout rate
- Self-sufficiency
- Smoking cessation
- Social emotional competencies
- Student engagement survey
- Teen pregnancy rate
- Transition rate out of government housing
- Tri-ethnic community readiness survey
- We have long and short term outcomes
- We not only track our referrals, we follow-up
- Youth outcome surveys

*Summary:* Responses to the question asking about quantitative measures of success indicated that all participating agencies have some method in place for tracking performance. The most common agency measure reported here was knowledge gained by programming recipients. Most measures mentioned by providers at this community input session on primary prevention tend to gravitate toward indicators of client established goals, knowledge gained, evidence-based programming measures, and annual performance reviews.

**Potential Collaboration – Primary Prevention**

During the community input session, the following were mentioned in response to the question: *Please describe potential collaborations you envision for addressing primary prevention services.* Responses with an asterisk (\*) or asterisks denote responses which were the same or similar among multiple respondents. Multiple asterisks equate to mentions of this item multiple times by respondents:

- Churches
- Collaboration is difficult when everyone is simply trying to stay afloat
- Collaboration must be across sectors
- Collaboration should happen using neighborhood based services such as community centers and churches for program implementation
- Collaboration would be strengthened with regards to in-home services if we could reduce redundancy
- Family and education training collaborations are vital
- MAPP process
- Need to improve the interfaces between primary and early childcare providers
- We want/need more collaboration
- We would like to be involved with more teen mentoring in rural areas
- Yes, we make referrals to other organizations





*Summary:* Many agencies simply listed the name of organization and individuals with which they collaborate. As seen in previous community input sessions, agencies use this “collaboration question” as an opportunity to articulate collaboration shortfalls and voice the desire for meaningful connections with agencies in the county.

**Conclusion**

BCCSB’s process of hearing input from agencies that provide primary prevention services was useful in identifying common themes. Top emerging themes include: educating and training parents; thorough preparation of teachers; and shared collaboration in data, referrals, and agency coordination. The theme of community initiatives emerged and pointed toward the desire for community-level approaches to prevention. Providers with these sentiments expressed that a community approach to prevention cannot be conducted in “*name only*,” but rather a community approach must be supported by agreed upon goals which are specific, measureable, attainable, realistic, and timely.

Some clarification is needed in regard to the emerging theme of teacher preparedness and training. During the course of the primary prevention community input session, participant comments and worksheets indicated that teacher preparedness was lacking. However, it was not made clear whether the issue lie with (a) the nuanced characteristics of teachers (such as accreditation levels), or (b) their specific shortcoming with regards to mental health, or (c) both. To the first point, it appears the accreditation for the early learning centers needs further examination to ensure basic teacher competency, which is largely a *Systems/Structure* issue. To the second point, comments made in this session, and in previous sessions, point toward a lack of skills/training/knowledge among all teacher groups as to appropriate mental health development of children, youth, and adolescents. The need for greater knowledge of children’s mental health also extends parents.

**Agency Worksheets**

<b>Agency:</b> Big Brothers Big Sisters of Central Missouri	<b>Respondent:</b> Ms. Heather Dimitt
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- One of the biggest needs we see on our caseloads is parents who have little to no knowledge about basic child development (physical, psychological and educational), how to provide a safe and structured home environment for a child and a very limited to non-existent support system.
- Similarly, there is a gap in the community’s knowledge, and thus in the pool of people from whom Big Brothers Big Sisters can recruit mentors, in regards to child and adolescent development benchmarks and in ways to build or strengthen developmental assets.





**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Because of the stigma attached to mental health issues and what often seems to be a denial of substance abuse issues, people tend to not recognize the warning signs of problems. When you don't recognize the warning signs, you are less likely to know the kinds of environments and supports that prevent problems from happening in the first place which means people don't always realize that changes need to occur in our community and that they need to be active in that change.

**3) Where is the gap in your primary prevention services?**

- Because of legal constraints and other agency regulations, we may not always have a complete picture of the family's and children's needs or the entirety of the services that they are receiving.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- Our primary focus is on increasing a child's developmental assets and resiliency. We use a measure called the Youth Outcomes Survey (YOS). The YOS is a researched based survey developed by Big Brothers Big Sisters of America to measure the child's developmental assets. It is given at the child's intake interview and then again at the yearly anniversary of the match. We also track educational progress, out of school suspensions and juvenile referrals for many of our children.

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- Because we are not a site dependent program (i.e. we pair individual adults with individual children to engage in activities), we can partner with any school district, church or other organization to provide mentors to children that those organizations or parents feel need a mentor. We have already had conversations with other youth serving organizations about ways to provide this individualized support to their neediest children and to recruit older teens to serve as mentors themselves.

<b>Agency:</b> Central Missouri Community Action	<b>Respondent:</b> Mr. Darin Preis
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- Accessibility to mental health services, particularly "in-home" providers, including those who represent cultural diversity (African-American and Latino). Given the complexity of daily life for low-income families, whose basic needs take priority over health and emotional well-being, scheduling and keeping offices visits is not typical. Further, their



employment positions don't generally allow for time off to accommodate therapy services. Services that could be delivered to families in their own environments, and on their terms, would likely create stronger levels of buy-in to the process and lead to more interest in voluntary participation. Many times, those we see involved with mental health services are either court ordered or are seeking disability determination, as opposed to being voluntarily sought for the purposes of health and happiness.

- Additional Home Visitation/Family Development Advocate Services (not mental health specific but, with nearly half of the referrals received as the result of some pressing crisis, mental health was identified by families themselves, as being a core need on top of the other types of crisis being experienced). Over the 2012-13 (most recent data available) we found that 46% of all referrals receives for FDA (Family Development Advocate) services during the 2012-13 program led to families identifying a current mental health issue and, 23% of those were successfully connected with mental health services. During periods of crisis, usually relating to unmet immediate needs, families tend to more vulnerable. With the probing of a skilled professional, and partnership conversation with a family advocate with whom a relationship exists, emotional issues (relating to the consuming stress of the current situation) can be used as a door opener to the need for mental health services and/or long-standing patterns of unmet mental health needs. The family advocate who is familiar with navigating the insurance/Medicaid systems, and who have established contacts with the local mental health providers, can facilitate referrals for immediate services where this is much more challenging for the families themselves.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Eligibility requirements often prevent families from having access to needed mental health services, especially when it comes to expediting services. Generally, there has to be documentation of an extreme risk to get services in place quickly and when families are most vulnerable (for example - suicidal ideations, child abuse, arrest, etc.). Further, services are typically very time limited with approval for only a few sessions. This doesn't accommodate primary prevention. Services are very "deficit" driven. If we could engage families in mental health services based on the strengths they present (for example - their abilities to function despite extreme adversities, their desires to buffer kids from traumatic family life events and their willingness to engage with a mental health service provider as a means of strengthening their parenting capacities, based on their acknowledgement of need and interest in services) we would reach far more who need and would respond well to treatment and would be building family developmental assets in the process.



- Very few opportunities for the uninsured to receive mental health services. Where there are organizations that serve the uninsured who receive some form of public assistance, waitlists are long and treatments provided are only minimal.
- With many of the families served by CMCA Head Start, there seems to be a negative stigma attached with mental health services. This is oftentimes based on previous experiences with mental health providers who were involved with their families as the result of very negative experiences and, those services are viewed as threats to the stability of their families. This oftentimes stems from experiences in their own childhoods that involved the court systems. In other words, mental health services are viewed as dangerous as opposed to helpful.
- Lack of funding to coordinate "low-literacy" engagement opportunities with a focus on mental/emotional well-being. We have been funded to provide low-literacy health and dental health trainings and, over the course of more than 7 years, have collected data to show very promising outcomes of these training gatherings. We can almost guarantee strong levels of participation if funding would allow for the coordination of such training events targeting mental health, and ideally trained mental health providers would be available for screening and supporting families based upon identified mental health needs.
- Lack of training and inexperience of staff in regard to identification and response to mental health red flags presented by parents. We have a strong system in place for screening and responding to mental health concerns identified in children, but has consistently seen correlations between the child's mental health and issues present in their home environments.

### ***3) Where is the gap in your primary prevention services?***

- Service coordination for parents relating to adult mental health and, the lack of family therapy services in response to mental health issues identified with children.

### ***4) What is a quantitative measure of your success when working with primary prevention services?***

- The social-emotional competencies of each child entering into CMCA Head Start's programs are screened using a nationally-normed assessment, The Devereux Early Childhood Assessment, within the first 45 days of their enrollment. This assessment evaluates, by both parents and teachers, the three primary protective factors of attachment, initiative and self-control. If a child fails this screening, another is administered no later than the his/her 166th day of enrollment and, if the second screening results in another fail, formal follow up is coordinated, the DECA-C (clinical) is conducted and families, teachers are equipped with individual strategies to support enhanced competency and, referrals for additional evaluations and/or services are made when determined necessary.



- Over the course of the current year, in Boone County only:
  - 42 infants and toddlers were screened using the DECA-IT and 4 failed their first screening. Of those, 3 families received follow up services from our Mental Health Administrator.
  - 127 pre-school aged children were screened using the DECA. Of those, 35 failed their first screen and are currently undergoing the second screening. Thus far, 10 have failed the second screen and, will be evaluated using the DECA-C, to develop strategies for families and teachers to implement in response to areas of delay or concern.
  - Central Missouri Community Action Head Start entered into partnership with Crittenton Children's Center to implement the Head Start, Trauma Smart initiative in September of 2013. The focus of Head Start Trauma Smart is to help Head Start agencies create trauma (toxic stress) informed communities that support the social/emotional and educational needs of young children who have experienced trauma and he caregivers (parents and Head Start staff). The Head Start Trauma Smart Model involves three components; 1) trauma -focused staff/parent training 2) classroom consultation 3) trauma-focused support for children/families affected by trauma.
  - Since the partnership was developed between CMCA Head Start and Crittenton Behavioral Health, each of our teaching staff have participated in 20 hours of training which incorporates didactic learning, discussion and experiential learning exercises. Each of our classrooms are incorporating the ten primary concepts having been taught. These concepts are taught in the ARC model, which is recommended by the National Traumatic Stress Network, and two licensed clinical social workers are consulting with staff in their classrooms on a very regular basis to reinforce the principles/building blocks of the ARC model and to ensure they are being applied. These building blocks are:
    - Attachment - including caregiver affect management, attachments, consistent response, routines and rituals.
    - Self-Regulation - including affect identification, affect modulation, and affect expression.
    - Competence - including executive function, self-development and identity, and trauma experience integration.
    - In addition, 19 children have/are receiving individual therapy with the Head Start Trauma Smart Therapists and families are learning to understand how to meet their needs through a trauma sensitive parenting approach. Eight of those children and families reside in Boone County.

***5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.***



- Columbia Cares for Kids Coalition
- University of Missouri, Child and Family Assessment and Consultation Clinic
- Family Impact Center
- True North
- Children's Division and Juvenile Court
- Burrell Behavioral Health and Family Counseling Center
- Boone County Health and Human Services
- State of Missouri Medicaid and MC+ providers
- Lutheran Family and Children's Services
- Pathways Community Behavioral Healthcare
- Parentlink
- Rainbow House

<b>Agency:</b> Columbia Housing Authority Low-Income Services	<b>Respondent:</b> Ms. Becky Markt & Mr. Phil Steinhaus
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***1) What are the top two issues you feel need to be addressed in your service population for primary prevention?***

- We see a need to prevent long-term effects of poverty on the mental and emotional health of the children living in housing supported by the Columbia Housing Authority. We know that the stress of growing up in poverty can cause biological changes that dampen a child’s ability to develop Executive Function skills. Children raised in these fragile families are more likely to reach adulthood with lower education, which means lower income as adults, and are therefore more likely to raise their children in the same type of environment and repeat the cycle of poverty.
- We believe that fragile families should have access to targeted and coordinated evidence-based supports that build upon each other over time to produce emotionally healthy homes. Growing up in nurturing, enriching environments from birth can create a sturdy foundation for later school achievement, economic productivity, and good citizenship.

***2) Are there systemic obstacles to your success when working with primary prevention services?***

- Fragmented services targeting the general public often miss the most at-risk families served by the CHA. The population is often distrustful of service providers, transient, and fearful. Families move in and out of the CHA all the time. With the current model, true one-one-one coordination of services doesn’t begin until the first intervention, and may be limited to an agency or organization. A lack of coordination through a central point means that service providers may not know what other service providers are already doing for the family.



**3) Where is the gap in your primary prevention services?**

- One-on-one coordination or case management of primary prevention services for the low-income families living in public housing and in Housing Choice Voucher system through Boone County.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- CHA Low-Income Services, Inc. has aligned their programming with the Search Institute’s 40 Developmental Assets and the America’s Promise Alliance -5 Promises All Kids Need to Succeed. We are also aligned with the Columbia Cradle to Career Network and the United Way Community Impact Project. There are many indicators that can be used to measure forward movement as the family and child progress toward family health, self-sufficiency, and success. Our ultimate goal is to have our families successfully transition from government assistance to full self-sufficiency.

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- CHA Low-Income Services, Inc. already collaborates with many service providers and will continue to seek out new partnerships in order. To develop a targeted primary prevention system for families we envision collaborating with Central Missouri Community Action Center, Big Brothers/Big Sisters, First Chance for Children, Parents as Teachers, COMPASS, Burrell, Columbia/Boone County Health Department, Adult Basic Education, and Columbia Public Schools. CHALIS could collaborate with these agencies to provide families receiving CHA housing assistance in Boone County with case management, referrals, service coordination, pre-assessment of needs, home visits, transportation assistance, evidence-based prevention strategies and incentives to complete desirable activities.

<b>Agency:</b> Child Care Aware of Missouri	<b>Respondent:</b> Dr. L. Carol Scott
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- Issue #1: The knowledge and skills baseline about young children’s indicators of mental health (i.e., emotional and social skill development), among teaching and program administration staff working in early care and education programs, including child care. National research findings predict that at least 10 to 15 percent of Missouri children from six months to five years of age are either already experiencing social and/or emotional deficits, or are at risk of developing them.<sup>i</sup> Some national studies indicate that as many as 32 percent of children at this age have behavioral problems.<sup>ii</sup> A 2011 pilot project,





funded through an American Recovery and Reinvestment Act (ARRA) grant, provided social/emotional training and follow up coaching to early childhood educators. A pre-intervention screening revealed that 21 percent of 1,768 Missouri children, ages birth – five, scored as delayed. In fact, six percent had screening scores *twice as high* as the cut-off for determining a mental health concern in their age group, or higher. Early care and education teachers participate significantly in promoting mental health in young children. Yet, in Missouri, many child care teachers have no pre-service education in child development.<sup>iii</sup> “Understanding early social [and] emotional development will enable a [teacher] to enhance her relationships” with the children in her classroom.<sup>iv</sup>

- Issue #2: In general, the minimal training required for teaching and program administration staff who work in early childhood programs, including child care, doesn’t translate to adoption of best classroom practice that are more supportive of children’s overall development. Data from our *Framework for Accountable Service Delivery* (outcomes/performance indicators) show that, although there is an average gain of 13.75 points from pre- to post test scores for our training workshops, only 71% of participants report any change in their approach to children and families after these training sessions. Recent research syntheses conclude that features such as the content and intensity of training are critical to understanding the effectiveness of professional development (Weber & Trauten, 2009; Whitebook, Gombay, Bellm, Sakai, Kipnis, 2009; Zaslow, Tout, Halle, Vick & Lavelle, 2010). Furthermore, the degree to which professional development is individualized and emphasizes the application of knowledge to practice is emerging as a critical factor in professional development.<sup>v</sup>

## 2) *Are there systemic obstacles to your success when working with primary prevention services?*

- No statewide requirements for pre-service education for teaching staff in early care and education programs; licensing requirements are for 18 years of age and free of TB, with no high school diploma necessary.
- Minimal training requirements in licensing rules; just 12 clock hours of documented workshop content per year for all teaching staff.
- Few standards for training quality, although training is approved by the Department of Health and Senior Services/Section for Child Care Regulation; no approval of trainers’ education and experience backgrounds as appropriate for their content.
- Licensing rules do not incorporate any way for staff to get credit for coaching they receive, as they do for training in which they participate.
- The service population tends to have salaries at or not far above minimum wage, with few opportunities for advancement, even with higher education.
- Staff turnover in the service population is high (measured in MO at 28% in 2011), so investments made in training and coaching follow the individual staff member to new employment when there is turnover.
- There is little sustained government financing for the professional development (training and coaching) of early care and education staff; various program strategies from several departments of Missouri state government target different sub-groups within the service population, with different approaches.



**3) Where is the gap in your primary prevention services?**

- Most of the training that we provide now—with funding from Department of Social Service, United Way of Central Missouri, and other funders—is not followed by any coaching, to promote and assure changes in teachers’ practices with children and families. Even in projects that provide support for coaching, there may be insufficient coaching time to help staff at some programs make the needed changes.
- Also, the amount of training being financed is insufficient for the potential need. In Boone County, the estimated 900 staff in licensed programs need to earn a total of 10,800 clock hours each year. If every workshop is full at 40 participants, then Boone County needs 270 hours per year of high-quality training, followed by coaching. As one training organization, we have contracts to deliver just over 40 hours of training, not all inside Boone County.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- In general, participants in our training demonstrate an average gain of 13.75 points from pre- to post test scores for our training workshops. Approximately, 71% of training participants also report at least one change in their approach to children and families after these training sessions. By fall 2014, there will also be data showing changes in teachers’ practices with children and families following this combination of training and coaching.

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- If we realize that the need for services is greater than can be provided (e.g., diagnostic testing), we already make referrals to:
  - Burrell Behavioral Health
  - Departments of early childhood special education in the Columbia Public Schools and other school districts in Boone County
  - First Steps in Boone County
- Waiting lists at other organizations (e.g., Thompson Center, Family Health Center), which slow families’ access to related services or next steps in addressing their needs and goals.
- To address the systemic challenges identified in #2, above, we work through the voice of our CEO, who is a Governor-appointed representative on the Missouri Coordinating Board for Early Childhood, and a Commission-elected representative on the Missouri Children’s Services Commission

End notes:

- i) Feil, E.G., Small, J.W., Forness, S.R., Serna, L.A., Kaiser, A.P., Hancock, T.B. et al. (2005). Using different measures, informants, and clinical cut-off points to estimate prevalence of emotional or behavioral disorders in preschoolers: Effects on age, gender, and ethnicity. *Behavioral Disorders*, 30(4), 375-391; Kaiser, A. P.,



- Hancock, T. B., Cai, X., Foster, E. M., & Hester, P. P. (2000). Parent-reported behavior problems and language delays in boys and girls enrolled in Head Start classrooms. *Behavioral Disorders*, 26(1), 26-41.
- ii) West, J., Denton, J. & Reaney, L.M. (2001). The kindergarten year: Findings from the Early Childhood Longitudinal Study Kindergarten class of 1999-1999. Washington, DC: US Department of Education, National Center for Education Statistics.
- iii) Child care licensing regulations in Missouri do not even require a high school diploma; teaching staff must be 18 years of age and tested for tuberculosis.
- iv) CSEFEL. (2008). *Infant mental health and early care and education providers*. Nashville: Vanderbilt. Retrieved from the web on August 13, 2011 at [http://csefel.vanderbilt.edu/documents/rs\\_infant\\_mental\\_health.pdf](http://csefel.vanderbilt.edu/documents/rs_infant_mental_health.pdf).
- v) Isner, T., Tout, K., Zaslow, M., Soli, M., Quinn, K., Rothenberg, L., & Burkhauser, M. (2011). Coaching in early care and education programs and quality rating and improvement systems (QRIS): Identifying promising features. Washington, DC: Child Trends. Taken from the internet on March 20, 2014 at <http://www.childtrends.org/wp-content/uploads/2013/05/2011-35CoachingQualityImprovement.pdf>

<b>Agency:</b> City of Columbia/Boone County, Missouri Department of Public Health and Human Services	<b>Respondent:</b> Ms. Stacia Reilly
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- The Columbia/Boone County Department of Public Health & Human Services (PHHS) provides multiple services in this domain including the Teen Outreach Program (TOP); Women, Infants and Children (WIC); HIV/STD prevention; immunizations; tobacco cessation; and a community garden program.
- PHHS and its partners have collected data over the past year through our Mobilizing for Action through Planning and Partnerships (MAPP) process. Based on data gathered through state sources, stakeholder interviews and county-wide surveys and focus groups, the top two issues are:
  1. Chronic diseases, to include obesity
  2. Behavioral health (defined to include mental health and substance use prevention)

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Obstacles include:
  - Priorities of agencies (lack of resources, including people and money dedicated to these issues)
  - Cultural barriers
  - Lack of behavioral health services
  - Environments which are not supportive of healthy lifestyles (includes schools, workplaces and communities in general)

**3) Where is the gap in your primary prevention services?**

- While we have the WIC program, tobacco cessation and a community garden program and have partnered with other organizations on various chronic disease related programs, there is not a coordinated county-wide program to promote healthy lifestyles. In



addition, some of our prevention services can be difficult for citizens outside of Columbia to access.

**4) What is a quantitative measure of your success when working with community-based programs and/or family intervention services?**

- Some measures of success include:
  - School dropout rate
  - Course failure rate
  - Teen pregnancy rate
  - Number of individuals who quit smoking
  - Pounds of food grown in the garden and given away to WIC families
  - Number of WIC checks redeemed

**5) Please describe potential collaborations you envision for addressing challenges in the community-based programs and/or family intervention services service area?**

- Through the MAPP process mentioned previously there have been five strategic issue areas identified county-wide, and two of those are Healthy Lifestyles and Behavior Health. Action Teams have been developed to identify goals, strategies and specific activities to address these issues. Members of the Action Teams include representatives from the city, county, University, various non-profits and social service agencies. Other members will also be sought.

**Agency:**

Cradle to Career

**Respondent:**

Dr. Philip Peters, Jr.

**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- **Cradle to Career Columbia (C2C)** hopes to work closely with the Children’s Services Board to foster more effective preventive practices. We wish to collaborate with the Board, not to receive funding from it. C2C itself does not provide direct services.
- Cradle to Career Columbia is a coalition of community leaders working to measurably improve student success in Columbia and eventually all of Boone County through more systematic and durable collaboration between the school district and the other community and governmental agencies that serve infants, children and youth. Our philosophy is to use local data to identify strategies that work and to replicate them. As a result, we will emphasize measurable outcomes and data-based decisions.
- Cradle to Career Columbia will target student success at five key stages on the cradle to career path:
  1. Kindergarten readiness
  2. 3<sup>rd</sup> grade reading proficiency
  3. Successful transition into and out of middle school
  4. Graduation from high school ready for college or career
  5. Enrollment in college or career training and completion



- Student emotional well-being and mental health is a core aspect of student progress at each of these stages. As a result, we would like to collaborate as much as possible with the Boone County Children’s Services Board.
- Collaboration and alignment of effort will be especially important at two stages where the goals of Cradle to Career Columbia most significantly align with the mission of the Children’s Services Board. The first is readiness for kindergarten. We hope you will join us in encouraging the Columbia public schools to adopt a comprehensive measure of kindergarten readiness that will allow us to track not only pre-literacy skills (which the district already measures) but also child development in other domains such as emotional well-being and self-regulation. A more comprehensive assessment will help us measure the effectiveness of local efforts to foster children’s emotional development. Later this spring, we will convene an Early Childhood Collaborative Action Network that will mine local data to identify effective practices and spread their use. We hope that the Board and its agencies will play an important role in the Network.
- The second area of substantial shared interest is the transition into and out of middle school. C2C will be tracking several community-level indicators to measure how well our youth are handling those transitions (see below). A number of those indicators are signals of student mental health (such as attendance, student engagement, and, in the future, disciplinary referrals). We are encouraging the district to regularly administer a reliable and comprehensive assessment of student psycho-social well-being and risky behavior. The resulting data could greatly inform the work of the Children’s Services Board and its grantees, so we hope that you will participate in the upcoming discussions. We are inviting several faculty from MU to inform those brainstorming sessions. The result could be a major improvement in our ability to monitor success and to make well-informed investments.
- In short, we will be tracking the success of local prevention efforts and helping providers and funders make evidence-based decisions. We hope to collaborate with the CSB as much as possible.

2) ***Are there systemic obstacles to your success when working with primary prevention services?***

- Working separately, our community organizations are often unable to measurably change the outcomes of our children. To change that, our entire community will have to work together in an unprecedented way. School, nonprofits, philanthropies, parents, and government agencies must collaborate as they rarely have before--aligning their goals, sharing data, and putting aside old rivalries. Cradle to Career Columbia was created to foster that collaboration.
- Our collaborative action networks will use the same continuous quality improvement methods that have been successful in the business sector. That means collecting, sharing, and analyzing data on student outcomes in order to identify promising opportunities to improve outcomes and strategies shown to make a difference. The networks will create action plans based on that data and then they will measure the impact of their plans on student thriving to determine whether those strategies should be expanded, refined or replaced.
- We very much invite the participation and guidance of the Children’s Services Board as the networks shape their collaborative strategies and select metrics by which to measure their success.



**3) Where is the gap in your primary prevention services?**

- Our collaborative action networks will mine local data to determine the service gaps whose closure has greatest potential to affect community-level outcomes. They could, for example, use geomapping or disaggregation of needs data by student demographics to identify the most promising targets and strategies. They will also emphasize using existing resources more effectively.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- Cradle to Career Columbia will annually report on more than a dozen community-level indicators that we are using to measure student thriving at five key stages in the cradle to career path. We will work to align these metrics with any selected in the future by the Board
- Comprehensive assessment of cognitive and social-emotional readiness
- Student engagement survey
- Engagement
- Attendance
- Missouri Student Survey of Behaviors

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- In addition to the collaborative steps outlined above, we hope to work with the Children’s Services Board and other local funders to maximize the extent to which C2C’s target outcomes align closely with the targets that you have asked your grantees to improve. That targeted focus will increase the odds of actually improving community-level outcomes.
- We encourage you to select specific community-level outcomes that you hope to improve so that you can measure the effectiveness of your grants and recalibrate over time.
- We encourage you to set aside a portion of your funding for collaborative action plans and to require that the plans include measureable outcomes aligned with your own community-level targets.
- We encourage you to employ one or more data analysts to assist local agencies in making the cultural shift to data-based decision-making and outcomes measurement that your RFPs will likely require. This shift requires trained staff that few agencies currently have.

<b>Agency:</b> Family Counseling Center of MO & Pathways Community Behavioral Health	<b>Respondent:</b> Ms. Karen Wallace & Ms. Linda Frost
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- The top issues needing to be addressed in our service population for primary prevention are:



- Violence Prevention including bullying, suicide, gang violence, and domestic violence.
- Mental health awareness and literacy including issues related to adverse affects on mental health related to alcohol and marijuana use.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Systemic obstacles related to our success when working with primary prevention include:
  - Lack of district wide policies; practices and programs; lack of community awareness of mental health issues and literacy; lack of collaboration between various community groups as well as communities; territorial boundaries; lack of community wide vision; lack of prevention experts and knowledge at the local as well as school level to lead prevention efforts, fragmented mental health system; no systemic way to screen, identify or refer people for services; and environmental factors conducive to risky behaviors such as easy availability of alcohol, reluctance to advocate for evidence based policies, lack of community data, and denial of problems

**3) Where is the gap in your primary prevention services?**

- Gaps in primary prevention services include: lack of funds to provide staff, training, materials, and to implement evidences based practices and programming; difficulty engaging or reaching parents in prevention efforts; lack of youth prevention groups; lack of alternative activities for youth outside of the Columbia area; lack of positive opportunities for youth to engage in communities; disconnect between prevention, early intervention and treatment resources; lack of prevention programming at the preschool, early childhood level; and lack of programming to promote positive asset building, coping skills and wellness in youth.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- A variety of quantitative measures are utilized to measure success when working with primary prevention including: pre and post tests; number of participants receiving services, number of people reached; number of evidenced based programs in place; and review of data such as Missouri Student Survey, MICA, Youth Behavior Risk Survey, Kids Count, status reports to analyze for trends and to evaluate effectiveness of programming. We also conduct community assessments yearly to identify specific community needs to develop a strategic plan including measure goals and objectives to address the identified needs.





**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- Potential collaborations would include: daycare providers and early childhood education providers; Children’s Division; schools, local coalitions and grass roots community groups; law enforcement; youth service providers and faith based organizations.

<b>Agency:</b> Family Health Center	<b>Respondent:</b> Ms. Gloria Crull
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- Children with ADHD whose parents lack an understanding of the management of this disorder. Specifically for children diagnosed in kindergarten or 1st grade, families need access to family counseling and parenting training. In home counseling/parenting training would work best because the families tend to miss appointments due to transportation, work conflicts, etc.
- Obese/overweight children whose parents lack an understanding of nutrition, long term effects of obesity, the role of exercise, etc. Families need access to nutritional education, and education about healthy behaviors and the long term effects of poor nutrition.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- We target the medically underserved population. Common obstacles to success include: lack/failure of transportation to services; work conflicts that interfere with schedule appointments resulting in cancelled/missed appointments; difficulty with ready access to co-pays for visits; lack of access to convenient training; and lack of access to safe, affordable exercise/recreation.

**3) Where is the gap in your primary prevention services?**

- There is a lack of funding to support educational services for patients. Services currently are limited to adult diabetes and nutrition education. Services could be expanded to include additional diagnostic categories such as ADHD, as well as child development, parenting, general nutrition and exercise, time management, etc. Children's group therapy services are lacking and would positively impact development of appropriate social skills in children diagnosed with ADHD, and other autistic spectrum disorders. Additional affordable child psychiatry services are needed.

**4) What is a quantitative measure of your success when working with primary prevention services?**





- Healthy People 2020 guides success measurement in federally qualified health centers such as Family Health Center. Measures are aligned with national standards; many are disease specific. An example would include hemoglobin A1c for diabetic patients, or in the case of childhood obesity the BMI. Outcomes are reported annually via the Uniform Data System (UDS) and compared to state and national norms for all other federally qualified health centers.

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- Family education and training collaborations with the Boone County Department of Public Health and Senior Services, University of Missouri School of Medicine, Nursing and Human and Environmental Sciences would be helpful and should be feasible. To address safe, affordable, accessible recreation possible collaborations might be the City of Columbia Parks and Recreation Department, the Columbia Police Department, the Columbia Housing Authority. Access to group therapy and child psychiatry partnerships might include area mental health providers and the University Of Missouri Department Of Psychiatry. Funding partnerships might include the MO Department of Mental Health, federal agencies and private foundations.

<b>Agency:</b> Great Circle/Boys and Girls Town	<b>Respondent:</b> Ms. Lanette Bowring
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- Great Circle prevention services target the highest need parents with an overarching goal of preventing child abuse and neglect through on-going education, support and linkage to community services including medical care.
- Thus,
  1. Parenting education on bonding/attachment and milestone development
  2. Medical access to promote well women’s health, child wellness, and immunizations

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- The population targeted for primary prevention has a variety of systemic challenges including the following:
  1. Transient nature of the population making it difficult to maintain contact, link to services
  2. Lack of transportation and telephone access creates barriers to services
  3. Difficulty accessing welfare services such as Medicaid, Food Stamps, TANF, and daycare assistance

**3) Where is the gap in your primary prevention services?**



1. Case management services to support primary prevention services
2. Mental health services for parents - both therapy and psychological evaluations
3. Lack of access to stable, low income housing

**4) What is a quantitative measure of your success when working with primary prevention services?**

- Specified program outcomes including:
  - Reduced child maltreatment;
  - Increased utilization of prenatal care and decreased pre-term, low weight babies;
  - Increased immunization rates.
  - Decreased dependency on welfare, or TANF (Temporary Assistance to Needy Families) and other social services;

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

1. Collaborations with other home visitation programs to promote partnership and lack of duplication of services
2. Embed services within local schools, health clinics and community collaborations to reach the high risk families

<b>Agency:</b> Love INC.	<b>Respondent:</b> Ms. Jane Williams
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- Lack of coping skills that can result in poor decisions, such as substance abuse and unplanned pregnancy. Poor interpersonal and conflict resolutions skills that lead to inability to get and keep a job, finish school, and respond appropriately to authority.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Lack of funding to implement programs, including funding for staff, materials, and possibly transportation, although we believe neighborhood-based programs are optimal.

**3) Where is the gap in your primary prevention services?**

- Our agency has an informal life skills program for adults and children that is primarily implemented through volunteers. In order to better serve the community, we would like to enhance the program and offer it in multiple neighborhoods/locations.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- Pre- and post-surveys that measure increased knowledge and application of new knowledge.



5) *Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.*

- Collaboration with neighborhood facilities such as community centers and churches to host classes or groups and use of community volunteers to help implement the programs.
- not being met on either side.

<b>Agency:</b> Mary Lee Johnston Community Learning Center	<b>Respondent:</b> Ms. Meg Bartlett
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1) *What are the top two issues you feel need to be addressed in your service population for primary prevention?*

- For all children in this community to have high quality early childhood experiences which starts as they leave the hospital through kindergarten entry and success to graduation and beyond. This also means that the costs associated with childcare must be dividedly affordable for every child, regardless of family situation to have the same potential access to quality success.
- There remains a huge gap in what we as a society are learning about nutritional needs and the changes within family’s lives to accomplish that change for the next generation. Eating healthier costs more, and the convenience of over processed foods in already stressed lives has become a survival choice.

2) *Are there systemic obstacles to your success when working with primary prevention services?*

- In order to provide high quality care and educational programming for the children preparing them for school readiness; providing the highest level of nutritional value in the foods served, and utilizing current materials to meet the needs of each individual child, there is expense. Professionally trained staff with Bachelor’s Degrees within this profession are paid at a rate equal to a high school graduate working as a receptionist. Purchasing whole grain, unprocessed, fresh foods costs more than empty calories. Material usage of very young children is hard on their longevity as children begin and learn the respect and care of materials. Additionally the time it takes to build trusting relationships with the families when they begin to open up their individual family needs and struggles takes time. Time equals money.
- All of that to say: our success is linked to our ability to obtain and sustain funding

3) *Where is the gap in your primary prevention services?*

- Our greatest gap comes in parent education. Although this is an area we attempt to assist; parents, especially young single parents, are still establishing self-survival skills: learning to budget, set priorities, complete school, hold a job, and many lack parenting skills. Need for quality care, positive interactions, nutritional meals, and understanding the



stages of development are all available to parents however responses have been less than desired.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- We utilize the ASQ-3 and ASQ-SE (indicators for cognitive and social emotional concern) every six months to track the individual children in our program. A parent teacher conference is offered after each completion for the parents and staff to discuss current development, projected milestones within the next six months, and any individual or family concerns.

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- We currently are a community partner with Central Missouri Community Action with their Early Head Start Partnership housing children that are dually enrolled in our facility and EHS. They are able, with broader funding to get deeper involved in family activities, expectations, and trainings. We have desired for some time to pull community resources to include ALL our parents in a social assistance support of our parents to provide these same level services.

**Agency:**

Nora Stewart Early Learning Center

**Respondent:**

Ms. Cheryl Howard

**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- In regards to childcare assistance from the State, families need to be able to integrate family strengthening approaches in order to maintain and keep a functioning family. We at Nora Stewart provide a secured environment for children while mom or dads are at work or school. There needs to be a social worker in place to communicate between our facility and the state.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- We, as childcare providers, are left to the unknown with a child’s childcare assistance case. At times this can cause a barrier for communication to the family and facility. The families are left sometimes deciding on how they are going to get the financial funding to pay for childcare services, which at times, leaves the family with no choice, other than to leave the child at home, unsupervised or with someone who is not qualified to supervise.

**3) Where is the gap in your primary prevention services?**

- Receiving and losing funding for the families at the last minute, which leaves us no choice but to relieve the families from our program for non-payment. The



families are not aware that they have lost the funding, nor is the facility aware, that they have lost the funding which is a lack of communication from the state.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- Being able to maintain families and affordable tuition rates. Communication between state and provider

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- Having an assigned social worker who could be a facilitator between the state, and our program. We are unable to hire a social worker and the state is unable as well, so therefore the family’s needs are not being met on either side.

<b>Agency:</b> Parents as Teachers – Centralia School District	<b>Respondent:</b> Ms. Mary Ann Sander
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- #1 The Parents as Teachers curriculum provides families with basic information on many facets of a healthy lifestyle: nutrition, benefits of active play, well-checks, immunizations, dental health, effects of smoking and others. There are many times, however, that families would benefit from more in-depth information or classes in various aspects of healthy lifestyles or referrals to a professional and these are almost never offered in our community. We need Columbia based services to be willing to come to the out-county areas to offer these types of services since transportation is almost always an issue for families who need these services.
- #2 Mental health definitely affects one’s physical health and interest in having a healthy lifestyle. Even after identifying a family, based on screenings we do with the families, that would benefit from mental health services we have basically no place to refer them. Access to mental health services is almost non-existent within our local community.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- One huge systemic obstacle is the lack of referrals to PAT from other agencies that serve families with young children. Physicians, hospitals, WIC, Department of Health and other agencies located in Columbia need to refer out-county families with preschool aged children to the appropriate Parents as Teachers program so that they can begin receiving basic information on healthy lifestyles for their family. While our program has received an occasional referral from Columbia PAT from contact they have made at WIC or



childbirth classes, we have never received a referral from any other individual or agency based in Columbia.

- We serve many families who fit the definition of the working poor. Services they may qualify for are often difficult to access because of location or hours. For example, even though we have a food pantry distribution site for the Food Bank for Central and Northeast Missouri, the hours of operation are 9-11am two Mondays a month. Families are assigned a day to come based on the first letter of their last name. This makes it difficult for the working poor to access without missing work. Several families we work with have commented that they have felt “looked down upon” for using the food pantry by those staffing the pantry. Lack of space at the local distribution site makes the ability to offer privacy when doing client intake difficult and volunteers doing the intake may not be aware of the importance of privacy in maintaining family dignity. Families have told us they do not use the local food distribution site because of these issues. They also do not travel to Columbia because of the cost of travel. The out-county food distribution sites often have a more limited choice of food options and are not able to offer the quantity of fresh or frozen food that is offered in Columbia because of storage limitations. This reduces access to more nutritious food for out-county families who use the local distribution site.
- The fact that many primary prevention services are not offered in our local community is a huge obstacle. We have few choices as to where to send them locally for anything other than food. We are not aware of any nutrition, food preparation, family exercise, smoking cessation or any other healthy lifestyle related services offered at no or low cost in our community. Immunization clinics are unavailable locally. We have a number of parents who may have state funded insurance for their children but who are uninsured themselves and therefore have no access to medical or dental care.

### ***3) Where is the gap in your primary prevention services?***

- There is a gap in being able to serve all families who desire to participate in Parents as Teachers and to serve them with model fidelity services. Model fidelity services would mean that families with one or no high risk indicators would receive at least monthly visits and families with two or more high risk indicators would receive twice monthly visits. We are far short of the funding required to meet the demand for these services. Being able to meet with families once or twice a month during the entire time the family was eligible for PAT services (beginning in pregnancy with their first child and continuing as long as they had a child not yet in school in their home) would give parent educators time to work with families on the many aspects of a healthy lifestyle for their family.
- The services discussed above need to be more accessible to families in terms of location, hours of operation and programs that are offered in the out-county areas.





**4) What is a quantitative measure of your success when working with primary prevention services?**

- Making community resource referrals are an integral part of Parents as Teachers services. We track resources suggested to families by parent educators on our computerized record keeping system and then follow-up later with the family to see if they accessed the resource. We then enter the result of the referral into our data base. Research has shown that three of the five short term outcomes produced by participation in Parents as Teachers are directly related to healthy lifestyles: 1) Increase in healthy pregnancies and improved birth outcomes, 2) Early detection of developmental delays and health issues, and 3) Improved family health and functioning.

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- We would be interested in exploring collaboration with all other providers working toward healthy lifestyles. We currently collaborate with First Chance for Children, Project Launch, and Head Start. Centralia PAT just recently agreed to collaborate with the Smile dental program to bring a 2 day dental clinic to our community for children ages 1-8 who do not have a regular dentist. Private pay, private insurance and Medicaid are accepted and a limited amount of free dental care will be provided.
- Although Centralia is fortunate to have a community recreation center, the reasonable admission/membership fee is still out of reach for many families. A reduced or subsidized fee on select days or hours during the late fall, winter and early spring would be desirable and increase the ability of families to be active in all types of weather.
- Parents as Teachers works with families on an individual basis and has regular, personal, in-home contact with families. Using PAT staff and other school personnel is an effective way to disseminate information to families with school-aged children in rural communities and inform them of healthy lifestyle classes, counseling and/or other services being offered locally.

<b>Agency:</b> Parents as Teachers – Columbia Public Schools	<b>Respondent:</b> Ms. Belinda Masters
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- The short term outcomes produced by PAT participation are:
  - Increase in healthy pregnancies and improved birth outcomes
  - Increase parent’s knowledge of their child’s emerging development and age appropriate child development
  - Improved parenting capacity, parenting practices and parent-child relationships
  - Early detection of developmental delays and health issues
  - Improved family health and functioning





- #1... When PAT can enroll parents during the prenatal period, the ability to retain them in the program over time and ability to produce outcomes listed above improves greatly. We need the health care community to recommend participation in PAT to all of their at risk patients. We need the ability to work closely with birthing centers to enroll at-risk parents. Many other hospitals in Missouri allow PAT Staff to visit patients during either antepartum stays or during post-partum stays.
- #2... We have a significant wait list for interested parents. All families who are currently waiting have one or more risk factors. I anticipate that the wait list will continue to grow over time as we see increased levels of poverty in the Columbia Public School District. We have not had an increase in our funding for over 5 years. Just 4 years ago we suffered a 60% decrease in funding from DESE...significantly limiting the number of families who could continue receiving PAT personal visits...in FY 2009 we were able to serve about 2,900 families. Today we have the budget to serve about 1,200 families.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Our community could benefit by creating a pathway of intervention from prenatal to adulthood...beginning with PAT participation and moving children through various levels of service. There needs to be a cohesive process to transition a child and family from one step to the next. All of the providers need to work together in building relationships with each other and the families we serve so that at each level, the current service provider can build a bridge for the family from their current service to the next.

**3) Where is the gap in your primary prevention services?**

- Inability to meet the demand for APT services from parents in our community

**4) What is a quantitative measure of your success when working with primary prevention services?**

- See comments above

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- PAT would like to strengthen our current partnerships with health care providers (physicians-Obstetricians, Pediatricians, Family Practice), medical social workers, county health departments, WIC office, birthing hospitals.

<b>Agency:</b> Preferred Family Healthcare	<b>Respondent:</b> Ms. Paula Brawner
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- Educating the public on the definition and importance of prevention. Prevention programming needs to start as early as grade K, programming should be consistent throughout the year, Prevention program needs to have supportive services connected to it like early intervention to help teach and develop resiliency skills and other protective factors, access to parents in the early grades is critical and there needs to be ongoing community awareness activities

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Difficultly involved with measuring outcomes over time. The school system plays a vital role in information gathering and being able to follow-up over time with identified participants.
- Limited resources to deal with the number of school aged children. Data on Youth in Boone County shows that 37% are enrolled in free/reduced lunches, 28.9 per 1,000 youth have been a victim of child abuse and/or neglect. Additionally 7.1% of youth reported using marijuana thirty days prior to the Missouri student survey, and 21.3% reported using alcohol. According to Missouri Kids Count, in Boone County 65 out of every 1,000 youth have been referred for juvenile law violations. The above numbers may be actually higher due to under-reporting because of the attached Stigma.

**3) Where is the gap in your primary prevention services?**

- The difficulty in identifying a specific time for prevention program in the school setting is on-going issue. Overcoming this issue is dependent upon communication with the school officials and the ability to remain flexible with scheduling program and activities

**4) What is a quantitative measure of your success when working with primary prevention services?**

- Prevention programming success can be measured with the use of pre-tests, post-tests, satisfaction survey. We also monitor grades, attendance and the number of referrals for disciplinary action within the school.
- Our current experience working with youth in schools (St. Charles, St. Louis, Lincoln and Franklin Counties) shows impact of this intervention with 89% of youth served gaining knowledge of substance abuse and/or mental health issues; 81% of youth reported development of risk management skills; 85% of youth reported improvement in school engagement and/or performance. Additionally, in our tax based outpatient services 82% of youth reported an improvement in school engagement and/or performance, and 84% of youth reported an improvement in relationships with family members/caregivers.



**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- It is vitally important to have good communication with families, school officials, and community agencies that are involved with the students or offering services that are supportive of families in need of services.

<b>Agency:</b> Project LAUNCH	<b>Respondent:</b> Ms. Isabel Rife
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

1. An increasing number of children entering kindergarten not socially or emotionally ready to learn
2. Providers lacking social-emotional competence to adequately support/serve needs of children and families

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Yes, several including:
  1. Fragmented, uncoordinated, sometimes redundant services with poor referral/follow-up outcomes
  2. Workforce ill-equipped to handle mental health needs of families; shortage of mental health professionals to address early identification and intervention needs
  3. Low awareness of importance of social-emotional health in children and lack of knowledge regarding available community resources
  4. Absence of data sharing mechanisms across agencies

**3) Where is the gap in your primary prevention services?**

- Per above, shortage of mental health professionals limits access to appropriate prevention/early intervention services within a reasonable time frame; greater coordination is needed between schools, health care, and community sectors; increased promotion of evidence-based practices and improved standards of care

**4) What is a quantitative measure of your success when working with primary prevention services?**

- Quantitative measures include: number of children screened for developmental and social-emotional delays; number of referrals to services; reduction in child care expulsion rates; number of providers trained to address mental health needs of families; number of



families receiving evidence-based parent education resulting in decreased parent stress and improved parenting practices; provider and parent satisfaction surveys

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- Potential collaborations could encompass improved interfaces between early care and education (ECSE, child care providers, school-based preschools, elementary schools) and primary care providers; another collaborative approach would focus on the integration of behavioral health in primary care

<b>Agency:</b> Rainbow House	<b>Respondent:</b> Ms. Jan Stock
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- 1) Poverty (which leads to issues such as substance abuse, domestic violence, child abuse, criminal activity, homelessness, etc.)
- 2) Getting parents of Rainbow House clients to engage in a way that allows us to remain a resource for them even after their child is no longer in residence or on our caseload.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Health care insurance maze Fragmented, uncoordinated, sometimes redundant services with poor referral/follow-up outcomes
  - Only qualify if you make below a certain amount of money, and then you have to provide for your own insurance (don't accept promotions unless they make substantial enough more money for the person to feel comfortable paying their own insurance)
  - Medicaid stops for youth who turn 19. Many of them are taking medications for mental health diagnoses. Without medication, their ability to function productively would be negatively impacted. Not all organizations will serve a person with no insurance or other way to pay for the service, so they are unable to access a psychiatric evaluation.
- Homelessness is a circular issue that is almost impossible to overcome.
  - Unemployment or underemployment can lead to homelessness
  - No permanent residence causes instability and inability to ensure basic needs are met
  - Difficult to find a job when you can't shower, eat and sleep regularly



**3) Where is the gap in your primary prevention services?**

- Availability of affordable mental health services for children and families.
- Availability of emergency shelter for special needs children who require intensive mental or physical health services, and/or who have extreme aggression/behavioral issues.
- Emergency shelter beds for children whose parent is in crisis and the child is not safe, when Rainbow House beds are full
- Emergency shelter beds for homeless youth when Rainbow House beds are full or the youth does not fit the criteria of the program

**4) What is a quantitative measure of your success when working with primary prevention services?**

- Every child and family served by Rainbow House is entered into the data system which allows us to generate a large variety of reports. We consider every activity to be a prevention activity. We know that if the child is residing in our teen or children’s shelter they are safe at least for the time they are at Rainbow House.
- For children served at the Child Advocacy Center, even if they have already suffered some abuse, it is our opportunity to engage with the parent/family and educate them about keeping the child safe in the future.
- All parents/families are provided with information about abuse/neglect, are given resource lists in Boone and the surrounding counties, and they will receive follow-up calls from staff in the particular program that served their child for a period of at least three months, but for as long as they are responsive and/or request our help.

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- This is a list of agencies Rainbow House frequently deals with, and we are happy to expand our list when other collaborative efforts are available: Children’s Division, Juvenile office, law enforcement, counselors, school personnel, homeless shelters in Boone and the surrounding counties, Job Point, Burrell Behavioral Health, Phoenix Programs, Empowerment Zone, True North, Lutheran Family & Children’s Services, Boone County Health Department, University of Missouri Health Care and other physicians and specialists, and others.

<b>Agency:</b> Voluntary Action Center	<b>Respondent:</b> Mr. Nick Foster
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- Access to affordable housing
- Access to stable housing



**2) Are there systemic obstacles to your success when working with primary prevention services?**

- Long waits at agencies that provide service for low-income clients
- Long waits for affordable housing
- Limited transportation options
- Limited access to healthy food

**3) Where is the gap in your primary prevention services?**

- Gaps in services are due primarily to limited resources available to the agency. VAC is currently in the process of a comprehensive study to determine where there are gaps in services and to determine how the agency can best respond.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- VAC keeps significant data identifying clients. Service effectiveness is measured through the use of follow up surveys by phone and on return office visits. Since VAC is primarily a safety net provider, services are measured primarily in terms of immediate effectiveness. Surveys indicate a very high (above 90%) satisfaction rate with services provided.

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- VAC maintains a broad range of partnerships with many other service-provision agencies in our community. VAC’s services often work in a complementary fashion, enhancing the services of others. In other words, VAC is able to provide supports for clients that the other agencies themselves are not able to provide. VAC is open to exploring closer ties and collaborations in order to make these services more seamless.

<b>Agency:</b> Youth Community Coalition	<b>Respondent:</b> Mr. Ryan Worley
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**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- **Environmental Change-** The environments that a child grows up in are very influential on their overall health. This includes their home, neighborhood, school, and broader community. In order to promote positive mental health outcomes, the overall Boone County environment must be developed to provide youth with the supports they need for each step of their development. In order to have the optimum success on a clinical level, the community must be aligned around positive outcomes for kids. This provides a mutually reinforcing environment where what happens in a youth program is echoed in the broader attitudes, norms, and values of the town.



- **Positive Youth Development-** Simply preventing problems is not enough. Our local communities must promote the comprehensive positive youth development of each child. This includes addressing individual and community risk factors, but also includes developing the assets they need to thrive. This builds on the idea that problem free is not fully prepared and fully prepared is not fully engaged.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- **Program Rich & System Poor-** One of the biggest challenges to changing a community is when resources, partnerships, and programs are not supported by a well-developed system. Such a system would facilitate data sharing, collaboration, continuous quality improvement, and capacity building.
- **Lack of Community Wide Youth Needs Assessment-** Boone County is desperately in need of a quality youth needs assessment to track the trends in mental health and social/emotional well-being.

**3) Where is the gap in your primary prevention services?**

- **County Wide Prevention Coordination & Support-** Currently there is a lack of a county wide network to foster collaboration and build capacity of local communities to respond to the substance abuse and mental health challenges they are experiencing. Ideally, such network would be a multi sector partnership of local stakeholders who see the value of raising up local leaders to be youth mental health champions. These local leaders would be best equipped to foster the positive changes in their local community environment needed to better support youth outcomes.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- We focus on two levels of quantitative measurement. First, we focus on community level indicators to assess the local community conditions and understand the most urgent needs for intervention. Second, we focus on consumer level indicators to measure the effectiveness of our programs and the individual progress a youth makes toward the identified outcome. Examining both the community level data and individual level data allows us to have a more complete picture of how a youth is doing and how the program itself is doing in addressing local community conditions.
- We found success in using an assessment tool called the Developmental Asset Profile created by the Search Institute. We also use community assessment tools like the Tri-Ethnic Community Readiness Survey to examine the readiness of community stakeholders to address issues in their town.





***5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.***

- The Youth Community Coalition consists of members that represent education, public health, parks and recreation, civic organizations, faith communities, treatment, prevention, housing, business, and other social services. This multi-sector approach has been very successful in addressing local conditions and achieving positive outcomes for youth. The Youth Community Coalition would like to build upon these partnerships and scale up the effective work of the Coalition to create positive community changes throughout Boone County.



**Appendix F: Community Input Session Components**

**Session #5 – Open Forum**

***Invitation to Participate***

**TO: Chief Burton & Krista Shouse-Jones**

April 2, 2014

**FROM:** Jacqueline Schumacher, Consultant, Boone County Children’s Services Board

**RE:** Invitation to the April 24, 2014 Community Input Session

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Dear Chief Burton,

The Boone County Children’s Services Board (BCCSB) is taking steps to gather information about children’s services in Boone County. The Chairman, Mr. Les Wagner, and his eight-member board seek targeted information from the perspective of local providers whose services and programming align with Missouri Statutes 67 & 210. With assistance from the Institute of Public Policy in the Truman School of Public Affairs at the University of Missouri, the Board is organizing a series of community input sessions, one of which you are specifically invited to attend.

For clarification, Missouri Statute 67 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children’s Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6.5 million dollars annually. According to Missouri Statute 210, the Children’s Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

**Service Funding Categories**

- 13. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
- 14. Respite care services
- 15. Services to unwed mothers and unmarried parent services
- 16. Outpatient chemical dependency and psychiatric treatment programs
- 17. Counseling and related services as a part of transitional living programs
- 18. Home-based family intervention programs
- 19. Community-based family intervention programs
- 20. Crisis intervention services (inclusive of telephone hotlines)
- 21. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
- 22. Professional counseling and therapy services for individuals, groups, or families
- 23. Psychological evaluations
- 24. Mental health screenings

You have been identified as a provider who offers non-conflicted referrals for children, youth and families. You, or a representative from your agency, are invited to participate in the Boone County



Children’s Services Board meeting **on April 24, 2014** in the Boone County Commission Chambers (RM 110) at 811 East Walnut, Columbia, Missouri 65201. The input session will begin with general input from the community-at-large starting at **4:30 PM**. The Board will hear from your agency at 5:30 PM. You will have 15 minutes to address the board and bring up any topic you feel are important for them to learn first-hand from your agency. The following is a schedule of the input session.

BOONE COUNTY CHILDREN’S SERVICE BOARD COMMUNITY INPUT SCHEDULE			
DATE	Scheduled Time	Participant	Questions
April 24	4:30 PM	<ul style="list-style-type: none"> <li>Community members</li> </ul>	n/a – Open forum input
	5:10 PM	<ul style="list-style-type: none"> <li>Children’s Division</li> </ul>	<ul style="list-style-type: none"> <li>Brief overview of your agency</li> <li>Describe you role in the community</li> <li>What are the top two issues you feel need to be address?</li> <li>What are systemic obstacles to your success?</li> <li>Where is the gap in services for children in care?</li> <li>What is a quantitative measure of your success?</li> <li>Please describe potential collaborations you envision for addressing challenges in your field</li> </ul>
	5:30 PM	<ul style="list-style-type: none"> <li>Columbia Police Department</li> </ul>	n/a – Open forum input

Please let me know if you are able to attend, you may reach me at [schumacherja@missouri.edu](mailto:schumacherja@missouri.edu) by or telephone, 573-882-6207. Do not hesitate to reach out to me for further information.

Sincerely,

JACQUELINE SCHUMACHER, MPA  
 Consultant, Boone County Children’s Services Board  
 INSTITUTE of PUBLIC POLICY  
*Truman School of Public Affairs- University of Missouri*  
 137 Middlebush Hall  
 Columbia, Missouri 65211  
 (573) 882-6207(phone)  
[schumacherja@missouri.edu](mailto:schumacherja@missouri.edu)



**TO: Michelle Oberlag**

March 31, 2014

**FROM:** Jacqueline Schumacher, Consultant, Boone County Children's Services Board

**RE:** Invitation to the April 24, 2014 Community Input Session

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Dear Ms. Oberlag,

The Boone County Children's Services Board (BCCSB) is taking steps to gather information about children's services in Boone County. The Chairman, Mr. Les Wagner, and his eight-member board seek targeted information from the perspective of local providers whose services and programming align with Missouri Statutes 67 & 210. With assistance from the Institute of Public Policy in the Truman School of Public Affairs at the University of Missouri, the Board is organizing a series of community input sessions, one of which you are specifically invited to attend.

For clarification, Missouri Statute 67 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children's Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6.5 million dollars annually. According to Missouri Statute 210, the Children's Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

#### **Service Funding Categories**

25. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
26. Respite care services
27. Services to unwed mothers and unmarried parent services
28. Outpatient chemical dependency and psychiatric treatment programs
29. Counseling and related services as a part of transitional living programs
30. Home-based family intervention programs
31. Community-based family intervention programs
32. Crisis intervention services (inclusive of telephone hotlines)
33. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
34. Professional counseling and therapy services for individuals, groups, or families
35. Psychological evaluations
36. Mental health screenings

You have been identified as a provider who offers non-conflicted referrals for children, youth and families. You, or a representative from your agency, are invited to participate in the Boone County Children's Services Board meeting **on April 24, 2014** in the Boone County Commission Chambers (RM 110) at 811 East Walnut, Columbia, Missouri 65201. The input session will begin with general input from the community-at-large starting at **4:30 PM**. The Board will hear from your agency at 5:10 PM. You will have 15 minutes to address the following:



- Brief overview of your agency
- Describe you role in the community
- What are the top two issues you feel need to be address?
- What are systemic obstacles to your success?
- Where is the gap in services for children in care?
- What is a quantitative measure of your success?
- Please describe potential collaborations you envision for addressing challenges in your field.

BOONE COUNTY CHILDREN’S SERVICE BOARD COMMUNITY INPUT SCHEDULE			
DATE	Scheduled Time	Participant	Questions
April 24	4:30 PM	• <i>Community members</i>	n/a – Open forum input
	5:10 PM	• <i>Children’s Division</i>	<ul style="list-style-type: none"> <li>• Brief overview of your agency</li> <li>• Describe you role in the community</li> <li>• What are the top two issues you feel need to be address?</li> <li>• What are systemic obstacles to your success?</li> <li>• Where is the gap in services for children in care?</li> <li>• What is a quantitative measure of your success?</li> <li>• Please describe potential collaborations you envision for addressing challenges in your field</li> </ul>
	5:30 PM	• <i>Columbia Police Department</i>	n/a – Open forum input

Please let me know if you are able to attend, you may reach me at [schumacherja@missouri.edu](mailto:schumacherja@missouri.edu) by or telephone, 573-882-6207. Do not hesitate to reach out to me for further information.

Sincerely,

JACQUELINE SCHUMACHER, MPA  
 Consultant, Boone County Children’s Services Board  
 INSTITUTE of PUBLIC POLICY  
*Truman School of Public Affairs- University of Missouri*  
 137 Middlebush Hall  
 Columbia, Missouri 65211  
 (573) 882-6207(phone)  
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**Meeting Agenda**

**AGENDA**  
**COMMUNITY INPUT SESSION #5**

**Boone County Children Services Board**

April 24, 2014 starting at 4:30

**Overview:** This input session is in place to hear input from the Boone County community-at-large. Following the community input, the Board will hear from two non-conflicted referrals sources (Boone County Children’s Division and the Columbia Police Department).

**Agenda:**

- 1) *Welcome & Overview:* Jacqueline Schumacher, consultant to the Board
- 2) *Input Session Moderation:* Christian Arment, consultant to the Board

SCHEDULE OF PARTICIPANTS APRIL 24, 2014		
Funding Category	Participant Name	Agency
4:30 PM	Lynelle Phillips	Access to Healthy Foods Program – <i>University of Missouri Master of Public Health Program &amp; Sustainable Farms and Communities</i>
4.35-5:10	Community Members	n/a
5:10 PM	Michelle Oberlag	Boone County Children’s Division Circuit Manager
5:30 PM	Chief Ken Burton	Columbia Police Department

- 3) *Follow-up and Clarification Questions:* Board Members
- 4) *Closing Remarks:* Kelly Wallis, Boone County Director of Community Services



## **Feedback Report**

### *Community Input Session – Open Forum*

The Boone County Children’s Services Board (BCCSB) is taking steps to understand more about children’s services in Boone County. BCCSB contracted with the Institute of Public Policy (IPP) in the Truman School of Public Affairs at the University of Missouri to organize and moderate five Community Input Sessions. BCCSB wishes to make wise expenditures of the Children’s Services Fund and seeks targeted information from local services aligning with the Missouri Statutes 67 & 210. This feedback document provides an overview of the information shared with the Board during the fifth input session and will help guide BCCSB’s future funding strategies.

Missouri State Statute 67.1775 authorizes a local sales tax of one-quarter of one cent to be levied by Missouri counties for the purpose of establishing a Children’s Services Fund. This tax was made possible in Boone County following voter approval on November 6, 2012 and is estimated to raise \$6.5 million dollars annually. According to Missouri Statute 210.861, the Children’s Services Fund may be expensed to purchase the following services for children age 0-19 within Boone County:

1. Up to thirty days of temporary shelter for abused, neglected, runaway, homeless or emotionally disturbed youth
2. Respite care services
3. Services to unwed mothers and unmarried parent services
4. Outpatient chemical dependency and psychiatric treatment programs
5. Counseling and related services as a part of transitional living programs
6. Home-based family intervention programs
7. Community-based family intervention programs
8. Crisis intervention services (inclusive of telephone hotlines)
9. Prevention programs which promote healthy lifestyles among children and youth and strengthen families
10. Professional counseling and therapy services for individuals, groups, or families
11. Psychological evaluations
12. Mental health screenings

**Overview:** The BCCSB hosted Boone County social services agencies at their bi-monthly board meeting on April 24, 2014. This open forum input session offered the Boone County community-at-large to address the Board. A total of five individuals participated, two of which submitted worksheets on the behalf of their agencies. In addition, two non-conflicted referral agencies (Boone County Children’s Division and the Columbia Police Department) addressed the Board. Table J is a reference guide to the Community Input Session #5 and quantifies the number of people engaged in the convening.





<b>Table J: Community Input Session #5 By the Numbers</b>	
Session #5	Date: April 24, 2014
	Topic: Open Forum
	Funding categories: n/a
	Number of invited participants: 2
	Number participants: 7
	Number of worksheets received: 2
	Number of individuals in attendance: 17

**Methodology:** This fifth and final community input session was open to the community-at-large and was held on April 24, 2014. No pre-established questions were distributed, community members were simply welcome to attend and raise their own comments and concerns. Two non-conflicted referral agencies (Boone County Children’s Division and the Columbia Police Department) were asked to attend to offer their insight.

**Findings:** The following responses are organized in two parts. The first focuses on community member participation and the second on non-conflicted referral agency participation.

**Community Participation:** The open forum input session resulted in five community member participants. They spoke on topics ranging from access to healthy foods, the stigma associated with mental health, the need for parent education with regards to substance abuse, and the need for more agency collaboration. Two community member participants explained their agency’s specific upstart projects which are in the development phase. Two other community member participants were from established and currently funded programs. They provided worksheets which addressed the Board’s set of pre-established questions used in previous sessions. Those worksheets may be found in Appendix A.

Finally, one community member offered a number of critiques – he noted his assessment of apprehension regarding the funds’ ability to actually impact the city and county. He feels mental health should be the primary concern even though there are a number of eligible funding categories. He is pleased the Board organized a series of community input sessions, but found it disheartening that the Board did not travel to the outer areas of the county to hear direct input.

**Non-Conflicted Referral Agency Participation:** A representative from the Children’s Division noted a number of concerns: lack of funding for services which can reunite families, lack of providers willing to accept services at a state-established rate, and transportation of families to services. The representative noted systemic obstacles including: a decreasing number of foster homes, increasing number of children entering foster care, and high staff turnover among Children’s Division staff. Children’s Division also has a limited amount of “spending dollars” for services which aim to reunite families. The Children’s Division representative has difficulty



finding providers who will attend to the state’s Medicaid-funded foster children – this contributes to the growing gap between expressed need and services.

Representatives from the Columbia Police Department voiced concerns pertaining to youth who have not yet broken the law but are at high risk of engaging in criminal activity due to lack of supervision. The law enforcement process for minors is easier when they have broken the law, however often police need a non-criminal environment for children to be housed, possibly assessed, and directed to family services. This is not easy to do on a community-wide scale unless there is a law in place, i.e. a curfew, which would give the police the ability to detain and transport a minor to a non-criminal assessment center.

**Agency Worksheets**

<b>Agency:</b>	<b>Respondent:</b>
Access to Healthy Foods	Ms. Lynelle Phillips

**1) What are the top two issues you feel need to be addressed in your service population for primary prevention?**

- **Hunger/Food Insecurity:** Columbia and Boone County are home to almost 29,000 families in poverty. The county as a whole has a food insecurity rate of almost 14% of total households with 21.6% of the population eligible for SNAP benefits.
- **Malnutrition/Obesity:** Over 14% of students in Missouri are considered obese. We rank thirtieth in the country in childhood obesity. Low-income populations are particularly at risk, as they are more likely to consume diets that are high in energy density, low in nutrients and containing more processed foods. These diets generally contain high amounts of fat, sodium and sugar which contribute to obesity and food-related illnesses such as diabetes and heart disease. Locally, over 75% of kids are not getting the recommended amount of fruits and vegetables in their diet. In a survey of adolescents in Boone County, over 10% of kids reported not having any fruit or vegetables in the prior 7 days.

**2) Are there systemic obstacles to your success when working with primary prevention services?**

- The prices of fresh fruits and vegetables can be cost-prohibitive for many families in poverty. In a survey conducted by the health department, 3 out of 4 responded that “reasonably priced fruits and vegetables” would help them eat healthier. Cost of healthy foods was the #2 reported barrier to a healthy lifestyle.
- Access to Healthy Food (AHF) supplements income for the poor by providing funds that match SNAP benefits redeemed at the Columbia Farmers Market. AHF matches the first \$25.00 each week for participants enabling them to purchase additional food products to eat. AHF targets low-income families participating in SNAP and/or WIC programs with children in the family under ten years of age. AHF also supports the consumption of locally produced, healthy food with a special emphasis on fruit and vegetables. This consumption pattern is intended to create healthy eating habits in the low-income



population by making it possible for participating families to avoid eating high energy, often cheaper processed food products.

**3) Where is the gap in your primary prevention services?**

- The eventual goal is for the AHF program to operate year round. To this point, budget constraints have limited the program to the Spring/Summer/Fall Outdoor Farmers Market only. We would like to expand the budget to serve more families and to offer the AHF benefit during the Winter Indoor Market as well.

**4) What is a quantitative measure of your success when working with primary prevention services?**

- In 2013, 120 families signed up for the AHF program. Participants increased the usage of program funds to over \$450 a week, up from less than \$250 a week in 2012. For 2014, AHF aims to enroll at least 150 families and increase the utilization of program funds to at least \$750 a week.

**5) Please describe potential collaborations you envision for addressing challenges in the primary prevention service area.**

- AHF is already a successful collaborative effort between Sustainable Farms and Communities, the University of Missouri Masters of Public Health Program, Sinclair School of Nursing, and Peace Corps Fellows Program, the Columbia Boone County Department of Public Health and Human Services. Volunteers and students from these programs enable the program to run without any paid staff, which means the vast majority of funds go directly for food.
- AHF is currently in the process of applying for a grant with the Heart of Missouri United Way for 2015. We are also in the initial stages of exploring a partnership with University of Missouri Health Care. The goals for these potential collaborations would be to increase the AHF budget and to embrace promotional and marketing opportunities to expand the program to operate year round and increase total enrollment.
- For the 2014 year, AHF intends to spend 90% of its total operating budget on Columbia Farmers Market tokens for participating families. AHF has no paid staff most of the remaining 10% of the budget is reserved to cover the printing and distribution of promotional materials for the program.

***Quotes from our participants!***

- ❖ “More healthy foods for my kids, more variety I know, more money to spend on good food.”
- ❖ “I have lost more weight due to farmers market because it’s healthier for me and I want to say thank you.”
- ❖ “My kids enjoy going to farmers market. I hope that they will be more likely to make healthier choices.”



- ❖ “My daughter gets to have fun and interact with farmers who are growing her food and we get to eat well. Also with the wooden coins she gets to learn about budgeting as she selects what she wants to buy.”
- ❖ “My children and I eat healthier foods. I would like to say thank you for such a wonderful program.”

<b>Agency:</b> Bridgeway Behavioral Health	<b>Respondent:</b> Mr. Scott Snodgrass
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**1) What are the top two issues you feel need to be addressed in your service population specifically for clinical and/or mental health services?**

- Education and Training of Doctors, Law Enforcement, Parents, Behavioral Health Clinicians, Teachers, and other Stakeholders on drug trends (synthetics, Rx, Heroin, potency of Marijuana), science of Addiction, and what treatment is and is not. Most of these folks have never had any sort of formal and/or informal education/training on any of the above. And often times their first people that Parents turn to for advice.
- Stigma surrounding substance abuse treatment.

**2) Are there systemic obstacles to your success when working specifically with clinical and/or mental health services?**

- Transportation—traditional model of bringing clients to a centralized office is not always the best option for young people. Embedding substance abuse counselors in clinics, afterschool programs, GED programs, residential’ s, etc. is often times much more impactful for the target population.
- Isolated impact because of funding models. Agencies function from their specific mission/vision versus meeting community needs.
- Children’s taxes get passed and implemented without a true understanding of specific needs. Example: each and every school/neighborhood has different needs and a different culture. They may not need and/or be receptive to all the services funded and/or those agencies that provide these services.

**3) Where is the gap in your clinical and/or mental health services?**

- Educating Parents, Doctors, Teachers, Law Enforcement and Mental Health Clinicians on signs and symptoms of drug abuse/experimentation, drug trends, drug language, addiction, and what treatment is and is not.
- Bridgeway Behavioral Health spends a ton of time and resources on educating/training Parents, Doctors, Teachers, DJO’s, and Mental Health Clinicians on drug trends, drug culture, addiction, and treatment.



- 4) ***What is a quantitative measure of your success when working with clinical and/or mental health services?***
  - Confusing question need more clarity before answering.
  
- 5) ***Please describe potential collaborations you envision for addressing challenges in the clinical and/or mental health service area.***
  - Treating substance abuse is an entire community initiative and is bigger than just Bridgeway Behavioral Health (BBH.) Getting sober is just the first step to living a happier, healthier, and more productive life. Collaborations between BBH, Schools, Parents, Family Court, Mental Health Agencies, Doctors, Hospitals, and Family are essential to successful treatment of young people.



## Appendix G: Invited Agencies and their Representatives

Table K identifies agencies invited to participate in at least one of the five Community Input Sessions. While some chose not to participate, others participated multiple times and sent a number of representatives over the course of the five input sessions.

<b>TABLE K: COMMUNITY INPUT SESSIONS INVITED AGENCIES AND THEIR REPRESENTATIVES</b>	
<b>Invited agencies</b>	<b>Agency representative(s) who presented</b> n/a = did not participate
ACT Missouri	n/a
Adventure Club	n/a
American Home Care	Carmelita White
Big Brothers Big Sisters	Heather Dimitt
Boys and Girls Club	n/a
Burrell Behavioral Health	Annie Jensen, Marlene Howser, Julie Arment
Central Missouri Community Action	Darin Preis, Ryan White
Centralia R-VI School District Parents as Teachers Program	Mary Ann Sander
Centro Latino de Salud	n/a
Child Care Aware of Missouri	L. Carol Scott
Children's House Montessori	n/a
Columbia Housing Authority	Phil Steinhaus, Becky Markt
Columbia Police Department	Ken Burton, Krista Shouse-Jones
Columbia Public Health and Department of Human Services	Scott Clardy, Steve Hollis, Stacia Reilly
Columbia School District Parents as Teachers Program	n/a
Coyote Hill Christian Children's Home	n/a
Cradle to Career	Phil Peters
Family Counseling Center	Karen Cade, Libby Brockman Knight, Matthew Gooch
Family Counseling Center of MO	Karen Wallace, Linda Frost
Family Health Center	Gloria Crull
First Chance for Children	Jack Jensen
For His Glory, Inc. Boys 2 Godly Men Mentoring Program	n/a
Fun City	n/a
Granny's House	n/a
Great Circle/Boys and Girls Town	Rebecca Nowlin, Marissa Peterson, Julia Adami
Hallsville R-IV School District Parents as Teachers Program	Karen Smith

Continued →



<b>TABLE K: COMMUNITY INPUT SESSIONS INVITED AGENCIES AND THEIR PARTICIPANTS</b>	
<b>Invited agencies</b>	<b>Agency representative(s) who presented</b> n/a = did not participate
Harrisburg R-VIII School District Parents as Teachers Program	n/a
Heart of Missouri CASA	Anna Drake, Candice Iverson
Z. Lois Bryant House	n/a
Love, Inc.	Kelly Hill
Lutheran Family and Children's Services	Christine Corcoran, Claycie Gerlt
MADD of Mid-Missouri	n/a
Mary Lee Johnston Community Learning Center	n/a
Missouri Department of Social Services –Children’s Division	Michelle Oberlag
New Life Evangelistic Center	n/a
Nora Stewart Early Learning Center	Cheryl Howard
Preferred Family Healthcare	Vinita Khanna, Drew Moffett, Una Bennett
Presbyterian Children's Home and Services Network	n/a
Phoenix Programs, Inc.	n/a
Project LAUNCH	Laine Young-Walker, Isabel Rife
Project Reach	n/a
Rainbow House	Jan Stock, Jerri Sites
Salvation Army Harbor House	Cindy Chapman
Southern Boone County R-I School District Parents as Teachers Program	Kim Lewis
St. Francis House	n/a
St. Raymond Center	Emma Benham
Sturgeon R-V School District Parents as Teachers Program	Shawn C. Schultz
True North	n/a
University of Missouri	Charles Borduin
University of Missouri	Deborah Bell
Voluntary Action Center	Nick Foster
Youth Community Coalition	Ryan Worley
Youth Empowerment Zone	n/a
n/a = did not participate	

End