Deliverable #3c: 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 7 were able to attend. A total of 7 agencies prepared and submitted formal comments on worksheets which addressed the Board members' predetermined questions. Table 1 is a

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

Table 1: Community Input Session #3 By the Numbers		
Session #3	Date:	March 27, 2014
	Topic:	Clinical & Mental Health 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 be begin to analyze the collective input across all community sessions wherein these additional topics may hold surprising results.

Appendix A: Boone County Children's Services Board's Community Input Session Worksheet from March 27, 2014

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 your completed worksheet to Jacqueline Schumacher (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.

Appendix B: Boone County Children's Services Board's Community Input Session Competed Worksheets from March 27, 2014

Agency:	**Respondent:**
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.

Agency:	**Respondent:**
City of Columbia/Boone County, Missouri Department of Public Health and Human Services	Ms. Stephanie Browning

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 3rd 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 3rd 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.

Agency:	**Respondent:**
Family Counseling Center of Missouri &	Ms. Karen Cade
Pathways Community Health (Compass)	Ms. Libby Brockman-Knight

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.

Agency:	**Respondent:**

Great Circle	Ms. Melissa Peterson

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

Agency:	**Respondent:**
NAVIG8 Adolescent Treatment Program	Mr. Matthew Gooch

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.)

Agency:	**Respondent:**
Preferred Family Healthcare	Ms. Paula Brawner

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

Agency:	**Respondent:**
Project LAUNCH	Dr. Laine Young-Walker

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

Agency:	**Respondent:**
University of Missouri Psychological Services Clinic	Dr. Deborah Bell & Dr. Kristen Hawley

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 servi**ces, 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). This network could serve as a starting point for the development of an **evidence-based provider network** for Boone County.