Report to Lincoln County Citizens

Assessing the Need for Children's Services

Evaluating Mental Health Programs' Impact on Our Community
Addressing Youth's Mental Health Priorities

Lincoln County Resource Board

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Report Adopted July of 2014

Stakeholders –

This report was designed to be a resource for you within Lincoln County. It is a lengthy report with sections that are relevant for different purposes, and it is recommended that the Table of Contents be utilized to review the respective sections necessary for your purposes. Therefore, it is important to mention that the Table of Contents was built to be interactive. Simply use your mouse to move the cursor over any of the headings in the Table of Contents, and click your mouse again to automatically go to this section of interest (for the Word version, hold down "ctrl" on your keyboard and then click).

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Introduction

This report represents the fifth study of children's mental health services conducted for Lincoln County, and the third study conducted since the creation of the *Community Children's Services Fund (CCSF).* The *CCSF* was created through a vote of the citizenry in November 2006 that authorized a 1/4 cent sales tax designated for children's mental health services for Lincoln County children and youth, ages 0-19.

The Lincoln County Resource Board (LCRB) oversees this funding, facilitating the establishment, operation and maintenance of mental health services for Lincoln County children and youth. The LCRB-funded programs and services have effectively prevented child abuse and neglect; homelessness; substance abuse; and school-based violence. In 2013, our providers served:

- Approximately 7,165 children and youth*
  *(*Total number served, 10,236, reduced by 30 percent to account for potential duplication when multiple agencies service a child or youth, e.g., in cases of mental illness and homelessness.)*
- 12,539 additional family members
- 22,775 Lincoln County residents

In total, 43% of residents received direct or indirect benefits from services, which included crisis care, counseling, in-school prevention programs, therapeutic mentoring and more.

By providing a comprehensive, multilayered system of intervention and treatment for effective care, all Lincoln County citizens reap benefits. These community benefits are derived from a better educated, more productive adult population and workforce and decreased taxpayer costs for crisis services and law enforcement. Above all, we are working to ensure that every child has a chance to reach his or her potential. As the economy slowly improves, LCRB-funded providers continue to address the effects of the 2008 recession, which increased family stressors and sparked greater needs for mental health services. At this time, need continues to outpace sales tax growth and available funding.

History of the Lincoln County Resource Board

In 2000, a group of concerned citizens began meeting regarding the lack of readily available mental health services in Lincoln County. The citizens worked to provide local services, such as suicide prevention programs for the county's high schools, and eventually formed a permanent county mental health board.

In 2003, the Lincoln County Commissioners established the *Lincoln County Children, Family and Mental Health Board of Trustees*, now called the *Lincoln County Resource Board (LCRB).* To learn more about the LCRB and its history, visit www.lincolncountykids.org/our-history.

The *LCRB* serves as an independent oversight board, comprised of volunteer trustees, responsible for:

- Improving the quality, access and system of mental health services for Lincoln County children and youth
- Providing leadership in the development and implementation of early intervention, prevention and life skills programs
- Examining mental health care providers' programs against Lincoln County's needs assessment, funding statute, utilization rates and proven clinical success
- Overseeing mid-year and annual clinical outcomes reporting; financial statements; and third-party audits
- Managing on-site provider audits to review billing and client files (audits are conducted twice annually)
- Conducting biennial county needs assessments to evaluate LCRB-funded programs' impact and confirm the highest priority needs
- Funding only services rendered—prohibiting pre-billing and ensuring any unused funding allocations are forfeited

The *LCRB* remains responsive to public opinion regarding children and youth mental health services and prioritizes spending decisions according to the voiced opinion of its citizenry and stakeholders. Since the inception of the *LCRB* in 2003, two public surveys have been conducted to solicit Lincoln County residents' feedback. LCRB trustees and staff meet regularly with local school leadership and counselors, law enforcement, civic leadership and concerned citizens to assess progress and needs.

The services listed below are eligible for funding through the Community Children's Services Fund, which is overseen by the LCRB (Missouri Statute RSMO.210.860 was used as a guide for this study). The services are divided below by those that are currently funded compared to those that are not currently funded by LCRB.

The services **currently funded** by the *Community Children's Services Fund (CCSF*) include:

- Outpatient Substance Abuse Treatment Services (previously called Outpatient Chemical Dependency Treatment).
- Outpatient Psychiatric Services
- Home and Community-based Family Intervention Services
- Individual, Group, and Family Counseling Services
- Early intervention screening services
- School-based Prevention Services (previously called Prevention programs to prevent drug use, violence, bullying and sexual abuse)
- Respite Care Services
- Therapeutic Mentoring Services

Three significant areas of identified need that were **not funded** during the 2014 funding cycle include:

- Crisis Intervention Services (previously called Crisis Care Services for children 0-12 years of age)
- Temporary shelter services for abused, neglected, runaway, homeless or emotionally disturbed youth
- Transitional living services
- Services for teen parents

Since the last report, which identified Respite Care Services and Therapeutic Mentoring Services as areas of need, the LCRB is proud to announce the board is funding both categories for 2014.

To demonstrate the positive aspect of our growth, consider the LCRB's funding trends since 2012, made possible by the increase in total county sales tax revenue. Due to the volume of *Request for Funding Proposals* for funding year 2012, the *LCRB was* able to finance $877,300 of the $1,061,000, or 82%, requested by local providers. In 2013, of the $1,097,240 requested by the agencies, nearly 100% was awarded. For 2014, the LCRB was able to fund $1,117,870 in services, or 87.4%, of the requested $1,262,673. Since 2012, the LCRB has increased its funding of services by $130,000, including a $20,000 increase from funding periods 2013 to 2104, which signifies that the economy is indeed improving and benefiting our youth. Still, available funding falls short of meeting the full scope of need. A full summary of the programs funded in 2013 and 2014 can be seen in Table 33.

LCRB funded programs served *10,236* youth in 2013, and project serving 9,396 youth in 2014. While this is a decrease in the number of youth to be served, it should be noted that 2013 is realized, and 2014 represents a conservative estimate with our funded agencies typically reaching more youth than forecasted.

To arrive at the percentage of Lincoln County youth being served, we have to account for youth who receive multiple services from several providers. For example, a child may experience a mental health condition while suffering from homelessness. Our providers are encouraged and expected to collaborate and refer among their available programs to promote effective care that treats the root cause of the crisis. Currently, there are an estimated 14,625 youths in Lincoln County (under 18 years of age). Youth represent approximately 28% of the Lincoln County population. If we make the incorrect assumption that each number is a unique child, we are serving 70% of the Lincoln County youth. A more accurate gauge is that the LCRB supports programs aimed at reaching 45-65% of the Lincoln County population (this estimate correlates with the percent of residents served in the introduction). We cannot determine the percentage of youth who are receiving services the family can afford, or paid for by another source. So while there may be some apparent needs to prioritize for community attention, we should applaud the impact the LCRB and its funded mental health programs have made, which just in 2013-2014 has served more than 19,500 youth (duplication across programs). The average cost of each intervention and/or educational contact point is $114.

This assessment report was purposefully redesigned to focus on the LCRB's next funding priorities.. In past years, an analysis of funding needs were not targeted and; therefore, resulted in millions of dollars reported as needed to resolve some of the issues facing our youth. These numbers were daunting, and made it difficult to assess need separate from cost.

What This Current Study Measures

In addition to summarizing the current state of the LCRB-funded programs, the current study also gauges what is transpiring in the community with specific indicators to assess areas that may need attention and areas that have been positively affected by the influx of programs and services funded by LCRB. The most current statistics available during the research phase of this project were accumulated for this study, with most of them reflecting information from 2007 – 2013.

The "Demographics of Lincoln County" section of the report illustrates an assessment of population and general demographic information, poverty, insurance, unemployment, income, children receiving cash assistance and food stamps, in addition to presenting data on the special needs population.

Following the demographics review, information about Lincoln County is seen with various community indicators and outcome measures—offering comparisons to other community resource boards and representative counties similar in some way to Lincoln County. The counties that are included for comparison are: Franklin, Montgomery, St. Charles and Warren. The county data is presented with the state data, if available, for every community indicator. The information will be presented for areas that are improving for Lincoln County, in addition to areas that are showing need, followed by areas that are somewhat mixed or follow state, etc., reporting trends.

The report also offers a summary of the Missouri Student Survey 2012 results, with a special focus on changes with Lincoln County youth since 2006 and comparative state information to help gauge need.

The presentation of the community indicators data, when paired with the profile of the current LCRB-funded programs, can lend support for a current program or demonstrate that additional funding is needed to help improve a current situation. Agency program contacts were also approached to gather some current information, which included:

- Descriptions of services and programs available to children
- Number of Lincoln County children and youth served in 2013 and anticipated numbers to be served in 2014
- Unit rate and funding information for 2013 and 2014 programs
- Number of youth placed on waiting lists
- The stage in the program's service delivery that mental health is identified, assessed and/or addressed and information about the program's response to mental health
- Eligibility criteria for the program
- Other sources of funding for the specified program
- Current, local information that can be used to validate the positive outcomes of the program
- If additional funding were available for an internal agency program/service, what would be selected to address the highest priority unmet or under-funded need; and if applicable, the annual cost to fulfill this need
- The greatest roadblock beyond funding that has hindered utilization or effectiveness in addressing a need
- Other providers/programs LCRB should consider funding that could enhance the effectiveness of the local system of care

All of the relevant non-profit organizations located in Lincoln County participated in the study, and several other sources of information were utilized to prepare this assessment. The LCRB-funded agencies provide the majority of low- to no-cost services to the populations for which Missouri Statute RSMO.210.860 was intended. In addition, LCRB hired Cynthia Berry, Ph.D. of Berry Organizational and Leadership Development, (BOLD), LLC, to demonstrate the connection and trends between services that have been funded and youth-related community outcomes/indicators, and to prepare this report.

The following agencies and organizations provided data for this assessment:

- *Berry Organizational & Leadership Development (BOLD), LLC*
- *Catholic Family Services*
- *Child Advocacy Center of Northeast Missouri*
- *Community Council of St. Charles*
- *Crider Health Center*
- *Division of Social Services*
- *Elsberry School District*
- *Family Advocacy and Community Training*
- *45th Judicial Circuit of Pike and Lincoln Counties*
- *Lincoln County Juvenile Office*
- *Lincoln County Wellness Center*
- *Missouri Department of Mental Health*
- *Missouri Department of Social Services*
- *Missouri Kids Count*
- *Preferred Family Healthcare*
- *St. Louis Crisis Nursery*
- *Sts. Joachim & Ann Care Service*
- *Silex School District*
- *The Community Council of St. Charles County*
- *Troy School District*
- *Winfield School District*

Demographics of Lincoln County

Population

Lincoln County is predominantly a rural community, with the hub of activity located in Troy. This county has 631 square miles with eleven municipalities. Additionally, there are four public school districts within its borders, including Elsberry, Silex, Troy, and Winfield, and five private schools (see Attachment A).

Situated just north of St. Charles County, Lincoln County has taken advantage of the population hike that occurred with its neighbor beginning in 1990. As affordable housing and land have become less available in St. Charles County, and as people continue to move away from the downtown St. Louis area, more and more people are finding Lincoln County an attractive place to live.

According to the U.S. Census in 2010, Lincoln County experienced a population growth of 35% since 2000, to a total of 52,566. (United States Census Bureau, *2012).* It could easily be determined that Lincoln County was one of Missouri's fastest growing counties during this 10-year span. However, as seen in the next table, the population has tapered off to a 1.2% growth from 2008-2012 and is now home to approximately 53,354 residents.

Poverty

A picture of need unfolds when the population growth is paired with the increasing poverty rate. This 1.2% population growth statistic for 2008-2012 is dwarfed in comparison to the 19.3% increase in poverty over that same period. In 2012, we can verify 6,488 individuals living in poverty, which represents 12.2% of the total population. The child resident remains a specific focus for the LCRB. In Table 2, you will see that 2,425 youth under age 18 are in poverty; 791 are age 0-4; and the remaining 1,634 are age 5-17.

So is Lincoln County unique in the increasing trends for number of children in poverty? Tables 3 and 4 provide a comparison to the state data and comparative entities, in addition to showing the changing percentages of those children who are in poverty. Lincoln County is showing a lower percentage of children in poverty at 21% compared to Missouri at 22%. There is a similar trend for the percent of children under 6 in poverty within Lincoln County at 22.9% compared to Missouri at 26.3%. You can see that Lincoln County falls in the middle of the comparative entities, with less children in poverty than Montgomery and Warren Counties, and demonstrates similar growth trends with the percent of children in poverty.

Throughout this report, various percentages of youth affected by different conditions or situations will be presented. Linking this to any increased growth, demonstrates the need for more services, especially when the impoverished population growth far exceeds the population growth, where more individuals will have difficulty affording services for their children.

Table 1. Population Growth Compared with the Increase in Poverty for Lincoln County in 2000, 2007 - 1012

General Population	2000	2007	2008	2009	2010	2011	2012	Growth 2000-2010	Growth 2008-2010	Change 2008-2012	Change 2010-2012
Population Total	38,944	51,528	52,726	53,311	52,566	53,076	53,354	35.0%	-0.3%	1.2%	1.5%
Poverty	3,449	4,768	5,438	5,795	5,834	6,902	6,488	69.2%	7.3%	19.3%	11.2%
% in Poverty	**8.9%**	**9.3%**	**10.3%**	**10.9%**	**11.1%**	**13.0%**	**12.2%**				

Source: http://www.census.gov/popest/data/counties/totals/2011/CO-EST2011-01.html

Table 2. Lincoln County - Poverty Estimates by Year

Age Groups	2006	2007	2008	2009	2010	2011	2012
All Ages	4,504	4,768	5,438	5,795	5,834	6,902	6,488
5-17 in Families	1,159	1,156	1,195	1,478	1,426	1,824	1,634
0-4 in Families	607	625	790	809	769	930	791
Under Age 18	1,766	1,781	1,985	2,287	2,195	2,754	2,425

Source: SAIPE

Table 3. Percent of Children In Poverty - County Comparison

Location	2007	2008	2009	2010	2011
Missouri	18.3%	19.1%	20.2%	21.3%	21.8%
Franklin	12.8%	14.3%	19.9%	18.1%	18.0%
Lincoln	15.7%	18.4%	16.6%	21.1%	20.9%
Montgomery	20.1%	22.1%	20.8%	22.2%	22.8%
St. Charles	5.8%	5.9%	6.5%	6.2%	7.7%
Warren	15.9%	17.2%	24.5%	28.1%	28.0%

Data Source: USDC, Bureau of the Census; Missouri Office of Administration, Division of Budget and Planning.

Definitions: Percentage of related children under age 18 who live in families with incomes below the U.S. poverty threshold, as defined by the Bureau of the Census. The 2011 poverty threshold was $22,350 for a family of four. For counties with a population of less than $20,000, an estimate based on county-PUMA ratio is reported.

Table 4. Percent of Children Under 6 in Poverty - County Comparison

Location	2007	2008	2009	2010	2011
Missouri	22.0%	23.0%	24.5%	25.5%	26.3%
Franklin	13.9%	15.6%	19.8%	16.2%	20.0%
Lincoln	15.5%	17.2%	19.6%	22.0%	22.9%
Montgomery	23.2%	26.7%	28.4%	27.1%	28.0%
St. Charles	6.1%	5.5%	7.7%	7.9%	9.9%
Warren	19.4%	19.2%	27.2%	35.0%	28.2%

Data Source: USDC, Bureau of the Census; Missouri Office of Administration, Division of Budget and Planning.
Definitions: Percentage of related children under age six who live in families with incomes below the U.S. poverty threshold, as defined by the Bureau of the Census

Unemployment and Income

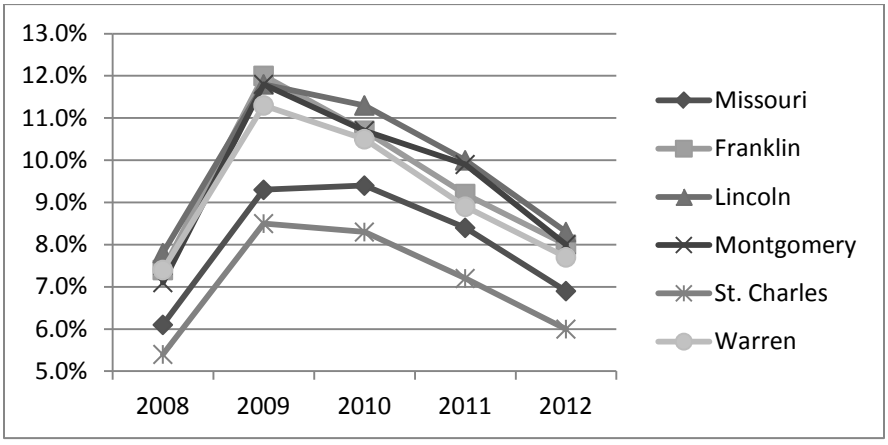
Clearly, our nation, our state and many local communities suffered from the recent economic crisis, but adult unemployment has shown some positive trends where Lincoln County had an 8.3% rate in 2012 compared to 11.8% at its height in 2009. It is necessary to show how Lincoln County compares to local counties and the state overall from 2008 to 2012 as shown in the table below. Lincoln County has the highest percentage of unemployed in 2012 with 8.3%. Figure 1 is a powerful display of the same trend experienced across all of the comparative entities.

Table 5. Adult Unemployment - County Comparison

Location	2008	2009	2010	2011	2012
Missouri	6.1%	9.3%	9.4%	8.4%	6.9%
Franklin	7.4%	12.0%	10.7%	9.2%	8.0%
Lincoln	7.8%	11.8%	11.3%	10.0%	8.3%
Montgomery	7.1%	11.8%	10.7%	9.9%	8.0%
St. Charles	5.4%	8.5%	8.3%	7.2%	6.0%
Warren	7.4%	11.3%	10.5%	8.9%	7.7%

Data Source: Missouri Department of Economic Development, Division of Employment Security.
Definitions: Percentage of the civilian labor force that is unemployed and actively looking for work.

Figure 1. Adult Unemployment – State/County Comparison - Trends from 2008 to 2012



Income is another factor that is important to review in parallel with unemployment rates. Lincoln County's median household income was $53,542 in 2012 with an average annual wage/salary of $33,775 (for 2011). The average annual wage/salary has increased 6% since 2007, but there is a decrease in the median household income for this same period of time. Lincoln County's average annual salary is approximately $9,000 less than the state of Missouri (at $42,579; see tables below)

Table 6. Median Household Income – Lincoln County – 2007 to 2012

	2007	2008	2009	2010	2011	2012
Median Income	$54,938	$54,740	$50,795	$50,307	$50,523	$53,542

Table 7. Average Annual Wage/Salary - County Comparison

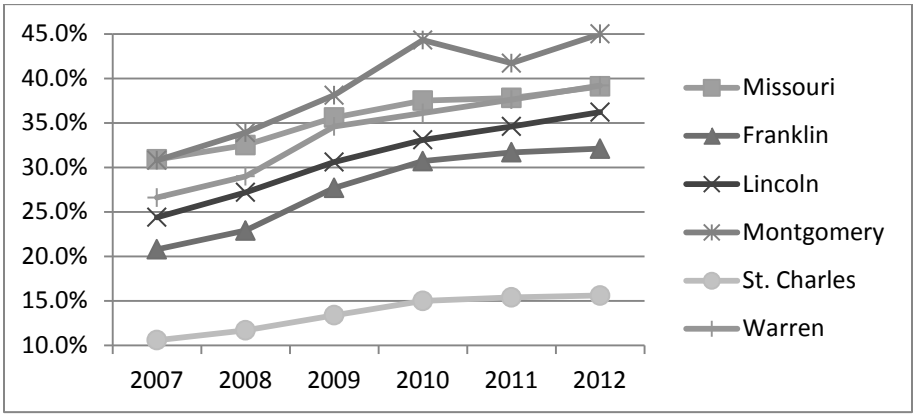
Location	2007	2008	2009	2010	2011	Growth '07-'11
Missouri	$39,500	$41,191	$40,925	$41,677	$42,579	8%
Franklin	$32,497	$33,187	$33,028	$34,043	$35,253	8%
Lincoln	$31,719	$32,531	$33,215	$33,145	$33,775	6%
Montgomery	$27,347	$27,168	$27,428	$28,098	$29,271	7%
St. Charles	$38,494	$38,750	$38,326	$39,054	$39,671	3%
Warren	$29,691	$30,382	$31,246	$31,676	$32,532	10%

Data Source: U.S. Department of Commerce, Bureau of Economic Analysis, Regional Economic Info. Systems.
Definitions: Average annual wage/salary per job. County data indicate annual wage/salary for all jobs located in that county. An employee may live in a different county from where they work.

Children Receiving Food Stamps and Cash Assistance

Another gauge for assessing needs is to look at the trends for children receiving cash assistance and food stamps. As can be seen in Figure 2, there is a slight increasing trend for all of the comparative entities and Lincoln County from 2007 to 2012, with Lincoln County showing approximately 25% in 2007 and 32% of children receiving food stamps in 2012. Lincoln County has a smaller percentage of children on food stamps, approximately 36%, than the state of Missouri, which is 39%.

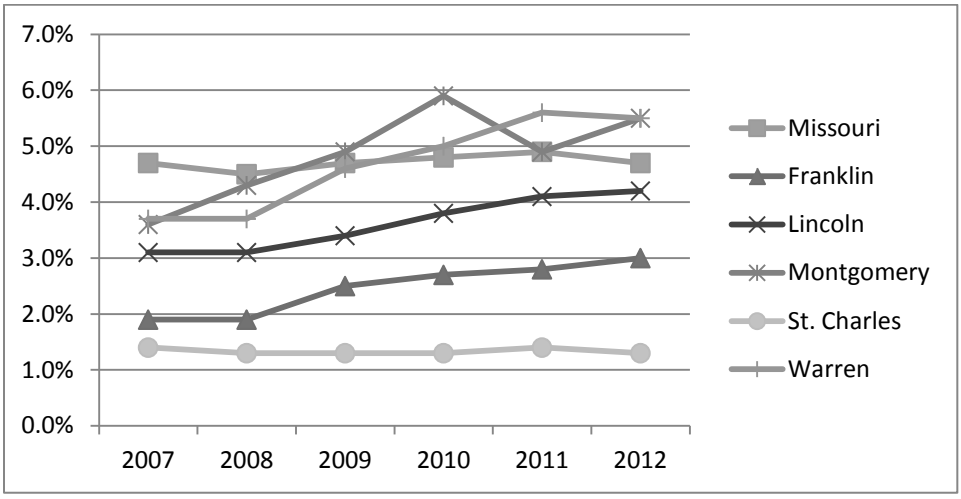
Figure 2. Percent of Children Receiving Food Stamps – County Comparison – 2007 to 2012



Source: Missouri Department of Social Services.
Definitions: Percentage of population under age 18 who live in households receiving food stamp benefits.

In Figure 3, cash assistance is defined as the average monthly percentage of the population under 18 who live in households receiving public cash assistance from specific sources. There is a slight increase in this percentage since 2007 when it was slightly over 3%. In 2012, 4.2% of children were receiving cash assistance in Lincoln County. Lincoln County is again doing better than the state where approximately 4.8% of children are receiving cash assistance.

Figure 3. Percent of Children Receiving Cash Assistance– County Comparison – 2007 to 2012



Data Source: USDC, Bureau of the Census; Missouri Office of Administration, Division of Budget and Planning.
Definitions: Average monthly percentage of population under age 18 who live in households receiving public assistance under Aid to Families with Dependent Children (AFDC) or Temporary Assistance for Needy Families.

Other Community Factors

There are other aspects of the community that are necessary to assess that can have a major impact on Lincoln County residents. The increased cost for gasoline, utilities, food, and other commodities can be associated with a past decrease in donors' ability to support local charities and the ability to keep up with other family members' needs. However, recent national data indicates an increase in support to charities in the past year or so.

The high gasoline prices have had a large impact on the people of Lincoln County, because workers typically travel an average of 35.1 minutes to work, an increase from the reported 32.3 minutes in the 2012 Needs Assessment (U.S. Census Bureau American Community Survey 2005-2009 Data). Utilizing the average mpg for vehicles made recently (2008-2014), which is 22-24 mpg, in conjunction with the information stated above, the average cost per adult working five days per week at $2 per gallon per week is $22.73 compared to $4 per gallon per week at $45.45, which results in an estimated savings or cost per year of $1,180 per adult working five days per week with gas at the lower amount. At the time this report was written, gas prices were approximately $3.50 per gallon. This example only relates to transportation costs of one adult to travel to work. The community has 22,611 individuals who commute to work, as seen in Table 8, which also includes other relevant commuting information for Lincoln County.

Table 8. Commuting To Work – Lincoln County Workers 16 years and over

Community to Work Categories	Number	Range	% of Workers 16 Yrs+
Workers 16 years and over	23190	+/- 645	
Workers 16+ who commute to work	22611	+/- 660	97.5
Car, truck, or van; drove alone	18989	+/- 647	81.9
Car, truck, or van; carpooled	3065	+/- 420	13.2
Public transportation (excluding taxicab)	61	+/- 50	0.3
Walked to work	340	+/- 148	1.5
Other means of commuting	156	+/- 81	0.7
Worked at home	579	+/- 156	2.5
Mean travel time to work in minutes	35.1	+/- 1.2	

Table 9. Lincoln County - Renter-occupied units

Renter Categories	Number	Range	% of
Renter-occupied units	3607	+/- 365	
Paying cash rent	3208	+/- 318	88.9
Paying no cash rent	399	+/- 153	11.1
Median rent	686	+/- 33	
Average gross rent	-		
Gross rent 30% or more of HH income	1590	+/- 275	44.1
Gross rent of $750 or more	1261	+/- 244	35

Housing information and some related trends should be viewed to identify a potential group of residents who are at risk of having minimal funding for their housing and/or other household and family needs. It is recommended for individuals to have 30% or less of their monthly household income to be utilized for rent/lease payments. Paying more than 30% can result in not being able to afford other items that are necessities. Of the 3,607 residents who are renters in Lincoln County, 44% or 1,590 residents, are paying 30% or more of their household income for rent, which puts them at risk of homelessness and/or maintaining their current housing situation (see Table 9). There are an additional 3,197 owners who pay more than 30% of their household income for their leases, which represent 30% of the total number of owner-occupied units in Lincoln County (see Table 10). Thus, almost 5,000 Lincoln County households are at risk of not being able to keep up with their standard of living and afford services that may be needed for their children.

Table 10. Lincoln County - Owner-occupied units

Owner Categories	Number	Range	% of
Owner-occupied units	15057	+/- 474	
Housing units with a mortgage	10664	+/- 450	70.8
Owner costs 30% or more of HH income	3197	+/- 384	30
Median owner costs	1293	+/- 31	
Housing units without a mortgage	4393	+/- 335	29.2
Nonmortgage owner costs 30% or more of HH income	603	+/- 169	13.7
Median owner costs	377	+/- 18	

General Population Information

Other general demographic information for Lincoln County is also important to provide and consider for future gaps and/or needs within the community. First, the percent of minority children is 7.6% of the number of children under the age of 18 (see Table 11). Furthermore, there are 106 estimated children with a Limited English proficiency in Lincoln County, which represents approximately 1% of the youth population (Table 12).

Table 11. Percent of Minority Children - County Comparison

Location	2008	2009	2010	2011	2012
Missouri	23.2%	23.5%	23.8%	23.9%	24.0%
Franklin	4.6%	4.8%	4.9%	5.1%	5.4%
Lincoln	7.3%	7.3%	7.2%	7.2%	7.6%
Montgomery	5.5%	5.3%	5.3%	5.6%	5.6%
St. Charles	12.5%	13.2%	13.6%	13.9%	14.2%
Warren	9.2%	9.1%	9.5%	9.5%	9.7%

Data Source: USDC, Bureau of the Census; Missouri Office of Administration, Division of Budget and Planning.
Definitions: Percentage of children under age 18 who are identified as non-white.

Table 12. Children With Limited English proficiency – Lincoln County & Missouri

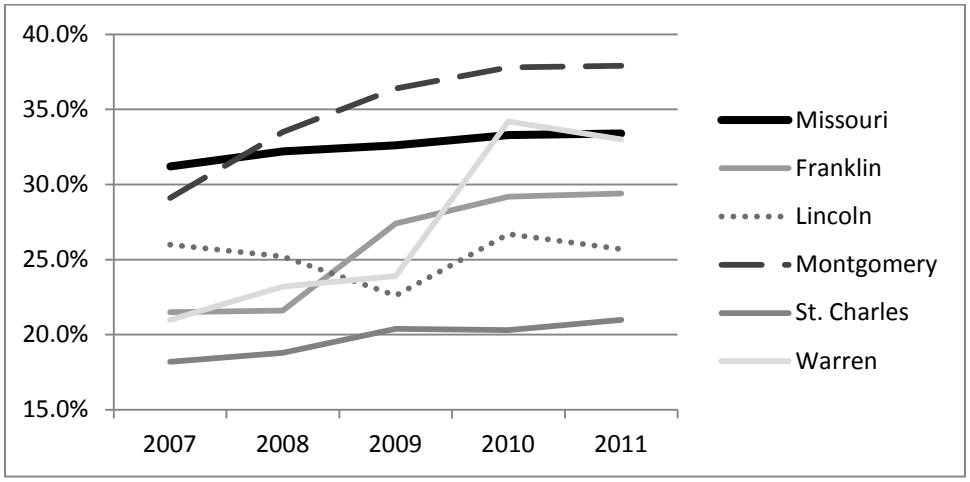
Location	2008	2009	2010	2011	2012
Missouri	19,053	19,238	19,986	21,539	24,402
Lincoln	87	80	86	99	106

Data Source: Missouri Department of Elementary and Secondary Education.
Definitions: Number of children reported by school districts as having limited English language skills.

Another important area to examine is the rate of children in single-parent households, which can be viewed in Figure 4. With the exception of St. Charles County, Lincoln County has the lowest percentage of children in single-parent households at 25%.

Additional information was collected for Lincoln County and is available by request and/or on the LCRB website (www.lincolncountykids.org). Look for Needs Assessment 2014 – Excel file. Tabs are marked Social, Housing, Economic and Demographic Information.

Figure 4. Rate of Children in Single-Parent Households



Special Needs Population

Because of the LCRB's role and organizational purpose, a review of children who have special needs is required to prioritize and assess potential service area gaps. As shown in Table 13, there are 885 children who are non-institutionalized and who have a qualified disability.

Table 13. Individuals under Age 18 (non-institutionalized) with a Disability

Categories	Number	Range	% of
Civilian non-institutionalized persons	52,158	+/- 144	
With a disability	8,031	+/- 652	15.4
Under 18	14,597	+/- 80	28
With a disability	885	+/- 300	6.1

Mental health data is gathered by the Missouri Division of Behavioral Health and the Substance Abuse and Mental Health Services Administration. (http://dmh.mo.gov/ada/mobhew). From this data source, it is stated that there is data available on those who receive treatment, but the availability of mental health data on the local level and about the general population is very limited. Here is a summary of information from the report provided by these sources, with additional analysis of trends conducted by BOLC, LLC.

Individuals struggling with serious mental illness are at higher risk for homicide, suicide and accidents as well as chronic conditions, including cardiovascular and respiratory diseases and substance abuse disorders. For 2012, 988 Lincoln County residents received treatment for serious mental illness at publicly-funded facilities (Table 14). This is an increase from 909 reported in 2011. Of the 988 individuals identified with a mental health condition, with a total of 1,453 individual diagnoses, here is a breakdown of the percentage per diagnosis: 43% had a mood disorder, 28% had anxiety disorder, 13% had an impulse control disorder, 2% had a developmental disorder, and 1% had an adjustment disorder. In fiscal year 2013, 903 Lincoln County residents received treatment for serious mental illness at publicly-funded facilities, with 1,129 reported diagnoses. By viewing Table 14, it's evident that the percentage per diagnosis was similar to what was reported in 2012. Based on BOLD, LLC's analysis,

there was a spike in the number of clients reported from 2011 to 2012, which then regressed again in 2013. Some promising findings can be seen with a significant decrease in diagnoses across multiple disorders from 2012 to 2013. Here are some of the findings:

- Anxiety disorder diagnoses decreased 25%
- Developmental disorder diagnoses decreased 19%
- Impulse control disorder diagnoses decreased by 26%
- Mood disorder diagnoses decreased by 23%
- Psychotic disorder diagnoses decreased by 9%

Table 14. Comprehensive Psychiatric Services- Numbers Served in Lincoln County

	FY2011	FY2012	FY2013	FY2012% of Total Diagnoses	FY2013% of Total Diagnoses	Change -2011 - 2012	Change 2012-2013
Total Clients	909	988	903			9%	-9%
Adjustment Disorder	0	19	11	1%	1%	*	-42%
Anxiety Disorder	332	404	302	28%	27%	22%	**-25%**
Developmental Disorder	28	26	21	2%	2%	**-7%**	**-19%**
Impulse Control Disorder	184	196	146	13%	13%	7%	**-26%**
Mood Disorder	603	630	487	43%	43%	4%	-23%
Psychotic Disorder	163	178	162	12%	14%	9%	-9%
Total diagnoses		1453	1129	100%			

*Change cannot be calculated due to no diagnosis for this disorder in 2011.

Additional information reported in the Behavioral Health Profile for Lincoln County (May,2014) identified that for Eastern Missouri, 20.7% of those 18 and older had a mental illness in the past year with 5.0% having a serious mental illness. Serious mental illness is defined as any mental disorder(s) resulting in 'substantial impairment in carrying out major life activities.'

To assess our youth, students (6th-12th grade) in the county were asked about their mental health via the Missouri Student Survey (separate section provided later in the report). In the last year, 10.4% of the surveyed students had considered suicide, 6.0% made a plan, and 1.4% actually attempted, resulting in an injury. In 2012, 11 Lincoln County residents committed suicide. Nationally, males are about four times more likely to commit suicide than females. Older males have higher rates of suicide than younger males.

Due to the unavailability of more data on mental health with Lincoln County youth, we look at national trends. Among US youth age 13-18 about 20% reported that they suffered from a mental disorder with symptoms severe enough to impair their daily lives. (Merikangas, Burstein, et al, 2010). Furthermore, approximately 11-13% of children and youth have a serious emotional disturbance (SED) that causes substantial impairment in how they function at home, at school, or in the community, and for 5% serious emotional disturbance causes extreme impairment in their functioning (Surgeon General's Conference on Children's Mental Health; Merikangas, He, et al, 2010; http://mchb.hrsa.gov/epsdt/mentalhealth/need.html).

Indicators and Outcome Measures For Lincoln County

This section provides information about various indicators and outcome measures within Lincoln County, in addition to assessing the county's progress against some similar counties' and state of Missouri data. The source of the information for each table and figure is provided so that additional data can be gathered as needed. The selection of indicators and outcome measures comes from a review of the KIDS COUNT Data Book of 2012, which utilizes rates and percentages to compare entities and assess changes over time within the selected region. However, percentages can sometimes be misinterpreted, so in some cases, the actual number of children or events is provided for interpretation and decision-making purposes. Information is categorized first by its positive, negative or mixed/null impact or trend in Lincoln County, and is grouped into one of four categories: Economic, Education, Family Support/Home or Health (Mental and/or Physical).

Community Indicators that are Positive for Lincoln County

Education

Annual High School Dropouts

Lincoln County has seen a steady decline in the number of students who are dropping out of high school from 2009 to 2013, 3.3% to 1.7% (Table 15). In 2009, there were 91 students who dropped out of high school compared to 47 in 2013. An analysis into school district specific trends can be researched through the Department of Secondary and Elementary Education (http://dese.mo.gov/). Lincoln County is doing better than the state, and is in line or doing better than the comparative counties.

Table 15. Percent of Annual High School Dropouts - County Comparison Over Time

Location	2009	2010	2011	2012	2013
Missouri	3.6%	3.2%	3.3%	3.0%	2.9%
Franklin	3.0%	2.4%	3.2%	2.5%	1.9%
Lincoln	3.3%	2.4%	2.1%	2.1%	1.7%
Montgomery	2.5%	1.7%	2.5%	1.2%	3.5%
St. Charles	2.6%	1.8%	1.7%	1.6%	1.5%
Warren	3.3%	2.9%	0.8%	0.6%	1.5%

Data Source: Missouri Department of Elementary and Secondary Education.
Definitions: Percentage of students (grades nine through twelve) enrolled in public schools who left school during the school year without graduating. Rate is expressed as percent of enrolled students. The formula used to calculate the rate accounts for transfers in and out of a district. Years indicated are school years; for example, 2010 indicates the 2009-2010 school year.

Health

Low-Birth Weight/Comparisons

In Lincoln County, 6.7% of the total known resident pregnancies fall into the low-birth weight category, an issue that has some relationship to developmental and physical health needs later in life. This percentage relates to 258 known events of low-birth weight from 2006 to 2010. Overall, this rate is low in comparison to the counties that were selected, and is significantly lower than the state of Missouri's rate, which is 8.1% of known resident pregnancies.

Table 16. Low Birth Weight - County Comparison

Location	Data Years	Number of Events	Rate	Significantly Different
Missouri	2006-2010	32,326	8.1	
Franklin County	2006-2010	491	7.4	N/S
Lincoln County	2006-2010	258	6.7	L
Montgomery County	2006-2010	54	7.2	N/S
St. Charles County	2006-2010	1,709	7.3	L
Warren County	2006-2010	122	5.4	L

Source: Community Data Profiles - Missouri Department of Health and Senior Services Rate is percent this number is of total known resident pregnancies. N/S = not significantly different than state. L = significantly less than the state. H = significantly more than the state.

Birth-related information specific to teens and mothers with less than 12 years of education

This area reports promising trends as viewed in the next three tables/figures provided. The first table provides three-year moving averages for just Lincoln County, and there are some positive findings with the rate of "Live Births to Mothers with Education less than 12 years." Based on the most recent three-year trend (2008 -2010), this rate is 15.4% of 1,000 live births compared to 19.5% for 2004-2006. There is a decrease in the teen fertility rate (under age 18), teen pregnancy rate (under age 18), and a slight decrease over time with teen birth rates.

Birth Type Categories	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Births by Age of Mother: Under 15	0.2	0.2	0.2	0.2	0.2
Births by Age of Mother: 15-17	2.9	3.2	2.9	2.8	2.6
Births by Age of Mother: 18-19	7.1	6.9	7.9	7.9	7.5
Mothers Education Less Than 12 Years	19.5	18.2	17.9	16.8	15.4
Live Births & Fertility Rate	72.4	73.5	74.6	76	74.5
Teen Fertility Rate Under Age 18	18.9	20.8	19.3	18.2	16.3
Teen Pregnancy Rate Under Age 18	21.5	24.8	22.8	21.4	18.4
Repeat Births Under Age 20	1.8	1.5	1.6	1.7	1.4
Abortions Mother Under Age 18	23.4	25.1	22.6	20.2	16.1

Source: Same as above. STD and Chlamydia rates are per year per 100,000 population and are age-adjusted to the U.S. population. Abortion indicator rates are per 1,000 live births. Birth indicator rates are per 1,000 live births

Table 17. Birth-related Data for Lincoln County – 3-Year Moving Average Rates/Percent

The information in Table 18 demonstrates that Lincoln County is doing better than the state rate for teen births, with 2.85 teen births per 100 compared to 3.15 teen births per 100, but this finding is not significant. Franklin, Montgomery and St. Charles County have a better rate of teen births per 100 than Lincoln County, with only Warren County doing worse.

Table 18. Teen Births Age 15-17 – County Comparison

Location	Years	Number of Events	Rate	Significantly Different
Missouri	2006-2010	12,593	3.15	
Franklin County	2006-2010	161	2.43	L
Lincoln County	2006-2010	110	2.85	N/S
Montgomery County	2006-2010	19	2.53	N/S
St. Charles County	2006-2010	284	1.22	L
Warren County	2006-2010	69	3.07	N/S

Rates are per 100 live births

Source: Community Data Profiles - Missouri Department of Health and Senior Services

Table 19 identifies that there were 636 events from 2006 to 2010 that met this criteria, with Lincoln County having a rate of 16.5 per 100 live births compared to the state rate of 17.84. This is a significant difference as identified by the Missouri Department of Health and Senior Services.

Table 19. Live Births to Mothers With Education Less Than 12 Years – County Comparison

Location	Years	Number of Events	Rate	Significantly Different
Missouri	2006-2010	71,325	17.84	
Jefferson County	2006-2010	2,044	14.08	L
Lincoln County	2006-2010	636	16.5	L
Montgomery County	2006-2010	143	19.04	N/S
St. Charles County	2006-2010	1,659	7.13	L
Warren County	2006-2010	386	17.19	N/S

Rates are per 100 live births

Source: Community Data Profiles - Missouri Department of Health and Senior Services

Family Support/Home

Juvenile Law Violation Referrals

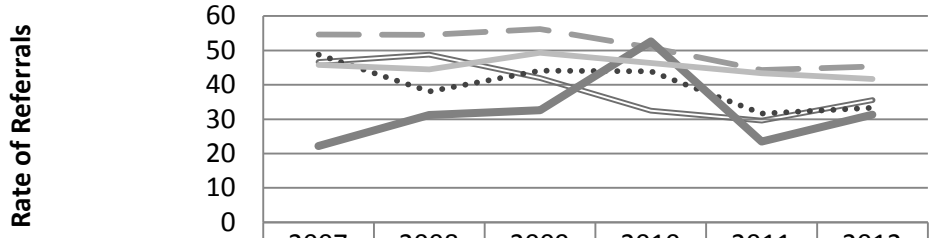
Juvenile law violation referrals represent an area reporting promising trends in Lincoln County. Figure 4 provides the trends for Lincoln County and the comparative entities from 2007 to 2012. The rate of juvenile law violation referrals per 1,000 has dropped from 49 in 2007 to 33 in 2012. Furthermore, the rate is significantly lower than the state rate of 45 in 2012. Lincoln County is also doing very well compared to other counties.

Table 21, Type of Referrals for Lincoln County Compared to the Total

Year		Misc.	People	Proper-ty	Peace Dis-turbance	Drugs	Status	CA/N	Total
2010	Lincoln	49	67	126	13	42	281	149	727
	% Lincoln	*7%*	*9%*	*17%*	*2%*	*6%*	*39%*	*20%*	
	Total	6,115	8,972	13,160	2,073	3,405	14,946	15,038	63,709
	% Total	**0.80%**	**0.75%**	**0.96%**	**0.63%**	**1.23%**	**1.88%**	**0.99%**	**1.14%**
2011	Lincoln	27	36	119	9	21	328	217	757
	% Lincoln	*4%*	*5%*	*16%*	*1%*	*3%*	*43%*	*29%*	
	Total	4,996	7,993	10,718	1,842	3,442	13,875	15,374	58,240
	% Total	**0.54%**	**0.45%**	**1.11%**	**0.49%**	**0.61%**	**2.36%**	**1.41%**	**1.30%**
2012	Lincoln	8	21	23	5	19	193	203	472
	% Lincoln	*2%*	*4%*	*5%*	*1%*	*4%*	*41%*	*43%*	
	Total	4,500	9,067	10,369	2,038	3,627	13,990	17,013	60,604
	% Total	**0.18%**	**0.23%**	**0.22%**	**0.25%**	**0.52%**	**1.38%**	**1.19%**	**0.78%**

Data Source: Missouri's Juvenile & Family Division Annual Reports (2009 through 2012). CA/N = Child abuse and neglect.

Figure 4. County Comparison and Trends -Juvenile Law Violation Referrals, Ages 10-17 (per 1,000)



	2007	2008	2009	2010	2011	2012
Missouri	55	55	56	51	44	45
Franklin	47	49	42	33	30	36
Lincoln	49	38	44	44	32	33
Montgomery	22	31	33	53	24	31
St. Charles	46	45	49	46	43	42

The types of Juvenile Law Violation Referrals are divided into multiple categories as seen in Table 21 to identify trends of juveniles in Lincoln County from 2010 to 2012. The total number of Juvenile Law Violation Referrals is provided as well. In Lincoln County, there were 727 referrals in 2009 compared to only 472 in 2012. Within this number of referrals, there has been an increase in the number of violations related to child abuse/neglect (CA/N), where 43% of the referrals for Lincoln County in 2012 were related to this type of offense compared to only 20% in 2010. Peace disturbance is the lowest type of

law violation in 2012 for Lincoln County with less than 5 referrals (1% of total number of referrals in Lincoln County). Status offenses are violations if committed by a juvenile, which include behavior injurious to self/others, habitually absent from home, truancy and behavior beyond parental control. The status category has been relatively steady over time with 41% of referrals relating to this type of juvenile offense. The remaining categories of offense tied to drugs, peace disturbance, property, people, and miscellaneous individually make up less than 5% of the total number for juvenile law violation referrals in Lincoln County.

Table 22 provides the type of Juvenile Law Violation Referrals and the outcome in the specified period of time. The Juvenile and Family Division respond to referrals through either a formal or informal process. Through the formal process, a juvenile officer files a petition to have a judge hear and determine an outcome of the allegation. The informal process has the juvenile officer determine the disposition of the allegations contained in the referral without filing a petition seeking a formal judicial process (see Appendix for interpretation of headings).

Moving left to right as they appear in the Table, the “True Out-of-Home” category through the “Dismiss” category falls under the formal disposition process. The category heading starting with “Inf. w/o Sup.” to “Reject” fall under the informal disposition process. Of most importance is the “Total Trues” category, which demonstrates that there were only 128 allegations that were validated as true for all referrals that were made, representing 21% of the total number for Lincoln County.

Table 22. Total Referral Outcomes for Lincoln County Compared to the State Total - 2009 through 2012

		Miss-ing	True Out of Home	True In Home	True No Service	Not True	Dis-miss	Inf. w/o Sup.	Inf. w/ Sup.	No Action	Trans. Other Court	Trans. Other Agency	Reject	Total	Total Trues	% of Total True
2009	Lincoln	2	83	81	4	2	26	47	68	533	15	27	88	976	168	17%
	Total	794	6,940	5,620	630	756	1,482	12,005	10,178	10,744	3,732	4,190	9,677	66,748	13,190	20%
	% Total	0.25%	1.20%	1.44%	0.63%	0.26%	1.75%	0.39%	0.67%	4.96%	0.40%	0.64%	0.91%	1.46%		
2010	Lincoln	6	56	68	5	1	19	64	77	296	25	21	89	727	129	18%
	Total	777	7,354	4,757	579	645	1,216	11,894	9,852	9,868	3,433	4,101	9,330	63,806	12,690	20%
	% Total	0.77%	0.76%	1.43%	0.86%	0.16%	1.56%	0.54%	0.78%	3.00%	0.73%	0.51%	0.95%	1.14%		
2011	Lincoln	3	64	81	3	-	17	27	85	360	9	18	90	757	148	20%
	Total	571	7,014	4,388	492	576	1,213	11,049	8,525	9,047	3,081	4,256	8,361	58,573	11,894	20%
	% Total	0.53%	0.91%	1.85%	0.61%	0.00%	1.40%	0.24%	1.00%	3.98%	0.29%	0.42%	1.08%	1.29%		
2012	Lincoln	9	73	47	8	4	15	43	65	242	17	34	59	616	128	21%
	Total	543	7,491	4,833	585	620	1,004	11,123	9,408	9,422	2,984	4,947	7,930	60,890	12,909	21%
	% Total	1.66%	0.97%	0.97%	1.37%	0.65%	1.49%	0.39%	0.69%	2.57%	0.57%	0.69%	0.74%	1.01%		

Source: Same as previous Table. See Appendix for information on definitions of headings.

Community Indicators that Identify Areas Needing Improvement for Lincoln County

Family Support/Home

Rate of Divorces Involving Children

Lincoln County has a significantly higher percentage of divorces involving children at 56.8% than the state of Missouri rate at 48.9% (based on 2011 data). While Lincoln County has the highest percentage out of all of the comparative communities, they all hover around the 50% divorce rate. Overall, Lincoln County had 104 divorces involving children in 2011.

Table 23. Number & Rate of Divorces Involving Children - County Comparison

Location	Year	Number of events	Rate	Significantly Different
Missouri	2011	11399	48.98	
Franklin County	2011	216	55.38	H
Lincoln County	2011	104	56.83	H
Montgomery County	2011	21	52.5	N/S
St. Charles County	2011	670	55.83	H
Warren County	2011	65	52	N/S

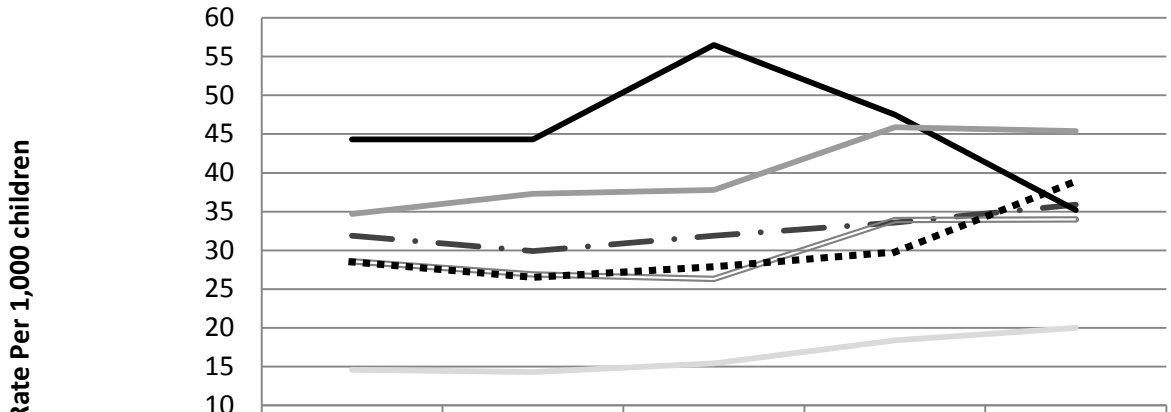
Source: Community Data Profiles. Information on Divorces Involving Children rates are the percent of reported divorces and annulments per year. * Fewer than 20 events in numerator; rate is unstable.

Child Abuse & Neglect

The Missouri Department of Social Services (MODSS) gathers information on the rate of child abuse victims with reports that are classified as "probable cause," indicating that child abuse or neglect has occurred, and from children receiving family assessments. The information on Figure 5 is presented as the rate per 1,000 children who populate the county. For 2012, Lincoln County has a rate of 39 child abuse and neglect victims per 1,000 children compared to the state rate of 36 per 1,000. With the exception of Warren County, Lincoln County has the highest rate of reported child abuse and neglect. Lincoln County has seen an increase in the rate of child abuse and neglect victims since 2009.

The Missouri DSS categorizes the type of child abuse and neglect incidents to assess and identify changing trends over time. By reviewing Table 24, titled Comparison of Missouri and Lincoln County for Percent of Substantiated Child Abuse & Neglect Incidents by Category, you can see that Lincoln County had 59 substantiated incidents in 2012, an increase of only 6 incidents since 2008. Compared to the state of Missouri, Lincoln County has a lower percentage of incidents labeled neglect (32% for Lincoln compared to 48% for MO). However, 47% of the incidents were classified as physical abuse in Lincoln County compared to 35% for Missouri. There is a similar rate of incidents classified as sexual abuse for both Lincoln County and Missouri, which is approximately 28-29%. Neglect, physical abuse and sexual abuse represent the three main types of child abuse incidents in Lincoln County. Emotional abuse, medical neglect and educational neglect represent less than a combined 10% of incidents.

Figure 5. Rate of Child Abuse & Neglect Victims (per 1,000) - County Comparison and Trends



	2008	2009	2010	2011	2012
Missouri	32	30	32	34	36
Franklin	29	27	26	34	34
Lincoln	29	27	28	30	39
Montgomery	44	44	57	48	35
St. Charles	15	14	15	18	20
Warren	35	37	38	46	45

Data Source: Missouri Department of Social Services.

Definitions: Rate of child abuse victims from reports classified as "probable cause" indicating that child abuse or neglect has occurred, and from children receiving family assessments. Rate is expressed per 1,000 children.

Table 24. Comparison of Missouri and Lincoln County for Percent of Substantiated Child Abuse & Neglect Incidents By Category

	2008		2009		2010		2011		2012	
Category	**MO**	**LC**	**MO**	**LC**	**MO**	**LC**	**MO**	**LC**	**MO**	**LC**
neglect	43.8%	38.3%	51.8%	63.3%	55.5%	39.6%	48.1%	58.1%	48.4%	32%
physical abuse	26.0%	40.0%	31.8%	38.3%	27.8%	31.3%	32.9%	30.7%	35.1%	47%
sexual abuse	23.1%	21.7%	26.4%	20.0%	24.5%	31.3%	27.7%	22.6%	28.0%	29%
emotional abuse	5.2%	16.7%	4.0%	10.0%	3.9%	0.0%	3.6%	0.0%	3.5%	2%
medical neglect	3.0%	1.7%	2.4%	5.0%	3.3%	8.3%	3.6%	0.0%	4.1%	5%
educational neglect	1.4%	0.0%	0.8%	1.7%	1.5%	0.0%	1.3%	0.0%	1.5%	0%
		N=53		N=60		N=48	4,294	N=62	4,370	N=59

Source: Missouri Department of Social Services; http://www.dss.mo.gov/cd/cfsplan

Table 25 on child abuse and neglect provides some mixed information about this serious topic. It can be seen that the total number of reported incidents has increased 6% from 2011 to 2012 (623 to 662), but the number of substantiated incidents has decreased from 62 to 59, representing a 5% decrease. Of special note, the FA category, which is defined as “family assessment and services needed,” shows an increase of 8.4% from 2011 to 2012. It is difficult to determine what type of service was provided, but it is clear that reporting is increasing with no

determination as to the causality. It could be ascertained that more individuals and professionals are being trained on how to properly report information that they may be a witness to or suspect child abuse and/or neglect has occurred.

Table 25. 2011 & 2012 Reported Incidents of Child Abuse/Neglect in Lincoln County

	Substantiated		Unsub- PSI		Unsub.		Other		FA		Total
	#	%	#	%	#	%	#	%	#	%	#
2011	62	10.0%	46	7.4%	217	34.8%	57	9.1%	241	38.7%	623
2012	59	8.9%	65	9.8%	196	29.6%	30	4.5%	312	47.1%	662
Rate of Change	-5%		29%		-11%		-90%		23%		6%

Source: Missouri Department of Social Services; http://www.dss.mo.gov/cd/cfsplan
Notes: Unsub-PSI = Unsubstantiated- Preventive Services Indicated
Unsub = Unsubstantiated
FA =Family Assessment and Services Needed

Out-of-Home Placements

This category is defined as the number of entries into the Division of Family Services alternative care, including foster care, group homes, relative care and residential settings. In Table 26, the number of entries for both Missouri and Lincoln County has seen a large increase, with Lincoln County reporting 69 DFS entries in 2012, compared to 36 in 2008. However, a spike of 70 entries occurred in 2009.

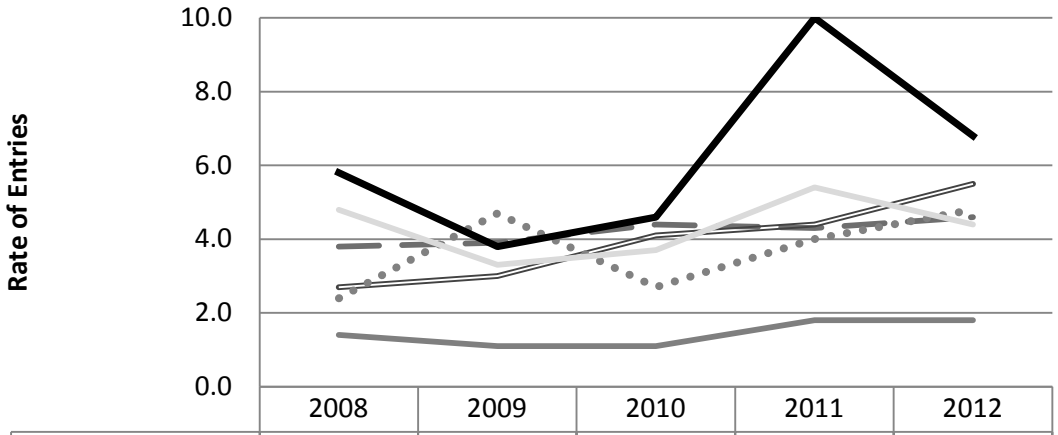
Table 26. Number of Out-Of-Home Placement Entries - Lincoln County & Missouri

Location	2008	2009	2010	2011	2012
Missouri	5,418	5,620	6,236	6,137	6,422
Lincoln	36	70	40	59	69

Data Source: Missouri Department of Social Services. **Definitions:** Number of entries into Division of Family Services alternative care, including foster care, group homes, relative care, and residential settings.

The county comparison for out-of-home placement entries in Figure 6 provides this information as a rate per 1,000 children, with Lincoln County at a rate of 4.8 compared to 4.6 for Missouri. Lincoln County is doing well though in comparison to the other communities, despite the increase in the rate from 2010 (2.7) to 2012 (4.8).

Figure 6. County Comparison and Trends for Out-of-Home Placement Entries (per 1,000)



	2008	2009	2010	2011	2012
Missouri	3.8	3.9	4.4	4.3	4.6
Franklin	2.7	3.0	4.1	4.4	5.5
Lincoln	2.4	4.7	2.7	4.0	4.8
Montgomery	5.8	3.8	4.6	10.0	6.8
St. Charles	1.4	1.1	1.1	1.8	1.8
Warren	4.8	3.3	3.7	5.4	4.4

Data Source: Missouri Department of Social Services.

Definitions: Rate of entries into Division of Family Services alternative care, including foster care, group homes, relative care, and residential settings. Rate is expressed per 1,000 children.

Community Indicators & Data That Are In Line with State and Other Comparative Entities or Demonstrate Mixed Results

There are many community indicators and/or data available on Lincoln County that shows little to no disparity between the various selected comparative communities and/or the state of Missouri.

Education

Percent of Students Enrolled in Free and Reduced Lunch Program

The rate of students enrolled in the Free/Reduced-Price Lunch program has increased over time from 2008 to 2013, with 47% of students in Lincoln County. However, this rate is less than the state rate of 49.9% of students. A similar increasing trend is found for the state and Lincoln County.

Table 27. Students Enrolled In Free/Reduced Price Lunch – County Comparison

Location	2008	2009	2010	2011	2012	2013
Missouri	42.0%	43.6%	46.8%	47.7%	49.4%	49.9%
Franklin	33.7%	37.0%	42.2%	43.2%	44.9%	46.7%
Lincoln	34.6%	37.4%	42.8%	44.8%	46.1%	47.0%
Montgomery	47.2%	50.2%	54.8%	55.5%	57.6%	57.3%
St. Charles	15.8%	17.0%	20.1%	21.5%	22.9%	23.8%
Warren	38.5%	42.7%	48.7%	50.3%	52.6%	55.3%

Data Source: Missouri Department of Elementary and Secondary Education.

Definitions: Percentage of students who are enrolled in the free or reduced-price National School Lunch Program. Children from households with incomes less than 130 percent of poverty are eligible for free lunches; those from households below 185 percent of poverty are eligible for reduced price lunches. Rate is expressed as percent of total school enrollment.

Health

Child Deaths Age 1 – 14 and 15-19 – All Causes

The first set of data to examine relating to the "Health" category involves the rate and number of events for child deaths from 2001 to 2011 for ages 1-14 and 15-19 (see Table 28 and 29). For Child Deaths Ages 1–14, there were 25 deaths that occurred with a rate of 21.2 per 100,000 youth in the population within the age criteria. This rate is slightly lower than the state rate of 21.56, but the difference is not significant. There were 24 deaths recorded in the period of 2001 to 2011 for children ages 15-19, and a rate of 60.03 per 100,000 youth in the population that meet the age criteria. With the exception of Franklin County, the rate of child deaths in this age range is very low.

Table 28. Child Deaths Ages 1-14: All Causes- County Comparison

Location	Data Years	Number of Events	Rate	Significantly Different
Missouri	2001-2011	2595	21.56	
Franklin County	2001-2011	42	19.5	N/S
Lincoln County	2001-2011	25	21.22	N/S
Montgomery County	2001-2011	8	32.58*	N/S
St. Charles County	2001-2011	108	14.07	L
Warren County	2001-2011	14	21.89*	N/S

Death rates are per year per 100000 specified age population.

* Fewer than 20 events in numerator; rate is unstable.

Table 29. Child Deaths Ages 15-19: All Causes- County Comparison

Location	Data Years	Number of Events	Rate	Significantly Different
Missouri	2001-2011	3529	75.92	
Franklin County	2001-2011	84	106.17	H
Lincoln County	2001-2011	24	60.03	N/S
Montgomery County	2001-2011	9	94.27*	N/S
St. Charles County	2001-2011	117	43.89	L
Warren County	2001-2011	19	83.03*	N/S

Death rates are per year per 100000 specified age population.

* Fewer than 20 events in numerator; rate is unstable.

Source: Community Data Profiles - Missouri Department of Health and Senior Services

Table 30 provides a more in-depth profile of the causes of death within Lincoln County for individuals age 1 through 19. The information is calculated as a three-year moving average rate. In recent years, there has been a decline in the rate of suicide for 14-19 year olds with 2009-2011 showing a rate of 8.48 suicides per 100,000 (in comparable age range) individuals in the community.

When you focus in on the motor-vehicle deaths in both age categories, there has been a recent rate increase. For ages 15-19, there is a 25.9 rate per 100,000 for 2009-2011, which increased from 8.5 in the 2008-2010 time period. For the 1-14 year old individuals, there was an 11.6 rate per 100,000 for the last two time periods (2008-10 and 2009-11), which represents an increase from 2.9 reported in 2007-2009.

Table 30. Lincoln County Deaths Profile - Age 1 – 19 – Three-Year Moving Average Rates

Years	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
Deaths Ages 15 - 19: All Causes	63.83	45.16	25.62	16.95	43.09
Deaths Ages 15 - 19: Total Unintentional Injuries	27.58	18.25	8.48	8.48	25.90
Deaths Ages 15 - 19: Motor Vehicle Deaths	27.58	18.25	8.48	8.48	25.90
Deaths Ages 15 - 19: Homicide	0.00	0.00	0.00	0.00	0.00
Deaths Ages 15 - 19: Suicide	17.79	17.79	17.14	8.48	8.48
Deaths Ages 15 - 19: All Cancers (Malignant Neoplasms)	0.00	0.00	0.00	0.00	0.00
Deaths Ages 15 - 19: Heart Disease	9.12	9.12	0.00	0.00	0.00
Deaths Ages 1 - 14: All Causes	21.37	20.65	23.47	26.20	29.16
Deaths Ages 1 - 14: Total Unintentional Injuries	9.34	5.95	5.84	14.54	14.55
Deaths Ages 1 - 14: Motor Vehicle Deaths	6.19	5.95	2.92	11.61	11.63
Deaths Ages 1 - 14: All Cancers (Malignant Neoplasms)	2.96	2.96	2.96	0.00	0.00
Deaths Ages 1 - 14: Birth Defects	0.00	0.00	0.00	0.00	2.93
Deaths Ages 1 - 14: Homicide	0.00	0.00	0.00	0.00	2.93
Deaths Ages 1 - 14: Heart Disease	0.00	0.00	0.00	0.00	0.00
Population Estimates: Ages 5 - 14	6.00	6.00	6.10	6.20	6.20
Population Estimates: Ages 15 - 17	5.00	5.10	5.10	4.90	4.80
Population Estimates: Ages 18 - 19	2.50	2.50	2.50	2.60	2.60

* Fewer than 20 events in numerator; rate is unstable.
Population estimates rates are the percent of total estimated resident population per year.
Death rates are per year per 100 000 specified age population.
Trends are available only if each 3-year period of the moving average has an average of 20 or more events.
Source: Community Data Profiles - Missouri Department of Health and Senior Services
http://health.mo.gov/data/mica/ASPsChildHealth/header.php?cnty=113

Information from the Missouri Division of Behavioral Health and the Substance Abuse and Mental Health Services Administration prepared the Behavioral Health Profile for Lincoln County, which summarized fatalities for Lincoln County residents in 2012. There were two alcohol fatalities, two drug fatalities, and two fatal crashes, but this information is not specific to the youth population.

Infant Mortality is another area that needs to be reviewed, and is defined as babies born alive and dying before their first birthdays. As demonstrated in Table 31, Lincoln County had 53 events of infant mortality from 2000-2010, with a rate of 7 out of 1,000 live births. Lincoln County is in line with the comparative entities and lower than the state rate of 7.4, although this difference is not significant.

Table 31. Infant Mortality – County Comparison

Location	Data Years	Number of Events	Rate	Significantly Different
Missouri	2000-2010	6,373	7.4	N
Franklin County	2000-2010	87	6	N/S
Lincoln County	2000-2010	53	7	N/S
Montgomery County	2000-2010	13	7.6*	N/S
St. Charles County	2000-2010	303	6.1	L
Warren County	2000-2010	19	4.3*	L

Rate is per 1,000 live births during the noted eleven year period; babies born alive and dying before 1st b-day.

* Fewer than 20 events in numerator; rate is unstable.

Children Receiving Public Serious Emotional Disorders (SED) Mental Health Services

Table 32 provides information on the number of children receiving public SED (serious emotional disorders) mental health services as of January 1st for the year reported and for whom the Department of Mental Health provided a service. It should be noted that there was a decline in the number of children who received this classification in Lincoln County from 2011 (375 children) to 2012 (295 children). Information on the rate or percentage of children receiving public SED mental health services was not provided by the data source and therefore a valid comparison with other entities cannot be made.

Table 32. Number of Children Receiving Public SED Mental Health Services – County Comparison Over Time

Location	2007	2008	2009	2010	2011	2012
Missouri	19413	18116	15183	24338	30253	24195
Franklin	219	177	102	192	438	505
Lincoln	201	171	163	231	375	295
Montgomery	47	37	36	69	113	104
St. Charles	1033	1058	988	1246	1696	1489
Warren	103	101	88	122	213	192

Data Source: Missouri Department of Mental Health.
Definitions: An unduplicated count of children receiving treatment through a division of the Missouri Department of Mental Health (DMH) for serious emotional disorders (SED) as of January 1st of the year reported for whom DMH provided a service in that calendar year.

Missouri Student Survey Trends for Lincoln County Youth – 2006 - 2012

This section provides a review of some of the positive and negative trends for Lincoln County (LC) students ranging from 6th to 12th grade collected from the 2006 to 2012 Missouri Student Surveys. The Missouri Student Survey asks students hundreds of questions on a variety of topics including: involvement in school, support from school, depression, ease of availability of drugs, use of drugs, disciplinary behavior issues, parent support/involvement, bullying experiences, perception of harm from using drugs, perception of their parents on various areas of a child's life, and perception of safety. Dr. Cynthia Berry, of BOLD, LLC was able to obtain the data from the Missouri Institute of Mental Health, and then developed the table in the Appendix comparing Lincoln County to the state of Missouri on every item. It is important to mention that the schools are instructed to have all 9th graders and a select additional grade level complete the survey. The selection process of this additional grade is not consistent over time or across all Lincoln County schools. Dr. Berry then estimates changes over time per item and the difference in percentage for each item assessed in 2012 between Lincoln County and Missouri (note that minimal rounding errors occur). Items that are showing positive trends are highlighted in green on the Table with items showing a negative trend highlighted in red. Due to the number of items included in the Missouri Student Survey, the information within this section will identify just the more significant positive and negative trends. Of the 132 items in the MO Student Survey, from 2006 to 2012, the Lincoln County sample improved on 17% of the items (or 23 items; note that items were identified if they changed more than 3% over time). An additional 16% of the items (22 items) demonstrated a negative trend in this same period of time. When comparing the Lincoln County sample to the state of Missouri sample, in 38% of the items (50 items), Lincoln County youth are lagging more than 2% on that item. Many of these items relate to alcohol use. Lincoln County youth are doing better than the Missouri youth sample on 17% of the items (greater than a 2% difference). Many of these areas related to bullying improvements.

For the 2012 Missouri Student Survey, the sample was 98,140 students. The age range was 12 to 16, with an average age of 14.45. The sample was evenly represented by males (48%) and females (52%), also similar to the state's gender distribution (49% males and 51% females) and the Lincoln County sample.

Please note that when reviewing the information below, the percentages were rounded to the nearest whole number and therefore some rounding errors appear to exist. The information on percentage that changed is accurate.

Positive Changes for Lincoln County Students -2006 to 2012

- Lifetime alcohol use decreased 8% - 62% in 2006 to 54% in 2012
- Parents notice students good work increased 16% - 64% in 2006 to 80% in 2012
- Parents tell the student when they've done well increased 20% - 61% in 2006 to 81% in 2012
- Past three months school detention decreased 11% - 26% in 2010 to 15% in 2012
- Past three months school discipline decreased 12% - 32% in 2010 to 20% in 2012
- Past three months victim of emotional bullying decreased 10% - 68% in 2010 to 57% in 2012
- Past month alcohol use decreased 12% - 39% in 2006 to 27% in 2012
- Past year fighting decreased 17% - 35% in 2006 to 18% in 2012
- Past year victim of bullying at school decreased 24% - from 51% in 2006 to 26% in 2012
- Student's agreement/perception of school safety increased 9% - 79% in 2010 to 88% in 2012

- Students believe it is okay to cheat decreased 16% - 44% in 2006 to 28% in 2012

Negative Changes for Lincoln County Students -2006 to 2012

- Chances to talk one-on-one with a teacher decreased 12% - 80% in 2006 to 68% in 2010 (no data collected in 2012)
- Ease of availability of alcohol increased 13% - 53% in 2006 to 66% in 2012
- Ease of availability of cigarettes increased 11% - 52% in 2006 to 63% in 2012
- Ease of availability of guns increased 5% - 43% in 2006 to 48% in 2012
- Ease of availability of marijuana increased 8% - from 35% in 2006 to 43% in 2012
- Past three months victim of bullying via cell (1+ time) increased 7% - 12% in 2010 to 18% in 2012
- Peer smoking marijuana (1+ friends) increased 13% - 29% in 2006 to 42% in 2012
- Perception of parental feelings on student alcohol use (being wrong or very wrong) decreased 12% - 79% in 2006 to 67% in 2012
- Perception of alcohol being wrong/very wrong decreased 13% - 63% in 2006 to 50% in 2012
- School notifies parents with praise (agree/strongly agree) decreased 16% - 46% in 2006 to 30% in 2012.
- Student engages in fighting if provoked (agree/strongly agree) increased 8% - 47% in 2006 to 55% in 2012
- Students help decide class activities (agree/strongly agree) decreased 11% - 59% in 2006 to 48% in 2012 (item not assessed in 2012)
- Teachers notice and comment on good work (agree/strongly agree) decreased 11% - 73% in 2006 to 62% in 2012

As stated previously, a comparison of the Lincoln County student data for 2012 with the state of Missouri was assessed. If an item was identified above as being a positive or negative change for Lincoln County, and follows a similar trend assessment with the county and state comparison, it will not be identified below. Only new items that show significant positive or negative comparison between these two entities will be identified.

Areas where Lincoln County (LC) is Doing Well in Comparison to the State Utilizing 2012 Data

- Only 15% of LC students stated that it was very easy or sort of easy to access other illicit drugs compared to 18% of Missouri youth overall.
- 14% of LC students reported that they bullied another student 1 or more times in the past three months in comparison to 21% of Missouri students.
- 20% of LC students reported that they had 1 or more incidents of being physically bullied by another student in the past three months in comparison to 25% of Missouri students.
- 18% of students reported that they had engaged in fighting in the past year at least one or more times compared to 22% of the Missouri sample of students.
- 2% of LC students were planning suicide in the past year compared to 9% of the Missouri sample.
- 7% of LC students identify 1 or more friends who carry a gun in comparison to 11% of the Missouri students.

Areas where Lincoln County (LC) is Underperforming in Comparison to the State Utilizing 2012 Data

- 33% of LC students have used cigarettes in their lifetime compared to 24% of the Missouri students.
- 54% of LC students have used alcohol in their lifetime compared to 40% of the Missouri sample.
- 27% of LC students have used alcohol in the past month at least one day or more compared to 18% of the Missouri sample.
- 66% of LC peers stated that at least one or more of their friends use alcohol in comparison to 53% of Missouri students.
- Multiple areas relating to how youth perceive laws/rules being enforced were assessed. There are less Lincoln County students who responded that laws are enforced for alcohol, guns, cigarettes, and marijuana compared to the Missouri students.
    - Alcohol – 19% for LC students compared to 30% for MO
    - Cigarettes – 13% for LC students compared to 25% for MO
    - Guns – 40% for LC students compared to 54% for MO
    - Marijuana – 31% for LC students compared to 41% for MO
- 67% of students responded that their parents feel alcohol use is wrong or very wrong compared to 79% of the Missouri students.

The Current State of Children's Services in Lincoln County – LCRB-funded Agency Program Profiles by Category

This section provides the current state of services available in Lincoln County, with the information gathered utilizing a survey tool developed by BOLD, LLC in conjunction with information that has been previously gathered by the LCRB. The identified categories in this section adhere to the list of programs and services that are funded by the Community Children's Trust Fund, and include a general description of the types of programs that can be funded within the category. Within each funding category, you will see "Funded Agency Program Profiles," which contain general information about the program, including eligibility criteria, funding trends, the number of youth whom have been served in 2013, the number of youth projected to be served in 2014, costs and unit rate information for the program and areas that need to be funded within the program, agency and/or community. A majority of this information was received via the survey tool completed by the agency's program contact and administered through Survey Monkey. Please note that these sections are written from the agency's perspective.

The cost, unit rate and number of children served is presented in Table 33 at the end of this section, which summarizes the total number of children served through LCRB funds in 2013, 2014 and the total cost of all the LCRB-funded programs.

Individual, Group, and Family Counseling Services

Individual, group and family counseling services include psychological evaluations, mental health screenings and individual, group and family therapy. These services are beneficial for assisting individuals and families to cope with, adapt to, or resolve a broad variety of stressful circumstances, such as life adjustments, depression, anxiety, sudden crisis or emotional trauma. Timely and affordable counseling services allow families the opportunity to address a crisis in its acute phase in an individual, family or group setting; thereby, minimizing the possibility that troubled feelings will emerge in a more convoluted form at a later time.

In 2013, LCRB funded these programs at $332,911, which served 878 youth. These programs requested $360,629 from LCRB for 2014 of which $324,919 was funded. This represents a $35,710 gap to fund these programs at the agency-requested level. With this funding, an estimated 969 youth will be served in 2014. If approximately 10-12% of the youth population has a serious emotional disorder, of which most counseling services are requested for, we can project that 1,425 to 1,755 youth are in need of this service. This is another figure that projects that the LCRB funds are potentially reaching 68% of the youth with this need. Some duplication may occur, but this is most likely limited within this program category.

Catholic Family Services - School-Based Counseling Services

Project Description - Catholic Family Services provided School-Based and Prevention Services for Lincoln County's three Catholic schools from January 1 through December 31, 2013. The services were provided by three part-time counselors: Margaret Verstraete, Margaret Yoesel and Lauri Cross Fink. Margaret Verstraete provided a half-day service once a week at St. Alphonsus in Silex; Margaret Yoesel provided services one day a week at Immaculate Conception School in Old Monroe; and Lauri provided services two days a week at Sacred Heart School in Troy. All of these counselors are trained in and utilize a variety of evidence-based treatment practices with students.

The program's services included individual counseling, small groups, observations and educational presentations. Observations allow counselors to observe students in their natural environments, providing much insight to administrators and parents concerning what happens in the classroom setting. This information allows the school to make accommodations in the classroom as needed.

Additionally, 509 students participated in interactive educaitonal presentations offered during the school year, including an Internet safety presentation offerd to fifth graders.

In addition, as this agency continues to work with the schools to put a stop to bullying behaviors, a bullying prevention program was provided to students in the fourth through the eighth grades, with 352 students participating in this programin 2013. Bullying presentations were age-level-appropriate and included information on different kinds of bullying and how to keep oneself and classmates safe from bullies. Emphasis was on taking responsibility and on each student to create a safe environment for themselves and others. The presentations' educational component included the role of the bystander. Students learned about the three types of bystanders and how they can be empowered to stand up against bullying.

Teachers also requested other types of presentations. These presentations were individualized to classroom needs (respect, friendships and how to get along, team building, goal setting, and motivation). The presentations were creative and included role playing, video, storytelling, interactive games and written exercises. There were 103 total presentations given during the year.

The individual counseling program served students who were dealing with issues, including depression, anxiety, grief, ADHD symptoms and academic and behavioral problems. Sessions typically were held for 30 minutes, and students were seen on an as-needed basis. (In the past, students were seen on a weekly or a biweekly schedule.)

During 2013, the counseling needs became greater in the three schools, necessitating the scheduling modification to an as-needed approach. Although there were no waiting lists, not all students were seen as often as requested (by parents, teachers and the students themselves). Students determined to have the most issues were seen first, and the other students were moved out until counseling slots became open. Therapists devised an individualized treatment plan, which provided important structural direction to the child's therapy.

Small group sessions became more popular during 2013. These sessions concerned social skills, organizational skills and anger. In addition, divorce groups were provided at each of the three schools.

Immaculate Conception School continues to offer virtue-based restorative discipline (VBRD). The program offers teachers, parents, students and schools a way to cultivate virtue while repairing harm from bullying and other hurtful behaviors (www.virtuebase.com).

Eligibility Criteria – Client must be 19 years or younger and a resident of Lincoln County.
2013 LCRB Funding – $54,979

Unit Cost-$53.69

Units - 1,024

Youth Served - 509 children/youth (44 for individual counseling). Counselors gave 103 presentaitons, 352 students participated in anti-bullying presentations

2014 Requested Amount - $64,140

2014 LCRB Funding - $59,971 Amount Not Funded - $4,169

Unit Cost - $53.45

Units - 1,122

Youth to be Served – 525

Other Sources of Funding – There are no other funding sources for this program

Waitlist Information – Currently there is no waitlist. All referred clients are seen in school-based programs; although, the frequency of the sessions has been reduced to meet the needs of an increasing number of students.

Information on when the program responds to mental health in the service delivery process- Often teachers identify a behavioral, social or academic problem and alert parents, administration and/or the on-site therapists. In the first counseling session, the therapist begins the process of identifying the problem, does a risk assessment, and determines a diagnosis for treatment. By the clients third counseling session a complete psychosocial assessment and treatment plan is complete. The treatment plan details the therapeutic intervention based on the diagnosis.

Outcomes Information –94% of youth served will maintain or improve their level of functioning in the following areas: social, psychological, interpersonal and physical. 93% of the students demonstrated increased coping skills. 94% of students served demonstrated a reduction in symptoms as a result of school counseling services

Information from agency on the real, local data demonstrating success of the program – Outcome data is measured by standardized tools. Currently in place is the Pediatric Symptom Checklist, which is completed at first session and then every 6-8 sessions to measure symptom reduction. Also used is the Global Assessment of Functioning (GAF), which is measured at first session and then every 6-8 sessions subsequently.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - Not applicable- all funds in this program are utilized and in fact there is typically a shortfall at the end of the year.

Catholic Family Services- Outpatient Counseling Program

Project Description - This program provides office-based individual counseling, group counseling, and anger management classes to Lincoln County youth. Further, it provides family counseling as well as Love and Logic parenting classes. Certified Catholic Family Services therapists provide all program services.

Eligibility Criteria – Client must be 19 years or younger and a resident of Lincoln County.

2013 LCRB Funding – $77,905

Unit Cost-Individual Counseling - $50.90 per unit for 1,404 units ($71,464). Anger Management - $70.74 per unit for 40 units ($2,830). Love & Logic - $112.88 per unit for 32 units ($3,612).

Youth Served - 165 children/youth, additionally 24 youth participated in anger management classes and 43 parents participated in love and logic

2014 Requested Amount - $86,861

2014 LCRB Funding - $78,000 Amount Not Funded - $8,861

Unit Cost - Individual Counseling - $57.68 per unit for 1,197 units ($69,043). Anger Management - $35 per unit for 164 units ($5,740). Love & Logic - $100.50 per unit for 32 units ($3,216).

Youth to be Served – 169 children/youth, and an estimated 55 youth to participate in anger management, and 65 parents for the love and logic class.

Other Sources of Funding – Private insurance, sliding fee scale.

Waitlist Information – Currently there is no waitlist

Information on when the program responds to mental health in the service delivery process- In the first counseling session the therapist begins the process of identifying the problem, does a risk assessment, and determines a diagnosis for treatment. By the clients third counseling session a complete psychosocial assessment and treatment plan is complete. The treatment plan details the therapuetic intervention based on the diagnosis.

Outcomes Information – 93% of youth served will maintain or improve their level of functioning in the following areas: social, psychological, interpersonal, and physical. 92% of the youth served maintained or decreased their symptom level. 92% of the youth served demonstrated progress on individualized treatment plan goals. 80% of the class participants demonstrated that they had learned two new anger management techniques. 85% of the class participants demonstrated that they had learned two new positive parenting techniques.

Information from agency on the real, local data demonstrating success of the program – Outcome data is measured by standardized tools. Currently in place is the Pediatric Symptom Checklist- completed at first session and then every 6-8 sessions to measure symptom reduction. Also used is the Global Assessment of Functioning that is measured at first session and then every 6-8 sessions subsequently.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - Lack of available Pediatric Psychiatrists, staffing issues, lack of licensed therapists in the area, and transportation issues of clients.

Crider Health Center- School-Based Mental Health Specialists

Project Description - The School-Based Mental Health Specialist (SBMHS) Program is designed to offer mental health services, direct therapeutic intervention, and provide supports to children and youth diagnosed with a serious emotional disorder. The services and supports are offered to children and youth in their schools, allowing for easy access and timely interventions. Core program components include: 1) assessing children to determine their eligibility for service; 2) linking families to appropriate mental health services within the community; 3) coordinating services between the family, school, and other community and natural resources; 4) monitoring progress and appropriateness of fit for services delivered to the family; 5) providing mental health education and resource materials; 6) providing on-site mental health consultation to school staff; 7) assisting school personnel with students experiencing a mental health crisis; and 8) providing direct therapeutic support to consumers.

Each School-Based Mental Health Specialist assists families in reconnecting with their communities, since parents of children diagnosed with serious emotional disturbance often feel isolated or disenfranchised from the school system due to their children's problematic behaviors. Each School-Based Mental Health Specialist offers school counselors and teachers an effective resource, allowing the school systems to serve participating children with a very targeted intervention.

School-Based Mental Health Specialists provide mental health expertise and bridge the gap between school and home. The primary role of the School-Based Mental Health Specialists is to link, monitor, and coordinate vital services for children and their families. Children with Serious Emotional Disturbance, along with their families, often need assistance from experts to gain the support necessary to maintain their mental health. The School-Based Mental Health Specialists provide this critical service using a strength-based, family-driven and wraparound approach to care. School-Based Mental Health Specialists identify what the family needs to be successful; think

outside of the box; use as many natural supports as possible; and "wraps" the family with their own individual plans. Crider does not employ a cookie-cutter approach to serving participating children or families given that each has very distinctive needs (and strengths).

Eligibility Criteria – Children must have a Serious Emotional Disorder to be eligible; they must also meet residency and age requirements as well.

2013 LCRB Funding – $200,027

Unit Cost-$77.29

Units - 2,588

Youth Served - 137 students (grades K-12), including 29 from pilot non-SED program

2014 Requested Amount - $209628

2014 LCRB Funding - $186,948 Amount Not Funded - $22,680

Unit Cost - $81

Units - 2,308

Youth to be Served – 155

Other Sources of Funding – The SBMHS services are funded by the LCRB for non-Medicaid consumers. For Medicaid consumers, Crider bills Medicaid and pays the Medicaid match by using designated Department of Mental Health funds.

Waitlist Information – Each SBMHS maintains an unofficial waitlist, with a conservative total wait list number of approximately 25.

Information on when the program responds to mental health in the service delivery process- Upon admission, each child receives a thorough psychosocial assessment that gathers a complete social history, includes a mental health status exam, a complete diagnositic formula and provides treatment recommendations. The SBMHS develops individual treatment goals with the child and family, provides 1:1 clinical intervenitons, and works with the child's family and school team to provide appropriate intervenitons and supports to maintain the child in their school settings successfully. There is no time limit for services, and the children are seen during holiday, spring and summer breaks.

Outcomes Information –95% of objectives defined in consumer treatment plans were achieved or in progress. (July through December: 95%) 99% or 120 out of 122 students in the program remained in school. (July through December: 98%) 98% or 120 out of 122 youth served were free from law enforcement and juvenile justice involvement. (July through December: 98%)

Information from agency on the real, local data demonstrating success of the program – Children diagnosed with SED are often at risk of being removed from their homes, their school settings, or both. Research has proven that clinical case management services targeting these children and their families have shown great success, and the service helps parents manage critical components of the child's treatment package (psychiatry, medication management, therapy, etc.). Utlizing a family-driven, wraparound approach allows clinical teams to treat each family uniquely, designing a clinical program geared to treat their family alone.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need – Not applicable.

Outpatient Psychiatric Services

Outpatient psychiatric treatment services consist of the services a child or adolescent needs in order to be evaluated medically for a psychiatric disorder by a psychiatrist. Often times, these disorders require the prescription of medications to reduce or eliminate symptoms. Psychiatric services include the initial assessment and on-going medication management by a psychiatrist, but also can involve a number of other supports including nursing, and laboratory tests. Without these services, many children are unable to function at school, at home and in the community, and there is an increased risk of acting out, juvenile delinquency and suicide. Additionally, these services can make it possible for other types of counseling services to work more efficiently.

In 2013, the LCRB funded the program with a $38,972 allocation, which served 139 youth last year. The LCRB's 2014 funding request was decreased to $18,243, which it met at 100% of funding to provide services for 36 youth, reflecting the funded psychiatrist's decision to treat patients from her O'Fallon office only—no longer seeing patients in Troy.

Catholic Family Services - Psychiatric Services

Project Description - Dr. Claudia Viamontes, a board-certified psychiatrist who specializes in pediatric psychiatry, provided all program services during 2013. As during previous years, the majority of her clients were concurrently benefitting from therapy, and most of the Lincoln County youth whom she treated were referred for psychiatric evaluation and care by their therapists.

There are various reasons why the therapists may refer a child to the doctor. 1) If the youth is working diligently in therapy but his/her emotional well-being is not increasing significantly. 2) When a counseled youth's attention span continues to be poor – a possible indicator for ADD or ADHD, both of which often respond well to medication. 3) Indications of possible bipolar disorder or the display of psychotic symptoms, while less common, nonetheless necessitate that a therapist automatically refer a youth to Dr. Viamontes.

When youth are referred to Dr. Viamontes by their therapists, the doctor, before her first session with the youth, speaks with his/her counselor to gain a preliminary overview of the child's issues and life situation. During her first session with each youth, she administers psychological assessments, such as the Global Assessment of Functioning (GAF), and will evaluate and diagnose the child. If she determines there is a possibility that a physiological issue, such as a thyroid disorder, may be causing or contributing to the child's symptoms, she will refer the youth to an appropriate physician.

Prior to diagnosing the youth, Dr. Viamontes gathers social information concerning the child. This process consists of gaining relevant information concerning the youth from adults who are familiar with his/her life situation. These adults typically are the child's parents, and they often can include teachers and other family members. The most common diagnoses among young patients are depression, ADHD, generalized anxiety disorder, bipolar disorder, mood disorders, and addiction. In some cases, a youth has co-occurring disorders, such as depression combined with addiction.

After diagnosing the youth, the doctor develops an individualized treatment plan, the key component of which is the prescription of medication that will best target the youth's symptoms. The doctor sometimes will later adjust the patient's dosage to better ensure the medication is providing maximum benefit for the youth. If the medication does not produce improvement for the child, she will switch the youth to a different medication that also has proven effectiveness in reducing the symptoms that the child is experiencing. In some cases, the doctor may prescribe two medications simultaneously for the youth. The child is seen on a regular basis. During the subsequent sessions, she gauges the youth's improvement level and updates his or her progress note and treatment chart. She determines the child's progress through speaking with the youth, via re-administration of the psychological assessments, and through maintaining contact with and obtaining input from the youth's parents. To further ensure the child's improvement, she may make adjustments to the youth's individualized treatment plan.

When the child's symptoms have become significantly reduced, Dr. Viamontes typically begins to taper the youth's medication dosage and reduces the frequency of sessions with the child. She later will conclude treatment when the child has gained markedly increased emotional well-being.

Eligibility Criteria – Client is eligible for Psychiatirc services if they are age 19 and under and a resident of Lincoln County.

2013 LCRB Funding – $38,972

Unit Cost-$207.30

Units - 188

Youth Served - 139

2014 Requested Amount - $18,243

2014 LCRB Funding - $18,243 Amount Not Funded - $0

Unit Cost - $294.24

Units - 62

Youth to be Served – 36

Other Sources of Funding – Insurance

Waitlist Information – 23

Information on when the program responds to mental health in the service delivery process- At the first session, the client is assessed by the psychiatrist for mental health functioning, self-harm and medication need. Client has an intial 45-minute psychiatric assessment and then follow-up medication/mental health functioning assessments every 6 weeks for 15 minutes.

Outcomes Information –87% of youth served will maintain or improve their level of functioning in the following areas: social, psychological, interpersonal and physical. 89% of the youth served maintained or decreased their symptom level. 86% of the youth served demonstrated progress on their individualized treatment plan goals.

Information from agency on the real, local data demonstrating success of the program – Outcome data is derived from the GAF (Global Assessment of Functioning) and the Pediatric Symptom Checklist. In addtion, the psychiatrist completes a medication compliance checklist to determine which clients are taking their medications as prescribed. At this time, there is no collective impact data.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - Lack of psychiatrists.

Crisis Intervention Services

Crisis intervention services help assure that support and other services are available when an individual experiences an emergency, whether it would be man-made or a natural disaster. It is vital for people who are experiencing trauma or severe difficulties to have access to someone who can assess risk, defuse the situation, have access to emergency service appointments, and make appropriate referrals. In addition, when communities are experiencing a trauma like a natural disaster, such as a flood, or a man-made trauma, like a school shooting, it is necessary for professional counselors to be available immediately to respond to the victims. In these situations, it can be extremely helpful to have a team of crisis counselors available to meet the emotional needs of many children or youth.

Currently there are no specific programs that are funded for Crisis Intervention by LCRB, although there are many local resources to call upon if an emergency occurs.

Lincoln County has access to a 24-hour free "800" crisis line through *Behavioral Health Response (BHR),* a private not-for-profit corporation, that is the hub for an Access Crisis Intervention (ACI) system. BHR provides confidential telephone counseling to people in mental health crises, as well as mobile outreach services, community referral services, and critical incident stress management (CISM). BHR's crisis hotline and mobile outreach services are provided, free of charge to the public, by paid professional staff that have master's degrees in their respective behavioral science disciplines. Their services are not well known within the county and are, therefore, accessed most often through service providers.

In addition, we have United Way Missouri 2-1-1 which is a fast, free, confidential way to get help, 24 hours a day, 7 days a week, for: basic human needs; physical and mental health resources; work initiatives; support for seniors and those with disabilities; or, support for children, youth and families. Trained, referral specialists manage these phone lines and refer callers to the appropriate resource based upon the information given by the caller.
Both Catholic Family Services and Crider Health Center have trained staff to provide needed crisis intervention services to any of the public, private or parochial schools in Lincoln County. Specific interventions will vary depending on the crisis and/or issue being addressed, as well as the ages of the children and the severity of the symptoms. Sts. Joachim and Ann Care Service is able to respond to emergencies and natural disasters. Many of our agencies have the ability to help us if a crisis were to affect Lincoln County youth. A cash reserve for this funding purpose would be an ideal way to plan for the unknown and inevitable.

Outpatient Substance Abuse Treatment

Substance use and abuse is a common problem among adolescents. It is important to note that Lincoln County has recently put in place a Drug and Alcohol Reduction Team (D.A.R.T.) Coalition, which has implemented various strategic planning initiatives identified from the Lincoln County Youth Drug and Alcohol Needs Assessment of 2012 completed by BOLD, LLC. This recent assessment focused on the youth population and inquired about drug/alcohol use, perception of risk, and other substance-use related behaviors. The full report of the findings can be found on the LCRB website under reports (http://www.lincolncountykids.org/pdfs/Lincoln_Co_Youth_Drug_Alcohol_Needs_assessment.pdf). D.A.R.T. was created to ensure Lincoln County had an organized grassroots initiative to not only address and educate the Lincoln County community on current substance abuse issues, but also to ensure we have a team of professionals ready to confront ongoing and future concerns as they arise. D.A.R.T. has one mission: Eliminate substance abuse in our community. Members, including the LCRB executive director, work on plans to remedy or improve upon key areas relating to substance use and abuse. Key issues for D.A.R.T. include alcohol-related behavior and use and misuse of prescription medications.

The Lincoln County Youth Drug and Alcohol Needs Assessment report included a sample of 1,698 students across 6th, 9th and 12th grades in all of the public and two of the private schools. Below, please find a summary of some of the key findings:

- Prescription drugs were identified as being “easy” or “very easy” to obtain by 39.4% of Lincoln County youth as compared to only 30.7% of Missouri youth.
- 45.6% of the Lincoln County youth sample reported lifetime use of alcohol compared to 38.2% of the Missouri sample. 12% of Lincoln County youth reported consumption of five or more alcoholic beverages during one event, in the past 30 days.
- 7.6% of Lincoln County youth used prescriptions and synthetic marijuana separately in the past 30-days (when assessed). The highest rate of use in the past 30 days was with stimulants.
- Of the substances listed, alcohol is used earliest by the youth with the average age of first use being 12.81 for Lincoln County youth. Prescription use begins on average at age 13.04. Overwhelmingly, females are experimenting with substances before males.
- There is minimal use of alcohol and other substances before or during school or school events. In 12th grade, less than 10% of students report some level of alcohol consumption before a school event, with less than 5% using during a school event.
- Alcohol is cited as the substance most used by peers at some level, with 18.1% of students stating that their peers consumed alcohol more than once a week.
- Almost 22% of students stated that their peers use prescriptions at some level, with 6.5% stating more than once a week.

Drug use among people of all ages is dangerous because it can lead to addiction, reduced self-control and impaired decision-making. In addition to other serious physical consequences, some drugs can alter the brain in ways that persist after the person has stopped taking drugs, and which may even be permanent. (*Missouri Department of Mental Health, 2012)*

Substance abuse has significant health and economic consequences for its citizenry. In 2011, Lincoln County residents had a total of 129 alcohol-related and 189 drug-related hospitalizations. Furthermore, there were 330 alcohol-related and 397 drug-related emergency room visits that did not include a hospital stay (Behavioral Health Epidemiology Workgroup, May 2012). Related to this, in 2012 Lincoln County had 386 DWI arrests, 40 liquor law violations and 265 drug-related arrests. There were three methamphetamine laboratory seizures in 2012 and four in 2013.

During 2012, 376 Lincoln County residents were admitted to substance abuse treatment at publicly-funded facilities. Of these 376, 163 had alcohol listed as their primary substance of abuse and 88 listed marijuana. (Behavioral Health Epidemiology Workgroup, May 2014)

These are just a few of the statistics that demonstrate the need of the Outpatient Substance Abuse Treatment Services. The average cost to treat youth with significant substance abuse issues is approximately $1,800-$1,900 per youth. Some adolescents, because of the extent of their addictions, are best treated in a residential or inpatient setting. Detoxification and 24-hour surveillance are often necessary in the beginning, because of the level of addiction and the risk to maintaining sobriety. For other adolescents, the appropriate level of care is intensive outpatient treatment; while, others are better suited for family therapy and educational sessions. Outpatient adolescent substance abuse treatment services include: assessments and evaluations, early interventions, educational groups, youth group counseling, individual counseling, group family therapy, family therapy and aftercare services.

Preferred Family Healthcare (PFH) received $84,242 in 2013, which allowed them to serve 42 youth. They requested $90,575 in 2014, of which $86,050 was granted. This represents a funding need of $4,525 based on the agency's perspectives. PFH aims to serve 27 youth in 2014.

Preferred Family Healthcare - Substance Abuse Treatment

Project Description - The outpatient services provided by PFH is built on the CSTAR framework and includes evidence-based approaches of Motivational Enhancement Therapy (MET), Cognitive-Behavioral Therapy (CBT), Strengths-Based Client-Centered Approach, and Motivational Interviewing (MI). The program also uses components of the Adolescent Community Reinforcement Approach, Brief Therapy, and the 12-Step program.
The services in the outpatient program include:

1. Initial Assessment - Each youth is evaluated to determine appropriateness of the program. This is conducted through the Comprehensive Health Assessment for Teens (CHAT), along with several other screening tools.

2. Individual Counseling - These are regular, individual, face-to face interactions between the consumer and the counselor. This is an opportunity for the consumer to address and resolve problems related to his or her alcohol or other drug use. Individual counseling can also include trauma and co-occurring therapy for those consumers with this specific need and history.

Case Management - PFH acts as a liaison, linking the consumer to community resources for building social support systems, accessing community resources, improving educational performance, obtaining employment, improving communication skills, developing healthy lifestyles, locating medical care, and establishing a supportive living environment. The Community Support Specialist works with consumers individually, while maintaining frequent contact with the consumer and persons involved in the consumer's recovery. This category also includes family counseling, which is designed to address and resolve the family's dysfunction, particularly as it relates to an alcohol and/or drug abuse problem.

Group Sessions - Groups offer goal-oriented interactions between staff and a group of youth and can be therapeutic or educational in nature.

Drug Testing - To monitor consumers' progress, regular and random alcohol and drug tests are conducted. Testing includes on-site quick tests and laboratory tests.

Eligibility Criteria – In order for a youth to meet criteria for substance abuse treatment, the youth must have been identified as having a substance use disorder.

2013 LCRB Funding – $84,242

Unit Cost-Diagnostic Assessment - $133.17 per unit for 23 units ($3,063). Individual Counseling - $69.47 per unit for 373 units ($25,912). Group Counseling - $16.59 per unit for 1,148 units ($19,045). Case Management - $50.79 per uni t for 448 units ($22,754).

Youth Served - 42 (13 carried over from 2012, 29 new admissions)

2014 Requested Amount - $90,575

2014 LCRB Funding - $86,050 Amount Not Funded - $4,525

Unit Cost - Diagnostic Assessment - $112.56 per unit for 26 units ($2,926). Individual Counseling - $80.66 per unit for 412 units ($33,232). Group Counseling - $14.80 per unit for 1,259 units ($18,633). Case Management - $54.28 per unit for 509 units ($27,628).

Youth to be Served – 27

Other Sources of Funding – The outpatient substance abuse treatment program is also funded through private insurance, Medicaid, and funding through the state of Missouri.

Waitlist Information – 0

Information on when the program responds to mental health in the service delivery process- Through the initial assessment process, PFH evaluates the appropriateness of the youth for the outpatient substance abuse treatment program. If other areas of need are identified, PFH refers these youth to appropriate agencies. Additionally, if a youth is currently enrolled in the program and is experiencing mental health issues at any juncture of the program, PFH assists the family in connecting with appropriate resources.

Outcomes Information –88% of consumers gained knowledge of substance abuse and/or mental health issues. 71% of consumers had a reduction in or free expression of psychiatric DSM Axis 1 diagnosis such as substance use, depression, etc. 76% of consumers had improved school engagement and performance. 76% of consumers had improved relationships with family members/caregivers.

Information from agency on the real, local data demonstrating success of the program – According to the Missouri Department of Elementary and Secondary Education, the dropout rate for Lincoln County schools decreased from

6.9 in 2012 to 5.1 in 2013. In Lincoln County, 14.1% of youth reported that they believe it would be easy to get drugs such as cocaine, methamphetamine, and ecstasy which is a decrease from 19.9% in 2012 (Missouri Department of Behavioral Health, 2014). Additionally, according to the Poison Control the number of calls for synthetic and bath salt use has decreased.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - Preferred Family Healthcare has had a high turnover rate in the programs. We continue to strive to fill these positions as quickly as possible in order to provide a seamless transition.

School-based Prevention Services

School-based prevention programs provide children with coping and response skills when exposed to various societal risk factors, and they provide for opportunities to detect issues that may allow for early intervention to prevent social, emotional, educational and developmental problems. These types of programs can identify mild forms of maladaptive behaviors that, if left unaddressed, could develop into more serious problems later on. In order to help children and youth handle the pressures they face every day, either at home or at school, it is important that they possess certain skills before the pressures arise. Parents are also in need of skills, particularly when they have children who are at risk of acting inappropriately. These skills can be developed and enhanced through prevention programs that build on the child's or parent's existing strengths, while teaching new skills that enable them to handle various difficulties. General prevention programs teach skills to handle multiple issues, while other prevention programs focus on specific problems.

School-based prevention programs are cost effective and convenient, as well as effective in circumventing other problems. Prevention programs are typically provided to all children that meet a specified age/grade criteria, which typically aligns with a relevant developmental stage. This type of program methodology allows for consistency of skills and messaging, with some variations requested by school officials/districts.

In addition, it is important to "inoculate" youth more than once with prevention programs tied to key areas that youth face during their development. It is hoped that all children in the county could learn the skills necessary to avoid alcohol and drug usage, violence (physical and emotional), abuse and neglect, and sexual harassment/assault. In addition, every child needs to learn skills to effectively handle conflicts without violence, and they need to value themselves enough so as not to take their own lives.

Parents can also benefit from prevention courses. A high percentage of child abuse and neglect, harassment, bullying, substance abuse and other issues can be prevented if parents are given family management and parenting skills and are taught age-appropriate expectations. By making structured educational courses available to parents with high-risk children, the incidence of abuse and the prevalence of these issues can be reduced, in addition to increasing the availability of resources and assistance for the youth of Lincoln County.

In 2013, a total of $323,556 was funded by LCRB for these programs, which reached 8,302 youth. These combined programs requested $377,175 for 2014, of which $355,922 was funded. This represents a $21,253 gap to serve the prevention programs based on what the agencies originally requested. The funded agencies estimate serving 7,627

youth in 2014 with these specific funds. There are approximately 9,000-10,000 students in grades K through 12 in Lincoln County for both private and public schools.

Crider Health Center - Violence Prevention

Project Description - Crider Health Center has a long history of providing prevention programs to the schools in Lincoln County. LCRB funding has allowed Crider's School-Based Violence Prevention curriculum to be added to the menu of programs offered to Lincoln County schools.

Crider Health Center's School-Based Violence Prevention Program is based on James Stanfield's successful program, BeCool. The curriculum is founded on the cognitive theory that children are what they think, which controls how they feel and act. BeCool teaches students to think about the consequences of their actions before reacting impulsively.

Through the use of trained and highly qualified Prevention Specialists, kindergarten through 8th-grade students are engaged in the classroom setting through high-energy, educationally-packed messages. Classes are interactive and challenge traditional myths and false thinking. Teaching critical thinking skills, programming is designed to educate, heighten awareness and teach safety measures.

Eligibility Criteria – N/A - no eligibility criteria for Prevention programming.

2013 LCRB Funding – $27,970

Unit Cost-$70.63

Units - 396

Youth Served - 6,362 students (Grades K-8)

2014 Requested Amount - $33,920

2014 LCRB Funding - $32,240 Amount Not Funded - $1,680

Unit Cost - $80

Units - 403

Youth to be Served – 6,000

Other Sources of Funding – The LCRB largely supports the Violence Prevention Programs in Lincoln County. United Way funding is also used to cover the gap of unfunded services.

Waitlist Information – N/A - No waitlist for Prevention.

Information on when the program responds to mental health in the service delivery process- N/A - There are no formal mental health assessments completed in the Prevention Program.

Outcomes Information –99% of youth surveyed reported knowing when to physically get away from a potentially violent or threatening situation (July through December: 100%). 99% of youth reported being able to recognize at least two signs of inappropriate responses to anger in themselves (July through December: 99%). 98% of youth surveyed reported being able to recognize at least two signs of bullying behaviors (July through December: 98%). 97% of youth will report being able to verbalize their feelings to their peers or adults when they feel peer pressure (July through December: 97%). 98% of youth surveyed will report being better prepared to seek adult support when faced with a potentially violent situation (July through December: 100%).

Information from agency on the real, local data demonstrating success of the program – Violence Prevention uses a number of EBP, best practices, and promising practices within the K-8th grade curriculum (James Stanfield's "Be cool," LifeSKills, Safe Date, Hazeldon - Cyber Bullying).
Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need – Not applicable.

Crider Health Center - Pinocchio

Project Description - The target population includes children in grades K-3 identified as having a mild to moderate emerging school adjustment concerns.

The Pinocchio Program was implemented in Missouri by Crider Health Center in 1982 to provide services to young children who are having difficulty adjusting to school, and thereby risking academic and school failure. The program is designed to improve services to identified children at risk, including weekly one-on-one sessions and weekly small-group sessions. After initial screenings are completed, parents, teachers, and Pinocchio staff assess children who are identified as needing mild to moderate interventions. Children are then assigned to the program based upon those assessments. Children identified as needing high levels of interventions (such as psychiatry, or more intensive Crider Health Center clinical programs) are linked to necessary resources within the agency and/or within the larger community.

The Pinocchio Program is based on an evidence-based program called the Primary Project, which is recognized on SAMHSA's national registry of evidence-based programs and practices. The Pinocchio Program utilizes the Primary Project model and training materials to train Pinocchio Associates, who serve as intervention specialists to enrolled children. The Pinocchio Program boasts a more intense parent component than the Primary Project, however. It is Crider's philosophy that a stronger family promotes childhood success--success that is achieved faster and has longer-lasting positive consequences.

The program begins with screenings to identify children with early school adjustment difficulties (e.g., mild aggression, withdrawal, and learning difficulties) that interfere with learning. Following identification, children are referred to a series of one-on-one sessions with a Pinocchio Associate (a trained paraprofessional) who utilizes developmentally appropriate child-led play and relationship techniques to foster adjustment to the school environment. Children generally are seen weekly for 30-40 minutes for 10-14 weeks. During each session, the Pinocchio Associate works to create a nonjudgmental atmosphere and facilitates interventions focused on fostering age-appropriate social skill development and improved self-esteem.

Targeted outcomes for children include increased task orientation, behavior control, assertiveness, and peer social skills. The overarching goal of Pinocchio is the successful application of early childhood interventions that prevent more intensive and costly individualized interventions later in the child's life.

Eligibility Criteria – Children are screened using the AML and TCR-S; the screening tools are scored; and the children that fall within a certain range of concern are observed in real time. Consultation with school staff and parents takes place, and, ulitmately, children identified as having mild to moderate adjustment issues are admitted into the Pinocchio Program.
2013 LCRB Funding – $36,960
Unit Cost-$44.53

Units - 830

Youth Served - 433 (K-3) students screened, 69 met initial program eligibility, 58 met full program eligibility

2014 Requested Amount - $41,169

2014 LCRB Funding - $39,000 Amount Not Funded - $2,169

Unit Cost - $50

Units - 780

Youth to be Served – 80

Other Sources of Funding – The Pinocchio Program is largely supported by the LCRB. It is not a Medicaid billable service. Some United Way funding does cover the program's cost.

Waitlist Information – The Pinocchio Program does not maintain a wait list.

Information on when the program responds to mental health in the service delivery process- Each child, K - 3rd grade, is screened for emerging behavioral issues. After the program's formal screening process is completed, children meeting the program's criteria are served throughout the school year. Individual goals are determined and the Pinocchio Associate works with the child 1:1 or in a small-group setting to improve the child's self worth and self-esteem. By gaining control of behavior issues, children are more successful in school, have improved peer relationships, and increase in their overall engagement level in their acedemic setting.

Outcomes Information –96% of children achieved one or more of their identified treatment plan goals, within one school year, as documented by the Pincocchio staff's individual treatment plan, the Child Associate (July through December: 95%). 99% of families reported an improvement in their child's behavior specific to their identified treatment plan goals, within one school year, as documented on parent surveys (July through December: 99%). 91% of classroom teachers reported an improvement in student behaviors for students receiving the Pinocchio Program, within one school year, as documented on teacher surveys (July through December: 92%).

Information from agency on the real, local data demonstrating success of the program – Pinocchio is an evidence based program with substantial research that illustrates the effectiveness of the program and it's interventions.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - For mental health providers, capacity to serve (aka funding) will always be our biggest roadblock. Crider can be cast in a negative light when we are over current capacity, and cannot readily admit someone in need of mental health services. We understand this and are sensitive to the position this places our consumers and co-providers in the system. Medicaid expansion would change the face of capacity issues. To date, Medicaid expansion does not seem to be a priority for our state.

Preferred Family Healthcare - Team of Concern

Project Description - There are many life situations that can put children at an increased risk of experimenting with alcohol and other drugs and potentially engage in other risky behaviors. Preferred Family Healthcare's (PFH's) Team of Concern (TOC) program provides early intervention and prevention services within all the public school districts in Lincoln County (Troy R-III, Silex R-I, Winfield R-IV, and Elsberry R-II). The goal of the TOC program is to strengthen children, families, and the community to ensure that every youth has a chance to overcome obstacles to live a healthy productive life. Team of Concern also provides individualized supportive services to at-risk youth, who are referred to the program.

TOC Universal Prevention activities are conducted by the School Teams Coordinator (STC) using evidence-based or promising practice models for service delivery. These activities are designed to align with both the Positive Behavioral Intervention Support programs and character education models in use in partner districts. This programming can easily be modified to meet the needs of both school districts and individual buildings on either an ongoing basis or as a situational enhancement. The prevention education/awareness component of the program will be presented in all Lincoln County school districts.

Eligibility Criteria – Youth admission in the TOC program does not require a specific clinical diagnosis. We offer a variety of resources for youth with varying levels of personal challenges. For example, individual sessions in the program range from a single, simple advice session, to a series of sessions focused on education and behavioral changes. Regular face-to-face interaction between the youth and the counselor is a factor in the program where the youth is able to address and resolve problems related to his or her alcohol/drug use or at-risk behaviors. The youth also will work on addressing resiliency skills, refusal skills, conflict resolution, emotion management, peer pressure, and positive friendships.

2013 LCRB Funding – $238,989

Unit Cost-Team of Concern Assessment - $138.16 per unit for 43 units ($5,941). Individual Counseling - $65.85 per unit for 385 units ($25,352). Case Management - $52.52 per unit for 684 units ($35,924). Presentation - $1,340.67 per unit for 9 units ($12,066).

Youth Served - 70 (24 clients carried over, 46 new clients)

2014 Requested Amount - $272,184

2014 LCRB Funding - $255,000 Amount Not Funded - $17,184

Unit Cost - Team of Concern Assessment - $149.60 per unit for 44 units ($6,582). Individual Counseling - $69.63 per unit for 665 units ($46,304). Case Management - $49.69 per unit for 424 units ($21,069). Presentation - $1,376.89 per unit for 9 units ($12,392).

Youth to be Served – 47

Other Sources of Funding – The Team of Concern program is currently funded through the LCRB.

Waitlist Information – 0

Information on when the program responds to mental health in the service delivery process- Through the initial assessment process, PFH evaluates the appropriateness of the youth for the Team of Concern program. If other areas of need are identified, PFH refers these youth to appropriate agencies. Additionally, if a youth is currently enrolled in the program and is experiencing mental health issues at any juncture of the program, Preferred Family Healthcare assists the family in connecting with appropriate resources.

Outcomes Information –96% of consumers gained knowledge about substance abuse and/or mental health issues. 94% of consumers identified as needing services beyond those provided through the Team of Concern program will receive appropriate referrals and will be admitted and/or attend one session of referral agency. 83% of consumers will develop risk-management skills to avoid risky behaviors. 83% of consumers will have improved school engagment and performance.

Information from agency on the real, local data demonstrating success of the program – According to the Missouri Department of Elementary and Secondary Education, the dropout rate for Lincoln County schools decreased from 6.9 in 2012 to 5.1 in 2013. In Lincoln County, 14.1% of youth reported that they believe it would be easy to get

drugs, such as cocaine, methamphetamine, and ecstasy, which represents a decrease from 19.9% in 2012 (Missouri Department of Behavioral Health, 2014). According to the Poison Control, the number of calls for synthetic and bath salt use has decreased. Additionally, Preferred Family Healthcare has received positive feedback from the school districts we serve regarding the impact of PFH services on student behavior/performance.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - Preferred Family Healthcare has had a high turnover rate in the programs. We continue to strive to fill these positions as quickly as possible in order to provide a seamless transition.

The Child Center - Sexual Abuse Prevention

Project Description - Sexual abuse and sexual assault prevention programs are presented to students, parents, and educators in Lincoln County schools in an effort to make these populations aware of sexual abuse and sexual assault. We teach skills to prevent, report, and respond to sexual abuse, sexual assault and Internet safety.

Eligibility Criteria – The eligibility for the Sexual Abuse Prevention program is age range, parent consent, and the schools consent to the program. The age-level appropriate contnent is determined by their grade. We present to first, fourth, fifth, and seventh grades. If it is our first time in the school, we will add second grade to the presentation using the first grade program's content. Parents have the option to allow or decline the presentation for their children on the Parent Permission Form. Parents can preview the program online to help them with this choice. Schools also determine if they want to schedule our program each school year.

2013 LCRB Funding – $19,637

Unit Cost-$377.64

Units - 52

Youth Served - 1,437 children, 265 parents viewed online materials, 61 professionals

2014 Requested Amount - $19,682

2014 LCRB Funding - $19,682 Amount Not Funded - $0

Unit Cost - $379

Units - 52

Youth to be Served –1,100

Other Sources of Funding – LCRB is the only funding source for this program in Lincoln County.

Waitlist Information – None

Information on when the program responds to mental health in the service delivery process- There are multiple times during prevention programs that mental health is addressed. Before a presentation, the school counselor will let the presenter know if there is a child that has been sexually abused that will be present during the program. The child's parent/guardian has marked on the permission form that they would like them to attend the program. The school counselor and the presenter will monitor the reactions and emotions. The school counselor is expected to attend all programs for first and fourth grades. During the program, students may make a verbal partial/full disclosure. At the end of the presentation students are asked to take an assessment to determine if they demonstrate the ability to identify all four of the Bill of Body Rights and have a clear understanding of the Touching Safety Rule. This is also a time that students can mark the box indicating that they would like to talk to the counselor in private about the topic. Students may write any questions or comments in this area of the assessment. Mental health is assessed and addressed at all of the above times. Response to mental health looks different at

each time. Before and during a presentation mental health is monitored and noted by the counselor and prevention specialist. After a program, the counselor will meet with the student individually to evaluate actions that need to take place The prevention specialist will follow up with the counselor to help validate and address proper action.

Outcomes Information –75% of preschool, 1st and 4th grade students attending schools in Lincoln County, who participate in the prevention program, will report learning their "Bill of Body Rights," the four steps to protecting against and reporting sexual abuse, by the end of the classroom presentation-Goal exceeded. 75% of students attending schools in Lincoln County will report learning how incidents of sexual harassment at school get reported and what the consequences are for such behavior by the end of the classroom presentation. Additionally, 50% of students will share in writing one change they are willing to make to help reduce sexual harassment at the school--Goal not achieved as TMS cancelled presentations, saying can't reference "sex" in any way. 75% of educators and community-based professionals employed in Lincoln County who attend the program will report learning about the dynamics of sexual abuse; know their responsibility as a mandated reporter in the State of Missouri; and how to appropriately handle a child's disclosure by the end of the presentation--Goal exceeded. 75% of 5th grade students attending schools in Lincoln County who participate in the Online Enticement Prevention program will demonstrate learning Internet safety and how incidents get reported by the end of the classroom presentation-Goal exceeded.

Information from agency on the real, local data demonstrating success of the program – Using current, local data collected by The Child Center, Inc. and evaluated by Dr. Cyndi Berry, our outcomes for the Bill of Body Rights were: 95% of the students identified that you need to say no to the individual. 96% of the students identified that you need to go to a safe place. 93% of the students identified that you need to tell an adult you trust. 93% of the students identified that you need to keep telling until you are believed. 88% identified all four statements correctly on the post-test. Dr. Cyndi Berry was able to measure a major shift in how the youth who attend this program view the Touching Safety Rule. Students were asked before the program, who is more likely to break the Touching Safety Rule. 33.8% stated that the Touching Safety Rule is most likely to be broken by a person that you know and trust, such as people we like, love or live with, compared to 72.5% on the post-test.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - At this time our biggest roadblock encountered is scheduling with the middle schools.

ThriVe– Best Choice Sexual Integrity/Abstinence Program

Project Description - The sexual integrity program encourages abstinence outside of marriage with a particular focus on teens 12-18. The science-based Best Choice Sexual Integrity program empowers middle school and high school students with inspiration, motivation, reasons, skills and support to choose abstinence/delay from sexual behaviors until marriage. ThriVe's program has a strong focus on the benefits of healthy relationships, boundaries and behaviors and discusses topics, such as sexually transmitted diseases, media influence, risky behaviors, healthy choice, brain chemistry and consequences of teen pregancy. The curricula provides medically accurate, culturally sensitive information and activities to young people at a critical time in their development.

Eligibility Criteria – The program is presented to all middle schools and high schools who are interested in getting the Healthy Choice message to the students.

2013 LCRB Funding – $0

Unit Cost-NA

Units - NA

Youth Served - NA

2014 Requested Amount - $10,220
2014 LCRB Funding - $10,000 Amount Not Funded - $220
Unit Cost - $500
Units - 20
Youth to be Served – 400
Other Sources of Funding – Also funded by CCRB.
Waitlist Information – None

Information on when the program responds to mental health in the service delivery process- N/A

Outcomes Information –Clinical goal 1: 12% increase of students who indicate they intend to be sexually abstinent until they are married between pre- and post-survey. Clinical Goal 2: 60% of students who complete our program will state they will talk to their parent(s) about sexual behavior. Clinical Goal 3: 70% of students who complete our program will state they have the information they need to say "no" to sex if that's their choice. (Note that program funding began FY2014)

Information from agency on the real, local data demonstrating success of the program – This is our first year with LCRB, so we have no data at this time.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - The school's board members and parents are fearful about this program. They assume the students are being misinformed, or they think the students are not sexually active. We're trying to educate, empower and equip the students with the correct information.

Teen Parent Services

To become productive citizens, teenage parents require special support for developing parenting skills, completing their education in order to gain employment, and obtaining adequate counseling and health care services. If their family and community do not support them, teen parents are vulnerable to long-term dependency on welfare resources. Furthermore, due to the increased stress of their situation and living conditions, they are at a greater risk of abusing and/or neglecting their children.

Currently, Lincoln County does not have a residential maternity group home. The only nearby facility is the Our Lady's Inn, which is located in New Melle in St. Charles County. This facility accepts 18 year-old or older women, as well as emancipated 17 year-old women. The capacity of Our Lady's Inn is 14 residents and they also accept minor children dependents.

Past services were provided through the Youth in Need Teen Parent program, which ended after the FY2009. Recurring problems with finding appropriate personnel resulted in Youth in Need's decision to not apply for funding since then. Parents as Teachers (PAT) of Lincoln County served a total of 26 teen mothers in 2011, providing them with a variety of support services and parent education. (Parents as Teachers, 2012)

Temporary Shelter Services

Temporary shelters can provide services for abused, neglected, runaway, homeless or emotionally disturbed youth for up to 30 days. Temporary shelters provide a safe haven for children and youth who face these difficult and even dangerous situations. Many of these youth have exhausted their resources and can no longer "couch hop" with friends and relatives, which leaves them vulnerable and left to their own defenses. Left on the street, these youth often turn to crime in order to eat, and they are often at great risk of being a victim of an assault themselves. This situation is particularly risky for female youth who can become a victim of a sexual assault or who could be lured into prostitution just to gain shelter and food. Shelters provide services to meet the basic needs of nourishment, housing and safety for up to 30 days while providing counseling, group therapy, family counseling, and support to re-enter school and find work. When it is clinically appropriate, and where there is no risk of abuse to the youth, the goal is to reunite families.

Currently, Lincoln County does not possess a temporary shelter facility. A temporary shelter facility is located in neighboring St. Charles County, and its services could be replicated should a shelter be built, located or other solution identified for Lincoln County. Youth In Need operates a 12-bed emergency shelter in St. Charles County and has been providing these services for over 28 years. They are nationally recognized as a model for these services. They operate a 24-hour crisis hotline dispensing advice and referrals.

A youth would have to be motivated to seek services in St. Louis or St. Charles County, and neither facility is convenient for parents who are interested in reunification. Adding to the problem is access for the youth. Since most youth who are homeless or have run away do not have transportation, getting to Youth in Need's facility is an issue. Once they get there, these youth run a great risk of not having a bed available. The number of beds at this facility has not increased since its opening in 1974.

It is estimated that the current need would be addressed with a two-bed unit/facility, with plans for a four-bed unit/facility (or some combination of) to allow for anticipated future needs. In addition, if you combine the need for this service with options for teen parents and transitional living, all of these needs could be at least minimally addressed with a four-bed shelter accessible somewhere in the community and paired with oversight, supervision and other comprehensive services.

Respite Care Services

Respite care services offer temporary emergency shelter and services for children of families experiencing a crisis that may increase the risk of child abuse or neglect. In addition to providing a safe haven for children, respite care workers also work with parents to help them learn age-appropriate expectations and coping skills to deal with stress. It is the hope that through the provision of these respite services that the generational cycle of violence and abuse can be broken. For families who have a child with a serious emotional disturbance, a few hours of respite on a regular basis can mean the difference between keeping a family together and having their child enter a residential facility.

Risk factors such as divorce rates, children in single parent households, and financial stress all increase the need for respite care services.

This service was newly funded by LCRB since the last needs assessment report of 2012. Furthermore, local facilities do exist with Family Support Services and Youth in Need. In 2013, Crisis Nursery of Wentzville received $38,995, which allowed them to serve 69 families. They requested $48,451 for 2014 of which $45,000 was awarded, representing a gap of only $3,510. They aim to serve 70 families in 2014.

Crisis Nursery Wentzville– Respite Care

Project Description - The Crisis Nursery provides a safe respite for Lincoln County children, birth through age 12, whose families are experiencing a crisis. Children may be admitted to the Crisis Nursery for any circumstance that jeopardizes their safety and well-being and necessitates temporary separation from their parents. The most common reasons for admittance include: risk of child abuse or neglect, overwhelming parental stress, domestic violence, lack of shelter, food or utilities, and or drug/alcohol-related crises. Children are provided: a medical exam, developmental assessment, three meals and three snacks daily, therapeutic activities, and many take-home supplies/toys. Parents receive crisis counseling, community resource referrals, and follow-up support services.

Eligibility Criteria – Families that live in Lincoln County, have children under the age of 12, and no support system are able to use respite care. These families are then invited into our Family Empowerment program.

2013 LCRB Funding – $38,995

Unit Cost-$11.00

Units - 3545

Youth Served - 69 unduplicated LC families; 71% under age 6

2014 Requested Amount - $48,510

2014 LCRB Funding - $45,000 Amount Not Funded - $3,510

Unit Cost - $11.55

Units - 3896

Youth to be Served – 70

Other Sources of Funding – Crisis care contract with the Children's Division.

Waitlist Information – None

Information on when the program responds to mental health in the service delivery process- During phone inquiry for service, during intake, during discharge, and throughout the Family Empowerment program. We respond with referrals, offer counseling services, etc

Outcomes Information –96% of families reported not having a substantiated child abuse hotline report while involved with CNW. 99% of children continued to reside in their natural family homes. The immediate crisis was resolved resolved in 75% of families calling the 24-hour helpline.

Information from agency on the real, local data demonstrating success of the program – 99% of the children that receive respite care return home with their families and do not go into foster care.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - Transportation for families.

Transitional Living Services

In order to develop independent living skills and become productive adults, homeless youth require more help than just housing assistance. They need counseling services, assistance with utilizing community resources in job training and education, and life-skills training and development (*National Network for Runaway Youth Services*; *U.S. Department of Health and Human Services, Administration for Children, Youth and Families).*

Counseling and related services, as part of a transitional living program, are about successfully supporting and reintegrating a young person from a homeless and hopeless arrangement into a safe living space with opportunities for developing independent life skills. Such services provide assistance with finding jobs, pursuing educational goals, developing healthy peer and community relationships, and living independently in the community.

No transitional living facility exists in Lincoln County and the facility in St. Charles County, operated by Youth in Need, is unavailable, as it is serving at capacity throughout the year. Their expertise could be sought when developing a transitional living home locally in Lincoln County. The absence of such a program leaves these youth homeless and without educational, employment, and counseling services to remain in Lincoln County.

The concentrated program for homeless prevention and awareness, delivered by Sts. Joachim and Ann Care Service, assists families with children who are homeless or on the verge of homelessness. In 2012, the Homeless Count, conducted by the Community Council and led by the Continuum of Care, identified 107 Lincoln County individuals "doubled up" and 22 truly homeless individuals. For 2014, the one-day homeless count identified 17 adults and 13 children who were truly homeless. This information is not inclusive of the school report and data from the Robertson Center. The winter of 2014 was incredibly harsh, which may have decreased the search committee's chances of finding truly homeless individuals. Many local sources, including the police departments, gas stations, food pantries and local motels were contacted for the homeless count. Families have approached the Sts. Joachim and Ann Care Service looking for direction and resources for this population.

The cost to the County: $25,000 per year for a youth in jail and $10,000 per year for a youth on public assistance.

Home and Community-based Family Intervention Services

Home-based, community-based and school-based family intervention programs seek to: 1) stabilize families and prevent the unnecessary hospitalization of children and youth; 2) prevent placement of children and youth away from their homes; 3) encourage family support services in the home to provide support and guidance for successfully mobilizing and completing treatment for a child or youth with a serious emotional disturbance (SED); and, 4) identify and provide services to children and youth with intensive mental health needs.

According to the *Missouri Department of Social Services*, over half of the children and adolescents who are hospitalized, placed in residential treatment programs, or placed in foster homes could remain with their own families and have better long-term outcomes if the family could receive timely intensive home-based, community-based or school-based services.

The *LCRB* funds a variety of services with local providers for home-based, community-based and school-based programs. In 2013, they provided a total of $229,868 for these programs, which served 794 youth. The total request of LCRB in 2014 was $257,100 of which $242,642 was granted. This represents a gap of $14,458 based on the need identified by the agencies. These programs estimate serving 617 youth in 2014.

F.A.C.T. and Crider Health Center– Partnership With Families (Parent Partner Program)

Project Description - F.A.C.T. hires parents that have children with emotional disorders to support the families in the Partnership With Families (PWF; linked to Crider) program. F.A.C.T. uses a peer-to-peer model that offers support, guidance, and resources from someone who has been through similar experiences. The Parent Support Partners (PSP's) help to enhance the family's ability to advocate successfully for the programs/services that meet the needs of their children and their families.**Eligibility Criteria –** The families must have a child with a mental health diagnosis, and must be receiving Medicaid or be eligible for Medicaid.

2013 LCRB Funding – $40,018

Unit Cost-$34.00
Units - 1,177
Youth Served - 74 children (15 new referrals)

2014 Requested Amount - $48,816

2014 LCRB Funding - $42,012 Amount Not Funded - $6,804

Unit Cost - $36.00
Units - 1,167
Youth to be Served – 60

Other Sources of Funding – F.A.C.T. partners with Crider Health Center in providing the Partnership With Families Program. This program is provided in Lincoln, Franklin, and St. Charles Counties. In order to receive funding from Medicaid we must subcontract through Crider.

Waitlist Information – None

Information on when the program responds to mental health in the service delivery process- Referrals come from the Crider Health Center. Crider determines whether or not a child has an eligible mental health diagnosis. They do the assessment as well as the identification. If a family contacted us for services, we would fill out the necessary paperwork, and then send that paperwork to Crider for entry into the program. When the referral is received, the parent of the diagnosed child is contacted to set up an appointment. F.A.C.T. does not work directly with the child, but rather directly with the parent. Parents/guardians are served so that they in turn can support their child/children. Information is offered on how to access local resources, as well as what resources are available to begin with. F.A.C.T. assists with getting immediate needs met both for parents/guardians and the child/children. Support is family driven, meaning that the family determines what they need and how F.A.C.T. can support them in addressing those needs. All of the services focus on empowering the parent so that they have the skills necessary to support their child.

Outcomes Information –75% of parents will have the support, information, training and resources to seek the school placement of their choice for their child.-Goal exceeded. 90% of children at risk of out-of-home placement will remain with their families after six months of service.-Goal exceeded. 80% of parent's seeking "Positive Behavior Support Plans" at school will have the support, information, training and resources to implement them.-Goal exceeded. 80% of children with a "Positive Behavior Support Plan" will experience greater success (less out of school suspensions and disciplinary incidents) in the school environment.-Goal exceeded. 60% of parents will increase their ability to advocate for their child and themselves, with decreasing PSP support across time.-Goal exceeded.

Information from agency on the real, local data demonstrating success of the program – The science and success behind peer-to-peer support models is well documented nationally and locally. Medicare & Medicaid Services (CMS) has published the following results in their information bulletin relative to the Parent Support Partner services provided in conjunction with Comprehensive Psychiatric Services (http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf):

•Reduced costs of care. State Medicaid agencies' annual costs per child were reduced significantly within the first 6 months.

•Improved school attendance and performance. After 12 months of service, children and youth improved their school attendance and improved their grades as compared to those not participating in the program.

•Increased behavioral and emotional strengths. These strengths include the ability to form interpersonal relationships, positive connection with family members, positive functioning at school, ability to demonstrate self-confidence.

•More stable living situations.

•Improved attendance at work for caregivers. Caregivers who were employed at intake reported missing an average of 6.2 days of work in the 6 months prior to participation in the program due to their child's behavioral or emotional problems. This decreased to 4.0 days at 12 months of program participation, and to 2.8 days at 24 months of program participation.

•Decreased contact with law enforcement. For youth involved in the juvenile justice system, arrests decreased by nearly 50 percent from intake into the program after 12 months of service.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - We have encountered transportation issues for families who have wanted to attend our support groups, but do not have gas money or transportation to do so.

Nurses for Newborns (NFN)– Putting Infants First In Lincoln County

Project Description - This program focuses on infants between the ages of 0 (which may include the prenatal mother) and 2 years of age, who reside in Lincoln County at the time services are provided and who are at highest risk for infant mortality, child abuse, and child neglect. Because the infant is dependent on the mother and/or caregiver(s), attention is paid to assessment and screening of the mother/caregiver as well as training in parenting skills, infant assessment, child development screening and referral to resources needed, which have been identified during nursing in-home visits. NFN's programs address the community's need to assure the survival, health and emotional well being of infants and their mothers or caregivers.

Eligibility Criteria – NFN accepts all referred pregnant women and mothers with new infants who have health or safety risks. Upon the first visit, the nurse will evaluate the risks of the infant and caregiver and assess the support they may have from any other program to determine whether ongoing NFN services will be needed. This means that virtually all referrals are accepted for at least the first visit unless the caregiver or referring agent is seeking services not performed by NFN or is only seeking material assistance (such as an infant crib) and not the comprehensive home visiting program that NFN provides.

2013 LCRB Funding – $13,590
Unit Cost-$117.99
Units - 115.18
Youth Served - 21 (2 prenatal)

2014 Requested Amount - $15,575

2014 LCRB Funding - $15,575 Amount Not Funded - $0
Unit Cost - $121.68
Units - 128
Youth to be Served – 17

Other Sources of Funding – Other sources of funding that help with the cost of NFN's in-home visits to infants in Lincoln County include Missouri's Children's Trust Fund, Missouri's Home Visitation Program, Alternatives to Abortion funds and individual, corporate and foundation donations.

Waitlist Information – None

Information on when the program responds to mental health in the service delivery process- Although sometimes referral sources may identify a mental health need for a referred client, usually assessment of mental health issues begins during the first visit to the caregiver's home when the nurse completes the Edinburg Depression Screening and assessment of individual and family stressors (Everyday Stressors Index). The screenings and assessments may require completion during the second home visit. Depending upon the scoring regarding mental health risks, the nurse will assist the caregiver with referrals to appropriate resources within NFN (such as the CBT therapy provided by a LCSW home visitor) or community resources within the LCRB family of agencies or other area mental health resources. At times, this may require immediate referral and engagement of emergency resources (such as law enforcement if suicide or homicide may be an imminent risk, or BHR for immediate assessment of high-risk conditions and admittance to inpatient mental health treatment) but more frequently is addressed by internal or community resources that are more accessible and acceptable to the caregiver. The nurse then monitors the caregiver's progress with treatment in subsequent visits, and assists the caregiver with any barriers she/he may

encounter in utilizing the mental health services. Referral, progress, and follow-up are noted in the infant/caregiver's electronic medical record.

Outcomes Information –Caregivers will gain knowledge of positive parenting. 80% of the parents will gain knowledge about positive parenting as measured at 6 months of service using the AAPI.-Goal exceeded. Infants will not suffer child maltreatment. 95% of clients will be free of substantiated incidents of child abuse and neglect during the project period.-Goal exceeded. Infants will achieve appropriate developmental progress. 90% of children will score within two standard deviations of the national mean on their 12 month ASQ3 screening.-Goal exceeded.

Information from agency on the real, local data demonstrating success of the program – As noted in the reports submitted to LCRB and via site visits, outcomes for the clients visited by NFN are very positive and in most categories exceed target outcomes. These include the following objectives and actual outcomes for the most recent evaluation period: Objective #1: 85% of the infants completing the program will not have a substantiated report of child abuse or neglect during their first year of life. FY13 Measurement: 99% of the infants completing the program did not have a substantiated report of child abuse or neglect during their first year of life as evaluated by the Missouri Department of Family Services. Objective #2: 75% of the mothers completing the program will have their infants completely immunized by age 6 months. FY13 Measurement: 90% of the mothers completing the program had their infants completely immunized by age 6 months as evidenced by ongoing monitoring and verification of immunization records provided. Objective #3: 80% of the infants in the program will not be re-hospitalized for preventable causes. FY13 Measurement: 99% of the infants in the program were not re-hospitalized for preventable causes as evaluated by self-report, nurse monitoring, and verification with hospitals as needed. Objective #4: 90% of the infants in the program will not sustain an injury from a household safety hazard. FY13 Measurement: 98% of infants served did not sustain an injury from a household safety hazard as evaluated by self report and nurse observation. Objective #5: 90% of families will have a "medical home" to receive regular primary preventive medical care regardless of insurance status or ability to pay. FY13 Measurement: 98% of families had a "medical home" to receive regular primary preventive medical care regardless of insurance status or ability to pay as evaluated by self-report, nurse monitoring, and verification with providers as needed.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - The greatest challenge for some families is caregiver transportation to needed services. Another challenge is transitional housing.

Sts. Joachim & Ann Care Service – Child & Family Development

Project Description - The Sts. Joachim & Ann Care Service (CS) utilizes the Social Service Case Management Model and strengths-based approach to provide wraparound services aimed at addressing the immediate and long-term needs of children who are homeless, on the verge of homelessness or in crisis. In addressing the needs of the child the whole family system is evaluated. Basic and educational needs are assessed as are the physical and mental health needs of the child and family. Maintaining each child's core needs is essential to ensuring stability and promoting better school performance and participation in extracurricular activities. The Care Service addresses the goal "Children require stability and a safe and stable home" by making referrals both inside and outside the agency, thus providing the necessary services to be reintegrated into the mainstream activities of the community.

Sts. Joachim & Ann Care Service works with the parents, family support systems, school districts, social service agencies, churches, and civic organizations to keep children safe, families in their homes, and children in school. Financial assistance, counseling, referrals and providing resources to families all reduce the family's propensity for homelessness, abuse and neglect.

Eligibility Criteria – In order to be eligible for the Child and Family Development Program through the Care Service, the family must be homeless or at risk of becoming homeless in addition to the following requirements: one must have children under the age of 18 in their custody; have lived in Lincoln County for at least six months; and they must be at or below 50% of the area median income for Lincoln County according to HUD. A family may be ineligible if they have children in the home over 18 years old; they do not have legal custody of the children in their home; if they exceed the 50% median income guideline according to HUD; or if they have not resided in the county for at least 6 months.

2013 LCRB Funding – $135,943

Unit Cost-$72.08

Units - 1,886

Youth Served - 459 children (317 adults, 212 families, 40 homeless families)

2014 Requested Amount - $152,393

2014 LCRB Funding - $144,739 Amount Not Funded - $7,654

Unit Cost - $63.26

Units - 2,288

Youth to be Served – 300

Other Sources of Funding – Other funds that have or will be used for the Child and Family Development Program include: MHTF emergency funds, MHTF Long Term rent, Housing First rent, and Dollar More. These funding sources provide for the direct financial housing assistance that goes to the families in need.

Waitlist Information – The Care Service does not utilize a wait list but rather a priority system. This system is based on three priorities. Priority 1 states that the client is literally homeless (on the street or in a car). This would be the highest priority when deciding if and when an appointment is needed. Priority 2 would be the next highest and states that the client is in a hotel/motel or shelter, or "doubled up" with family or friends. Priority 3 is the last priority when scheduling appointments and states that the client is at risk of eviction or foreclosure, or has a utility disconnect with a housing voucher/income-based housing.

Information on when the program responds to mental health in the service delivery process- All children actively working with the Social Service Worker have their physical and mental health status reviewed within 30 days of certification. The first step of this process is to build rapport to assess the family's physical/emotional strengths and needs. A comprehensive assessment, constructed based on best practices, is completed with the family in their natural environments. The needed information is obtained through parent report, Social Service Worker observations, school documentation/ phone calls, and information from other health professionals and/or other agencies that the family may be working with. When the above sources indicate a concern with one of the family members, the Social Service Worker will make the appropriate referrals to outside resources. The family's physical/emotional health is addressed during the initial home visit followed by regular monitoring through follow-up visits. The Social Service Worker will additionally attend meetings with the family and any other agencies working with them, if it is felt that the family does not have the resources or capability to follow the process.

Outcomes Information –100% of parents involved in this program will be informed of their children's educational rights by law within one week. 100% of the school-aged children will be enrolled in school within 7 days of entering the program. 100% of the school-aged children with special needs will be enrolled in school within 14 days of entering the program. Goal 2: Improvement of child's/family's basic needs--food, clothing, health, financial status--where 100% will have access to the Care Service's Direct Services, which include, but are not limited to, financial assistance, counseling assistance, food pantry, workforce development, energy assistance, and additional seasonal programs such as Adopt-A- Family. 100% of the children will have a review of their physical and mental health status within 30 days of certification and then on a biannual basis. 100% screened for eligibility for referral to mainstream financial resources such as: SSI, TANF, VA, SS Disability, Medicaid, Food Stamps, WIC within 30 days of certification and then on a biannual basis. Goal 3: To keep children safe and healthy during the high-risk period of homelessness and the stabilization process, where 85% will show one movement on the scale in one area of the physical and one area of the emotional well-being assessment component within twelve (12) months of the certification. Goal 4: Strengthen connection to social support systems, where 85% will be re-engaged or newly engaged in various social activities such as Big Brothers/Big Sisters, school and/or church activities and support groups within six (6) months of the certification. Goal 5: To find permanent homes for homeless children, where 70% of the children will be in stable housing within six months. This percentage is lower than the other outcomes based on the fact that this is contingent on having a significant amount of funding to allocate for financial housing assistance. Goal 6: To provide County-wide educational seminars regarding the homeless situation in Lincoln County including the resources to help families in need, and participate in local community forums (minimum of 8 per year).

Information from agency on the real, local data demonstrating success of the program – Up to 2012, Lincoln County had seen a major spike in its poverty rate while the population growth plateaus. Those in poverty are at a high-risk of becoming homeless. In the previous four years, the rate of poverty had increased 44.8%. From 2011 to 2012, poverty rates decreased almost 6%. In this same period of time, CS was funded by Lincoln County Resource Board for an increase to a 1.5 FTE staff dedicated to responding to families at risk of homelessness/those in poverty. In 2011, 252 youth were served with the CS-funded program compared to 441 youth in 2012, and then 459 youth in 2013. 80-90% of the youth served in 2012 and 2013 were assessed to be in stable housing six months past receipt of our services. This program targets low-income households with children and focuses on improving the components of the child's environment, but most importantly to secure/place the child in a stable home environment with financial housing assistance.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - The biggest roadblock, in addition to funding, would be transportation. The Care Service provides many of the needed resources for our clients at the main office, but many times it is too far for the clients to drive and/or find a ride in order to utilize these services.

The Child Center– Family/Child Advocate

Project Description - The Family Advocate provides crisis intervention, referrals, and continuous support to the non-offending caregiver(s) of a victim of alleged sexual abuse, and the entire family. The Family Advocate works with the family and multi-disciplinary team to ensure the child(ren)'s safety in the home as well as to reduce the risk of renewed maltreatment of the child. The Family Advocate is there to educate non-offending caregivers on their roles in the investigative process and to empower them to rebuild a safe and stable home. The Family Advocate's mission is to support non-offending caregivers to facilitate protection and support for child victims. Some of the services

include: providing emotional support, creating a safety plan for the family, helping the family understand the legal and child protective system, and assisting the family with resource referrals for requested/needed services, such as counseling, housing, transportation, education and finances.

Eligibility Criteria – The eligibility for this program is that the caregiver receiving services is not the offender and there has been an allegation of child maltreatment. The caregiver must express a willingness to protect the child and the reported perpetrator can no longer be in the home and does not have unrestricted access to the child. The non-offending caregiver expresses a willingness to work with the Family Advocate and exhibits ongoing cooperation with services/referrals provided.

2013 LCRB Funding – $40,317
Unit Cost-$27.04
Units - 1,491
Youth Served - 240 children (106 families)
2014 Requested Amount - $40,316
2014 LCRB Funding - $40,316 Amount Not Funded - $0
Unit Cost - $27.04
Units - 1,491
Youth to be Served – 240 children
Other Sources of Funding – None
Waitlist Information – None

Information on when the program responds to mental health in the service delivery process- Mental health can get identified, assessed and/or addressed as early as the first contact with the family member and/or multi-disciplinary team member. At that time resources are discussed, referred and/or implemented by talking directly with the family member and/or multidisciplinary team member. Counseling referrals are given through a phone call and/or after a child has been at The Child Center, Inc. for a forensic interview. Crisis counseling can be provided through phone calls and/or during meetings in person.

Outcomes Information –95% of clients referred to the Family Advocate for services will understand and abide by the child protective services safety plan to ensure the child's physical safety, and will demonstrate their ability to provide safety and stability for their child(ren) and use of the identified and needed resources available, during FY13.-Goal met.)—"90% of clients receiving services from the Family Advocate will have an understanding of the legal and child protective services and will demonstrate this through their responsibility to only support the child and to not interfere with the investigative process by gathering case facts, during FY '13.-Goal met. 1.)—"75% of clients will demonstrate their ability to protect their child(ren) by continuing to participate with the Family Advocate and/or any of the recommended support systems during FY '13.-Goal exceeded.

Information from agency on the real, local data demonstrating success of the program – The positive outcomes of our program are validated through our follow-up phone calls, work with other agencies in the community, counseling reports, and prosecution of offenders.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - Families scheduling counseling with therapists right away.

Therapeutic Mentoring Services

Therapeutic mentoring services are designed to help youth develop a positive set of values, improve family relationships, and reduce problem behaviors by teaching alternative skills and coping patterns. The mentors also worked closely with parents to identify and build upon their strengths and offer guidance regarding effective parenting strategies.

A national research report released recently found that mentoring is one of the keys to academic achievement and keeping students in school and on track. This new research reinforced the growing body of evidence that mentoring is also a critical asset in helping America's disconnected young people to persevere and find pathways to meaningful and productive lives*. (America's Promise Alliance, Civic Enterprises and Peter D. Hart Research Associates, 2012)* Therapeutic Mentoring is a newly funded program for LCRB since the 2012 Needs Assessment. In 2013, Presbyterian Children's Homes and Services received $37,998 and ended up serving 55 youth in 2013. This agency requested $56,545 in 2014, and was granted $44,993. This difference identifies a gap of $11,552 to serve the youth. With the 2014 funding, this program estimates they will serve 50 youth.

Presbyterian Children's Homes & Services– Therapeutic Mentoring Services

Project Description - A community-based program designed to provide therapeutic support to high-risk youth utilizing the practice of one-to-one mentoring by a trained adult mentor, focused on youth goal attainment and reduction of risk factors and at-risk behaviors.

Eligibility Criteria – To be eligible for therapeutic mentoring, the youth must be a Lincoln County resident between the ages of 6 and 19 and be at risk for poor outcomes in any key life domain areas such as school, home, mental health, and/ or be at risk for child abuse and neglect or juvenile justice system involvement. Exclusionary criteria include: actively suicidal or homicidal.

2013 LCRB Funding – $37,998

Unit Cost-$13.98

Units - 2,718

Youth Served - 55 youth/children

2014 Requested Amount - $56,545

2014 LCRB Funding - $44,993 Amount Not Funded - $11,552

Unit Cost - $20.14

Units - 2,234

Youth to be Served – 50

Other Sources of Funding – LCRB is currently the sole funder for this program. The agency is pursuing funding opportunities through grants and donations to increase the number of youth served in 2014 and beyond. At this time we are also applying to the Cuivre River Energy Cooperative.

Waitlist Information – 10

Information on when the program responds to mental health in the service delivery process- The first time that mental health needs are identified is on the Intake/Referral/Assessment form, which is completed by the referring party and the parent. The second point of mental health identification happens when the therapeutic mentor begins providing services. Often times, mental health needs are communicated by school personnel, or other professionals, to the Mentor Coordinator at the time of referral. When services are not in place to address specific mental health needs that are beyond the scope of the therapeutic mentoring program, the Mentor Coordinator makes a referral to services on behalf of the family (and with the family's consent) and provides a "warm transfer" to facilitate the child's engagement with those services.

Outcomes Information –1: 85% of clients will have improved school engagement and performance.-Goal exceeded. 2: 90% of clients will have improved relationships with family members, caregivers.-Goal exceeded. 3: 90% of clients will be free of substantiated incidents of child abuse or neglect.-Goal exceeded. 4: 90% of clients will have no out-of-home placements.-Goal exceeded. 5: 85% of clients will develop self-management skills-Goal exceeded. 6: 80% of clients will remain free from law enforcement involvement.-Goal exceeded.

Information from agency on the real, local data demonstrating success of the program – Our mid-year and annual report to the LCRB highlights specific outcomes achieved during 2013. Our current group of clients report satisfaction with services. Data for the mid-year 2014 report to the LCRB will be available in June. We continue to assess the strengths and benchmarks of success through an automated data collection system, pre- and post-measurements of the Child Global Assessment Scale, and Family Support Outcomes surveys. As of May 2014, the program's outcomes are being met across all of the stated objectives.

Agency's greatest roadblock that hinders utilization or effectiveness in addressing a need - Many students live in the more rural parts of the county so travel time can make it challenging for mentors to spend more than 2 hours with the youth each week. We have attempted to address this issue by recruiting mentors from each of the local communities within Lincoln County. Lincoln County also presents a unique challenge of not having many youth activity resources/places where mentors can interact with the youth in their residing communities.

Agencies' Prioritized Needs – What Comes Next

In the section above and on Table 33, information was presented regarding funding gaps specific to LCRB-funded agencies as derived from the agencies' 2014 grant requests. A total of $91,008 was not funded as requested by the agencies in 2014. Through the 2014 survey process, agency contacts were asked what they would fund next if funding were available. In addition, agency contacts provided the estimated cost to provide this service using current figures. This information can be seen in Table 34, with individualized cost information given to the Consultant. Here is a summary of those prioritized needs listed in no particular order of importance:

- Pediatric Psychiatric Services – more effective if provided on-site in the school setting.
- Additional mental health supports/providers in the school setting.
- Additional social workers to conduct home visits and work with parents and families on coaching and counseling.
- Support for families who have children with mental health diagnoses above and beyond those with Medicaid. Reach families before a crisis.
- Provide services to infant caregivers who have a psychiatric diagnosis or other mental health issue.
- Provide supportive therapeutic services to youth who are identified as high risk for substance use/abuse.
- Provide additional therapeutic services to youth in the various, untapped school districts, specifically Elsberry, Silex and Winfield.
- Provide an additional social service worker to reach the homeless and at-risk homeless population in Lincoln County.
- Shelter/accommodations for those youth in need in Lincoln County.
- Provide an additional full-time Child Sexual Abuse Prevention Provider for Lincoln County schools, identified as the first step for a child to disclose or know when and how to disclose.
- Allow for an additional therapist to respond to victims of child sexual abuse.
- Expand the Sexual Integrity program to additional middle and high school students.

The last question posed to the LCRB-funded agencies asked if there are other providers or programs in Lincoln County that would enhance the effectiveness of our local system of care, and; therefore, should be considered for funding. The areas the agencies identified in Table 35 include:

- Nurse Practitioner to prescribe psychiatric medications (which would require a psychiatrist as well)
- Educational Advocacy
- Transitional housing
- Cross collaboration from multiple agencies and the school districts to promote sharing of information and partnering of services for the benefit of the community. Getting information to parents about currently available resources.
- Partnership of services provided to homeless children and children at-risk of homelessness with the Bright Futures program to fill in service needs that are present, but not provided by the Care Service.

The Executive Director's View

What program category should be funded next based on your understanding of the needs of the respective county?

Transitional living programs: Lincoln County's children and youth greatly need a safe, stable place to reside as they work with our providers to emerge from crises, such as homelessness (it can take 24 hours or more for providers like Sts. Joachim and Ann Care Service to process qualified candidates). Furthermore, abandoned and homeless teens currently don't qualify for their services unless they are part of a "family unit" or they themselves have a child in the home. Being pregnant does not qualify these teens for the program, leaving many teens in our community homeless, or at higher risk of domestic violence and or abuse in the home (substance, physical, sexual, etc.).

What do you estimate to be the annual cost to fulfill this unmet or under-funded need? Please explain how you calculated this information and how many individuals would benefit.

The estimated cost remains undetermined as a transitional living program could be structured in many different ways. For example, the Lincoln County Health Department is currently exploring the option of building a facility on vacant property the department owns at its current location, #5 Health Department Drive. If this scenario materializes, it could open the door for the LCRB to lease space for programs and partners.

Another potential partnership/option could emerge through our partnership with Bright Futures Lincoln County and our local ministerial alliance. I'm personally aware of a couple churches in our community where deceased parishioners bequeathed their homes. Here, we could partner on a potential lease for space and bring our funded providers into the home to support our kids and their mental health needs.

One model we could examine, which provides shelter with services to address mental health needs and promote future independence through teaching life skills, is the Our Ladies Inn in St. Charles, (**http://www.ourladysinn.org/aboutus/history.html).**

I've also been told that our provider, Sts. Joachim and Ann Care Service, offers a transitional housing program in St. Charles County that I'd like to learn more about. Regardless of the model, I'd like to consider expanding our program so that both male and female youth could benefit.

Is there another provider or program you can think of that would enhance the effectiveness of our local system of care?

1. School-based social worker; although, this might only be an option if funded through the district. Further research is required to determine feasibility.
2. Youth in Need, which could potentially fill the transitional housing void noted above.
3. Expanding the therapeutic mentoring program based on its effectiveness in reaching kids with varying degrees of mental health needs and ability for mentors to get inside the homes of our kids and work with their caregivers.

What are the top three greatest, common issues and/or problems that you hear from stakeholders need attention/focus in the respective County? 1 prioritized as the greatest issue/problem/need.

1. Transportation
2. Poverty—driving and escalating mental health issues among our youth and serving as a catalyst for risky behaviors, i.e., substance abuse, sexual activity, etc.
3. Sexual abuse

Final Comments

I'm consistently impressed with the quality and compassion of our providers, particularly their universal willingness and effectiveness as collaborators, as community-based resources and problem-solvers who enthusiastically lend support or expertise when contacted with a need.

Cost Analysis Summary

Within each program profile provided in this section, the 2014 LCRB-requested funding amount was provided, in addition to the 2014 awarded figure. From this information, we can calculate the unfunded amount. If all of the programs were provided funding based on their requested amount, it would cost the LCRB an additional $91,008 a year. Further, the LCRB did not grant $53,892 in 2014 for basics/support classes requested by the National Alliance on Mental Illness (NAMI) ($14,392) and for a toolkit to aid youth with the Autism Spectrum diagnosis for the Center of Autism ($39,500).

Note that this is solely based on the request of funding by the agency and not tied to any determination of need and/or priorities. In the previous sections, you were provided with the information from the agencies on their highest priority need, in addition to an assessment by the agency contacts as to identifying other services or programs that would benefit the service delivery model for Lincoln County youth. If the minimum identified need provided by the agencies could be addressed, it would cost LCRB an additional $474,857 per year. There is most likely some overlap in what needs would be addressed by the unfunded amount for 2014 ($91,008), and the highest priority needs identified by the agencies at an estimated cost of $474,857.

Interestingly, when asking the agency contacts what other programs/services should be considered, there was a high degree of consensus between this information and the needs identified by the agencies themselves. Overwhelmingly, support is desired for mental health needs of youth (school-based therapists and community psychiatrists), addressing youth homelessness (transitional housing, support for other co-morbid issues like sexual abuse, substance abuse and domestic violence), and the prevention programs related to these issues.

It is encouraged that stakeholders of LCRB and those who want what is best for the youth of Lincoln County to review the information provided by these agencies, in addition to reviewing the LCRB Executive Director's view of the issues facing Lincoln County.

Conclusion

To be drafted by LCRB board and Executive Director

Table 33. LCRB Funded Agency/Program Information for 2013 and 2014

Agency	Official Name of the Program	LCRB Funding for 2013	Unit Cost 2013	Units 2013	LCRB Request 2014	Approved Funding for 2014	Amount Not Funded 2014	Unit Cost 2014	Units 2014	Youth served in 2013 through LCRB	Youth to be Served in 2014
Catholic Family Services	School-Based Counseling Services	54,979	53.69	1024	64,140	59,971	4,169	53.45	1122	509 youth (44 for counsel). Counselors gave 103 presentations, 352 students in anti-bullying presentations	525
Catholic Family Services	Outpatient Counseling Program	77,905	Ind. Counseling - $50.90/unit 1,404 units ($71,464). Anger Mgmt- $70.74/unit 40 units ($2,830). Love & Logic - $112.88/unit 32 units ($3,612).	Varies	86,861	78,000	8,861	Ind. Counsel- $58/unit1,197 units ($69,043).Anger Mgmt- $35/unit 164 units ($5,740). Love Logic - $101/unit 32 units ($3,216).	From funding tabs	165 youth & 24 youth in anger mgmt and 43 parents in love and logic	289
Crider Health Center	School-Based Mental Health Specialists	200,027	77.29	2588	209,628	186,948	22,680	81	2308	137 students (grades K-12), including 29 from pilot non-SED program	155
Catholic Family Services	Psychiatric Services	38,972	207.3	188	18,243	18,243	-	294.24	62	139	36

Agency	Official Name of the Program	LCRB Funding for 2013	Unit Cost 2013	Units 2013	LCRB Request 2014	Approved Funding for 2014	Amount Not Funded 2014	Unit Cost 2014	Units 2014	Youth served in 2013 through LCRB	Youth to be Served in 2014
Preferred Family Healthcare	Substance Abuse Treatment	84,242	Diagnostic-$133/unit, 23 units ($3,063). Ind. Counsel-$70/unit, 373 units ($25,912). Group Counsel-$17/unit,1,148 units ($19,045). Case Mgmt-$51/unit, 448 units($22,754). Family Counsel -$85/unit, 20 units ($1,692). Drug Screen-$25/unit, 161 units ($4,078).Meds-$7,682	Varies	90,575	86,050	4,525	Diagnostic-$113/unit, 26 units ($2,926). Ind. Counsel-$81/unit 412 units ($33,232). Group Counsel-$14.80/unit 1,259 units ($18,633). Case Mgmt-$54/unit 509 units ($27,628). Drug Screen -$26/unit 140 units ($3,622)	Varies	42 (13 carried over from 2012, 29 new admissions)	27
Crider Health Center	Violence Prevention	27,970	70.63	396	33,920	32,240	1,680	80	403	6,362 students (Grades K-8)	6000
Crider Health Center	Pinocchio	36,960	44.53	830	41,169	39,000	2,169	50	780	433 (K-3) students screened, 69 met initial eligibility, 58 met full eligibility	80

Agency	Official Name of the Program	LCRB Funding for 2013	Unit Cost 2013	Units 2013	LCRB Request 2014	Approved Funding for 2014	Amount Not Funded 2014	Unit Cost 2014	Units 2014	Youth served in 2013 through LCRB	Youth to be Served in 2014
Preferred Family Healthcare	Team of Concern	238,989	TOC assessment - $138/unit, 43 units ($5,941). Ind.Counsel - $65.85/unit 385 units ($25,352). Case Mgmt - $52.52/unit 684 units ($35,924). Presentation - $1,340.67/unit 9 units ($12,066). Drug Screen-$17/ unit 44 units ($744). School Consult- $67unit 2,394 units ($158,962).	See Unit Cost 2013	272,184	255,000	17,184	TOC Assessment - $149/unit 44 units ($6,582). Ind. Counsel- $69/unit 665 units ($46,304). Case Mgmt - $50/unit 424 units ($21,069). Presentation - $1,377/unit 9 units ($12,392). Drug Screen- $16/unit 44 units ($686). School Consult- $63/unit 2,683 units ($167,956).	See Unit Cost 2014	70 (24 clients carried over, 46 new clients)	47
The Child Center	Sexual Abuse Prevention	19,637	377.64	52	19,682	19,682	-	378.5	52	1,437 children, 265 parents, 61 professionals	1100
ThriVe	Best Choice Sexual Integrity/Abstinence	-	NA	NA	10,220	10,000	220	500	20	NA	400
Crisis Nursery Wentzville	Respite Care	38,995	11	3545	48,510	45,000	3,510	11.55	3896	69 unduplicated LC families; 71% under age 6	70

Agency	Official Name of the Program	LCRB Funding for 2013	Unit Cost 2013	Units 2013	LCRB Request 2014	Approved Funding for 2014	Amount Not Funded 2014	Unit Cost 2014	Units 2014	Youth served in 2013 through LCRB	Youth to be Served in 2014
F.A.C.T.	Partnership With Families (Parent Partner Program)	40,018	34	1177	48,816	42,012	6,804	36	1167	74 children (15 new referrals)	60
Nurses for Newborns	Putting Infants First In Lincoln County	13,590	117.99	115.18	15,575	15,575	-	121.68	128	21 (2 prenatal)	17
Sts. Joachim & Ann Care Service	Child & Family Development	135,943	72.08	1886	152,393	144,739	7,654	63.26	2288	459 children (317 adults, 212 families, 40 homeless families)	300
The Child Center	Family/Child Advocate	40,317	27.04	1491	40,316	40,316	-	27.04	1491	240 children (106 families)	240
Presbyterian Children's Homes & Services	Therapeutic Mentoring Services	37,998	13.98	2718	56,545	44,993	11,552	20.14	2234	55 youth/children	50
	Total	1,086,542			$ 1,208,777	$1,117,769	$91,008			10,279	9,396

Note: National Alliance on Mental Illness was not funded for 2014. They requested $14,392 for Basics support and Parent Educational Classes.

Center for Autism was not funded in 2014 for their requested $39,500 to provide a toolkit to serve youth with this diagnosis.

Table 34. Agency's Prioritized Needs and Cost to Provide Service

Agency	If funding were available, what would the agency fund?	Cost to fund identified need	Minimum Amount Needed
Catholic Family Services	Psychiatric services - provision for another Psychiatrist. However there is a lack of Pediatric Psychiatrists in the region, so even if funds were available there would be a difficult time finding a Psychiatrist. School-based services - Would also recommend expanding school-based services county-wide. Services would be more effectively delivered to youth if all public and private schools in the county had an on-site mental health therapist at least 1-2 days per week.	$25,000 for Psychiatric Services- need to serve an additional 30 clients at a cost of $140/30 minute unit- at 6-8 sessions per client. School-Based Services- Add an additional 2 days a week back to 2 schools served. Cost of 2 full days in a school at the current unit rate is $865/week for about 36 weeks in a school year= $30,000 Total= $55,000	$55,000
Crider Health Center	Additional Mental Health supports in the school setting; School-Based Therapists and School-Based Mental Health Specialists targeting students diagnosed with SED, at risk of being removed from school due to their extreme behaviors.	The cost of school-based therapy is $85 per session, an estimate of 1176 billable hours annually = cost of $99,960 per Therapist. To adequately cover the Lincoln County public schools, an estimate of 7 additional SBMHS would be a great addition to the number currently in place, an estimate of $356,335.00 would be needed to cover the non-Medicaid and Medicaid match needed to provide services to children with Medicaid coverage.	$99,960
Crisis Nursery Wentzville	More family empowerment services for Lincoln County.	$20,000 to fund a part time Social Worker to do home visits and parent coaching and counseling with 50 families as well as community outreach to hundreds of families.	$20,000
Nurses for Newborns	Focus on expanding the existing program in order to assist more infants whose caregivers have a psychiatric diagnosis or other mental health challenge. The numbers of mothers facing these challenges has grown so additional resources for this purpose would be very helpful. The funds would support nursing and social work visits for these mothers to help ensure the physical and mental health of their infants.	$8,000 would this program to serve 10 families impacted by mental health issues exceeding current provision of service and $5,000 to help support legal services for 5 families during the grant period. It is anticipated that $2,800 would be needed for provision of a monthly space and transportation of 10 families per month during the grant period, for a total of $ 15,800.	$15,800

Agency	If funding were available, what would the agency fund?	Cost to fund identified need	Minimum Amount Needed
F.A.C.T.	F.A.C.T. would support all families in Lincoln County that had children with a mental health diagnosis, not just those with Medicaid. F.A.C.T. would also support families that would benefit from assistance, but had not yet reached a crisis level. All of the families referred to F.A.C.T. are experiencing crisis situations. If they could be reached by F.A.C.T. before their children had reached crisis levels it would be more cost effective.	It currently costs approx. $90,000 to serve 60 families in a given year. It is estimated that there are 872 (6% of the general pop. has a mental health condition, 27% of LLC's population of 53,860 are under the age of 18) children/young adults in Lincoln County under the age of 18 with a mental health disorder. This means that there are possibly 812 children and young adults whose families may need support but are not receiving support from F.A.C.T. Just having another Parent Support Partner would be a start. F.A.C.T.'s cost from the LCRB for one more PSP, assuming they were Medicaid eligible, would be $42,012. To support 20% of non-Medicaid eligible families, and 80% of Medicaid eligible families the cost would be $50,749.	$42,012
Preferred Family Healthcare (PFH)	One unmet need that PFH has identified is specific services for youth that are identified as high risk. In Franklin County, PFH has an A.R.T.C. program that provides adolescents with unique therapeutic opportunities for hands-on, interactive artistic expression. It supports/builds on other therapy and education and helps youth personalize what they are learning about themselves, and about life lessons, reinforcing the messages we are bringing to them. Each project has a unique purpose and objective, and includes questions for discussion and reflection both before and after. Issues addressed include: identifying emotions, impact/effects of substance abuse, self-concept clarification, self-worth enhancement, appropriate emotional expression and management, development of health pro-social interests, effective collaboration abilities, family issues, past trauma, and coping strategies. The youth are typically involved in other services, but this enhances the services by providing nontraditional services for youth to express themselves.	The estimated annual cost for this unmet need would be $80,000 which would include one full time staff member and supplies to provide these services.	$80,000

Agency	If funding were available, what would the agency fund?	Cost to fund identified need	Minimum Amount Needed
Presbyterian Children's Homes and Services	Additional funding would allow us to expand services to a larger number of youth across the county. Elsberry, Silex, and Winfield School Districts have identified many youth who are currently not able to be served by the program.	$33,835 dollars would allow this program to serve 20 more youth beginning in May and through December at a rate of $ 20.14/ hour with those youth receiving 12 hours of mentoring each month.	$33,835
Sts. Joachim and Ann Care Service	The Child and Family Development program is in need of a third full time Social Service Worker to keep up with the need in Lincoln County. Tools such as more in depth child and family assessments and items like those could be completed in a more efficient manner, which allows the Care Service to reach additional clients. Lincoln County is also in great need of a shelter, however this is something that would cost far more than $50,000 and would take the entire community to sustain.	The cost of a new social service worker is a little over $33,000 annually, with an estimated benefits calculation of 25% (an additional $8,250). Assessment tools and notebook computers for the staff to use in home would cost a total of $2,000 up front. Cost of transitional housing is unknown.	$43,250
The Child Center	If funding were available Lincoln County children and adults would benefit by increasing from a part-time Prevention Education Specialist to a full-time specialist. This would allow the prevention program to be presented to the preschools in Lincoln County and outreach for Mandated Reporter Training. For the youth who are victims of sexual abuse, an in-house full-time therapist would be requested by The Child Center.	The estimated annual cost to fulfill this unmet or under-funded need is $35,000 for a full-time Prevention Specialist. This would cover the cost of salary plus benefits to serve an undetermined number of preschool students in the private and public sectors. In addition to preschoolers and their families benefiting in early sexual abuse prevention the prevention specialist could educate a wider range of professionals in Mandated Reporter Training. (examples: nurses, coaches, church volunteers, day care providers, etc.). $50,000 salary plus benefits to serve up to 100 kids receiving therapy for 4 months each.	$85,000
Thrive	Expand the current program by providing it to all middle and high school students in Lincoln County.	No cost information provided.	
		TOTAL FUNDS NEEDED TO RESPOND TO NEXT AREA OF PRIORITY IDENTIFIED BY CURRENT FUNDED AGENCIES	**$474,857**

Table 35. Other Providers/Programs LCRB Should Consider to Enhance Effectiveness of Our Local System of Care

Agency that Provided Information	Response from Agency Contact
Catholic Family Services	Perhaps a Nurse Practitioner that can prescribe medications. However, this would also require a Psychiatrist to "sign-off" and they are still unavailable to do that.
Crider Health Center	School-Based Therapy. Often children in need of therapy are unable to obtain this needed service for many socioeconomic reasons, having SB-Therapist located in the school setting removes virtually all barriers. The program is funded by the FCCRB and has proven to be highly successful in meeting the needs of children who would benefit from therapeutic services.
F.A.C.T.	Educational Advocacy.
Nurses for Newborns	A service that helps with transitional housing would be valuable, but I am not aware of another provider that would have this currently available.
Presbyterian Children's Homes and Services	Presbyterian Children's Homes and Services states that partnering with Crider Center, Preferred Family Healthcare, and the schools is an advantage to their program, and utilizing the SOC meetings and interagency meetings to be of great benefit for all involved. The school districts and Children's Division are a vital part of the local system of care too and should be encouraged to fully participate in promoting the services of the LCRB and sharing information with all parents about the resources available through the LCRB.
Sts. Joachim and Ann Care Service	Sts. Joachim and Ann Care Service states their clients would benefit from the LCRB assisting the new Bright Futures program. There are gaps in services, such as emergency funds, clothing needs, household item needs, and utility assistance. Bright Futures may possibly be able to fill in where the Care Service cannot.

*Agency name is listed if an additional comment was provided.

APPENDIX

List of Schools in Lincoln County

Public School

- Elsberry R-II School District – Elsberry
  - Clarence Cannon Elementary School (PK-04)
  - Ida Cannon Middle School (05-08)
  - Elsberry High School (09-12)

- Silex R-I School District – Silex
  - Silex Elementary School (K-06)
  - Silex High School (07-12)

- Troy R-III School District – Troy
  - Culvre Park Elementary School (K-05)
  - William R. Cappel Elementary School (K-05)
  - Lincoln Elementary School (K-05)
  - Boone Elementary School (K-05)
  - Main Street Elementary School (K-05)
  - Hawk Point Elementary School (K-05)
  - Claude Brown Intermediate School (05-06)
  - Troy Middle School (06-08)
  - Ninth Grade Center (09)
  - Troy Buchanan High School (10-12)

- Winfield R-IV School District – Winfield
  - Winfield Elementary School (PK-02)
  - Winfield Intermediate School (03-05)
  - Winfield Middle School (06-08)
  - Winfield High School (09-12)

Private Schools[edit]

- Calvary Christian School – Winfield (01-12) – Pentecostal
- Troy Holiness School – Troy (K-12) – Methodist
- Sacred Heart School – Troy (K-08) – Roman Catholic
- St. Alphonsus School – Silex (PK-08) – Roman Catholic
- Immaculate Conception School – Old Monroe (K-08) – Roman Catholic

Table 36. Missouri Student Survey of 2012 Data Specific to Lincoln County and Missouri from 2006 to 2012

Item - Brief Descriptions	LC 2006	MO 2006	LC 2008	MO 2008	LC 2010	MO 2010	LC 2012	MO 2012	Lincoln Co % Change Over Time*	2012 % Diff. - LC & MO**	LC Grand Total	MO Grand Total	Rating
Amount of sleep							69%	72%		-3%	69%	72%	7+
Chances to get involved at school	90%	92%	90%	91%	87%	88%			-2%	0%	89%	90%	Agree/Strongly
Chances to participate in class	84%	86%	76%	85%	77%	87%			-8%	0%	79%	86%	Agree/Strongly
Chances to talk one on one with a teacher	80%	79%	73%	79%	68%	76%			-12%	0%	73%	78%	Agree/Strongly
Days missed due to safety concerns							4%	5%		1%	4%	5%	1+ Days
Days skipped or cut							28%	28%		-1%	28%	28%	1+ Days
Depression scale - Student eating disruption					15%	19%	20%	17%	5%	-2%	17%	18%	Often or Always
Depression scale - Student feels hopeless					10%	12%	15%	11%	5%	-4%	12%	12%	Often or Always
Depression scale - Student irritable					21%	25%	25%	25%	4%	0%	23%	25%	Often or Always
Depression scale - Student school work disruption					20%	24%	23%	24%	3%	1%	21%	24%	Often or Always
Depression scale - Student sleeping disruption					23%	26%	22%	21%	-2%	-1%	23%	23%	Often or Always
Depression scale - Student very sad					16%	19%	21%	19%	5%	-2%	18%	19%	Often or Always
Ease of availability - alcohol	53%	50%	64%	48%	63%	58%	66%	57%	13%	-9%	62%	53%	Very Easy/Sort of
Ease of availability - cigarettes	52%	50%	61%	48%	63%	57%	63%	54%	11%	-9%	60%	52%	Very Easy/Sort of
Ease of availability - guns	43%	33%	48%	33%	42%	35%	48%	36%	6%	-12%	45%	34%	Very Easy/Sort of
Ease of availability - marijuana	35%	41%	35%	38%	38%	40%	43%	40%	8%	-3%	38%	40%	Very Easy/Sort of
Ease of availability - other illicit drugs	19%	20%	25%	18%	20%	20%	15%	18%	-4%	3%	20%	19%	Very Easy/Sort of
Ease of availability – over the counter drugs							57%	54%		-3%	57%	54%	Very Easy/Sort of
Ease of availability – prescription drugs							32%	31%		-1%	32%	31%	Very Easy/Sort of
Lifetime alcohol use	62%	56%	63%	54%	46%	43%	54%	40%	-8%	-15%	56%	48%	Yes
Lifetime alcohol use (times)							54%	39%		-15%	54%	39%	Yes

Item - Brief Descriptions	LC 2006	MO 2006	LC 2008	MO 2008	LC 2010	MO 2010	LC 2012	MO 2012	Lincoln Co % Change Over Time*	2012 % Diff. - LC & MO**	LC Grand Total	MO Grand Total	Rating
Lifetime chew use	17%	13%	18%	13%	13%	11%	18%	10%	1%	-7%	16%	12%	Yes
Lifetime cigar use					13%	14%				0%	13%	14%	Yes
Lifetime cigarette use	36%	38%	35%	29%	30%	27%	33%	24%	-4%	-9%	34%	30%	Yes
Lifetime club drug use	2%	3%	2%	3%	2%	2%	2%	2%	0%	1%	2%	3%	Yes
Lifetime cocaine use	3%	3%	2%	2%	2%	2%	2%	2%	-1%	0%	2%	2%	Yes
Lifetime gambling					34%	38%				0%	34%	38%	Yes
Lifetime hallucinogen use					3%	3%	3%	3%	-1%	1%	3%	3%	Yes
Lifetime heroin use					1%	1%	1%	1%	0%	1%	1%	1%	Yes
Lifetime inhalant use	10%	10%	8%	9%	6%	6%	4%	5%	-5%	1%	7%	8%	Yes
Lifetime marijuana use	19%	21%	14%	19%	15%	19%	19%	19%	0%	-1%	17%	20%	Yes
Lifetime methamphetamine use					1%	1%	1%	2%	1%	0%	1%	1%	Yes
Lifetime money lost to gambling					15%	17%				0%	15%	17%	Yes
Lifetime over the counter drug abuse					6%	8%	7%	6%	1%	-1%	7%	7%	Yes
Lifetime prescription drug abuse					8%	11%	10%	9%	2%	-1%	9%	10%	Yes
Lifetime steroid abuse	2%	2%	6%	2%	1%	1%	1%	2%	-1%	0%	3%	2%	Yes
Lifetime synthetic drug use							9%	7%		-2%	9%	7%	Yes
Natural disaster							3%	5%		2%	3%	5%	Yes
No discrimination in student treatment					70%	76%	73%	74%	3%	-1%	71%	75%	Agree/Strongly
Parents check on students homework	79%	82%	73%	80%	77%	81%	74%	80%	-4%	-5%	76%	80%	Agree/Strongly
Parents consult student when making decisions	66%	68%	64%	66%	70%	70%	65%	69%	0%	-4%	66%	68%	Agree/Strongly
Parents give the student chances to have fun	71%	73%	59%	72%	73%	74%	71%	74%	0%	-4%	69%	74%	Agree/Strongly
Parents notice students good work	64%	66%	53%	64%	82%	83%	80%	82%	16%	-2%	70%	74%	Agree/Strongly
Parents tell the student when they've done well	61%	66%	52%	63%	84%	86%	81%	85%	20%	-4%	70%	75%	Agree/Strongly
Past 3 month bullying online					10%	11%	9%	9%	-1%	0%	10%	10%	1+ Times
Past 3 month bullying via cell					11%	13%	10%	11%	-1%	1%	10%	12%	1+ Times

Item - Brief Descriptions	LC 2006	MO 2006	LC 2008	MO 2008	LC 2010	MO 2010	LC 2012	MO 2012	Lincoln Co % Change Over Time*	2012 % Diff. - LC & MO**	LC Grand Total	MO Grand Total	Rating
Past 3 month emotional bullying					72%	71%	64%	62%	-8%	-2%	68%	67%	1+ Times
Past 3 month physical bullying							14%	21%		6%	14%	21%	1+ Times
Past 3 month rumor spreading					30%	32%	25%	27%	-6%	2%	28%	30%	1+ Times
Past 3 month school detention					26%	27%	15%	19%	-11%	4%	21%	23%	1+ Times
Past 3 month school discipline					32%	30%	20%	25%	-12%	5%	27%	28%	1+ Times
Past 3 month school suspension					10%	10%	3%	5%	-7%	2%	7%	8%	1+ Times
Past 3 month victim of bullying online					11%	12%	16%	13%	4%	-3%	14%	13%	1+ Times
Past 3 month victim of bullying via cell					12%	13%	18%	15%	7%	-3%	15%	14%	1+ Times
Past 3 month victim of emotional bullying					68%	66%	57%	59%	-10%	2%	63%	63%	1+ Times
Past 3 month victim of physical bullying							20%	25%		5%	20%	25%	1+ Times
Past 3 month victim of rumor spreading					52%	52%	48%	47%	-4%	0%	50%	49%	1+ Times
Past month alcohol use	39%	28%	34%	26%	24%	20%	27%	18%	-12%	-9%	31%	23%	1+ Days
Past month binge drinking					17%	12%	20%	11%	3%	-9%	18%	11%	1+ Days
Past month chew use	7%	5%	10%	5%	7%	6%	10%	6%	2%	-4%	9%	5%	1+ Days
Past month cigar use					7%	7%				0%	7%	7%	1+ Days
Past month cigarette use	18%	14%	13%	13%	17%	14%	12%	12%	-5%	-1%	15%	13%	1+ Days
Past month driving under the influence	11%	7%	11%	6%	3%	3%	8%	4%	-3%	-4%	8%	5%	1+ Days
Past month gambling					23%	24%				0%	23%	24%	1+ Days
Past month gun carrying					3%	4%				0%	3%	4%	1+ Days
Past month inhalant use	4%	4%	3%	4%	2%	3%	1%	2%	-2%	1%	3%	3%	1+ Days
Past month marijuana use	10%	10%	5%	9%	8%	10%	8%	10%	-2%	2%	7%	10%	1+ Days
Past month over the counter drug abuse					4%	5%	3%	4%	-1%	1%	3%	4%	1+ Days
Past month prescription drug abuse					5%	7%	4%	5%	0%	1%	4%	6%	1+ Days
Past month riding with a driver under the influence	31%	23%	24%	22%	22%	22%	22%	20%	-9%	-2%	25%	22%	1+ Days

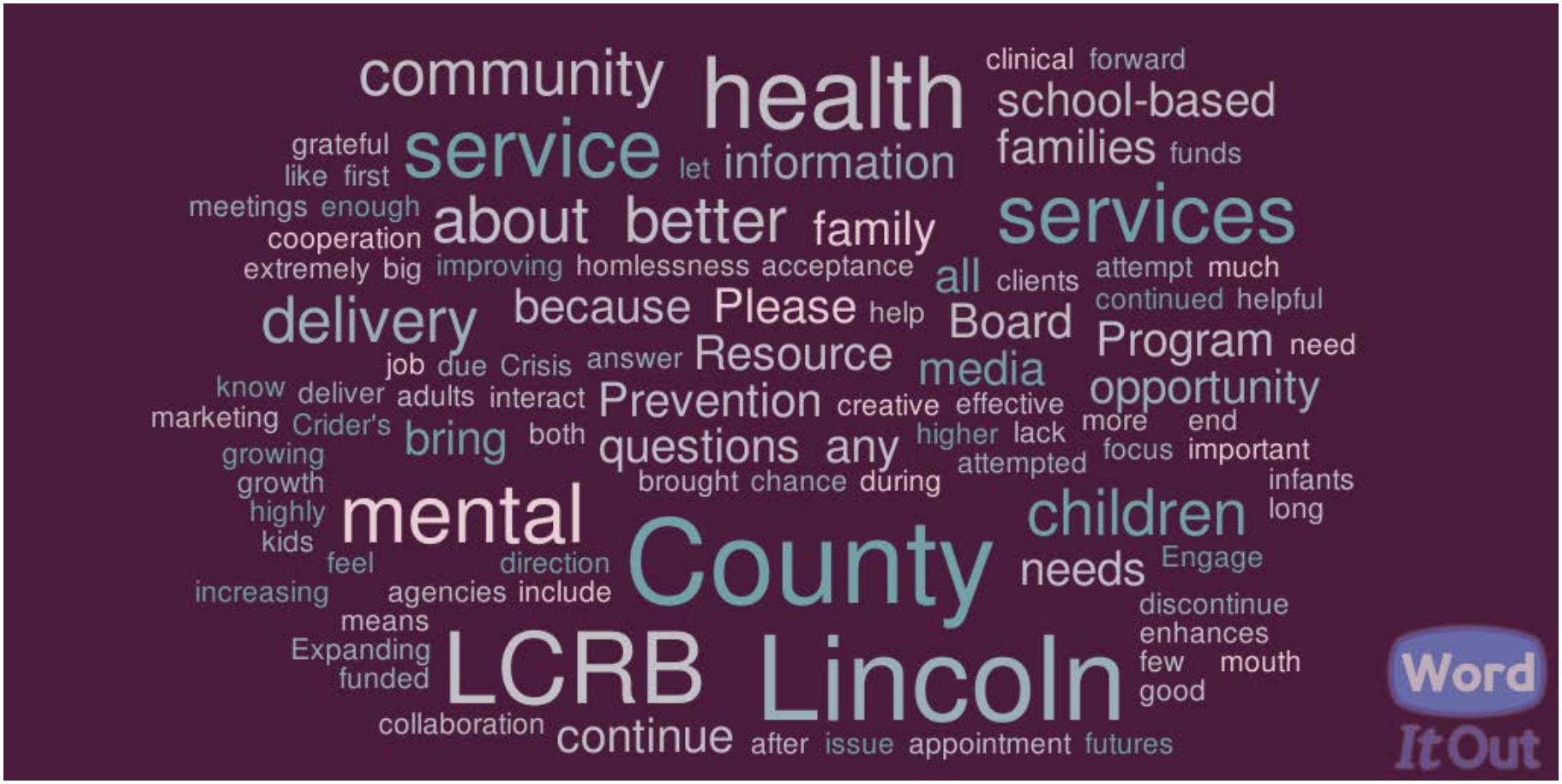
Item - Brief Descriptions	LC 2006	MO 2006	LC 2008	MO 2008	LC 2010	MO 2010	LC 2012	MO 2012	Lincoln Co % Change Over Time*	2012 % Diff. - LC & MO**	LC Grand Total	MO Grand Total	Rating
Past month school missed due to feeling unsafe					5%	5%				0%	5%	5%	1+ Days
Past month synthetic drugs							5%	3%		-2%	5%	3%	1+ Days
Past month weapon carrying					16%	15%				0%	16%	15%	1+ Days
Past month weapon carrying at school					4%	4%	4%	5%	1%	1%	4%	5%	1+ Days
Past two weeks binge drinking	19%	13%	15%	13%			20%	11%	0%	-9%	18%	12%	1+ Times
Past year attempting suicide	5%	7%	9%	6%	5%	6%	5%	6%	0%	1%	6%	6%	1+ Times
Past year fighting	35%	37%	36%	39%	28%	24%	18%	22%	-17%	4%	29%	31%	1+ Times
Past year fighting with injury					6%	4%	2%	4%	-4%	2%	4%	4%	1+ Times
Past year planning suicide	10%	10%	16%	11%	8%	8%	2%	9%	-8%	7%	9%	10%	Yes
Past year seriously considering suicide	15%	14%	18%	14%	10%	12%	10%	12%	-5%	2%	13%	13%	Yes
Past year suicide with injury	4%	3%	7%	3%	2%	2%	1%	2%	-2%	1%	3%	3%	Yes
Past year victim of bullying at school - version 1	51%	46%	49%	46%			26%	30%	-24%	3%	42%	41%	1+ Times
Past year victim of bullying at school - version 2					26%	24%	27%	29%	1%	2%	27%	26%	1+ Times
Past year victim of weapon threat at school	11%	12%	13%	13%	12%	10%	5%	7%	-6%	2%	10%	10%	1+ Times
Peer alcohol use	70%	56%	66%	54%	67%	57%	66%	53%	-4%	-13%	67%	55%	1+ Friends
Peer gun carrying					10%	13%	7%	11%	-3%	3%	9%	12%	1+ Friends
Peer other illicit drug use					17%	18%	15%	15%	-3%	1%	16%	17%	1+ Friends
Peer smoking cigarettes	46%	41%	45%	39%	52%	47%	48%	43%	2%	-5%	48%	43%	1+ Friends
Peer smoking marijuana	29%	34%	34%	32%	38%	39%	42%	39%	13%	-3%	36%	36%	1+ Friends
Perception of enforcement - alcohol	17%	25%	19%	26%	26%	31%	19%	30%	2%	-11%	20%	28%	yes or Yes!
Perception of enforcement - cigarettes	18%	21%	15%	23%	23%	28%	13%	25%	-4%	-12%	17%	24%	yes or Yes!
Perception of enforcement - guns					46%	53%	40%	54%	-6%	-14%	43%	54%	yes or Yes!

Item - Brief Descriptions	LC 2006	MO 2006	LC 2008	MO 2008	LC 2010	MO 2010	LC 2012	MO 2012	Lincoln Co % Change Over Time*	2012 % Diff. - LC & MO**	LC Grand Total	MO Grand Total	Rating
Perception of enforcement - marijuana	30%	33%	31%	33%	36%	41%	31%	41%	0%	-10%	32%	37%	yes or Yes!
Perception of harm - alcohol					73%	73%	66%	70%	-7%	-4%	70%	72%	Mod./Great Risk
Perception of harm - cigarettes					79%	80%	79%	80%	1%	-1%	79%	80%	Mod./Great Risk
Perception of harm - marijuana					69%	72%	69%	70%	0%	-1%	69%	71%	Mod./Great Risk
Perception of harm - other illicit drugs					91%	92%	93%	92%	2%	0%	92%	92%	Mod./Great Risk
Perception of harm - over the counter drug abuse							80%	80%		-1%	80%	80%	Mod./Great Risk
Perception of harm – prescription drug abuse							86%	85%		1%	86%	85%	Mod./Great Risk
Perception of parental feelings on student marijuana use	95%	95%	96%	95%	92%	93%	92%	92%	-2%	0%	94%	94%	Wrong/Very
Perception of parental feelings on fighting	83%	84%	75%	83%	76%	77%	78%	80%	-6%	-2%	78%	81%	Wrong/Very
Perception of parental feelings on fighting to defend self					22%	20%	20%	24%	-2%	-4%	21%	22%	Wrong/Very
Perception of parental feelings on student alcohol use	79%	86%	79%	86%	72%	78%	67%	79%	-12%	-12%	74%	82%	Wrong/Very
Perception of parental feelings on student cigarette use	89%	92%	84%	92%	87%	89%	86%	90%	-2%	-4%	86%	91%	Wrong/Very
Perception of parental feelings on student illicit drug use					95%	97%	99%	97%	4%	2%	97%	97%	Wrong/Very
Perception of parental feelings on student over the counter drug abuse							95%	95%		0%	95%	95%	Wrong/Very
Perception of parental feelings on student prescription drug abuse							95%	94%		1%	95%	94%	Wrong/Very
Perception of safety to and from school					85%	87%	90%	89%	5%	1%	88%	88%	Agree/Strongly
Perception of school safety					79%	83%	88%	88%	9%	1%	83%	85%	Agree/Strongly

Item - Brief Descriptions	LC 2006	MO 2006	LC 2008	MO 2008	LC 2010	MO 2010	LC 2012	MO 2012	Lincoln Co % Change Over Time*	2012 % Diff. - LC & MO**	LC Grand Total	MO Grand Total	Rating
Perception of wrongness - alcohol	63%	72%	65%	72%	56%	59%	50%	61%	-13%	-11%	58%	66%	Wrong/Very
Perception of wrongness - cigarettes	76%	79%	69%	79%	76%	78%	77%	80%	1%	-3%	74%	79%	Wrong/Very
Perception of wrongness - fighting					83%	83%				0%	83%	83%	Wrong/Very
Perception of wrongness - marijuana	86%	84%	85%	84%	82%	79%	77%	79%	-8%	-1%	83%	81%	Wrong/Very
Perception of wrongness - other illicit drugs					94%	94%	96%	95%	2%	1%	95%	94%	Wrong/Very
Perception of wrongness - over the counter drug abuse							87%	88%		-1%	87%	88%	Wrong/Very
Perception of wrongness - prescription drug abuse							90%	89%		0%	90%	89%	Wrong/Very
Rules are enforced fairly					57%	64%	57%	62%	0%	-5%	57%	63%	Agree/Strongly
School alcohol use							4%	3%		-1%	4%	3%	1+ Days
School marijuana use							1%	3%		1%	1%	3%	1+ Days
School notifies parents with praise	46%	42%	35%	42%	35%	42%	30%	39%	-16%	-10%	36%	41%	Agree/Strongly
Self-injury							12%	13%		1%	12%	13%	Agree/Strongly
Student believes in being honest with parent					82%	82%	87%	85%	5%	2%	84%	83%	Agree/Strongly
Student believes it is ok to cheat	44%	34%	37%	34%	24%	25%	28%	24%	-16%	-4%	33%	29%	Agree/Strongly
Student believes it is ok to steal					12%	10%	6%	7%	-5%	1%	9%	9%	Agree/Strongly
Student believes parents could be asked for help	81%	79%	74%	78%	77%	77%	74%	76%	-7%	-1%	77%	77%	Agree/Strongly
Student engages in fighting if provoked	47%	49%	56%	50%	54%	51%	55%	50%	8%	-5%	53%	50%	Agree/Strongly
Student ignores rules	21%	22%	29%	24%	27%	25%	20%	24%	-1%	3%	24%	23%	Agree/Strongly
Student is oppositional	15%	16%	22%	17%	21%	18%	17%	16%	2%	-1%	19%	17%	Agree/Strongly
Students help decide class activities	59%	57%	51%	54%	48%	58%			-11%	0%	52%	56%	Agree/Strongly
Teachers ask students to work on projects	80%	81%	81%	81%	81%	85%			1%	0%	81%	82%	Agree/Strongly
Teachers notice and comment on good work	73%	75%	68%	74%	67%	72%	62%	69%	-11%	-7%	68%	72%	Agree/Strongly
Teachers praise students	54%	55%	50%	54%	51%	57%	53%	56%	-1%	-3%	52%	55%	Agree/Strongly

*Note for Interpretation: For the "Lincoln County % Change Over Time" Column. Information represents difference in the percentage for that item from the initial point-in-time that data was collected for that item (as far back as 2006) in comparison to the percentage for that item in 2012 for Lincoln County. Items highlighted in green show areas that Lincoln County has improved over time. Items highlighted red are areas that have weakened over time. Roughly 10% of items on the high and low end were selected for this review and interpretation.
**For the "2012 % Difference LC & MO" Column. Information represents the difference in the percentage for that item in 2012 between Lincoln County and the state of Missouri (MO) data. It is ideal for Lincoln County to be in line with or doing better than the state. A negative percentage is to be interpreted as Lincoln County doing "worse than" Missouri on that item. A positive percentage is to be interpreted as Lincoln County doing "better than" Missouri on that item. Approximately 10% of the items on the negative end (where Lincoln County is worse than the state) are highlighted in red. The top 10% of the items on the positive end (where Lincoln County is doing better than the state) are highlighted in green.
Source: County and State data per item comes from the Missouri Student Survey conducted by the Department of Mental Health on even years. Information is collected from schools who provide consent to be a part of the survey process. Data is collected on grades 6 through 12, which grade 9 being the required grade. Schools select at least 1 additional grade. For detailed information about the Missouri Student Survey go to: http://dmh.mo.gov/docs/ada/progs/mobhew/webtool/DataSourceDescriptions.pdf

Appendix: Word Cloud - Qualitative Assessment of the Agency Contact's Final Comments about LCRB



Appendix – Juvenile Law Violation Referral Status – Definitions

Formal Dispositions:

Allegation True, Youth Receives Out-of-Home Placement – A judicial action finding the allegation true. Youth is placed out-of-home with the Division of Youth Services (DYS), in foster care, with a relative or another private or public agency. [JIS Docket = DVPTN]

Allegation True, Youth Receives In-Home Services – A judicial action finding the allegation true. Youth receives services while remaining in his or her home. This disposition requires the youth to receive supervision through the juvenile division. [JIS Docket = DVPTN]

Allegation True, No Services – A judicial action finding the allegation true, however, the youth receives no services or supervision. [JIS Docket = DVPTN]

Allegation Not True – A judicial action which results in the termination of a juvenile case during the initial juvenile division hearing due to insufficient evidence. [JIS Docket = DVPTN]

Sustain Motion to Dismiss – A judicial action which results in a motion to dismiss the petition before the initial division hearing. [JIS Docket = DVPTN]

Sustain Motion to Dismiss for Certification - A judicial action sustaining a motion to dismiss a petition to the juvenile division and allow prosecution of youth under the general law. [JIS Docket = DVPTN]

Informal Dispositions:

Informal Adjustment with Supervision: Any informal non-judicial activity that occurs without the filing of a petition and involves supervision of youth by written agreement and complies with Missouri Supreme Court Rules for an informal adjustment conference and the relevant contact standards contained in the Standards for the Administration of Juvenile Justice. This disposition requires completion of the risk and needs assessment when the referral is for a status or delinquency allegation. [JIS Docket = VAIWS]

Informal Adjustment without Supervision: Any informal non-judicial activity that occurs without the filing of a petition and involves supervision of youth by written agreement and complies with Missouri Supreme Court Rules for an informal adjustment conference. Although services may be monitored, this disposition does not include direct supervision of a youth in accordance with the Standards for the Administration of Juvenile Justice. However, because the disposition is applied on the basis of an informal adjustment conference, completion of the mandated risk and needs assessments is required when the referral is for a status or delinquency allegation. [JIS Docket = VIANS]

Informal Adjustment, Counseled and Warned: Any informal non-judicial activity that entails no more than brief face-to-face, telephone, or warning letter with the intent to inform, counsel, and warn the youth and/or family regarding a referral received. No official informal adjustment conference, per Supreme Court Rule is held; therefore completion of the mandated risk or needs assessments is not required when the referral is for a status or delinquency allegation. [JIS Docket = DVCAW]

Transfer to Other Juvenile Division: A non-judicial activity where a youth's case file and associated records are transferred to another juvenile division for disposition. Depending on when this disposition is applied, an

official informal adjustment conference and associated assessments may or may not occur. [JIS Docket = DUTJC]

Transfer to Other Agency: A non-judicial activity where a youth's case file and associated records are transferred to another agency (CD, DMH, DYS, or other public or private agency) for disposition. Depending on when this disposition is applied, an official informal adjustment conference and associated assessments may or may not occur. [JIS Docket = DVTA]

Referral Rejected: The referral is rejected because there is insufficient information for administrative action to proceed or the referral is found not true. No informal adjustment conference is conducted and no assessments are required. [JIS Docket = DVRIE – Insufficient information;
DVRNT – Not True]

About the Consultant Who Prepared This Report

Cynthia Berry, Ph.D.
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Cynthia Berry, Ph.D., is a Psychologist with a specialization in Industrial/Organizational, Personality and Experimental Psychology, and founded BOLD, Berry Organizational and Leadership Development, in January of 2006.
She has over sixteen years of experience in Human Resources, Organizational Development, Evaluation and Research, Psychometrics and Training with an expertise in statistical design, survey development and data analysis. She has vast experience in organizational and community-based assessments allowing for guided strategic plan development complete with outcome measurement tools and procedures to match.

BOLD is further strengthened by providing services for full organizational and program budget development, fund development and writing in-depth policies. It was a combination of these skills, her education and experience that lead Cynthia to start BOLD in 2006 at the age of 30. For her first BOLD project, she prepared the 2005 Community Health Assessment report for St. Charles County involving over 1,494 residents on 162 questions, which has been used by a majority of the local hospitals and clinics, health not-for-profit agencies and many other entities for community and organizational planning purposes. Other notable projects include:

- Handling the evaluation plan and report for Crider Health Center, which was a necessity to become a Federally Qualified Health Center in 2008.
- 2012 Lincoln County Needs Assessment for youth; additional project to assess drug and alcohol perceptions and behaviors among 6th, 9th and 12th grade youth in Lincoln County. BOLD is currently working on the Needs Assessment project for both Lincoln County and Franklin County to be completed in 2014.
- Community and Children's Resource Board of St. Charles 2010 and 2012 Client Satisfaction Project covering 3,500 youth served in our region- focuses on a variety of child-development outcomes.

Cynthia's program evaluation expertise led to successful grant writing and fundraising for not-for-profits in St. Charles and St. Louis County, where Cynthia has raised over $7.5 million dollars in the past seven years on many programs she has helped develop and implement. She planned, led and successfully completed phase 1 of Sts. Joachim and Ann Care Service's Capital Campaign to build the first one-stop shop for social services in St. Charles County for low-income families and led this organization through a major accreditation awarded by the Council on Accreditation in January, 2011.

She has worked with numerous not-for-profits such as: Reading Success Center (literacy), United Services (special education/developmentally disabled youth), Foundations of Love (home/support for individuals with developmental disability), the Child Center (child sexual abuse prevention), OASIS (support for older adults), Living Well Foundation (health programming) and Strong Tower Ranch (youth skills). Community organizations include: O'Fallon and Wentzville Fire Districts, the City of Creve Coeur, City of Grain Valley, City of O'Fallon (MO), St. Charles Community College, Duckett Creek Sanitary District, Community and Children's Resource Board of St. Charles, Lincoln County Resource Board, St. Charles County Fair Board, Franklin County Children's Resource Board, the Community Council, and other local organizations with regular training and development activities for their staff, board members, and stakeholders. Finally, she is an adjunct professor for the Evaluation of Programs and Services at the George Warren Brown School of Social Work at Washington University.

The diversity of BOLD to focus on both the for-profit and not-for-profit community allows Dr. Berry to align with the highest community priority at the time.