Community Health Needs Assessment

Prepared for Crittenton Children's Center

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2012

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The authors would like to acknowledge the contribution of Patrick Altenhofen, Steven Butner, and Ben Miller. They developed the Community Health Needs Assessment for the year 2011, which helped guide the production of this updated version. The 2012 report reflects a portion of their research efforts.

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Executive Summary

Introduction

The mental health needs of children and adolescents are increasing in the Kansas City area. Addressing these needs is important to the community. The purpose of this report is to convey the status of the community and Crittenton Children Center's role in providing care. Since 1896, Crittenton Children's Center has served as the region's premier psychiatric care provider for children, adolescents and their families. It opened Kansas City's first children's psychiatric hospital in 1979. Crittenton Children's Center has continued providing children and adolescent services with 3,158 youth served in 2011. They are meeting and evolving their services as needs change and arise for the future of Kansas City's children and adolescents.

Purpose

As part of the Patient Protection and Affordable Care Act, the federal government has required not-for-profit hospitals to perform a community health needs assessment (CHNA) once every three years. The following three essential public health services were identified as Crittenton Children's Center's goals in developing the CHNA:

- Monitor the health status of the community to identify and mitigate community health issues
- Diagnose and investigate health issues and health hazards in the community
- Inform, educate, and empower the surrounding community about health issues

Methodology

The guidelines provided by the Missouri Hospital Association (MHA) were followed in order to prepare the CHNA (see page 8). Primary and secondary data were collected and analyzed to perform the assessment of children's behavioral health needs. Primary data included interviews with various organizations that are involved with children and adolescent mental health needs. The interviews revealed various indicators of health (e.g., poverty) that were then researched to better understand the needs of the community. Secondary data was drawn from the Kansas City Regional Children's Behavioral Health Needs Assessment (Mid-America Regional Council, 2012), as well as reliable journal and web based resources.

Community Health Needs

Based on the data from our research the following community health needs were identified:

Top 10 Behavioral Health Children Needs

1. Education in community (schools) to deal with behavioral health needs
2. Assessment of the behavioral health needs early in childhood
3. Coordination with other systems of care (e.g., school)
4. Specialist to treat children with behavioral health needs
5. Transportation to/from services
6. Inpatient services
7. Partial (day services) and intensive outpatient services
8. Outpatient substance abuse
9. Detoxification
10. Inpatient substance abuse

Requirements

The MHA provided the following guidelines for conducting a CHNA per the requirements set by the IRS (MHA, 2011; MHA, 2012).

MHA Issue Brief Step & Task	Pages
Step 1: Define the Community Served by a Hospital Facility	
Define counties, zip codes, population density, and demographics	14-15,33-34
Define trends throughout past 10 years and known major risks for community safety	24-29
Step 2: Identify the Partners and Individuals Representing the Broad Interests of the Community	
Identify individuals with expertise in public health and leaders of medically underserved population	17-21
Identify agencies with current data or relevant information	17-21
Step 3: Gather Available Data and Current Assessments	
Gather available data collected by the hospital and other organizations	N/A
Step 4: Develop and Conduct Primary Research	
Contact and interview community stakeholders	17-21
Step 5: Aggregate Primary and Secondary Research	
Summarize key findings	29-30
Step 6: Document Process and Methods Used to Conduct Assessment	
Describe sources and dates of data and information used and justify approach for data collection	16-17
Describe analytical methods applied to identify community health needs	16-17
Describe information gaps that affect ability to identify community health needs	30
Identify 3rd parties that collaborated with hospital for CHNA	2
Describe stakeholders (name, title, affiliation, expertise), and when and how we consulted with them	17-21
Explain successful/non-successful approaches to seek community input	17-21
Step 7: Identify and Prioritize Health Needs of the Community	
Describe priorities identified through primary and secondary data	29-30
Describe process used to rank community health needs	30
Step 8: Develop and Implement a Strategy to Address the Identified Priority Health Issues	Document attached
Step 9: Widely Disseminate the CHNA	

Crittenton Children's Center Profile

Mission Statement

Crittenton Children's Center is a faith-based, not for profit organization dedicated to providing the highest quality innovative behavioral health services to children and families as part of the Saint Luke's Health System.

Vision

The Best Place to Get Care and the Best Place to Give Care.

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Children's Mercy Hospital & Clinics

About Crittenton Children's Center

Crittenton Children's Center:

- Is located on a picturesque, 96-acre campus in South Kansas City, which provides children the serenity and privacy they need to assist their healing process.
- Employs more actively practicing board-certified psychiatrists than any other similar facility in the region and uses multiple evidence-based therapy interventions to ensure the best outcomes for patients.
- Has highly trained professional staff that works intensively with patients to help them achieve stability and positive mental health, and to acquire the skills and resources needed to mature into healthy and productive adults.

Accreditations, Licensures, and Designations

Crittenton Children's Center is:

- Accredited by The Joint Commission Comprehensive Hospital and Behavioral Health Standard
- TRICARE certified for both hospital and residential care
- A United Way Funded Program
- Designated Psychiatric Residential Treatment Facility (PRTF) for the state of Kansas
- Licensed as a Psychiatric Hospital by the Missouri Department of Health and Senior Services
- Licensed as a Child Placing Agency and Residential Child Care Agency by the Missouri Department of Social Services-Children's Division

Services and Highest Quality Individualized Care

Crittenton Children's Center offers a range of services:

- Psychiatric hospital program for young children and adolescents
- Residential treatment for adolescent girls and boys
    - Intensive residential services
    - PRTF (psychiatric residential treatment facility)
    - Juvenile aggression unit
    - Family focus transition program
- Intensive in-home services
- Foster care and adoption services – case management; foster family training, licensing and support
- Chemical dependency intensive outpatient and after-care program
- Head Start-Trauma Smart

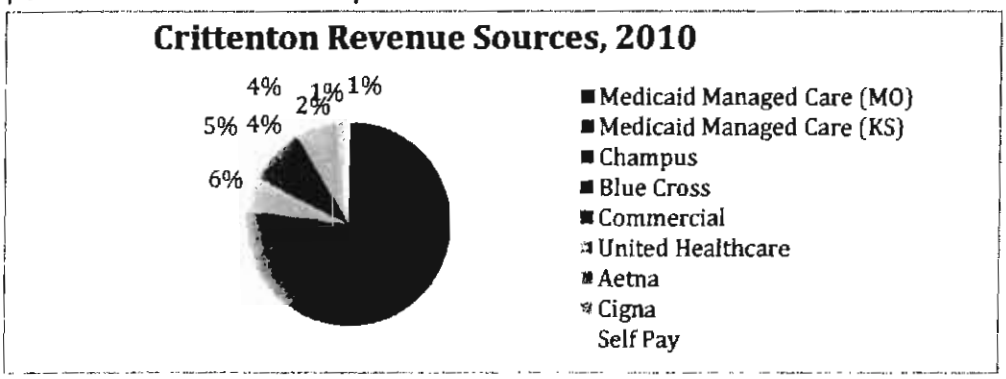
In order to provide the highest quality behavioral health services, Crittenton continues to lead in the use of evidence-based treatment. Each child's individual experiences require varied and specific therapy methods. Therapists are trained in **Trauma-Focused Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing** and **Dialectical Behavioral Therapy** to provide treatment for each child's specific trauma needs. Additionally, Crittenton's staff that provide direct care are uniquely trained in **ARC (Attachment, Self-Regulation and Competency)** milieu training – a synergistic model that ensures consistency of care by teaching youth to better regulate their bodies and emotions while also supporting staff in their role as caregivers. Crittenton ARC Champions – staff who are leaders in this effort to create a sustainable, trauma-sensitive culture – engage in regular consultation with ARC developers to ensure consistency of implementation and the strongest application serving the needs of each child.

Crittenton by the Numbers

In the midst of a tough economic year, Crittenton met the needs of 3,158 youth in 2011 (an 11 percent increase from 2010). Historically, because of a high demand for services, Crittenton had 690 diversions in 2009, which resulted in a 400 percent increase from 2008. In 2010, diversions increased by 8 percent to 748 patients. Crittenton responded with the increased community demand for acute care by converting 8 Intensive Residential beds to Acute Psychiatric Hospital beds, which reduced their inpatient diversions to 348 in 2011. In addition, a related trend that Crittenton has identified is a 19 percent increase in pre-adolescent inpatients from 2010 to 2011. To meet this need, Crittenton added expertise and modified program structure and facilities to accommodate the specific needs of this younger age group.

Financial

Unfavorable economic conditions created a challenging year for Crittenton Children's Center and its clients. The result was yet another increase in the number of clients without means to pay for care. In 2010, mid-year reimbursement reductions from Missouri Medicaid reinforced the wisdom of Crittenton's emphasis to diversify payer sources. MO HealthNet paid the largest portion of revenue at 59.93 percent.



Facilities

Crittenton Children Center's facility, which currently includes capacity for 54 hospital patients and 65 intensive residential patients, is secure and provides for maximum patient safety as well as flexibility for a wide array of programming interventions. Renovations and updates began in 2010 and continue in patient living areas, in an effort to more effectively and comfortably care for children, create a modern look, and design a more efficient work environment. Additional plans are in place to enhance children's recreation and exercise areas to increase usability and provide new recreation opportunities as part of the Healthy Lifestyles program.

Development and Growth

Crittenton Children's Center is proud to be one of only 10 awardees selected from a national field of 161 applicants to the 2010 Robert Wood Johnson Foundation (RWJF) Local Funding Partnerships (LFP) matching grants program. A RWJF grant of $500,000 over three years is being matched by $700,000 from local funding partners for a total of $1.2 million to support Head Start—Trauma Smart. This project addresses the high incidence of complex trauma that negatively affects pre-school aged children. Using children's natural environment, Head Start-Trauma Smart staff educates anyone from classroom personnel to parents about the symptoms of trauma, identifying its impact, and how to effectively intervene. Portions of the program have been extended to a four state region, and additional services for parents and family members have been contracted through the Mid-America Regional Council for Mid-America Head Start affiliate sites. Also, intensive in-home services have been extended to include six counties in the Kansas City Metropolitan area in an attempt to better reach families before a crisis occurs and to support the transition from acute inpatient to home.

Volunteers

Volunteer support is important and the community was actively involved at Crittenton Children's Center in 2011. In 2011, 654 volunteers provided 7976.5 hours of service. Individuals and groups shared their common desire to make a difference in the lives of children and youth, offering activities and expertise in tutoring, social activities, enhancement of career counseling efforts, support of self-expression via yoga, writing, and other artistic endeavors, office support and facility updates. Recruitment and training of mentors for residential and foster care children holds ongoing importance. Mentors develop one-on-one relationships with children who have no family or other positive adult resources to help instill confidence and self-esteem, or to introducing new skills needed to become happy and productive members of the community.

Collaborative Relationships

As a member of the Kansas City community for 116 years, Crittenton Children's Center has established a wide cadre of collaborative relationships by which it can most effectively serve clients across all of their programs, as well as improve the quality of their organizational function and that of others in the community. Highest quality care is the objective of a myriad of relationships with the community entities including, but not limited to:

- Department of Mental Health
- Missouri Coalition of Children's Agencies
- Missouri Department of Social Services – Children's Division
- State of Kansas – Social and Rehabilitative Services
- COMBAT
- Missouri Family Court
- Jackson County Community Mental Health Levy Fund
- Children's Mercy Hospitals and Clinics
- Economic Opportunity Fund Head Start
- Operation Breakthrough
- St. Mark's Child and Family Development Center
- United Way

Crittenton Children Center's staff maintains referral and working relationships with numerous other service providers such as community mental health centers, faith communities, AA groups, transportation resources, and schools. Working collaboratively with this strong network of service providers enhances their success. Further, Crittenton is actively staying in touch with needs and state and federal advocacy initiatives by involvement with the following organizations:

- Missouri Coalition of Children's Agencies – A coalition of organizations, groups and individuals representing abused and neglected children and the people and agencies who care for them and their relationship with the government (MCCA, 2012).
- National Crittenton Foundation - This national foundation and its family of 27 agencies helps young women and girls to overcome obstacles of sexual and physical abuse, poverty, domestic violence, substance abuse and sexual trafficking (National Crittenton Foundation, 2011).
- Kansas City Child Abuse Roundtable – This bi-state (Missouri and Kansas) coalition of 30-plus community advocates, elected officials, and state agency staff from both the Kansas City area and Jefferson City regularly meet as advocates against child abuse. Their focus on child abuse is: how do we prevent it, how to we educate citizens to recognize the signs of it, how do we treat children who have experienced it, and how do we support families who are touched by it (Kansas City Child Abuse Roundtable, 2012).

Working with these advocacy groups has helped Crittenton develop collaborations with other organizations and state and federal agencies to work together to be part of the solution to help meet the behavioral health needs of children and their families in the community.

Community Profile

Kansas City Area Mental Health Providers

Since 1896, Crittenton Children's Center has served as the region's premier psychiatric care provider for children, adolescents and their families. In 2011, 70 percent of inpatients were from Missouri and 30 percent were from Kansas. Other mental health providers in the Kansas City area include:

- Comprehensive Mental Health
- Johnson County Mental Health
- KVC Health System
- Cornerstones of Care
- ReDiscover
- Research Psychiatric Center
- Swope Health Services
- Tri-County Mental Health
- Truman Medical Center Behavioral Health Network
- Two Rivers Psychiatric Hospital
- Wyandotte Center

Primary Service Area Demographic and Economic Profile

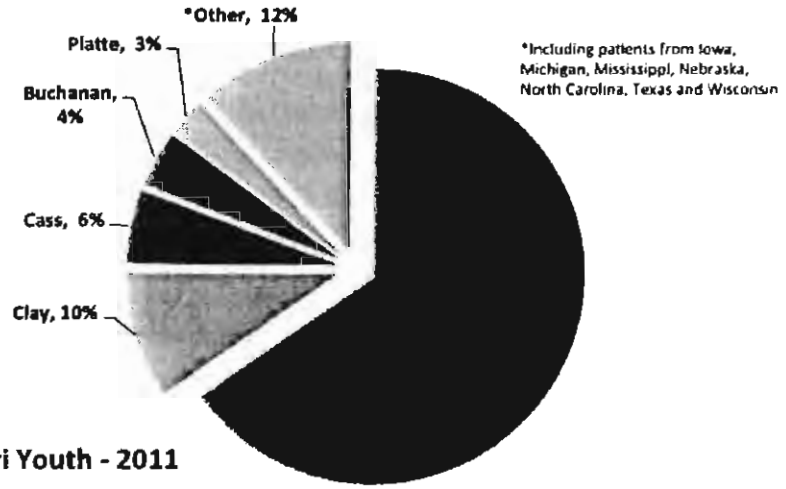
Crittenton Children's Center's primary service area was determined by the volume and demographic locations of youth served in 2011 (see graph below). The primary service area includes the following Missouri counties: Jackson, Clay, Cass, Buchanan, and Platte. It also includes Wyandotte County and Johnson County of Kansas.

Jackson County and Wyandotte County represent the highest proportion of the population served, and thus these counties will be emphasized in the community profile. The population density is above 1,000 persons per square mile in Jackson and Wyandotte, which are more densely populated than the other counties besides Johnson. The age of around one-third of the population (i.e., range of 32.5 percent in Platte to 37.8 percent in Wyandotte) is under 24 years. In comparison to the other counties, Jackson and Wyandotte represent more ethnic diversity. Black or African Americans represent 23.9 percent and 25.2 percent of the population in Jackson and Wyandotte, respectively, while the other counties percentages are below six percent. Wyandotte has the highest percentage of Hispanic or Latinos (i.e., 26.4 percent) while the other counties percentages are below nine percent. The percentage of people under 18 years living below the poverty level is highest in Jackson and Wyandotte at 25.4 percent and 36.4 percent, respectively. Lastly, the percentage of people with no health insurance coverage is also highest in Jackson and Wyandotte at 17 percent and 26.4 percent, respectively.

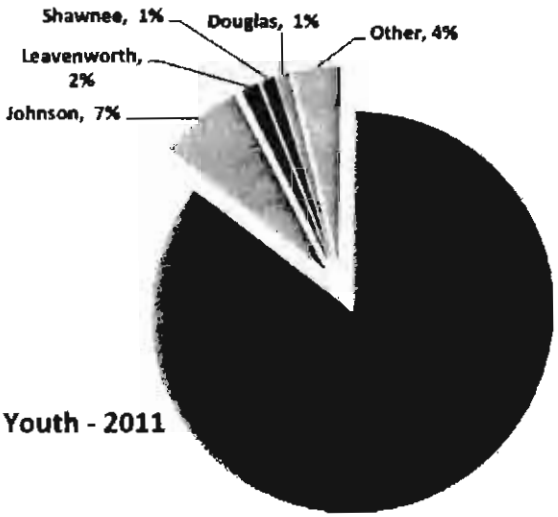
The population density and demographics of each county were obtained from the U.S. Census Bureau website and the data are displayed in Appendix II.

Crittenton Children's Center Youth Served in Kansas and Missouri, 2011

Crittenton Children's Center
SAINT LUKE'S HEALTH SYSTEM



2250 Missouri Youth - 2011



964 Kansas Youth - 2011

Community Health Needs Assessment Process

Purpose

A CHNA is the foundation for improving and promoting the health of county residents. As part of the Patient Protection and Affordable Care Act, the federal government has required not-for-profit hospitals to perform a community needs assessment once every three years.

The purpose of this community health needs assessment is to identify health conditions, factors, and behaviors affecting the health of Crittenton Children's Center patient population. The assessment will help Crittenton Children's Center improve their care delivery and predict future mental health trends. A CHNA involves three essential public health services:

- Monitor health status to identify and mitigate community health issues,
- Investigate health issues and health hazards in a community, and
- Inform, educate, and empower the surrounding community about health issues.

There are many different social and environmental resources that can affect a child's health status. Social determinants are resources that are necessary to maintain health. The indicators we decided to research all can be considered social determinants of health. Each community has its own set of determinants that has the potential to create health inequities.

Methodology

Primary and secondary data were collected and analyzed to identify mental health indicators that could affect Crittenton Children's Center patient population. Primary data included interviews with knowledgeable community stakeholders who work in organizations that have a special interest in mental health of children within the community. Mid America Regional Council-Kansas City Region was contacted and contributed to the assessment with a summary of the Kansas City Regional Behavioral Health Needs Assessment. The Missouri Department of Mental Health was also contacted and input regarding the community's behavioral health needs was obtained from the Chief of Children's Community Operations. Finally, the President of ReDiscover, a mental health agency and area leader for serving underserved children, was interviewed as a primary data source.

The main source of secondary data used to help identify mental health indicators was the Kansas City Regional Behavioral Health Needs Assessment. This assessment was conducted using consumer and health provider surveys to collect and prioritize the behavioral health needs of the region. Also provided were recommendations to help mitigate those needs. Reviews of web-based materials, peer review papers, published journal articles, and large-scale

studies were completed in order to determine the indicators that would have the most impact on mental health needs of children and adolescents. Seminars focusing on the mental health needs of children and adolescents in the area were attended as well. One such seminar was the Kansas City Regional Health Care Initiative's System Change Committee. The seminar, attended by last year's assessment team, provided four assessments from prominent area organizations that all study child and adolescent mental health. It should be stated that, while reviewed and updated if possible, some of the secondary data was compiled by the previous year's team and was kept in the assessment, as new data was not available.

Primary Data

Data collected first-hand is known as primary data. Collaborative efforts forged among county, public health and community health leaders can begin to answer key questions related to the strengths of the community, the county residents' health concerns, emerging health issues, and resources needed to address community health concerns.

Public health activities are delivered through multiple organizations that vary widely in resources, missions, and operations. Without strong coordination mechanisms, these delivery arrangements may perpetuate large gaps and inefficiencies in public health activities.

Interviews 2011

Patrick Altenhofen, Steven Butner, and Ben Miller conducted interviews in 2011 with the following organizations in the primary service area to better understand the needs of the community (see Appendix I for their list of contacts).

- Crittenton Children's Executive Team
- Saint Luke's Health System
- KC Regional Health Care Initiative's System Change Committee
- Missouri Department of Mental Health
- National Association of Mental Illness
- Mid-America Regional Council / Kansas City Regional Health Care Initiative
- MO HealthNet (Medicaid)

When speaking with professionals in the above organizations, they discussed a variety of topics that can help one better understand the mental health needs of the community. Common themes that were mentioned during interviews and appeared in their research included:

- Alcohol Sales
- Autism
- Calls to Suicide Hotline
- Court Involvement
- Death in Family
- Divorce Rates
- Foreclosures
- Free/Reduced Lunch
- Incarceration Rates
- Poverty
- School Drop Outs
- Section 8 Housing
- Suicide Rates
- Unemployment Rates
- Violent Crime Rate

Interviews 2012

While taking the above information into account, we collected recent primary data by interviewing key personnel of selected major stakeholder organizations in the Kansas City Metro Area known to service or advocate for underserved populations (see next page). The goals of the interviews were to obtain opinions, facts, assumptions, and perceptions from interviewees on children's behavioral health needs. Each interview consisted of the following five open-ended questions:

1. What do you consider are some of the strengths in the county?
2. What do you consider are some of the challenges for the county?
3. What do you consider are the major mental health concerns for children and young adults in the county?
4. What do you consider are some of the needs for children and young adults that are not being addressed? In your opinion, why are they not being addressed?
5. What sources would you recommend to find data on these health needs?

The following summary describes the stakeholders recommended by the Crittenton administrative team, the methods we used to consult them, and the key information we obtained from the interviews.

Mid American Regional Council-Kansas City Region (MARC)

MARC is a regional council of non-for-profit organizations, city and county governments from the bi-state Kansas City region. This council collaborates to advance social, economic and environmental issues (MARC, 2012). Our primary contact was Jody Denson, Health Planner III of the Regional Health Care Initiative (RHCI). She holds a bachelor's degree in psychology and a master's degree in public administration. She has five years experience as a policy analyst and program coordinator for MARC's Early Learning Department. Further, she has over 15 years experience working with regional safety net service providers, state social service departments and local social welfare agencies (RHCI, 2012).

Savanna Greer contacted Jody Denson via email to request an interview. The thirty-minute interview took place in person on Thursday, March 1, 2012. Denson provided the executive summary of the Kansas City Regional Behavioral Health Needs Assessment, which will be described further in the secondary data section of this report.

Denson identified that there is a "good collaboration of agencies" as a major strength of the county. This strength is necessary to help with care coordination (i.e., staying in care and receiving follow-up care as needed), which happens to be one weakness of the county. Jody described the need for behavioral health services in schools. Some programs have been successful in schools, but the funding is unsustainable. She mentioned that Crittenton can play a big role in addressing the behavioral health needs.

Missouri Department of Mental Health (MDMH)

The Missouri Department of Mental Health (MDMH) provides services, education and oversight for the state of Missouri's population suffering from mental health disorders, substance abuse, developmental disabilities and compulsive gambling (MDMH, 2012).

Graduate student Robert Eklofe interviewed Bonnie Neal, Chief of Children's Community Operations over the phone for forty-five minutes on March 16, 2012. Mrs. Neal responded to the preformatted questions by the project team. The questions for this interview focused on the services for children and families strengths, challenges, major mental health concerns and needs not being addressed in the Kansas City Regional area.

Mrs. Neal relayed the strengths in the Kansas City Metro counties appears to be that there is adequate amount of inpatient beds for children in the Kansas City Regional Area and good working relationships between private entities and the state organizations and seamless transition of sharing treatment and care information (care coordination) with families and other community providers. In addition, since the closing of Western Missouri Mental Health children's wing, the funding was transferred to a community "Children's Enhancement Development" fund to assist in paying for care for those high needs children (developmental delayed, multiple diagnosis, and coexisting mental and primary health issues) in the community.

During the interview the challenges in the regional area mentioned by Bonnie Neal were the lack of acute care facilities to admit developmental delay (DD) youth with behavioral health concerns; Crisis stabilization in Jackson County; Children getting services in their home county. Also expressed was the traditional use of long term residential care. Specially, if there is not good coordination children may be in residential care for extended periods of time (six months or more). Further challenges included the general over use of medication to treat children and not enough use of clinical practices of applied behavior analysis and trauma informed care.

The major mental health concerns for children and young adults shared by Mrs. Neal in the Kansas City Regional area are the fetal exposure to substance abuse which causes a

detrimental effect on the brain. The diagnosis of fetal alcohol syndrome has developed in an evolving society into a much more complex syndrome since it is not only alcohol, but abuse of multiple substances by some mothers which has contributed to a trauma brain syndrome in children which leads to developmental delay issues. The community has been developing programs for preschoolers, but there is still a gap of services and supports for those children as they become older.

Some of the needs not being addressed for children and young adults stated by Mrs. Neal are mothers with high risk behavior having multiple children with high care needs and the obstacles of identifying children needing services at an early age. There is community support and many clinics which provide substance abuse prevention, awareness and prenatal series for mothers. The problem is some of these mothers still abuse substances and may have five or more children which might need special developmental, behavioral and mental health services for the rest of their life. For these children early detection is important. Even though the community is improving DD services for younger children there are challenges of access to qualified professionals to getting children identified through developmental assessments from age birth to age three years old to receive that care.

ReDiscover

ReDiscover is a not-for-profit community mental health agency that offers a full spectrum of programs and services for people whose lives have been affected by serious mental illness and/or substance abuse. ReDiscover helps men, women, and children who have limited income, no insurance or who are under-insured and known as a key leader in the Kansas City area to serving underserved children (ReDiscover, 2012).

Andrew Zillner contacted Alan Flory, President of ReDiscover, via telephone on March 19, 2012 to request an interview. The interview took place immediately after in which Mr. Flory provided answers to a set of questions pertaining to the community's behavioral health needs.

Mr. Flory said that there are far more youth needing help than ones who receive it due to a multitude of problems. One problem is that many times some behavioral issues in youth are identified very late, which causes the youth to suffer from their particular issue for a long period of time. Also, it can take time for youth to get referred and many referrals come from the criminal justice department, a testament to the delay in behavioral health care. Mr. Flory stated that the majority of the people who are getting identified late or not receiving care at all typically have the least amount of resources, whether it is proper funding or parental support. Thus, he felt it is imperative to better

coordinate care between school systems and facilities such as Crittenton in an effort to identify and treat behavioral health needs as early as possible. Finally, Mr. Flory felt the best place to find data supplementing Crittenton's community health needs assessment would be the Kansas City Regional Behavioral Health Needs Assessment.

Swope Health Services

Swope Health Services is a Federally Qualified Health Center (FQHC) that tries to develop self-empowered, healthy people in healthy communities by providing primary health care, outreach and behavioral health services throughout the greater Kansas City metro area. Swope Health is a key safety-net provider for the medically underserved (90 percent of patients live below the poverty level) (Swope Health Services, 2012).

Tyson Sterling made multiple attempts to contact Dave Barber, Interim CEO and President of Swope Health Services via email and telephone. However, no contact was made.

Secondary Data

Kansas City Regional Health Care Initiative's System Change Committee (2011)

Patrick Altenhofen, Steven Butner, and Ben Miller attended a seminar conducted by the Kansas City Regional Health Care Initiative's System Change Committee. The seminar discussed the need to assess the mental health needs of children and adolescents in the Kansas City area. This group provided four assessments completed by respected organizations that study child and adolescent mental health. The organizations were the University of Missouri-Kansas City, the Resource Development Institute, Human Systems and Outcomes, Inc., and Missouri Department of Mental Health.

The University of Missouri-Kansas City's assessment was a study that gathered existing information about local needs, conducted surveys, focus groups, community meetings, and collected new information about unmet needs and underserved groups. The University of Missouri-Kansas City concluded that all community members have foster care issues, lack of resources, depression, and poor communication with School District Personnel. All indicators can have an effect on a child's mental health.

The Resource Development Institute conducted an electronic survey of 21 community agencies. The survey indicated that 10,284 youth and young adults suffer from Severe Emotional Distress (SED) Syndrome. Out of that 10,284 youth and young adults, more than half are struggling with some form of substance abuse. Furthermore, the survey indicated that there were many

barriers that limit community agencies helping these youth. The barriers were: lack of knowledge of services and existence, funding, communication, and eligibility requirements.

The Human Systems and Outcomes assessment reviewed and analyzed how well SED youth and families are doing are intervention and practices yielding desired results, and how can practices be improved. The review found out that there are limited resources for each community, lack of useful risk assessments, deep cuts in state spending, and a lack of trauma-informed assessment and intervention strategies.

Lastly, the seminar concluded with the Missouri Department of Mental Health implementing a program named "Through the Futures Now: Transitioning Youth Partnership." The program is designed to collaborate with child serving agencies in order to develop and implement a model comprehensive transition approach for youth (16-25) with SED and young adults.

Kansas City Regional Children's Behavioral Health Needs Assessment (2012)

In July 2011, the Mid-America Regional Council commissioned the Kansas City Regional Children's Behavioral Health Needs Assessment through the System Change Committee and its Regional Health Care Initiative. The purpose of the assessment was to "conduct a needs assessment and develop recommendations to improve access to an integrated and well-coordinated system of quality behavioral healthcare for children in the Kansas City metropolitan area" (MARC, 2012, p. 6).

Their methodology included both primary and secondary research on a local and national basis. The target population was children aged 0-25 in the Kansas City metropolitan area, which included six counties (Allen, Johnson and Wyandotte in Kansas; Cass, Jackson and Lafayette in Missouri) and portions of Clay and Platte counties (MARC, 2012, pp. 7-8).

The assessment conducted by MARC has much valuable information, which will not be presented in full detail for the purposes of the present assessment (to view the full report, please visit www.marc.org). Findings from their consumer and provider surveys will be presented. The consumer survey was administered in 2011 from mid-August through November and received 602 respondents, who were parents or guardians of children with diagnosed or suspected behavioral health issues (MARC, 2012, p. 9). The purpose of the survey was to assess the use, need, barrier (trouble obtaining), and gaps (unable to obtain) of services by 'special populations'. The populations consisted of transitioning youth (ages 16-25), foster care children, and children in the juvenile justice system. The provider survey was an online survey administered to thirty behavioral health providers including Community Mental Health Centers, County Mental Health Districts, and Foster Care providers. The surveys helped identify areas of need that are not being adequately addressed or that more emphasis should be placed.

Key Findings

The summary of their findings covered community access, presenting behavioral health issues, levels of care, history of abuse, fragmentation of services, barrier and gaps of services and recommendations generated by consumers and providers. Access to care in the consumer survey results listed no insurmountable issues of access to services, but there were still some areas of concern reported with the insurance coverage for behavioral services. Specifically, insured consumers were concerned with behavioral services cost (10.4 percent); affordability of co-payments (20.5 percent); and limited insurance co-payment on child face to face physician time for behavioral health services (7.2 percent).

Presenting behavioral health issues listed in the figure below (MARC, 2012, p. 14) are the results from the consumer survey. A careful review recognized a high prevalence of the categories comparing the Kansas City regional area to the national average "mood disorders including anxiety" (25 percent vs. 14 percent) and "depression" (19.1 percent vs. 11.2 percent). All other categories were very similar to national average rates.

❖ **Presenting Behavioral Health Issue**

DETAIL UNDER EACH CATEGORY	Suspected Of	Diagnosed With	Treated For	'Suspected Of' in Consumer Survey vs. National Statistics
Mood Disorders including anxiety	310	272	151	25% (14%)
Personality Disorders	98	91	88	16.3% (16%)
Psychotic Disorders including schizophrenia	11	8	5	1.8% (1%)
Depression	115	103	40	19.1% (11.2%)
ADHD/ADD	174	105	65	12% (9%)
Substance Abuse	87	63	46	No national figure available
Autism Spectrum Disorder including Asperger's	90	76	64	10.6% (9%)
Developmental Delay	109	93	91	18.1% (16.7%)
Eating Disorder	26	18	15	4.3% (2.7%)

Identified risk factors in the survey were identified as the History of Abuse or Family History of Behavioral Health Issue and fragmentation of care. When respondents were surveyed 29.3 percent listed their child had a history of abuse and 57.5 percent listed their child had a family history of issues with mental health and/or substance abuse. Many of the same respondents also cited fragmentation of care from behavioral health and school professions, especially for children with co-occurring disorders as a problem.

According to the survey, the most pressing need that is not being met among all of the respondents is the coordination of care with other systems of care, most specifically school. Transportation to and from services was the second highest ranked in both barrier and gap categories. Other areas of concern were the ability to obtain respite care and ability to see a

specialist for a child's treatment. Both assessments of behavioral health issues and education to deal with the behavioral health issue were highly ranked in usage and need, and ranked low in barrier and gap. Comparative rankings between the population groups were conducted to assess the differences among each. However, there was little variation in the services respondents had trouble obtaining, or were unable to obtain. Coordination with other systems of care and transportation to and from services were the most highly ranked among each population. For the full list of rankings, please see Appendix III.

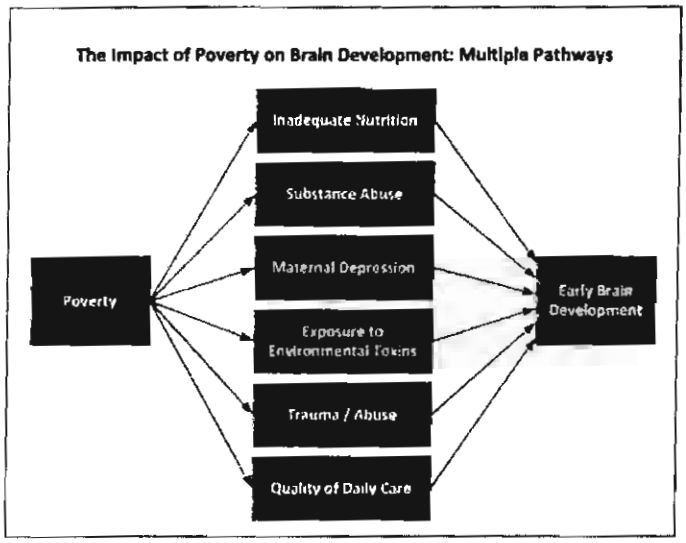
The provider survey results validated many of the important behavioral issues reported by the Consumer Survey (MARC, 2012, p. 18). Some of the most important issues to come up included the following:

- The fragmented nature of the current behavioral health system in the Kansas City area
- The increase in reported behavioral issues within the school system as health care has moved to a community and outpatient focus for care
- A recognized need for a more broad-based, community-oriented screenings based on metrics developed by behavioral health professionals
- A need to increase the timeliness of referrals from an initial assessment
- High levels of unmet needs relating to youths when migrating from a child-based behavioral health system to an adult-based system
- The urgency of integrating behavioral health with physical health care
- An increase in demand for child behavior services while there are decreasing reimbursement amounts for care, particularly for uninsured and under-insured patients
- Increasing expectations for quality outcomes by funders although reimbursement is on the decline especially concerning Medicaid

Review of Mental Health Indicators for Children and Adolescents

In speaking to community organizations' leaders and reviewing research health risk factors from the range of year 2000 to 2010, multiple indicators were identified that can help evaluate the mental health needs of children and adolescents in Crittenton's Primary Service Area. Multiple factors are needed to make healthy and productive people. When multiple inputs are disrupted, we see serious emotional trauma. In an effort to understand the mental health needs of the community, data was gathered to analyze trends and themes of the community. As seen in the figure below poverty may have a relationship and impact on factors that may influence early brain development, which is a risk indicator for services. Due to this and other sources we concentrated on the regional poverty related data (i.e., poverty rates, school free and reduced lunches, unemployment rates, and children receiving public SED services) and

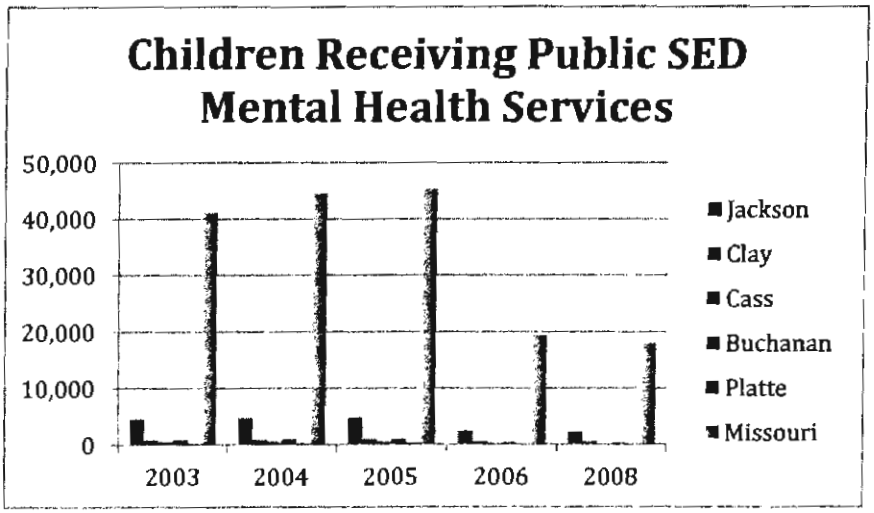
children risk factors (i.e., mental health diagnoses, suicide rates, school dropout rates, and involvement with judicial systems). The trends described below for each risk factor with available data from 2000 to 2010 is meant as snapshot and is not all inclusive. The following sources of data for this section were used from many sources, but primarily from the KIDS COUNT project of The Annie E. Casey Foundation and the U.S. Census Bureau.



Source: Impact of Poverty on Early Brain Development, National Center for children in Poverty (1997)

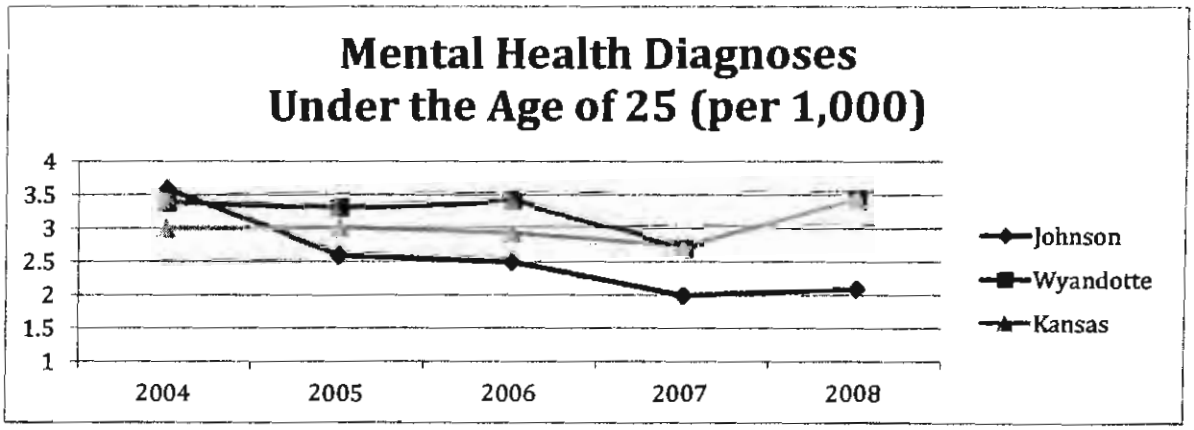
Mental Health

For the State of Missouri, data is collected on the number of children receiving treatment for serious emotional disorders (SED) through the Missouri Department of Mental Health. As the graph below illustrates, the extreme need for mental health services exists. It is also notable that 2006 saw a significant drop in children receiving these services.



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.
Data Source: Missouri Department of Mental Health. Data for 2007 is not available.

In the state of Kansas, the rate of mental health diagnoses of children under the age of 25 has seen a recent increase. This trend, illustrated in the below graph, indicates that organizations providing mental health services for children must continue to monitor the situation closely.



Definitions: The number of child hospital discharges of mental health diagnoses per 1,000 children under age 18. Mental health diagnoses range from Diagnosis-Related Groups (DRG) 425-432 which also cover all the medical DRGs in the Major Diagnostic Categories 19 – Mental Diseases and Disorders. Data are provided by the Kansas Hospital Association and Kansas Department of Health and Environment. Population estimates data are from the U.S. Census Bureau. The current rate represents the number of discharges per 1,000 children for federal fiscal year 2008. Data Source: Kansas Hospital Association and Kansas Department of Health and Environment

Poverty Rate

Researchers have known that poverty and mental illness have a correlation. Hudson (2005) suggested that poverty, acting through economic stressors such as unemployment and lack of affordable housing, is more likely to precede mental illness than the reverse. The findings indicate that poverty may cause, and at least intensify, the risk that an individual will suffer from mental illness.

According to data from the United States Department of Commerce, the percent of children in poverty under the age of 18 in key Missouri counties being served by Crittenton has risen considerably since 2000. Jackson County, which commanded 65 percent of Crittenton's inpatients in 2011, saw a 21 percent increase in the number of children in families with less than $21,200 for a family of four between years 2000 and 2007. All other counties in Crittenton's Missouri Primary Service Area saw similar increases as pictured in Graph 1 (see Appendix IV). It is also important to note that Jackson and Buchanan Counties have a larger percent of children in poverty than Missouri as a whole.

An April 13, 2011 article from the Johnson County Sun News conveyed results of a recent study, conducted for the U.S. Department of Housing and Urban Development, underscoring the fact that the growth in the numbers of Crittenton's most economically needy residents is not confined to the urban core. Even in one of the most affluent suburbs, Johnson County, Kansas,

the homeless rate has grown 50 percent in the last two years. Among the homeless, more than half are children, with two in every five of these children under 6 years of age (Stanton, 2011). Record numbers of area families cannot afford food and shelter and, at best, are foregoing health matters in lieu of basic survival. These trends can be seen in Graph 2 (see Appendix IV).

Free and Reduced Lunch

Students who participate in the free or reduced lunch program are from families who are at or below the poverty level (Grunderson, Krieder, & Pepper, 2009). Scholar H. Gregory Hawkins, Ph.D. points out that, "Poverty is a prevailing risk factor that multiplies the likelihood children will be exposed to several other risk factors, which result in negative impacts on early brain development, ability to learn, and quality of later life" (Hawkins 2001, p. 7). Although the free and reduced lunch program is a good indicator of the juvenile mental health needs of a community, research has also shown once receipt of free and reduced price lunches begin through the National School Lunch Program (NSLP) the health outcomes of children improve (Grunderson, Krieder, & Pepper, 2009).

As shown in the graphs 3 and 4 in the appendix, the Missouri counties of Jackson, Clay, Cass, Buchanan, and Platte all show a rise between 2004 and 2008 in the utilization of the free or reduced lunch program in Missouri. The counties of Platte, Clay, and Cass are below the Missouri average of 40 percent while Jackson and Buchanan County are above the Missouri average.

The Kansas counties of Wyandotte and Johnson have a similar rise between 2006 and 2010 in the utilization of the free or reduced lunch program. Wyandotte is the above the Kansas average of around 40 percent, rising from close to 60 percent to close to 80 percent in 2010. Johnson County is well below the Kansas average at 10 percent in 2006 to close to 20 percent in 2010.

Suicide Rate

The statistics associated with key mental health risk factors affecting all children are a grave concern. Nationwide, suicide is the third leading cause of death for youth between the ages of 10 and 24 (Centers of Disease Control and Prevention, 2007). While this is an eye-opener, suicide incidence nationally has declined in the last 3 years. Sadly, the number of children taking their own lives in the Kansas City metropolitan area is on the rise. While there are multiple causes for suicide, the most prevalent is untreated depression and other mental illness. As seen in graph 5, suicide rates in the Missouri Primary Service Area counties see a decreasing trend in suicides with children ages 15 to 24 (Missouri Department of Health and Senior Services, 2007). Although a decrease and consistent with national rates of suicide, the

variability between the years should be a concern for mental health providers (CDC, 2007). In the Missouri counties, there is an increasing trend in childhood suicide by those less than 15 years of age. This is a concern, but such rates remain low compared to the national rate of suicide of 0.9 noted by the CDC in 2007 (CDC, 2007). This can indicate a growing need for mental health services aimed at combating childhood suicide.

Violent Crimes per 1,000 Residents

A violent crime is defined by the Federal Bureau of Investigation as any felony of murder, rape, aggravated assault, and/or robbery (Federal Bureau of Investigation, 2009). The rate of violent crimes can be associated with juvenile mental health and is proven through research. Susanna Mustanoja et al. (2011) stated, "The cycle of victimization starts at home and continues up to adolescence. This vicious cycles leads to subjects' lower self-esteem, depression, fear and incapacity of being assertive with peers." Graphs 7 and 8 below show the relationship of bullying behavior to the psychological impact of violence among boys and girls in the United States (Mustanoja et al., 2011).

As shown in graph 9, between the years of 2005 and 2006 there was an increase in the violent crime rate from 525 to close to 550 violent crimes per 100,000 inhabitants in Missouri (FBI, 2009). From 2007 to 2009 there was a decrease of 50 violent crimes per 100,000 inhabitants (FBI, 2009). In Kansas the violent crimes per 100,000 inhabitants rose from close to 400 to 450 between the years 2005 and 2007 (FBI, 2009). Following that time period the violent crimes dropped from 450 back down to 400 violent crimes per 100,000 (FBI, 2009).

School Dropout Rate

High School dropout rates are a problem across the country. The U.S. Department of Education found that 50 percent of 14 year olds diagnosed with a mental or behavioral health disorder dropped out of high school in the United States (NAMI, 2010). Within Metropolitan area, the Kansas City School District has the highest percentage of high school dropouts at 16.4 percent, much higher than the Missouri rate of 3.5 percent (MDESE, 2012). Clay, Cass, Buchanan, and Platte have fluctuated between 2008 and 2011 but have remained at and below the overall Missouri high school dropout rate. The Metropolitan dropout rate, broken down by school district, is shown in graph 10.

In Kansas there is a significant difference between neighboring Wyandotte and Johnson County. The Kansas City School District in Wyandotte County had a dropout rate of 3.1 in 2010, about a 50 percent increase from the state average of 1.5 percent (KSDE, 2012). Comparatively, Johnson County School Districts were all below the state average with Shawnee Mission Public Schools having the highest rate of 1.3 percent.

Unemployment Rates

There have been many studies that show that unemployment rates and mental illness have a correlation. A large scale study done by Kammerling and O'Connor (1993) concluded that unemployment rates are an extremely powerful indicator of the rates of serious mental illness that will need treatment in a hospital setting. This study also showed that people with serious mental illness living in areas of high unemployment could be faced with considerable hardships.

Involvement with Judicial System

As seen in Graph 12, the Primary Service Areas in Missouri have a variety of behaviors in juvenile law violation referrals. Most importantly, it should be noted that Jackson County has seen an increase in referrals between 2006 and 2007. This is the county that Crittenton received 65 percent of their inpatients in 2011. This upward trend occurs when the referrals for the state of Missouri is declining. This is a clear indication that there is a greater need for mental health services for children in at least Jackson County. The changes in referrals can reflect both changes in behavior and adjustments to police enforcement. Data for Kansas Primary Service counties were unavailable.

Primary and Secondary Data Summary

The data was gathered to analyze trends and themes of the community. The supplied information identified children risk factors for behavioral health services, community strengths and challenges, and general service needs throughout the primary service area.

There was a focus in the data on risk factors that may influence early brain development of children, which included regional poverty related data (poverty rates, school free and reduced lunches, unemployment rates, and children receiving public SED services) and children risk factors (mental health diagnoses, suicide rates, school dropout rates, and involvement with judicial systems). This information showed from 2000 to 2010 an increase in poverty and risk factors and a decrease of available SED services. The data also indicated a downward trend of suicides with children ages 15 to 24, but the suicide rate for less then 15 years of age increased.

The strengths of the community service area identified were a good collaboration of agencies, care coordination, adequate amount of inpatient beds for children, and good working relationships between private entities and state organizations. Reoccurring pronounced community challenges and needs found were evident in behavioral health services in schools and the funding for sustainability; shortage of acute care facilities to serve developmental delay (DD) children in crisis; focused assessment resources for young children (pre-school, Head Start

and early elementary grades) to identify and treat behavioral health needs at a earlier age; treating primary and behavioral health needs concurrently, and trauma focused care and interventions. This data assisted in recognizing what to prioritize on the community behavior health needs of children in the great Kansas City region.

Information Gaps

While the information contained within this assessment is considerably detailed and referenced, there were some specific information gaps that we identified. There were additional community organizations we would have liked to collaborate with to gain knowledge about children's health services and unmet community needs. However, we were unsuccessful in making those connections. In addition, some of the data for the mental health indicators were not current through 2012, although we used the most up-to-date information available.

Identification and Prioritization of Community Health Needs

Analysis from the primary and secondary data described above provided much information for consideration in identifying the community health needs of Crittenton's primary service area. We used the Comparative Need Ranking list reported by MARC (2012, p. 16) as a starting point, and then vetted these issues with healthcare professionals and the behavioral health community to verify and agree on their priority order. Using input from health care professionals within the behavioral health community and based upon common threads in the data sources identified above, Crittenton Children Center prioritized the top ten health needs in the community. The following page lists the top needs and the attached implementation plan outlines how Crittenton will address these needs.

Top 10 Behavioral Health Children Needs

1. Education in community (schools) to deal with behavioral health needs
2. Assessment of the behavioral health needs early in childhood
3. Coordination with other systems of care (e.g., school)
4. Specialist to treat children with behavioral health needs
5. Transportation to/from services
6. Inpatient services
7. Partial (day services) and intensive outpatient services
8. Outpatient substance abuse
9. Detoxification
10. Inpatient substance abuse

Appendix 1 – List of Contacts (2011)

Patrick Altenhofen, Steven Butner, and Ben Miller provided the following contact list of their primary data collection in 2011.

Contact List

Name	Title	Organization
Bonnie Neal	Chief of Children's Community Operations	MO Dept of Mental Health
Mary Kettlewell	Program Officer	Health Care Foundation of Greater Kansas City
Alan Huxman	Mgr, Quality and Performance Improvement	Crittenton Children's Center
Krista Allen	Development Officer	Crittenton Children's Center
Kathy McClelland	Chief Nursing Officer	Crittenton Children's Center
Janet Krueger	Clinical Director	Crittenton Children's Center
Janine M. Hron	Chief Executive Officer	Crittenton Children's Center
Jody Denson	Health Planner III	Mid-America Regional Council Kansas City Regional Health Care
Lisa Clements	Clinical Director	MO HealthNet (Medicaid)
Rick Cagan	Executive Director	National Alliance on Mental Illness (NAMI)
Randy House	VP, Health Informatics	Saint Luke's Health System
Liz Cessor	VP, Mission & Community Services	Saint Luke's Health System

Appendix II – Demographic and Economic Profile of Primary Service Area

	Missouri					Kansas	
	Jackson	Clay	Cass	Buchanan	Platte	Johnson	Wyandotte
Population (2010)							
Total Population	674,158	221,939	99,478	89,201	89,322	544,179	157,505
Under 5 years	7.1%	7.3%	6.8%	6.9%	6.4%	7.2%	8.7%
5 to 9 years	6.8%	7.3%	7.4%	6.4%	6.8%	7.5%	7.9%
10 to 14 years	6.6%	7.0%	7.8%	6.2%	7.1%	7.4%	7.2%
15 to 19 years	6.6%	6.5%	7.0%	7.1%	6.7%	6.3%	7.1%
20 to 24 years	6.8%	5.7%	5.2%	7.8%	5.5%	5.1%	6.9%
25 to 34 years	14.5%	14.4%	12.2%	13.4%	13.0%	14.6%	15.1%
35 to 44 years	12.9%	14.4%	13.3%	12.1%	14.3%	14.4%	12.5%
45 to 54 years	14.6%	14.8%	15.3%	14.6%	16.4%	15.1%	13.4%
55 to 64 years	11.5%	11.4%	11.5%	11.5%	12.7%	11.6%	10.4%
65+ years	12.6%	11.3%	13.5%	14.0%	11.2%	10.9%	10.7%
Total Males	48.3%	48.8%	48.8%	50.0%	49.2%	48.8%	49.3%
Total Females	51.7%	51.2%	51.2%	50.0%	50.8%	51.2%	50.7%
Race/Ethnicity (2010)							
Race							
White	66.9%	87.5%	91.7%	89.1%	87.2%	86.0%	54.6%
Black or African American	23.9%	5.2%	3.5%	5.2%	5.9%	4.3%	25.2%
American Indian and Alaska Native	0.5%	0.5%	0.5%	0.4%	0.5%	0.4%	0.8%
Asian	1.6%	2.1%	0.6%	0.8%	2.3%	4.2%	2.5%
Native Hawaiian and Other Pacific Islander	0.2%	0.3%	0.1%	0.2%	0.3%	0.1%	0.1%
Some Other Race	3.8%	1.8%	1.4%	1.8%	1.3%	2.5%	12.9%
Ethnicity							
Hispanic or Latino	8.4%	5.9%	4.0%	5.2%	5.0%	7.2%	26.4%
Not Hispanic or Latino	91.6%	94.1%	96.0%	94.8%	95.0%	92.8%	73.6%

	Missouri					Kansas	
	Jackson	Clay	Cass	Buchanan	Platte	Johnson	Wyandotte
Income/Insurance (2010)							
Income and Benefits (In 2010 Inflation Adjusted Dollars)							
Total households	268,583	87,497	36,057	34,117	35,402	211,193	54,411
Less than $10,000	10.0%	4.7%	2.7%	9.9%	3.8%	3.8%	13.5%
$10,000 to $14,999	6.9%	4.0%	5.3%	7.7%	3.6%	2.8%	6.5%
$15,000 to $24,999	11.5%	10.1%	6.5%	14.8%	7.3%	7.8%	13.0%
$25,000 to $34,999	11.7%	10.0%	9.9%	10.7%	8.5%	7.3%	13.6%
$35,000 to $49,999	14.9%	16.6%	16.4%	16.2%	12.5%	11.7%	16.1%
$50,000 to $74,999	17.9%	19.2%	24.1%	16.9%	23.0%	19.3%	18.5%
$75,000 to $99,999	11.7%	13.7%	15.1%	11.0%	12.6%	16.2%	9.7%
$100,000 to 149,000	10.2%	17.2%	14.7%	9.9%	19.0%	17.9%	6.2%
$150,000 to $199,000	2.9%	2.7%	3.4%	1.0%	5.5%	6.6%	1.8%
$200,000 or more	2.4%	1.9%	1.8%	1.8%	4.2%	6.6%	1.1%
Percentage of People Whose Income in the Past 12 Months is Below the Poverty Level							
All People	17.1%	10.1%	7.9%	15.5%	8.1%	6.6%	24.3%
Under 18 Years	25.4%	16.6%	10.5%	22.2%	11.1%	8.3%	36.4%
Health Insurance Coverage							
Civilian noninstitutionalized population	670,432	220,599	98,758	85,939	89,379	542,381	156,924
With health insurance coverage	83.0%	91.4%	89.1%	88.9%	93.0%	90.5%	73.6%
With private health insurance	65.2%	80.4%	74.5%	71.6%	83.9%	83.5%	54.9%
With public coverage	27.8%	21.9%	26.5%	32.0%	19.3%	17.3%	28.7%
No health insurance coverage	17.0%	8.6%	10.9%	11.1%	7.0%	9.5%	26.4%
Geography (2010)							
Land Area in Square Miles	604.46	397.30	696.84	408.03	420.19	473.38	151.60
Persons per Square Mile	1,115.3	558.6	142.8	218.6	212.6	1,149.6	1,039.0

Data source: U.S. Census Bureau American Fact Finder and State & County QuickFacts

Appendix III – Consumer Survey Results (MARC)

COMPARATIVE USE RANKING

SERVICE CATEGORY	USE -ALL	USE-FC	USE-JJ	USE-TY
Assessment of BH Issue	1	1	1	1
Education to deal with BH Issue	2	2	1	2
Specialist to treat Child	3	3	2	3
Crisis services when acute	11	4	3	4
Emergency Placement	6	7	4	7
Inpatient services	5	7	4	8
Partial outpatient (day services)	10	8	8	9
Intensive Outpatient Services	8	9	6	6
Detoxification	13	12	10	Not ranked
Outpatient Substance Abuse	12	11	11	Not ranked
Inpatient Substance Abuse	14	13	11	Not ranked
Respite Care	9	10	9	11
Transportation to/from services	7	6	7	10
Coordination with other Systems of Care (e.g. school)	4	5	5	5

Key: FC=Foster Care; JJ=Juvenile Justice; TY=Transitioning Youth

COMPARATIVE NEED RANKING

SERVICE CATEGORY	NEED-ALL	NEED-FC	NEED-JJ	NEED-TY
Assessment of BH Issue	2	1	2	1
Education to deal with BH Issue	1	3	1	2
Specialist to treat Child	4	4	3	4
Crisis services when acute	7	7	7	8
Emergency Placement	8	8	9	8
Inpatient services	9	9	10	8
Partial outpatient (day services)	10	10	8	6
Intensive Outpatient Services	10	10	10	7
Detoxification	12		11	Not ranked
Outpatient Substance Abuse	11	10	12	Not ranked
Inpatient Substance Abuse	13	11	13	Not ranked
Respite Care	5	5	6	5
Transportation to/from services	6	6	5	5
Coordination with other Systems of Care (e.g. school)	3	2	4	3

Key: FC=Foster Care; JJ=Juvenile Justice; TY=Transitioning Youth

Data source: Mid-America Regional Council's Kansas City Regional Children's Behavioral Health Needs Assessment

COMPARATIVE BARRIER RANKING

SERVICE CATEGORY	BARRIER-ALL	BARRIER-FC	BARRIER-JJ	BARRIER-TY
Assessment of BH Issue	7	8	5	4
Education to deal with BH Issue	4	4	3	4
Specialist to treat Child	3	3	2	
Crisis services when acute	5	5	4	3
Emergency Placement	6	6	6	4
Inpatient services	8	6	5	Not ranked
Partial outpatient (day services)	8	7	7	4
Intensive Outpatient Services	8	8	7	Not ranked
Detoxification	Not ranked	Not ranked	Not ranked	Not ranked
Outpatient Substance Abuse	9	Not ranked	Not ranked	Not ranked
Inpatient Substance Abuse	Not ranked	Not ranked	Not ranked	Not ranked
Respite Care	Not ranked	Not ranked	4	3
Transportation to/from services	2	2	3	2
Coordination with other Systems of Care (e.g. school)	1	1	1	1

Key: FC=Foster Care; JJ=Juvenile Justice; TY=Transitioning Youth

COMPARATIVE GAP RANKING

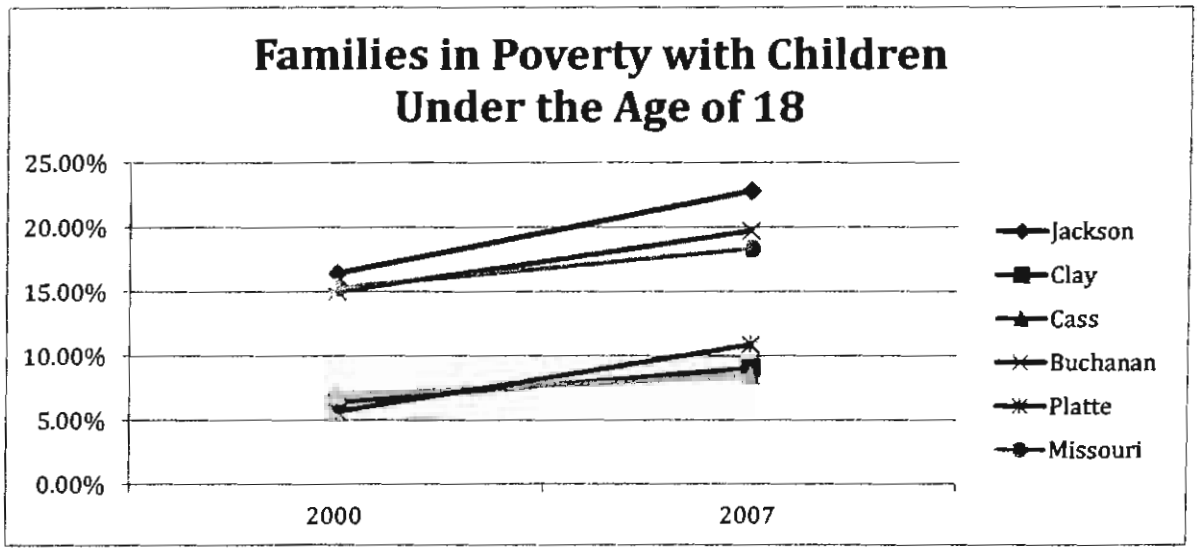
SERVICE CATEGORY	GAP-ALL	GAP-FC	GAP-JJ	GAP-TY
Assessment of BH Issue	Not ranked	7	6	5
Education to deal with BH Issue	7	7	5	4
Specialist to treat Child	3	5	5	5
Crisis services when acute	4	4	4	3
Emergency Placement	6	5	2	Not ranked
Inpatient services	8	6	6	4
Partial outpatient (day services)	8	Not ranked	4	Not ranked
Intensive Outpatient Services	8	7	5	Not ranked
Detoxification	Not ranked	Not ranked	6	Not ranked
Outpatient Substance Abuse	Not ranked	Not ranked	6	Not ranked
Inpatient Substance Abuse	Not ranked	Not ranked	6	1
Respite Care	5	2	4	Not ranked
Transportation to/from services	2	3	3	2
Coordination with other Systems of Care (e.g. school)	1	1	1	5

Key: FC=Foster Care; JJ=Juvenile Justice; TY=Transitioning Youth

Data source: Mid-America Regional Council's Kansas City Regional Children's Behavioral Health Needs Assessment

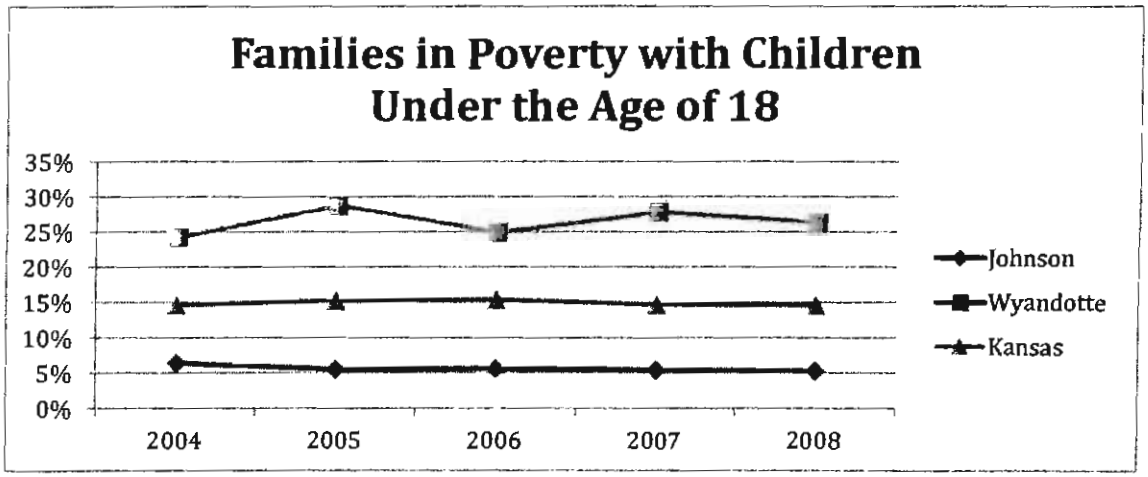
Appendix IV - Graphs

Graph 1 Families in Poverty with Children under the Age of 18



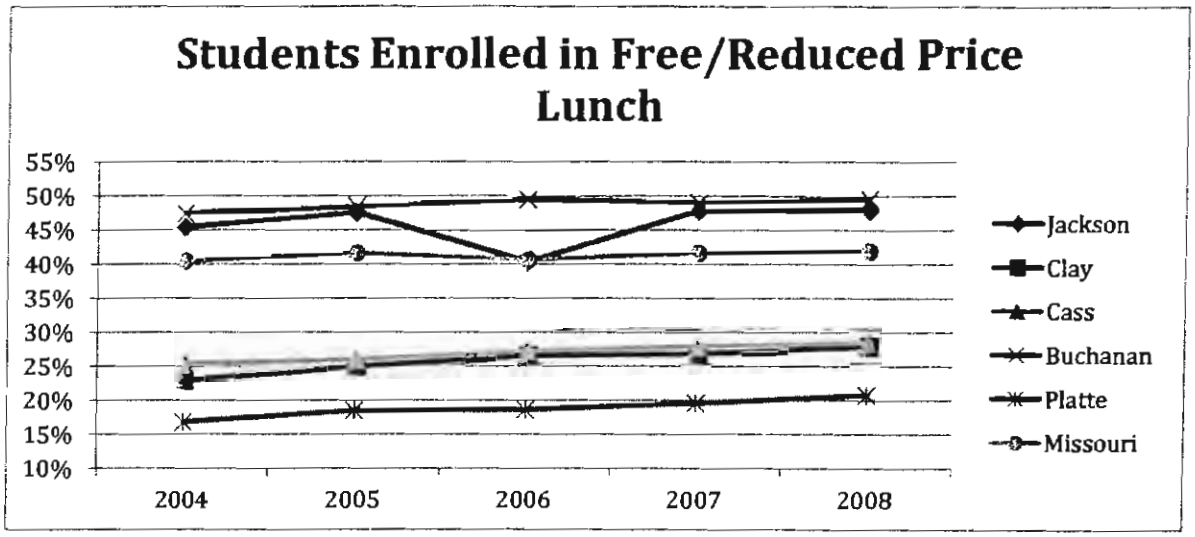
Definitions: Percentage of related children under age 18 who live in families with incomes below the U.S. poverty threshold, as defined by the Bureau of the Census. The 2008 poverty threshold was $21,200 for a family of four. For counties with a population of less than $20,000, an estimate based on county-PUMA ratio is reported.
Data Source: United States Department of Commerce, Bureau of the Census.

Graph 2 Families in Poverty with Children under the Age of 18



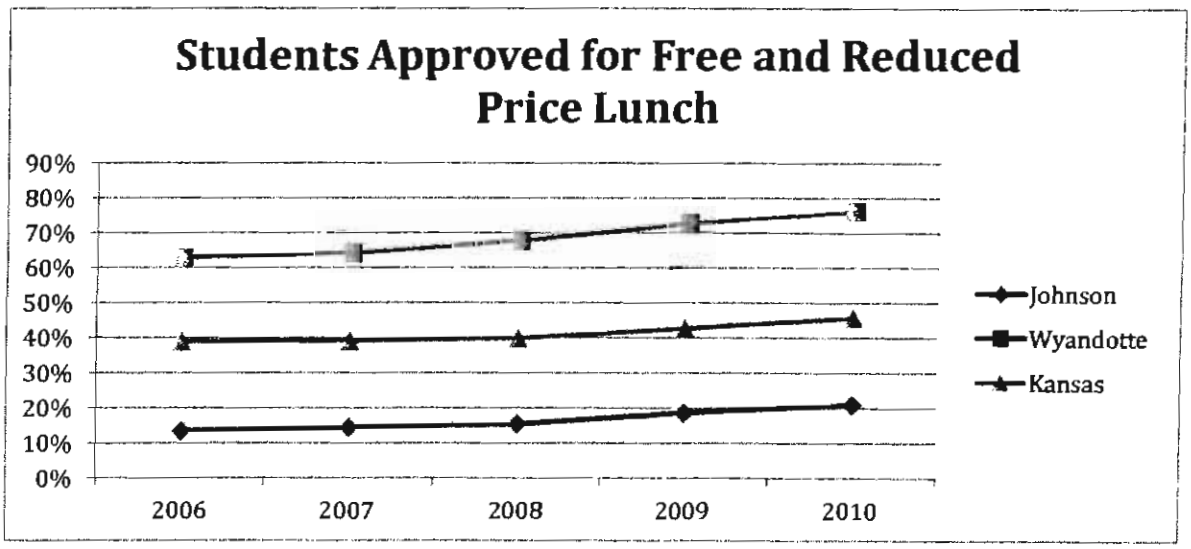
Definitions: The estimated percentage of children under 18 years of age who live in families with incomes below 100% of the U.S. poverty threshold as defined by the U.S. Office of Management and Budget. Data are based on the U.S. Census Bureau's Small Area Income and Poverty Estimates. The current rate represents the percentage for calendar year 2008.
Data Source: U.S. Census Bureau's Small Area Income and Poverty Estimates

Graph 3 Students Enrolled in Free or Reduced Price Lunch



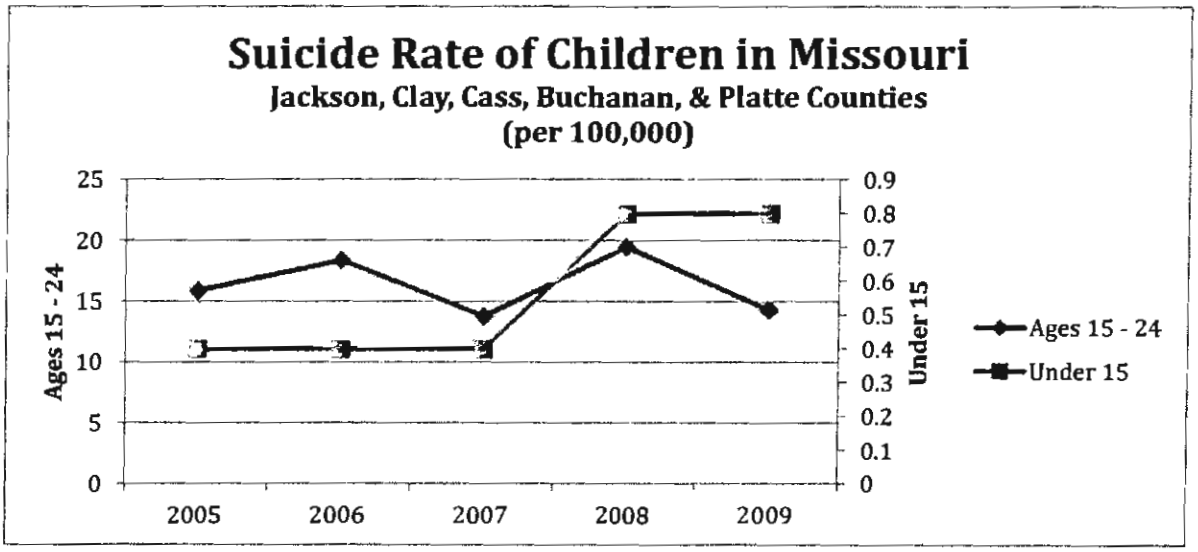
Definitions: Percentage of students who are enrolled in the free or reduced price Notional School Lunch Program. Children from households with incomes less than 130 percent of poverty are eligible for free lunches; those from households below 185 percent of poverty are eligible for reduced price lunches. Rate is expressed as percent of total school enrollment.
Data Source: Missouri Department of Elementary and Secondary Education; Missouri Office of Administration, Division of Budget and Planning.

Graph 4 Students Approved for Free and Reduced Price Lunch



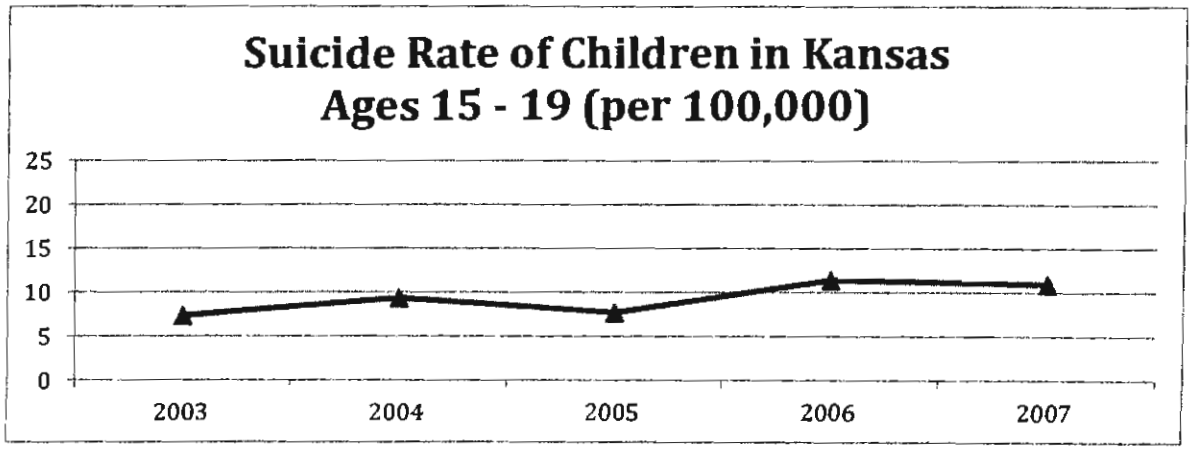
Definitions: The percentage of public school students who are approved for the Free and Reduced Price Lunch Program at the beginning of the academic year. Data are provided by the Kansas State Department of Education. The current rate represents academic year 2009-2010.
Data Source: Kansas State Department of Education

Graph 5 Suicide Rate of Children in Missouri



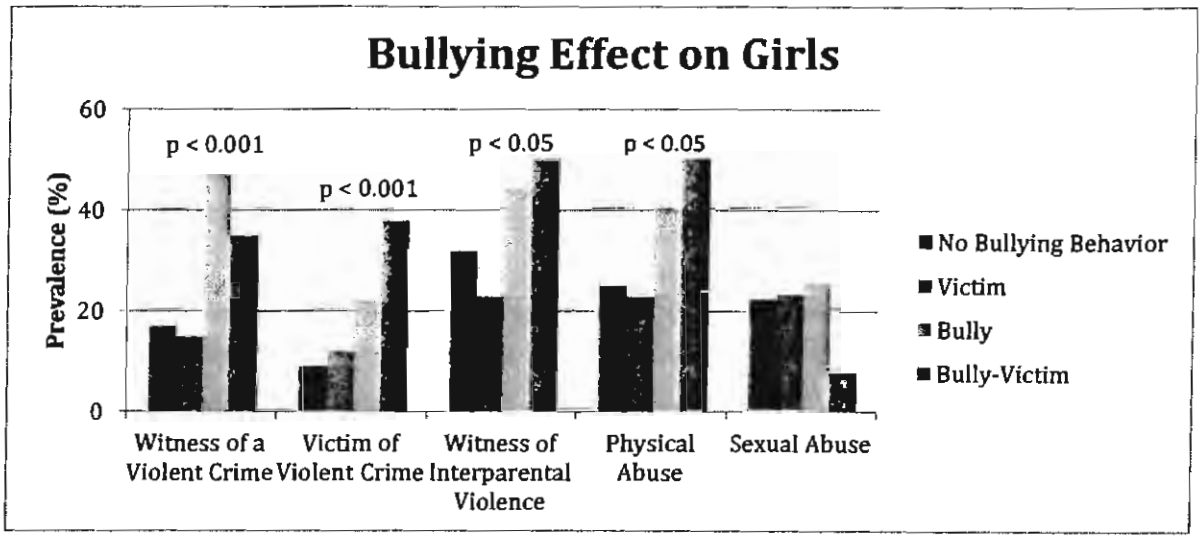
Data Source: State of Missouri Department of Health and Senior Services

Graph 6 Suicide Rate of Children in Kansas



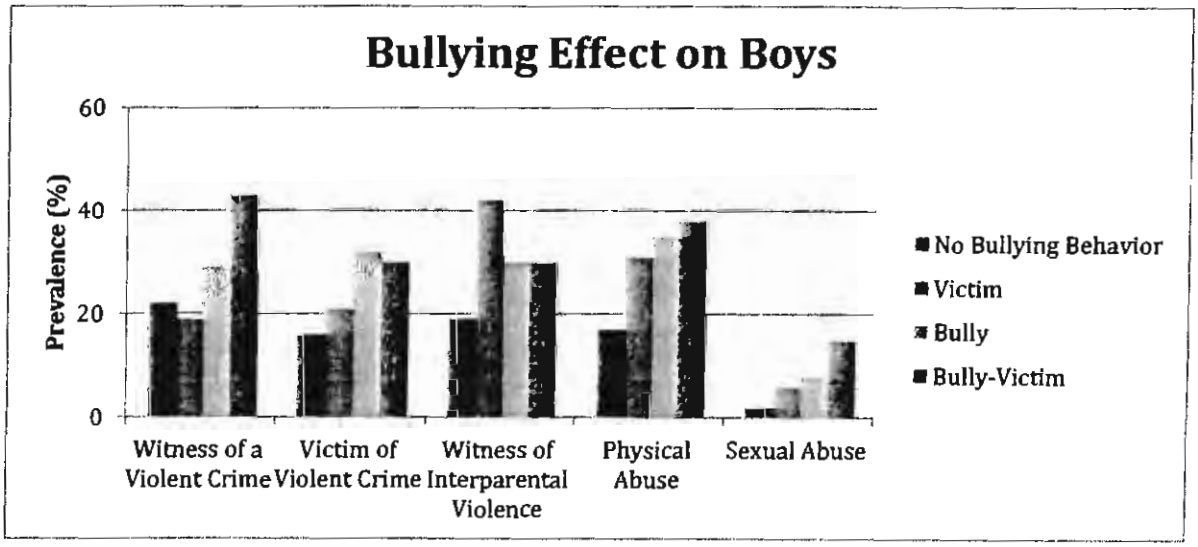
Data Source: CDC WISQARS On-line Database, compiled from Compressed Martality File 2003-2007

Graph 7 Bullying Effect on Girls



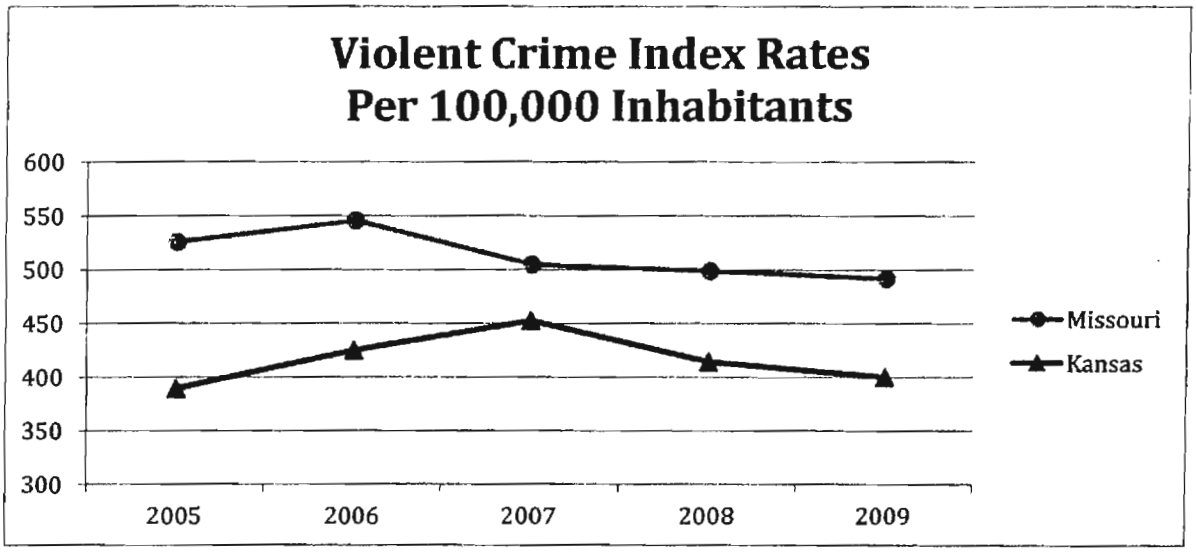
Data Source: Child Psychiatry Human Development

Graph 8 Bullying Effect on Boys



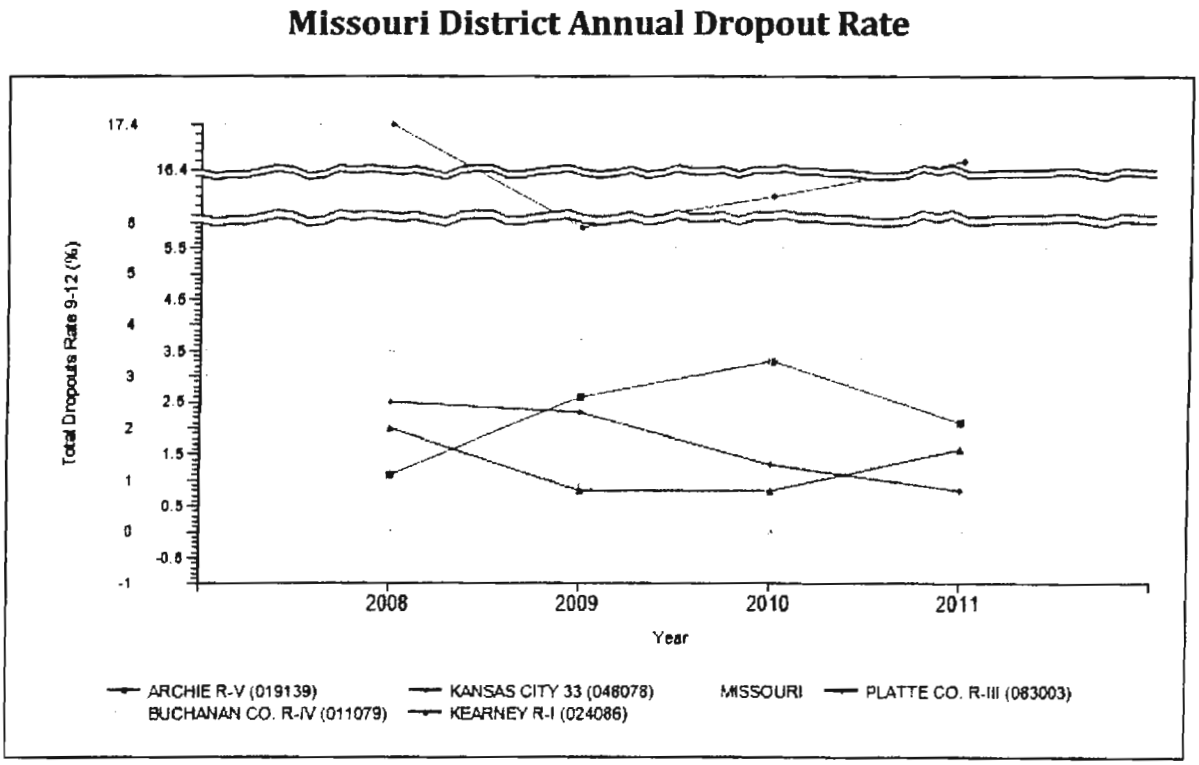
Data Source: Child Psychiatry Human Development

Graph 9 Violent Crime Index Rates



Data Source: FBI, Uniform Crime Reports

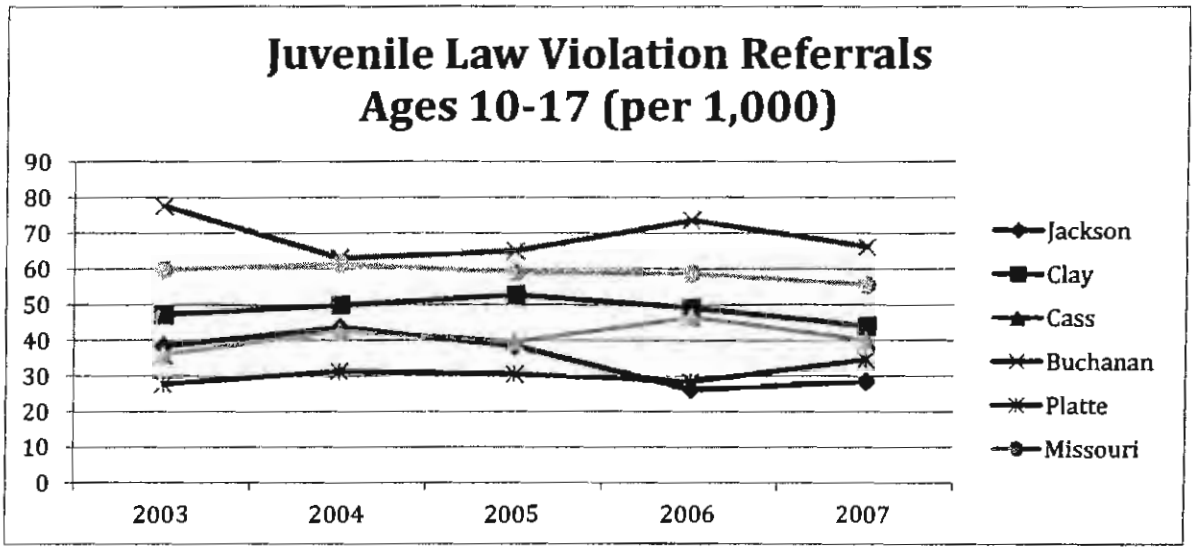
Graph 10 Annual High School Dropouts



Definitions: Percentage of students (grades nine through twelve) enrolled in public schools that 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, 2008 indicates the 2007-2008 school year.
Data Source: Missouri Department of Elementary and Secondary Education.

Graph 11 Juvenile Law Violation Referrals



Definitions: Rate of referrals to one of the 45 juvenile courts in Missouri for acts that would be violations of the Missouri Criminal Code if committed by an adult. The numbers represent seporately disposed court referrals, not individual youth. Rate is expressed per 1,000 youths ages ten through 17.
Data Source: Missouri Department of Social Services; Missouri Office of Administration.

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