



Date: January 31, 2018

FACE OF BOONE COUNTY ANNUAL REPORT—YEAR TWO

Mission Statement

The Family Access Center of Excellence (FACE) of Boone County is a cross-sector implementation center that aims to provide a coordinated, transparent, and collaborative approach to improving access to quality social, emotional, and behavioral health services for all Boone County families with a child (age 0-19). FACE works to achieve this aim through a two pronged approach:

1. Providing Non-Conflicted and Scientifically-Based Case Management Services

- providing free developmentally responsive child-focused and family-based assessments;
- utilizing evidence-based practices (i.e., Motivational Interviewing [MI]) to enhance family engagement;
- providing a scientific approach (i.e., Family Check-Up [FCU]) to developing a measureable action plan;
- increasing access to family choice of providers to address prioritized problem areas listed in action plan;
- reducing barriers to services through on-going family contact with licensed mental health professionals;
- monitoring the success of treatment plans using evidence-based youth/family progress monitoring tools.

2. Promoting and Sustaining a Continuum of Evidence-Based Programs and Practices

- providing technical assistance (EBP implementation support, coordinating services, data linking);
- offering creative financing support (collaborative grant writing, sustaining & brokering of services);
- improving quality of care (training & coaching, progress monitoring, monitoring gaps in continuum).

Executive Summary

The Family Access Center of Excellence (or FACE) of Boone County has continued to grow, improve, and thrive during 2017. In our initial proposal and our first annual report, we described substantial barriers to youth and families in need of social, emotional, and behavioral health care. Key among these challenges are limited access to services and poor outcomes even among youth who do receive mental health services (i.e., they typically do not benefit more than youth who receive no services). To combat these problems, our community has invested in an innovative and cutting-edge access center known as FACE. In essence, everything we do at FACE is aimed at reducing these barriers. The data and our experiences suggest we are making important advances in Boone County to improve both access and outcomes for youth and families—just 16 months after opening our doors.

In this report, we highlight all that has been accomplished in the past year. In short, the FACE leadership team and staff work dutifully to advance all promised activities and rely heavily on regular and ongoing data collection to drive decisions. We employ ongoing training, supervision and data-based performance feedback to continually evaluate and improve the services provided at FACE. We have experienced little to no staff turnover at year 2—a sign that our staff remain energized and dedicated to the work that they engage in every day and a testimony to the support and culture that the FACE director, Erin Reynolds, has committed herself to creating for FACE staff and—by extension—all families who visit FACE. Our 2017 accomplishments include the following:

- Opened an extension office in Centralia;
- Continued to refine our data systems and rely on these data to drive decision systems;
- Engaged in >251 hours of outreach with nearly 3,000 Boone County residents;
- Developed partnerships and campaigns to raise awareness of behavioral health;
- Received 515 referrals from many sectors of Boone County;
- Engaged 257 youth and their families in an evidenced-based assessment, feedback, referral, and progress monitoring process known as the Family Check Up;
- Provided 16 trainings (1,474.25 hours) to 454 service providers;
- Reduced the lag time between referral and engagement by 50% compared to 2016.

We also highlight the concerns we see in the youth and families who visit FACE to access help and support. As you will see detailed in this report, the youth and families seen at FACE are among the most at-risk in our community. Here is a brief summary of the social, emotional, and behavioral health risks experienced by the Boone County families served by FACE:

- 75% of youth display serious disruptive behavior and conduct problems;
- 68% of youth struggle with hyperactivity and impulsivity;
- 71% of youth show significant attention problems;
- 66% of youth display serious behavior problems at school;
- 90% of youth have poor school performance;
- 23% of youth experience thoughts of suicide;
- 62% of families show poor relationship quality within their family system;
- 63% of families struggle to implement positive, effective parenting practices;
- 24% of families contend with substance use problems.

Through FACE efforts to connect families with needed services, we have also gained significant insights into areas for growth and improvement, and identified several, critical gaps in services and supports for Boone County families. To date, FACE data indicate that the availability of the following services are insufficient to fully meet Boone County family needs:

- Basic needs, including affordable housing and emergency shelter, food, furniture, utilities, employment, transportation, health insurance, prescription drug coverage;
- Free, evidence-based parent training and parenting education;
- Mentoring support programs;
- Free individual and family therapy for uninsured and low income families;

- Services to meet the needs of families beyond Columbia;
- Timely assessment and intervention for early childhood developmental delays;
- Intensive, family-focused services for severe adolescent conduct problems;
- Comprehensive services for severe adolescent mood dysregulation and self-harm risk;
- Child psychiatrists who can prescribe and monitor psychiatric medications.

In summary, FACE is the culmination of the tireless work of many in our community over several years, including those who helped pass the tax funding initiative to support youth mental health and those who conceived of a program to help families and youth access non-conflicted mental health care. As such, FACE holds the hopes and aspirations of an entire community for improving the social, emotional, and behavior health of all youth in Boone County. In this report, we summarize the activities and accomplishments of FACE during the past year as well as lessons learned and future directions. Much work remains to be done in order to achieve all that we aim to do. We hope that this annual report can inform all FACE stakeholders of the progress we have made toward realizing the goals established in the original FACE proposal. We are honored to be entrusted with the task of bringing the vision of an access center to life in the form of FACE. We look forward to the coming year's challenges and opportunities to fully realize FACE as a cross-sector implementation center that provides a coordinated, transparent, and collaborative approach to improving access to quality social, emotional, and behavioral health services for all Boone County youth and their families.

Format of Report: Year Two Development Report

Because FACE is a multifaceted organization with various influences, levels of oversight, aims, and activities designed to achieve those aims, it is challenging to organize reports of FACE activities in a manner that fully communicates all that FACE staff accomplish in a single year. That said, the format of this report is organized differently than prior reports. Instead of listing broad headers, we have organized the report using questions that attempt to get at the activities, outputs, and outcomes specific to FACE. The report examines several groups of key questions regarding:

- A. What we do at FACE: oversight, staff, process, and operations/activities;
- B. Who we serve at FACE: demographics and conditions reported by youth/families engaged in FACE's process;
- C. What kind of Impact is FACE having for families: outcomes for family self-report on Top Problems Assessment; and
- D. What are the next steps and lessons learned from 2017?

The key questions posed above capture information listed in the year 2 timeline (see [Appendix A. FACE Development Timeline: Year 2](#)) in the proposal drafted by the FACE Development and Leadership Team (Drs. Thompson, Reinke, Herman, and Hawley) and approved by the Boone County Children's Services Board on January 13, 2016. In addition, there is a list of appendices at the end of this narrative which detail all of the FACE employee procedures, provide some information regarding the detailed training of FACE staff, offer insight into family information and services offered at FACE, and give some guidance as to the plethora of data collection and

database systems developed to track FACE activities, efforts, family risks and processes, and efforts to market FACE and collaborate with other entities in our community to achieve common goals. The Key questions examining the second year of development of the FACE of Boone County are summarized here.

A. WHAT FACE DOES: DEVELOPMENTS IN OVERSIGHT, OPERATIONS AND FACE PROGRAM ACTIVITIES IN 2017?

A.1. Oversight: Board of Representatives. As of January 1 to December 31, 2017 the FACE Board of Representatives has gathered for six oversight meetings. In August of 2017, Dr. Matt Martens resigned from the FACE board leaving an open seat. The Leadership and Development Team and FACE Board of Representatives agreed to nominate Dr. Chris Riley Tillman to represent the University of Missouri, and his nomination was approved. In March of 2017, Dr. David Ballenger was nominated and appointed to the FACE board by the Children's Services Board and initially agreed to serve as vice chair. However, Dr. Ballenger unfortunately resigned the position due to unforeseen circumstances. Presently, the FACE Board consists of the following members:

1. FACE Board Chair, Tim Harlan
2. 13th Circuit Family Court, The Honorable Leslie Schneider
3. Boone County Sheriff's Department, Chief Deputy Tom Reddin
4. Columbia Police Department, Officer Steven McCormack
5. Centralia Public Schools, Superintendent Darin Ford
6. Columbia Public Schools, Superintendent Peter Stiepleman, PhD
7. Juvenile Court Services, Officer Ruth McCluskey
8. Columbia/Boone Cty Public Health Dept., Community Serv. Manager Steve Hollis
9. Community Representative, Ms. Verna Laboy
10. Boone County Community Services, Director Kelly Wallis (non-voting representative)
11. University of Missouri, Chris Riley-Tillman, PhD (non-voting representative)

A.2. Operations: Leadership Team, FACE Staffing and Offices, and Integrated Data Systems. The core FACE Leadership Team includes Drs. Thompson, Reinke, Herman, and Hawley along with support from Drs. Peters and Schieltz. The leadership team and FACE staff regularly meet to discuss implementation of FACE activities (twice per month), ongoing FACE staff supervision and discussion of best practices and Family Check Up processes (twice per month), to examine data and data systems (once per week) as well as other meetings as needed to provide feedback or engage in problem solving or corrective program action. The FACE Leadership Team oversees a data manager to organize and assist in the development of FACE data systems for ongoing quality performance monitoring. The FACE Leadership Team also continues to work with the contracted entity, Bright Beam, to develop, revise, and amend the FACE integrated assessment, case management, and referral system.

A.3. FACE Offices. FACE currently maintains two office locations, the main office located at 105 East Ash St. in Columbia and the northern Boone satellite office located in Centralia. Opened in March 2017, the Centralia office is staffed one day per week. At present, a total of 229 of 257 (89%) assessments were conducted from the Columbia office or at other neutral or family home locations. By contrast, 29 of 257 (11%) assessments were held at the Centralia

location with 24 of those scheduled ahead of time and 5 of those assessments being the result of a walk-in.

A.4. FACE Staff. Regarding FACE staffing, personnel have remained steady. In 2017, one clinical case manager departed and was quickly replaced with a licensed professional.

Table 1. FACE of Boone County Direct Service Staff, 2017

Title	Number of Employees
Director	1
Clinical Case Manager (40 hrs/week)	6
Community Liaison (~28 hrs/wk)	4*
Graduate Research Assistants	3
Office Support Staff	1

*One CL doubles as an interpreter as needed for Spanish speaking families.

Two additional clinical case managers were hired this year to bring the clinical staff to a total of 7, including the FACE Director. Clinical case managers (CCMs) are largely responsible for family assessment, feedback, referral, and linking families. CCMs also follow-up with families when needed and engage in some outreach work. At the time of this report, CCM efforts are supported by four community liaison workers (CLs).

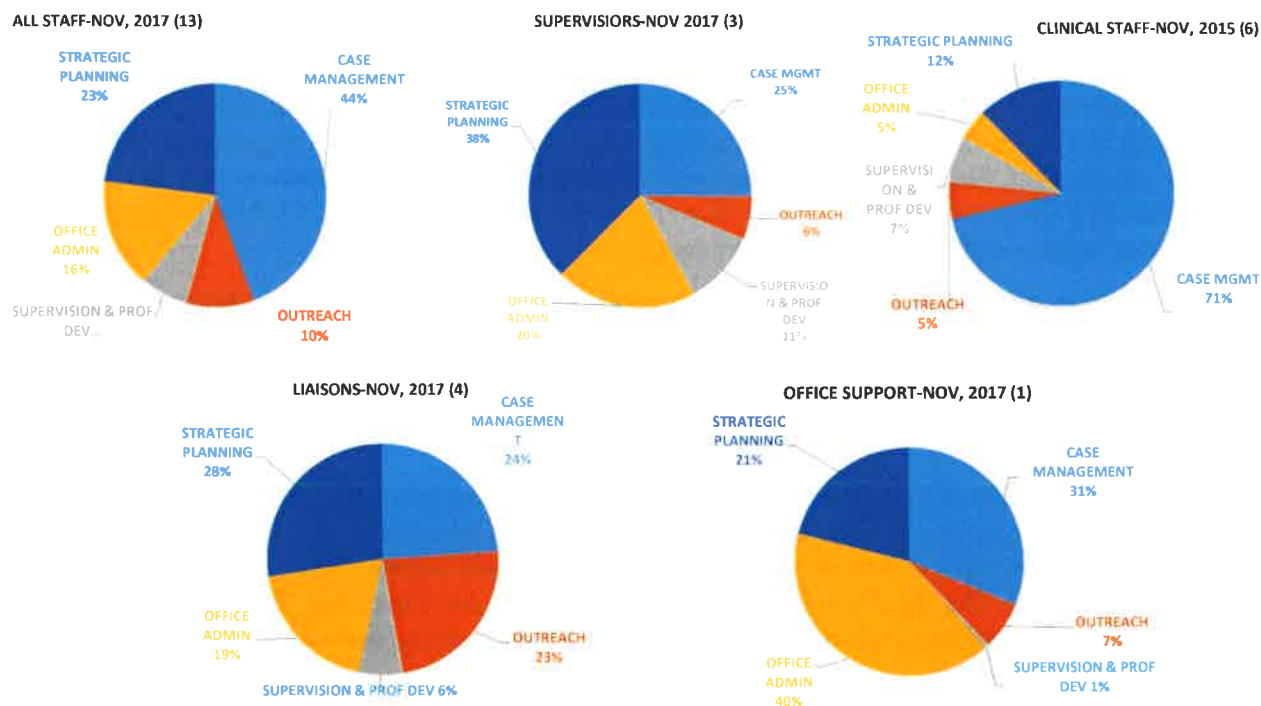
CLs engage in outreach efforts, reach out to families who are difficult to engage, follow-up with families and conduct top problems assessments, and execute other duties as assigned by the FACE Director. During 2017, three University of Missouri graduate students worked alongside FACE staff and received supervision while engaging in assessment, feedback, referral-linkage and follow-up efforts.

In November of 2017, FACE staff began developing procedures to track activities and tasks regarding how they spend their time. When combined with outreach and quality performance data, these tracking data will be used to inform where we spend efforts and where we need to direct more efforts. The figures below display the November and December 2017 percentages both by all staff and also by specific staffing or work assignment categories.

As shown, all staff focus an average of 45% of their time on direct case management services. Within specific categories, the time and task report for clinical staff indicates that more than 70% of time each month is spent on direct case management service related tasks—including scheduling, assessment, feedback, linking families to services, and follow-up. These estimates exclude graduate research assistants and the estimates for personnel broken out by the “Supervisors” category duplicate two personnel included in the Clinical Staff chart.

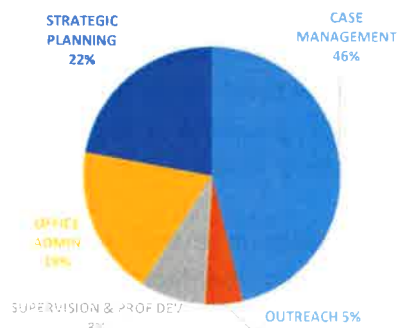
To gain more insight into the detailed work of our staff at FACE, please review the documents listed under [Appendix B., Daily Operations](#) (i.e., Employee Handbook; Assessment Workflow Training Worksheet; Documentation Worksheet; Top Problems Action Plan; Front Office Manual; Registration and OBC Manual; CM/CL Case Transfer Form). To better understand the type of support and training we provide to our CCMs and our CLs at FACE, please see [Appendix F., FACE Staff Training and Supporting Documentation](#) (i.e., FACE Coalition integration model; Family CheckUp Training; Motivational Interviewing Training; FACE Confidentiality Training).

Figures 1-5. FACE Staff Time and Task—November, 2017: All Staff and by Category (Supervisors, Clinical, Liasons, Office Support)

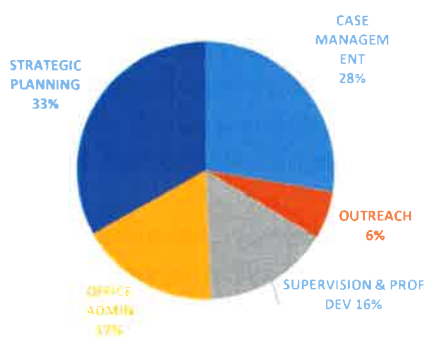


Figures 6-10. FACE Staff Time and Task—December, 2017: All Staff and by Category (Supervisors, Clinical, Liasons, Office Support)

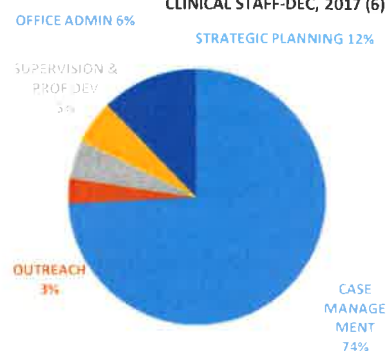
ALL STAFF-DEC, 2017 (13)



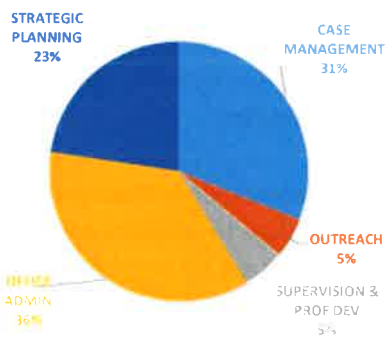
SUPERVISORS-DEC, 2017 (3)



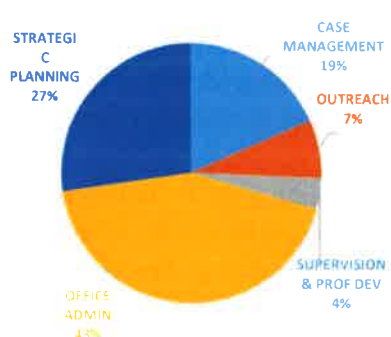
CLINICAL STAFF-DEC, 2017 (6)



LIAISONS-DEC, 2017 (4)



OFFICE SUPPORT-DEC, 2017 (1)



A.5. Development of Integrated FACE Data Systems. The FACE Assessment, Case Management, and Referral system continues to undergo improvements. Our team completed several audits of the assessment system in 2017 to ensure accuracy of data collection, scoring, summarizing, and reporting. This web-based case management system houses strength and risk factor assessments that are developmentally responsive and family systems oriented and it provides an automated, user-friendly system for collecting and summarizing assessment and progress monitoring data. For all domains assessed please see Table 7 on page 26.

Several advancements have been made to the system during the past year:

1. *Provider List:* The electronic provider list was introduced into the FACE information management system in April 2017. The purpose of the provider list was to categorize all community health and social service providers and the specific services they offer by risk area. Then, as families view the report with a FACE clinician and prioritize their concerns for specific problem areas, the FACE integrated information management system will populate a list of area providers who offer services that could address those specific concerns. As such, families would have all available options before them to support an open and unbiased discussion with clinicians about each option (i.e., cost, insurance and Medicare or other reimbursement details, transportation issues, etc.).

Building and populating this extensive, up-to-date, searchable database on several hundred mid-Missouri health and social service providers and agencies, and integrated it seamlessly with the FACE assessment system has been met with a series of challenges (e.g., incomplete listings of new service providers, retained listings for expired services and closed programs, lack of detailed information on program features and costs). The Leadership Team, FACE staff, and our contracted computer programmer are excited to be addressing these challenges and improving the functionality and usefulness of this unique resource for Boone County youths and families.

In the meantime, FACE clinicians continue to practice case management as social case managers always have—by offering families choices to services and providers available using other means (e.g., searchable database organized by problem area for FACE, local service directories, and professional and institutional knowledge). Notably, the scientific studies demonstrating the effectiveness of the interventions used at FACE (i.e., the Family Check Up and motivational interviewing) were all based on using these traditional, non-automated, referral methods. To our knowledge, this kind of referral system has never before been accomplished in any community. However, we believe the time and effort in developing this automated provider list linked to targeted areas of concern is worth the investment given that it has the potential to maximize efficiency of clinician and family time, support informed family choice, and ensure that referral options are as accurate and up to date as possible.

To gain a better sense of the types of ongoing quality improvement and assurance efforts being conducted at FACE—please see the items listed under [Appendix C., QI Processes](#)

(CM Monthly Case Audits; Time Tracking Logs;; Family Feedback Tracking; Sample Case Review).

2. *Family Status Monitoring:* Changes have been made to the FACE system over the past several months of 2017 so that the status of each family can be tracked more accurately. Our audits have provided a continuous improvement cycle that has improved the accuracy of the data collection and reporting system. Additionally, it has yielded important insights for improving the alignment of the clinical-focused aspects of the integrated system (e.g., scoring and summarizing feedback for families) with the clinic administration data system (e.g., number of families engaged, time to linkage, etc.). For instance, we have developed clear definitions of relevant family statuses in the FACE process (e.g., referral, engagement, assessment, feedback, linked, maintenance, closed) and added marks and time stamps in ways that can be more readily extracted for use in the creation of an administrative dashboard. Based on these developments, we have made significant process in developing administration dashboard templates and alterations in the system to capture information that can quickly be culled into a broad array of easy-to-read graphics that promote data-based decision making that is attuned to family progress and program activities. Using these data, we can more closely monitor the progress of families, quickly appraise CCM caseload for families in various stages of the process, identify unresponsive families, see exactly where families become unresponsive, and follow-up with nonresponders so that we can better re-engage those families and help them meet their needs.
3. *Follow-up Outcome Assessment:* The FACE system now has operationalized and institutionalized systematic follow-up procedures to monitor progress of families over time using the Top Problems Assessment¹ (TPA). We report these outcome data and examine family reported change in severity of their self-ranked top problems below.

A.6. FACE Staff Outreach. More than 251 hours were dedicated in 2017 to outreach efforts. These efforts ranged from FACE-Hosed Events, tours of the office facility, engagements with local partners and agencies, formal presentations, meeting with community organizations, and developing and handing out informational materials to market FACE in communities across Boone County. All told, these efforts reached more than 2,835 Boone County residents across more than 100 agencies, schools, healthcare settings, houses of worship, and service providers.

Efforts going forward for 2018 will include capturing feedback data from those we engage in our outreach efforts. Ultimately, we hope to see an increase in our referral data from various sources that we have categorized—as such, we aim to close the feedback loop between (a) where referrals are originating from [communities, sources, zip codes] and (b) targeting our outreach activities to increase activity and exposure from all corners of Boone County.

Another collaboration FACE staff engage in regularly is with the Columbia-Boone County Public Health and Human Services Department. Specifically, FACE staff assist the Health Department to disseminate materials and information regarding mental health symptoms and information on where to get help in the “Look Around-Boone” campaign. The goal of the campaign is to reduce the stigma around mental health help seeking and hopefully reduce the



risk of substance abuse and suicidality of adolescent and teen-aged youth in Boone County. The FACE development and leadership team as well as FACE staff participated in many meetings with other community representatives. Through these efforts, the message, logos, feel of the campaign were developed overtime. The goal of the next year is to spread the message of the campaign far and wide across all communities in Boone County schools, doctor's offices, and other public and private venues that family and youth visit. At the end of the funding for the Health Department's campaign—FACE will inherit the campaign and all related materials and has

committed to carrying the message forward as part of the FACE brand. FACE staff, as part of all outreach efforts, regularly disseminate posters and other campaign materials at all outreach events and regularly track the numbers of outreach efforts made for the Health Department. In addition, the impact of the campaign hopes to appraise its capacity to increase awareness of its impact to raise awareness of help by relying on survey data collected from the Boone County Schools Mental Health screening and data collection process.

Another key tool for outreach is the FACE website, located at <https://faceofboonecounty.org/>. As part of the development of the website, we regularly track traffic and views of the page. According to our web analytics, the FACE website saw 2,594 unique users in 2017—a 29% increase in traffic from 2016. The unique users visited the website for a total of 3,853 times for an average duration of 1 minute and 52 seconds. The majority of users migrated to the FACE website via our Facebook and Twitter pages—and the majority of users rely on mobile devices.

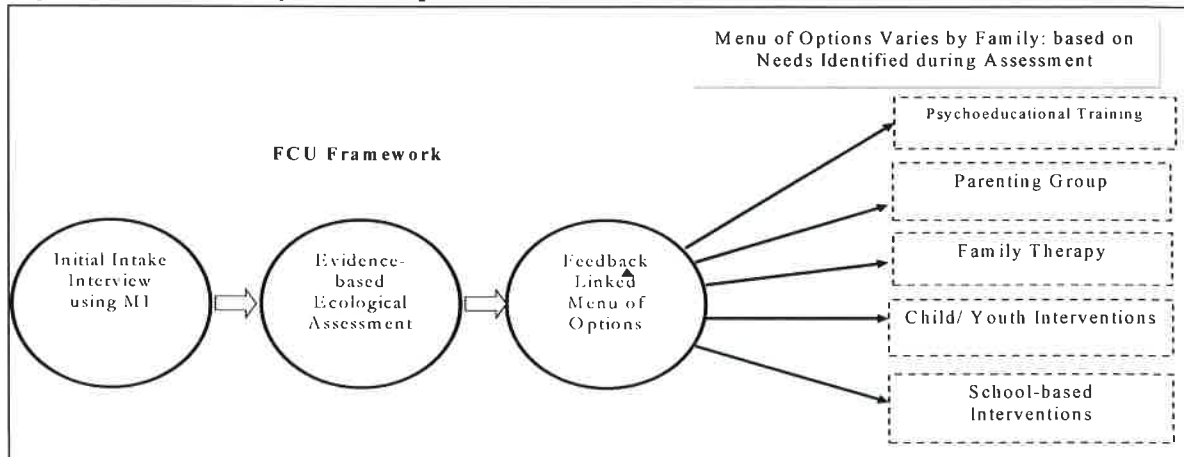


To get a more thorough understanding of all of the efforts at FACE to spread the work and word to all sectors of our community—please see the list of items under [Appendix D.. Marketing](#) (i.e., Before you Refer, Law Enforcement Referral Guide; School Based Referral Guide; General Referral Guide; FACE Blue Card; FACE Brochure, FACE Flyer; FSD Flyer; FACE Court Services Brochure; and FACE Outreach Presentation).

A.5. FACE Family Experience Overview: The FACE Process. Following referral to FACE, FACE staff follow up with the family and see if families wish to engage in our services in an accepting, supportive, no fault, no judgement manner. If the family agrees, we collect basic demographic data and schedule an intake and assessment date.

The FACE assessment process is conducted using structured clinical interviews and valid and reliable automated assessment instruments to produce an easy to read and family friendly report. The engagement and assessment process is based upon the Family Check-Up model (see Figure X), a motivational interviewing infused approach to family systems assessment that has been proven to increase family engagement in the resulting treatment plan.

Figure 11. The Family Check-Up Framework



The assessment is thorough and can be lengthy dependent upon family dynamics and complexity of problems. The present data suggests that nearly all families complete the assessment in a single visit with typical assessment times ranging 2 to 3 hours. Going forward, we will continue to hone the assessment, while maintaining the technical adequacy of the measures and the accuracy of feedback provided to families.

After FACE clinical staff engage families in the motivational interview and capture functioning on important youth and family risks and assets during the assessment, CCMs transition to the feedback phase, typically during the same visit. Clinicians use the feedback form (see Figure 12) which is automatically generated from the assessment data to guide the conversation.

Using the feedback form, clinical staff can summarize areas of risk (red), areas at risk (yellow) and also take time to celebrate the strengths or assets of a child and his or her family (green). The purpose of the feedback session is to strengthen motivation and commitment to change and help families focus on 1 – 3 areas of concern, which we call the top problems.

Once families prioritize concerns, they are asked to rate the severity of the problem before clinical staff assist the families to rank order those problems. Lastly, CCMs then work to link those families to existing community providers who offer services to reduce risk or build strengths to buffer the negative impact of those concerns on family functioning. The feedback and linking phase typically takes 30-40 minutes.

Figure 12. FACE Final Family Report (*Fictitious report)

General
Intake
Assessments
Self Assessment
Clinician Assessment
Family Assessments
FA - Wendy Reinke
FA - Wendy Reinke (Self) (I)
FA - Keith Herman
FA - Keith Herman (Self) (S)
Family Report
Summary Report
Goals
Case Notes
Access Tokens

Kennedy Herman
(Age 9)
Case Number
FC00059
Case Manager
reynolds | Re-Assign
Last Activity Date
1/6/2017
Status
Closed

Development / Basic Needs

Early Developmental Milestones		
Physical Health		
Access to Medical or Dental Care		
Safety	(Self) I see gang activity in my school - Sometimes	
Basic Needs		

Youth Adjustment

Disruptive Behavior / Conduct		
Hyperactivity/Impulsivity		
Anxiety		
Depression		
Attention		
Substance Use	(Self) Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)-Yes (Self) Smoke any marijuana or hashish?-Yes (Self) Use anything else to get high? ("anything else" includes: illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")-Yes	
Peer Relationships		

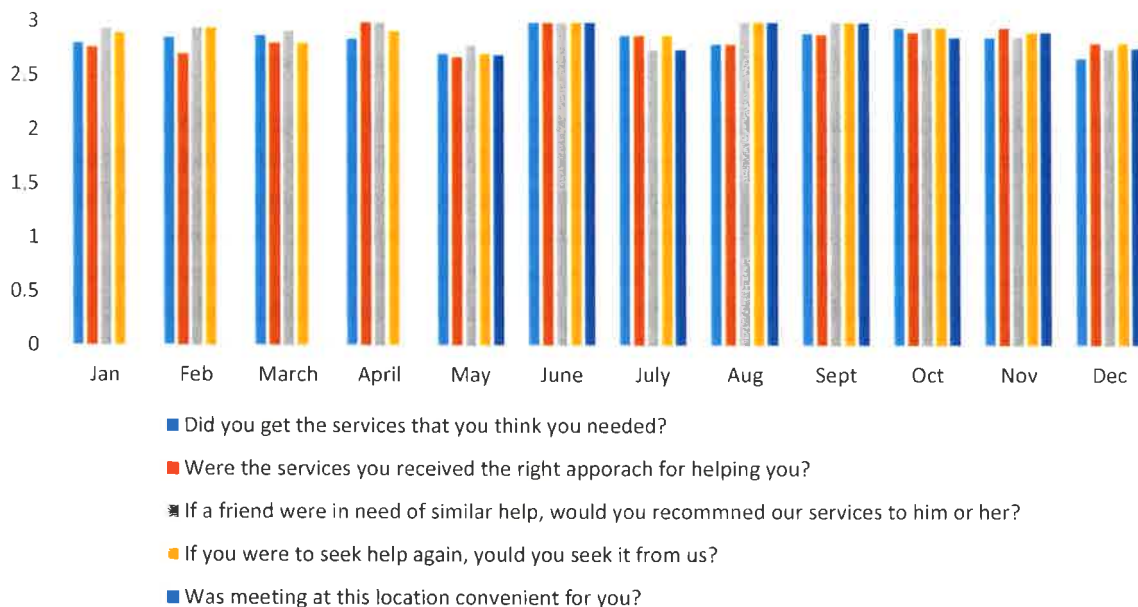
To get a better understanding of the kind of information that families leave FACE with, please visit the documents collected under [Appendix E. Green Folder](#) (Welcome to FACE; Your Family's Excellence; Notice of Privacy Practices; HIPAA Acknowledgement; Consent to Services and Releases; Consent to Treat Minors; ROI).

A.6. Family Feedback—Consumer Satisfaction Survey on the FACE process. Once families participate in the assessment process at FACE, they are asked to complete a very brief exit survey indicating their level of satisfaction with FACE services. Specifically, families are asked if they got what they needed, if the approach was right for them, if they would recommend others

come to FACE, if they would come to FACE again, and if the meeting was in a convenient location.

The Table below presents the family feedback summary scores—which are ranked on 3-point scale along with an open notes field for them to provide any comments they wish.

Figure 13. Family Satisfaction Feedback Scores—2017 (N=257)



On average, approximately 58% of families elected to leave no comment but for the 42% of families who do comment, they typically rank FACE services quite favorably (90%). Open family comments include positive notes like:

- *"This is an amazing program. This will work wonders and give opportunity to our family."*
- *"Very welcoming and supportive!"*
- *"I am in disbelief how amazing coming here has been - it almost feels too good to be true. [FACE STAFF] was AMAZING & [FACE STAFF] & everyone that has interacted with us has been SO kind, warm, welcoming. THANK YOU!!!!!!!!!!"*

The survey also asks family what they liked the least about their visit. Even with this prompt, FACE staff received only a small proportion of negative comments—but among those notes left:

- *"Wish there were assessment times slightly later since high school don't get out until 4."*
- *"Relatively long intake, extensive questionnaires to link with services rather than comprehensive assessment."*
- *"I wasn't able to do medical, DHS or other concerns at this location. Also I have to go to the SSI office and file a claim with them. I couldn't get help with food and clothing today as well."*
- *"I didn't like being cut off when speaking, but I understand wanting to go home."*

- *The first meeting was a long process-although thorough. I may feel differently if I hadn't done this before."*

Negative feedback is often more helpful to inform changes than positive feedback. First, we are investigating ways to better use DHS family support workers who are housed at FACE. Reliance upon DHS family support workers presents challenges as those workers are only housed at FACE once per week. As such, family support workers are unable to assist families with accessing their benefits when they visit FACE on days where those workers are not present. One solution we have attempted to work towards is to schedule families who need those supports on days that family support workers are present—but in the 7 months that family support workers have been present, only 11 FACE families have been seen by those personnel.

Second, remaining true to the motivational enhancement and family engagement while completing the detailed family and child assessment is a key focus of our ongoing staff training and supervision. For the most part the length of the assessment does not appear to be a barrier for most families. Indeed, judging from the majority of the feedback from families, the overwhelming message is that most FACE families accept the assessment as a component of getting high quality help and foundational to the FACE process. Still, working alongside clinic staff, the Leadership Team continues to examine ways to reduce the assessment (e.g., we are exploring the possibility of opt-out options so families don't need to complete all items within a section if it is clear there are no concerns in that domain) and to create more flexible options for families to complete the assessment (e.g., by giving families an option to schedule one or two visits).

A.7. Collaborations to Provide Free Services to Boone County Families. Presently, there are several collaborations to offer free, ongoing, child and parent services to Boone County families. These services are free of cost to any FACE family who may meet the requirements of participating in these services, and offered at a time convenient to the families. Through these clinics (summarized below), free services have been offered to approximately 36 high risk and very needy families who have youth with significant behavioral challenges.

First, FACE presently provides office space for a Missouri Department of Social Services, Family Service Division employee. The family support worker assists any FACE family to access benefits that they are eligible for. The family support worker currently spends one work day per week in the office—and since the collaboration has started this past fall, 11 families have taken advantage of this service.

Second, *The Behavioral and Psychoeducational Clinic (BPC)*, directed by Dr. Kelly Schieltz, at the University of Missouri (MU) is a departmental training clinic within the Department of Educational, School and Counseling Psychology at MU. BPC provides behaviorally-based assessment and treatment related services to children with and without developmental disabilities who engage in challenging behavior such as self-injury, aggression, and severe noncompliance. Specifically, BPC conducts brief (90- to 120-min) behavior analytic assessments by directly observing the child interact with care providers during structured, systematic conditions to determine the influence of environmental variables on the occurrence of challenging behavior at home, at school, or in the community. The focus of the clinic evaluation is to develop behavioral

recommendations based on the direct observation of child behavior and on a clinical interview of the child's living and education situation. Follow-up with care providers and school teams occurs by phone, email, telehealth, local resources, or return visits to the clinic.

BPC utilizes two clinic rooms, one day per week, within FACE of Boone County. BPC opened February 2017, with three School Psychology PhD graduate students serving as clinic therapists under the direct supervision of Dr. Schieltz who is a licensed psychologist, board certified behavior analyst, and health service psychologist. To date, approximately 30 children have been evaluated, free of charge, with an average of 3 children evaluated per month. Currently, there are 12 children scheduled for upcoming evaluations and 8 on the referral list waiting to be scheduled. Of the children evaluated and/or scheduled, 47% were referred by FACE CCMs, with the remaining referrals coming from providers at the Thompson Center, Psychological Services Clinic, the pediatrics clinic at South Providence, and other pediatricians across the State of Missouri who participate in ECHO Autism. Of the families who returned the BPC's acceptability survey (n = 8), all families indicated that the services received, the approach used for determining why challenging behavior occurred, and the recommendations provided to address those concerns were highly acceptable (score of 7 on a 7-pt Likert scale). Anecdotally, families offered the following strengths:

Third, a postdoctoral fellow from the *Missouri Prevention Center* at the University of Missouri offers direct behavioral therapy to children and families who are appropriate for and elect to receive those services. The fellow's time and position is fully supported by a federal training grant award and she is supervised by Dr. Reinke. Since starting at FACE this past fall, the fellow has provided behavioral therapy for six clients with concerns ranging from adjustment issues and relational problems to physical aggression utilizing evidence-based approaches to address concerns, including contingency management, parent training, and cognitive behavioral therapy. According to client and caregiver reports, improvements have been noted at home and school, included increased quality of relationships and consistent attainment of behavioral goals.

A.8. FACE Trainings for Community Providers. FACE collaborates closely with the Center for Evidence-Based Youth Mental Health (CEBYMH) to provide high quality, evidence-based, continuing professional education training at no cost to mental health providers working with Boone County youths 0-19 years and their families. Collaboration with the CEBYMH at the University of Missouri provides free space for our trainings, access to nationally and internationally recognized experts in mental health and substance abuse, and a professionally accredited educational program that meets Missouri standards for ongoing professional development and continuing education. The trainings focused on the most prevalent youth emotional and behavioral concerns, employed a range of training techniques to maximize participant learning (e.g., didactics, Q&A, discussion, case vignettes, role-plays), and focused on assessment and intervention strategies with scientifically demonstrated effectiveness for youths and families. FACE co-sponsored 16 trainings in 2017, providing 1,474.25 hours of training to 454 providers (note that many providers attend more than 1 workshops (range 1-14 workshops attended; total number of unduplicated providers = 203)).

In 2017, FACE worked with the CEBYM to refine their evaluation procedures. We now collect two forms of evaluation for our provider trainings. Already, the CEBYMH collect evaluation data from attendees at each workshop including two important scales: (1) satisfaction with the training (6 items, 1-5 Likert scale covering satisfaction with the training overall, including acceptability of its content, presenters, organization, execution, level of complexity), (2) feasibility of the assessment and treatment practices covered in the training (3 items, 1-5 Likert scale, covering how useful the training was for participants' everyday practice, including the extent they expect to be able to use the information/techniques from the training, and its compatibility with practical realities of their workplace). In 2017, evaluations were completed by 389/454 (85.7%) of attendees. Rates of satisfaction are consistently very high (4.56 out of 5, with 357/389 or 91.8% giving a 4 or 5 satisfaction rating). Provider perception of feasibility of implementing the strategies learned into their practice was also high (4.25 out of 5, with 285/388 or 73.5% giving a 4 or 5 feasibility rating).

We carefully developed and helped CEBYMH to implement a far more detailed annual provider registration questionnaire that each participant must complete annually in order to register for the free workshops. This questionnaire includes basic provider and practice information, two meaningful precursors to behavior change (provider attitudes toward evidence-based practices via the EBPAS and knowledge about which practices are supported by scientific evidence via the KEBSQ), along with actual provider behavior (provider implementation of evidence-based practices with youths and families via the EBSS). These three scales (EBPAS; KEBSQ; EBSS) have existing research support and will allow us to better evaluate the impact of these trainings for our community. We currently have baseline data on over 200 participants and expect to have sufficient twelve-month follow-up data to report on training outcomes in the mid-year report.

Finally, we administered a training survey to inform plans for upcoming trainings and help us better target the trainings to perceived community need. The Provider Training Survey was conducted this past fall (2017) and had 98 provider respondents. It covered pragmatics (e.g., days, times, length of training that providers most prefer) along with provider perception of two important, substantive issues: community need for specific workshop content (e.g., trauma, self-harm) and the most helpful techniques to maximize provider learning in the workshops (e.g., lecture, role-plays). We are using the feedback from both the individual workshop evaluations and this training survey to design the 2018 training schedule.

We are energized by the work thus far and plan several additional efforts for 2018. First, despite provider interest in and enthusiasm for the Therapy Tracker (an automated system to monitor therapist fidelity to evidence-based treatment and client symptom/functioning progress), provider follow-through has been minimal. We are working with CEBYMH to identify effective incentives for use of this evidence-based practice. We are also developing a proposal for an authorization process by which providers in the community who serve Boone County youths and track therapist fidelity and client progress with the Therapy Tracker, could recoup payment for services by billing the Boone County Services funds on a monthly basis at an agreed upon unit cost. This reimbursement process could serve as both incentive for providers to routinely

implement this evidence-based practice, and an effective means for the county to track and reimburse for the provision of quality mental health care to its youths. Finally, as the FACE dashboard is completed, we are excited to be able to use the data on client linkages (e.g., to what extent are various youth ages and presenting concerns able to find service providers) and client symptom/functioning improvement (e.g., to what extent are improvement rates in Boone County meeting established benchmarks) to further inform and tailor our trainings to meet community need and help fill training gaps for area providers. For more details regarding the workshop by workshop information for the 2017 calendar year, please see data presented in [Appendix G., Training Data.](#)

B. KEY QUESTIONS REGARDING WHO WE SERVE AT FACE.

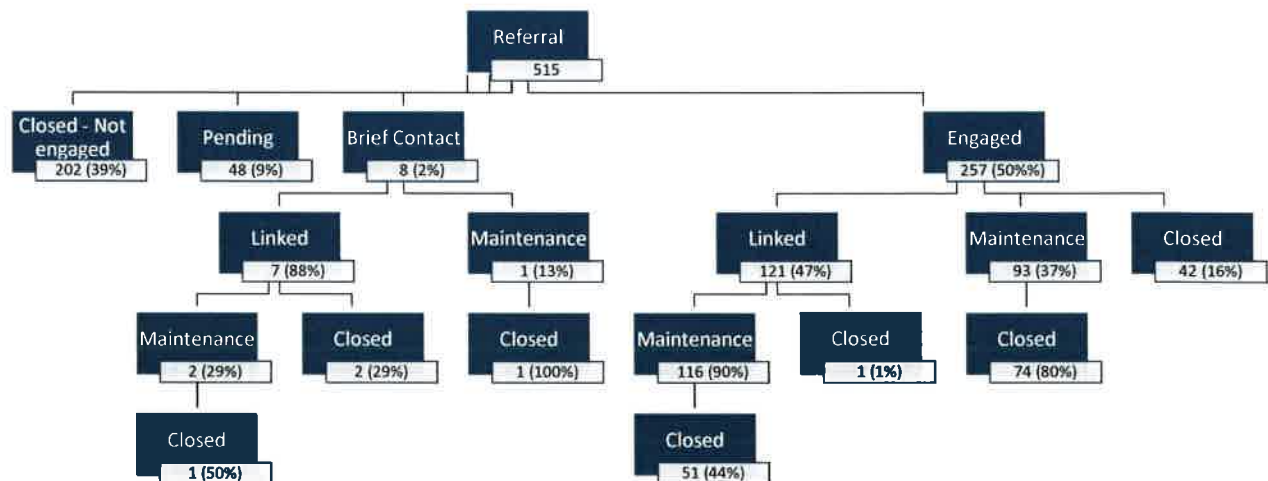
B.1. What does the flow of families through FACE's Family Check Up process look like: From referral to engagement, assessment, linkage, maintenance, and closure? As shown in Figure 14 below, a total of 515 (100%) families were referred to FACE between January 1, 2017 and December 31, 2017. Of those 515 families, 202 (39%) were closed without any form of engagement due to the family being unresponsive to our efforts to contact with them.

This group is largely composed of families who a referring party contacted FACE and requested outreach to the family (i.e., these are not families who reached out FACE on their own or with the help of a referring party). Additionally, 8 (2%) families had only brief contact with FACE (i.e., seeking information for a specific concern); of these, 7 (88%) were linked with a direct referral without completing an assessment at FACE. Finally, 48 (9%) families are listed as “pending” at the time of this report.

FACE successfully engaged and assessed 257 (50% of all referred) families between January 1 and December 31, 2017. Among those families, 121 (47%) families were linked with services following their assessment; 93 families were placed on a maintenance status without being linked, and 42 were closed due to unresponsiveness. Among 121 families who were linked, 116 families were followed for a period of time varying anywhere from 1 week to 30 weeks. A total of 51 cases were assessed, linked, followed through to service acquisition, and closed.

There is a great deal of variability in the reasons that referred families are unresponsive to FACE engagement efforts. We make an effort to understand these here by presenting demographic and other data captured at the point of referral, alongside data captured only on youth and families who actually engage with FACE.

Figure 14. Flow of Families in Contact with FACE: January 1, 2017 through December 31, 2017



Notes * 91 cases are actively open (35%); *Referral*=family or youth referred to FACE; *Closed - Not engaged*=closed due to inability to contact; *Pending*=attempting to contact or assessment scheduled; *Brief Contact*=inquiry or seeking information; *Engaged*=Assessment completed; *Linked*=referral provided and family went; *Maintenance*=follow-up with family who is linked; *Closed*=unable to reach, moved, successful support plan completed

B.2. Who sent referrals between January and December of 2017? Table 2 below reveals the source of referrals to FACE for 2017. As in 2016, the bulk of referrals originated from school personnel (i.e., school counselors, outreach counselors, and Boone County Schools Mental Health Coalition Regional Coordinators). There were several noteworthy increases in referrals from other community sectors. First, the total number of self/family referrals doubled compared to 2016 (80; 26.2%), an important indicator that individual families are learning about FACE and increasingly coming to FACE to seek help. Second, the total number of referrals made by other social service agencies in Boone County nearly quadrupled from 2016 (16; 5.2%) with 81 referrals accounting for nearly 16% of referrals for 2017. Next, health care providers increased slightly over 2016 (31; 10.2%).

The category of court services and law enforcement was combined in the 2016 report—however the category has been disaggregated for the 2017 report. Whereas the 2016 annual report indicated that law enforcement/courts made a combined 19 referrals (6.2%) to FACE, the 2017 data show the total number of referrals made by law enforcement were down over 50% with only 7 referrals while referrals from court services and juvenile services increased and accounted for 24 (4.7%) all referrals to FACE.

In summary, the lesson learned here is that in 2018 we aim to work more closely with the law enforcement and judicial and court services representatives who occupy seats on the FACE Board of Representatives to ensure FACE is considered an option for consenting families and youth whose problems and concerns are appropriate for FACE services.

Table 2: Referral Sources and Percent Engaged by Source, 2017

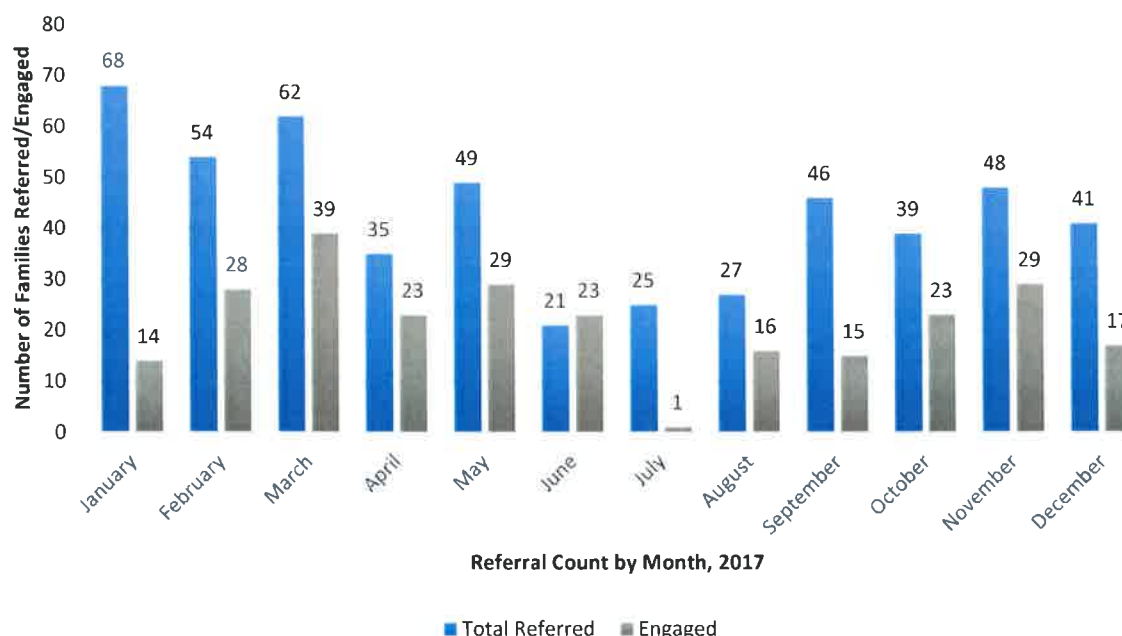
Source	# Referred	# Engaged	Percent Engaged by Source
Schools	186	88	47%
Self/Family Referred	165	109	66%
Social Service Agencies	81	26	32%
Healthcare Providers	43	19	44%
Courts/Juvenile Office	24	9	38%
Unknown	8	6	75%
Law Enforcement	7	0	0%
Community Member	1	0	0%
Totals	515	257	100%

Upon deeper examination of the referral data by source, we can see those families who were responsive to FACE services varied by referral source. This is important to consider as we aim to increase the total number of families engaged, and thus can work with representatives from each referral source listed below to increase the likelihood that families will be responsive to FACE when engaged. Consistent with research findings on behavioral health and motivation to seek help, families who self-referred were more likely to follow through and engage with FACE clinicians.

Nearly 50% of referrals from school officials also engaged in FACE services—promising as FACE staff have conducted a significant amount of outreach to streamline and clarify the referral process for school personnel. Consistent with our future efforts to increase referrals from law enforcement, we will also seek to improve the likelihood of follow-through of families to engage with FACE. Strategies to improve these engagement numbers may include outreach presentations for relevant audiences including law enforcement for optimal engagement methods and improved social media outreach including the creation of brief videos illustrating the FACE assessment process that can be easily accessed on our webpage or on Facebook.

B.3. How many youth/families were referred/engaged between January-December, 2017? As shown in the bar graph below, the months of February, March, May, September, and November represent the busiest months in terms of referrals. Notably, these same months showed the largest discrepancies between referral and engagement with FACE. In this next year—and in particular the next few months—increased efforts will be undertaken to ensure that we can quickly engage all families referred to FACE. These efforts should also include a systematic review of how we can better understand why some families are not participating.

Figure 15. Youth and Families Referred/Engaged by Month, 2017

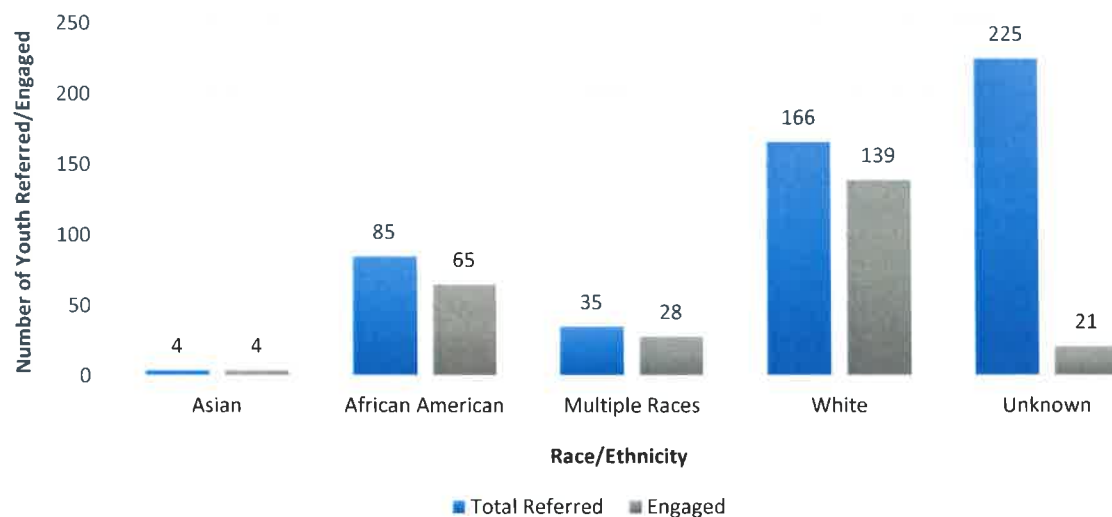


B.4. What was the race/ethnicity of youth referred/engaged between January-December, 2017? As shown in the Figure below, a majority of families who were both referred (32%) and engaged (54%) at FACE self-identified as white or Caucasian. On average, families by race/ethnicity category who were both referred to AND engaged at FACE are roughly proportional to those observed in the community according to US census data. That said, increased outreach in both Columbia and communities beyond will hopefully see an increase

similar to the proportions of these demographics seen this year to ensure no disparities in terms of access at FACE.

As a side note, the majority of families referred to FACE refuse to self-report their own race/ethnicity. This results in a loss of data that makes it difficult to understand as much as we can about who is refusing to engage or respond to follow-up calls after the referral. As such, we have made several changes in our referral process. We will ask referrers to provide race/ethnicity and other basic demographic information. Then, for families who engage in our assessment process, we will continue to ask them to self-report on these questions. Self-report data will supercede referrer-reported data whenever available; however, referrer-reported data will be used when needed to reduce the amount of missing data on these important questions.

Figure 16. Number of Youth Referred/Engaged at FACE by Race/Ethnicity, 2017

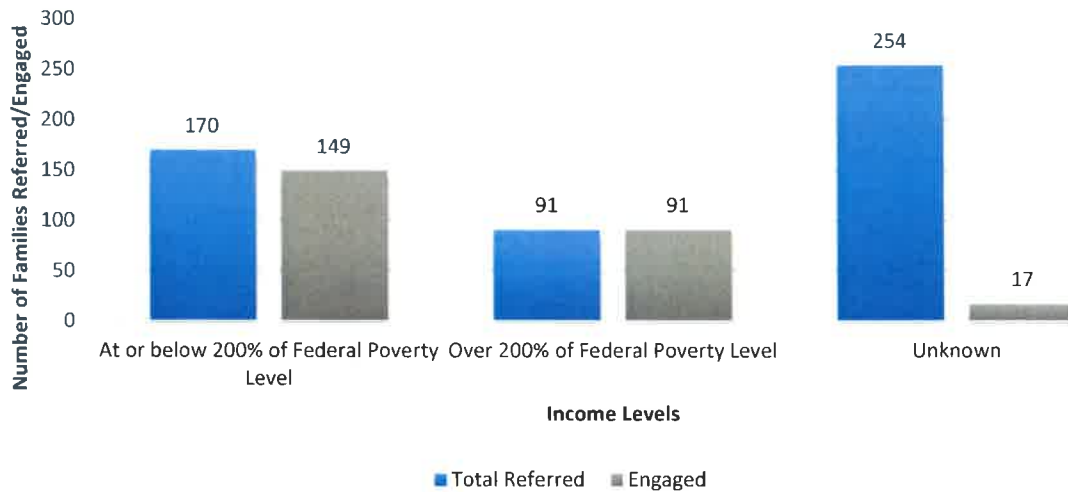


* 7% of youth identified as Hispanic

B.5. What was the income level of families referred/engaged between January-December, 2017? Similar to data captured from 2016, the majority of families often prefer not to self-report their income level. Some survey research suggests that families refuse to do this because they feel it is an invasive question or are concerned they will be charged for services if they are found to be at a certain income level. At FACE, we do our best to be honest and genuine when asking personal questions such as race and income and we do not want to force families to respond to any questions. However, to better improve the acquisition of these data, at intake we aim to ask referral sources if they can approximate responses to these data (e.g., school personnel for example often know which students are eligible for free and reduced lunch at school—a proxy for income). Then, for families that are engaged at FACE—instead of asking these question during the intake interview, we aim to allow families to provide this information during the self-assessment component of the FACE assessment (i.e., enter directly into the tablet). We hope that this will be experienced as less invasive and result in an increased number of families reporting these data.

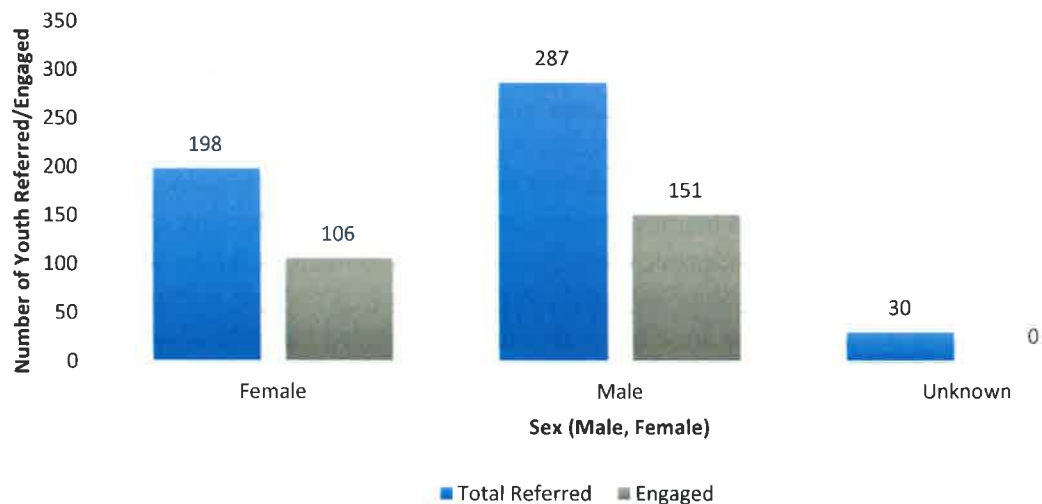
In summary, during 2017, a majority of families seen at FACE reported that they were in the category of making less than 200% of the Federal Poverty levels. The estimated levels between those who were referred and those who were engaged was roughly the same by bracket, with the below 200% category being less likely to be engaged. As such, using this as an indicator at intake, we may be able to identify families who are more likely to refuse to engage in FACE services and make a bit more effort to retain their participation.

Figure 17. Income Level of Families Referred/Engaged, 2017



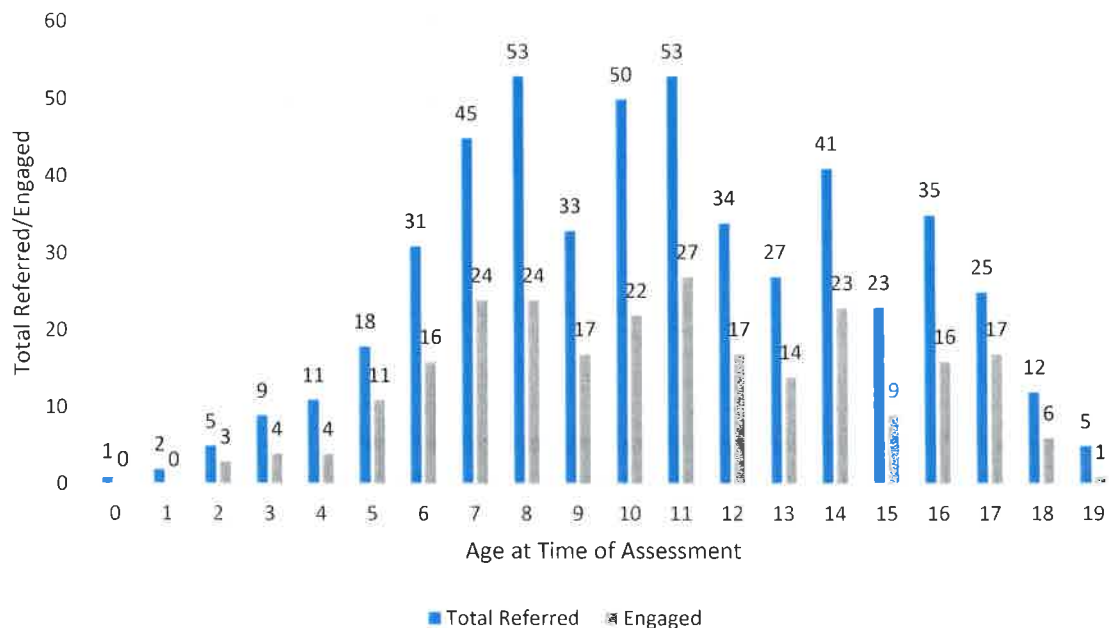
B.6. What was the sex of the youth engaged between January and December of 2017? As revealed in the figure below, more boys than girls were referred to FACE. Even though these numbers are different by gender, the percentage of referred males who engage (47%) is nearly identical to that of females (46%).

Figure 18. Sex of Youth Referred/Engaged, 2017



B.7. What was the age of referred youth between January and December of 2017? The average age of the 515 youth who were referred to FACE in 2017 was 10.14 (Max=19; Min=1; std = 4.029) The average age of the 257 youth who engaged with FACE in 2017 was 10.17 yrs. (Min=1; Max=19; std = 3.97 yrs). As shown below, the largest discrepancy between those referred and engaged at FACE is with youth between the ages of 7 and 16—incidentally also the largest referral age ranges.

Figure 19. Age of Youth Referred/Engaged, 2017

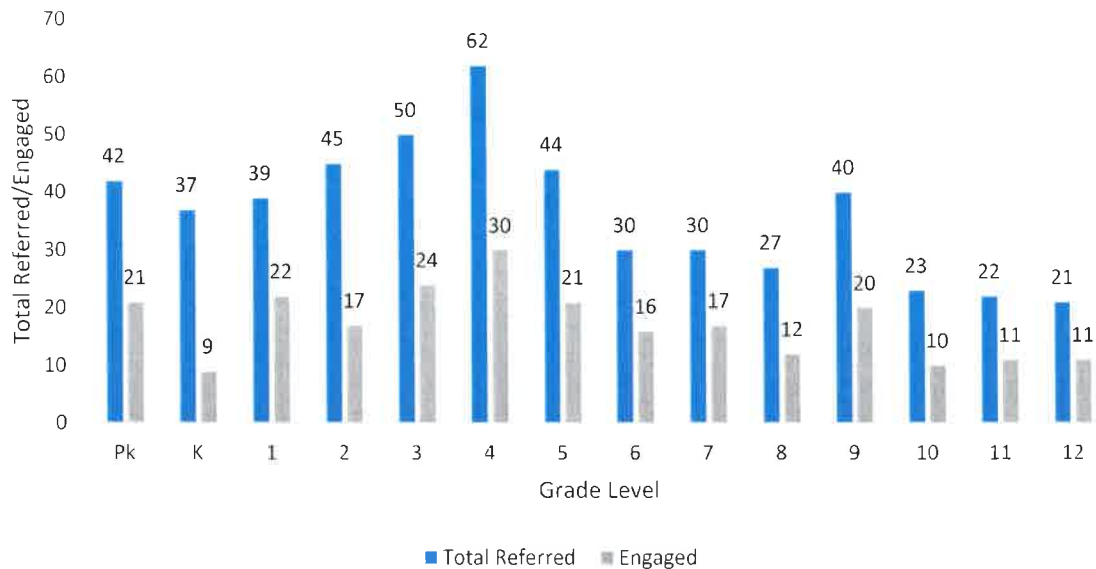


B.8. What was the grade level of referred youth between January and December of 2017?

The greatest number of referrals came from middle and upper elementary grades in 2017. Compared to data from 2016, this was a very similar pattern. Cross referencing grade and referral source, we can see that a majority of these referrals originate from school personnel.

When examining the proportion of discrepancy across age ranges, we see a fairly similar proportion of youth not engaging with FACE from each category (~50%) with some notable larger differences between referred and engaged for youth in second grade and kindergarten.

Figure 20. Grade of Youth Referred/Engaged, 2017



B.9. What was the lag time between referral and engagement for families who accessed FACE services? Table 4 below summarizes the average lag time in the number of days in 2017 that it took families to respond to FACE staff once they were referred. The 2016 averages are also presented as a point of comparison. The average time between referral and engagement in 2017 was approximately 50% faster than 2016, with 17.8 average days (range from 0-336 days).

Also shown in Table 4 below, the average time for families from referral to linkage in 2017 was 56.7 days. During this period of time, FACE staff conduct full child and family assessments, provide detailed feedback to families—sometimes during multiple visits—then discuss service options and family choice of providers for the top problems identified by the family, make contacts with the preferred agencies to schedule appointments. These lag times also include wait times for families to make it to the first appointment with an outside agency.

Table 4: Lag Time Between Referral to Engagement and Referral to Linkage

2017 Lag Time	Average Lag Time in Days	
	Jan-Dec, 2017 (N)	Jan-Dec, 2016 (N)
Referral – Engaged	17.83 days (N=257)	35.33 days (N=270)
Referral – Linked	56.67 days (N=121)	Data unavailable

Because there is such a spread in the total number of days due to some extreme outliers in the case of families who were difficult to reach or missed repeated appointments or were rescheduled multiple times, Table 5 below shows the disaggregated lag time for 167 families

who were engaged within 2 weeks of engagement (67% of cases) as well as families who were linked with services within a 2 week window (45% of cases).

Table 5: Number of Cases within a 2-Week Lag Time for Referral to Engagement and Referral to Linkage

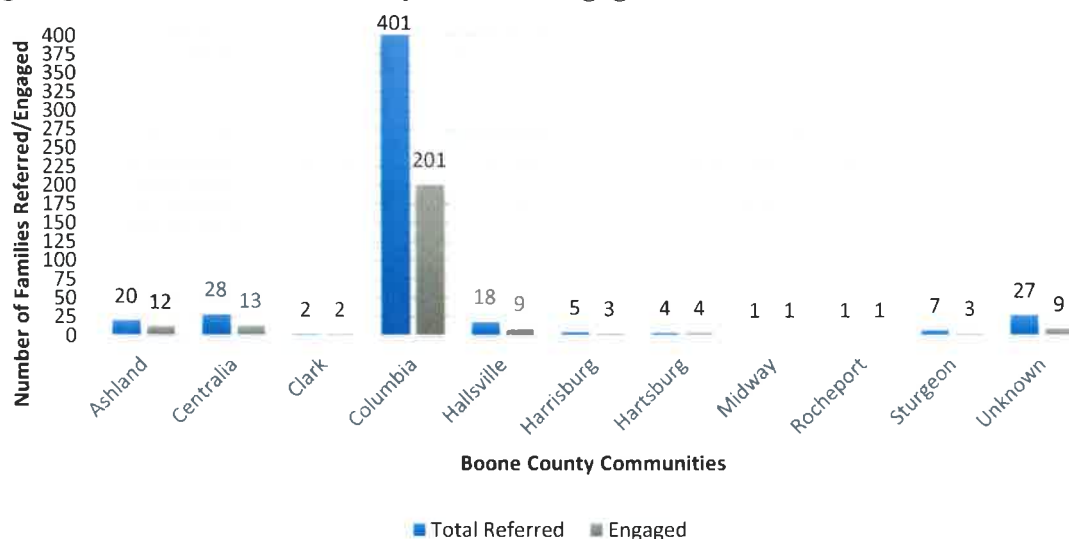
2017	Number of Cases within 2 week Lag Window
Engaged within 2 weeks	167 (67% of engaged cases)
Linked within 2 weeks	51 (45% of engaged cases)

B.10. Where did referrals come from between January and December of 2017? As predicted, the majority of referrals to FACE came from the Columbia community—but it was a proportion that was similar to 2016 (i.e., 77% of all referrals). Likewise, the discrepancy between referral and engagement is approximately equal across all communities.

Important to note here, there was a slight increases in the proportion of referrals from some Boone County communities—whereas there were declines in others—when comparing 2016 data to the data captured this past year, 2017.

- Ashland down 5.6% in 2016 to 3.6% in 2017
- Centralia up from 4.1% in 2016 to 5.4% in 2017
- Hallsville up 3.3% in 2016 to 3.5% in 2017
- Harrisburg up .7% in 2016 to 1.1% in 2017

Figure 21. Boone Communities by Referral/Engagement, 2017



B.11. What types of problems did families and youth who engaged and were assessed at FACE present as primary problems.

Table 6: Youth & Families Assessed: Assets, At- and In-Risk Counts & Proportions (N = 257*)

Domain	Subdomain	Asset N (%)	At-Risk N (%)	In-Risk N (%)	Missing (%)
Dev./Basic Needs	Developmental Milestones+	175 (68.1)	--	82 (31.9)	0
	Physical Health+	176 (68.5)	--	81 (31.5)	0
	Access to Medical/Dental+	176 (68.5)	--	81 (31.5)	0
	Safety	194 (75.5)	26 (10.1)	37 (14.4)	0
	Basic Needs+	187 (72.8)	--	70 (27.2)	0
Youth					31 (12.1)
Adjustment	Disruptive Bx/Conduct	35 (13.6)	--	191 (74.3)	
	Hyperactivity/Impulsivity	48 (18.7)	--	174 (67.7)	98 (38.1)
	Anxiety	88 (34.2)	17 (6.6)	54 (21.0)	98 (38.1)
	Depression	109 (42.4)	26 (10.1)	24 (9.3)	98 (38.1)
	Attention+	39 (15.2)	--	183 (71.2)	35 (13.6)
	Substance Use	144 (56.0)	8 (3.1)	17 (6.6)	88 (34.2)
	Coping Skills	49 (19.1)	21 (8.2)	99 (38.5)	88 (34.2)
	Peer Relationships	123 (47.9)	6 (2.3)	128 (49.8)	0
	Stress	46 (17.9)	9 (3.5)	114 (44.4)	88 (34.2)
Family					0
Adjustment	Relationship Quality	35 (13.6)	64 (24.9)	158 (61.5)	
	Parenting Practices	42 (16.3)	52 (20.2)	163 (63.4)	0
	Parental Supervision	216 (84.0)	11 (4.3)	30 (11.7)	0
	Involvement With School	204 (79.4)	29 (11.3)	24 (9.3)	0
	Substance Use	187 (72.8)	9 (3.5)	61 (23.7)	0
	Domestic Conflict	223 (86.8)	10 (3.9)	24 (9.3)	0
	Stress	136 (52.9)	87 (33.9)	34 (13.2)	0
School					0
Adjustment	Attendance+	224 (87.2)	--	33 (12.8)	
	School Performance+	16 (6.2)	11 (4.3)	230 (89.5)	0
	Attitude About School	134 (52.1)	59 (23.0)	64 (24.9)	0
	School Behavior	82 (31.9)	5 (1.9)	170 (66.1)	0
High Risk					0
Indicators	Suicidality+	199 (77.4)	--	58 (22.6)	
	Trauma	104 (40.5)	55 (21.4)	98 (38.1)	0
	Domestic Violence+	242 (94.2)	--	15 (5.8)	0
	Gang Involvement+	248 (96.5)	--	9 (3.5)	0
	Exposure to Racism	137 (53.3)	30 (11.7)	90 (35.0)	0
	Psychosis+	172 (66.9)	--	85 (33.1)	0

Notes. *not all families actually complete assessments—as such the Asset, At-Risk, and In-Risk N and %s represent families who opted to participate in the FACE assessments. The rest of the 320 families opted to not participate or youth who were too young (<11 yrs.) to take self-assessments; + = dichotomous items only coded as “strength” or “in-risk”.

Using the public health model of risk, values in the above table are highlighted according to aggregated risk reported by FACE families. That is, if 80% of FACE families endorse experiences with assets then it is highlighted as green, if 20% of the population expresses some concerns or are considered to be at-risk on any specific domain it is highlighted yellow, and if more than 5% of FACE families and youth endorse items suggesting significant risk then the value is highlighted red. In doing so, there are highlighted categories in the table above that are noteworthy.

Specifically, the table above reveals that of the youth and families arriving at FACE, nearly all assessment categories are considered to be “at-risk.” These data are aggregated, so that does not mean everyone, but on average, FACE is seeing some of the highest risk youth and families in our county. Noteworthy among these risks, an alarmingly high proportion of youth arriving at FACE manifest behaviors that cause great concern for significant disruptive behaviors/conduct problems (74.3%), hyperactivity (67.7%), and attention problems (71.2%)—three concerns that are often observed together in national samples of youth struggling with conduct problems. In addition, a large proportion of FACE youth are perceived as having significant peer relationship problems (49.8%), experience significant levels of stress (44%), and have difficulties with school adjustment—including attendance (12.8%), performance (89.5%) and behavior (66.1%). School-based programs and school-community linked support services are effective buffers to assisting these youth to avoid developing more positive coping skills and avoid adopting aggressive problem solving strategies.

Similar to our previous report, the table above reflects the 257 families who engaged in FACE procedures and participated in youth, family, and clinician assessments. Specifically, the table above provides aggregated data for youth and family reports on all domains assessed at FACE. Several issues condition the interpretation of these numbers.

First, not all families and youth complete every assessment when coming to FACE. Some families are not at risk and thus we do not request information on those domains (e.g., youth and families are asked gated questions where the first gate screens for a risk factor and, if they endorse the risk factor, a second gate assesses with greater depth the intensity and frequency with which that risk factor is experienced). Also, some assessments are not used with some youth. For example, some youth are not old enough to participate in the self-assessments (<11 years of age), some measures (such as the clinical measure for anxiety and depression) are presently only rated for youth ages 13+. Second, these data represent the status of some of the most at-risk families in Boone County. As such, these data do not represent a normative sample in Boone County. Third and last, not all families who contact or are referred to FACE are assessed. Some families know exactly what they are looking for and simply want information. Alternatively, some families are unresponsive after initial contact has been made. As such, each domain has a different total sample size.

B.12. What types of services were FACE families linked to between January-December, 2017?

A total of 314 linkages were made for Boone County families in 2017 by FACE staff. Among the most common services linked were for individual child-, parent-, and family-focused counseling services. As a nonconflicted entity, FACE offers access to a full range of all service

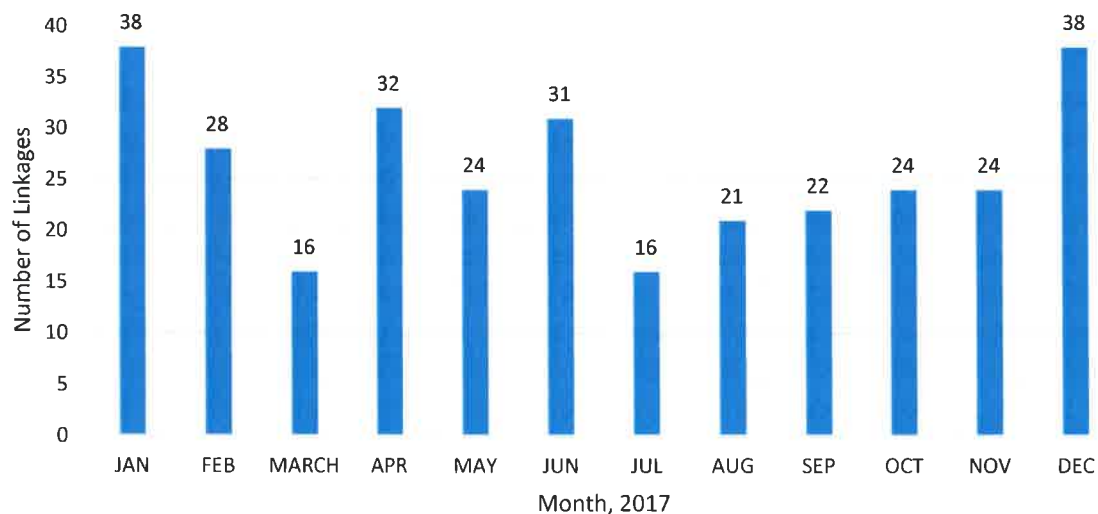
providers who provide support services in our community to target their specific area of concern. Family choice is the paramount guide in selecting any specific provider. The table below summarizes the service type offered from January to December of 2017.

Table 7: Service Type and Successful Linkages of FACE Families to Needed Services

Service Type	Number of Linkages
Basic Needs (Food Security, Utility Support, Housing, etc.)	66
Individual & Family Therapy (counseling, parenting, etc.)	117
Diagnostic Assessment & Psychiatric Services	24
Psychoeducational Services	29
School-based Support Services	22
Therapeutic Mentoring Services	19
Career & Employment Support Services	11
Medical or Dental Services	17
Afterschool Programming Services	9

The bar graph below expresses the total number of referrals made by month throughout this past year. The two lowest active months were in March and July of 2017, with slow increases in the fall months when school returned in session. It is important to note that a single family may identify 3 areas of concern and may, as a result, receive more than one referral.

Figure 22. Total number of Linkages, 2017



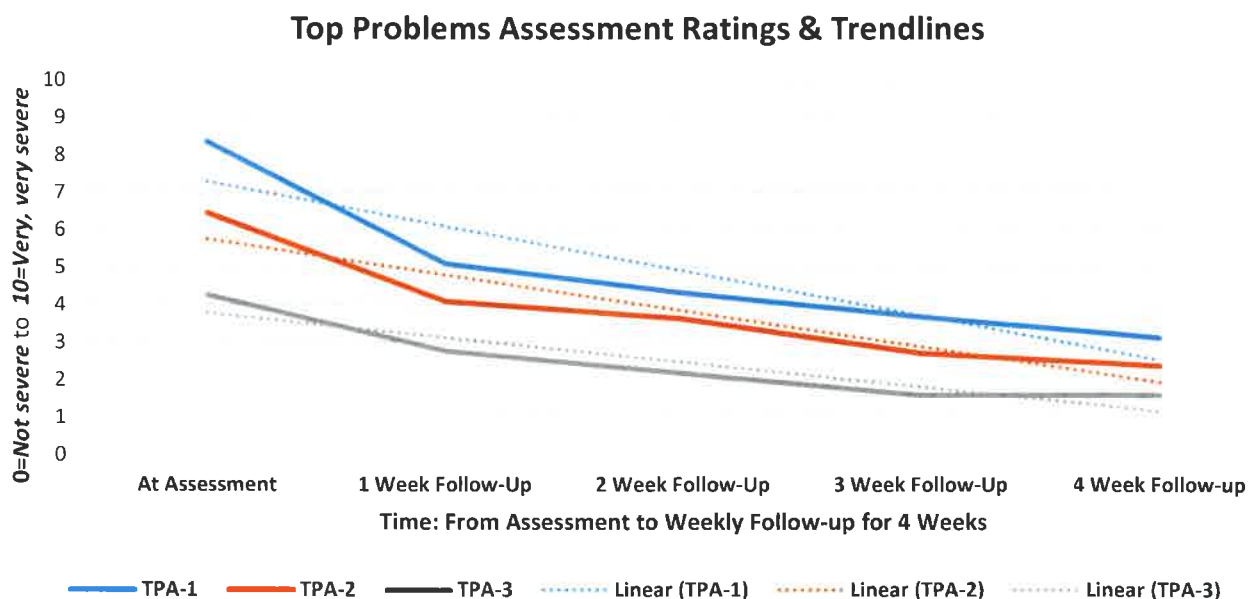
C. KEY QUESTION: IS FACE MAKING AN IMPACT: FAMILY SELF-REPORT OF PROBLEM SEVERITY—TOP PROBLEMS ASSESSMENT

The Top Problems Assessment (TPA; Weisz, Chorpita, Frye. et al., 2011) is a family-guided assessment used at FACE to identify treatment needs and track progress or change following

assessment. Following the FACE assessment and family feedback procedures, families are asked to list the problems they are most concerned about (e.g., “My son and I argue a lot”). FACE clinicians then log each concern stated and then read the list back to the family and ask if they feel there are any problems missing from the list. After the list is complete, FACE clinicians obtain severity ratings for each problem (“How big of a problem is this for you [or your child] on a scale ranging from 0-*not at all* to 10-*very, very much*?”). The family is then given the list and asked “which of these is the biggest problem right now?” or “which of these is most important to work on now?” The problem identified is ranked TPA-1. The next problem is ranked, and named TPA-2, and then next is listed as TPA-3. The result is a ranked list of up to three top problems identified by families along with a measure of severity ranging from 0-*not at all* to 10-*very, very much* (Weisz et al., 2011).

The figure below shows the average decline in TPA ratings for family self-selected problems from the initial assessment each week to the four week follow-up.

Figure 23. Top Problems Assessment from Initial Assessment to Week 4 Follow-up



The table below lists TPA scores for all families completing Top Problems Assessments between January and December, 2017. Of the 255 families who were engaged in the FACE assessment process, at least 245 families selected one top problem. The table below shows the average ratings across all families for each TPA at assessment and for a weekly follow-up check-in for four weeks straight. At the bottom of the table we examined the average amount of family self-reported change on the TPA from assessment to the week 4 follow-up point. In sum, the amount of improvement in family rated top problems reflected a significant and positive change across family ratings for TPA-1 (average reduction of 5.16), TPA-2 (average reduction of 3.66) and TPA-3 (average reduction of 2.40).

Table 8. TPA Average Scores, Change Scores, and Significance Tests TPA-1 to TPA-5

Time	TPA-1 <i>Mean (n)</i>	TPA-2 <i>Mean (n)</i>	TPA-3 <i>Mean (n)</i>
At Assessment	8.36 (245)	6.46 (222)	4.27 (183)
Week 1 Follow-up	5.10 (197)	4.09 (182)	2.77 (162)
Week 2 Follow-up	4.32 (186)	3.63 (172)	2.18 (141)
Week 3 Follow-up	3.69 (167)	2.71 (151)	1.60 (131)
Week 4 Follow-up	3.13 (160)	2.38 (146)	1.60 (126)
<i>d</i> from Assessment-Week 4	5.16 (s.d.=3.83)	3.66 (s.d.=4.06)	2.40 (s.d.=2.40)
Paired <i>t</i>-test (<i>p</i>-value)*	<i>t</i> = 17.01 (159 <i>df</i> ; <i>p</i> <.001)	<i>t</i> = 10.88 (145 <i>df</i> ; <i>p</i> <.001)	<i>t</i> = 7.163 (124 <i>df</i> ; <i>p</i> <.001)

Note. Average score across FACE families from January 1 to December 31, 2017; *d* = average change from TPA score at assessment to week 4; *standard statistical test *p*-value of .05 was adjusted to *p*<.016 using a Bonferroni correction to reduce the likelihood of detecting a significant finding in error.

For families who provided TPA responses shown above, not all of those families were linked for services (i.e., the improvement is occurring without additional services). Of the 245 families who listed at least one Top Problem, 120 (48%) were linked to a community service to address that problem, 125 (52%) families were not linked but still reported a decline in the severity of their TPA ratings, a testament to the impact of the FACE assessment intervention.

D. Lessons Learned and Next Steps: A summary of 2017 and the Road Ahead to 2018

First and foremost, it is important to note that FACE has continued to grow, improve, and thrive during the past year. In our initial proposal, we documented the many challenges that interfere with community uptake and maintenance of mental health initiatives for youth. Most prominent among these challenges are the poor outcomes for youth in most communities who seek mental health services (i.e., they typically do not benefit more than youth who receive no services).

We built FACE with attention to these lessons offered by existing literature with the hope that our community would have a valuable resource for improving not just access to care for youth with mental health concerns and their families, but ultimately helping them get better. Although we encountered many challenges in realizing our vision for FACE during the past year, we met nearly all of our goals with the help and support of key partners in the creation and development of FACE. Moreover, we now have initial evidence that our efforts are indeed impacting youth in the ways our community hoped when it invested in this effort. To be clear, we are still in the development phase of FACE, just 16 months after we opened the doors. Much work remains to make it into the world-class entity that we aim to achieve.

At the same time, the accomplishments to date are on par with where we hoped to be at this phase. Families are accessing FACE and, in turn, accessing available health and social services. Community providers are accessing trainings in evidence-based practices that, in turn, increase their ability to provide the high quality care our youths and families need. Finally, families are also reporting significant improvement in the top concerns that led them to seek care, indicating that these efforts are making a difference for youth who come to FACE and seek other services in our community. These are no small feats.

Second, our continuous improvement cycle has yielded important insights for areas of continued improvement.

A key deliverable for FACE is identification of unmet family and community needs. Since opening our doors in August 2016, we have identified the following gaps in available services:

- (1) Basic needs, including affordable housing and emergency shelter, food, furniture, utilities, employment, transportation, health insurance, prescription drug coverage, for families (This is a consistent need, VAC has limited spaces and limited funds, and especially with the loss of CMCA's Targeted Coaching program, we struggle to provide the hands-on help in accessing and navigating basic services that many families need);
- (2) Free, evidence-based parent training and parenting education (Although a few agencies do provide Parent-Child Interaction Training and Parent Management Training, the need far outstrips available services);
- (3) Mentoring support programs (e.g., Big Brothers Big Sisters, Presbyterian Children's House & Services Therapeutic Mentoring Program) are usually at capacity with a waitlist to receive a mentor;
- (4) Free individual and family therapy for uninsured and low income families (As with parent training, only a few agencies provide free services and the need consistently outstrips available services);
- (5) Few services available outside of the city of Columbia (Families in Centralia, Hallsville, Sturgeon, Ashland, Hartsburg, and rural areas must travel to Columbia for most services; Childcare and transportation are significant barriers for many families but there are few home- or community-based services in Boone County);
- (6) Timely assessment and intervention for early childhood developmental delays, learning disabilities and Autism Spectrum diagnoses (The Thompson Center continues to have long waitlists and there are few options besides traveling to Cape Girardeau, Kansas City, or St. Louis);
- (7) Intensive, family-focused services for severe adolescent conduct problems including aggression, delinquency and substance abuse (The MST program accepts a limited number of referrals and requires the youth already have a juvenile officer; The Parachute and Apex programs closed in December 2017);
- (8) Comprehensive services for severe adolescent mood dysregulation and self-harm risk (The Adolescent DBT program has limited number of spots and typically a long waitlist; The two adult-serving DBT programs, Columbia-DBT and MU PSC-DBT, also have limited spots and long waits);
- (9) Child psychiatrists who can prescribe and monitor psychiatric medications for youths (The MU BRIDGE program is an excellent resource, but there are limited options for families who do not wish to go through BRIDGE; community waitlists are typically 6-8 weeks).

As we complete the data dashboard in the coming months, we look forward to providing increasingly detailed reports to the BCSSB with more specific data on numbers of youths and family whose needs remain unmet because services are unavailable and exact wait times for available services.

Regarding outcome and impact assessments we will continue to use the TPA as our primary progress monitoring tool. That said, we will be building in normed clinical measures of child and family progress. We will supplement TPA ratings with well-established clinician rating tools

called the Symptom Severity Index and the Clinical Global Improvement (CGI). After the closure of each case, clinicians will be trained to make a CGI rating. This data will provide a second informant's perspective on improvement. It also will likely reduce families with missing outcome data as clinicians will make this rating for every family that they engage. Additionally, we will add a standardized and normed symptom and functioning improvement scale (e.g., the Peabody Symptom and Functioning Severity Scale) to our assessment that will be completed at key outcome points (e.g., 3 months post feedback session).

We are excited to embark on the third year of the development of FACE. Progress during the past year offers much reason to be optimistic about the future of this valuable community resource. During the coming year, we plan to continue to use data to guide program refinements, reach even more families, and help ensure optimal outcomes for the providers, families, and youth who work with FACE.

Respectfully Submitted by:

MU Leadership Team (*Drs. Aaron Thompson, Wendy Reinke, Keith Herman, & Kristin Hawley*)
FACE Executive Director (*Erin Reynolds, MSW*)

List of Appendices

A. Face Development Timeline: Year 2

B. Daily Operations

- a. Employee Handbook and Policy/Procedures Manual
- b. Assessment Workflow Training Worksheet
- c. Documentation Training Worksheet
- d. Top Problems Action Plan & TPA Calls Training Worksheet
- e. Front Office Manual
- f. Registration and OBC Manual
- g. CCM Case Transfer to CL form
- h. CL Transfer to CCM Form

C. QI Processes

- a. Clinical Case Review Description
- b. Staff Time Tracking Log
- c. Family Feedback—Central, North, & South
- d. Sample Case Review

D. Marketing

- a. Before You Refer
- b. Law Enforcement Referral
- c. School Based Referral
- d. General Referral
- e. Children's Division Referral Guide
- f. FACE Blue Card (Front and Back)
- g. FACE Brochure
- h. FACE Brochure Insert/Bookmark (info graphics)
- i. FACE Flyer
- j. FSD Flyer
- k. FACE Court Brochure
- l. FACE Presentation
- m. FACE Poster

E. Green Folder

- a. Welcome to FACE
- b. Your Family's Excellence
- c. HIPAA Notice of Privacy Practices
- d. Consent to Services and Releases
- e. Consent to Treat Minors
- f. ROI
- g. Family Feedback Forms

F. FACE STAFF Training and Supporting Documentation

- a. FACE Coalition (explanation/visual)
- b. FCU PowerPoint
- c. MI Training
- d. FACE Confidentiality Training

G. Training Data

Appendix A. FACE Development Timeline: Year Two

- **Phase 2—Year 2 (Jan 2017 – Jan 2018): Intermediate Development of FACE.**

At the close of the first fiscal year of the FACE of Boone County, we anticipate that a Director will be hired, that the Director and board have established operating procedures, that staff and clinicians will be hired, and that an integrated information system will be started but not completed. As such, the intermediate developmental phase 2 year will focus on:

- a) ***Jan, 2017:*** Revise existing MOUs
 - Referral points
 - Service providers
- b) ***Jan, 2017:*** Revise FACE hours of operation and staff contracts to reflect data
 - Hire two additional clinicians (projection—based on need)
 - Develop student training and supervision procedures for MU graduate students being trained in social work, school psychology, clinical psychology, and counselling psychology
- c) ***Jan, 2017:*** Revise FACE process and operations
 - Assessment battery revisions
 - Integrated Case management system
 - Case management procedures
 - Identify training needs for FACE clinicians
- d) ***Jan, 2017:*** Continue public awareness campaign
- e) ***Feb, 2017:*** Identify training needs for community providers
 - *March, 2017:* offer second round of trainings based upon need
- f) ***Feb, 2017:*** Begin procedures to capture third party
 - *Feb, 2017:* gain consultation and train FACE billing manager
 - *March, 2017:* Complete applications for insurance and entitlement service reimbursements
 - *Aug, 2017:* Develop internal billing procedures
- g) ***March, 2017:*** Begin offering free, research supported prevention programs
 - Parenting programs
 - Positive youth development programs
 - Brief-solution focused counselling
- h) ***April, 2017:*** Begin submitting proposals for programming (intervention research projects, training grants, etc.)
 - Pursue an accredited internship training program for PhD level clinicians to expand scope and reach of FACE
- i) ***April, 2017:*** Begin accepting proposals for research supported projects
- j) ***June, 2017:*** Mid-year report to Boone County Children Services Board
 - FACE Development Report (e.g., facilitates and operations, development of integrated information system, etc.)
 - FACE inputs and outputs (i.e., number of open/closed cases, referral sources, primary concerns, etc.)

- FACE impact (i.e., increases in youth and family functioning, effects of community awareness campaign, impact of training model on community providers)
 - FACE next steps (i.e., budget revisions, recommendations for funding targets, etc.)
- k) Aug, 2017:** Begin cost-benefit study for law enforcement and schools
- Law enforcement outcome: hours recuperated due to FACE accepting referrals for status and minors in need of supervision
 - School outcomes: reduced truancy, suspension, increased savings in average daily attendance
- a) Sept, 2018:** Continued extended FACE service plan
- Integrated Health Clinic in collaboration with Columbia/Boone County Dept. of Public Health and Human Services
 - Offer needed services in Boone County school buildings
- l) Oct, 2017:** Identify additional training needs for community providers
- m) Nov, 2017:** offer third round of trainings based upon need
- n) Dec, 2017:** End-year report to Boone County Children Services Board
- FACE Development Report (e.g., facilitates and operations, development of integrated information system, etc.)
 - FACE inputs and outputs (i.e., number of open/closed cases, referral sources, primary concerns, etc.)
 - FACE impact (i.e., increases in youth and family functioning, effects of community awareness campaign, impact of training model on community providers)
 - FACE next steps (i.e., budget revisions, recommendations for funding targets, etc.)

Appendix B. Daily Operations

- a. Employee Handbook and Policy/Procedures Manual
- b. Task Specific Manuals:
 - i. Assessment Workflow Training Worksheet
 - ii. Documentation Training Worksheet
 - iii. Top Problems Action Plan & TPA Calls Training Worksheet
 - iv. Front Office Manual
 - v. Registration and OBC Manual
 - vi. CM/CL Case Transfer Form/Process