2017 St. Louis Youth Behavioral Health Community Needs Assessment

Submitted to: St. Louis Mental Health Board and St. Louis Region System of Care

Submitted by: Behavioral Health Network of Greater St. Louis

Behavioral Health Network of Greater St. Louis

ACKNOWLEDGEMENTS

These acknowledgements are with deep appreciation for the families, staff, and organizations who show their commitment to improving the lives of people living with behavioral health challenges in our region. Expressions of appreciation to:

- The over 200 youth, caregivers, providers, and administrators who generously gave their time and expertise to the participatory groups and key informant interviews.
- Leadership at agencies instrumental to conducting the Participatory Group Sessions - Gene Slay's Girls' & Boys' Club of St. Louis, Grace Hill Settlement House, Kingdom House, Mathews-Dickey Boys and Girls Club (Youth Health Ambassadors), St. Louis Association of Community Organizations (SLACO), Thomas Dunn Learning Center, Vision for Children at Risk (Project LAUNCH).
- Health Departments – St. Louis County City/County Departments of Public Health, their leadership of the St. Louis Partnership for a Healthy Community, Leadership and Planning Team, begun 2017, with the vision to align community health assessment efforts across the St. Louis region; and the County's Behavioral Health Workgroup. Special thanks for efforts from the following staff and contractors: Michele Bildner, Spring Schmidt, Echo Wang, Nhial Tutlam, of the St. Louis County Department of Public Health; and contractors Laurie Call and Antonia Lalagos of the Illinois Public Health Institute.
- St. Louis Region System of Care (SOC) – Membership of the Family and Youth Leadership Cabinet, SOC Council, Executive Committee, and leadership staff, especially Riisa Easley and Tom Giles.
- Mental Health Board (MHB) – Membership of the Executive Committee, Board of Directors and leadership staff, especially Jama Dodson, Cassandra Kaufman, and Serena Muhammad.
- Behavioral Health Network of Greater St. Louis (BHN) – Membership of the Board of Directors, Adult Services Advisory Board, the St. Louis Children's Services Coalition (which functions as BHN's Children's Services Advisory Board), Hospital Community Linkages (HCL) Policy Workgroup and Liaisons Committee, Bridges to Care & Recovery Steering Committee and volunteer Wellness Champions. Efforts from the following staff were instrumental: Alison Kraus, Sally Haywood, Wendy Orson, Kim Harrison, Laura Lee, Shawn Billings, Tamela Strayhorn, Whitney Bunts, and Rose Jackson-Beavers.
- Our sub-contracted partners made essential contributions: Cynthia Berry, Owner/Chief Organizational Development Director, Berry Organizational & Leadership Development (BOLD), LLC; and Teresa Wildman Wilke, Owner/Principal at Silver Arrow Strategies.

BOLD, LLC
(Quantitative Data Analysis)

and

SILVER ARROW STRATEGIES
(Review of Key Regional Reports)

TABLE OF CONTENTS

Acknowledgements ---- 1

Executive Summary ---- 5

Background and Purpose of the 2017 Youth BH Needs Assessment ---- 5

Scope and Overview of Approach ---- 5

Thematic Recommendations and Opportunities ---- 6

1. Recommendation: Transform Behavioral Health (BH) Services to be Optimally Accessible to Youth ---- 7

2. Recommendation: Invest in Family Systems Approaches and Caregiver Supports to Address Youth BH ---- 7

3. Recommendation: Strengthen the Service Providing Community's Responsiveness (BH and non-BH providers) ---- 7

4. Recommendation: Respond to Youth Experiences of Trauma ---- 8

5. Recommendation: Increase Early Identification of BH Vulnerability and Provide Early Intervention ---- 8

6. Recommendation: Invest in School-Based Capacity to Address BH Needs ---- 8

7. Recommendation: Increase BH Engagement by Addressing Social Determinants of Health / Environmental Stressors ---- 9

8. Recommendation: Foster Positive Youth Social Development (PYD) ---- 9

Alert: Prioritize Supports for Vulnerable Populations ---- 9

Conclusion / Next Steps ---- 10

Introduction ---- 11

Background and Partnership ---- 11

Objectives of the 2017 Youth BH Needs Assessment and Partnership: ---- 11

Definitions ---- 12

Overview of Approach ---- 12

Report Structure ---- 15

Limitations ---- 15

Review of Key Regional Reports ---- 16

Overview ---- 16

Methodology ---- 16

Key Findings ---- 20

Detailed Findings ---- 21

Qualitative Data Analysis ---- 27

Overview ---- 27
Methodology ---- 27
Data Analysis ---- 32
Key Findings ---- 33
Detailed Findings ---- 34
Resources and Assets ---- 34
Barriers and Gaps ---- 37
Opportunities ---- 43
Quantitative Data Analysis ---- 44
Overview ---- 44
Methodology ---- 45
Key Findings ---- 45
Detailed Findings ---- 55
Demographics of St. Louis City ---- 55
General Population Information ---- 59
Housing-Related Information ---- 68
St. Louis City Community Indicators – A Focus on Our Youth ---- 74
Health ---- 109
Behavioral Health Community Based Treatment ---- 119
Acute Youth Mental Health Treatment ---- 120
Findings from the St. Louis County Student Survey: Top BH Issues St. Louis County Students Face at School or in their Community ---- 125
Substance Use ---- 129
Missouri Student Survey – 2016 – St. Louis County Student Sample - Key Findings to be Generalized to the St. Louis City Student Population ---- 129
Behavioral Health Response Data Analysis: Trends for the 2015 St. Louis County Youth Cases and FY2017 St. Louis City Youth Cases ---- 135
Eastern Region Behavioral Health Access to Care Survey Data ---- 139
Thematic Recommendations and supportive key findings ---- 147
1. Recommendation: Transform Behavioral Health (BH) Services to be Optimally Accessible to Youth ---- 147

2. Recommendation: Invest in Family Systems Approaches and Caregiver Supports to Address Youth BH ---- 149

3. Recommendation: Strengthen the Service Providing Community's Responsiveness (BH and non-BH providers) ---- 149

Recommendation: Respond to Youth Experiences of Trauma ---- 150

5. Recommendation: Increase Early Identification of BH Vulnerability and Provide Early Intervention ---- 151

6. Recommendation: Invest in School-Based Capacity to Address BH Needs ---- 151

7. Recommendation: Increase BH Engagement by Addressing Social Determinants of Health / Environmental Stressors ---- 152

8. Recommendation: Foster Positive Youth Social Development (PYD) ---- 153

Alert: Prioritize Supports for Vulnerable Populations ---- 154

Appendices ---- 156

Appendix A. Community Report References ---- 156

Appendix B. Qualitative Question Set Sample ---- 158

Appendix C. Detailed KEY Informant Interview Contributions (By Stakeholder Type) ---- 160

Appendix D. Additional St. Louis City Indicator Tables ---- 181

Appendix E. Additional Survey Data Tables ---- 184

Appendix F. Additional BHR Data Tables ---- 202

EXECUTIVE SUMMARY

BACKGROUND AND PURPOSE OF THE 2017 YOUTH BH NEEDS ASSESSMENT

The St. Louis Mental Health Board (MHB) and the St. Louis Region System of Care (SOC) initiative contracted with Behavioral Health Network of Greater St. Louis (BHN) as a partner to design and implement the **2017 Youth Behavioral Health** (BH) **Community Needs Assessment**. This Needs Assessment intends to highlight St. Louis City, County, and the region's assets and strengths, barriers and gaps, and opportunities and recommendations. These will inform our continued pursuit of a collective vision for investing and strengthening an integrated system of social, behavioral, and physical health services to build an equitable, thriving community. BHN, too, is dedicated to the goal of enhancing individuals' quality of life by developing a coordinated, accessible, effective and accountable system of BH and integrated supports. This Needs Assessment offers the opportunity for these entities and the region to align community priorities to foster the ability of community members to reach their highest potential.

The purpose of this Needs Assessment is to identify assets and needs that directly impact our community, then to use these to inform recommendations and opportunities for the region's response to youth's BH needs. The process of developing this Report also provides the framework to build upon existing organizational relationships, formalize processes, and develop system-level means to address BH through a network of safety-net providers. BHN intends that this Report will be utilized as a resource document for funders and other stakeholders to develop informed decisions regarding programs and initiatives that will improve the health and wellbeing of youth and families in our region.

SCOPE AND OVERVIEW OF APPROACH

To meet the 2017 Youth BH Needs Assessment purpose, BHN has focused foremost on BH services, while remaining attentive to a range of aspects related to youth and family wellbeing. For these purposes, "behavioral health" is a broadly applied term that encompasses concerns and services for mental health and/or substance use concerns, at all levels of severity and points on the service continuum. The Needs Assessment centers on safety-net providers of BH services and publicly available services. Data collection and analysis utilizes a health equity lens, with attention to geographic and demographic disparities. This Report combines findings from three categories of source information:

- **Review of Regional Reports** –To build on the Region's existing work, BHN conducted a review, summary and analysis of key recent Eastern Region Reports and identified common themes related to the Needs Assessment objectives. This review included thirteen regional reports produced since 2013 and nine recent Hospital Community Health Needs Assessments.
- **Qualitative Data Analysis** – BHN solicited perspectives from over 200 people through both group and key informant interview approaches. Our methods included: nine BHN staff-led Participatory Group Sessions of community members (youth, caregivers, general residents) and service providers (community-based BH providers and hospitals); 13 Key Informant Interviews from various sectors of care; and analysis of over 10 sets of summary notes from other organizations' recent focus group and qualitative process sessions.
- **Quantitative Data Analysis –** BHN gathered and analyzed numerous sources of key indicator data, trending over time and providing comparisons of Missouri, St. Louis City, and St. Louis County, which incorporated BH-specific data and indicators tied to youth BH (e.g. poverty metrics, graduation rates, etc.). Sources include governmental data sets, private and non-profit data sources.

Through all three categories of source information, we sought insights regarding aspects of BH services: Resources/Assets, Barriers/Gaps, Opportunities, to inform thematic recommendations.

A synopsis of key findings from each method can be found in the three respective sections of this report, and provide details to support data such as the following.

Descriptors of the City's Youth:

- City's pop is 315,685, of whom 71,044 are youth (23% of City pop is youth)
- The Youth population is declining rapidly - 29% decrease in 10 years, with 76% of the City's population decrease being youth
- Greater Diversity - Percent of youth who are racial/ethnic minorities is increasing
- Children (age 5-17) with Limited English Proficiency – 3.5% of St. Louis City Youth (2,175), rate has not changed notably since 2004

St. Louis City Youth at Risk – High rates of:

- Poverty - almost 2 out of 5 live in poverty (almost double the MO rate)
- Homeless – in schools noted as homeless (almost 1 out of 5, triple the 2010 reported rate)
- Risk of homelessness – Per gross rent costs of 30% or more of their household income (48% of households)
- Children benefiting from Food Stamps (almost 3 out of 4, more than double MO rate)
- Violent Teen Death Rate (more than double the MO rate)
- Juvenile Law Violation, Violent offenses
- Neglect Offenses
- School Drop-out rate (11.7%, 5 x MO)
- Out of school suspensions (more than double the MO rate)
- Disciplinary incidents (more than double the MO rate)

Youth Mental Health:

- Of St. Louis City's 71,044 youth ages 0-19,
    - Over 17,000 projected to have MH challenges that qualify for a diagnosis (24%)
    - Over 3,500 are projected to have a mental illness with severe impact (5%)
- MH & Overall hospitalizations for youth have sharply increased.
- Of 949 youth receiving DMH psychiatric services in 2015, clients trending younger (6-9 year olds)
- ER youth encounters with BH diagnoses increased by 11% over the past year and account for 32% of all ER encounters in 2015.
- Behavioral Health Response (BHR) – 44% of City callers considered high risk cases (209/475 cases); and 27-28% of County cases.

THEMATIC RECOMMENDATIONS AND OPPORTUNITIES

While the nature of a Needs Assessment may appear at face value to be deficit-based, it is important to note that community assets and strengths are highlighted throughout the full report document and are readily apparent in all forms of data collected—from community report (p16) and community member emphasis on progress in qualitative sessions (p27), to positive trends of improvement in quantitative community indicators (p44). Moreover, the willingness of community members to engage in the Needs Assessment process and the collaborative approach this work has taken is a testament to the strengths in the St. Louis community that foster growth toward a strong, healthy, and equitable environment, particularly for BH.

The Needs Assessment concludes with overall "Thematic Recommendations" regarding community response to youth BH needs. These recommendations are supported by a selection of key findings and are representative of wide consensus across the sources and methodologies utilized. See the full report, section "Thematic Recommendations and Supportive Key Findings" for a sampling of the data that elevated the theme to be a Recommendation (p147-155). Recommendations and some of the identified opportunities are provided below as part of this Executive Summary. Recommendations are listed with a sense of priority order, yet should be viewed

in tandem, recognizing that these interplay and are complimentary to address youth BH needs and opportunities identified.

1. RECOMMENDATION: TRANSFORM BEHAVIORAL HEALTH (BH) SERVICES TO BE OPTIMALLY ACCESSIBLE TO YOUTH

Enhance access to programs and services; Re-organize to increase responsiveness in service "gap" areas; Integrate follow-up and case management. Invest in system level disconnects and sustainable policies and care integration that can have sustainability.

Opportunities to Transform Behavioral Health (BH) Services to be Optimally Accessible to Youth:

- Address Broad Barriers to access - Transportation and location of services; Address distrust of providers, negative past experiences with BH services, and stigma roadblocks for families and youth.
- Improve follow-up activities for youth who transition to a new or different program or service.
- Expand specialty services, specifically to include: respite, counseling (especially family counseling), home-based services, intensive outpatient programs/treatment, 24/7 crisis access/response service, inpatient supports, longer-term care/case management/follow-up (especially post-crisis), etc.
- Enhance care coordination within and across agencies and systems to improve access and engagement.

2. RECOMMENDATION: INVEST IN FAMILY SYSTEMS APPROACHES AND CAREGIVER SUPPORTS TO ADDRESS YOUTH BH

Services for youth BH needs must be integrated with and understanding that the youth cannot be understood in isolation, but rather as a part of their family, [1] and that providers must attend to caregivers' needs.

Opportunities to Invest in Family Systems Approaches and Caregiver Supports to Address Youth BH:

- Fund services that allow for intergenerational approaches and caregiver specific services to improve caregivers' ability to recognize and manager BH issues with their youth. Invest in family systems approaches.
- Invest in resources to provide BH supports/treatment to caregivers in need of services.
- Integrate Family Support Providers (peer mentors) to assist families and caregivers.
- Facilitate caregivers' awareness and navigation of available services and resources.
- Increase the availability of family counseling.
- Improve digital / online information about available services, and ensure it includes eligibility parameters to minimize future accessibility issues and frustration of the family and youth.
- Strengthen caregivers' general parenting skills and knowledge, including understanding developmental milestones.

3. RECOMMENDATION: STRENGTHEN THE SERVICE PROVIDING COMMUNITY'S RESPONSIVENESS (BH AND NON-BH PROVIDERS)

Enhance service agencies and providers to be better equipped to respond to community youth BH needs, regardless of care setting or sector. Improve approaches to transitions of care for youth with agency/provider expertise, coordination, and collaboration.

Opportunities to Strengthen the Service Providing Community's Responsiveness (BH and non-BH providers):

- Invest in a linkage & referral data-informed network—details of available community programs/services and how families can access them. Make eligibility restrictions/requirements more transparent.
- Foster provider collaboration across care sectors and care settings.

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[1] Kerr, Michael E. "One Family's Story: A Primer on Bowen Theory." The Bowen Center for the Study of the Family. 2000. http://www.thebowencenter.org.

- Investigate funding strategies that support flexibility and address geographic boundaries for funding and service delivery (i.e. City/County boundary barriers).
- Establish stronger "front doors" for families to know about BH services options and assistance to access care.
- Strengthen providers' capacity to support client/family navigation of the service delivery system, especially across primary care and BH care settings.
- Leverage technology to improve communication, enhance care coordination, and strengthen regional data reporting.

RECOMMENDATION: RESPOND TO YOUTH EXPERIENCES OF TRAUMA

Violence, traumatic experiences, and toxic stress can have a devastating impact on youth, affecting their physical, emotional, cognitive, and social development. Trauma encompasses a range of adverse childhood experiences. Of note, community violence is a special consideration in St. Louis City and a key trigger for BH needs in the region. Services and supports are needed to be available and tailored to these environmental realities.

Opportunities to Respond to Youth Experiences of Trauma:

- Increase the trauma-informed competency of organizations and trauma-expert practitioners in the community.
- Expand trauma-focused services and targeted case management.
- Increase specialized services for survivors of trauma, with attention to demographic differences (e.g. racial and grade-level) to respond to youth who are at highest risk of experiencing trauma with the least supports and access to BH services and programs.
- Assess factors that may have led to a decline in violent juvenile law violation offenses to replicate best practices.

5. RECOMMENDATION: INCREASE EARLY IDENTIFICATION OF BH VULNERABILITY AND PROVIDE EARLY INTERVENTION

Foster BH intervention earlier in the life- and disease-course. Enable assessment of BH needs and expedite youth access to services and to promote an understanding of youth needs.

Select Supporting Data:

- Regional reports showed that in the Fall of 2016, one of the largest providers of psychological evaluation services for youth in the St. Louis region had 15% of youth (counted at one time as 247 youth in St. Louis County only) who needed this service put on a waitlist. Waitlist times ranged from 15-19 weeks.
- Needs emerge in early childhood and often go un-addressed, until school-age; Schools then particularly see the ramifications of these needs
- Qualitative data reflected a wide sense that there is limited access to services until a crisis takes place.

Opportunities to Increase Early Identification of BH Vulnerability and Provide Early Intervention:

- Increase diagnosis and evaluation availability and accessibility (esp. in St. Louis City), to improve early identification and treatment of BH needs.
- Increase early childhood screenings (esp. in St. Louis City; worsens for youth age 10+).
- Increase screenings in medical and other settings for BH needs. Include BH screening for children 0-5 and parents (mothers and fathers) during perinatal care.
- Expand access to Individualized Education Plan (IEP) assessments, advocacy, and support (esp. in St. Louis City).
- Establish earlier intervention / screening / connection to services for BH issues in children through primary care.

6. RECOMMENDATION: INVEST IN SCHOOL-BASED CAPACITY TO ADDRESS BH NEEDS

Bolster the infrastructure and reach of schools for BH prevention, awareness, skill building, and connection to needed treatment.

Opportunities to Invest in School-Based Capacity to Address BH Needs:

- Evaluate the current efforts in the Mental Health First Aid trainings for teachers and staff to determine gains in knowledge, skill, and application, in addition to assessing remaining gaps in training focused on youth behavioral health. Then, invest in BH support for teachers and school staff to include supports beyond training—ongoing skill development to identify and respond to generalized BH needs of students (see supporting data above). Support implementation of mandated reporter training for teachers and other professionals.
- Invest in more BH counseling and surveillance within the schools to address youth treatment needs (i.e. depression, anxiety, emotion-control, SU, etc.). Have BH specialists in public elementary, middle and high schools (regardless of whether they are school counselors or contracted/external BH specialists).
- Implement school-based MH awareness, trauma screening, fighting/violence remediation (see student survey data).

7. RECOMMENDATION: INCREASE BH ENGAGEMENT BY ADDRESSING SOCIAL DETERMINANTS OF HEALTH / ENVIRONMENTAL STRESSORS

Significant BH and physical health improvements can be gained by mobilizing innovative approaches to addressing social determinants of health, including intentional collaborations with other sectors of care.

Opportunities Increase BH Engagement by Addressing Social Determinants of Health / Environmental Stressors:
- Address youth's / families' basic needs through partnerships and alignment with the social service sector to promote access, health, wellness, and equity.
- Decrease access barriers by increasing transportation of youth and families to and from services; improve the location of services to better meet youth/family needs; and/or provide more sites or places where people can access services.
- Help more families gain insurance.
- Address families' housing instability.

8. RECOMMENDATION: FOSTER POSITIVE YOUTH SOCIAL DEVELOPMENT (PYD)

Support intentional efforts to provide opportunities for youth's positive community engagement and activities for personal empowerment (i.e. interests, skills, and abilities) and recreation, via programs designed to optimize developmental progress. [2]

Opportunities to Foster Positive Youth Development:
- Increase youth skill building for independent living, including healthy relationships. Foster positive self-concept among youth.
- Increase Positive Youth Development (PYD) programming that is future-focused. Increase activities to build knowledge and job-readiness skills, promote career awareness, and develop social responsibility and leadership skills.

ALERT: PRIORITIZE SUPPORTS FOR VULNERABLE POPULATIONS

It is recommended, that within all the thematic priorities, the data calls for an investment in responsiveness to the BH care needs of particular populations, due to inequities in available BH services in general and those tailored to vulnerable populations' unique needs. Some of these populations might represent a smaller portion of the youth population, yet with high needs. Populations in great need include the following (see quantitative and qualitative data), as some of these are a small portion of the youth population with high needs and some are a large portion of the youth population:
- Youth with co-occurring substance use (SU) disorder.

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[2] *"Positive Youth Development in the U.S.: Research Findings on Evaluations of Positive Youth Development Programs". Retrieved April 9, 2014.*

- Youth with co-occurring Intellectual/Developmental Disabilities (IDD) and BH needs.
- Youth with co-morbid BH and physical health needs.
- Youth who have experienced violence or trauma.
- Transition-age youth. Including those transitioning from adolescence to young adulthood, aging out of foster care system, and aging-out/emancipated minors with severe needs.
- Early childhood (Children ages 0-5) populations are repeatedly the smallest population served per provider report.
- Juvenile justice-involved youth.
- Child welfare system-involved youth.
- Youth who are homeless or housing unstable.
- Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) youth.
- English Language Learners.

CONCLUSION / NEXT STEPS

Based on the 2017 **Youth Behavioral Health** (BH) **Community Needs Assessment** findings and recommendations, improvements are needed for the region's response to youth's BH needs. There are great strengths in our community and impressive strides have been made to improve services to youth. Hopefully this report can guide further improvements to addressing access to care, care coordination, quality of care, and addressing health disparities which directly impacts the community health of our youth. Together, through partnerships with leadership from human service agencies, BH providers, business leaders, and community members, we can create a better system of care for youth and their families.

To enhance access and usage of this Needs Assessment, the full report and much of the data informing it will be available via BHN's web site and on the "Think Health" site, which is a source of population data and community health information designed to be a tool for community assessment, strategic planning, identifying best practices for improvement, collaboration, and advocacy.

As part of BHN's ongoing commitment, we will utilize these findings and recommendations to inform development of an accessible and coordinated system of BH care and support services throughout the Eastern Region of Missouri. In this vision, BHN depends on engaging the collaborative efforts of providers (hospital, primary care, substance use, community mental health, etc.), advocacy organizations, government leaders, and community stakeholders. Thank you for reviewing this report and for your service and commitment to improving the lives of youth and families living with BH challenges in our region.

Community members are encouraged to utilize the findings of this this Needs Assessment within their own organizations and participate with the following groups as we seek to inform regional planning and coordination for BH services: St. Louis Region System of Care Council and Family and Youth Advisory Board; BHN Planning groups, particularly BHN's Advisory Board.

INTRODUCTION

BACKGROUND AND PARTNERSHIP

Behavioral Health Network of Greater St. Louis (BHN) has partnered with the St. Louis Mental Health Board (MHB), the St. Louis Region System of Care (SOC) initiative, and our collaborative partners to design and implement a 2017 **Youth Behavioral Health** (BH) **Community Needs Assessment**. This is an effort building on the missions and strengths of the three entities and the region.

BHN is a not-for-profit organization, representing a collaborative effort of providers (hospital, primary care, substance use, and community mental health), advocacy organizations, government leaders, and community stakeholders. We are dedicated to developing an accessible and coordinated system of behavioral health care throughout the 7-county Eastern Region of Missouri. The mission of BHN is to improve the community by leading behavioral health planning and coordination. Our vision is to develop a coordinated, accessible and accountable system of behavioral health and support services, so the people in our region will reach their highest potential.

St. Louis Mental Health Board (MHB) mission is, "MHB improves the quality of life for city residents by investing and participating in a coordinated system of social, behavioral, and physical health services aligned with community priorities." MHB is committed to administering tax revenues funds entrusted to it meet the vison, "MHB is a strategic visionary leader investing in and strengthening an integrated system of social, behavioral and physical health services to build an equitable, thriving community."

St. Louis Region System of Care (SOC) initiative, through our networks, seeks to provide more comprehensive and effective care for children and their families, especially around BH needs. The MHB received a one-year planning grant (10/2014 – 9/2015), and subsequent four-year Cooperative Agreement (10/2015–9/2019), from the Substance Abuse and Mental Health Services Administration (SAMHSA) to convene key stakeholders to enhance and expand Children's Mental Health System of Care serving youth and their families, aged birth to 21, residing in St. Louis City and County.

MHB and SOC contracted with BHN to do two things: (1) Conduct a 2017 Youth BH Needs assessment to include recommendations, focusing on the needs of children, adolescent and young adult (for ages 0-21) in St. Louis City and St. Louis County; (2) Conduct this work in a means which improves behavioral health planning and coordination processes in the region, over time. Toward this longer-term goal, BHN will continue its partnership with MHB and SOC through at least 2019.

OBJECTIVES OF THE 2017 YOUTH BH NEEDS ASSESSMENT AND PARTNERSHIP:

The objectives of the 2017 Youth Behavioral Health Needs Assessment and partnership include:

1. Identify assets, gaps/needs, opportunities, and use these to inform recommendations for the region's response to youth's BH needs, especially those which might be addressed by service providers and supported by funders.
2. Build upon existing organizational relationships to formalize processes for monitoring community needs in an ongoing way.
3. Utilize this process to lead planning/coordination in the region regarding development of system-level means to address BH needs through a network of safety-net providers.

We collaboratively aim to use this Needs Assessment as a stepping stone in the process to align the efforts of planning/coordinating, minimize duplicative efforts, prioritize regional needs, and move toward collaborative efforts to implement and track improvement activities to better address the behavioral health needs of youth across the region.

DEFINITIONS

This Needs Assessment uses the following definitions of terms:

- ***Youth****:* A term used in this report to include children, adolescents and young adults (ages 0 to age 21), with reach to age 25 for Transition-Age Youth.
- ***Behavioral Health (BH)****:* A broadly applied term that encompasses needs and services for mental health and/or substance use concerns, at all levels of severity and points on the service continuum.
- ***Mental Health (MH) Services****:* Efforts delivered to treat and improve functioning of those experiencing crisis, acute or long-term needs related to challenges in thinking, mood, and/or behavior.
- ***Substance Use (SU) Services****:* Efforts delivered to treat and improve functioning of those experiencing crisis, acute or long-term needs related to the recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment.
- ***Health Care Safety Net****:* Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations.[3] They are distinguished by their commitment to provide access to care for people with limited or no access to health care due to their financial circumstances, insurance status, or health condition.[4]
- ***Cross-Sector Providers/Services:*** Sectors where a youth's Behavioral Health needs would likely be identified and potentially addressed, yet BH treatment is not the mission of that sector. For the purposes of this report, these include: Education, Juvenile Justice, Housing/ Homelessness, Child Welfare, Physical Health, Vocational, Recreational, and Social Support services (sectors defined by SAMHSA for SOC).
- ***Missouri's Eastern Region****:* The seven counties of Franklin, Jefferson, Lincoln, St. Charles and Warren, St. Louis, and St. Louis City. This is the focus area of BHN. The focus of this Youth BH Needs Assessment is St. Louis City and St. Louis County.

OVERVIEW OF APPROACH

The 2017 Youth BH Needs Assessment objectives have been addressed through the implementation of the following methods and activities, utilizing both quantitative and qualitative data. The focus for the Needs Assessment has been foremost on behavioral health (BH) clinical services, with secondary emphasis on early intervention BH services, while remaining attentive to aspects of wellbeing. Focus remained on safety-net

[3] Institute of Medicine (IOM), America's Health Care Safety Net: Intact but Endangered, 2000.

[4] Larry Gage. "What is a Safety Net Hospital?" National Association of Public Hospitals and Health Systems (NAPH), 2015, Retrieved from www.literacynet.org

providers of BH services and publicly available services. Throughout the Needs Assessment process, we engaged key leaders from BHN/MHB/SOC and our collaborative partners, including the Department of Mental Health, to ensure the objectives of the Needs Assessment were met and to inform the work (e.g. establishing design, content, process, timeline; access to partners' data and community stakeholders; development of recommendations based on Assessment findings). In conjunction with St. Louis MHB and SOC staff, BHN identified priorities, cross-sector services, and data elements to pursue for the Assessment.

This Needs Assessment combines findings from three categories of source information: (1) Key regional reports, summary and analysis thereof; (2) Qualitative data collection through participatory groups and key informant interviews; and (3) Quantitative data indicators, comparing City/County/State and showing trends over time. We sequenced some of these approaches, and conducted some concurrently, seeking that each would inform the processes for the others. Explicit efforts were made to apply an "equity lens" when conducting this assessment, meaning maintaining cognizance of the impact of internal and external processes, as well as foundational assumptions and interpersonal engagement, on marginalized and under-served individuals and communities.[5] Through all three categories of source information BHN sought insights regarding the following aspects of BH services: resources/assets, barriers/gaps, and opportunities to inform recommendations.

The sequencing of information in this report is as follows: First, via review of regional reports, we sought to share insights from the abundance of assessment work in recent years. Next, we share our qualitative data, in which we solicited perspectives/observations/experiences to inform underlying meanings and patterns. Then we share rich indicator data to examine measurable aspects of behavioral health and key contributing factors to health and wellbeing of youth. Each of the three sections summarizes key findings and recommendations derived from that method. The report concludes with a set of Thematic Recommendations (see below).

1. **Key Regional Reports** (p16-21) –
   To build on the region's existing work, BHN conducted a review, summary and analysis of key recent community reports and identified common themes related to the Needs Assessment objectives. This review included thirteen regional reports produced since 2013 and nine recent Hospital Community Health Needs Assessments. Most of these reports included both primary and secondary data analysis, as well as qualitative data solicited from key stakeholders and/or individuals representing the community of focus, and some synthesis of data gleaned from secondary sources. The barriers and challenges identified by these reports could be categorized as those experienced individually by the youth, families, provider constraints, and broader systemic barriers that are pervasive across the system of care or involve "upstream" determinants and systems. This Needs Assessment was not designed to replace the existing reports, but to complement and supplement.

The mixed data methods we utilized are further summarized below, tied to the lettering in this table:

	Primary data	Secondary data
Qualitative data	A	B
Quantitative data	C	D

2. **Qualitative Data** (p27-43) –
   A. Primary: BHN collected qualitative data both early in our Needs Assessment process for exploratory discussions, and later in the process to seek feedback for understanding data received. Our qualitative data

[5] "Tools for Integrating an Equity Lens," 2017, Spark Policy Institute, Retrieved from www.tools.sparkpolicy.com

collection included perspectives from community members and providers (line staff and leadership) from various sectors of care. Primary qualitative data collection methods included:

- Facilitated Discussions: At BHN's and SOC's various regular meetings in 2017 to gather perspectives.
- Participatory Group Sessions: Nine BHN staff-led groups of community members (youth, caregivers, general residents) and service providers (community-based BH providers and hospitals). We structured activities to elicit information related to Needs Assessment Objectives. Participants included 6-32 people per group, with a culminating event of 52 people, to include, overall perspectives from over 200 people.
- Key Informant Interviews: Thirteen BHN staff-facilitated structured conversations with key regional service provider leaders from the following sectors of care: Criminal Justice System, Homeless/Housing/Social Service Providers, FQHC/Physical Health Providers, Education, Child Welfare, Violence Prevention, Youth Development, and Employment. Structured interviews focused youth's needs in the community and related to behavioral health (BH).

B. Secondary: BHN analyzed over 10 sets of summary notes from other organizations' recent focus group and qualitative process sessions.

3. **Quantitative Data** (p44-146) **–**

Primary and secondary quantitative data enrich understanding of St. Louis City, County, and regional trends. BHN collaborated with multiple stakeholders to identify a core list of behavioral health and related indicators that reflect a more comprehensive and cohesive view of the life experiences, assets, needs, barriers, and gaps experienced by youth.

C. Primary: Beginning in 2015, BHN has collaborated with the Regional Health Commission's annual Access to Care Report team to add additional data on access to BH services (p139). BH Data for "Access to Care" is collected annually from major publicly funded health providers in Missouri's Eastern Region. These providers had not been surveyed since the 2005 Access to Behavioral Health Assessment completed by the RHC. Data collection for calendar year 2016 informed this Needs Assessment.

D. Secondary: We gathered and analyzed numerous sources of existing data sources, trending over time and providing comparisons of Missouri, St. Louis City, and St. Louis County, which included:

- Secondary data sets with key quantitative indicators, including behavioral health-specific data (e.g. youth hospitalization rates, etc.), and secondary indicators tied to youth behavioral health (e.g. poverty metrics, graduation rates, etc.). Sources include governmental data sets, private and non-profit data sources. Data is sourced from a variety of publicly available secondary datasets, with sources noted.
- Existing MHB and SOC programmatic datasets from funded agencies (e.g. Behavioral Health Response, p135).

Direct requests for data were coordinated with other groups in the region (i.e. St. Louis City and County Health Departments, several hospitals, etc.) who seek similar data elements to determine need for their specific planning. While the focus of this Needs Assessment is St. Louis City, St. Louis County data is included to recognize the importance of a broader perspective to youth behavioral health and for comparison purposes. When easily feasible, BHN gathered data for comparison amongst all seven Missouri Eastern Region counties.

REPORT STRUCTURE

BHN organized this report by the three methods of data collection detailed above. A synopsis of key findings and recommendations from each method can be found in the three respective sections of this Report.

Method	Page of Key Findings
Regional Reports	16
Qualitative Data	21
Quantitative Data	44

The Report concludes with overall Thematic Recommendations regarding community response to youth BH needs. Through the source information, BHN identified where the data conceptually reinforced each other, usually emphasized in all three sources, and developed major Thematic Recommendations. Each Recommendation theme is followed by a sampling of key findings which informed the prioritization of that theme to the status of a Recommendation. This process is further explained in the **Thematic Recommendations section, page 148**.

LIMITATIONS

It was beyond the scope of this Report to compare individual clients' needs with services received. We studied thirteen key Regional Reports and five Hospital Community Health Needs Assessments (CNA), however this review was not all inclusive and we drew from the findings of those who produced the reports. We recognize that some qualitative data collection group and key informant participants' contributions are based on perception and their own, as well as their contacts', experiences and may not be fully informed by other perspectives or new evidence-based approaches. Sample sizes of youth qualitative groups from BHN and others were small, yet gave us an exposure to youth perspectives. BHN worked with stakeholders and partners to select BH and related data indicators, and some may perceive an omission. Certain quantitative data are difficult to secure for St. Louis City, creating some information gaps. Of note, it is the recommendation of BHN to engage with the St. Louis Public Schools of St. Louis City to foster participation in future Missouri Student Survey data collection efforts.

REVIEW OF KEY REGIONAL REPORTS

OVERVIEW

In order to build on the region's existing work, Behavioral Health Network (BHN) conducted a review, summary, and high level analysis of key recent Eastern Region Reports and identified common themes related to the Needs Assessment objectives. This review included thirteen regional reports produced between 2013-2017 and nine most recent Hospital Community Health Needs Assessments. Regional community reports studied were prioritized by those developed in response to regional events or community initiatives and centered on addressing health, behavioral health, equity, and social determinants [6] of health.

METHODOLOGY

BHN conducted a scan of the data, analyses, and recommendations contained in recent published reports to identify common themes and unique insights relating to youth behavioral health (BH), particularly in the areas of system resources/assets, barriers and gaps, opportunities, and recommendations. Geographically-based differences and data limitations in the City of St. Louis and St. Louis County were also assessed and noted. Most of these reports (**Table 1**) included both primary and secondary data analysis, as well as qualitative data solicited from key stakeholders and/or individuals representing the community of focus. Two reports synthesized data gleaned from secondary sources (**Table 2**).

Table 1: Reports with Primary Data Capture and Analysis [7]

Report	Geographic Scope	Primary Data and Methodology
1. Project LAUNCH Environmental Scan, 2013	City of St. Louis-Zip Codes 63106 & 63107	Individual interviews with stakeholders (N=10); 5 focus groups with parents, including those in a SU recovery program, homeless parents, teen parents, Head Start parents, and those unconnected to services; Online survey of Regional Early Childhood Council members and community service providers (N=41); Online survey of State Young Child Wellness Council members (N=21)
2. RECAST Needs Assessment, 2017	St. Louis Promise Zone [8]	Resource needs categorized by RECAST team then prioritized by 75 community members using a dot-voting system to focus Community Strategic Planning and the RECAST Community-Based Participatory Budgeting

[6] Social Determinants of Health are the highly inter-connected social and economic factors (zip code, income, education, etc.) which affect our health, well-being, and how long we live. DeMilto L, and Nakashian M, "Using Social Determinants of Health Data to Improve Health Care and Health: A Learning Report," Robert Wood Johnson Foundation, 2016, Retrieved from www.rwjf.org/en/library

[7] The full references of these reports are in Appendix A, p156.

[8] The U.S. Department of Housing and Urban Development (HUD) names "Promise Zones" across the country – high poverty areas in select urban, rural and tribal communities. Through the *Promise Zone Initiative*, the Federal government works strategically with local leaders to boost economic activity and job growth, improve educational opportunities, reduce crime and leverage private investment to improve the quality of life in these vulnerable areas. The St. Louis Promise Zone was designated in 2015 and includes parts of North St. Louis City and North St. Louis County.

Report	Geographic Scope	Primary Data and Methodology
3. Youth Mental Health Needs Assessment, 2014	City of St. Louis	Public Schools Missouri Student Survey, STL Mental Health and Housing Transformation Grant, St. Louis Provider Survey (N=86), St. Louis Mental Health Board (STLMHB) provider demographic and outcome data
4. Department of Health CHA & Community Health Improvement Plan (CHIP), 2014	City of St. Louis	CHA -- Seven resident focus groups (N=89), Survey administered to Residents Advisory Group (N=17), Immigrant interviews (N=8); CHIP – Community shaped implementation plan and prioritization of objectives via Residents Advisory Group (N=22) and diverse organizational representatives including educational institutions, regional coalitions, service providers, government agencies and businesses (N=24)
5. Coro Report of Behavioral Health Stakeholders, 2016	City of St. Louis & St. Louis County	Interviews with behavioral health system stakeholder and providers (N=46)
6. Regional Health Commission Access to Care 2016, 2017	City of St. Louis and St. Louis County	Self-reported data from participating organizations; Annual operating statistics from primary, specialty, and emergency care safety net healthcare provider institutions; Includes hours of operation and appointment availability for regional safety net provider institutions from the most recent calendar year, utilization volumes, and outcomes of the Gateway to Better Health Pilot Program; BH services data comprised of data from major publicly funded BH providers in the Eastern Region of Missouri
7. Children's Services Fund (CSF) - BH & SU Needs Assessment, 2017	St. Louis County	Survey of CSF-funded agencies (N=64) and CSF-funded programs (N =106 direct; 16 prevention programs); St. Louis County public school students (N = 4,248); Analysis of BHR data for St. Louis County youth callers/clients.
8. Department of Public Health CHNA & CHIP, 2014	St. Louis County	Community focus groups, key stakeholder interviews, telephone surveys (N=2,149); Data examined by Stakeholder Advisory Committee (N=58 organizations); Local Public Health System Assessment involved additional 70 community leaders; CHIP developed by St. Louis County Partnership for a Healthy Community
9. United Way 2020, 2014	7 MO Counties 9 IL Counties	Web-based survey of executive directors at local health and human service agencies (N=144); Phone survey of community members (N=275); Analysis of United Way programmatic and 2-1-1 data
10. Forward through Ferguson, 2015	Ferguson and St. Louis Region	17 open commission meetings in which almost 2,000 people participated; 38 public meetings held by working groups of subject matter experts, professionals, practitioners and citizens, including group focused on child well-being and education equity; Testimony and presentations by subject matter experts; Research support from the Institute of Public Policy at the University of Missouri
11. For the Sake of All, 2014	City of St. Louis	Researchers at WUSTL and SLU engaged key stakeholder and community partners via a Community Partner Group, which helped guide the overall structure of the project and provided substantive feedback on each policy brief; Public comments were invited using the project's website; Community Feedback Forum engaged over 90 local stakeholders

Table 2: Reports Comprised of Exclusively of Secondary Data Analysis

Report	Geo. Scope	Key Data and Reports Included
12. Promise Zone Needs Assessment and Crosswalks	St. Louis Promise Zone	Youth Mental Health Needs Assessment, For the Sake of All, Forward through Ferguson, St. Louis Adult Behavioral Health Needs Assessment, Regional Health Commission Access to Care and Decade Review, St. Louis County Department of Health Strategic Plan, St. Louis City Department of Health Needs Assessment
13. Ready by 21 Landscape Report, 2015	St. Louis City/County & St. Charles County	U.S. Census Bureau, MO Department of Elementary and Secondary Education, Missouri Children's Division, Missouri Department of Health and Senior Services, Map of the Meal Gap (Food Insecurity), City/Co Public Health Data

Source reports and analyses are cited per the numbers assigned in the tables above and in Appendix A (p156). For this section of the report, to facilitate comparison across reports and analyses, the term "behavioral health" (BH) may be used when a source identifies data relating to "mental health" and "substance use." If "mental health" (MH) or "substance use" (SU) are identified separately, they are reported specifically.

Furthermore, BHN examined nine (9) Community Health Needs Assessments conducted by hospitals that identify their Primary Service Area (PSA) [9] in St. Louis City or St. Louis County. Per the Patient Protection and Affordable Care Act (PPACA), these CHNAs must incorporate resident stakeholder input into validating and/or prioritizing the community's health needs. Most hospitals then establish their top priorities for community benefit investments and resource commitments based, in part, on their *capacity to impact metrics* associated with the health issue. In **Table 3** below, we summarize the service areas, stakeholder input, BH focus, and overall priorities established by hospitals serving the City of St. Louis and St. Louis County. We also indicate below whether any of the hospital's MH, SU or violence/harm priorities have youth focus. A summary of pertinent BH, SU, and violence findings from these assessments are located below.

[9] Primary Service Area (PSA) – Table sorted by PSA, City of St. Louis (City) and/or St. Louis County (Co).

Table 3: Hospital Community Health Needs Assessments (CNA) and Priorities

Hospital CHNAs	PSA	Stakeholder Input	Substance Use		Mental Health		Violence & Harm		Topical area has a Child/ Youth Focus?
			Need	Priority	Need	Priority	Need	Priority	
Barnes Jewish Hospital (BJH)	City	Focus Group (N=10), Internal Working Group	X	X	X		X	X	Violence
St. Louis Children's Hospital (SLCH)	City	Focus Group (N=14), Parent Survey (N=1,083)	X		X	X	X		MH
SSM Health Cardinal Glennon Children's Hospital	City	Focus Group (N=14)					X		
SSM St. Mary's Health Center	City / Co	Focus Group (N=15), Internal Executive Team	X	X	X		X		Neonatal Abstinence Syndrome
SSM St. Louis University Hospital (SLU)	City / Co	Focus Group (N=35)	X	X	X	X	X	X	
St. Anthony's Medical Center	City / Co	Focus Group (N=19), Telephone Survey (N=500)	X	X	X	X	X		Child/ Adolescent Psychiatry
Christian Hospital	Co	Focus Group (N=17), Internal Working Group	X		X				
Mercy Hospital St. Louis	Co	Survey (N=535), MAPP Process, Focus Groups	X	X	X	X			Adolescent MH/SU Services
SSM DePaul Health Center	Co	Physician Survey, Focus Group (N=18)			X		X		

St. Louis continues to be one of the most racially and economically segregated regions in the country, and the area's children, adolescents, and young adults are *deeply* impacted by the compounding stressors of violence, racism, abuse, poverty, and other early traumas. Youth BH **needs** include the following key themes and categories:

- Improved Access to Behavioral Health Providers
- Early Screening for Behavioral Health Concerns
- Violence, Trauma, and Toxic Stress
- Substance Use Treatment
- Fostering Healthy Relationships

In addition to identifying an overall shortage of providers, several reports articulate specific **barriers and challenges** that hinder youth access to existing BH services. These include:

- Lack of Service Awareness/Inability to Navigate System
- Stigma
- Mistrust of Providers
- Cost of Care/Lack of Insurance
- Provider Capacity (Wait Lists)
- Disconnected Youth
- Logistical Challenges Accessing Office-Based Care

Several of the reports examined focus on synthesizing needs and barriers without explicitly offering recommendations for improving BH care quality or access. For reports that include solutions and recommendations, we chose to highlight findings that articulate specific, actionable strategies and investments that can be made by service providers, stakeholders, backbone/convening organizations, and multi-sector partners. The following themes emerged as **recommendations for providers, stakeholders and community-based partners**:

- Invest in School-Based Services for Prevention and Early Intervention
- Promote Family Involvement, Community Awareness and Screenings
- Bolster Provider Workforce and Primary Care Coordination
- Foster Youth Skills and Emotional Intelligence
- Mitigate Logistical Barriers to services

It is encouraging that several reports focused on broader systems level strategies and advocated for data improvements to better understand the nature of the problem and to better assess the impact of interventions. **System-level recommendations** include the following themes and categories:

- Improve Data Utility and Resource Alignment
- Promote Evidence-Based Programs
- Integrate Primary, School-Based and Behavioral Health Care
- Expand System Capacity

The interdependence of **social determinants** of health were acknowledged across all analyses and reports, including the BH aspects of maternal health, interactions with law enforcement, educational attainment, and school discipline policies, housing stability, economic opportunity, sexual health, and personal relationships. The most prevalent barrier mentioned across reports was the lack of ***transportation access***, and there was a pervasive interest in ***school-based programs*** and leveraging the infrastructure and reach of schools for prevention, awareness, skill building and connection to treatment.

DETAILED FINDINGS

Note: The parenthetical numbers below (#) tie to the regional report, listed on pp16-17, from which the finding is drawn. The findings below from Regional reports are a summary pulled from full data reports, which have complete citations, tables, supporting data. This section is written with brevity in mind. See Appendix A. Community Report References, p156, for information to find the full reports.

YOUTH BEHAVIORAL HEALTH SERVICE GAPS AND NEEDS

Community Violence and Trauma Supports. Violence, traumatic experiences, and toxic stress can have a devastating impact on children, affecting their physical, emotional, cognitive, and social development. (10) Youth who have experienced trauma, who are at risk of abuse, and who are dealing with co-occurring MH and SU disorders are populations with high need for BH services. (3) Several assessments identified the need for trauma-informed services to address high rates of toxic stress, poverty, youth violence and child abuse in the City of St. Louis and St. Louis County. (2, 12, 13) St. Louis youth experience trauma in the form of physical abuse, neglect, and community violence. (2, 3, 13) For example, 79% of homeless adults in St. Louis reported having at least one traumatic experience before the age of 19, and St. Louis City adults receiving MH services through the SAMHSA Transformation project reported high rates of trauma, with many of the traumatic events having occurred during childhood. (3)

Data focused on the City of St. Louis highlighted the high rate of gun violence and youth homicide, and the City Department of Health promoted the CDC strategy that addresses and promotes the following: skills youths need to avoid violence, supportive relationships with youths, health and safety of communities in which they live. (4) Juvenile truancy offenses in St. Louis City outpace St. Louis County three to one, despite the considerable population size difference. (3) A higher percentage of juvenile court referrals in the general abuse/neglect/custody are due specifically to neglect for youth in St. Louis City (compared to St. Louis County and Missouri statewide). Furthermore, violent offenses disproportionately impact City youth as illustrated by the rate of deaths due to homicide with firearms (2008-2012) for City youth ages 15-19, at 85 per 100,000 compared to 14 in St. Louis County and 13 statewide; a rate six times greater than both of these comparisons. In St. Louis North County and Central County, middle school students identified greater concerns regarding threats of violence or being injured by another peer than other regions, as well as higher issues with self-controlling emotions/conflict management. (7)

Cumulative emotional and psychological wounding over the lifespan and across generations manifest in certain cultural, ethnic, religious, and racial groups. (10) In 2011, the rate of emergency room visits for MH conditions in St. Louis among African American youth was double the rate among white youth, and 36% of African American parents in St. Louis County reported drug and alcohol abuse as a challenge for youth in their neighborhoods. (11)

High need populations include youth who experience trauma, those with co-occurring disorders, academically struggling children and youth, and youth in transition from adolescence in adulthood. (3, 12) Violence, safety, child injury prevention, and abuse were also high priorities in several hospitals' needs assessments (See Table 3, p19).

Substance Use Treatment. Several reports identified the need for youth-focused or otherwise expanded access to SU treatment (2, 6, 7, 9). The City Department of Health (DOH) identified that one in four youth self-reported binge drinking and one-third reported marijuana use. However, the City's Community Health Improvement Plan (CHIP) focuses on reducing SU and addiction among pregnant women, training DOH staff on screening/referral, and support for the regional heroin task force, not on youth SU or misuse. (4) Reports identified a rise in ED visits for BH needs (6, 8), more students are reporting lifetime prescription drug misuse in recent years than ever before (12.7%), primarily pain medication; and 63% of surveyed (local) high school youth identified drug abuse/use as key BH issue. (7)

Fostering Healthy Relationships. Strengthening connections with caring adults and improving parent capacity to identify BH issues was suggested through the need for family counseling, parent education, and family involvement in services (1, 2, 7), which was evidenced in, part, by high rates of abuse and neglect. (2) A higher percentage of youth and adults in the City report inadequate social support than surrounding areas. (3) Fostering healthy peer relationships and skill building for independent living, and teen/pre-teen recreational services and activities were also identified as BH needs. (9) Top BH issues expressed by Middle School Students included Bullying/Cyber-bullying (61%), friend/peer relationships/social skills (54%), controlling emotions/anger/conflict (44%), anxiety/worry (39%), feelings of acceptance (35%). (7)

Early Screening for Behavioral Health Concerns - Primary Care/School Programs. There is a need for early screening and identification of BH issues for young children exposed to high rates of violence, crime, (12) as well as unique school-based BH concerns (e.g., bullying), and teacher training (1,9). There were primarily two pathways identified for increasing the reach of early screening and referral services – **schools** and **primary care.** There is some overlap with improved coordination, but in terms of early screening stakeholders identified the need for training primary care providers to identify BH issues in children and to incorporate BH assessments in all health evaluations. (1)

The need for school-based programming was demonstrated through references to bullying and the impact of negative student behavior and school suspensions disrupting educational attainment. (2, 10) School bullying was identified as an indicator of poor social and emotional well-being, with a strong association with depression / anxiety. (2) Bullying online or via cell or text is also increasing among youth, and needs focus (7). Among the top BH issues expressed by high school students were anxiety/worry (51%), friend/peer relationships / social skills (49%), depression/sadness (44%), and Bullying/Cyber-bullying (44%). (7)

Within the St. Louis Promise Zone[10], indicators of youth risk included high rates of juvenile justice involvement, suicide, and self-harm. (2) In St. Louis County, overall, self-harm / suicide was identified as a significant BH issue by 29% of High School students (38% of High School students living in South County) and 17% of Middle School students. All of the suicide-related items peaked in 11th grade, with 12.3% who planned a suicide, 18% seriously considered it, 6.9% attempted suicide, and 1.8% attempted suicide resulting in an injury (in the past year). Self-injury peaked in 10th grade with 19.6% attempting self-injury in that year. (7) The rate of deaths due to suicide among youth ages 15-19 (over a five-year period) per 100,000 was higher in St. Louis County and statewide in Missouri than in St. Louis City. (3)

Improved Access to Behavioral Health Providers. St. Louis has almost 72,000 youth ages 0-19 of which over 17,000 are projected to have MH challenges that qualify for a diagnosis. Over 3,500 of them are projected to have a mental illness with severe impact. (3) Across the board, reports and analyses offered data demonstrating a lack of capacity and shortage of providers for BH services. A planning group focused on BH for the St. Louis County CHIP indicated that the public health department lacks adequate resources to address MH, and high ED utilization for certain MH related conditions may indicate access barriers to inpatient, ambulatory and/or crisis

[10] See Reference #6 above.

services. (8) Specific references to funding limitations, wait times for appointments that extended past one month (5, 7), high numbers of youth BH clients (7) and unserved youth provided hard evidence of demand outpacing provider capacity in both St. Louis City and County. (2) Specific services identified as requiring additional capacity included crisis intervention and suicide prevention services (2), counseling, respite services and community/home/school based programs. (7) Respite services had 329 clients on a wait list, with more than half of these clients living in North County; and a snapshot report identified 15% of clients needing services were placed on a waitlist (7) Community/home/school based programs were unable to serve 15% of youth who needed services – 3,078 youth; in 2016, there were 2,280 youth on waitlist and more than half resided in North County. (7) In the Fall of 2016, one of the largest providers of psychological evaluation services for youth in the St. Louis region had 15% of youth (counted at one time as 247 youth in St. Louis County only) who needed this service put on a waitlist. Waitlist times ranged from 15-19 weeks. (7)

As safety net providers of BH services, community mental health centers (CMHCs) are operating at capacity and thus, limited in the ability to meet local needs. (5) There was an identified need for specialized MH treatment options focused on life phase or immediate circumstances, including families in crisis, teens and new mothers. (9)

BARRIERS TO YOUTH BEHAVIORAL HEALTH SERVICE ACCESS

Missouri ranks 12th in need for MH services among the states, but 31st in access to services. (5) The barriers and challenges identified by existing analyses could be categorized as those experienced individually by the youth, families, provider constraints, and broader systemic barriers that are pervasive across the system of care or involve "upstream" determinants and systems. Often these barriers intersect and exacerbate one another, but the distinction is made for the purposes of facilitating strategy development.

Individual and Provider Barriers. **Individual** barriers to care include: lack of service awareness or general inability to navigate the health care system (1, 2, 3, 7, 9); stigma associated with seeking MH services or being diagnosed with a MH condition (2, 3, 7, 11); mistrust of providers (11); lack of translation/language services (in St. Louis County) (7); and cost of care, limitations of insurance coverage or lack of insurance (1, 9, 10). **Providers** struggle to schedule youth clients and reduce no-shows (7); coordinate services effectively with schools or across school buildings (7); secure space/facilities to meet local needs (7); and scale up or expand services in primary care settings to meet system demands for BH services (5).

Systemic Barriers. Systemic barriers include indicators of system capacity limits like the inability to get an appointment with a provider or a long wait for an appointment (3, 6, 7, 9). The total number of BH users served in 2014 increased by 120% compared to 2005, then remained steady in 2015 (6), but staffed bed capacity decreased by 5% in 2015 (33 beds, mainly in St. Louis County. (6) Upstream systemic barriers include lack of safe, reliable transportation (1, 2, 3, 5, 7, 9); disconnected youth who struggle to stay in school or enter the workforce, limiting their access to connecting services (13); and area violence that creates geographic barriers (12), limits service hours, and makes it challenging to recruit providers of home-based services. (1) Additional system issues involve public regulations and reimbursement policies. For example, safety net CMHCs have increased their percentage of users who are Medicaid enrollees, Uninsured, Grant/Tax Levy and Self-Pay (6), but their finite service areas may be restricting youth access (5). Providers indicated that reimbursement rates do not justify relatively high risk and cost for inpatient psych facilities, and the lack of Medicaid expansion in Missouri and budget cuts for social welfare and safety net care have impacted the quality and capacity of the St. Louis area BH system. (5)

Connected Social Determinants of Health. Transportation was the most commonly cited barrier to BH access. (1, 2, 3, 5, 7, 9) Behavioral health access was also linked to the following interdependent factors that exacerbate trauma and toxic stress for children and youth in the City of St. Louis and St. Louis County: teen pregnancy (13), poor prenatal health (1, 11), child abuse/neglect and violence (2, 3, 11, 13), involvement in the juvenile justice

system (2, 7, 10, 13), housing instability (3, 5, 7), developmental delays and disabilities (7), school suspensions and drop outs (2, 7, 9, 10, 11), unemployment and economic opportunity (3, 10, 13).

HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT FINDINGS

Barnes Jewish Hospital (BJH) identified SU (heroin, prescription drug abuse) as its #3 priority, followed by public safety and violence (child abuse, firearm injuries). BJH reported that more Emergency Department (ED) visits were due to fights than any other assault or injury, a rate that was 1 ½ times higher than the state rate. Hospitalizations due to firearms were more than 5 times the state rate, and child abuse hospitalizations were the second highest rate in the City. Finally, BJH reported that heroin treatment among those admitted increased 17.1% from 2012 to 2014. ***St. Louis Children's Hospital (SLCH)*** reported insufficient numbers of child and adolescent psychiatrists in the state and a shortage of diagnosticians in their service area. Their focus group identified injury/violence as their #3 priority, and their parent survey ranked "stress" as their #2 concern, followed by Attention deficit hyperactivity disorder (ADHD) (#3) and bullying (#5). ***Cardinal Glennon Children's Hospital*** acknowledged that violent crime and premature death rates were significantly higher than state and national averages, but did not identify these as priorities because they have a Level I pediatric trauma center and are working to address these issues through a partnership with Missouri Poison Control. ***St. Mary's Hospital*** identified high-risk pregnancies as their #2 priority, including perinatal SU and opioid use during pregnancy. Though trauma/stress was identified as a community health concern, it was not identified as a CHNA priority because St. Mary's is not a trauma center, and they provide emotional and psychosocial support to patients with traumatic illness seen in the Emergency Department. ***Saint Louis University (SLU)*** identified BH as its #1 priority, followed by violent crime as it's #3 priority. Their focus group expressed concern in the rise of illicit drug use, particularly heroin and overdose cases. SLU recognized violence as a public health concern and committed to dedicating resources to violence prevention. ***St. Anthony's Hospital*** identified BH as its #2 priority, and their focus group named BH and alcohol/SU as their highest concern. Almost 60% of physicians responding to their survey identified SU as a significant problem. ***Christian Hospital*** reported that symptoms of depression were higher in North St. Louis County, and that St. Louis County has been identified by the CDC as a high-intensity drug trafficking area for prescription drugs and heroin. Christian chose not to identify BH as a priority due to financial constraints, but their work group indicated that "SU, mental disorders, and the relationship of violence must be elevated…for children in North County." ***Mercy Hospital*** identified BH as its #2 priority. Survey respondents identified illicit drug use among teens as their #2 concern, and the hospital reports that heroin use has reached an "epidemic level," along with increases in prescription drug misuse and excessive drinking. ***DePaul Hospital*** did not identify BH, SU or violence as priorities, in part, because the hospital has already invested significant resources in North St. Louis County and because they work with law enforcement and rely on them to collaborate regarding community violence. Note: In the hospital needs assessments, data was not separated by residence of patients.

RECOMMENDATIONS FROM REPORTS

PROVIDER LEVEL RECOMMENDATIONS

Recommendations have been grouped at the provider level and the systems level, though we understand that there is some crossover and that, in many reports, issues that are termed "needs" look a lot like "recommendations" and vice versa. As such, there may be some duplication or mirroring of needs and recommendations, as well as parallel and intersection between provider-level and system-level strategies.

Invest in School-Based Services for Prevention and Early Intervention. Given the role that schools play in most children's lives, they are natural partners in the mission to support overall student health and well-being. (10) School-based health centers can provide access to the services—medical, nursing, behavioral counseling, oral health care, reproductive health counseling, nutrition education, and general health promotion—that enable children and adolescents to thrive. (10) In St. Louis County, Children's Services Fund (CSF) agencies are estimated to be delivering services to 54-67% of public school students in need of counseling services, including three school-based programs, and more youth report that they are receiving help for a BH condition from school than in the community. (7) CSF programs are also estimated to reach 64-71% of school-aged youth with at least one dose of prevention programming. (7) However, youth are still fearful of what their peers might think when accessing behavioral health services, so attention to the reduction of this fear is necessary. (7)

Create trauma-informed schools and districts (10, 12) by providing evidenced-based trauma-informed training and support to families, teachers and students (1, 5, 10, 12). Some of the discipline gap can be attributed to teacher bias, which predisposes them to expect less of minority students and to discipline them more frequently and more harshly. (10) Partner with the Alive and Well Campaign and include multiple other youth serving partners in the schools. (10) Several school-based interventions were recommended, including an early warning system for tracking and responding to all students' successes and challenges (10); MH awareness, trauma screening, fighting/violence, SU treatment; counseling and surveillance (3, 11, 12); and placing BH specialists in public elementary, middle and high schools. (5) Addressing BH issues can also reduce suspension and expulsion to keep kids in school, sports, and activities, and help ensure that their mental, social, and emotional needs are met. (10)

Promote Family Involvement, Community Awareness, and Screenings. Improve MH awareness using community-wide education to change community norms and increase screenings in medical and other settings. (11) Promote stability for children and the presence of a caring, supportive adult by improving the ability of parents to recognize BH issues, manage their own BH, and improve parenting skills. (1, 2, 9) Foster emotional well-being from the earliest stages of life to build a foundation for overall health and well-being. (13)

Facilitate awareness and navigation of available services and resources, and improve digital/online information about available services. (2, 9) Develop a media campaign to minimize stigma/shame as a singular issue: A vast number of issues (hunger, MH/illness, homelessness, obesity, poverty, incarceration, etc.) are compounded by the presence of stigma and shame. Showcase the fact that we all suffer from some stigma/shame, and through these shared stories and conversations, we can become more compassionate, empathetic, understanding and supportive of each other. (10) Along with focused efforts to prevent violence, specialized services are needed for those who have been victimized. (9)

Promote Youth Life Skills and Emotional Intelligence. Provide a combination of activities to build knowledge and job-readiness skills, promote career awareness, and develop social responsibility and leadership skills. (13) Foster positive self-concept among youth, and promote employment opportunities for meaningful work (e.g., fair wages) to financially empower youth. (2) Provide safe places for youth during evenings, weekends, and summer. (2) Expand prevention, promotion, education and early intervention programs which support youth resilience and yield better recovery trajectories. (3) Additional workforce and program investment recommendations included: Increase free or low-cost options for BH services; increase number of MH providers (1); Expand psychological/psychiatric testing and services, respite care, lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ) -focused services, SU treatment services or youth, and early childhood education (7); and expand prevention and after-care services (in addition to the early intervention and treatment services currently funded), so that both social and financial return on investment is greater (7).

Mitigate Logistical Barriers. Specific recommendations for improving care access by mitigating barriers, included expanding mass transit to improve transportation access (2); developing plans for transporting consumers and

families to and from services to address accessibility (3); and (3) increasing access to healthcare by supporting Medicaid expansion

SYSTEM LEVEL RECOMMENDATIONS

Improve Data Utility and Resource Alignment. Data regarding BH requires stronger routine community surveillance to better track key indicators of BH integration and access, and backbone organizations were encouraged to promote consistent instruments and patient tracking among providers. (12) Project LAUNCH identified limitations of zip code level data, data timeliness, and inability to verify authorship or ownership which made triangulation challenging. (1) A BH planning group for the St. Louis County Community Health Promotion & CHIP (Community Health Improvement Plan) identified the need for improving mental health (MH) and SU registries and MH surveillance. (8) Several child- and youth-focused analyses identified the need to leverage the St. Louis Public School System and granular provider data to improve understanding of utilization trends, program outcomes, and progress towards goals. (3, 12) Specifically, the St. Louis City Children's Services Fund was advised to encourage schools to participate in the MO Student Survey, which includes MH indicators. (3) Funders and backbone organizations were advised to capture data for smaller geographies and disaggregate data for a more refined picture of problems, as well as broaden use of data to include predictive modeling, community education, capacity building, and learning forums. (13) Forward through Ferguson and Ready by 21 advocated improvement in collecting dependable and robust data for measuring child well-being. (10, 13) BH stakeholders recommended developing a centralized system for client data and evaluating quality of care (e.g., clinically actionable electronic health record system that connects client data across CMHCs, CHCs and hospitals) (5). For the Sake of All called for improving the quality and availability of MH data by establishing regional systems for tracking and reporting on the prevalence of MH conditions and their treatment, and increasing data collection and sharing to improve MH awareness and knowledge in racial and ethnic minority communities. (11)

Using a common outcome framework like the Forum for Youth Investment's domains of positive youth development (Thriving, Connecting, Learning, Leading, Working) could help align funding and metrics, and the Children's Services Funds serving the City and County could collaborate to identify common outcome measures. (3, 9) This will require training and technical assistance on outcome measurement process for performance assessment/improvement among grantees and service providers. (9)

Funding limitations and constraints included global reductions and limits on school funding and lack of funding for interpreters (7); funder restrictions on use of BH and primary care funding (5); insufficient funding for direct and ancillary services, including Medicaid coverage of BH services and social welfare services (e.g., housing and transportation) (5); and low reimbursement rate for psychiatric services. (5)

Promote Evidence-Based Programs. The prior St. Louis City Youth Mental Health Needs Assessment advocated continued support for services that demonstrate they are methodologically sound, evidence-based, and deliver measurable and effective outcomes. (3) The improvement of data integrity and utility will help demonstrate the progress and impact of funded programs.

Integrate Primary, School-Based and BH Care. Better coordination and integration among systems and services (e.g., primary care and BH care) was a universal recommendation system-wide (1, 2, 3, 5, 9, 10, 12). Specifically, this could include training primary care providers to identify and respond to the BH needs of patients and improve tracking of data related to existing BH needs in primary care (5); and improving referral networks and coordination among schools, doctors, and MH providers (1, 2).

Health care and social assistance organizations are more densely situated in the City, but not all are conveniently located to help consumers with multiple health and socio-emotional issues. (3) St. Louis County CHIP includes

building an integrated system of care by including a BH consultant to increase patient encounters in department health centers. (8)

Expand System Capacity. All reports acknowledged the need for increasing system capacity to provide BH services, including increasing the number of BH providers and resources (e.g., trauma-informed, hospital and community-based) (1, 2); and investing in more outpatient community mental health centers, particularly in areas of need (5) and coordinating screenings and referrals for high-risk populations. (5)

There is a heavy demand for children and youth services in far north St. Louis neighborhoods (zip codes 63137 and 63147) and in far south St. Louis neighborhoods (zip code 63118). (3) North County had the highest number of youth on the waitlist for BH services in 2016 and unable to be served in 2015 (7)

Agency barriers include lack of access to funding, difficulty with engaging and recruiting youth, retaining clients in services, and staffing changes. (3,5,7) Providers complain it is challenging to find and hire psychiatrists, as well as Advance Practice Nurses (APNs), and it is costly to certify staff in evidence-based treatments. (5, 7)

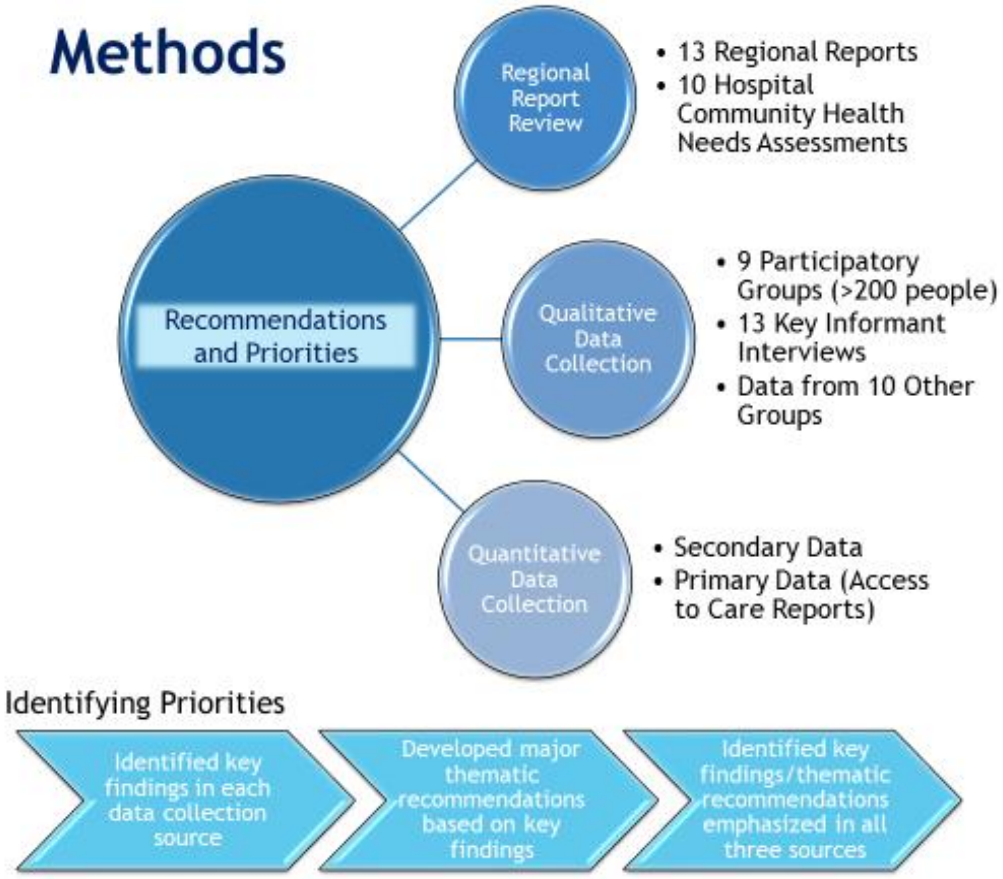
QUALITATIVE DATA ANALYSIS

OVERVIEW

Qualitative data collection for this needs assessment focused on understanding the current state and needs related to youth behavioral health (BH) in St. Louis, by gaining a community voice, including lay-person, consumer, community organization, and service provider perceptions in this arena. The following sections summarize the approach taken and analysis of findings from participatory groups and key informant interviews conducted mid-May through early August 2017. Participatory groups and key informant interviews explored observations and experiences in the community and/or with BH supports for youth, including resources, assets, gaps, barriers and opportunities. A total of 9 participatory groups and 13 key informant interviews were led by BHN. Additionally, the data from 7 qualitative groups (listening sessions) carried out as part of the St. Louis City and St. Louis County Public Health Departments' collaborative Community Health Needs Assessment and pre-existing qualitative groups conducted by community organizations were incorporated into data analysis.

METHODOLOGY

The diagram below provides a quick reference overview of the methodology that was utilized to complete the Qualitative Data Analysis.



PARTICIPATORY GROUPS

Qualitative approaches are particularly useful, as they enable the ability to uniquely explore individuals' subjective perceptions and experience not otherwise accessible. Groups allow individuals to interact and build on one another's comments and allow for facilitators to probe further for details and clarifications in real-time.

BHN led facilitation of participatory groups mid-May through early August 2017, recruiting the participation of individuals with a relationship to the community and context engaged. Participatory groups followed semi-structured open-ended session facilitation guides, which were designed to be engaging and empowering for the group participants. These were tailored and informed by community member input whenever possible. A mix of interactive nominal group technique (a structured approach to seeking input and developing consensus) and divergent (meant to gain individual perspectives) and convergent (meant to gain group consensus or perspective) activities were utilized to engage participants. Groups consisted of ninety-minute sessions with questions and activities to facilitate broad inquiry around community needs, barriers, and opportunities. A sample participant question set can be found in **Appendix B** (p156).

Ninety-four providers of BH and youth-related non-BH services, and fifty community stakeholders—youth, caregivers, and community members (general residents)—were engaged in BHN-led groups (**Tables 1 and 2**, pp 26-27). Participant demographics can be found in the tables that follow. As described in the Needs Assessment Limitations (p15), BHN recognizes that some qualitative data collection group and key informant participants' contributions are based on perception and their own, as well as others', experiences and may not be fully informed; and sample sizes, particularly of youth were relatively small. The scope of this Report did not allow us

to pursue scientific “saturation,” however we pursed input from a variety of stakeholders. Participant identities are protected and reflected anonymously in this report.

Table 1. Provider Participatory Group Details and Demographics

Stakeholder Group	Stakeholder Sub-Group	Host Organization	Primary Location	Number in Attendance	Group Demographics
Providers	Community-Based Behavioral Health Providers	Children's Service Provider Leadership	St. Louis City and St. Louis County	30	Executive leadership of community-based BH and child-serving agencies providing supports or services anywhere on the care continuum
		Direct Care Community Providers	St. Louis City and St. Louis County	32	Clinician and non-clinician frontline staff, and supervisors of community-based BH and child-serving agencies providing supports or services anywhere on the care continuum
	Hospitals	Direct Care Hospital Providers	St. Louis City and St. Louis County	22	Clinician and non-clinician frontline staff and supervisors of St. Louis region hospitals with and without youth BH services
		Hospital Leadership	St. Louis City and St. Louis County	10	Executive leadership of St. Louis region hospitals with and without youth BH services

Table 2. Community Member Participatory Group Details and Demographics

Stakeholder Group	Stakeholder Sub-Group	Primary Location	Number in Attendance	Group Demographics
Community Members	Youth (see p29 regarding additional youth perspectives gleaned)	North City/ North County	10	Race: 1 Caucasian, 7 African American, 2 Multiracial Age Range: 13-18 Gender: 1 Male, 9 Female History of seeking Youth BH Services (self-report): 3/10 (30%)
		South City	9	Race: 8 African American, 1 Multiracial Age Range: 5-18 Gender: 3 Male, 6 Female History of seeking Youth BH Services (self-report): 4/9 (44%)
	Parents/Caregivers	North City/ North County	25	Race: 24 African American, 1 Multiracial Age Range: 19-65 Gender: 7 Male, 18 Female History of seeking Youth BH Services (self-report): 10/25 (40%) In parent or guardian role: 22/25 (88%)
		South City	6	Race: 1 Caucasian, 2 African American, 1 Multiracial Age Range: 25-44 Gender: 6 Female History of seeking Youth BH Services (self-report): 3/4 (75%) In parent or guardian role: 6/6 (100%)

Additionally, BHN hosted a full stakeholder meeting, also ninety minutes in length, and included invitations to all those from the participatory groups, key informant interviews, and other relevant stakeholders. Fifty-six (56) individuals attended this event, which focused on interactive review of and strategic recommendation response to secondary and primary quantitative and qualitative data collected to-date. Feedback from this session is largely reflected in the "Recommendations and Select Key Findings Section" at the end of this report.

Finally, in addition to the participatory sessions described above, BHN worked closely with St. Louis City and St. Louis County Public Health Departments' shared Community Health Needs Assessment, required for health department accreditation. These efforts were conducted under contract with Illinois Public Health Institute. As part of this work, the Public Health Departments conducted listening sessions with participants in vulnerable populations (e.g. individuals who are sight and hearing impaired, English language learners/immigrants and refugees, LGBTQ, etc.) (**Table 3**). BHN drafted brief questions that address youth/BH concerns that were included in each of these sessions. BHN sought general community member participation through a special session which was conducted in concert with the Public Health Departments.

BHN also leveraged notes including qualitative data sources generously provided by collaborating groups' recently conducted sessions with youth—including Matthews-Dickey (Youth Health Ambassadors) and Ready by 21—as well as qualitative data prepared by the Women's Foundation of Greater St. Louis [11], the St. Louis Area

[11] "I Hear You. I Am You. A St. Louis Region Listening Tour," 2017, Women's Foundation of Greater St. Louis, Retrieved from www.wfstl.org/2017-listening-tour.

Violence Prevention Collaborative, and United Way 2-1-1 with the Evaluation Center at the Brown School for the St. Louis Accountable Health Community Collaborative (now PAHE—"Partnering to Advance Health Equity").

Table 3. Public Health Department Community Member Listening Session Group Details and Demographics

Stakeholder Group	Stakeholder Sub-Group	Primary Location	Attendees	Group Demographics
Community Members	Community health and wellness activity participants	St. Louis City	13	Age range: ~15-65 Gender: 13 Women Race/Ethnicity: 4 African American 9 Hispanic/Latina
	Individuals with sight and hearing impairments	Not provided	23	Age range: Not provided Gender: 16 Women 9 Men Race/Ethnicity: Not provided
	Behavioral Health consumers	1 St. Louis County 9 St. Louis City	10	Age range: ~30-50 Gender: 6 Women, 4 Men Race/Ethnicity: 7 African American 3 Caucasian
	Seniors	Not provided	10	Age range: ~65+ Gender: 7 Women, 3 Men Race/Ethnicity: Not provided
	Individuals with physical disabilities	Not provided	Not provided	Age range: ~30-70 Gender: Not provided Race/Ethnicity: Not provided
	Consumers engaged in job readiness/ employment training	15 St. Louis County 3 St. Louis City	18	Age range: ~18-65 Gender: 18 Men Race/Ethnicity: 18 African-American
	Community neighborhood association participants [12]	12 St. Louis City	12	Age range: ~25-65 Gender: 11 Women, 1 Man Race/Ethnicity: 7 African-American 5 Caucasian

KEY INFORMANT INTERVIEWS

In addition to other quantitative and qualitative work, Behavioral Health Network of Greater St. Louis (BHN) conducted structured, face-to-face key informant interviews. The methodology of key informant interviews allows facilitators to gain insights from a limited number of well-connected and informed community experts with diverse backgrounds in a frank and open environment, and to be able to ask in-depth and probing questions. For this Report, the purpose of key informant interviews was to gain information and a broader perspective about youth BH in the service community from agencies or organizations whose focal areas are not BH, but who regularly intersect with youth BH needs and concerns (cross-sector providers).

[12] Community neighborhood association group was conducted at the request of and in partnership with BHN.

Two to three agency participants were present per key informant interview session, usually a key leader at the agency and their colleague(s). Key Informant can be found in the table that follows. Participants and agency identities are reflected anonymously in this report. Key Informants are frequently referenced as non-BH providers throughout the detailed findings section that follows.

Given the large scope of information and sector perspectives acquired in key informant engagement, contributions are captured in both findings sections below and further detailed in Appendix C: Detailed Key Informant Interview Contributions (pp 158-180).

Table 4. Key Informant Interview Details

Key Informant Interview Sectors	Number of Interviews
Juvenile Justice System	2
Housing/Social Service	1
Physical Health	3
Schools	2
Child Welfare and Violence Prevention	2
Youth Development	2
Transition-Age Youth Services	1
Total	13

DATA ANALYSIS

Participatory groups and key informant interviews were captured via detailed notes taken in-session. Additionally, key informant interviews were tape-recorded as a back-up, with the consent of the participants. BHN systemically analyzed participatory group and key informant interview detailed notes and physical products of engagement participatory group activities using a combination of techniques to ensure comprehensive review of qualitative products. Several phases of analysis were deployed and methods utilized in qualitative analysis included:

- "Pawing," in which analysis of texts begins with proofreading the material and simply underlining key phrases—referred to as the *ocular scan method*. In this method, data is reviewed multiple times with best practice indicates the need to review texts at least twice.[13]
- "Word repetitions," an approach focused on observation of the words participants use. Word repetitions can be analyzed formally and informally. Informally this involves the reviewer reading the text and noting words or synonyms that people use a lot. Concepts that connect the works and explanations emerge in this process.
- "Compare and contrast," approach is based on the idea that themes represent the ways in which texts are either similar or different from each other.
- "Coding," requires the development of pre-set codes based on question categories and emergent codes based on text review in accordance with techniques listed above. **Pre-set codes** were based on question set categories. **Emergent codes** code categories developed using a grounded theory approach, based on responses, listing ideas or diagramming relationships, watching for word repetitions, keywords or quotes. Coding then eliminated, combined or divided categories looking for repeating ideas and larger themes that connect codes. Repeating ideas are considered different than themes, themes are large topics that organizes or connects repeating idea groups.

[13] Bogdan, R., & Biklen, S. K. (1982). Qualitative research for education: An introduction to theory and methods. Boston: Allyn and Bacon.

Key questions considered during coding included:

- What common themes or patterns emerge in response to specific topics? How do these patterns or lack thereof illuminate the question at hand?
- Are there deviations from these patterns? If so what are they? What factors might explain these?
- How are participants' environments or experiences related to their responses? E.g. Are there health equity considerations or geography components?
- What interesting quotes or stories (e.g. cases or examples) emerge from the responses? How do they help illuminate central questions?
- Do these patterns suggest the need for additional data that we should flag? Are patterns that emerge similar to other report findings in the region? If not, what might explain differences?

Findings across all qualitative stakeholder participant types and approaches (groups and key informant interviews) were assessed individually and in relation to one another to determine where interconnectedness of perspectives and experiences emerged into major themes. The major themes detailed here reflect high levels of agreement and consistency within and among groups, however when the theme was discussed differently, these variations are emphasized and detailed.

KEY FINDINGS

Qualitative processes yielded rich findings, which are detailed in the next section. Key findings noted here reflect consensus that emerged within and among stakeholder groups related to resources and assets, barriers and gaps, and opportunities in St. Louis youth BH.

Prominent **resources and assets** identified included the domains of:

- Currently Available BH Resources, including:
  - Increased Availability of Services
  - Specific Community Agencies and Programs with
- Provider Strengths, including:
  - Improved Provider Expertise
  - Provider Relationships/Collaborations
  - Provider Attributes (fostering successful linkage and referral)
- Broader Community Strengths, including:
  - Youth Recreational Activities and Youth Development Programs (when available)
  - Collaborative Community Relationships

Additionally, stakeholders considered what unmet needs and challenges are present in youth BH, to inform the following barriers and gaps. Specific **barriers** that obstruct access to existing youth BH resources include:

- Transportation and location of services
- Affordability of services
- Eligibility restrictions/requirements
- Negative experiences and stigma (of youth and families)
- Care coordination (among provider sectors and care settings)
- Barriers within family / supportive environments

Gaps identified in youth BH supports included limited or lack of:

- Accessible Behavioral Health Programs and Services
- Assessment and Early Intervention
- School Supports
- Family Systems Approach/Caregiver Supports
- Services for Specific Populations
- Community Strengthening

- Community Violence and Trauma
- Youth Development Opportunities
- Barrier Reduction for Social Determinants/Environmental Stressors

Stakeholders also highlighted opportunity areas in the St. Louis community, leveraging existing resources or investing in the aforementioned areas of need. Opportunities for providers, stakeholders and community-based partners included:

- BH Resources and Programming
  - Enhanced Access to Existing Programs and Services
  - Increased Programs and Services
  - Emphasis on Follow-up and Case Management
- BH Community Actions:
  - Expanded Training
  - Integrated Services
  - Improved Provider Collaboration
  - Funding transformation
- Broader Community Actions, including:
  - Reducing Barriers and Environmental Stressors
  - Investing in Community Engagement and Youth Development
  - Increasing Public Awareness

DETAILED FINDINGS

RESOURCES AND ASSETS

AVAILABLE BEHAVIORAL HEALTH RESOURCES

INCREASED AVAILABILITY OF SERVICES

The majority of participants cited an overall increase in youth BH services, programs, and treatment options offered in terms of number, variety, and availability health in the St. Louis region. Providers did strongly emphasize regional service gaps, noting that while increased, there was still great unmet need for these and other services. Also, many discussed geographic differences in the increase of services, with St. Louis County reporting more expansion due to the St. Louis County Children's Services Fund. Specific services that were named as having expanded in the region included:

- Therapeutic resources
- Some psychiatry access
- Improved inpatient and outpatient services
- Shelter services for youth <18 (particularly in St. Louis County)

By all providers, psychological assessments and evaluations have become more accessible and are of better quality than in the past. Non-BH providers indicated some ease in getting the initial intake completed for new clients, since this is the necessary first step in outlining a treatment plan. Schools play an important role in the intake and assessment process, as they can help identify BH needs through well-developed Individualized

Education Programs (IEPs)[14] and 504 plans.[15] Key Informants (non-BH providers) noted how vital it is to have a high-quality assessment, specifically tailored to each individual.

All providers listed several therapy options available for youth in the St. Louis region (i.e., individual, group, and family therapy services). While these options exist, they did note some service downfalls in that many programs are restrictive, have long waitlists, and are time-limited. One contributor to increased youth access is the integration of therapeutic services within other youth facilities. Non-BH providers detailed the integrated relationships of psychologists, psychiatrists, and social workers within schools, primary care settings, juvenile detention centers. Increased in-school and home-based services, making it easier for youth to access treatment and reduce barriers. These efforts help reduce therapy access barriers for youth and non-BH providers particularly indicated a strong need to continue integration of BH services into youth-serving agencies.

Regarding service availability, it's important to note the differing number of services, programs, and treatments located within St. Louis County versus St. Louis City. BH and non-BH providers made a point to mention the impact the St. Louis County Children's Service Fund (CSF) has on increasing the number of programs available to County residents. While the impact of the CSF has been great in the County, City residents are at a disadvantage in terms of number of services available.

Youth and caregivers highlighted the availability of supports in the form of: trained professionals/facilities (such as school counselors, teachers, hotlines, facilities/hospital) and informal supports (such as family/social network of parents/caregivers, friends, social media). Youth also noted a strong presence of anti-bullying programming, particularly in schools. Youth noted the dichotomous benefits of these existing resources, highlighting that, while these resources exist, they are not always supportive (e.g. social media bringing additional stress, or the ineffectiveness of bullying education).

SPECIFIC COMMUNITY AGENCIES AND PROGRAMS

When asked about available resources within the community, many participants stated specific agencies (e.g., The SPOT) or programs (e.g., P-Square, which uses the Positive Parenting Program intervention) deemed successful in addressing youth and family BH needs. Non-BH providers were most complimentary on services and characteristics of an agency that work well (e.g., open intake hours, walk-in capability, ability to take care of specialized needs, etc.). Providers of all types cited close working relationships with some agencies and the ability to leverage those relationships for referrals. Caregivers also highlighted particular resources in the community, including Behavioral Health Response (BHR), integrated community health center mental health services, Youth in Need, and area churches support.

PROVIDER STRENGTHS

Improved Provider Expertise. Overall, BH and non-BH providers noted an increase in provider training, knowledge, and expertise. Many providers are training staff to be more trauma-aware/informed and better equipped to handle the needs of youth who have experienced trauma. It was noted that more organizations are becoming focused on youth experiences with domestic and sexual violence. Key Informants were particularly

[14] The Individualized Educational Plan (IEP) is a plan or program developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives specialized instruction and related services. "What is the difference between an IEP and a 504 Plan?," website Do-It, University of Washington, 2016, Retrieved from www.washington.edu/doit/

[15] The 504 Plan is a plan is similar and focuses on accommodations (vs. IEP specialized instruction), ibid.

positive when describing providers with specialized knowledge to handle issues unique to youth and other special populations. It was noted repeatedly that service quality has increased in that staff are better trained to handle crisis situations, providers are becoming more trauma-aware, and some offer holistic treatment plans that address needs that go beyond BH. Non-BH providers expressed trust in and dependence on providers' expertise for consultation about cases and guidance on treatment/referral options.

Provider Relationships/Collaborations. When referring clients to services outside of their own agency or service sector, non-BH providers noted a direct relationship between successful referrals and their established connections with other providers or agencies within the St. Louis region. Non-BH providers who closely collaborate with BH providers, schools, and other community agencies leverage those pre-existing relationships when finding appropriate services for their clients. These relationships allow for an increased number of referrals with a warm hand-off and better coordination of care for clients between agencies. All provider groups noted an overall increase in collaboration among service providers, hospitals, and schools. Identification of services has increased due to interagency collaboration and has resulted in a more coordinated community response. Again, providers noted that these relationships were especially strong among agencies receiving St. Louis County Children's Service Funds.

Provider Attributes. Other highlighted regional strengths focused on contributors of successful linkage and referral. Comments centered on attributes and capabilities of the service provider organization. Agencies whose services are accessible (i.e., short waitlists), work to reduce client barriers, and offer high quality services, increase the rate of successful referral outcomes. Non-BH providers noted that coordination and follow-up are particular provider / organizational strengths. It is easiest to link youth to services when agencies are collaborative, follow-up after referral, and attempt to coordinate care. Barrier reduction is essential to increase service accessibility and enhance referral viability. Agencies which offer transportation assistance, home-based services, and help youth navigate the system increase the likelihood that youth and their families will be able to access BH services. Some agencies were noted as being persistent and/or having a high level of client engagement. Non-BH providers expressed the value of providers who deliver holistic treatment options and are able to address client needs beyond BH needs. Many clients have multiple challenges that need to be addressed (e.g., help with housing, transportation, childcare, etc.), and agencies which specialize in intensive case management are an asset to the community. Once again, this high service quality was linked as a direct contributor to successful referral outcomes.

BROADER COMMUNITY STRENGTHS

YOUTH RECREATIONAL ACTIVITIES AND YOUTH DEVELOPMENT PROGRAMS (WHEN AVAILABLE)

The most cited community strength contributing to positive youth BH were recreational activities, though these too were noted to be limited in availability and accessibility. Community members, caregivers, and non-BH providers discussed the benefits for youth who are engaged in programs offered through recreational and community centers, afterschool programming, organized sports teams, youth clubs, and other organized activities. Examples included extracurricular activities at school, programs like Big Brothers Big Sisters or the Thomas Dunn Learning Center. Those working with delinquent youth emphasized the importance for young people engaging in positive, pro-social activities which give them a link to the broader community. Juvenile Justice and other non-BH providers stressed the importance of youth needing social activities that give them a positive outlet and keep them from engaging in delinquent behaviors. Stakeholders noted some access barriers and disparities. For many St. Louis families, cost and transportation limit participation in these types of activities.

In addition to youth recreation, youth development programs were cited as important community strengths benefiting youth BH. Programs focused on academic support are beneficial to keep youth engaged in school, keep them from falling behind, and increase the likelihood of graduation. Furthermore, non-BH providers

highlighted the positive outcomes associated with workforce development programs (i.e., job readiness training and youth employment agencies). Participants and community qualitative data described the importance of the following youth development services:

- Academic support/tutoring
- Mentoring programs
- Workforce development programs, employment programs, and job readiness training
- Interpersonal skills, life skills, and self-management/decision-making programming

COLLABORATIVE COMMUNITY RELATIONSHIPS

In discussing broader community strengths, BH and Non-BH providers also explained the benefits of collaborative community relationships with other agencies that serve youth. For example, caregivers and non-BH providers reported having used churches to link families to resources for basic needs and other types of family support. Relationships with law enforcement were described as beneficial, especially when non-BH providers step in to help youth and families in crisis situations. These relationships allow multiple agencies to come together when attempting to find treatment or intervening in crisis situations. Additionally, positive outcomes were associated with the engagement of school staff in youth treatment plans.

BARRIERS AND GAPS

BARRIERS

Stakeholders discussed how families have a difficult time accessing resources for various reasons, arranged below in order of priority established by participants:

Transportation and location of services: Notably, all stakeholder types identified transportation as lacking and a top roadblock in families accessing services. Even when public transportation or Medicaid-provided transportation is available, participants noted that logistical barriers make utilization prohibitive (e.g. the inability for youth to use Medicaid transportation alone). Transportation challenges are particularly present when multiple appointments or trips to multiple provider sites are needed to initiate or engage in services. The all the sources of qualitative did not specifically parse out the particular aspects of transportation and location are barriers, but respondents mentioned: Frequency of visits required to complete treatment, the hours of the day that services are available; Some caregivers expressed a willingness and ability to access a service that may be inconvenient when they have an urgent need, when they consider the service to be a high priority, or if appointments are infrequent. Sometimes caregivers did not view follow-up appointments and ongoing visits as high priorities. While transportation and location were emphasized, there could be implications for the way services are delivered, not just physically getting to and from services.

Affordability: While it was cited that many youth have *Medicaid access*, insurance access and coverage for youth, and particularly for uninsured caregivers, were noted to be key barriers. Cost of services and follow-up medications were reported by providers, youth and caregivers as making engagement in care difficult. Program options for the underinsured—those that fall into gaps where they do not qualify for subsidized services but do not have coverage or means to access care—are specifically lacking per BH and non-BH provider report. Moreover, community members, caregivers, youth, and providers of all types noted many families are struggling to meet basic needs and don't have the extra means to focus on BH challenges. Providers noted limited funding available for providers and programs, particularly for innovations to meet community BH needs.

Eligibility restrictions/requirements: Both providers and community members, specifically caregivers, noted challenges with program restrictions that make the family/caregiver/youth ineligible. Many providers, of all types,

noted programs are too restrictive and don't always provide services to youth who need them the most (e.g., age restrictions, residence restrictions). Moreover, lack of standardization of program requirements complicates referral and linkage– programs similar in nature have slightly different requirements, making it difficult to find services that fit each client (e.g., youth age restrictions, some are birth-16, while others are birth-18). Families noted that these restrictions are often not clearly communicated early in their engagement with providers, leading to frustration, delays, and too often, never receiving services. Providers noted requirements to receive services or access programs can vary across agencies and change over time, causing coordination challenges. Key informants underscored this challenge as a particular barrier, given that communication of such changes or maintenance of current knowledge is difficult when working outside of the BH system explicitly. Multiple providers highlighted operational and structural/system level challenges exacerbate these issues. Among operational challenges was: funding, regional divisions (e.g. programs support for only St. Louis County or City respectively), staffing (including retention/recruitment of quality staff), and limited capacity and bandwidth to address additional priorities. City/County boundaries were repeatedly mentioned as an ongoing issue when trying to match clients to available services. *Navigation:* Participants identified navigation challenges which included both the lack of awareness of services available and complexity of the care system to access these services. While all stakeholder types acknowledged navigations challenges, these were especially highlighted as barriers by caregivers and non-BH providers. Many non-BH and BH providers indicated they were unsure where to look to find the most up-to-date information about service providers and agencies. These entities undergo frequent changes (i.e., changes in open hours, appointment availability, programs offered), making it difficult for other providers to make appropriate referrals since they don't always know when these changes have occurred. Non-BH providers noted they are often required to find creative solutions for clients if there aren't programs that address their specific needs.

Negative experiences and stigma: Caregivers, Youth, BH and non-BH providers noted that negative past experiences provide a significant barrier for treatment-seeking and engagement. Older and transition-age youth were emphasized as populations particularly impacted by this, given that these experiences often accumulate over time and are worse for those who may have been engaged in multiple youth-serving sectors, such as child welfare/foster care or juvenile justice. This past experience, as well as cultural competence and bureaucratic or wait barriers, were perceived as contributing to youth and family's distrust of providers. The aforementioned stakeholder types also noted stigma as a key roadblock for caregivers seeking support for their children, noting again fear of labeling, medication-centered interventions, or perceptions that bringing up problems is a reflection of their parenting/caregiving ability.

Care coordination: All provider types expressed the need for enhanced care coordination within and across agencies and systems to improve access and engagement. Both non-BH and BH providers noted that they sometimes have difficulty with warm hand-offs (coordinated client transitions between providers that often occur in real-time) and client transitions between services, often due to limited cross-agency infrastructure, key contacts, or logistical barriers. Poor communication between providers and a lack of follow-up on cases on both ends of a referral were highlighted as contributing factors. Similarly, both BH and non-BH providers noted difficulties following-up with a case once they've made a referral (i.e., did the client show up, how is treatment going?), with particular barriers around confidentially/privacy policies. High degrees of transiency in families also make follow-up with youth and providing subsequent treatment challenging.

Barriers within family / supportive environments: Youth group participants reported challenges with feeling supported by trusted adults (e.g. caregivers, staff at school) who dismiss their problems when they bring them up (i.e., you're too young to be stressed). They reported feeling unheard and that adults don't intervene when necessary. Youth reported that they aren't sure whom to turn to for help nor whom to trust with sensitive issues. Caregivers echoed these challenges, noting youth have trouble knowing whom to trust, so they don't always bring their issues to adults or talk about them. Caregivers and community members stressed that non-BH providers in the community, particularly law enforcement and school staff, are not well-equipped to handle youth BH issues and crisis situations. Providers of all types and community members noted limited caregiver support as a key

barrier to youth BH and wellbeing and engagement in services. It was also noted by providers that some youth do not have parents/caregivers to advocate for them (sometimes due to lack of parental engagement, other times because caregivers don't have the knowledge to do so). Language barriers also serve as a challenge to caregivers serving in this role and youth engaging in services. Competing demands of having other children (often with varying needs or who may suffer as a result of their sibling's BH concerns), needing childcare services, and the burden of work (preventing time to take their child to appointments) also serve as significant barriers to caregiver engagement.

GAPS

Qualitative data analysis of participatory groups and key informant interviews revealed six overarching themes related to needs in youth BH.

Table 5. Qualitative Data Collection Need Themes
Accessible Behavioral Health Programs and Services
Assessment and Early Intervention
School Supports
Family Systems Approach/Caregiver Supports
Services for Specific Populations
Community Strengthening

ACCESSIBLE BEHAVIORAL HEALTH (BH) PROGRAMS AND SERVICES

Across all stakeholder groups and approaches, the accessibility of BH programs and services was universally noted to be limited in the St. Louis region and particularly St. Louis City. Participants noted numerous dimensions related to access—limited capacity and availability, significant delays in treatment (often resulting in escalation of need), prohibitive cost/poor affordability, and challenging physical access (e.g. difficulty getting to locations).

Limited Providers and Specific Services. Several specific BH programs and services were cited as key gap areas in St. Louis. Lack of access to psychiatry, particularly pediatric psychiatrists, was highlighted as the top gap area by provider stakeholders. Youth and caregivers also frequently highlighted limited access to prescribing physicians, particularly for proper diagnosis, but further stressed the need for non-medical interventions such as therapy/counseling. Additionally, limited availability of specialty services to meet specific needs in the community were highlighted. While this was shared by all stakeholder types, providers, particularly those coordinating care from acute to community-based settings emphasized limited access to specialty services. Specific services repeatedly named across stakeholder types included:

- Respite care services
- Therapy/counseling (esp. family counseling)
- Home-based service/outreach
- Intensive Outpatient Programs/Treatment for youth
- 24/7 crisis access/response services
- Acute/inpatient care
- Longer-term care/case management/follow-up services, particularly following a crisis

Housing Facilities. Of note, BH and non-BH providers as well as community members noted lack of affordable housing options in the region. Providers noted placement and homeless youth options were particularly limited for youth with behavioral issues, especially those with specific situations (e.g. pregnancy), co-morbid illness or severe needs/behaviors. Transitional housing options were highlighted as lacking (especially for youth 16-18).

Limited services tailored for or provider expertise in specific populations was also highlighted and will be detailed in subsequent sections.

Gaps in Substance Use Supports. BH supports particularly related to substance use/abuse were distinctly noted to be limited throughout the St. Louis region across the lifespan and specifically for youth, thought substance use

was one of the most important challenges youth and adult community members stressed as affecting the St. Louis community. Challenges noted included: limited options and poor access for substance use treatment, limited emphasis on and availability of services for substances such as marijuana and alcohol, a perception that few substance use prevention activities in the community: youth particularly highlighted a perceived lack of substance use prevention activities in in St. Louis Public Schools.

ASSESSMENT AND EARLY INTERVENTION

Assessment and early intervention also emerged as a central gap across the range of stakeholders in both participatory groups and key informant interviews.

Assessments. All stakeholder types addressed challenges in the way that BH needs are identified for youth. One key arena in which the need for enhanced availability and accessibility of assessments was in screening and evaluation. Multiple providers of BH and non-BH sectors noted that assessments were particularly important for clients to access services and funding for programming. Caregivers and youth noted that identification of needs, including diagnosis, and supports subsequently provided to youth were impacted by assessments being performed and the accessibility of those who provide assessments and supports both formally and informally as being limited. Caregivers noted difficulty to get children evaluated and given a diagnosis and experiences with children being misdiagnosed and prescribed incorrect medications. Caregivers also relayed that once a child has been diagnosed and/or treated, there is a lack of follow-up with the child/caregivers. Stakeholders stressed assessments were particularly limited in St. Louis City, as compared to surrounding areas. Limited access was also noted by providers to be magnified by limited qualified workforce availability of professionals that meet requirements to provide evaluations (namely psychologists).

Further specific challenges identified with assessments in screening, evaluation and diagnosis included:

- *Limited early childhood screenings*. This lack was noted to worsen for youth as they age and be particularly present for St. Louis City youth. For example, cognitive/developmental screenings were noted to be somewhat available to youth ages 10 and up, but were virtually inaccessible after that point for City youth, while County youth have some additional access points.
- *Limited Individualized Education Plan (IEP) assessments*. Multiple providers working across BH and non-BH sectors noted a severe lack of screening and subsequent support for youth with potential development or intellectual needs that impact their functioning in school and the community, specific and inequitably burdensome for youth in St. Louis City. Participants reported funding and staffing barriers as limitations for schools providing these, particularly for youth outside of those with severe needs. A key informant agency noted regularly engaging in student advocacy and referring clients to legal supports in the community to address educational rights and poor IEP access.

Early Intervention. Discussion of early intervention gaps address key omissions early in both the disease course and life course. Community members, particularly general lay-persons, stressed a lack of early identification and treatment, as did many non-BH sector providers, such as schools. Stakeholders noted that this tied closely to challenges youth, their families, and providers of BH and non-BH supports face limited access to services until a behavioral disruption or BH crisis takes place. Multiple BH and non-BH providers noted that needs often emerge in early childhood and often go un-addressed, until school-age. Acute care and sectors outside of BH—particularly schools, juvenile justice, and child welfare—then see the ramifications of these unmet needs and become the entry points for management of these needs.

SCHOOL SUPPORTS

Given the day-to-day role schools play in young people's lives, schools were named as a primary avenue to identify and provide for BH and related needs by all participants. Youth noted the role of teachers and other adult school figures as trusted adults who many peers come to with BH concerns or who become aware of

psychosocial needs. However, across community members and providers, including schools, it was acknowledged that while schools often interact with BH needs, there are limitations on how well-equipped schools are to meet those needed.

Limited BH Services in Schools. Youth and caregivers vocalized school as a key intervention point opportunity and support for young people, however many noted concerns with the response of adults within, namely the opportunity for training to effectively respond to and foster trust. Schools emphasized competing demands of a primary focus on educating students, while acknowledging that BH needs directly impact that ability. School key informants noted challenges in the ability to address BH service needs by school staff or with limited funds to support external services. Social work or related support services to intervene early or respond to BH needs were noted to be limited particularly in the St. Louis City Public Schools, frequently due to one staff serving multiple schools within the district. Also growing are BH services in schools being provided by external partners with expertise in BH. Key informants highlighted that these models show strong promise, based on established programs, particularly in St. Louis County, including those to physical health clinics. Stakeholders stressed that access to in-school BH services, both provided by schools and in partnership with external entities was particularly limited in St. Louis City—in both public and charter schools.

Needed Support for Teachers/School Staff. Community members, particularly youth, as well as both BH and non-BH providers, including school key informants, noted the opportunity for schools to be strengthened by training and skills to identify and respond to BH needs. Balanced with this, youth noted experiences of "over-reaction" to disclosed BH concerns, leading to a feeling of mistrust or fear of the impact of seeking support from school staff. Caregivers and other community members added concerns of medical interventions, labeling and psychiatric medications being the primary route youth are then guided toward. Training was seen as a primary means to provide safe places and holistic responses. Additionally, school key informants highlighted the need for support for secondary trauma and compassion fatigue, to better equip staff to effectively respond to and cope with youth BH needs and impact in the classroom and community.

FAMILY SYSTEMS APPROACHES/CAREGIVER SUPPORTS

Providers of all types noted that family-focused services/intergenerational approaches are limited in the St. Louis community. BH providers particularly noted a lack of funding and infrastructure to support caregiver and child supports. Often, providers are not funded to work with the whole family or to overcome the challenges of working with multiple family members. While supports may be affordable or accessible to youth, uninsured adults with needs experience great difficulty in accessing and receiving services. Those family-centered programs that do exist or family counseling resources were reported to be available on a limited basis and at times only for special populations (e.g. court-involved youth).

Community members and all provider types noted that parental/caregiver education and social and formal supports are needed to enhance caregiver and child engagement and strengthen families and communities. This was reported as a general need for families, as well as particular need for pregnant or parenting teens, particularly per BH providers. This was also seen as an opportunity to reduce stigma and raise awareness in the community. Youth and caregivers vocalized need for training on how to respond effectively to youth BH issues and provide youth support.

SERVICES FOR SPECIFIC POPULATIONS

Another core gap area identified across participants were vulnerable populations, for which tailored services or provider expertise were of particular need. When discussing these needs, providers of BH and non-BH services and community members noted limited regional provider capacity, training in services for and working with specific populations. Provider groups noted a need to increase cultural competency to meet some of the specific needs/characteristics of youth clients in the St. Louis area as well as the potential to increase staff training and expertise. Youth populations with specific needs repeatedly noted throughout qualitative data collection included:

- *Transition-age youth/young adults* – This population includes individuals ages 16-25, transitioning from adolescence to young adulthood. Providers of all types highlighted needed supports for those "aging out" of the foster care system and "aging-out"/emancipated minors with severe BH needs.
- *Early childhood* – This population includes children ages 0-5.
- *Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) youth* – This population was highlighted by community members and providers as a key group in need of supports during youth.
- *Youth with co-occurring Intellectual/Developmental Disabilities (IDD) and BH needs.*
- *Youth with co-morbid BH and physical health needs*– This population particularly includes youth with chronic or severe physical health needs and was highlighted by providers as having limited access to integrated resources, as well as specialty BH care that requires the management of physical health needs (e.g. residential or respite care).
- *Youth who have experienced violence or trauma.*
- *Juvenile justice-involved youth.*
- *Child welfare system-involved youth.*
- *Homeless youth.*
- *English Language Learners* – This population includes youth who are non-native English speakers and who may or may not have been foreign-born.

COMMUNITY STRENGTHENING

Community Violence and Trauma. Repeatedly, the role of community, including environment, cohesion, and engagement was addressed as a key impact on youth BH. All stakeholder types noted crime and community violence were of particular emphasis given their role in trauma and toxic stress experienced by youth and families. Non-BH providers highlighted trauma as the most prevalent issue they see in youth they serve. Non-BH providers and community members noted limited support offered to families and children who experience trauma. BH and non-BH providers added that while trauma-informed training is expanding in the community and providers of all types, there is a lack of trauma-focused services and practitioners in the community.

Youth Development Opportunities. As previously mentioned, youth recreation and development activities are seen as clear assets in the community across stakeholder types. Caregivers, community members and non-BH providers emphasized in qualitative interviews that limited affordable and accessible recreational activities (esp. after school programming and during the summer day) and a lack of future-focused programming, such as job training and opportunities. Community members and non-BH providers stressed limited opportunity for positive community involvement, especially for teens. Providers of all types noted a need for youth skill building for independent living, including healthy relationships. BH and non-BH providers noted services could also benefit from utilizing Positive Youth Development approaches as well. The qualitative data did not parse out the particular aspects of recreation barriers, i.e. Are youth not accessing services because it is not what the youth are interested in, or are youth being waitlisted or turned away from services? In future qualitative work, it would be ideal to gather feedback from teens regarding their interests in recreational activities, i.e. types of activities in which they have enjoyed in the past.

Barrier Reduction for Social Determinants/Environmental Stressors. All stakeholder types noted gaps in families and providers being able to meet needs happening in the home or community that preclude youth BH services. All stakeholders also noted that many families, particularly in St. Louis City, struggle to meet basic needs. Transportation and location of services was noted as a top barrier and gap area identified by families, community members, and all provider type. Non-BH providers and community members noted youth and families often live in very stressful environments, where safety, crime and lack of opportunities is an issue. Additionally, limited provider ability to meet needs of a large population of those without insurance access and cost make it difficult to receive and afford care. This was particularly noted by BH and non-BH providers for the underinsured population. Also per BH and non-BH providers, housing instability, transient families and homelessness were all identified as factors that influence ability to stay in school and access and engage in BH services, particularly with services divided by regional catchment areas and funding sources.

OPPORTUNITIES

BEHAVIORAL HEALTH RESOURCES AND PROGRAMMING

Enhanced Access to Existing Programs and Services. It was acknowledged by multiple stakeholders that there are many services in the region, but there exists a pressing need to increase capacity, reduce restrictions and wait times so more people can access them. Caregivers noted a desire for easier access and navigation to existing services. It was acknowledged by multiple stakeholders that there are many services in the region, but a pressing need to increase capacity and reduce restrictions so more people can access them.

Increased Programs and Services. All stakeholder types noted a desire for additional programs and services targeting BH—from general to specific programs and services due to need. The most common included: Psychiatry access, Therapy programs that support the family (family therapy, parental therapy/support), substance use and prevention supports, and programs for specific/vulnerable populations. Multiple participants noted the need for more accessibility in the form of centralized community and BH resources, walk-in facilities with open intake hours or same day access for appointments (particularly medication management). For those with severe needs or co-morbidities, more facilities for longer-term or respite care were desired, particularly by BH providers.

Emphasis on Follow-up and Case Management. Caregivers and BH and non-BH providers noted the possibility for longer-term supports through case management. Many non-BH providers noted the need for more long-term, intensive case management services, reporting that families need support beyond the 60-90 day windows of some program and adding that individualized needs mean time-limited programs do not work for everyone. All providers and caregivers discussed the importance in continuity of care and consistent follow-up as contributors to successful meeting of needs.

BEHAVIORAL HEALTH COMMUNITY ACTIONS

Expanded Training. All stakeholder types noted more BH training for community and providers would benefit youth BH. Opportunities to train in trauma, Mental Health First Aid, and other youth BH models were emphasized by all providers for staff that serve youth in non-BH settings (e.g., pediatric staff, law enforcement, etc.). Greater depth in specific need areas identified throughout this report were also emphasized for both these staff and BH provider staff.

Integrated Services. All provider types noted successes of integrated BH services in other care settings and community agencies (schools, primary care settings, juvenile justice system) and these models could be replicated and leveraged, particularly in St. Louis City. Successful primary care models were specifically highlighted by providers.

Improved Provider Collaboration. BH provider group participants and non-BH providers, as well as caregivers, had discussions around increasing agency collaboration. Providers stressed the opportunity of moving towards a collaborative care model.

Funding transformation. BH and non-BH providers brought up the limitations and restrictions that come with most funding sources. These limitations were reported to restrict families from access and providers from delivering services. Multiple BH and non-BH providers noted opportunities to move toward a regional healthcare model,

removing the barriers that arise with City/County boundaries. Such regional funding would be helpful for many programs, as well as a funding shift to focus on collaborative efforts instead of individual ones. Some termed this as “funding a need” or funding collaboration, rather than funding an organization. BH providers also encouraged more funders to provide sustainable, long-term funding, to achieve longer-term outcomes. BH providers cited that many funding cycles are 1-3 years, making it difficult to keep programs up and running long enough to achieve impact.

BROADER COMMUNITY ACTIONS

Reducing Barriers and Environmental Stressors. All stakeholder types stressed the opportunity to address the social determinants that impact youth BH and service engagement. Opportunities included the possibility of transportation initiatives, strengthening community resources, and provider ability to assist with basic needs (i.e., housing, food).

Investing in Community Engagement and Youth Development. As addressed in gaps, youth recreation and development, as well as pro-social environments, were emphasized as key to youth health and wellbeing, and community cohesion. Community members, caregivers and non-BH providers noted the potential for affordable youth development programs (including healthy lifestyle education/activities, mentoring, tutoring, and workforce development) in the region. This was reported as a means to build natural supports (positive relationships and social support) to benefit youth BH needs—the prevention of, greater identification of, and enhanced support for response to those needs.

Increasing Public Awareness. Community members, caregivers, youth and non-BH providers noted the opportunity for increase in public awareness of youth BH needs, responses, service options and how to access services. These stakeholder types also highlighted the opportunity for media attention to youth BH concerns as a potential asset in the region. Youth noted social media as an opportune means of intervening and providing youth BH supports in ways that felt safe and trusted by youth. Non-BH providers, community members and caregivers noted the opportunity for stigma reduction to enhance treatment seeking and the potential for greater awareness of resources through media.

QUANTITATIVE DATA ANALYSIS

OVERVIEW

Primary and secondary quantitative data enrich understanding of St. Louis City and regional trends. To foster alignment with regional children’s tax levy service funds and continue St. Louis Mental Health Board and St. Louis Region System of Care (SOC) priorities in monitoring key indicators, BHN collaborated with multiple stakeholders to identify a core list of BH and related indicators that reflect a more comprehensive and cohesive view of the life experiences, assets, needs, barriers, and gaps experienced by youth and families in St. Louis City and regional and statewide comparisons. Data to illustrate this is sourced from a variety of publicly available secondary datasets, with sources noted throughout. BHN contracted with Berry Organizational & Leadership Development LLC (BOLD) as a partner to complete this section of this needs assessment focusing on St. Louis City, in addition to comparative data for the state, St. Louis County, and in some cases, the other counties in the Eastern Region of Missouri. BOLD, LLC recently worked on the St. Louis County Children’s Service Fund Behavioral-Health Needs Assessment, and included other relevant student data available on with St. Louis County students.

METHODOLOGY

A major section of this report focuses on what has happened in the St. Louis City community with specific youth-focused indicators in an effort to assess areas that may need attention as well as areas that have been positively affected. The most current secondary data from various sources were accessed for this study, with most of the data representing 2004 through 2015 (if available). The "*Demographics of St. Louis City*" section of the report illustrates an assessment of population and general demographic information for youth.

The following is a demographics review, with relevant community indicators about St. Louis City youth. In many cases, a comparison to Missouri data is presented to use as a gauge, in addition to comparisons with counties that are close to or similar to St. Louis City including Franklin, Jefferson, Lincoln, St. Charles, and St. Louis County. Comparative data allows for stakeholders to see areas of strengths and areas needing improvement, and to allow for data-driven community actions. Many data points present the number of children or youth, in addition to the percentage of youth that meet some criteria. The information is presented for topical areas that improved for St. Louis City, areas that need attention, and areas that showed mixed results with the data.

The report also offers a summary of the 2016 Missouri Student Survey and the 2016 St. Louis County Student Behavioral Health Survey results, both of which were only administered to the St. Louis County population. This section highlights changes with St. Louis County youth since 2008 and comparative Missouri data, in addition to identifying significant racial and/or grade level differences.

Additionally, BHN leveraged BHN-collected data and engaged with regional stakeholders to secure primary quantitative data published or recently publicly utilized for regional planning and coordination efforts. These include: St. Louis Regional Health Commission annual Access to Care survey (provider self-report survey data on organizational operating statistics) and Behavioral Health Response Youth Connection Hotline data.

The presentation of the community indicators data, when paired with the findings from the various qualitative methods of data collection used for this assessment, can lend support for a current program or demonstrate the need for additional services or attention.

KEY FINDINGS

KEY FINDINGS OF THE ST. LOUIS CITY COMMUNITY INDICATORS

This section presents the key findings of demographic information and community indicators about the City of St. Louis youth population, and in some cases, for the general population.

The first section presents demographic information about the St. Louis City youth population that are important to understand so that services, resources, and educational opportunities can be specialized for the varying groups of youth within the City. After this section, indicators are divided into three categories based on the data and trends covering 2004 through 2015 (if data is available).

The first section (**Community Indicators that Need Attention**) groups all of the indicators that diminished over time, or were not comparable to local regions or with state trends. These indicators need special attention, resources, and services to resolve.

The second section (**Community Indicators with Mixed Results**) groups all of the indicators with data trends that showed mixed results, meaning that the city data was not conclusive as to what might have been occurring

(plausible explanations). Mixed results could also be tied to an indicator where the trend was showing promise, but demonstrated a struggling youth population in comparison to other local regions or with the state. Mixed results can shed light on community changes, interventions, processes, or policies that could be moving the mark, but require continued resources and services to remain on this positive trend and/or to move closer to the rates of comparative regions.

The third section (**Community Indicators with Positive Findings**) groups all of the indicators that had shown some promising trends. These are areas that should be celebrated, duplicated, and replicated if underlying interventions/strategies that may have had an impact can be identified.

DESCRIPTIVE DEMOGRAPHIC INFORMATION - YOUTH POPULATION IN ST. LOUIS CITY

- **Youth Population** – between 2006-2015, the general population decreased by 11%, from 353,821 to 315,685 individuals. Since 2006, the population decreased by 38,136 individuals; 76% of them were youth 0 to 19 years of age (28,835 less youth). During this ten-year period, youth 10 to 14 years of age decreased in number by 39%, with a 34% decrease seen with youth 15 to19, followed by a 20.5% decrease for 5 to 9 year-olds, and a 20.4% decrease in children 0 to 4. There were 71,044 youth in St. Louis City for 2015; an overall decrease of 29% covering these ten years.

- **Race –** For the St. Louis City general population, 47% were White; 47% were Black or African American; 3% were Asian, and 2% were two or more races, with 4% Hispanic. By comparison, the youth population's racial breakdown shows a much lower percentage than the general population who were White (35%), with a higher percentage of youth who were Black or African American (57%), Hispanic (6%), and multi-race (5%) (see Figure 3).

- **Minority Children** - As of 2015, 68.4% of the children under age 18 (see Table 4, p61) were minority children representing 43,379 children. By comparison, there were 24.9% who were minority children in Missouri; a difference of 43.5% between these two percentages.

- **Median Household Income** - Income is another factor that can directly impact a youth's access to some of the services. St. Louis City's median household income was $37,948 in 2015, $35,681 in 2014, and $28,069 in 2004. This represents an improvement of 35% from 2004 to 2015 or $9,879. However, St. Louis City's median household income was approximately $12,000 less than Missouri's median income, and was the lowest by far out of the comparable entities (see Table 15, p72).

- **Adult Unemployment -** Adult unemployment peaked in 2010 with a 12.8% rate, but as of 2015, was at an all-time low of 6.1% (St. Louis County was at 4.6%). The same unemployment pattern could be seen across all of the comparable entities from 2004 to 2015 (see Figure 12 p73), but St. Louis City's unemployment rate was still the highest in 2015. The city's rate was 1.1% greater than Missouri rate of 5%. The city's unemployment percentage decreased by 2.7% from 8.8% in 2004 to 6.1% in 2015.

ST. LOUIS CITY COMMUNITY INDICATORS THAT **NEED ATTENTION**

- **Children in Poverty** - As of 2015, there were 39% of the St. Louis City children (age 0-17) who were in poverty in comparison to 26% of the general population (78,089 in poverty); a trend that has been consistent from 2004 to 2015 (Figure 13, p74). Focusing on youth age 0-17, there was a 22.4% decrease in the number of those who were in poverty, but this is paired with a 28.6% decrease in this population of youth (see Table 17). The percentage of youth in poverty (0 to 17) in this age range increased by 2.8% since 2004 (36.5% to

39.3%). The number of children age 5-17 who were in poverty decreased 19% to an estimated 16,385 children, yet the percentage of children in poverty in this age range increased by 5.3% (2004 to 2015) to 39.8%. Poverty is outpacing population growth for children age 5-17. All combined, there were 30,191 St. Louis City youth who were in poverty in 2015. St. Louis City had the highest rate of youth 0-17 in poverty (39.3%), 5-17 in poverty (39.8%), and overall population in poverty (25.5%) (see Figures 14, 15, 16, and Table 18). This also increased over time. The percentage of youth in poverty in Missouri was, by comparison, 20.4%, and 20.7% for the nation. The St. Louis City rate was almost 19% higher than both the state and nation.

- **Households at Risk of Homelessness** - There were 6.3% more renters in St. Louis City (48.2%) than Missouri who had gross rent costs of 30% or more of their household (HH) income (MO rate = 41.9%; Table 12), which puts them at risk of homelessness and living in poverty, to name a few detrimental outcomes. In all regional comparisons, St. Louis City had the higher percentage of individuals who spent 30% or more of their HH income on their monthly housing/rent payment. In 2015 alone, 30.7% of St. Louis City owners spent 30% or more in comparison to only 23.6% of Missouri owners.

- **Children in Single Parent Families** - The St. Louis City percentage of children in single-parent households is by far the highest in 2017 at 60%, with St. Louis County next at 34.9%, in comparison to 33.7% for Missouri (Figure 10). Additional resources need to be extended to children in single-parent families so their basic needs, including educational, and social-emotional, can be met. Resources also need to be extended to the single parent, especially focused on employment and assuring financial resources are available. Numerous research studies have found support for these heightened needs of children in single-parent families. McLanahan, S., & Sandefur, G. (1994); Herwig, J. E., Wirtz, M., & Bengel, J. (2004); Amato, P.R. (2005).; Kelly, J. B. (2001); Usakli, H. (2013) - See Appendis A: References, page 157.

- **Percentage of Children in Families Receiving Supplemental Nutrition Assistance Programs Benefits** (SNAP; aka Food Stamps) - There were 9,813 less children on SNAP in 2015 than in 2004. However, St. Louis City's rate increased for children receiving SNAP by 2.9% from 2004 to 2015, in comparison to Missouri's rate increase of 4%. In addition, Missouri had 34% of children on SNAP in comparison to 72% of the children that were living in the City of St. Louis. For this reason, the indicator is marked as an area that needs attention. It is important for St. Louis City stakeholders to address the 45,476 youth in need (see Tables 19 and 20).

- **Students Enrolled in the Free/Reduced Price Lunch program** - The rate of students enrolled in the Free/Reduced-Price Lunch program increased by 10% over time from 2004 to 2016, with 94.6% of students, or 31,184 on this program in St. Louis City (2016). However, the number of students enrolled in this program decreased by 9% or 3,089 students since 2004. This is most likely associated with diminishing school enrollment. For 2016, the St. Louis City rate was 43% greater than the Missouri rate of 52% of students (see Figure 18, Table 23).

- **Homelessness** - The percentage and number of reported homeless youth in St. Louis City increased by 12.5% from its 2010 rate of 5.3%. For 2016, 17.9% of children in schools were noted as homeless, or 5,952 homeless youth. The number of homeless youth in St. Louis City was more than St. Louis County, which had higher school enrollment numbers. By comparison, Missouri and St. Louis County's rates have increased by 1.1-1.7%, and for 2016 were at 3.5% for MO and 3.7% for St. Louis County. A large majority of the school districts within St. Louis City have not provided this information consistently over time. Focusing on the largest school district, St. Louis City school, there was a 215% increase in the number of reported students who were homeless since the 2009-2010 homeless count. For the 2015-2016 school year, they reported 5,451 homeless students.

- **Disability Types** - Increases in certain disability types are very critical for St. Louis City planning as well. It is clear that Autism surged in the public school districts, with a 137.9% increase from 2007 to 2016. There were 421 children with the Autism diagnosis in the public schools for 2016, so teachers and other school staff should be well prepared to handle the needs of these children. The city experienced a 119% increase in children with a speech impairment, which included 725 youth in 2016. Young children with a development delay, which includes children age 3 through pre-kindergarten (typically five year olds) increased by 33.7% with 357 youth diagnosed in 2016. Go to the full section of the report to see all of the trends with disability types.

- **Low-birth weight infants** - The city's low-birth weight infant rate was 12.2% in 2010-2014 compared to 8% for Missouri, and 8.8% for St. Louis County. The city's rate increased by .4% covering the 2004-2008 range to 2010-2014 (Table 55).

- **Violent Teen Death Rate -** The violent teen death rate (ages 15-19) improved by 9% to 108.2 out of 100,000 youth in 2011-2015 (from 118.4 to 2004-2008). However, St. Louis City had more than double the state rate of 49.2, and was considerably higher than all of the other county comparisons (see Table 62 and Figures 27 and 28).

- **Youth Receiving Psychiatric Services** – St. Louis City youth (949) made up 14% of the total number of individuals (6,921) who received psychiatric services from the Division of Behavioral Health in 2015. This was an overall decrease in the number of youth who received psychiatric services from 1,074 in 2009. However, there were different trends within different age ranges of youth. The largest increase in youth receiving Psychiatric services between 2009 and 2015, was 52% found with 6-9 year olds (see Table 68). There were 41% less youth age 14 to 17 who received psychiatric services from this source covering this same period of time.

- **Juvenile Law Violation - Neglect Referrals** - The types of Juvenile Law Violation Referrals are divided into multiple categories. Violent offenses made up the majority of law violation offenses at 413 offenses, which should be an area within juvenile offenses that receives attention. Truancy is the only status violation that did not decrease as much as the other status or law violation offenses, and had the third highest number of offenses in 2014 at 234. Neglect had the highest number of offenses out of all categories with 596 for 2014. Across the alcohol, neglect and custody types of referrals, neglect is the only offense that increased by 5% in number of offenses from 2004 to 2014. Neglect represented the highest number of offenses out of all known offenses, at 596 for 2014, and is an area that needs focused attention.

ST. LOUIS CITY COMMUNITY INDICATORS & DATA THAT DEMONSTRATED **MIXED RESULTS**

- **Children Receiving Cash Assistance** - From 2004 to 2015, there was an 8.7% decrease in the number of children receiving cash assistance, which as of 2015 included 6,455 city youth (see Table 22). The rate of children receiving cash assistance was 10.2% for St. Louis City, 2.7% for St. Louis County, and 3.4% for the State of Missouri (see Figure 17). This indicator has improved over time in St. Louis City. The number of children receiving cash assistance decreased by 38-39% in St. Louis County and State, and by 57% in the City (2004 to 2015).

- **High School Dropout Rate** - St. Louis City experienced a 17% decline in the number of students who dropped out of high school from 2004 to 2015, from 1,075 to 892, although the rate increased by 1.8% of students (Table 28) to 11.7%. By comparison, St. Louis City's drop-out rate was 9.6% higher than the state rate of 2.1% and 9.9% higher than St. Louis County's rate of 1.8%. However, this rate decreased since its peak of 17% in 2011, so this indicator is marked as one that had mixed results.

- **Disciplinary Incidents** - The largest school in the City of St. Louis, St. Louis City school experienced a very minor increase of .2 per 100 students in the disciplinary incident rate from 2007 (2.8) to 2016 (3.0) (see Table 32). However, if you focus on the data reported in 2009 where the rate was 6.6, there was a significant improvement over time to the rate of 3.0 in 2015, with stability experienced for a four-year span from 2013 to 2016. The number of disciplinary incidents decreased by 23% to 682 incidents in 2016, but enrollment had decreased by 30%. This St. Louis City school's rate of 3.0 was more than double the Missouri rate of 1.3 in 2016.

- **Out-of-School Suspensions** - This school district had a slight increase in the out-of-school suspension rate per 100 students covering 2007 to 2016 (2.7 to 2.8), in comparison to the state's rate that improved from 1.7 to 1.1 in the same period of time. For 2016, the school's rate was 2.5 times greater than the state's rate as well. However, this rate improved since its peak in 2009 (6.4 to 2.8 per 100 students), the year the variance between these two regions was its greatest (see Figure 19). The last three indicators all illustrate that there was a shift that occurred within the city schools around 2009 to 2011 that impacted these various data points in a positive way. These efforts need to be discussed and evaluated, with positive strategies continued so that the trend does not level off.

- **Infant Mortality** - Infant mortality is defined as babies born alive and dying before their first birthdays. St. Louis City experienced a reduction of 17% from 2004 to 2015 in the number of infants who died (Table 56), and the rate decreased by .8 to 9.8 in the 2011-2015 time range (Table 57). There were 232 infants who died in 2011-15. While there has been improvement, this indicator needs attention because the rate did not decrease as much as the state or county rate, and was still considerably higher than both of their rates at 6.4-6.5. This indicator and findings are similar to the rate of low-birth weight infants, and should be combined for future analysis, discussions, and interventions.

ST. LOUIS CITY COMMUNITY INDICATORS THAT ARE **POSITIVE**

- **Graduation Rates** - While there had been an increase of 8% in the St. Louis City high school graduation rate, as of 2016 it's at 70%, which is the lowest rate in comparison to the other counties and the state (Table 26). However, the graduation rate of 70% in 2016 was the highest it's been covering 2004 to 2016, so this item has been marked a positive finding. This indicator should be paired with the other educational indicators showing mixed, yet promising results.

- **Juvenile Law Violation Referrals** - Although the St. Louis City referral rate per 1,000 youth, age 10-17, was in most of the annual comparisons higher than the Missouri rate (since 2006), the difference between these rates has decreased substantially over time (Figure 21). In 2006, juvenile law violation referrals peaked in St. Louis City to a rate of 115.6 out of every 1,000 youth in this age range. The rate consistently dropped until it reached its lowest rate of 43 for 2015. As of 2015, the disparity between St. Louis City and Missouri (rate of 29.6) was the smallest it has been covering this twelve year span of time (Table 36). All three of the law violation offenses decreased in this period of time; violent offenses decreased by 59% (999 to 413 in 2014), drug offenses by 59% (to 191 to 79 in 2014), and alcohol offenses by 43% (7 to 4 in 2014).

- **Substantiated Cases of Child Abuse and Neglect** - For 2015, St. Louis City had 4,198 reported incidents (12.8% increase from 2005) of child abuse and neglect, with 6,250 reported children (6% increase from 2005); both with similar increasing trends found over time. However, the number of substantiated incidents and children decreased substantially since 2005. There were 229 substantiated cases in 2015, relating to 293 children, a reduction of 52% in substantiated incidents and 56% in substantiated children since 2005. Substantiated incidents made up 5% of the total reported incidents for St. Louis City in 2015; they made up

13% of incidents in 2005. These findings support the continued practice of mandated reporter training, and continually improving reporting practices so child cases can be identified early, or avoided through prevention programming. The number of unsubstantiated incidents (both with and without "preventive serviced indicated" (PSI)) and children increased by 40% or more from 2005 to 2015. Here is a breakdown of the types of incidents that were documented. Neglect made up the majority of cases in 2015 for St. Louis City (45%). Physical abuse made up 29% of the total number of substantiated cases, while sexual abuse was the third highest abuse experienced in making up 26% of the cases in St. Louis City (Tables 38 – 42). These three areas of child abuse and neglect needs to be a focal point for discussion and the provision of services.

- **Out-of-Home Placements** - The number of out-of-home placement entries for Missouri increased by 6%, while St. Louis City decreased by 43% from 2004 to 2015 (see Table 43). In 2015, there were 329 out-of-home placement entries for St. Louis City. Since this statistic doesn't account for the change in the population, it is important to look at the entries per 1,000 children, which were 5.2 for St. Louis City in comparison to 5.1 for Missouri. The city entry rate decreased from 7.2 to 5.2 out of 1,000 children from 2004 to 2015, while the Missouri rate diminished over time and was at 5.1 in 2015.

- **Births to Teens** - The number of births to teens in St. Louis City decreased by 60% from 2004 to 2015, with a reported 300 in 2015. The rate of teen births decreased by 45% from a rate of 78.3 in 2004 to 35.8 in 2015. St. Louis City's births to teens' rate improved dramatically over time, but its rate was still 10.8% more than the state rate (see Figure 24).

- **Child Deaths, ages 1 – 14** - Child deaths, ages 1-14, steadily improved over time with a rate decrease of 6.4 per 100,000 children from 26.4 in 2004-08 aggregated period to 20.0 in 2011-15. The city rate was greater than the state rate of 18 per 100,000 children, but not by much.

- **Youth Suicide and Self-Injury Rate** - St. Louis City had the lowest rate at 2.06 and number of suicides at five (5) covering 2003 through 2013 for youth, between 15 to 19 years old. The City of St. Louis' rate was significantly lower than the state rate of 8.55 (see Table 64). For youth 15-19 years of age, the St. Louis City self-injury rate for hospitalizations and emergency room visits were again better than the Missouri rate and all of the other comparable entities.

- **Youth Admitted into Substance Use Treatment Program** - Of the 3,459 total individuals admitted into a Substance Use Treatment Program, only 114 were youth under the age of 18, which decreased by 54% since 2009. Youth under 18 years old made up 3.3% of the total number of individuals who were admitted to a substance abuse treatment program in 2015 (Table 71).

ADDITIONAL KEY FINDINGS OF FROM YOUTH BEHAVIORAL HEALTH SURVEYS

Various sources were utilized to identify the BH needs of St. Louis City youth, but it is important to note that the remaining findings are tied to survey projects conducted with St. Louis County youth only. These include the Missouri Student survey (last conducted in 2016) and the St. Louis County Student Survey (conducted in the fall of 2016 for the St. Louis County Children's Service Fund Youth Needs Assessment report). St. Louis City schools chose not to participate in the Missouri Student survey for reasons unknown, and were not included in the scope of the St. Louis County survey project due to the funder of the project being aligned with St. Louis County only. Future efforts should allow for BH surveying of a representative sample of the St. Louis City student population. To assist in the generalizability of the county results, items were analyzed by race and grade for the Missouri Student survey, and by region for the St. Louis County survey project.

MISSOURI STUDENT SURVEY 2016 (ST. LOUIS COUNTY STUDENTS)

The Missouri Student Survey is administered in even-numbered years to 6th through 12th grade students in participating school districts. This survey can provide estimates for youth in St. Louis County who attend the public schools (the Missouri Student Survey results are reported in the St. Louis County Children's Service Fund Youth-Behavioral Health Needs Report showing all of the items and the trends over time).

THEMES EMERGING FROM THE **POSITIVE FINDINGS** SEEN WITH MISSOURI STUDENT SURVEY:

- The average age of first use of cigarettes increased by almost a year with only 11.8% reporting lifetime use and 4.3% using in the past month. Since 2008, there has been an 11.9% decrease in the percentage of students who reported they have one or more friends who smoke cigarettes (currently reported for 24.9% of students).
- 54% of St. Louis County youth believe that it would be easy to get alcohol, but this item was one of the only items that showed a negative trend with alcohol for these youth. The average age of drinking increased from 12.8 in 2008 to 13.5 in 2016, and 21.8% less youth had used alcohol in their lifetime than in 2008 (reported at 33.5% of youth). The monthly use of alcohol also declined by roughly 12% with a reported 17% for 2016. There were 43% of students who reported they had one or more peer who consumes alcohol, but this was a 12% decrease from the 55% reported in 2008. Overall, trends with alcohol use among youth seem to be improving.
- Lifetime drug use for many substances had decreased over time, with the following drugs who had the lowest percentages of use reported ever including: chew use (3.7%), cigarette use (11.8%), club drug use (1.2%), cocaine use (1.1%), hallucinogens (2.0%), heroin (.3%), methamphetamine (.3%), and synthetic drug use.
- Marijuana use seemed to be of less concern to students, their peers, and their parents over the past few years, but there were still 75% of youth who believed it is wrong or very wrong, and 90% of their own peers believed the same. With that being stated, the average age of first use increased to 14.4 in 2016 from 13.1 in 2008, which was a very positive trend for the St. Louis County youth. There were 19.9% of youth who reported using marijuana in their lifetime with 11.3% who reported using it in the past month. Lifetime use had decreased over time, while past month use increased from 2008 to 2016.

THEMES EMERGING FROM THE **NEGATIVE FINDINGS** SEEN WITH MISSOURI STUDENT SURVEY:

- Youth perception and ease of availability of marijuana has not improved.
- Being a victim of and perpetrator of online bullying or bullying by cellphone, or being a victim of bullying at school has increased (three related items).
- Youth perception of and lifetime use of prescription drugs has gotten worse.

FINDINGS THAT REQUIRE ATTENTION:

- 5.3% increase in the percentage of youth reporting they had used electronic cigarettes in their lifetime (20.6%), yet past month use had decreased slightly, with a reported 10.7% for 2016.
- An alarming item was the average age of first use for inhalants, which was 10.9. This age had decreased from 11.5 years old reported in 2010 for St. Louis County youth. However, only 2.7% reported that they had used an inhalant in their lifetime, with only 1.1% in the past month.
- More students are reporting lifetime prescription drug misuse (12.7%), and 8.6% reported misusing prescription drugs in the past month in comparison to only 5.9% of the 2008 student sample. The prescription drugs that were most likely to be misused by youth were pain medication, where 13.2% of youth reported misuse in the past year. Prescription drug misuse had a more negative perception by youth and their peers and parents than alcohol, cigarettes, and marijuana. Prescriptions drugs were viewed as almost as risky as illicit drugs, which includes heroin, crack, and cocaine.

- 55% reported over the counter drugs as being easily accessible, yet only 1.8% of youth reported past month use. 54% reported alcohol as easily accessible, and this is the item that had the highest reported past month use at 16.6%.

ADDITIONAL KEY FINDINGS FOR RACIAL AND GRADE-LEVEL COMPARISONS

- **Depression -** In five out of the six items assessing depression on the Missouri Student Survey (St. Louis County student sample only), there was a significantly greater percentage of Hispanic students who were depressed than White and Black students. All of the depression items peaked in 11th grade.

- **Bullying Victims** - White students had the highest percentage (62.2%) of those who were victims of emotional bullying. Black students had the lowest percentage at 54.7%, which is still considered high. Black students had the lowest percentage (19.7%) who had been a recent victim of bullying online or via cell phone. Both Hispanic (27%) and White (26.5%) students were at much higher percentages for this type of bullying than Black students. 9th grade students had the highest percentage who bullied online or via cell phone (24.8%) and who spread rumors (28.7%) at least one time in the past three months, and who were victims of online or cell phone bullying (28.9%), emotional bullying (64.1%), and rumor bullying (46.6%). Sixth grade students had the highest percentage who physically bullied others (18.5%), and who were victims of physical bullying (29.6%) at least one time in the past three months, and 33.6% who were a victim of bullying at least one time in the past year.

- **Fighting** - Sixty grade students were also at the highest percentages for fighting once or more in the past year (22.3%) and fighting with injury (3.2%).

- **Suicide Trends with Hispanic Students** - Covering all of the suicide and self-harm items, Hispanic students had the highest reported numbers, with 17% who had seriously considered suicide in the past year. The only item with a significant difference was for self-injury; 23.2% of Hispanic students in comparison to only 13% of Black students. All of the suicide-related items peaked in 11th grade, with 12.3% who planned a suicide, 18% seriously considered it, 6.9% attempted suicide, and 1.8% attempted suicide resulting in an injury (in the past year). Self-injury peaked in 10th grade with 19.6% attempting self-injury in that year.

- **Weapons Trends** - The alarming finding with weapons was that 18.9% of Black students reported that their peers carry a gun, which was significantly higher than all other regional and racial comparisons.

- **Prescription Drugs Most Likely to be Misused** - The drugs that were most likely to be reported as misused in the past year were pain medications (13%) and other prescription medications (10%). There were significantly higher percentages reported for pain (20%) and other prescription (15%) medications with Black students than other groups of students, especially White students. The highest percentage of other prescription medication misuse (unidentified) was found with 6th graders at 16.6% (at least one time in the past year). Almost 16% of 8th graders had misused pain medications at least once in the past year, which was the highest percentage across all of the grades. Anxiety medication misuse was the highest at 5.7% with 11th graders. Sleeping meds were misused the most by 8th graders at 6.5%.

- **OTC Drugs** - White students had a significantly higher percentage of students (58.3%) that said over-the-counter (OTC) drugs were easily available in comparison to only 45.6% of Black students. There were also significant differences between these groups on their perception of harm about OTC and prescription drug misuse. Seventy-two percent (72%) of Black students rated OTC misuse as a moderate or great risk in comparison to 82% of White students. Seventy-eight percent (78%) of Black students rated prescription misuse as moderate/great risk in comparison to 90% of White students. Similar results were also noticed with perception of harm about synthetic drugs, which would suggest the necessity for education to this student population so that the harms of these drugs can be shared. *Black students had higher percentages who reported lifetime (7.5%) and past month (3.6%) OTC drug misuse, and lifetime (16.8%) and past month (12.2%) prescription misuse.*

- **Students with a Driver Under the Influence** - The same percentage (19.6%) of 8th and 12th grade students had been with a driver under the influence for at least one day out of the past month, which is more than 5% greater than the Missouri percentage. This is an item that needs attention in the St. Louis County region.

KEY FINDINGS FROM THE ST. LOUIS COUNTY STUDENT SURVEY

Students were given a list of BH-related issues that they might face at school or in the community, and were asked to identify the top issues. This information was analyzed separately for middle and high school students, and is summarized below. The data is important to understand issues in the County and for St. Louis City generalizability, given it is a large sample (over 4,200 youth respondents). Regretfully, there is no comparable data for the City.

Middle School Student trends:

- Bullying/cyber-bullying –61% of students identifying this as a pressing issue; top issue across all sub-regions.
- Friend/peer relationship, social skills, problem-solving and self-esteem -one of the top issues across all of the sub-regions by 54% of all students.
- Controlling emotions, anger management, and conflict resolution - the third most prevalent issue by 44% of middle school students. 50% of North County students dealt with this in comparison to only 34% of South County students.
- Anxiety/worrying a lot -one of the top issues in all of the sub-regions with the exception of North County. In North County, this issue is replaced by threats of violence or being injured by another peer by 39% of student, and gang violence by 35% of students. Threats of violence or being injured by another peer was also a concern for central county students (31%).

High School Student trends:

- There was more sub-regional variation in the top issues high school students face at school or in the community with high school students. Drug use/abuse - first or second issue in all of the sub-regions, with 60% or more of the students selecting this issue.
- Anxiety/worrying a lot -one of the top issues in all of the sub-regions with the exception of North County. In North County, only 30% of students identified this issue, and instead had bullying/cyber-bullying as its second highest need issue at 50%, followed by gang violence at 46%.
- Friend/peer relationships, social skills, problem-solving and self-esteem (as one issue) - one of the top five issues across all of the sub-regions with 49% of all students.
- Depression/being sad a lot - one of the top issues across St. Louis County, with South County students experiencing this the most at 53%.
- Bullying/cyber-bullying - 44% of students identified this as a pressing issue.
- Controlling emotions, anger management, and conflict resolution - identified as one of the top issues in North County only.

While this item did not show up in the top five issues, self-harm and/or suicide was identified by 29% of high school students, with 38% of South County students identifying this as an issue. Seventeen percent of middle school students identified self-harm and/or suicide as an issue, so this gets much worse in high school.

KEY FINDINGS FROM BEHAVIORAL HEALTH RESPONSE DATA

- Behavioral Health Response (BHR) handled an estimated 2,100 St. Louis County youth calls in 2015, 50% for North County youth. Sixty-four percent (64%) of the cases were youth age 10 to 18. Data reports were limited for St. Louis City youth at the time of this needs assessment, but it is known that there were 475 St. Louis City youth cases handled between July 2016 and March 2017 (projecting out to 632 estimated for a 12-month period).
- For St. Louis City, 209 out of the 475 callers or 44% were considered high risk cases in comparison to 27-28% of the St. Louis County cases (571 out of 2,128 total cases; high risk is based on criteria if youth is suicidal, either in past or currently, or has engaged in self-harm or self-injurious behavior). In the county, 36% of the 10-14 year old cases were high risk, followed by 29% of the youth age 15-18, and 24% of the 6-9 year old children.
- The top five primary problems of the 2,128 BHR cases (in the County), which made up 88% included: childhood/adolescent problems (35%), non-acute mental health needs (22%), housing (15%), currently suicidal (9%), and education and assistance with referral (7%).
- 20% of the BHR county cases (out of 2,128), and 13% of the city cases (out of 475) required emergency services upon the intake call. Eleven percent (11%) of the county youth, and separately of the city youth, required psychiatric and/or psychological services. Twenty-five percent of 15 to 18 year olds in the county needed emergency services (N = 114), the highest among all of the age ranges.
- 86% of the high-risk cases in St. Louis County were linked to services within two days of the call, and 89% were linked within 14 days. After accounting for the clients that could not be reached during follow-up, only 21 youth (3.7%) were not linked to a service within two days, and two youth (.4%) within 14 days. There were 80% of the high risk cases (169 out of 209) in St. Louis City who wanted to be linked to services within 14 days, with 167 of them who were linked (99% of those who agreed to follow-up service).
- There were 433 St. Louis County cases or 20% of clients that experienced barriers, with 508 total barriers noted for these cases. Out of the 2,128 BHR cases, insurance was a barrier for only two of them, finances/funding for two cases, and transportation for four cases (when looking at all of the barriers noted by the caller/client). The largest barrier was not being able to very or re-connect (contact) the client associated with the case (12%), followed by 5% declining follow-up or referrals (99 clients), and 3% (56 clients) not needing the services. Perhaps additional contact information should be gathered during intake to increase the likelihood of contacting these clients, but it is more likely a result of these youth not wanting to be contacted. with twelve cases needing services that were not available. There were 179 cases or 38% of youth that experienced barriers in St. Louis City. Similar to St. Louis County, lack of insurance, finances, and transportation were barriers for less than four total callers/clients. The largest barrier was once again not being able to verify or re-connect (contact) the client associated with the case, which represented 25% of cases; 4% declined follow-up; with 3% of guardians declining referrals upon the follow-up call.
- St. Louis callers had 20% of students hear about BHR from school or teachers, followed by 9% from agency workers. For St. Louis City youth, 44% heard about BHR from school or teachers, followed by 10% from agency Agencies and school officials need to continue to provide BHR contact information to their clients and students.

KEY FINDINGS FROM BEHAVIORAL HEALTH ACCESS TO CARE DATA

- The total number of BH users served by BH safety net providers remained stable as compared to 2014.
- Wide variation exists in the rate of serving the safety-net population within the designated service areas of respective BH safety net administrative agents in Missouri's Eastern Region.

- Newly admitted users served at BH safety net providers increased by 7% (nearly 500 additional users) in 2015 as compared to 2014.
- BH encounters at safety net primary care providers have increased by 22% over the past five years, but remained stable from 2014 to 2015.
- Emergency department encounters with BH diagnoses (primary and secondary) have increased by 11% over the past year and account for 32% of all emergency department encounters in 2015. The top primary and secondary BH diagnoses were tobacco use, mood disorders and anxiety disorders. However, when looking at primary diagnoses only, mood disorders, schizophrenia/delusional disorders and alcohol use disorders are the top BH diagnoses (page 145).
- While acute psychiatric encounters remained stable overall in 2015 (page 147), inpatient psychiatric staffed bed capacity decreased by 5% (33 beds) in 2015, as compared to 2014. Much of this decline (a net loss of 29 beds) took place in St. Louis County, subsequent to the Christian Hospital inpatient psychiatric service closure (page 146).

DETAILED FINDINGS

DEMOGRAPHICS OF ST. LOUIS CITY

To better understand the experiences of youth, it is important to recognize the demographics of the communities in which they live. Today, the nation's children are racially and ethnically more diverse than ever, and the number of children from immigrant or non-English speaking families is growing. To effectively meet their needs, communities must deliver services and programs with cultural competency and a focus on equitable outcomes, while ensuring these services are affordable and accessible. The "*Demographics of St. Louis City*" section of the report illustrates an assessment of population and general demographic information for the St. Louis City youth.

Following the demographic section, relevant community indicators about St. Louis City youth are presented. In many cases, a comparison to Missouri data is presented to use as a gauge, in addition to comparisons with counties that are geographically close to or similar to St. Louis City, including St. Louis County, St. Charles, Franklin, Jefferson, and Lincoln. Comparative data allows stakeholders to see areas of strength and those needing improvement to allow for data-driven community actions and assessment.

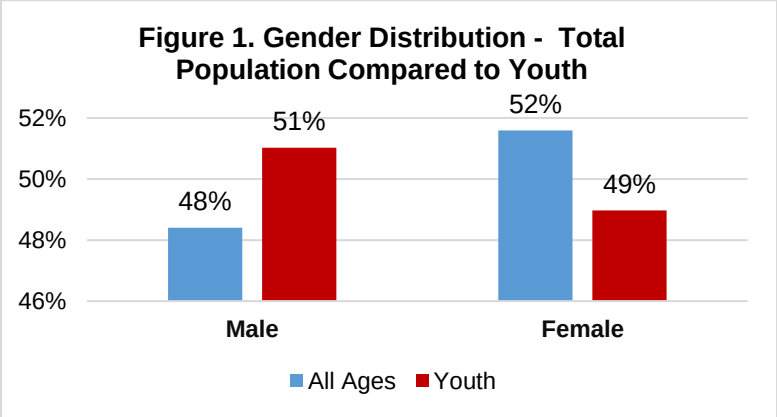
Indicators that need attention are those where the trend has diminished over time (a negative change covering the years of data presented), or data points are far off from comparable or close regions, or with the state data. These indicators require special attention, resources, and services to resolve, with the goal being to minimize the negative change occurring within St. Louis City, and gaps in comparison to other data.

Indicators with data trends that showed mixed results could mean that the county data was not conclusive as to what might have been occurring (plausible explanations). Mixed results could also be tied to an indicator's trend that was positive over time, but recent data still demonstrated a struggling youth population in comparison to other local regions or with the state. Mixed results can shed light on community changes, interventions, processes, or policies that could be moving the mark, but require continued resources and services to remain on this positive trend and/or to move closer to the rates of comparative regions.

Indicators that have shown some promising trends should be understood, celebrated, duplicated, and replicated if underlying interventions/strategies that may have had an impact can be identified.

In 2015 St. Louis City had a total estimated population of 315,685 – with an estimated 52% who were females and 48% who were males. The median age was 40.2 years. An estimated 22% of the population were under 18 years of age, with an estimated 49% who were females and 51% who were males (see Figure 1).

Table 1 shows that the general population decreased by 11%, from 353,821 to 315,685 individuals. Since 2006, the population decreased by 38,136 individuals; 76% of them were youth 0 to 19 years of age (28,835 less youth). During this ten year period, youth 10 to 14 years of age decreased in number by 39%, with a 34% decrease seen with youth 15 to19, followed by a 20.5% decrease for 5 to 9 year olds, and a 20.4% decrease in children 0 to 4. Therefore, the population of youth in St. Louis City has decreased rather rapidly since 2006, with the most dramatic decrease occurring between 2009 and 2010, which coincided with the census.



Across all of the age ranges, the percentage and number of youth in the population decreased (see Figure 2). There were 71,044 youth in St. Louis City for 2015; an overall decrease of 29% covering these ten years.

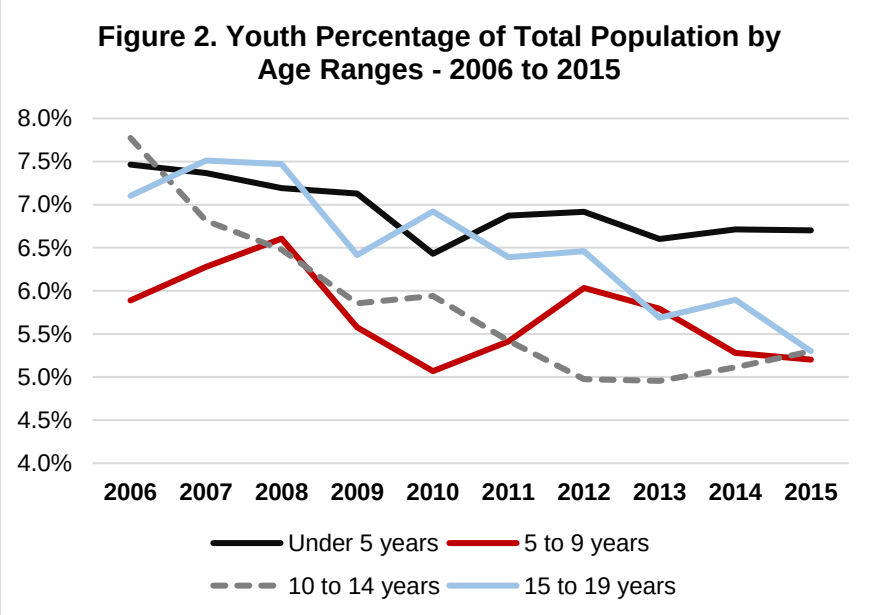


Table 1. Population by Age Ranges – 2004 to 2015 – St. Louis City

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.	% Ch.
Population Total	353,821	350,759	354,361	356,587	319,156	318,069	318,172	318,416	317,419	315,685	-38,136	-10.8%
Under 5 years (0-4)	26,411	25,842	25,481	25,425	20,522	21,864	22,011	21,016	21,306	21,017	-5,394	-20.4%
% of Total - Under 5	7.5%	7.4%	7.2%	7.1%	6.4%	6.9%	6.9%	6.6%	6.7%	6.7%	-0.8%	
5 to 9 years	20,831	22,024	23,407	19,889	16,175	17,216	19,202	18,440	16,761	16,566	-4,265	-20.5%
% of Total - 5 to 9	5.9%	6.3%	6.6%	5.6%	5.1%	5.4%	6.0%	5.8%	5.3%	5.2%	-0.7%	
10 to 14 years	27,504	23,891	22,955	20,877	18,965	17,238	15,827	15,778	16,223	16,762	-10,742	-39.1%
% of Total - 10 to 14	7.8%	6.8%	6.5%	5.9%	5.9%	5.4%	5.0%	5.0%	5.1%	5.3%	-2.5%	
15 to 19 years	25,133	26,348	26,478	22,873	22,093	20,320	20,554	18,111	18,717	16,699	-8,434	-33.6%
% of Total - 15 to 19	7.1%	7.5%	7.5%	6.4%	6.9%	6.4%	6.5%	5.7%	5.9%	5.3%	-1.8%	
Youth Population 0-19	99,879	98,105	98,321	89,064	77,755	76,638	77,594	73,345	73,007	71,044	-28,835	-28.9%
% of Total Population - <18	28.2%	28.0%	27.7%	25.0%	24.4%	24.1%	24.4%	23.0%	23.0%	22.5%	-5.7%	

Source: U. S. Census Bureau; American Community Survey and SAIPE

*Note: **Diff.** = the difference between the first and last time period presented in the table, which for this table would be the difference between 2006 and 2015. **% Ch.** = the percentage of change over this same period of time; did the number or rate increase or decrease by a certain percentage. This coding is used throughout the report.*

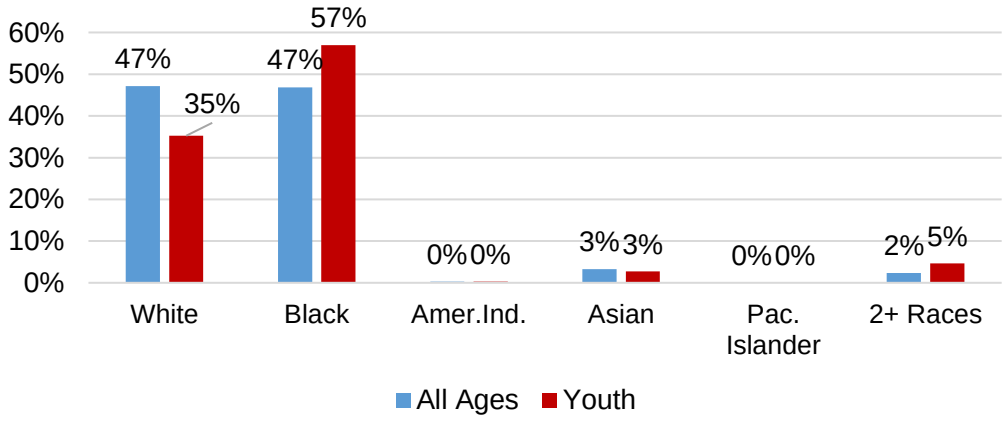
Table 2. St. Louis City Total Population and Youth Population 2015 -Top Four Races and Hispanic Ethnicity

	White		Black		Asian		2 or More Races		Hispanic		Total
All Ages	148,733	47.1%	147,961	46.9%	10,391	3.3%	7,522	2.4%	12,261	3.9%	315,685
0-4	8,437	39.8%	10,867	51.3%	566	2.7%	1,198	5.7%	1,314	6.2%	21,176
5-9	6,461	35.9%	10,160	56.4%	362	2.0%	966	5.4%	1,153	6.4%	18,002
10-14	4,727	31.2%	9,383	61.9%	348	2.3%	657	4.3%	779	5.1%	15,155
15-19	5,471	32.5%	10,161	60.3%	678	4.0%	515	3.1%	772	4.6%	16,858
20-24	9,313	38.4%	13,048	53.8%	1,128	4.7%	668	2.8%	1,065	4.4%	24,247
All Youth		35.3%		57.0%		2.7%		4.7%		5.6%	

Source: U.S. Dept. of Commerce, Bureau of the Census; prepared by the Missouri Department of Mental Health. Figures are mid-year (July 1) estimates released annually by the U.S. Department of Commerce, Bureau of the Census.

Table 2 (above) shows the breakdown of the St. Louis City youth population and general population by the four majority races, and for residents who are Hispanic. For people reporting one race alone, 47% were White; 47% were Black or African American; 0.2% were American Indian and Alaska Native; 3% were Asian; less than 0.2% were Native Hawaiian and “Other Pacific Islander", and 2% were some other race. An estimated 2% reported that they were two or more races. An estimated 4% of the people in St. Louis City residents were Hispanic. An estimated 49% of the people in St. Louis City were White non-Hispanic. People of Hispanic origin may be of any race.

Figure 3. 2015 St. Louis City Population Percentage by Race



By comparison, the youth population’s racial breakdown shows a much lower percentage than the general population who were White (35%), with a higher percentage of youth who were Black (57%), Hispanic (6%), and multi-race (5%) see Figure 3). Ten percent more youth were Black and 12% less youth were White.

GENERAL POPULATION INFORMATION

HOUSEHOLDS AND FAMILIES

In 2015, there were an estimated 141,312 households in St. Louis City with the average household size of 2.2 members and average family size of 3.2.

In St. Louis City, 22% of all households had one or more individuals under the age of 18 (31,625); 21% of all households had one or more individuals 65 years and over (28,954). Among individuals 15 and older, 31% of males and 27% of females were currently married.

Non-family households made up 55% of all households in St. Louis County. Most of the non-family households (81.5%) were people living alone, but some were composed of people living in households in which no one was related to the householder.

Families made up 45% of the households in St. Louis City. Sixty-eight percent (68%) of individuals lived in a family household. Twenty-three percent were married-couple families (32,569 households) and married families who have their children less than 18 years of age making up 19% (approximately 27,223 households). For the other family category, 18% were female householders, and 4% were male householders. There were approximately 2,225 (1.6%) male householders with children under 18 years old and 14,403 (10.2%) female householders with children under 18 years of age. All combined, there were an estimated 31,625 households in St. Louis City with children who were under 18 years of age.

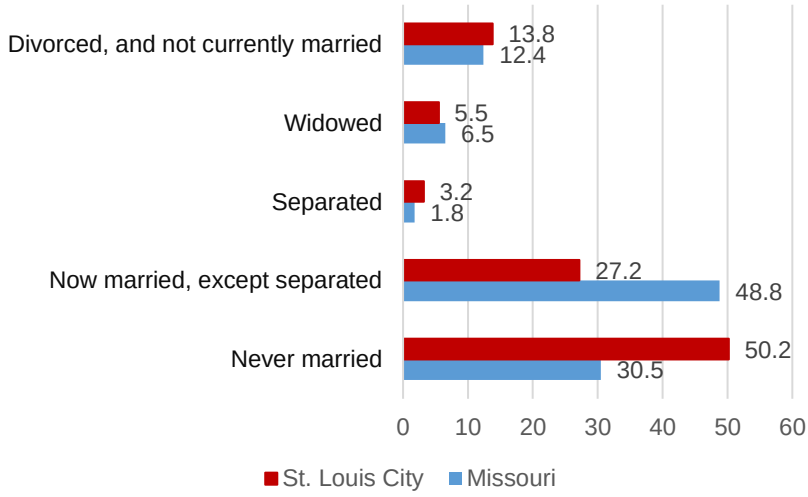
The majority, or 50.2% of St. Louis City residents, 15 years and over, had never been married, compared to 30.5% for Missouri (see Table 3 and Figure 4). In Missouri, 48.8% of these individuals were married which is 20% greater than St. Louis City, where only 27.2% were married. This descriptive information about the population of St. Louis City youth and adults is particularly interesting as the almost 20% difference in the “never married” percentage relates to the needs of youth.

Table 3. Persons 15 Years and Over in St. Louis City and Marital Status - 2015

	Missouri	St. Louis City
Persons 15 years and over - Total	**4,931,458**	**261,340**
Never married	30.5	50.2
Now married (except separated)	48.8	27.2
Separated	1.8	3.2
Widowed	6.5	5.5
Divorced; not currently married	12.4	13.8

In St. Louis City (2015), 6,268 grandparent households had grandparents that lived with their grandchildren under 18 years old. Of those grandparent households, 42.3% of them had financial responsibility for their grandchildren. This is in comparison to 35.4% of grandparent households in St. Louis County (5,594 out of 15,800), and 44.1% for Missouri grandparent households.

Figure 4. Marital Status- Percentages - State Comparison



MINORITY CHILDREN

An estimated 93% of the people living in St. Louis City in 2015 were native residents of the United States and 72% of these residents were living in the state in which they were born. An estimated 7% of the people living in St. Louis City were foreign born.

As of 2015, the percent of minority children was 68.4% of the children under age 18 (see Table 4), representing 43,379 children. The percent of total children, that were minorities, decreased by 5.3% from 2004 to 2015, while the number decreased by 15,846. By comparison, the percentage of minority children was 24.9% in the state of Missouri for 2015, a difference of 43.5% with the City's percentage of 68.4%. By viewing the table below, that shows the changes in the percentage of and number of minority children in one year, you can see that the percentage and number for St. Louis City decreased by 3.3% while the state's numbers increased by .7%.

Table 4: Number and Percentage of Minority Children in St. Louis City, Missouri from 2004 to 2015

	# - Missouri	# -St. Louis City	% - Missouri	% - St. Louis City
2004	306,340	59,225	21.6%	73.7%
2005	313,475	57,436	22.0%	74.2%
2006	320,709	55,777	22.5%	74.5%
2007	327,343	54,324	22.9%	74.8%
2008	331,826	53,275	23.2%	75.1%
2009	335,349	51,686	23.5%	75.1%
2010	337,947	50,023	23.7%	74.4%
2011	337,650	48,308	23.9%	73.0%
2012	338,841	47,051	24.1%	71.6%
2013	340,840	45,656	24.4%	70.6%
2014	343,852	44,856	24.7%	69.6%
2015	346,233	43,379	24.9%	68.4%
Diff.	39,893	-15,846	3.3%	-5.3%
% Ch.	13.0%	-26.8%		

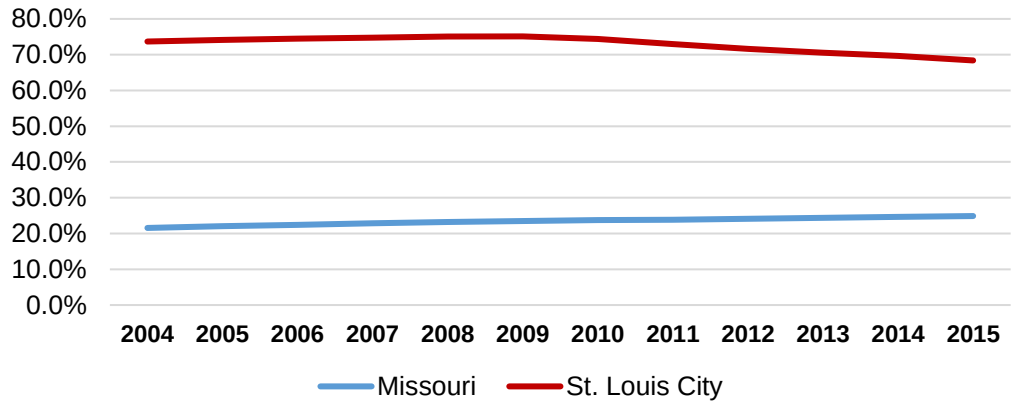
Source: USDC, Bureau of the Census; Missouri Office of Administration, Division of Budget and Planning.

Definitions: Percentage of children under age 18 who are identified as non-white.

Table 5 2014-2015 Minority Children Change

	Diff	Change
# - Missouri	2,381	0.7%
# - St. Louis City	-1,477	-3.3%
% - Missouri	0.2%	
% - St. Louis City	-1.2%	

Figure 5. Percentage of Youth Population that are Minority Children

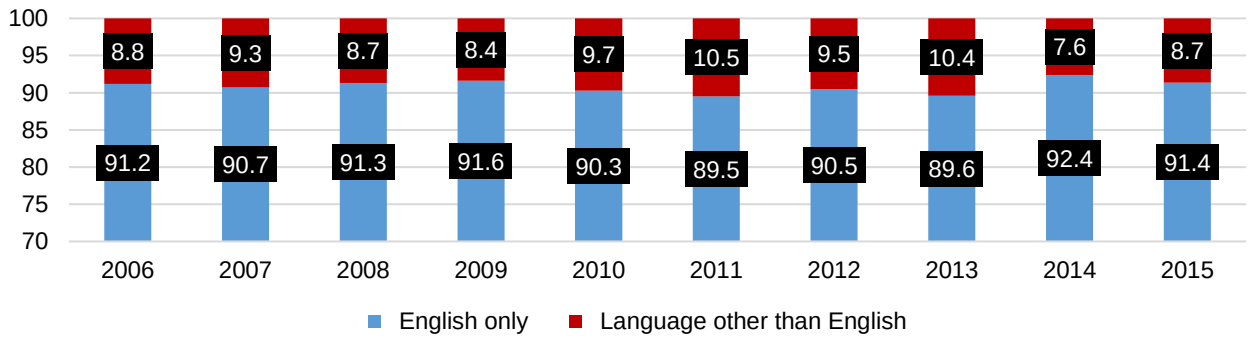


LANGUAGE

The language of these youth is important so that resources and services are tailored to respond to these needs, especially surrounding education and awareness of programming. Among people at least five years old living in St. Louis City (269,167), 8.7% spoke a language other than English at home (see Figure 6). This has remained relatively stable covering the ten years from 2006 to 2015. Of those who spoke a language other than English at home, 36% (9,178) spoke Spanish. Approximately 5% of St. Louis City residents did not speak English very well (13,171 residents).

As of 2014, 3.4% or 2,175 St. Louis City children had limited English proficiency. This number decreased by 21% or 593 children from 2004 to 2014.

Figure 6. Language Spoken at Home- St. Louis City Population 5 Yrs+



Source: ACS Social, 1 –year estimates for St. Louis City.

Table 6: Number of Children with Limited English Proficiency in St. Louis City, Missouri 2004 to 2014

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Diff	% Ch.
Number	2,768	2,905	2,673	2,563	2,438	2,157	2,173	2,172	2,243	2,191	2,175	-593	-21.4%
% of all children	3.1%	3.4%	3.2%	3.5%	3.4%	3.1%	3.2%	3.2%	3.3%	3.4%	3.4%	0.3%	

Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2015 American Community Survey.

Definitions: The share of children ages 5 to 17 that speak English less than "Very well". Data not provided for St. Louis City in 2015 by MO Kids Count.

Table 7. Language Spoken - St. Louis City (STL) Population 5 years and over

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	# 2015	2015 -MO	STL vs. MO	Diff.
English only	91.2	90.7	91.3	91.6	90.3	89.5	90.5	89.6	92.4	91.4	269,167	94.0	-2.7	0.1
Language other than English	8.8	9.3	8.7	8.4	9.7	10.5	9.5	10.4	7.6	8.7	25,501	6.0	2.7	-0.2
Speaks English less than "very well"	49.5	52.3	60.2	53	47	49	44.1	36.3	35.2	37.2	9,475	35.4	1.8	-12.3
Speak Spanish	2.5	2.9	2.7	2.6	2.9	3	3.5	3.6	2.3	3.1	9,178	2.6	0.51	0.61
Speaks English less than "very well"	52.7	56.1	58.5	33.2	48.3	41.2	48.3	30.2	31.2	40.3	3,696	37.9	2.4	-12.4

Source: ACS Social, 1 –year estimates for St. Louis City. Table information based on total population estimate of 294,668, with the exception of the two gray highlighted rows which are a percentage of the totals in the previous row.

DISABILITY POPULATION (AREA NEEDS ATTENTION)

A review of youth who have special needs is required to prioritize and assess potential service area gaps.

As of 2015, there were 3,602 St. Louis City youth age 5 to15 who were non-institutionalized and who had a qualified disability. Among the civilian non-institutionalized population over five years of age in 2015, 15.8% had a disability, which equates to an estimated 49,315 St. Louis City citizens. The likelihood of having a disability varies by age; from 5.7% of youth age 5-15 to 13.7% of people 16 to 64 years old, and to 47.1% of those 65 and over. The percentage of children with disabilities (population estimates) has varied across the years, but comparing 2006 to 2015, did not change. The rate of youth, age 5 to 15 with a disability has been as low as 3.6% since 2006, but it increased to one of its highest rates in 2015 over the ten year period at 5.7%. Over this period of time, the percentage of all individuals in the population with a disability decreased by 3.6%. Figure 7 below provides the state and city youth disability percentage trends.

Table 8. Percentage of Youth, Age 5-15 with a Disability - St. Louis City and MO

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.
Missouri	7.0	7.1	4.7	4.5	4.5	4.5	5.0	4.5	4.7	4.7	-2.3
St. Louis City	5.7	5.3	4.3	3.6	5.8	3.7	3.6	4.2	5.0	5.7	0.0

Source: U.S. Census Bureau, American Community Survey 1-Year Estimates

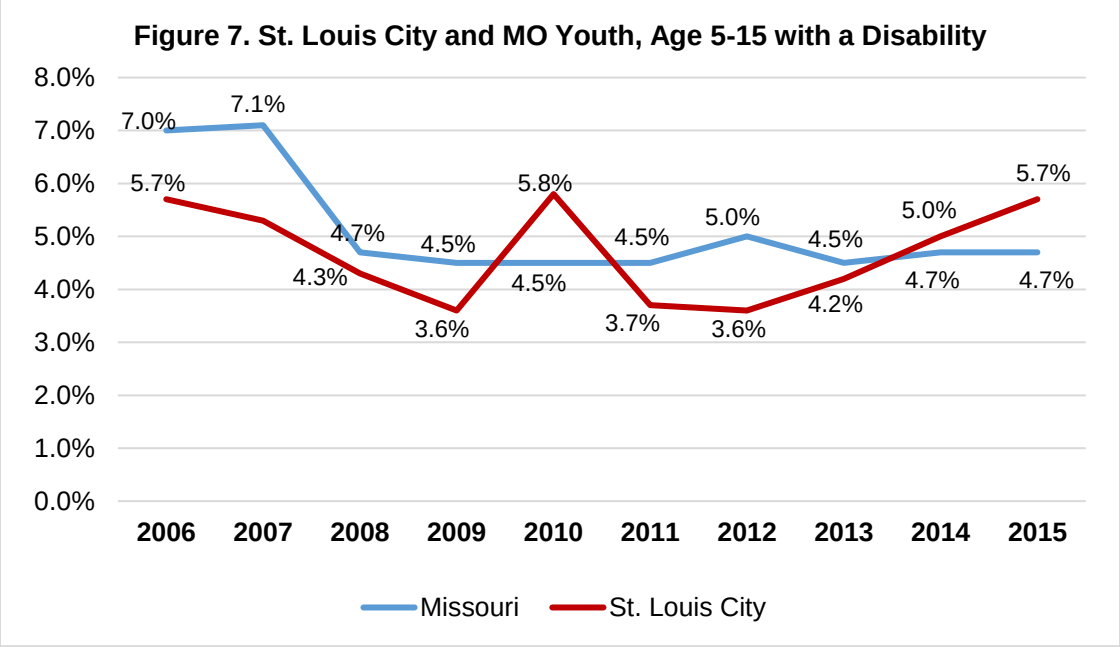


Table 9. Percent of Disabled Individuals by Age - St. Louis City and Missouri - 2006 to 2015

	2006		2007		2008		2009		2010		2011		2012		2013		2014		2015		Diff.	STL vs.
	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO
Persons 5 yrs+																						2015
With a disability	19.4	17.1	19.1	17.1	14.9	13.9	14.2	14.1	14.6	13.8	14.1	13.9	14.9	14.3	15.2	14.4	15.8	14.7	15.8	14.5	-3.6	1.3
Persons 5 to 15	16.7	16.1	16.3	16.0	25.0	24.5	22.8	24.3	21.4	24.0	21.5	23.9	21.6	23.7	20.6	23.5	20.4	23.3	20.3	23.2	3.6	-2.9
With a disability	5.7	7.0	5.3	7.1	4.3	4.7	3.6	4.5	5.8	4.5	3.7	4.5	3.6	5.0	4.2	4.5	5.0	4.7	5.7	4.7	0.0	1.0
Persons 16 to 64	70.7	70.1	71.7	70.1	63.6	62.5	67.1	62.4	67.8	62.3	67.9	62.2	67.3	62.0	68.5	61.8	68.5	61.7	68.3	61.4	-2.4	6.9
With a disability	17.0	14.2	17.3	14.4	13.9	12.2	13.4	12.4	13.5	12.0	12.3	12.2	14.2	12.4	14.6	12.7	14.5	13.1	13.7	12.6	-3.3	1.1
Persons 65 yrs+	12.6	13.8	12.1	13.9	11.4	13.1	10.2	13.3	10.9	13.7	10.6	13.9	11.1	14.3	10.9	14.7	11.1	15.0	11.3	15.3	-1.3	-4.0
With a disability	50.6	43.3	48.7	42.3	43.8	39.5	43.7	39.3	39.2	38.7	46.3	37.8	40.8	37.9	40.2	37.1	43.8	36.7	47.1	37.1	-3.5	10.0

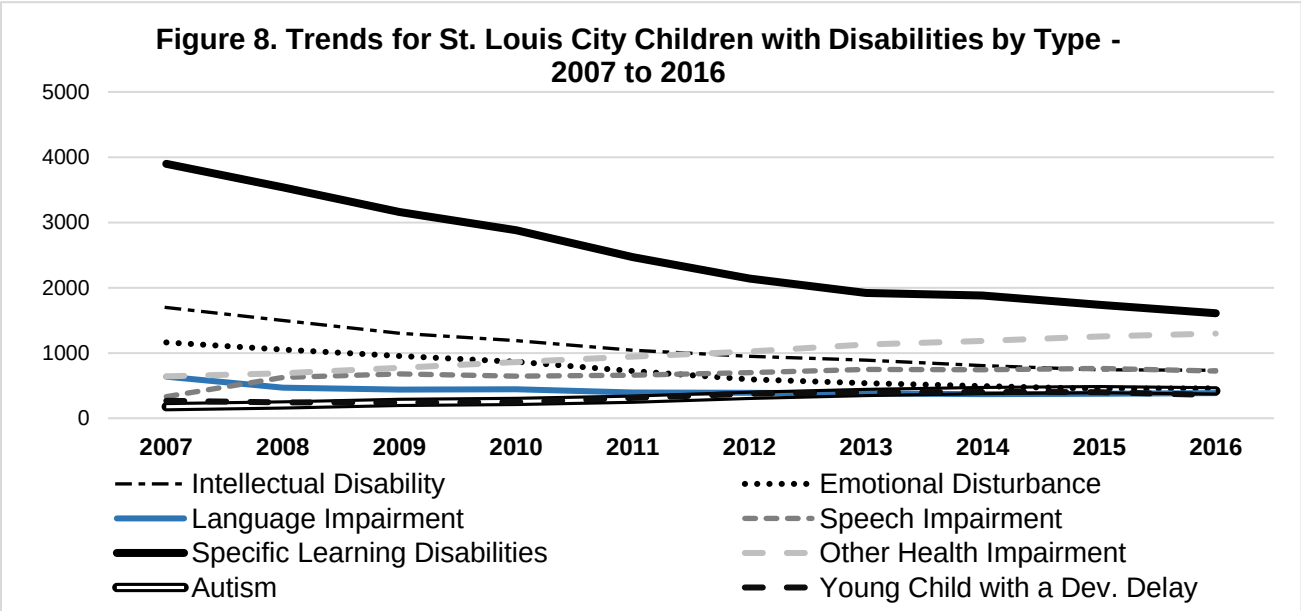
Source: U.S. Census Bureau, American Community Survey 1-Year Estimates

The Missouri Department of Elementary and Secondary Education (DESE), Office of Special Education gathers information on the number of disabilities and by type for students in the public school districts. This information should be viewed to see the changing trends with the types of disabilities that are present, so as to better know and respond to their needs. By viewing Table 10, you can see the number of students who were classified with disabilities decreased by 31.4% from 2007 to 2016. There were 6,222 children with disabilities identified in 2016 across the district reports. Perhaps more children with disabilities were seeking educational services outside of the public school district. Of the twelve disability types, the type that decreased the most was "emotional disturbance", which decreased by 61% to 458 children for 2016. The second highest decrease was with those classified as having "specific learning disabilities", which decreased by 58.7% to 1,609 children. It is believed that some of these children have been classified in other categories, as opposed to this being a true decrease in the percentage of children who have these types of learning disabilities. The next largest decrease of 56.7% was seen with children who have an intellectual disability, followed by children who have a language impairment which decreased by 39.2%.

Increases in certain disability types are very critical for St. Louis City planning as well. It is clear that Autism surged in the public school district, with a 137.9% increase from 2007 to 2016. There were 421 children with the Autism diagnosis in the public schools for 2016, so teachers and other school staff should be well prepared to handle the special needs of these children. The city also experienced a 119% increase in children with a speech impairment, which included 725 youth in 2016. The "other health impairment" type increased by 102.2% (2007 to 2016), but this could have been tied to the re-classification of children who were previously grouped in the "specific learning disabilities" type. Young children with a development delay, which includes children age 3 through pre-kindergarten (typically five year-olds) increased by 33.7% with 357 youth diagnosed in 2016. The remaining disability categories that had percentage increases over time, had small numbers reported, they included hearing impairment, orthotic impairment, deaf, blindness, and Traumatic Brain Injury (TBI).

Figure 8 presents all of the disability types that were prevalent in the school districts, including: "specific learning disabilities", "other health impairment", "intellectual disability", "speech impairment", "emotional disturbance", and "Autism".

Figure 8. Trends for St. Louis City Children with Disabilities by Type - 2007 to 2016



Source: Missouri Department of Elementary and Secondary Education.

Table 10. Number of Children with Disabilities & Type - St. Louis City Public School District Reports - 2007 to 2016

Disability Categories	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Diff.	% Ch.
Intellectual Disability	1697	1498	1303	1188	1040	951	889	807	745	735	-962	-56.7%
Emotional Disturbance	1162	1053	956	864	721	597	537	491	451	457	-705	-60.7%
Language Impairment	637	469	439	443	394	392	380	369	373	387	-250	-39.2%
Speech Impairment	331	625	680	643	658	698	746	741	763	725	394	119.0%
Visual Impairment	0	0	0	0	0	0	0	0	13	16	16	N/A
Hearing Impairment	51	0	0	42	0	42	58	56	50	69	18	35.3%
Specific Learning Disabilities	3898	3537	3162	2881	2469	2139	1922	1882	1740	1609	-2289	-58.7%
Other Health Impairment	642	687	772	861	945	1024	1131	1184	1255	1298	656	102.2%
Multiple Disabilities	115	159	146	119	128	136	108	98	102	97	-18	-15.7%
Autism	177	202	243	259	292	353	397	422	438	421	244	137.9%
Young Child with a Dev. Delay	267	243	239	247	312	373	394	404	400	357	90	33.7%
Orthotic Impair., Deaf, Blindness, & TBI	21	69	62	17	58	17	0	0	47	24	3	14.3%
TOTAL	9071	8638	8084	7661	7094	6806	6630	6521	6414	6222	-2849	-31.4%

Source: Office of Special Education

*County totals represent the number of children reported by the public school districts in each county.

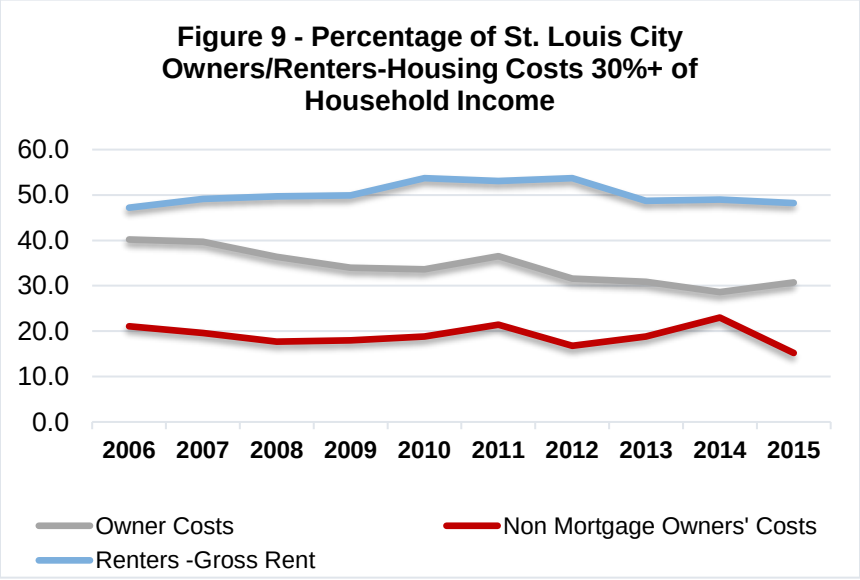
Children served by state operated programs^; Division of Youth Services and Department of Corrections are not reflected in these totals. TBI = Traumatic Brain Injury

Children are reported by their primary disability category only.

HOUSING-RELATED INFORMATION

HOUSEHOLDS AT RISK OF HOMELESSNESS (AREA NEEDS ATTENTION)

Housing information and related trends should be viewed to identify a potential group of residents who are at risk of having minimal funding for their housing and/or other household and family needs, which can lead to an increase in abuse, neglect, and crisis-oriented incidents, especially homelessness. The US Department of Housing and Urban Development (HUD) suggests families that utilize more than 30% of their monthly household income for housing payments are considered cost burdened and may have difficulty affording necessities such as food, clothing, etc.



In 2015, there were an estimated 175,644 housing units in St. Louis City with 141,312 occupied housing units (80.5% occupancy rate); 60,645 (43%) owner occupied and 80,667 (57%) renter occupied. An estimated 54% of householders had moved into these units since 2010. An estimated 67% of the owner-occupied units had a mortgage. Further, an estimated 3% of the households did not have telephone service, and an estimated 22% did not have vehicles available (in comparison to 7% in St. Louis County).

The median monthly housing costs for owners with mortgages, 15% of owners without mortgages, and 48% of renters in St. Louis City spent 30 percent or more of their household (HH) income on housing. As can be seen in Figure 9 and Table 11, there was a positive trend from 2006 to 2015 with the percentage of owners who paid 30% or more of their income on housing decreasing. The percentage of non-mortgage owners who spent this much decreased by 5.9% over time, while owners with a mortgage decreased by 9.5% from 2006 to 2015. Renters were at the greatest risk of homelessness considering the percentage of renters who spent at this level on housing costs increased by 1% over time, and considerably higher than owners' costs with and without a mortgage.

Table 12 presents comparative data with Missouri, which shows that there were 6.3% more renters in St. Louis City (48.2%) than Missouri who had gross rent costs of 30% or more of their HH income (MO rate = 41.9%). In all comparisons, St. Louis City had the higher percentage of individuals who spent 30% or more of their HH income on their monthly housing/rent payment. In 2015 alone, 30.7% of St. Louis City owners spent 30% or more in comparison to only 23.6% of Missouri owners.

Table 11. Percent of St. Louis City Owners/Renters - Housing Costs -30% or more of Household Income

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.
Owner Costs – with Mortgage	40.2	39.7	36.4	34.0	33.6	36.5	31.6	30.9	28.6	30.7	-9.5
Non Mortgage Owners' Costs	21.1	19.6	17.7	18.0	18.8	21.4	16.8	18.8	23.0	15.2	-5.9
Renters -Gross Rent	47.2	49.1	49.7	49.9	53.7	53.1	53.7	48.7	49.0	48.2	1.0

Source: U.S. Census Bureau, American Community Survey 1-Year Estimates

Table 12: Percent of Owners/Renters – Housing Costs 30% or More of Household Income – St. Louis City Compared to Missouri

	2006		2008		2010		2012		2014		2015		Diff.	STL vs.
	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO	STL	MO -2015
Owner-occupied units														
Housing units with a mortgage	66.9	66.8	67.9	67.2	67.0	65.9	67.0	64.1	65.3	62.7	66.7	62.3	-0.2	4.4
Owner Costs 30%+ of HH income	40.2	28.7	36.4	28.4	33.6	30.1	31.6	27.7	28.6	25.2	30.7	23.6	-9.5	7.1
Housing units without a mortgage	33.1	33.2	32.1	32.8	33.0	34.1	33.0	35.9	34.7	37.3	33.3	37.7	0.2	-4.4
Non Mortgage Owner Costs 30%+ of HH Income	21.1	11.8	17.7	11.9	18.8	12.1	16.8	12.2	23.0	13.2	15.2	11.3	-5.9	3.9
Renter-occupied units														
Gross Rent 30%+ of HH Income	47.2	42.3	49.7	41.1	53.7	45.8	53.7	46.4	49.0	43.6	48.2	41.9	1.0	6.3
Gross Rent of $750 or more	26.5	26.8	32.1	33.5	38.5	36.9	41.2	40.8	49.6	47.3	51.0	48.0	24.5	3.0

Source: U.S. Census Bureau, American Community Survey 1-Year Estimates. STL = St. Louis City. STL data highlighted in red if rate is greater than the state rate for that year.

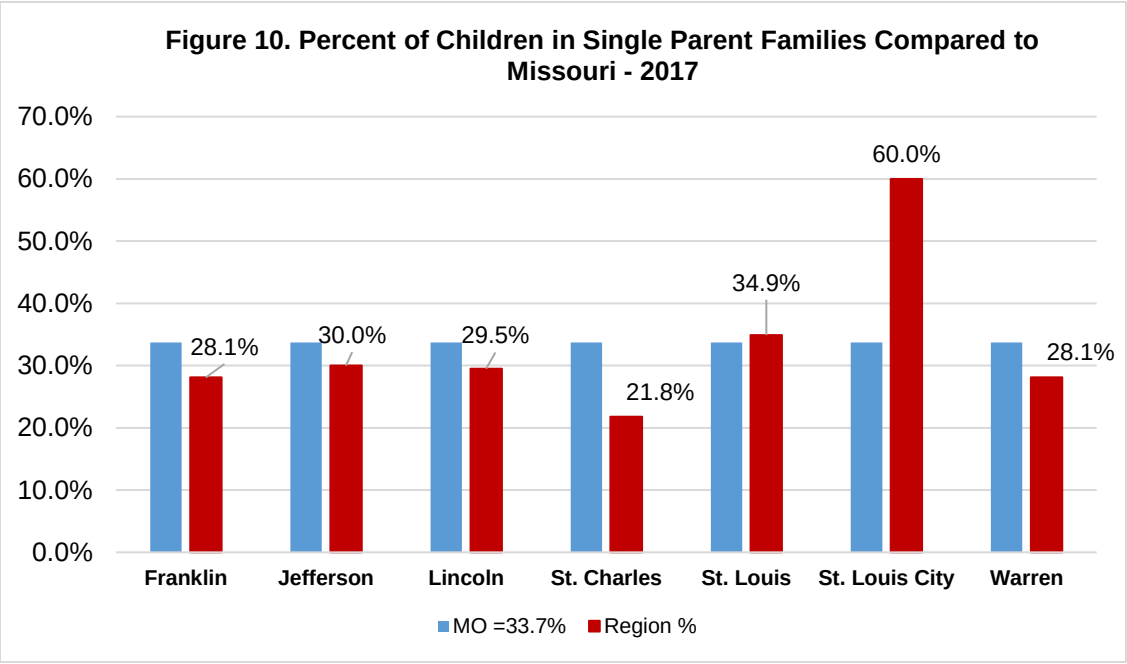
CHILDREN IN SINGLE PARENT HOUSEHOLDS (NEEDS ATTENTION)

Another important area to examine is the rate of children in single-parent households, which can be viewed in Table 13. From 2007 to 2017, St. Louis City was the only community that experienced a decrease in the number of single parent households, which was .6%, where 60% of St. Louis City youth lived in a single parent household. The number of children who live in single parent households decreased by 36% since 2007, and included 38,299 children (see Table 14). As can be seen in Figure 10, the St. Louis City percentage of children in single-parent households is by far the highest for 2017 at 60%, with St. Louis County next highest at 34.9%, in comparison to 33.7% for Missouri.

Table 13. Children in Single Parent Household- Percentage

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Diff.
Missouri	31.2%	32.2%	32.6%	33.3%	33.4%	33.5%	32.8%	33.4%	33.6%	33.4%	33.7%	2.5%
Franklin	21.5%	21.6%	27.4%	29.2%	29.4%	27.0%	26.4%	28.1%	29.0%	27.7%	28.1%	6.6%
Jefferson	25.1%	25.4%	26.7%	28.0%	30.0%	28.5%	26.4%	27.0%	26.9%	28.3%	30.0%	4.9%
Lincoln	26.0%	25.2%	22.6%	26.7%	25.7%	27.5%	25.7%	24.4%	26.4%	28.3%	29.5%	3.5%
St. Charles	18.2%	18.8%	20.4%	20.3%	21.0%	21.0%	19.3%	19.9%	20.7%	21.8%	21.8%	3.6%
St. Louis City	60.6%	60.2%	64.8%	62.5%	60.2%	57.7%	63.3%	62.8%	61.6%	61.3%	60.0%	-0.6%
St. Louis County	31.9%	33.0%	33.6%	35.1%	34.4%	34.9%	34.4%	34.8%	35.3%	34.2%	34.9%	3.0%
Warren	21.0%	23.2%	23.9%	34.2%	33.0%	33.1%	27.3%	28.9%	30.3%	28.6%	28.1%	7.1%

Source: USDC, Bureau of the Census; Missouri Office of Administration, Division of Budget and Planning Definitions: Related children under age 18 who live in families headed by a person without a spouse present in the home.



INCOME (MIXED RESULTS)

Income is another factor that can directly impact a youth's access to services. St. Louis City's median household income was $37,948 in 2015, $35,681 in 2014, and $28,069 in 2004. This represents an improvement of 35% from 2004 to 2015 or $9,879. However, St. Louis City's median household income was approximately $12,000 less than the State of Missouri's median income (see Figure below), and was the lowest by far out of the comparable entities (see Table 15). St. Charles County has the highest household income rate, followed by St. Louis County at $61,569.

Figure 11. Median Household Income - 2004-2015
Missouri, St. Louis City and County

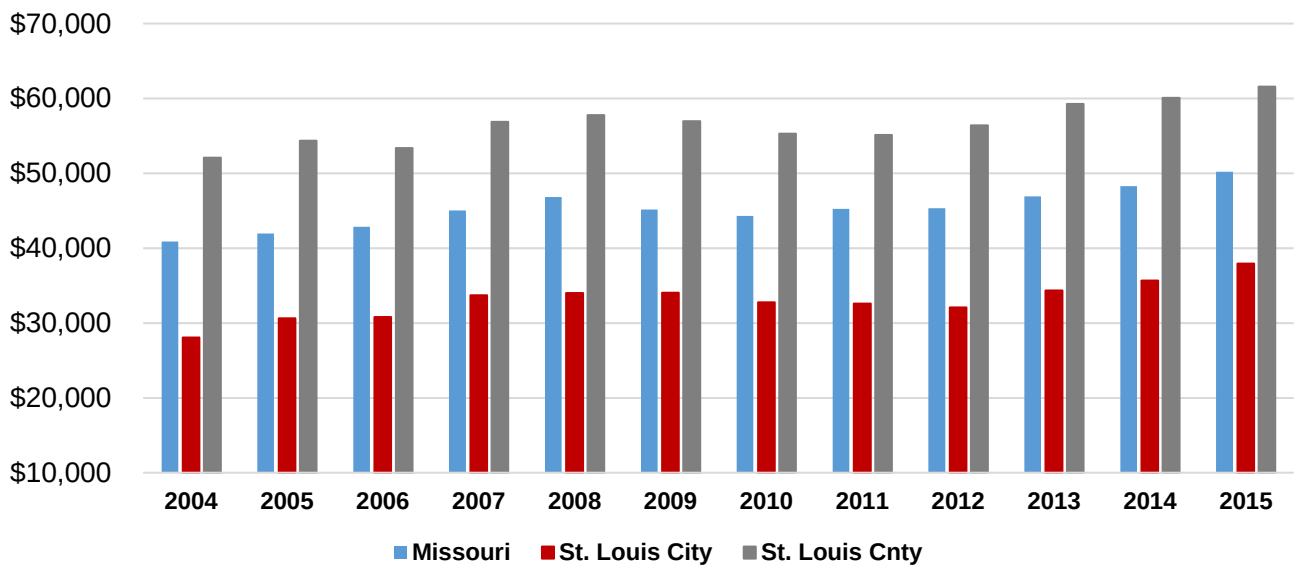


Table 14: Children in Single Parent Households - St. Louis City, County and Missouri - 2007 to 2017

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Diff.	% Ch.
Missouri	444072	461415	464447	472380	472205	471304	461557	467069	468527	463095	465659	21587	5%
St. Louis City	53596	48615	44821	42498	40626	37836	43261	42301	40341	39543	38299	-15297	-36%
St. Louis County	74004	77930	79211	81893	79351	79704	80301	80280	80592	77319	78066	4062	5%

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

Table 15. Median Household Income County Comparisons 2004 to 2015

Regions	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.	% Ch.
U.S.	44,334	46,242	48,451	50,740	52,029	50,221	50,046	50,502	51,371	52,250	53,657	55,775	11,441	26%
Missouri	40,885	41,946	42,838	45,012	46,847	45,149	44,306	45,231	45,320	46,905	48,288	50,200	9,315	23%
Franklin	46,384	46,736	45,788	50,717	49,064	49,034	47,530	47,663	45,061	51,138	51,978	50,438	4,054	9%
Jefferson	51,135	51,077	53,419	56,755	57,897	53,939	52,841	51,008	53,013	55,305	58,976	58,747	7,612	15%
Lincoln	48,182	49,277	50,425	54,938	54,740	50,795	50,307	50,523	53,542	54,144	53,804	54,584	6,402	13%
St. Charles	64,581	63,463	65,059	67,611	72,428	68,669	65,281	67,074	70,456	70,468	74,220	74,009	9,428	15%
St. Louis City	28,069	30,629	30,780	33,698	33,993	34,065	32,767	32,576	32,084	34,346	35,681	37,948	9,879	35%
St. Louis Cnty	52,097	54,342	53,349	56,864	57,782	56,939	55,290	55,131	56,409	59,284	60,093	61,569	9,472	18%
Warren	46,883	45,759	49,714	50,986	45,779	49,201	49,157	50,773	49,068	52,517	52,959	51,933	5,050	11%

Source: US Census Bureau. Definitions: Median income of family households with children under 18. Based on ACS 5-year estimates.

UNEMPLOYMENT (POSITIVE FINDING)

Adult unemployment peaked in 2010 with a 12.8% rate, but as of 2015, was at an all-time low of 6.1% (St. Louis County was at 4.6%). The same unemployment pattern could be seen across all of the comparable entities from 2004 to 2015 (see Figure 12), but St. Louis City's unemployment rate was still the highest in 2015. The city's rate was 1.1% greater than the state of Missouri rate of 5%. The city's unemployment percentage decreased by 2.7% from 8.8% in 2004 to 6.1% in 2015.

For 2015, 71.9% of the population 16 and over were employed; 21.8% were not currently in the labor force.

Figure 12. Adult Unemployment – State/St. Louis City/County Comparison - Trends from 2004 to 2015

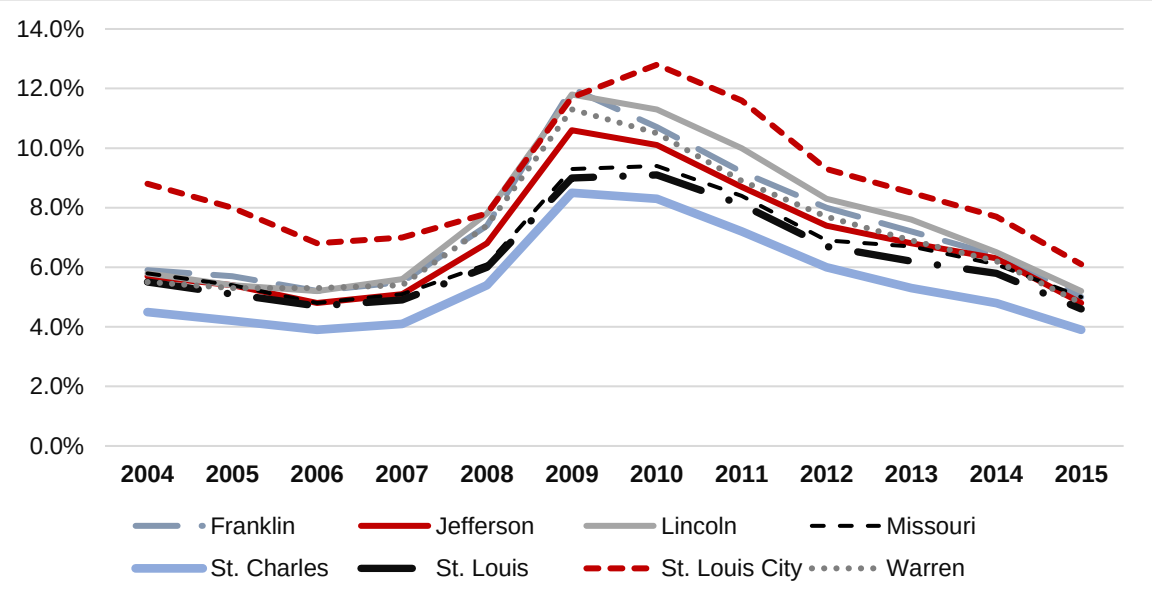


Table 16. Adult Unemployment - 2004 to 2015

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.
Missouri	5.8%	5.4%	4.8%	5.1%	6.1%	9.3%	9.4%	8.4%	6.9%	6.7%	6.1%	5.0%	-0.8%
St. Louis City	8.8%	8.0%	6.8%	7.0%	7.8%	11.7%	12.8%	11.6%	9.3%	8.5%	7.7%	6.1%	-2.7%
St. Louis Cnty	5.5%	5.1%	4.7%	4.9%	6.0%	9.0%	9.1%	8.1%	6.7%	6.2%	5.8%	4.6%	-0.9%

Source: Missouri Department of Economic Development, Division of Employment Security.

Definitions: Percentage of the civilian labor force that is unemployed and actively looking for work.

ST. LOUIS CITY COMMUNITY INDICATORS – A FOCUS ON OUR YOUTH

This section provides information about community indicators for St. Louis City youth, in addition to assessing the city's status in comparison to State of Missouri data and in many cases, St. Louis County as well. The source of the information for each table and figure is provided so that additional data can be gathered as needed. The selection of indicators comes from a review of various sources including the KIDS COUNT Data Book covering the last few years. This data source utilizes rates and percentages to compare and assess changes over time within the selected region, and in some cases, other regions. If available, percentages and numbers of children or events are provided for interpretation and decision-making purposes. Community indicators are grouped into the following categories: Economic Well-Being, Education, Health (Mental and/or Physical), and Safety/Risky Behaviors.

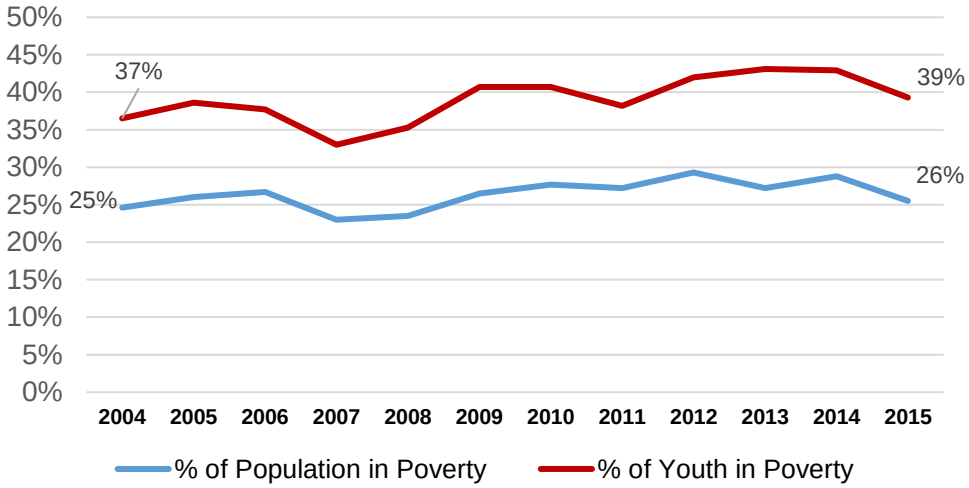
ECONOMIC WELL-BEING

POVERTY (AREA NEEDS CONTINUED ATTENTION)

A picture of need unfolds when the population growth is paired with the increasing poverty* rate for children 0-17 years of age in St. Louis City. The youth population declined by 29% since 2004, with an estimated 63,499 youth noted for 2015. Table 17 provides the estimated number of youth in poverty for separate age ranges as well as all youth under 18 years of age. Figure 13 shows that the percentage of children in poverty was consistently higher across the span of time covering 2004 to 2015. As of 2015, there were 39% of the St. Louis City children (age 0-17) who were in poverty in comparison to 26% of the total population (78,089 in poverty).
Up to 2014, the number of individuals in poverty (88,571) increased by 5% despite an approximate 7% decrease in the population. Then, 2015 data reported 78,089 impoverished individuals, a decrease of 6.1% since 2004 (83,140).

Focusing on youth age 0-17, there had been a 22.4% decrease in the number of those who were in poverty, but this is paired with a 28.6% decrease in this population of youth (see Table 17). The percentage of youth in poverty (0 to 17) in this age range also increased by 2.8% since 2004 (36.5% to 39.3%).

Figure 13. Percent of St. Louis City Individuals in Poverty



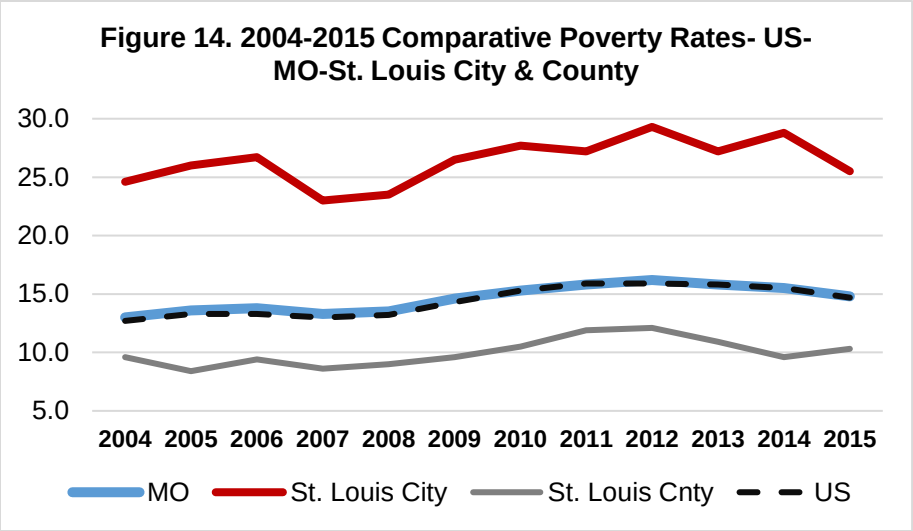
The number of children age 5-17 who were in poverty decreased 19% to an estimated 16,385 children, yet the percentage of children in poverty in this age range increased by 5.3% (2004 to 2015) to 39.8%. *Poverty is outpacing population growth for children age 5-17*. All combined, there were 30,191 St. Louis City youth who were in poverty in 2015. The percentage of youth age 0-4 in poverty decreased by 11.6% since 2004 and is at 38.2% for 2015. The population of youth in this age group was at one of its lowest in this span of time at 21,017.

Table 17: Population and Poverty Data for City of St. Louis, Missouri from 2004 to 2015

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.	% Ch.
# of Individuals in Poverty	83,140	86,361	90,068	78,451	81,148	92,243	85,618	83,819	90,199	83,767	88,571	78,089	-5,051	-6.1%
Pop. Est. Total	343,314	352,588	353,821	350,759	354,361	356,587	319,156	318,069	318,172	318,416	317,419	315,685	-27,629	-8.0%
% of Pop. in Poverty	24.6%	26.0%	26.7%	23.0%	23.5%	26.5%	27.7%	27.2%	29.3%	27.2%	28.8%	25.5%	0.9%	
# Youth in Poverty- Age 0-17	31,445	32,521	33,437	28,427	30,232	31,594	26,898	25,315	27,775	27,318	27,003	24,414	-7,031	-22.4%
Youth Pop. Est. - 0-17	88,884	84,480	83,148	87,955	87,722	79,541	67,569	67,575	67,797	64,855	64,101	63,499	-25,385	-28.6%
% of Youth - Age 0-17 - In Poverty	36.5%	38.6%	37.7%	33.0%	35.3%	40.7%	40.7%	38.2%	42.0%	43.1%	42.9%	39.3%	2.8%	
% of Total Pop - Youth Age 0-17 in Poverty	9.2%	9.2%	9.5%	8.1%	8.5%	8.9%	8.4%	8.0%	8.7%	8.6%	8.5%	7.7%	-1.4%	
# Youth in Poverty - Age 0-4	11,218	9,985	10,639	9,656	9,589	10,389	9,415	8,991	9,376	9,169	8,561	8,029	-3,189	-28.4%
% of Youth- Age 0-4 - In Poverty	49.8%	44.8%	40.3%	37.4%	37.6%	40.9%	45.9%	41.1%	42.6%	43.6%	40.2%	38.2%	-11.6%	
# Youth in Poverty - Age 5-17	20,227	22,536	22,798	18,771	20,643	21,205	17,483	16,324	18,399	18,149	18,442	16,385	-3,842	-19.0%
% of Youth - Age 5-17 - In Poverty	34.5%	38.7%	36.6%	31.2%	34.3%	40.5%	38.6%	36.6%	41.5%	43.0%	44.1%	39.8%	5.3%	

Source: U. S. Census Bureau; American Community Survey and SAIPE. Population data and change over time is presented within this table for comparison

*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 2016 poverty threshold was $24,300 for a family of four; $11,880 for a family of one; and $32,580 for a family of six. Poverty status is defined by family; either everyone in the family is in poverty or no one in the family is in poverty. The characteristics of the family used to determine the poverty threshold are: number of people, number of related children under 18, and whether or not the primary householder is over age 65. Family income is then compared to the poverty threshold; if that family's income is below that threshold, the family is in poverty.



Figures 14, 15, and 16 and Table 18 provide national, state, and county comparison data, which shows that *St. Louis City had the highest rate of youth 0-17 in poverty, 5-17 in poverty, and overall population in poverty.* This also increased over time. The percentage of youth in poverty in the state was, by comparison, 20.4%, and 20.7% for the nation. The St. Louis City rate was almost 19% greater than both the state and national percentage.

Table 18. Numbers and Rates of US, MO and City of St. Louis Individuals living in poverty 2004 to 2015

Year	US	Rate	Missouri	Rate	St. Louis City	Rate
2004	37,039,804	12.7	735,642	13.0	83,140	24.6
2005	38,231,474	13.3	760,759	13.6	86,361	26.0
2006	38,757,253	13.3	783,101	13.8	90,068	26.7
2007	38,052,247	13.0	758,844	13.3	78,451	23.0
2008	39,108,422	13.2	774,937	13.5	81,148	23.5
2009	42,868,163	14.3	850,316	14.6	92,243	26.5
2010	46,215,956	15.3	888,471	15.3	85,618	27.7
2011	48,452,035	15.9	922,103	15.8	83,819	27.2
2012	48,760,123	15.9	945,435	16.2	90,199	29.3
2013	48,810,868	15.8	928,778	15.8	83,767	27.2
2014	48,208,387	15.5	908,394	15.5	88,571	28.8
2015	46,153,077	14.7	875,704	14.8	78,089	25.5
Diff.	9,113,273	2.0	140,062	1.8	-5,051	0.9
% Ch.	24.6%		19.0%		-6.1%	

Source: Small Area Income & Poverty Estimates (SAIPE). Rate is per 100.

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

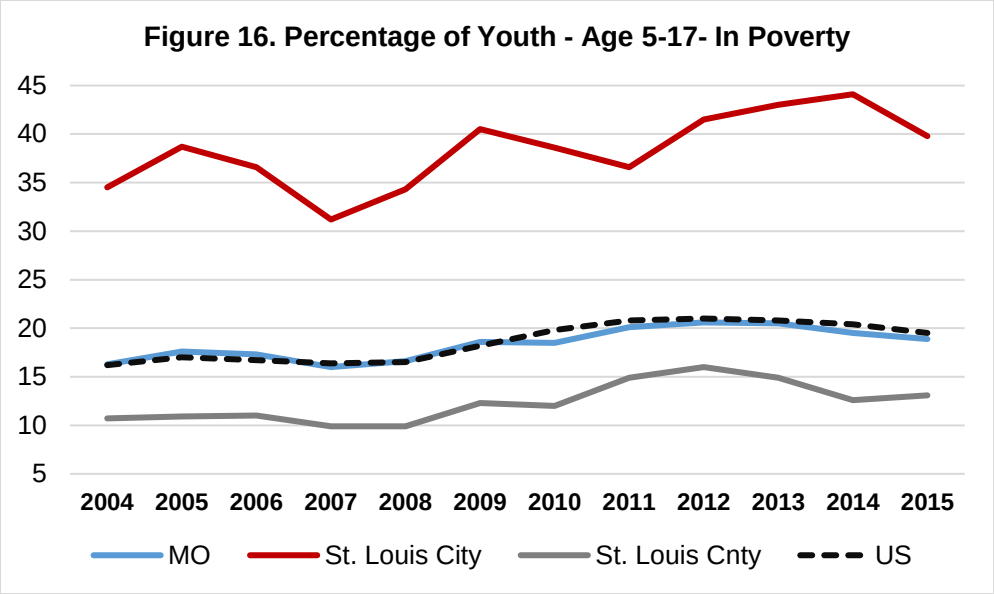


Figure 16. Percentage of Youth - Age 5-17- In Poverty
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2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
MO
St. Louis City
St. Louis Cnty
US

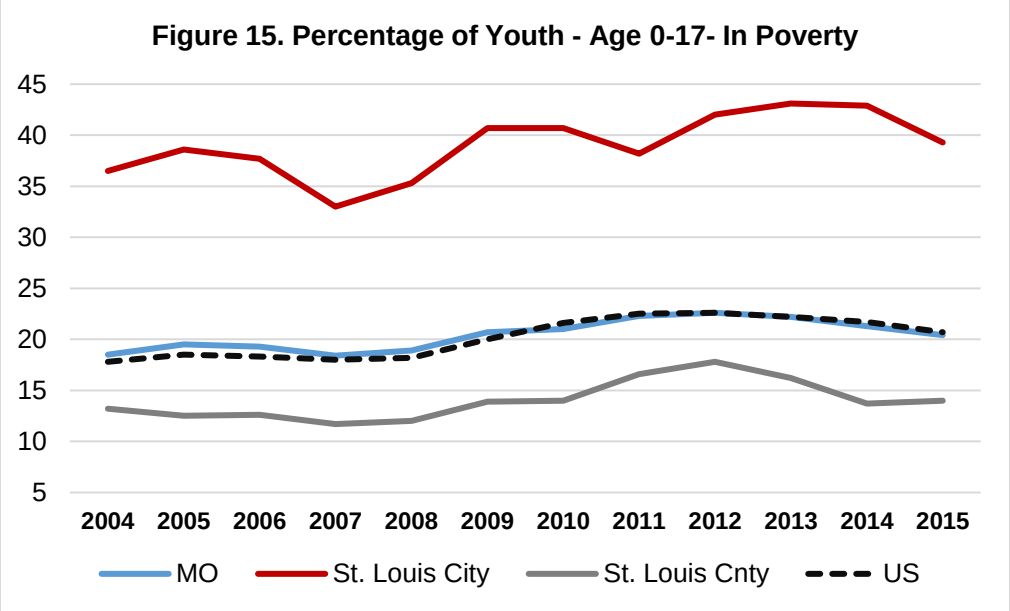
Figure 15. Percentage of Youth - Age 0-17- In Poverty
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St. Louis City
St. Louis Cnty
US

FAMILIES WITH CHILDREN IN FAMILIES RECEIVING SNAP (FOOD STAMPS) (AREA NEEDING ATTENTION) AND CASH ASSISTANCE (MIXED RESULTS)

Another gauge for assessing need is to look at the trends for children in families receiving cash assistance and the Supplemental Nutrition Assistance Program (SNAP, aka. food stamps). As can be seen in Table 19, there were 9,813 less children on SNAP in 2015 than in 2004. However, St. Louis City's rate increased for children in families receiving SNAP by 2.9% from 2004 to 2015, in comparison to Missouri's rate increase of 4% (Table 20). In addition, Missouri had 34% of children on SNAP in comparison to 72% of the children that were living in the City of St. Louis. For this reason, the indicator is marked as an area that needs attention. It is important for St. Louis City stakeholders to address the 45,476 youth in need.

Table 19. Number of Children in Families Receiving SNAP -2004 to 2015

	2004	2008	2012	2015	Diff.	% Ch.
St. Louis City	55,289	51,844	52,049	45,476	-9,813	-17.7%
St. Louis County	50,077	57,811	69,828	63,746	13,669	27.3%

Table 20. Children in Families Receiving SNAP -2004 to 2015

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.
MO	30.1%	30.8%	30.6%	30.9%	32.5%	35.6%	37.5%	37.8%	39.0%	36.9%	34.7%	34.2%	4.1%
St. Louis City	68.8%	70.9%	71.4%	71.6%	73.1%	77.1%	78.8%	77.0%	79.2%	75.8%	72.7%	71.7%	2.9%
St. Louis County	20.3%	21.3%	21.9%	22.9%	24.3%	26.8%	28.8%	29.9%	30.6%	29.6%	28.3%	28.6%	8.3%

Source: MO Dept. of Social Services; US Census Bureau; MO Office of Administration, Division of Budget and Planning.
Definitions: Number of children in households receiving benefits under the Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps.

Cash assistance is defined as the average monthly percentage of the population under 18 who live in households receiving public cash assistance from specific sources. From 2004 to 2015, there was an 8.7% decrease in the number of children receiving cash assistance, which as of 2015 included 6,455 city youth (see Table 22). The rate of children receiving cash assistance was 10.2% for St. Louis City, 2.7% for St. Louis County, and 3.4% for the State of Missouri (see Figure 17). This indicator has improved over time in St. Louis City. The number of children receiving cash assistance decreased by 38-39% in St. Louis County and State, and by 57% in the City (2004 to 2015).

Figure 17. Children Receiving Cash Assistance - 2004 to 2015

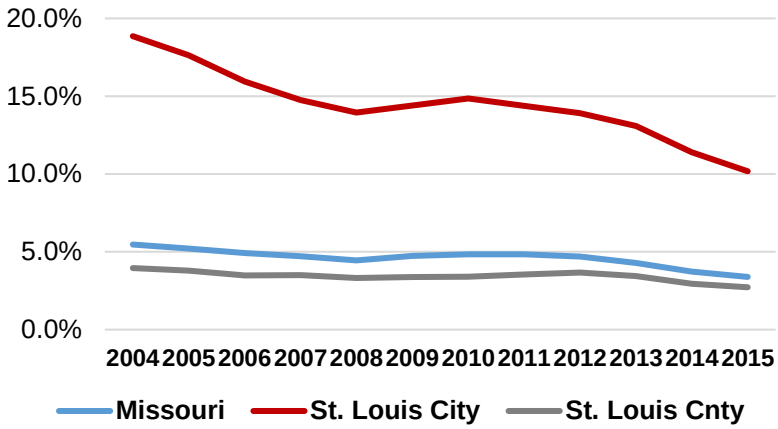


Table 21. Percentage of Children in Families Receiving Cash Assistance

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.
Missouri	5.5%	5.2%	4.9%	4.7%	4.5%	4.7%	4.8%	4.8%	4.7%	4.3%	3.7%	3.4%	-2.1%
Franklin	2.1%	2.0%	1.9%	1.9%	1.9%	2.5%	2.7%	2.8%	3.0%	3.0%	2.6%	2.7%	0.6%
Jefferson	2.6%	2.3%	2.2%	2.1%	1.9%	2.3%	2.4%	2.6%	2.7%	2.6%	2.2%	2.0%	-0.6%
Lincoln	2.7%	2.3%	2.5%	3.1%	3.1%	3.4%	3.8%	4.1%	4.2%	4.1%	3.5%	3.0%	0.3%
St. Charles	1.5%	1.5%	1.4%	1.4%	1.3%	1.3%	1.3%	1.4%	1.3%	1.1%	1.0%	0.9%	-0.6%
St. Louis City	18.9 %	17.6 %	15.9 %	14.8 %	14.0 %	14.4 %	14.9 %	14.4 %	13.9 %	13.1 %	11.4 %	10.2 %	-8.7%
St. Louis Couty	4.0%	3.8%	3.5%	3.5%	3.3%	3.4%	3.4%	3.5%	3.7%	3.4%	2.9%	2.7%	-1.2%
Warren	2.8%	2.5%	3.5%	3.7%	3.7%	4.6%	5.0%	5.6%	5.5%	5.1%	4.1%	3.5%	0.8%

Source: MO Dept. of Social Services; US Census Bureau; MO Office of Administration, Division of Budget and Planning.
Definitions: # of children in households receiving public assistance under Temporary Assistance for Needy Families (TANF).

Table 22. Number of Children in Families Receiving Cash Assistance

	Missouri	St. Louis City	St. Louis County
2004	77,691	15,156	9,756
2005	74,194	13,652	9,260
2006	70,410	11,931	8,483
2007	67,390	10,720	8,423
2008	63,621	9,903	7,865
2009	67,453	9,914	7,956
2010	68,783	9,990	7,955
2011	68,593	9,516	8,166
2012	65,857	9,140	8,370
2013	59,806	8,460	7,752
2014	51,856	7,350	6,595
2015	47,116	6,455	6,067
Diff.	**-30,575**	**-8,701**	**-3,689**
% Ch.	**-39%**	**-57%**	**-38%**

PERCENT OF STUDENTS ENROLLED IN THE FREE AND REDUCED LUNCH PROGRAM (AREA NEEDING ATTENTION)

The rate of students enrolled in the Free/Reduced-Price Lunch program increased by 10% over time from 2004 to 2016, with 94.6% of students, or 31,184 on this program in St. Louis City (2016). However, the number of students enrolled in this program decreased by 9% or 3,089 students since 2004. This is most likely associated with diminishing school enrollment. *For 2016, the St. Louis City rate was 43% greater than the Missouri rate of 52% of students (see Figure 18 and Table 23).* St. Louis County had 44% of 2016 students enrolled in this program. A similar increasing trend was found for all of these regions where we they experienced an average 10% increase from 2004 to 2016.

Figure 18. Percentage of Students Enrolled in Free/Reduced Price Lunch

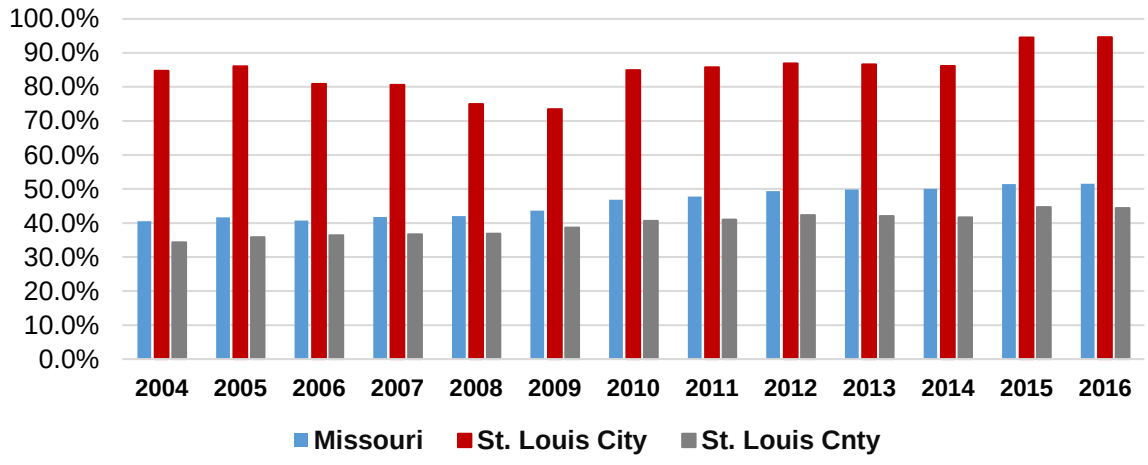


Table 23. Percentage of Students Enrolled in Free/Reduced Price Lunch

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Diff.
MO	40.5%	41.7%	40.7%	41.7%	42.0%	43.6%	46.8%	47.7%	49.4%	49.8%	50.0%	51.5%	51.5%	11%
St. Louis City	84.7%	86.1%	80.9%	80.6%	75.0%	73.4%	85.0%	85.8%	86.9%	86.6%	86.2%	94.5%	94.6%	10%
St. Louis County	34.3%	35.8%	36.4%	36.7%	36.9%	38.7%	40.6%	41.0%	42.3%	42.0%	41.7%	44.7%	44.4%	10%

Source: Missouri Department of Elementary and Secondary Education. Definitions: Number of students who are enrolled in the free or reduced price National School Lunch Program. Children from households with incomes less than 130 percent of poverty are eligible for free lunches; those from households below 185 percent of poverty are eligible for reduced price lunches.

Table 24. Number of Students Enrolled in Free/Reduced Price Lunch

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Diff.	% Ch.
MO	353807	363678	365838	364980	366243	377292	407133	414354	427246	431759	433804	446727	446780	92973	26%
St. Louis City	34273	33694	31136	28539	25606	25362	28710	28758	29180	28661	28852	31716	31184	-3089	-9%
St. Louis County	49992	51585	52478	52436	52785	53272	56279	56118	57436	57090	56632	60538	60058	10066	20%

EDUCATION

The total school enrollment in St. Louis City for 2015 was 76,026. Table 25 shows the enrollment numbers by nursery school, kindergarten, elementary, high school, and college enrollment. There has been a decrease in the number and percent of students enrolled in elementary and high school grades, with increases in number and percentage of college or graduate school students. In comparison to state enrollment percentages for 2015, St. Louis City had a greater percentage of nursery school and preschool students, and college students, but had a lower percentage of kindergarten, elementary and high school students. Beyond enrollment data, other education data points and information regarding a student's homeless status that are typically reported by school districts were missing or incomplete for various years for St. Louis City (see Homeless data Table 48). Therefore, the researchers gathered the data that was available for the largest school district within St. Louis City, which is known as St. Louis City school district. Table 28 is an example of education data that was available and reported by the Missouri Department of Elementary and Secondary Education (DESE).

Table 25: Population Three years and over Enrolled in School – 2006 to 2015

	MO - 2016	2006- St. Louis City		2015- St. Louis City		2006- St. Louis County		2015- St. Louis County	
	Pct	Number	Pct	Number	Pct	Number	Pct	Number	Pct
Population 3 years+		332,331		303,842		963,752		967,168	
Population 3 years and over enrolled in school	25.8	94,573	28.5	76,026	25.0	273,659	28.4	256,849	26.6
In nursery school, preschool	5.9	6,889	7.3	6,509	8.6	17,713	6.5	18,140	7.1
In kindergarten	5.3	3,170	3.4	2,804	3.7	12,226	4.5	11,871	4.6
In elementary school, grades 1-8	40.7	39,878	42.2	25,889	34.1	107,346	39.2	102,262	39.8
In high school, grades 9-12	21.0	21,161	22.4	12,801	16.8	62,298	22.8	54,934	21.4
In college or graduate school	27.0	23,475	24.8	28,023	36.9	74,076	27.1	69,642	27.1

Source: American Community Survey - Social Profiles; one year estimates

GRADUATION RATES (POSITIVE FINDING)

Graduation rates are an important indicator to look at as well, and Table 26 shows that while there had been an increase of 8% in the St. Louis City high school graduation rate, as of 2016 it's at 70%, which is the lowest rate in

comparison to the other counties and the state. However, this rate for 2016 was the highest it's been covering 2004 to 2016, so this item has been marked a positive finding.

Table 26. High School Graduation Rates - 2004 to 2016

Regions	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Diff.
Missouri	86%	86%	86%	86%	86%	86%	86%	87%	88%	88%	89%	90%	92%	6%
Franklin	84%	86%	87%	87%	87%	87%	86%	87%	87%	91%	91%	92%	91%	8%
Jefferson	87%	87%	88%	89%	90%	89%	90%	90%	89%	92%	92%	94%	94%	8%
Lincoln	87%	87%	84%	87%	85%	84%	87%	90%	91%	91%	95%	94%	92%	6%
St. Charles	89%	88%	89%	89%	90%	90%	92%	91%	92%	94%	94%	94%	95%	6%
St. Louis City	62%	60%	55%	55%	54%	59%	63%	66%	67%	53%	56%	58%	70%	8%
St. Louis County	89%	90%	90%	89%	90%	91%	89%	90%	91%	90%	91%	91%	93%	3%
Warren	85%	86%	86%	86%	84%	89%	88%	87%	91%	93%	96%	97%	95%	9%

Source: MO Dept. Elementary and Secondary Education. Definitions: Number of students' grades 9 through 12 enrolled in public schools that graduated within four years. The formula used to calculate the rate accounts for transfers in and out of a district (adjusted 4-year cohort graduation rate). Years indicated are school years; for example, 2015 indicates the 2014-2015 school year.

Table 27. High School Graduation Numbers- 2004 to 2016

	Missouri	St. Louis City	St. Louis County
2004	58,040	1,640	10,022
2005	57,843	1,617	9,866
2006	58,474	1,622	9,976
2007	60,201	1,489	10,328
2008	61,942	1,784	10,550
2009	62,788	1,843	10,834
2010	64,058	1,994	10,894
2011	63,033	2,064	10,823
2012	61,609	2,137	10,646
2013	61,589	1,895	10,519
2014	61,259	1,769	10,314
2015	60,604	1,727	10,061
2016	61,403	1,802	10,064
Diff.	3,363	162	42
% Ch.	5.8%	9.9%	0.4%

The number of high school students increased by almost 10% to 1,802 graduates in 2016 (see Table 27). The largest district in the city known as St. Louis City (referred to in this report as St. Louis City school) was one of the only schools that provided consistent data to DESE. This school's graduation rates from 2011 to 2016 are provided in Table 28. The 2016 overall graduation rate had increased by 16.7% since 2011 to 71.5% of high school seniors. The Hispanic graduation rate had the lowest rate among all racial/ethnic categories presented at 63.2%. The White graduation rate was the next lowest at 70%. Both of these groups had a 10-12% increase in their graduation rates since 2011. The Black graduation rate increased 17.9% from 2011 to 2016, and had the second highest graduation rate among the racial groups presented at 71.7%. The Asian graduation rate was the highest at 77.9%, but this had not changed over time. Lastly, the female graduation rate (75.6%); was 8% more than the male graduation rate of 67.3%. In all comparisons, St. Louis City graduation rates were well below the Missouri graduation rates (see STL vs. MO column in Table 28).

Table 28. District 4 Year Graduation Rate - St. Louis City School - 2011 to 2016

ST. LOUIS CITY	2011	2012	2013	2014	2015	2016	Diff.	% Ch.	MO 2016	STL vs. MO
Total Number of Graduates	2,122	1,509	1,581	1,434	1,448	1,399	-723	-34%		
Number of Students	3,877	2,391	2,309	1,989	1,992	1,958	-1,919	-49%		
Graduation Rate (%)	54.7	63.1	68.5	72.1	72.7	71.5	16.7	31%	89.0	-17.6
Total Number of Asian Graduates	39	52	58	60	61	60	21	54%		
Number of Asian Students	50	66	75	77	72	77	27	54%		
Asian Graduation Rate (%)	78.0	78.8	77.3	77.9	84.7	77.9	-0.1	0%	93.1	-15.2
Total Number of Black Graduates	1,807	1,238	1,291	1,178	1,180	1,134	-673	-37%		
Number of Black Students	3,357	1,995	1,908	1,635	1,625	1,582	-1,775	-53%		
Black Graduation Rate (%)	53.8	62.1	67.7	72.1	72.6	71.7	17.9	33%	79.0	-7.3

ST. LOUIS CITY	2011	2012	2013	2014	2015	2016	Diff.	% Ch.	MO 2016	STL vs. MO
Total # of Hispanic Graduates	43	31	36	52	34	43	0	0%		
Number of Hispanic Students	84	58	64	69	46	68	-16	-19%		
Hispanic Graduation Rate (%)	51.2	53.5	56.3	75.4	73.9	63.2	12.1	24%	83.1	-19.9
Total Number of White Graduates	231	183	195	141	172	159	-72	-31%		
Number of White Students	384	266	260	205	245	227	-157	-41%		
White Graduation Rate (%)	60.2	68.8	75.0	68.8	70.2	70.0	9.9	16%	91.6	-21.6
Total Number of Male Graduates	995	687	721	648	635	657	-338	-34%		
Number of Male Students	2,060	1,191	1,138	961	945	977	-1,083	-53%		
Male Graduation Rate (%)	48.3	57.7	63.4	67.4	67.2	67.3	19.0	39%	86.9	-19.6
Total # of Female Graduates	1,127	822	860	786	813	742	-385	-34%		
Number of Female Students	1,817	1,200	1,171	1,028	1,047	981	-836	-46%		
Female Graduation Rate (%)	62.0	68.5	73.4	76.5	77.7	75.6	13.6	22%	91.3	-15.7

Source: MO Dept. Elementary and Secondary Education.

ANNUAL HIGH SCHOOL DROPOUTS (MIXED RESULTS)

St. Louis City experienced a 17% decline in the number of students who dropped out of high school from 2004 to 2015, from 1,075 to 892, but the rate increased by 1.8% of students (Table 28) to 11.7%. By comparison, St. Louis City's drop-out rate was 9.6% higher than the state rate of 2.1% and 9.9% higher than St. Louis County's rate of 1.8% (see Figure 19, Tables 29 and 30). However, this rate decreased since its peak of 17% in 2011, so this indicator is marked as one that had mixed results.

Figure 19. Annual High School Dropout-Rate-Comparison

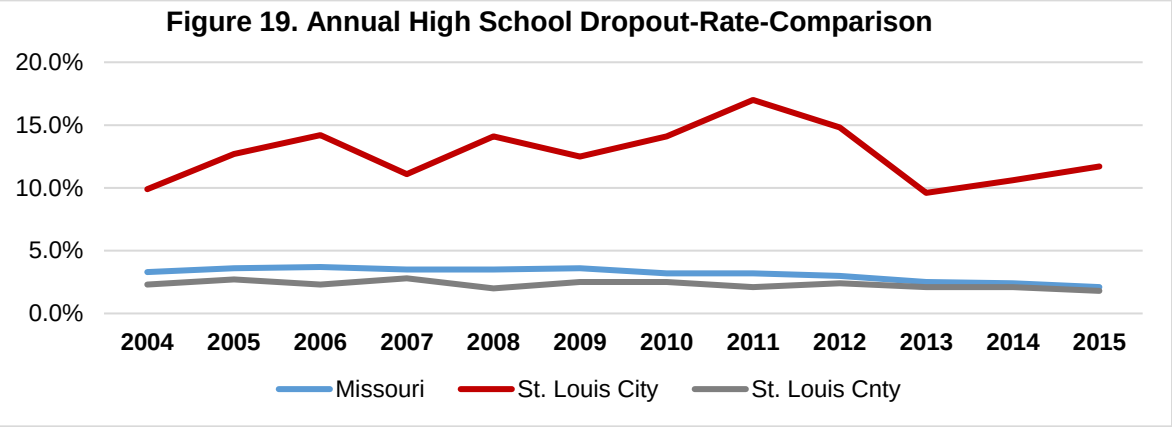


Table 29. Annual High School Dropout Percentage

	Missouri	St. Louis City	St. Louis County
2004	3.3%	9.9%	2.3%
2005	3.6%	12.7%	2.7%
2006	3.7%	14.2%	2.3%
2007	3.5%	11.1%	2.8%
2008	3.5%	14.1%	2.0%
2009	3.6%	12.5%	2.5%
2010	3.2%	14.1%	2.5%
2011	3.2%	17.0%	2.1%
2012	3.0%	14.8%	2.4%
2013	2.5%	9.6%	2.1%
2014	2.4%	10.6%	2.1%
2015	2.1%	11.7%	1.8%
Diff.	-1.2%	1.8%	-0.5%

Source: Missouri Department of Elementary and Secondary Education. Definitions: Percentage of students (grades 9 through 12) enrolled in public schools that left school during the school year without graduating.

Table 30. High School Dropout Numbers

	Missouri	St. Louis City	St. Louis County
2004	8,917	1,075	1,054
2005	9,692	1,368	1,262
2006	10,338	1,532	1,111
2007	10,003	1,156	1,353
2008	9,852	1,385	1,004
2009	10,213	1,301	1,229
2010	8,866	1,371	1,217
2011	8,771	1,590	1,016
2012	7,906	1,351	1,103
2013	6,561	803	941
2014	6,493	855	956
2015	5,458	892	781
Diff.	-3,459	-183	-273
% Change	-38.8%	-17.0%	-25.9%

An analysis of St. Louis City's largest school district is shown in Table 31. The total dropout rate was 15.7% in 2016, an increase of 4.1% since 2007. The state rate was 2.2% for 2016. The number of dropouts decreased by 195 to 961 in 2016, but this was most likely linked to the decreasing enrollment figures. Below are some of the findings when comparing racial dropout rates. The Asian dropout rate was at its all-time high of 11.1% in 2016, and had experienced an increase of 2.1% since 2007. This rate is almost 10 times the state rate of 1.2%. The white dropout rate was also at its all-time high of 14.9% in 2016. It had increased 4.2% since 2007 and was almost ten times the state rate of 1.5%. The black dropout rate was at its highest rate in four years at 16.2%, but had experienced an improvement since its peak year in 2011 at 22%. Since 2007, the rate increased by 4.2%, and was almost three times higher than the state rate of 5.5%. There were similar trends found with Hispanics where 14% dropped out in 2016. This had increased by 5.8% since 2007, but was less than its peak of 17% in 2011.

Table 31. District Annual Dropout Rate - St. Louis City Public School District

ST. LOUIS CITY	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Diff.	MO 2016	STL vs. MO
Asian Dropout Rate 9-12 (%)	8.0	7.2	6.1	7.3	9.1	4.3	3.7	5.7	6.6	11.1	3.1	1.2	9.9
Black Dropout Rate 9-12 (%)	11.9	14.1	13.9	17.5	22.0	17.0	9.4	12.5	13.1	16.2	4.3	5.5	10.7
Hispanic Dropout Rate 9-12 (%)	8.2	21.6	10.7	10.3	17.0	14.1	8.3	10.4	9.3	14.0	5.8	2.9	11.1
White Dropout Rate 9-12 (%)	10.7	12.1	10.8	10.6	9.4	9.6	9.4	12.5	12.4	14.9	4.2	1.5	13.4
Total Dropout Rate 9-12 (%)	11.6	13.9	13.3	16.3	19.8	15.5	9.2	12.2	12.6	15.7	4.1	2.2	13.5
Total Dropouts 9-12	1156	1197	1145	1299	1404	1101	653	814	787	961	-195	5818	4857

DISCIPLINARY INCIDENTS (MIXED RESULTS) AND OUT-OF-SCHOOL SUSPENSIONS WITHIN THE ST. LOUIS CITY SCHOOL DISTRICT (MIXED RESULTS)

Disciplinary Incidents across St. Louis City are important to assess for consideration of prevention and direct support programs that may be necessary for the student population of St. Louis City. (Disciplinary incidents are defined by MO DESE as an incident that results in the removal of the student by 10 or more days, and can include an incident involving a weapon, drugs, alcohol, tobacco, and/or violence as the major categories. Incident rate is expressed per 100 students). However, since there is a lack of consistency in the schools that report data to DESE, the Consultant pulled data from the St. Louis City School District, the one district where data was available across time, and had been regularly provided.

As can be seen in the Table 32, this St. Louis City school experienced a very minor increase of .2 in the disciplinary incident rate from 2007 (2.8) to 2016 (3.0). However, if you focus on the data reported in 2009 where the rate was 6.6, there was a significant improvement over time, with stability experienced for a four year span from 2013 to 2016. The number of disciplinary incidents decreased by 23% to 682 incidents in 2016, but enrollment had decreased by 30%. This St. Louis City school's rate of 3.0 was more than double the Missouri rate of 1.3 in 2016. The types of offenses within this school district can be viewed in Table 33. "Other" offenses made up the majority of the 2016 total offenses at 432 (rate of 1.9). These types of offenses can include habitual tardiness or being disrespectful to a school staff member, and other non-violent related offenses. It's important to note that the "other" offenses improved over time, especially in comparison to the 2009 rate of 5.0 out of 100 students with 1,305 offenses. This category of offenses remained relatively low and stabilized starting in 2012, which may be tied to an implemented intervention or other programming. Violent acts was the second highest offense out of the 2016 total at 145 incidents or a rate of .6. Both weapons' offenses and drugs' offenses tied for third highest offense, at 57 incidents in 2016 or a rate of .3.

Table 32. Disciplinary Incident Information (rate) - 2007 to 2016 out of 100 students – St. Louis City School and Missouri

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Diff.	% Ch.
Missouri												
Enrolled	900,781	895,826	894,283	892,391	889,653	886,116	888,174	887,358	886,477	885,138	-15,643	-2%
# Incidents	16,705	17,636	17,362	16,525	17,276	15,314	13,166	12,182	12,120	11,402	-5,303	-32%
Incidents Rate	1.9	2.0	1.9	1.9	1.9	1.7	1.5	1.4	1.4	1.3	-0.6	-32%
St. Louis City												
Enrolled	32,135	27,574	26,108	25,046	23,576	22,516	25,200	24,869	24,154	22,506	-9,629	-30%
# Incidents	886	1,745	1,714	1,319	1,060	914	679	656	772	682	-204	-23%
Incidents Rate	2.8	6.3	6.6	5.3	4.5	4.1	2.7	2.6	3.2	3.0	0.2	7%

Source: DESE District Report Card

Table 33. Enrollment, Disciplinary Incidents, and Types of Offenses for the St. Louis Public Schools City School District

ST. LOUIS CITY	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Enrollment	32,135	27,574	26,108	25,046	23,576	22,516	25,200	24,869	24,154	22,506
Total Number of Incidents	886	1,745	1,714	1,319	1,060	914	679	656	772	682
Incident Rate (per 100)	2.8	6.3	6.6	5.3	4.5	4.1	2.7	2.6	3.2	3.0
Type of Offense										
Alcohol (number | rate)	0 | 0.0	0 | 0.0	0 | 0.0	1 | 0.0	4 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0
Drug (number | rate)	0 | 0.0	125 | 0.5	114 | 0.4	130 | 0.5	138 | 0.6	155 | 0.7	102 | 0.4	97 | 0.4	111 | 0.5	57 | 0.3
Tobacco (number | rate)	0 | 0.0	0 | 0.0	2 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	4 | 0.0	0 | 0.0
Violent Act (number | rate)	0 | 0.0	290 | 1.1	224 | 0.9	286 | 1.1	193 | 0.8	207 | 0.9	147 | 0.6	121 | 0.5	223 | 0.9	145 | 0.6
Weapon (number | rate)	0 | 0.0	105 | 0.4	69 | 0.3	111 | 0.4	72 | 0.3	69 | 0.3	51 | 0.2	49 | 0.2	45 | 0.2	57 | 0.3
Other (number | rate)	886 | 2.8	1225 | 4.4	1305 | 5.0	791 | 3.2	653 | 2.8	483 | 2.1	379 | 1.5	389 | 1.6	389 | 1.6	423 | 1.9
Type of Removal										
In-School Suspension (number | rate)	12 | 0.0	25 | 0.1	40 | 0.2	146 | 0.6	121 | 0.5	11 | 0.0	17 | 0.1	35 | 0.1	41 | 0.2	60 | 0.3
Out of School Suspension (# | rate)	867 | 2.7	1720 | 6.2	1674 | 6.4	1173 | 4.7	939 | 4.0	903 | 4.0	662 | 2.6	621 | 2.5	731 | 3.0	622 | 2.8
Expulsion (number | rate)	7 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0	0 | 0.0
Length of Removal										
10 Consecutive Days (number | rate)	886 | 2.8	1737 | 6.3	1688 | 6.5	1294 | 5.2	1053 | 4.5	911 | 4.0	674 | 2.7	654 | 2.6	762 | 3.2	676 | 3.0
More than 10 Consecutive Days (number | rate)	0 | 0.0	8 | 0.0	26 | 0.1	25 | 0.1	7 | 0.0	3 | 0.0	5 | 0.0	2 | 0.0	10 | 0.0	6 | 0.0

Out-of-school suspensions are related to the BH status of the school population, with information for the largest public school district in St. Louis City presented below. This school district had a slight increase in the out-of-school suspension rate per 100 students covering 2007 to 2016 (2.7 to 2.8), in comparison to the state's rate that improved from 1.7 to 1.1 in the same period of time. For 2016, the school's rate was 2.5 times greater than the state's rate as well. However, this rate had improved since its peak in 2009 (6.4 per 100 students), the year the variance between these two regions was its greatest (see Figure 20).

Table 34. Out-of-School Suspension (number) - St. Louis City School - 2007 to 2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Diff.	% Ch.
Missouri	15,036	15,716	15,708	15,052	15,529	13,771	11,703	10,783	10,650	9,953	-5,083	-34%
St. Louis City	867	1,720	1,674	1,173	939	903	662	621	731	622	-245	-28%

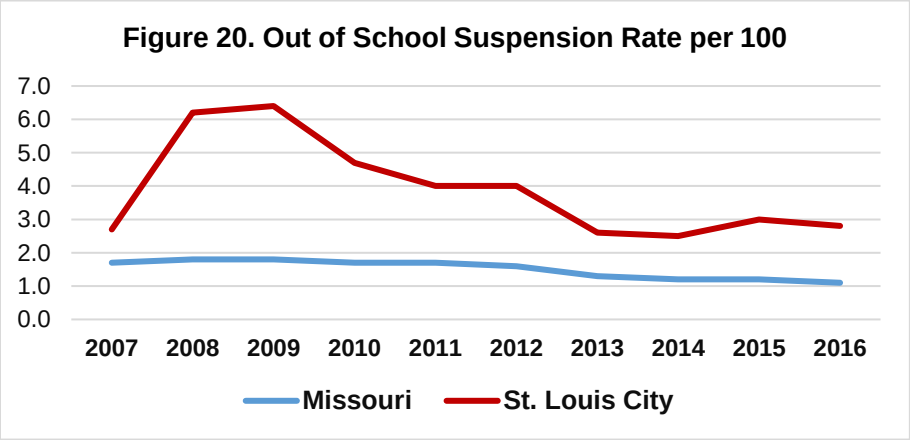


Table 35. Out of School Suspension (rate) - 2007 to 2016 per 100 students

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Diff.
Missouri	1.7	1.8	1.8	1.7	1.7	1.6	1.3	1.2	1.2	1.1	-0.6
St. Louis City	2.7	6.2	6.4	4.7	4.0	4.0	2.6	2.5	3.0	2.8	0.1

Source: DESE District Report Card

JUVENILE LAW VIOLATION REFERRALS (POSITIVE FINDING)

Juvenile law violation referrals represent an area reporting some very promising trends in St. Louis City and the County. Figure 21 provides the trends for St. Louis City in comparison to Missouri from 2004 to 2015. Although the St. Louis City referral rate per 1,000 youth, age 10-17, was in most of the annual comparisons higher than the Missouri rate, since 2006, the difference between these rates has decreased. In 2006, juvenile law violation referrals peaked in St. Louis City to a rate of 115.6 out of every 1,000 youth in this age range. The rate had been consistently dropping to its lowest rate of 43 for 2015. As of 2015, the disparity between St. Louis City and Missouri was the smallest it had been covering this twelve-year span of time.

Figure 21. Juvenile Law Violation Referrals for Youth-Ages 10-17 (per 1,000)

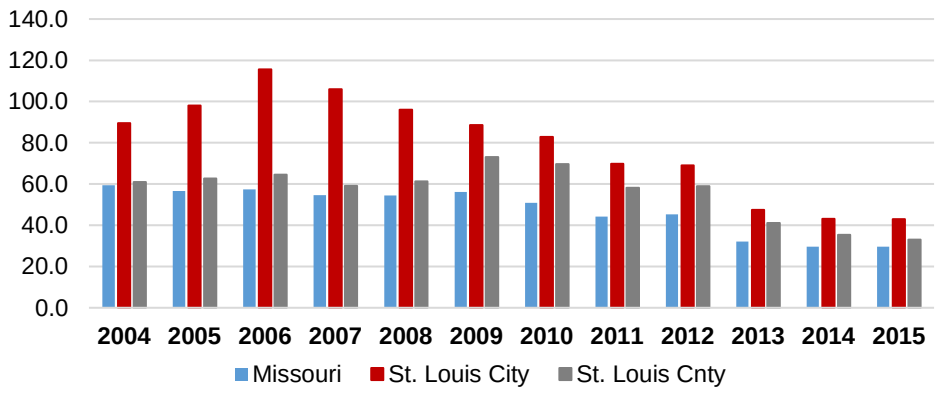


Table 36: Juvenile Law Violation Referrals for Youth -Missouri & Regional Comparison, Ages 10-17 (per 1,000 youth this age)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.
Missouri	59.5	56.7	57.4	54.6	54.5	56.2	50.8	44.3	45.3	32.2	29.7	29.6	-29.9
Franklin	58.8	40.4	43.6	46.6	48.8	42.0	32.6	29.7	35.5	23.8	36.6	29.2	-29.7
Jefferson	53.7	51.2	48.5	50.5	53.4	45.3	47.3	46.2	53.1	42.4	34.6	29.7	-24.1
Lincoln	66.6	63.3	51.0	48.8	38.1	44.1	44.0	31.6	33.3	25.1	30.1	32.3	-34.3
St. Charles	48.2	31.0	47.2	45.8	44.5	49.3	46.3	43.2	41.4	26.4	20.4	23.0	-25.2
St. Louis City	89.5	98.0	115.6	105.9	96.0	88.6	82.9	69.8	69.1	47.5	43.2	43.0	-46.5
St. Louis	61.0	62.7	64.5	59.1	61.3	73.1	69.6	58.2	59.0	41.1	35.3	33.0	-28.0
Warren	49.0	64.0	61.1	55.7	49.7	44.8	31.1	42.4	36.4	12.0	15.8	25.5	-23.5

Source: Missouri Department of Social Services; Missouri Office of Administration. Definitions: Number of referrals to juvenile courts in Missouri for acts that would be violations of the Missouri Criminal Code if committed by an adult. The count represents separately disposed court referrals, not individual youth. Rate is expressed per 1,000 youths ages 10 through 17.

The types of Juvenile Law Violation Referrals are divided into multiple categories, as seen in Table 37, to identify trends and types of juvenile offenses found in the City from 2004 to 2014. All three of the law violation offenses decreased in this period of time; violent offenses decreased by 59% (999 to 413 in 2014), drug offenses by 59% (to 191 to 79 in 2014), and alcohol offenses by 43% (7 to 4 in 2014). *Violent offenses made up the majority of law violation offenses, which should be an area within juvenile offenses that receives attention.*

All four categories within status offenses decreased by a range of 17% to 65%. *While truancy decreased by 17% since 2004, it still had 234 offenses, the most out of any status offenses, for 2014.* "Beyond parental control" and "runaway/absent from home" offenses decreased by the largest percentage in this period of time, but represented the next two highest offenses for 2014. There were only six offenses noted as injurious behavior for 2014.

Within the alcohol, neglect and custody types of referrals, neglect is the only offense that increased; 5% in number of offenses over time. *Neglect represented the highest number of offenses out of all known offenses, at 596 for 2014, and is an area that needs focused attention.*

In addition, Table 37 shows some of the trend information about the underlying reasons for the out-of-home placement of the child in 2014. Cases involving parental drug-use made up 21% of the placement cases, with alcohol by itself and/or combined with drug use, which made up less than 10% of the out-of-home placement cases. Parental cases that involved drug use decreased by 40% from 98 in 2004 to 59 in 2014. Seventy-two percent of out-of-home placements were for other general reasons, which decreased by 35% since 2004.

Table 37: Juvenile Offenses for St. Louis City, Missouri from 2004 to 2014

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Diff.	% Ch.
Law Violation Offenses													
Violent Offenses	999	1,118	1,214	1,042	797	756	698	583	546	398	413	-586	-59%
Alcohol Offenses	7	6	14	6	3	7	8	4	6	-	4	-3	-43%
Drug Offenses	191	205	222	205	154	121	134	83	102	89	79	-112	-59%
Status Offenses													
Truancy	282	310	360	299	241	191	278	216	169	198	234	-48	-17%
Beyond Parental Control	139	189	100	66	40	46	50	83	78	63	53	-86	-62%
Runaway/Absent from Home	101	88	87	94	66	60	84	51	42	46	35	-66	-65%
Injurious Behavior	8	10	4	2	9	-	2	6	10	5	6	-2	-25%
Abuse/Neglect/Custody Offenses													
Abuse	108	98	81	88	78	54	68	63	50	33	43	-65	-60%
Neglect	567	611	474	387	429	390	372	517	436	610	596	29	5%
Custody Disputes	123	90	48	100	33	28	71	94	53	72	66	-57	-46%
Juvenile Court Placements													
Parental Alcohol Use Related	9	9	1	7	10	3	8	2	3	5	19	10	111%
Parental Drug Use Related	98	141	99	88	99	56	60	49	76	68	59	-39	-40%
Parental Alcohol and Drug Related	15	28	7	11	4	1	1	-	3	1	1	-14	-93%
Child Removed for Other Reasons	312	320	274	282	255	200	166	162	132	217	204	-108	-35%

Source: City of St. Louis Juvenile Court Offices

CHILD ABUSE & NEGLECT (POSITIVE FINDINGS; CONTINUE ATTENTION)

The Missouri Department of Social Services (MODSS) gathers information on the rate of child abuse and neglect victims on an annual basis. Both the number and rate of incidents and children are captured, with cases defined as substantiated or unsubstantiated (with or with preventive services or psi), other, and/or if child/case required a family assessment. The information in Table 39 provides the percentage and number of incidents from 2005 to 2015 in St. Louis City, and those changes over time. Table 38 presents this information for reported children, in addition to providing the substantiated and reported rate per 1,000 children who populate the county.

For 2015, St. Louis City had 4,198 reported incidents (12.8% increase from 2005) of child abuse and neglect, with 6,250 reported children (6% increase from 2005); both with similar increasing trends found over time. However, the number of substantiated incidents and number of children involved decreased substantially since 2005. There were 229 substantiated cases in 2015, relating to 293 children, a reduction of 52% in substantiated incidents and 56% in substantiated children since 2005. Substantiated incidents made up 5% of the total reported incidents for St. Louis City in 2015; they made up 13% of incidents in 2005. The number of unsubstantiated incidents (both with and without "preventive serviced indicated" (PSI)) and children increased by 40% or more from 2005 to 2015. Family assessments for incidents increased by 17% and made up the majority of the reported incidents for 2015. All combined, we had approximately 3,700-4,500 children in 2015 who needed trauma-based BH-related services for potential abuse and neglect. This lends support for the mandated reporting training, school staff, and parent training increases that have been trending over the last few years. It also lends support for showing that as more cases are reported, more substantiated cases have increased, or just been discovered.

Table 38: Number of Children Involved in Child Abuse/Neglect Substantiated Incidents for City of St. Louis, Missouri - 2005 to 2015

Type	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	% Ch.
Substantiated	673	433	433	377	297	273	247	220	202	249	293	-56%
Unsub. - PSI	231	250	400	420	311	355	400	303	253	391	325	41%
Unsub.	1,105	1,260	1,776	1,655	1,852	1,903	2,203	1,922	1,714	1,938	1,719	56%
FA	2,878	2,247	2,310	2,280	2,114	2,000	2,278	2,079	2,193	2,766	3,098	8%
Other	1,028	1,120	546	400	257	442	443	949	1,161	646	815	-21%
Total	5,915	5,310	5,465	5,132	4,831	4,973	5,571	5,473	5,523	5,990	6,250	6%

Source: Missouri Department of Social Services Annual Reports from 2005 to 2015. Notes: Unsub-PSI = Unsubstantiated- Preventive Services Indicated; Unsub = Unsubstantiated; FA =Family Assessment and Services Needed. Definitions: Rate of child abuse victims from reports classified as "probable cause" indicating that child abuse/neglect has occurred, and from children receiving family assessments. Rate is per 1,000 children.

Table 39. Information on Reported Incidents of Child Abuse and Neglect for City of St. Louis, Missouri - 2005 to 2015

Type		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	% Ch.
Substantiated	#	472	335	330	241	221	209	195	173	159	198	229	-51.5%
	%	13%	10%	10%	7%	7%	6%	5%	5%	4%	5%	5%	-7.2%
Unsub.-(PSI)	#	144	159	253	240	209	246	259	206	175	257	219	52.1%
	%	4%	5%	7%	7%	7%	7%	7%	6%	5%	7%	5%	1.3%
Unsub.	#	686	755	1,080	1,072	1,255	1,232	1,377	1,264	1,111	1,243	1,114	62.4%
	%	18%	22%	32%	33%	40%	37%	38%	35%	31%	32%	27%	8.1%
FA	#	1,786	1,429	1,427	1,466	1,304	1,328	1,466	1,326	1,409	1,817	2,090	17.0%
	%	48%	43%	42%	45%	41%	40%	41%	37%	39%	46%	50%	1.8%
Other	#	632	682	331	237	160	298	300	611	777	402	546	-13.6%
	%	17%	20%	10%	7%	5%	9%	8%	17%	21%	10%	13%	-4.0%
Total		3,720	3,360	3,421	3,256	3,149	3,313	3,597	3,580	3,631	3,917	4,198	12.8%

Source: Missouri Department of Social Services Annual Reports from 2005 to 2015;

The Missouri Department of Social Services (DSS) categorizes the type of child abuse and neglect incidents to assess and identify changing trends over time. By reviewing Table 41, you can see that St. Louis City had 229 substantiated incidents in 2015. Here is a breakdown of the types of incidents that were documented. Neglect made up the majority of cases in 2015 for St. Louis City (45%) and County (51%). In both regions, physical abuse made up 29% of the total number of substantiated cases in the city and county. Sexual abuse was the third highest abuse experienced in both regions making up 26% of the cases in St. Louis City, and 23% in St. Louis County. The remaining types including emotional maltreatment, medical, and educational neglect made up 6% or less of the total number of substantiated incidents for 2015. However, there had been significant decreases, ranging from 41-80% in both the number of incidents and children across all six types of abuse and neglect from 2005 to 2015.

Table 40. Type as Percentage of Total Number of Children Involved in Child Abuse/Neglect for St. Louis City and County - Comparing 2005 to 2015

	St. Louis City		St. Louis County	
	% of Total	% of Total	% of Total	% of Total
Type	2005	2015	2005	2015
Physical	35%	29%	33%	29%
Neglect	38%	45%	41%	51%
Emotional Maltreatment	5%	6%	5%	5%
Medical	4%	4%	3%	3%
Educational Neglect	3%	1%	2%	1%
Sexual	20%	26%	23%	23%
Total	673	293	1719	819

Table 41. Types of Reported Incidents of Child Abuse/Neglect for City of St. Louis, MO- 2005 to 2015

Type	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	% Ch.
Physical	208	183	160	105	107	81	92	82	66	83	77	-59%
Neglect	157	89	96	88	74	81	63	56	67	79	90	-43%
Emotional Maltreatment	29	14	6	7	8	5	3	13	12	15	11	-66%
Medical	24	9	9	15	6	8	4	7	12	11	11	-54%
Educational Neglect	15	1	-	4	3	6	1	2	1	2	2	-76%
Sexual	132	45	61	64	57	57	46	38	42	66	68	-57%
Total	472	335	330	241	221	209	195	173	159	198	229	-53%

Source: Missouri Department of Social Services Annual Reports from 2005 to 2015

Table 42. Types of Reported Children of Child Abuse/Neglect for City of St. Louis, MO – 2005-2015

Type	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	% Ch.
Physical	571	578	520	371	305	247	249	262	236	218	241	-58%
Neglect	706	461	657	560	347	375	354	318	347	393	415	-41%
Emotional Maltreatment	93	50	77	52	25	18	14	26	26	43	37	-60%
Medical	59	17	48	34	19	20	16	21	27	30	27	-54%
Educational Neglect	30	1	31	14	8	15	3	15	16	16	6	-80%
Sexual	394	269	343	303	191	169	159	140	163	163	185	-53%
Total	1719	1395	1423	1343	803	745	733	679	672	723	819	-52%

OUT-OF-HOME PLACEMENTS (POSITIVE FINDING)

This category is defined as the number of entries into the Division of Family Services alternative care, including foster care, group homes, relative care, and residential settings. In Table 43, the number of entries for Missouri increased by 6%, while St. Louis City decreased by 43% from 2004 to 2015. In 2015, there were 329 out-of-home placement entries for St. Louis City. Since this statistic doesn't account for the change in the population, it is important to look at the entries per 1,000 children, which were 5.2 for St. Louis City in comparison to 5.1 for Missouri. The city entry rate decreased from 7.2 to 5.2 out of 1,000 children from 2004 to 2015, while the Missouri rate worsened over time and was at 5.1 in 2015.

Table 43. Out-Of-Home Placement Entries - County Compared to Missouri - 2004 to 2015

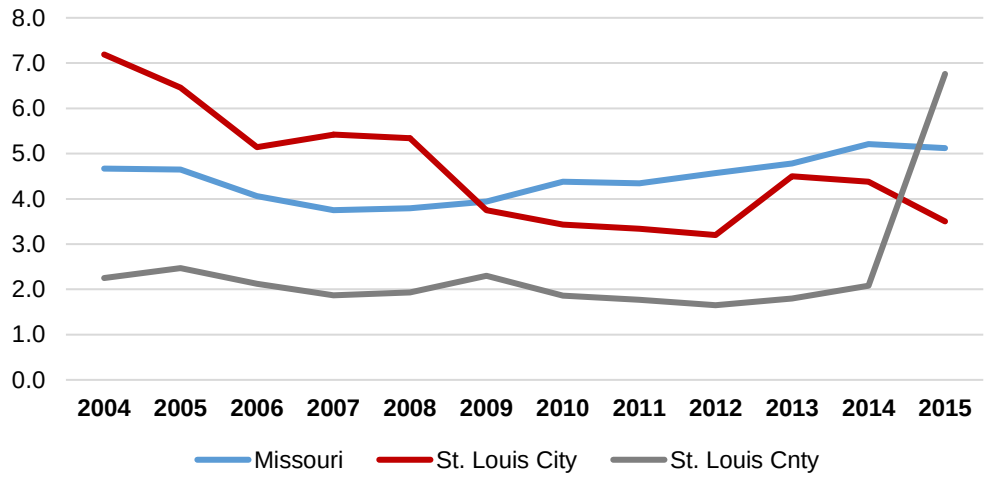
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.	% Ch.
Missouri	6641	6613	5797	5362	5418	5620	6236	6137	6422	6688	7259	7058	417	6%
St. Louis City	578	500	385	394	379	258	231	221	210	291	282	329	-249	-43%
St. Louis County	555	605	516	449	459	542	435	408	377	405	467	531	-24	-4%

Table 44. Out of Home Placement Entries - Rate per 1,000 Children - 2004 to 2015

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.
Missouri	4.7	4.7	4.1	3.8	3.8	3.9	4.4	4.3	4.6	4.8	5.2	5.1	0.4
Franklin	4.4	4.8	3.9	2.2	2.7	3.0	4.1	4.4	5.5	5.1	4.7	5.1	0.7
Jefferson	6.0	5.5	5.1	4.1	5.2	5.6	5.7	5.2	7.0	6.6	6.9	6.8	0.8
Lincoln	4.4	6.5	3.2	4.2	2.4	4.7	2.7	4.0	4.8	3.0	2.1	3.5	-0.9
St. Charles	1.2	1.3	1.3	1.2	1.4	1.1	1.1	1.8	1.8	1.6	1.5	1.6	0.4
St. Louis City	7.2	6.5	5.1	5.4	5.3	3.8	3.4	3.3	3.2	4.5	4.4	5.2	-2.0
St. Louis County	2.3	2.5	2.1	1.9	1.9	2.3	1.9	1.8	1.7	1.8	2.1	2.4	0.1
Warren	9.9	6.8	6.1	6.6	4.8	3.3	3.7	5.4	4.4	4.4	5.7	4.8	-5.1

Source: MO Dept. of Social Services; US Census Bureau; MO Office of Administration, Division of Budget and Planning.
Definitions: Number of entries or reentries into Division of Family Services alternative care, including foster care, group homes, relative care, and residential settings. Rate is expressed per 1,000 children.

Figure 22. Out-of-Home Placement Rate per 1,000 children - 2004 to 2015 - Comparisons



HOMELESSNESS – (NEEDS ATTENTION)

Homeless Youth data is collected by the public school districts (Missouri Department of Elementary and Secondary Education) with the information presented in Tables 45 and 46. The percentage of reported homeless youth in St. Louis City increased by 12.5% from its 2010 rate of 5.3%. For 2016, 17.9% of children in schools were noted as homeless, or 5,952 homeless youth. The number of homeless youth in St. Louis City was more than St. Louis County, which had higher school enrollment numbers. Figure 22 shows how much higher the St. Louis City rate has increased over time in comparison to the Missouri and St. Louis County rates (shown in Table 45). However, a large majority of the school districts within St. Louis City have not provided this information consistently over time. Focusing on the largest school district, St. Louis City school, there was a 215% increase in the number of reported students who were homeless since the 2009-2010 homeless count (Table 48). For the 2015-2016 school year, they reported 5,451 homeless students. This report does not document the landscape of school services available to homeless students, including federal requirements about the type of care homeless students should be able to access through their school district.

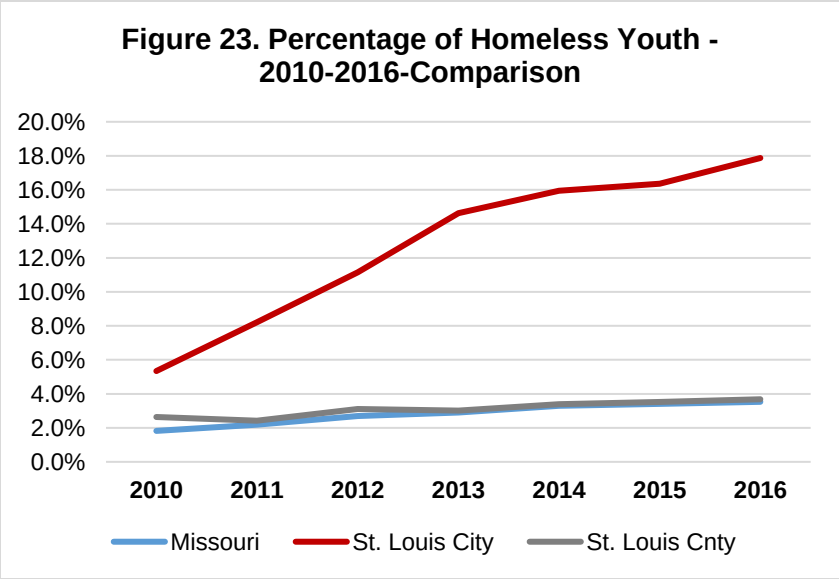


Table 45. Percentage of Homeless Youth - 2010 to 2016

	2010	2011	2012	2013	2014	2015	2016	Diff.
Missouri	1.8%	2.2%	2.7%	2.9%	3.3%	3.4%	3.5%	1.7%
St. Louis City	5.3%	8.2%	11.1%	14.6%	16.0%	16.4%	17.9%	12.5%
St. Louis Cnty	2.6%	2.4%	3.1%	3.0%	3.4%	3.5%	3.7%	1.1%

Source: MO Dept. of Elementary and Secondary Education. Definitions: Number of children counted as homeless by school districts based on the McKinney-Vento Act.

Table 46. Number of Homeless Youth - 2010 to 2016

	2010	2011	2012	2013	2014	2015	2016	Diff.	% Ch.
Missouri	16162	19370	23889	25749	29127	30049	31213	15051	93%
St. Louis City	1850	2782	3785	4929	5441	5548	5952	4102	222%
St. Louis Cnty	3796	3475	4403	4264	4728	4902	5094	1298	34%

Table 47 breaks down the numbers of school children designated as homeless by the Department of Elementary and Secondary Education (DESE) in 2014 by district and shelter type. It is apparent that there is a significant population of homeless school children, and that the City of St. Louis School District has the largest population by far. With respect to the disposition of these children, the highest numbers – over 4,000 – are ”doubled-up”. This high number is congruent with the large percentage of households with children that reported staying with family and friends prior to entering emergency shelter (reported in a later section). Together these indicators illustrate the degree to which many families are challenged to find stable housing in the City of St. Louis. Although doubled-up situations are tracked in terms of where the night prior to entering shelter or other housing is spent, this is not considered among criteria for designating a child or adult as home- less, according to HUD’s definition of homelessness. This is not true for school districts. The City of St. Louis School District also has a large number of unsheltered children, the second largest population in Missouri. The DESE data provides another perspective on homeless families and the implications for children who lack stable housing. It also shows what a wide divergence there is from the HUD regulations. This is an area that needs to be addressed considering the instability of the “doubled-up” living situation.

Table 47. Homeless Enrolled School Children, by Category, City of St. Louis COC – 2013-2014

St. Louis City CoC School Districts	Doubled-Up	Hotel Motel	Shelters	Unsheltered
City of St. Louis	4178	169	640	47
Confluence Academies	228	-	23	-
St. Louis Lang Immersion School	47	-	-	-
Premier Charter School	37	-	-	-
JAMAA Learning Center	19	-	6	-
Lift for Life Academy	17	-	-	-
Eagle College Prep Endeavor	16	-	-	-
Construction Careers Center	15	-	-	-
Carondelet Leadership Academy	15	-	-	-
Grand Center Arts Academy	9	-	-	-
Preclarus Mastery Academy	8	-	-	-

Source: Department of Elementary and Secondary Education (DESE) *Numbers in this table are only included for districts that reported more than five homeless enrolled students in each category.

Table 48. Homeless Student Counts for Local School Districts - 2009-10 to 2015-16

School District	09-10 H. Count	10-11 H. Count	11-12 H. Count	12-13 H. Count	13-14 H. Count	14-15 H. Count	15-16 H. Count	Diff	% Change
ST. LOUIS CITY	1732	2637	3551	4582	5034	5182	5451	3719	214.7%
LIFT FOR LIFE ACADEMY	0	0	0	19	18	29	14	14	N/A
PREMIER CHARTER SCHOOL	64	42	37	39	41	39	35	-29	-45.3%
CONFLUENCE ACADEMIES	54	103	158	209	256	250	281	227	420.4%
CITY GARDEN MONTESSORI	0	0	0	0	0	0	0	0	N/A
ST LOUIS LANG IMMERSION SCHOOL	0	0	0	18	54	0	28	28	N/A
NORTH SIDE COMMUNITY SCHOOL	0	0	0	25	0	0	0	0	N/A
KIPP ST LOUIS PUBLIC SCHOOLS	0	0	17	13	0	0	40	40	N/A
CARONDELET LEADERSHIP ACADEMY	0	0	22	24	17	24	30	30	N/A
GATEWAY SCIENCE ACAD/ST LOUIS	0	0	0	0	0	0	0	0	N/A
GRAND CENTER ARTS ACADEMY	0	0	0	0	0	0	14	14	N/A
PRECLARUS MASTERY ACADEMY	0	0	0	0	0	0	0	0	N/A
ST. LOUIS COLLEGE PREP	0	0	0	0	0	24	36	36	N/A
JAMAA LEARNING CENTER	0	0	0	0	0	0	0	0	N/A
BETTER LEARNING COMM ACADEMY	0	0	0	0	0	0	0	0	N/A
EAGLE COLLEGE PREP ENDEAVOR	0	0	0	0	21	0	23	23	N/A
LAFAYETTE PREPARATORY ACADEMY	0	0	0	0	0	0	0	0	N/A
HAWTHORN LEADERSHIP SCHL	0	0	0	0	0	0	0	0	N/A
THE BIOME	0	0	0	0	0	0	0	0	N/A
LA SALLE CHARTER SCHOOL	0	0	0	0	0	0	0	0	N/A
TESSERA HALL ACADEMY	0	0	0	0	0	0	0	0	N/A

Source: Missouri Department of Elementary and Secondary Education

Additional homeless findings about the City of St. Louis were recently included in the Missouri Statewide Homelessness Study Report 2015 (March, 2016) by the Public Policy Research Center at the University of Missouri – St. Louis. Narratives were pulled directly from that report to include for consideration with this needs assessment research.

Greater St. Louis encompasses three Continua of Care (CoCs), one of which is the City of St. Louis CoC. The CoC's catchment area is among the most highly urbanized segments of the St. Louis, MO-IL metropolitan statistical area (MSA). Since the City of St. Louis and St. Louis County are very much interconnected, the two counties joined in a collaborative effort to address homelessness, the outlines of which are found in the 2005 Ten-Year Plan to End Chronic Homelessness.[16] Comparatively, the City of St. Louis Continuum of Care (St. Louis CoC) has a much larger homeless population than does St. Louis County. The City is home to a variety of services and modes of transportation, which likely serves as a strong attraction for many homeless individuals and families. Additionally, services to some particular populations are only available in the City, such as Peter and Paul Community Shelter, one operated specifically for men. Although the majority of its participating agencies are city-based, the services provided often span both the City and County areas. The latest revision to the ten-year plan, "Moving Forward," describes the CoC's ongoing strategies for reducing chronic homelessness.[17]

Key Findings:

- **HOMELESS POPULATION**: The total homeless population has not fluctuated much since 2009. However, the population has been decreasing since hitting its peak in 2012. The total tally for 2015 represents an eight percent decrease since 2013.
- **CHRONICALLY HOMELESS:** A reduction in chronic homeless individuals and families in shelter prompted a significant drop in total numbers in this category. However, the number of homeless individuals and families in this population who are unsheltered reached a high point in 2015.
- **BEACH PROJECT:** One caveat is that totals for the sheltered population are still being finalized. If current numbers stand, the count represents a record low over a six-year period. These results speak to the success of intensive local efforts like the BEACH project, a comprehensive effort to identify, house, and support homeless individuals and families.

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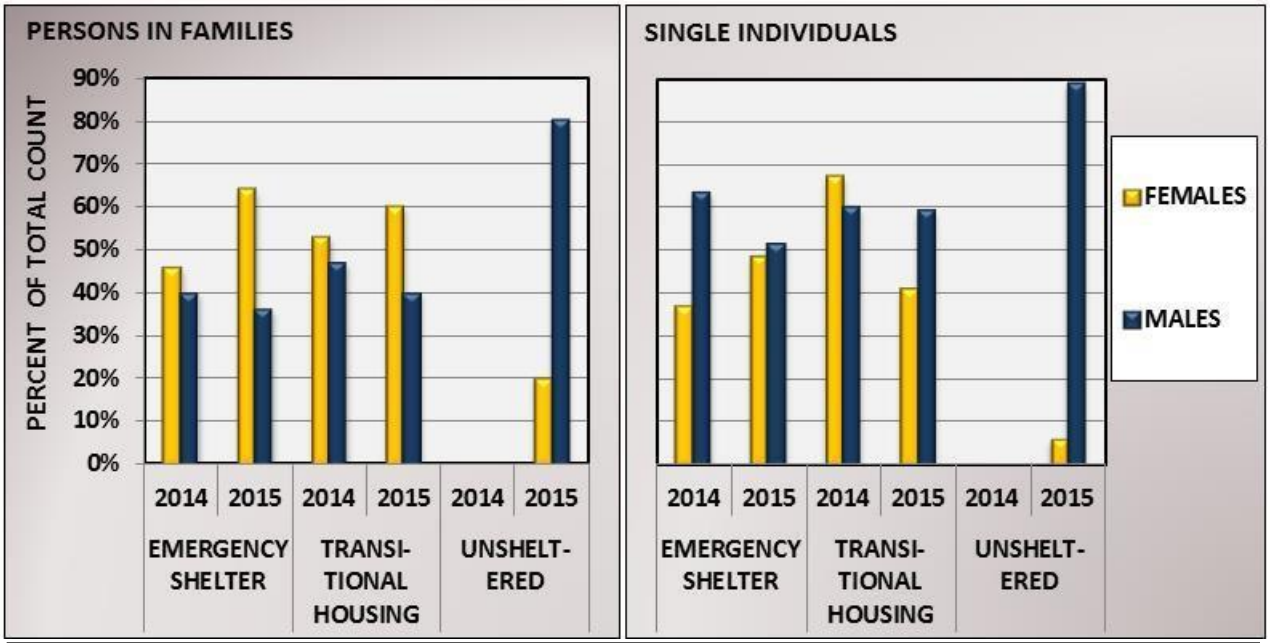
[16] St. Louis City Department of Human Services and St. Louis County Department of Human Services. "St. Louis City and St. Louis County: Ten-Year Plan to End Chronic Homelessness." August 2005. Details at https://www.stlouis-mo.gov/government/departments/human-services/homeless- services/documents/upload/Homeless10yearPlan.pdf Accessed November 30, 2015.

[17] "*Moving Forward: Policies, Plans & Strategies for Ending and Preventing Chronic Homelessness, City of St. Louis 2012."(2012)*.Details at https://www.stlouis-mo.gov/government/departments/human-services/homeless-services/documents/upload/Moving-Forward-2nd-Edition-2012.pdf Accessed December 14, 2015.

- **UNSHELTERED POPULATION:** The number of unsheltered homeless individuals and families has increased significantly since 2014. Numbers have bounced back to a level slightly higher than the period prior to the BEACH project.
- **RACIAL DISTRIBUTION**: Although African-Americans comprise roughly half of the general population, they account for a significant portion of the homeless population, between 60 to 95% in different shelter types. African-Americans are more likely to experience homelessness than any other racial group in the CoC.
- **AGE DISTRIBUTION:** Children under 17 are most numerous in emergency shelter, where the majority is between the ages of one and 12. While the 6-to-12 age bracket represents the largest share of children in permanent supportive housing, persons 13-to-17 account for one third of youth in this shelter type. With respect to adults, the 31-to-50 age group is predominant across all shelter types. However, the population in permanent supportive housing appears to be aging, with those in the 51-to-60 group recently nearing 30% of the population. While the frequency of children in permanent supportive housing decreased, single adults accessed this programming in greater numbers, showing a 47% increase from 2010-11 to 2013-14.
- **DOUBLED-UP:** Sixty to 70% of families resided with family or friends prior to entering emergency shelter, an indication that this type of accommodation could be a common pathway to homelessness. Numbers reported by the Department of Elementary and Secondary Education shed additional light on this trend. In 2014 DESE records showed that over 4,000 homeless students in the St. Louis Public School system were housed in similar arrangements.

CHART 1.8. PROPORTION OF MALE TO FEMALE BY HOUSHOLD TYPE AND PROGRAM
2014 AND 2015 POINT-IN-TIME COUNTS
CITY OF ST. LOUIS CoC



	PERSONS IN FAMILIES				INDIVIDUALS WITHOUT CHILDREN			
	2014		2015		2014		2015	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
EMERGENCY SHELTER	87	131	94	167	268	155	104	98
TRANSITIONAL HOUSING	167	188	191	287	145	97	85	59
UNSHELTERED	0*	0*	12	3	0*	0*	86	11

GENDER DISTRIBUTION AND FAMILY/CHILDREN STATUS

The chart above illustrates the distribution of the genders across program type, as well as the unsheltered group, based on point-in-time counts (PITCs) for 2014 and 2015. The percentages are derived from the total for all homeless persons in each program type by year. The following observations highlight a number of considerations:

With respect to families in 2014 and 2015, females were predominant in both emergency shelter and transitional housing. In emergency shelters, females exceeded the percentage of men in both years: by 5.6 percentage points in 2014 and 28 percentage points in 2015.

As for individuals without children in the PITC for the same years, men outnumbered women in emergency shelter. However, the discrepancy of 26.8 percentage points in 2014 narrowed to three percentage points in 2015.

As noted above, the 2014 count was subject to review. No unsheltered of either gender was documented in the 2014 count, but this result may still be tentative. In 2015, the number of males with families was equal to the number of females without. Twelve men with children appear in that year's count.

The degree to which men predominate in populations without children is evident in the disproportion between men and women, with 86 unsheltered identified during the 2015 PITC. In that year, women are present among the unsheltered, appearing as individuals as well as persons in families. Still, unsheltered men outnumber unsheltered women, by 4 to 1 in family households and nearly 8 to 1 in the group with no children.

RACIAL DISTRIBUTION OF THE HOMELESS POPULATION OF INDIVIDUALS AND PERSONS IN FAMILIES

As seen in Table 49, 49.2% of St. Louis City is Black/African-American. Non-Hispanic Whites comprise another 42 percent of the population. While these two racial categories are in close proportion to one another, within the homeless population, disparities along racial lines are evident.

Table 49. Racial Composition of the Population of the City of St. Louis Based on 2014 Census Estimates.

	White	Black/African American	Hispanic/ Latino	Asian	Multiple Races	Native American/ Alaskan Native	Pacific Islander
St. Louis City	42.2%	49.2%	3.5%	2.9%	2.4%	0.3%	--

Source: Census QuickFacts.

Table 50 presents data on the racial composition of homeless individuals and persons in families by shelter type and household status. As the table illustrates, in all categories, irrespective of programming, household type or veteran status, a distinct trend emerges in regard to the Black/African-American population. While comprising less than half of St. Louis City's general population, this racial group accounts for 60 to 95% of the homeless population. This equates to approximately 10 to 35% in excess of their presence in the general population.

This is particularly true of emergency shelter. Whether it's a question of families or individuals, Black/ African-Americans represent the overwhelming majority of the occupants. Of all persons in families in emergency shelter, African Americans account for approximately 90 to 95% of this population. Among individuals in the same venue, African-Americans comprised as much as 77% in 2010-11. In 2012-13, the amount was 68% in 2013-14, 70%. These numbers suggest, however, that the share of African Americans has decreased relative to the pool of individuals in the shelter population overall, by nearly ten percent. There was a smaller, but steady decline in African-American families as well.

Table 50. Racial Distribution of Homeless Individuals and Persons in Families, By Household and Programming – St. Louis City CoC

HOMELESS POPULATIONS	EMERGENCY SHELTER				TRANSITIONAL HOUSING				PERMANENT SUPPORTIVE HOUSING			
PERSONS IN FAMILIES	2010-11	2011-12	2012-13	2013-14	2010-11	2011-12	2012-13	2013-14	2010-11	2011-12	2012-13	2013-14
BLACK/AFRICAN-AMERICAN	94%	91%	89%	89%	92%	91%	93%	88%	93%	93%	91%	89%
WHITE, NON-HISPANIC, NON-LATINO	3%	4%	7%	5%	4%	5%	4%	6%	5%	6%	7%	8%
WHITE, HISPANIC OR LATINO	0%	0%	1%	1%	0%	0%	0%	0%	1%	0%	0%	0%
MULTIPLE RACES	3%	5%	6%	5%	4%	4%	3%	6%	1%	1%	2%	2%
OTHER	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
INDIVIDUALS [NO CHILDREN]												
BLACK/AFRICAN-AMERICAN	77%	.	68%	70%	71%	66%	67%	67%	79%	77%	76%	75%
WHITE, NON-HISPANIC, NON-LATINO	20%	.	28%	28%	26%	31%	29%	28%	19%	21%	21%	23%
WHITE, HISPANIC OR LATINO	1%	.	1%	1%	1%	1%	1%	2%	0%	0%	0%	1%
MULTIPLE RACES	1%	.	2%	1%	1%	2%	2%	2%	1%	1%	2%	1%
OTHER	0%	.	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%

AGE DISTRIBUTION

Table 51 below compares the ratios of children in various programming by age, based on data compiled in AHAR reports. A few conclusions are listed below:

Table 51. Distribution of Children by Age Groups and Service Type for City of St. Louis COC

CHILDREN IN FAMILIES	EMERGENCY SHELTER				TRANSITIONAL HOUSING				PERMANENT HOUSING			
	2010-11	2011-12	2012-13	2013-14	2010-11	2011-12	2012-13	2013-14	2010-11	2011-12	2012-13	2013-14
TOTALS, UNDER 18	829	1066	714	856	382	445	341	456	580	535	502	527
UNDER 1	13.0%	14.4%	15.6%	12.6%	13.6%	13.0%	13.1%	11.8%	4.8%	3.3%	3.3%	5.1%
AGE 1 TO 5	35.2%	39.1%	37.3%	38.9%	38.2%	34.8%	35.1%	35.5%	20.6%	18.6%	16.0%	24.0%
AGE 6 TO 12	40.0%	37.6%	26.2%	39.9%	37.9%	41.5%	39.5%	40.1%	40.8%	46.3%	47.6%	38.7%
AGE 13 TO 17	11.7%	8.8%	7.7%	8.5%	10.2%	10.5%	12.0%	12.5%	33.6%	31.5%	31.8%	32.0%
COUNT OF UNACCOMPANIED CHILDREN:	*Across all service types, the most frequently recorded children are school age youngsters, while unaccompanied children appear to be fairly rare. The ones counted were limited to the 13-to-17 age range.*											
AGE 13 TO 17	0	-	0	9	4	8	5	7	0	0	0	0

**No unaccompanied minors in AHAR report.

- Children under 17 are most numerous in emergency shelter. They are found in the smallest numbers in transitional housing.
- The total tally for all children in emergency shelter is slightly higher in 2013-14 than in 2010-11. Over the same period, numbers increased by 19% in transitional housing and decreased by 9% in permanent supportive housing.
- Over the four-year period, the group that represents the largest share of emergency shelter residents is children age 1-to-12, accounting for 63 to 78% of the population under age 17.

- This age group (1-to-12) is also the predominant group among children in transitional housing, with percentages ranging from 74 to 76%.
- In permanent supportive housing, the population skews older. While the 6-to-12 age group is predominant, youths 13-to-17 constitute the next largest group, generally accounting for almost one-third of children. In total, children ages 6-to-17 represent 70 to 79% of the youth population, depending on the year.

Table 52 details the unaccompanied youth population in the CoC. For the St. Louis City CoC, children in this category are most numerous in transitional housing and numbers are uniformly low.

Table 52. AHAR DATA for Unaccompanied Youth by Programming Type for City of St. Louis CoC

	Emergency Shelter					Transitional					Permanent Supportive				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Unaccompanied Youth	0	-	0	9	4	8	5	7	9	2	0	0	0	0	0

PITCs provide another source of data for this population. Table 53 summarizes statistics for youth under age 18 who were recorded as persons in households containing only children during the counts from 2009 to 2015. These data are similar to the AHAR results, in that the count of unaccompanied children is low. Numbers peaked at 14 in 2013.

Table 53. PITC for Homeless Youth in Households without An Adult in City of St. Louis CoC

	2009	2010	2011	2012	2013	2014	2015
Total	0	8	7	10	14	9	1
Sheltered	0	8	7	10	14	9	1
Unsheltered	0	0	0	0	0	0	0

HEALTH

MATERNAL AND CHILD HEALTH

The Healthy People 2020 goal states “Improve the health and well-being of women, infants, children and families.”

“Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. The objectives of the Maternal, Infant, and Child Health topic area address a wide range of conditions, health behaviors, and health systems indicators that affect the

health, wellness, and quality of life of women, children, and families. Infant and child health are similarly influenced by sociodemographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors.

Social Determinants of Maternal Health - These include pre-pregnancy health behaviors and health status, which are influenced by a variety of environmental and social factors such as access to health care and chronic stress.

Physical Determinants of Maternal Health - Common barriers to a healthy pregnancy and birth include lack of access to appropriate health care before and during pregnancy. In addition, environmental factors can shape a woman's overall health status before, during, and after pregnancy by:

- Affecting her health directly
- Affecting her ability to engage in healthy behaviors
- Social Determinants of Infant and Child Health

The social determinants that influence maternal health also affect pregnancy outcomes and infant health. Racial and ethnic disparities in infant mortality exist, particularly for African American infants. Child health status varies by both race and ethnicity, as well as by family income and related factors, including educational attainment among household members and health insurance coverage.[18]

ADOLESCENT HEALTH

The Healthy People 2020 Goal states "Improve the healthy development, health, safety, and well-being of adolescents and young adults." "Adolescents (ages 10 to 19) and young adults (ages 20 to 24) make up 21 percent of the population of the United States.1 The behavioral patterns established during these developmental periods help determine young people's current health status and their risk for developing chronic diseases in adulthood.

Although adolescence and young adulthood are generally healthy times of life, several important public health and social problems either peak or start during these years. Examples include:

- Homicide
- Suicide

Motor vehicle crashes, including those caused by drinking and driving

[18] "Maternal, Infant, and Child Health," Health People 2020 Topics and Objectives, US Office of Disease Prevention and Health Promotion, 2016, Retrieved from www.healthypeople.gov

- Substance use and abuse
- Smoking
- Sexually transmitted infections, including human immunodeficiency virus (HIV)
- Teen and unplanned pregnancies
- Homelessness

The leading causes of illness and death among adolescents and young adults are largely preventable. Health outcomes for adolescents and young adults are grounded in their social environments and are frequently mediated by their behaviors. Behaviors of young people are influenced at the individual, peer, family, school, community, and societal levels.[19]

INFANT HEALTH (AREA NEEDS ATTENTION)

All of the comparative regions have experienced a decrease in the number of low-birth weight infants since 2004-2008 to 2010-2014. St. Louis City had 243 less (8%) infants that were low weight at birth when comparing these years, and reported 2,863 low-birth weight infants for 2010-2014. The city's low-birth weight infant rate was 12.2% in 2010-2014 compared to 8% for Missouri, and 8.8% for St. Louis County. The city's rate increased by .4% covering the 2004-2008 range to 2010-2014 (Table 55).

Table 54. Low birth weight infants – Numbers

	2004-2008	2005-2009	2006-2010	2007-2011	2008-2012	2009-2013	2010-2014	Diff.	% Ch.
Missouri	32428	32390	32311	31747	31123	30584	30345	-2083	-6%
St. Louis City	3106	3127	3067	3032	2992	2928	2863	-243	-6%
St. Louis Cnty	5537	5428	5453	5406	5198	5114	5192	-345	-8%

Source: Missouri Department of Health and Senior Services. Definitions: Number of live infants recorded as having a birth weight under 2,500 grams (five pounds, eight ounces). Data were aggregated over five-year periods in order to provide more stable rates.

Table 55. Low birth weight infants - Rate

[19] "Adolescent Health," Health People 2020 Topics and Objectives, US Office of Disease Prevention and Health Promotion, 2017, Retrieved from www.healthypeople.gov

	2004-2008	2005-2009	2006-2010	2007-2011	2008-2012	2009-2013	2010-2014	Diff.
Missouri	8.1%	8.1%	8.1%	8.1%	8.0%	8.0%	8.0%	-0.1%
St. Louis City	11.8%	11.9%	11.9%	12.0%	12.1%	12.2%	12.2%	0.4%
St. Louis Cnty	9.1%	8.9%	9.0%	9.0%	8.7%	8.7%	8.8%	-0.3%

Infant mortality is another area that had mixed results, but needs continued attention. Infant mortality is defined as babies born alive and dying before their first birthdays. As demonstrated in Table 56, St. Louis City experienced a reduction of 17% from 2004 to 2015 in the number of infants who died, and the rate decreased by .8 to 9.8 in the 2011-15 time range (Table 57). There were 232 infants who died in 2011-15. While there has been improvement, this indicator needs attention because the rate did not decrease as much as the state or county rate, and was still considerably higher than both of their rates at 6.4-6.5.

Table 56. Infant mortality (number)

	2004-2008	2005-2009	2006-2010	2007-2011	2008-2012	2009-2013	2010-2014	2011-2015	Diff.	% Ch.
Missouri	2966	2947	2855	2738	2621	2526	2418	2411	-555	-19%
St. Louis City	280	288	281	286	283	278	255	232	-48	-17%
St. Louis Cnty	501	486	445	432	377	357	360	382	-119	-24%

Table 57. Infant mortality (rates)

	2004-2008	2005-2009	2006-2010	2007-2011	2008-2012	2009-2013	2010-2014	2011-2015	Diff.	% Ch.
Missouri	7.4	7.3	7.1	6.9	6.8	6.6	6.4	6.4	-1.0	-13.5%
St. Louis City	10.6	11.0	10.9	11.3	11.5	11.6	10.9	9.8	-0.8	-7.5%
St. Louis Cnty	8.2	8.0	7.3	7.2	6.3	6.1	6.1	6.5	-1.7	-20.7%

Source: Missouri Department of Health and Senior Services. Definitions: Number of deaths to infants under one year of age. Data were aggregated over five-year periods in order to provide more stable rates. Rate is per 1,000 live births.

BIRTHS TO TEENS (POSITIVE FINDING)

The number of births to teens in St. Louis City decreased by 60% from 2004 to 2015, with a reported 300 in 2015. The rate of teen births decreased by 45% from a rate of 78.3 per 1,000 youth in 2004 to 35.8 in 2015. As can be seen in Figure 24, St. Louis City's births to teens' rate improved dramatically over time, but its rate was still 10.8% more than the state rate.

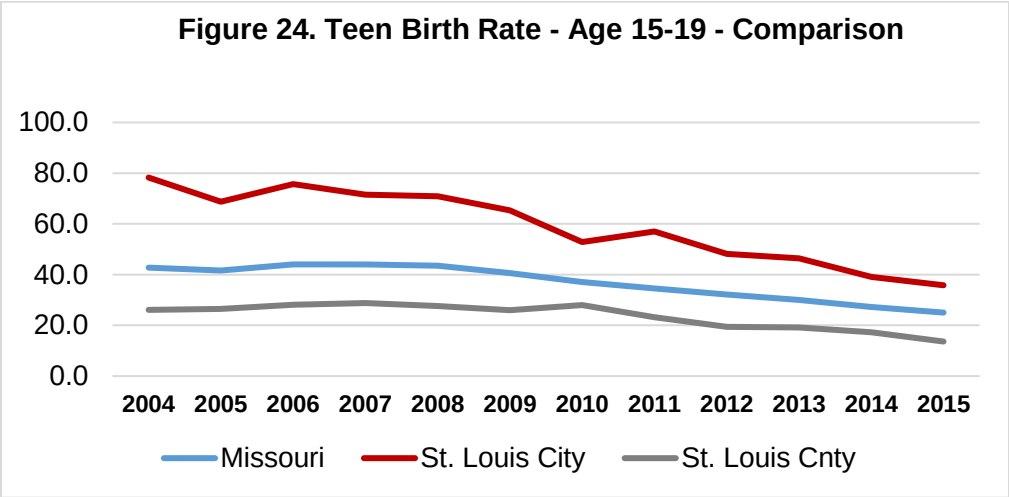
Table 58. Births to teens, ages 15-19 (number)

	Missouri	St. Louis City	St. Louis County
2004	8,747	898	910
2005	8,602	793	935
2006	9,179	878	994
2007	9,232	835	1,023
2008	9,154	820	979
2009	8,496	754	916
2010	7,625	582	975
2011	6,937	591	798
2012	6,314	470	648
2013	5,812	421	626
2014	5,230	336	552
2015	4,835	300	433
Diff.	-4,002	-499	-471
% Ch.	-43%	-60%	-46%

Table 59. Teen Birth Rate - Age 15-19 - Per 1,000 Youth

	Missouri	St. Louis City	St. Louis County
2004	42.8	78.3	26.1
2005	41.7	68.7	26.5
2006	44.0	75.7	28.1
2007	44.0	71.6	28.8
2008	43.5	70.9	27.6
2009	40.6	65.3	26.0
2010	37.0	52.8	28.0
2011	34.5	57.0	23.2
2012	32.2	48.2	19.4
2013	30.0	46.4	19.2
2014	27.2	39.1	17.2
2015	25.0	35.8	13.6
Diff.	-16.8	-32.5	-11.6
% Ch.	-38%	-45%	-40%

Source: Missouri Department of Health and Senior Services. Definitions: Number of live births that occur to girls ages 15 to 19. Rate is expressed per 1,000 young women of that age group.



CHILD DEATHS (POSITIVE FINDING) AND VIOLENT TEEN DEATHS (AREA NEEDING ATTENTION)

Child deaths, ages 1-14, steadily improved over time with a rate decrease of 6.4 per 100,000 children from 26.4 in 2004-08 aggregated period to 20.0 in 2011-15. The city rate was greater than the state rate of 18 per 100,000 children, but not by much. The city still was the highest rate among comparative entities for 2011-2015 (see Figure 25, 26 and Table 61).

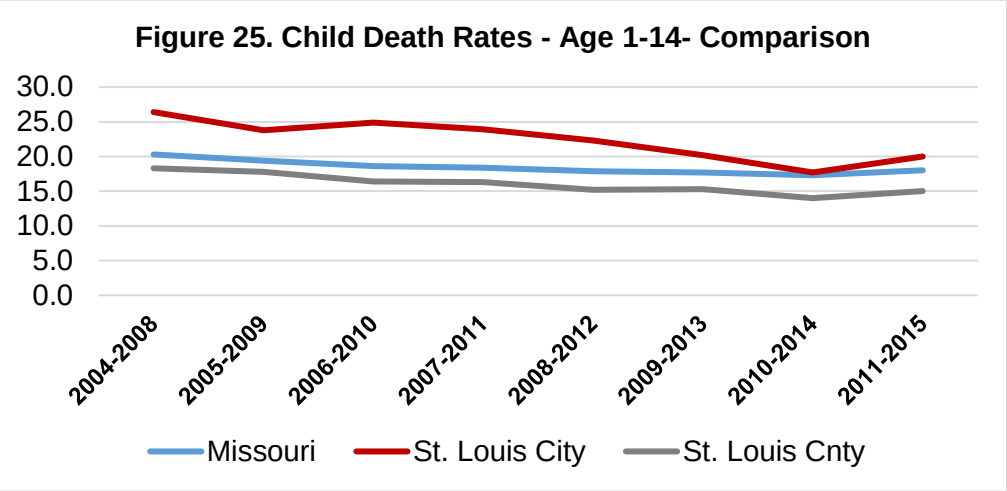
Table 60. Child deaths, ages 1-14 (number)

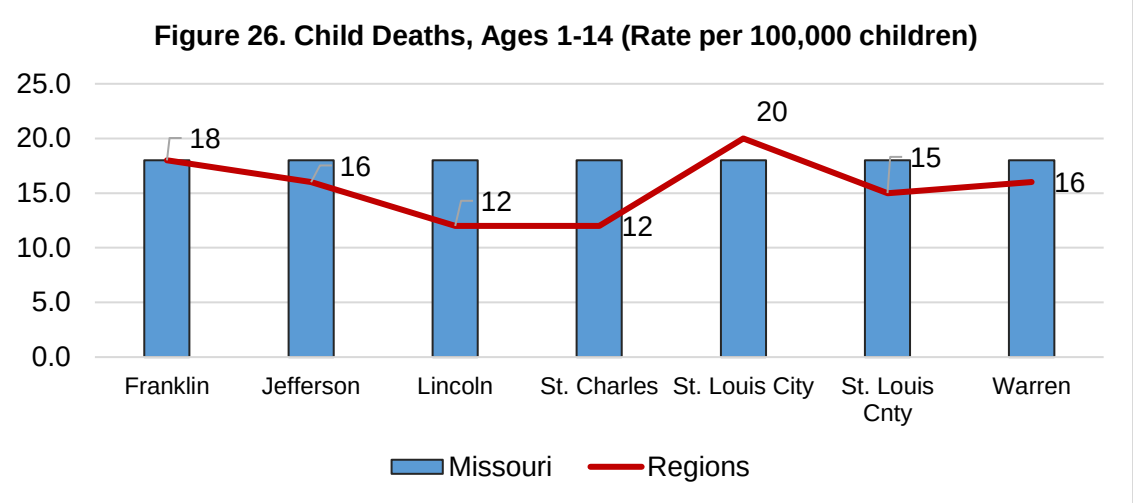
	2004-2008	2005-2009	2006-2010	2007-2011	2008-2012	2009-2013	2010-2014	2011-2015	Diff.	% Ch.
Missouri	1187	1139	1093	1080	1050	1035	1006	1041	-146	-12%
St. Louis City	87	74	74	68	63	56	49	54	-33	-38%
St. Louis Cnty	179	173	158	155	143	143	130	141	-38	-21%

Source: Missouri Department of Health and Senior Services. Definitions: Number of deaths from all causes of children ages one to 14. Data were aggregated over five-year periods in order to provide more stable rates. Rate is expressed per 100,000 children of that age group.

Table 61. Child deaths, ages 1-14 (rate)

	2004-2008	2005-2009	2006-2010	2007-2011	2008-2012	2009-2013	2010-2014	2011-2015	Diff.	% Ch.
Missouri	20.3	19.4	18.6	18.4	17.9	17.7	17.3	18.0	-2.3	-11%
St. Louis City	26.4	23.8	24.9	23.9	22.3	20.2	17.7	20.0	-6.4	-24%
St. Louis Cnty	18.3	17.8	16.4	16.3	15.2	15.3	14.0	15.0	-3.3	-18%





The violent teen death rate (ages 15-19) improved by 9% to 108.2 in 2011-2015 (from 118.4 to 2004-2008). However, as can be viewed in Table 62 and Figures 27 and 28, St. Louis City had more than double the state's rate of 49.2, and was considerably higher than all of the other county comparisons.

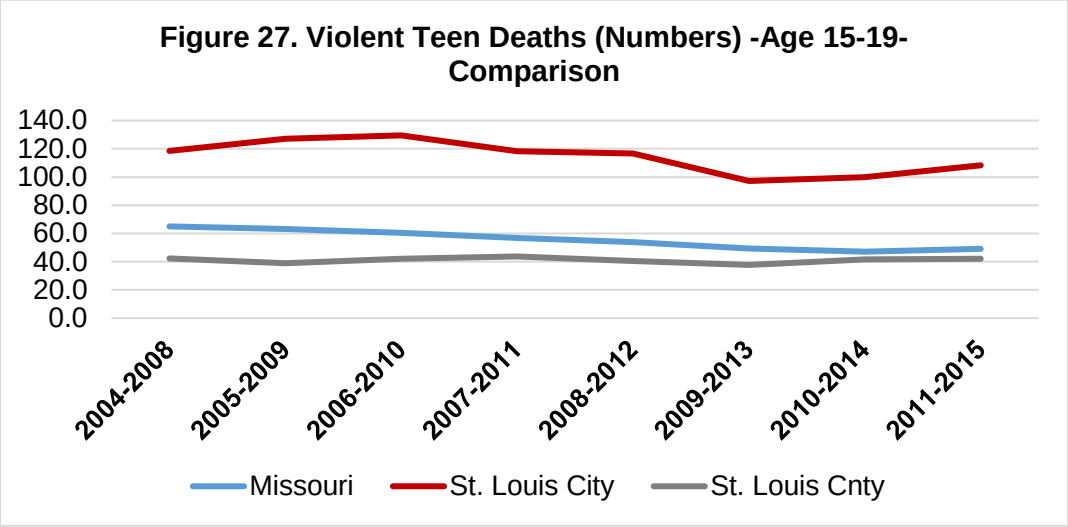
Table 62. Violent teen deaths, ages 15-19 (rate)

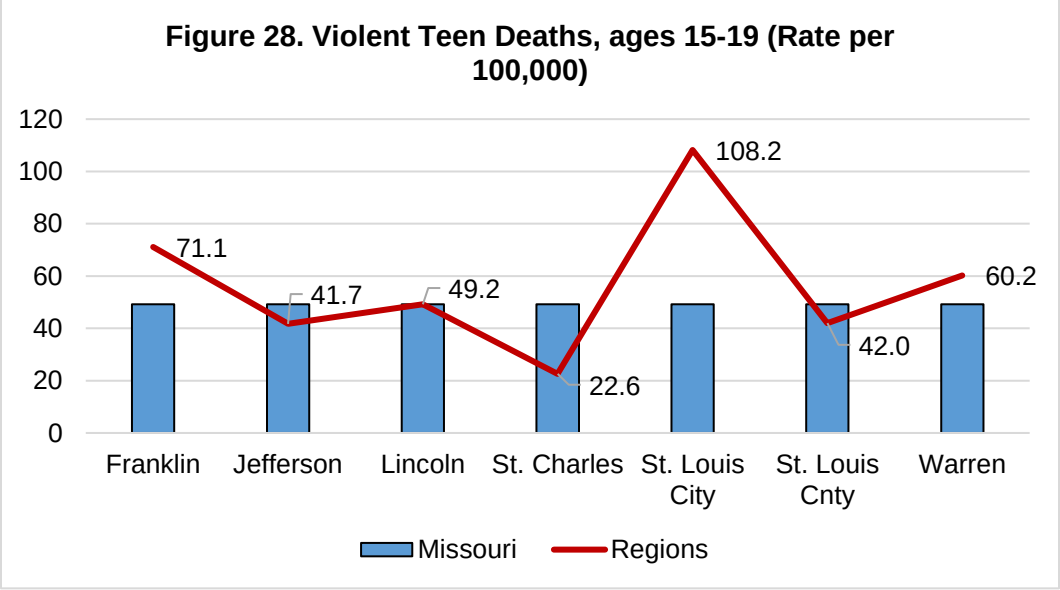
	2004-2008	2005-2009	2006-2010	2007-2011	2008-2012	2009-2013	2010-2014	2011-2015	Diff.	% Ch.
Missouri	65.0	63.1	60.5	56.9	53.8	49.3	47.1	49.2	-15.8	-24%
St. Louis City	118.4	127.1	129.5	118.3	116.7	97.2	99.9	108.2	-10.2	-9%
St. Louis Cnty	42.4	38.8	42.0	43.7	40.5	37.7	41.6	42.0	-0.4	-1%

Table 63. Violent teen deaths, ages 15-19 (number)

	2004-2008	2005-2009	2006-2010	2007-2011	2008-2012	2009-2013	2010-2014	2011-2015	Diff.	% Ch.
Missouri	1371	1345	1291	1210	1129	1018	957	588	-783	-57%
St. Louis City	140	149	150	133	127	101	98	53	-87	-62%
St. Louis Cnty	153	140	151	157	144	132	143	87.2	-65.8	-43%

Source: Missouri Department of Health and Senior Services. Definitions: Number of deaths from homicides, suicides, motor vehicle crashes, and other accidents to teens ages 15 to 19. Data were aggregated over five-year periods in order to provide more stable rates. Rate is expressed per 100,000 teens of that age group.





SUICIDE RATE AND SELF-HARM FOR YOUTH (POSITIVE FINDING)

The number of suicides and the suicide rate for Missouri, the city, and other regions are shown below. St. Louis City had the lowest rate at 2.06 and number of suicides at 5 total covering 2003 through 2013 for youth, between 15 to 19 years old. The City of St. Louis rate was significantly lower than the state's rate of 8.55 (see Table 64). We have included the confidence limits at the lower and upper 95% level, which shows the margin of error (variation) in the data for the computed suicide rate.

Table 64. Suicides 2003-2013 - Ages 15-19 - Comparison

Geography	#	Rate	Lower 95% Conf. Limit	Upper 95% Conf. Limit	Sign. Diff.
Missouri	395	8.55	7.73	9.44	
Franklin	9	11.58	5.3	21.98	N/S
Jefferson	18	10.88	6.45	17.2	N/S
Lincoln	4	9.75	2.66	24.96	N/S
St. Charles	23	8.43	5.34	12.65	N/S
St. Louis City	5	2.06	0.67	4.81	L
St. Louis Cnty	64	8.18	6.3	10.45	N/S
Warren	2	8.64	1.05	31.21	N/S

Source: DHSS-MOPHIMS Community Data Profiles - Child Health. Note: N/S = Not significantly different from the Missouri Rate; L = significantly lower than the Missouri Rate; H = significantly higher than the Missouri Rate. Note: Lower 95% and Upper 95% Conf. Limit provides the

More detailed data about self-inflicted injuries and resulting events for the St. Louis City youth population is available covering the 10-year period from 2003 to 2013. For youth ages 0-19, there were 778 total serious injuries, with 8 deaths (see Table 65). For youth ages 15-19, there were 5 deaths, with 3 for ages 15 and under (see Table 66 and 67). The death rate for children ages 0-15 was .5 in comparison to 2.1 for youth 15-19 years of age. The death rate from self-injuries for children under 15 was less than the Missouri rate, and all of the other comparable entities. For youth 15-19 years of age, the St. Louis City rate was again better than the Missouri rate and all of the other comparable entities.

Table 65. Self-Inflicted Injuries and Resulting Events – 2003 to 2013

	Deaths	Hospitalizations	ER Visits	Total Serious Injuries
Missouri	474	5696	11234	17404
Franklin County	9	82	222	313
Jefferson County	22	157	302	481
St. Charles County	29	321	625	975
St. Louis City	8	259	511	778
St. Louis County	78	947	1486	2511

Source: Missouri Department of Health and Senior Services. http://health.mo.gov/data/communitydataprofiles/index.html

Table 66. Self-Inflicted Injuries and Resulting Events (15-19 years old) – 2003 to 2013

	Deaths	Death Rate	Sign. Diff.	Hospitaliz-ations	Hospital Rate	Sign. Diff.2	ER Visits	ER Visits Rate	Sign. Diff.3
Missouri	395	8.6	N/A	4777	10.3	N/A	8442	1.8	N/A
Franklin County	9	11.6	N/S	69	8.9	N/S	173	2.2	H
Jefferson County	18	10.9	N/S	140	8.5	L	212	1.3	L
St. Charles County	23	8.4	N/S	271	9.9	N/S	460	1.7	N/S
St. Louis City	5	2.1*	L	216	8.9	N/S	398	1.6	N/S
St. Louis County	64	8.2	N/S	790	10.1	N/S	1130	1.4	L

Table 67. Self-Inflicted Injuries and Resulting Events (Under 15 years old) – 2003 to 2013

	Deaths	Death Rate	Sign. Diff.	Hospitaliz-ations	Hospital Rate	Sign. Diff.2	ER Visits	ER Visits Rate	Sign. Diff.3
Missouri	79	0.6	N/A	919	0.7	N/A	2792	0.2	N/A
Franklin County	0	0	N/A	13	0.6	N/S	49	0.2	N/S
Jefferson County	4	0.8	N/S	17	0.3	L	90	0.2	N/S
St. Charles County	6	0.7		50	0.6	N/S	165	0.2	N/S
St. Louis City	3	0.5	N/S	43	0.7	N/S	113	0.2	L
St. Louis County	14	0.7	N/S	157	0.7	N/S	356	0.2	L

Note: N/S = Not significantly different from the Missouri Rate; L = significantly lower than the Missouri Rate; H = significantly higher than the Missouri Rate.

Other suicide data is reported in the Missouri Student Survey, but with St. Louis County students only. When students (6th-12th grade) in St. Louis County were asked about their mental health, 13.9% had seriously considered suicide in the last year, 9.4% made a plan, and 1.0% actually attempted, resulting in an injury. Students' seriously considering suicide has decreased from 15.2% in 2008, and is about a half of a percent less

than the state rate. Students who reported that they had attempted to commit suicide, which resulted in an injury has decreased by 2.2% from 2008, which is a significant decrease over time. This rate was also lower than the state rate.

BEHAVIORAL HEALTH COMMUNITY BASED TREATMENT

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

In state fiscal year 2015, 6,921 Saint Louis City residents received treatment (psychiatric services) for serious mental illnesses/disorders at publicly-funded facilities. There were…

- 7 children under age 6
- 270 children between the ages of 6 and 9,
- 338 youth between 10 and 13 years of age, and
- 334 youth who were age 14 to 17….

For a total of 949 youth who received psychiatric services.

Youth (949) made up 14% of the total number of individuals (6,921) who received psychiatric services from the Division of Behavioral Health in 2015. The largest increase of 52% from 2009 to 2015 was found with 6-9 year olds (see Table 68). There were 41% less youth age 14 to 17 who received psychiatric services from this source covering this same period of time.

Table 68: Number of Youth in St. Louis City who received Psychiatric Services from the Division of Behavioral Health - FY 2009-2015

Age Ranges	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	% of total - 2015	Diff.	% Ch.
Under 6	6	12	15	17	19	17	7	0.1%	1	16.7%
6 to 9	178	115	161	217	274	287	270	3.9%	92	51.7%
10 to 13	329	252	223	299	308	309	338	4.9%	9	2.7%
14 to 17	561	332	294	335	379	357	334	4.8%	-227	-40.5%
Total Youth	1074	711	693	868	980	970	949	13.7%	-125	-11.6%
General Pop. Total	8,112	7,130	6,228	6,713	6,686	6,797	6,921		-1191	-14.7%

Source: Status Report on Missouri's Substance Use and Mental Health; Division of Behavioral Health, Missouri. Note: Individuals who received psychiatric services had one of the disorders listed in the next table. The total number of diagnoses is larger than the number served because some individuals had more than one type of disorder.

General information reported about Eastern Missouri[20] shows that 18.3% of those 18 and older had a mental illness in the past year with 4.4% having a serious mental illness. Serious mental illness is defined as any of the mental disorders asked about and 'these disorders resulted in substantial impairment in carrying out major life activities'. Approximately 7.1% of Eastern Missouri residents ages 18+ had at least one major depressive episode in the past year. A major depressive episode is characterized by an extended period of depressed mood, loss of interest or pleasure, and impaired functioning. Typically, females are more likely to report having had a major depressive episode. National data sources state that among US youth age 13-18 about 20% reported that they suffered from a mental disorder with symptoms severe enough to impair their daily lives.[21] Furthermore, approximately 11-13% of children and youth have a serious emotional disturbance (SED) that causes substantial impairment in how they function at home, at school, or in the community, and for 5% serious emotional disturbance causes extreme impairment in their functioning.[22]

ACUTE YOUTH MENTAL HEALTH TREATMENT

BH data on hospital-based treatment is gathered by the Missouri Department of Health and Human Services. Form this data source, accessed through the St. Louis County Public Health Department's Think Health in partnership with epidemiologists at the Department, data available on those who experience emergency room (ER) visits and hospitalizations for youth mental health is reflected below.

PEDIATRIC EMERGENCY ROOM VISITS FOR MENTAL HEALTH

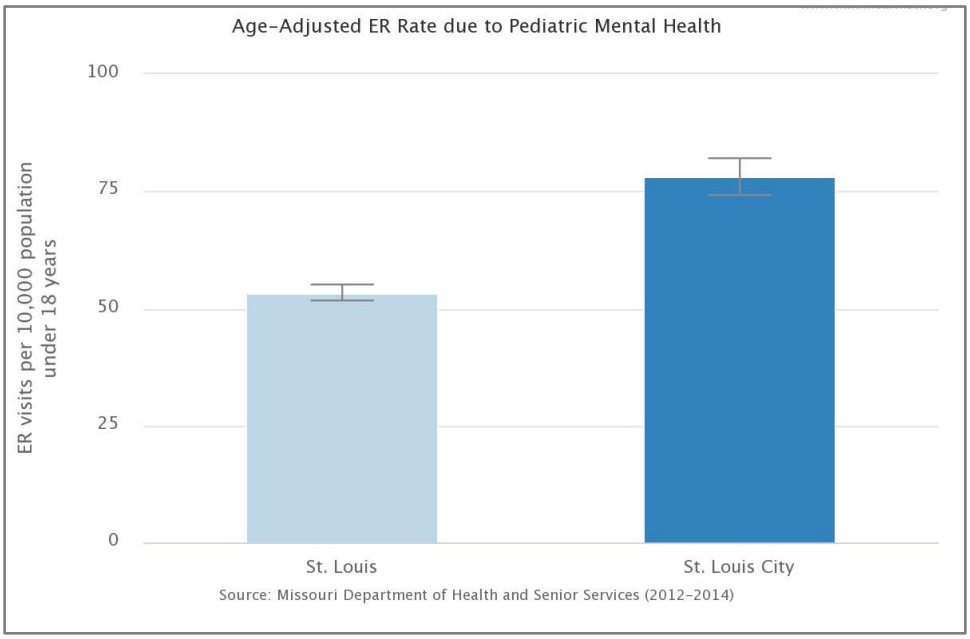
When compared, St. Louis City residents have a markedly high age-adjusted rate of youth ER visits due to mental health at 78.1 ER visits per 10,000 under 18, as compared to the St. Louis County resident rate of 53.3 ER visits per 10,000 under 18 (Figures 29-31).

[20] "Missouri BH Epidemiology Workgroup," Alcohol & Drug Use, Missouri Department of Mental Health, 2016, retrieved from www.dmh.mo.gov

[21] Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, and Swendsen J.(2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey.

[22] Surgeon General's Conference on Children's Mental Health; Merikangas, He, Burstein, et al, 2010. Replication--Adolescent Supplement (NCS-A). J Am Acad Child Adolesc Psychiatry. 2010 Oct;49(10):980-9. doi: 10.1016/j.jaac.2010.05.017. Epub 2010 Jul 31.

Figure 29. Age-Adjusted ER Rate due to Pediatric Mental Health, County Comparison



Both St. Louis City and County have experienced an increase in overall ER visits for the youth population within the period between 2010-2014.

Figure 30. Age-Adjusted ER Rate due to Pediatric Mental Health Trends, St. Louis City, 2010-2014

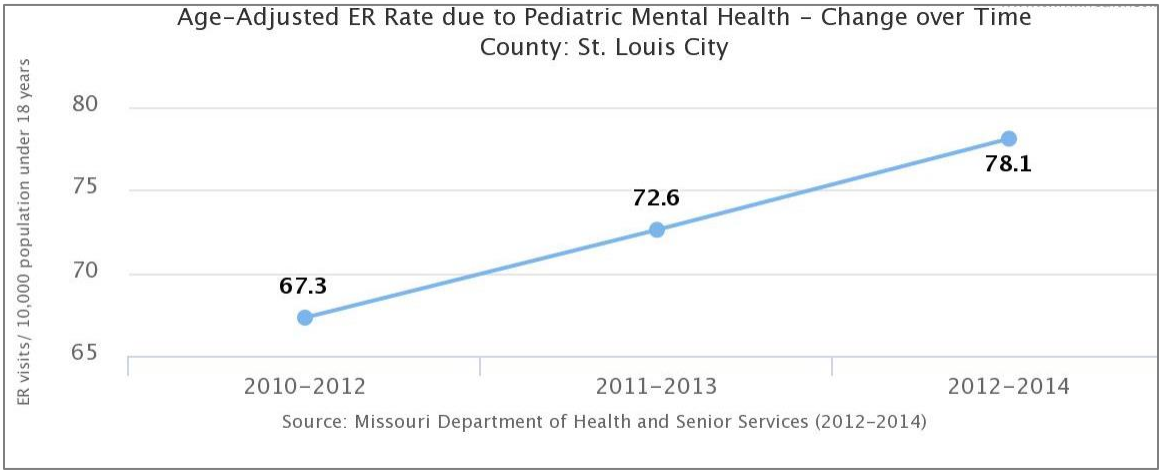
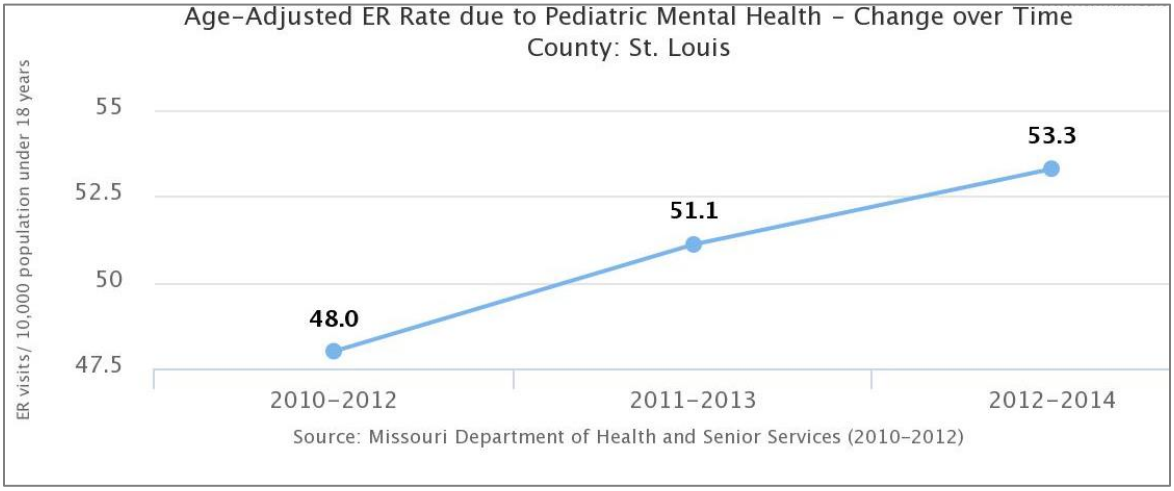


Figure 31. Age-Adjusted ER Rate due to Pediatric Mental Health Trends, St. Louis County, 2010-2014



Within and across counties, ER rates vary by demographic groups. For both St. Louis City and County, Black/African-American youth experience ER visits at the highest rate of any racial or ethnic category and higher than the overall rate for the population. For both counties, ages 5-11 and 12-14 have the highest rates of ER visits and markedly higher (two times or more) than that of the overall population. Also, in St. Louis County, females experience higher rates of ER utilization due to pediatric mental health (57.3.for females in comparison to 49.5 for males). There is not a major gender difference found with St. Louis City youth (78.2 for females in comparison to 77.9 for males), although the city's rate is higher than the County rate as previously presented.

Table 69. Age-Adjusted ER Rate due to Pediatric Mental Health by Demographic Group, St. Louis City and County, 2012-2014

	Age (in years)				**Race/Ethnicity**				**Sex**		
	0-4	5-11	12-14	15-17	Asian	Black or African American	Hispanic, any race	White, non-Hispanic	Female	Male	**Overall**
St. Louis County	2.7	98.5	132.9	34.8	12.9	77.2	18.7	43.9	57.3	49.5	53.3
St. Louis City	5.2	160.5	154.3	60.1	-	86.1	23.6	65.9	78.2	77.9	78.1

Data is suppressed for St. Louis City's Asian population, given small population size.

PEDIATRIC HOSPITALIZATIONS FOR MENTAL HEALTH

Both St. Louis City and County have experienced a sharp increase in overall hospitalizations for youth within the period between 2010-2014. St. Louis County experienced a slight drop mid-period, but increased notably since that time and maintained rates above St. Louis City throughout that period (Figures 32-34).

Figure 32. Age-Adjusted Hospitalization Rate due to Pediatric Mental Health, County Comparison

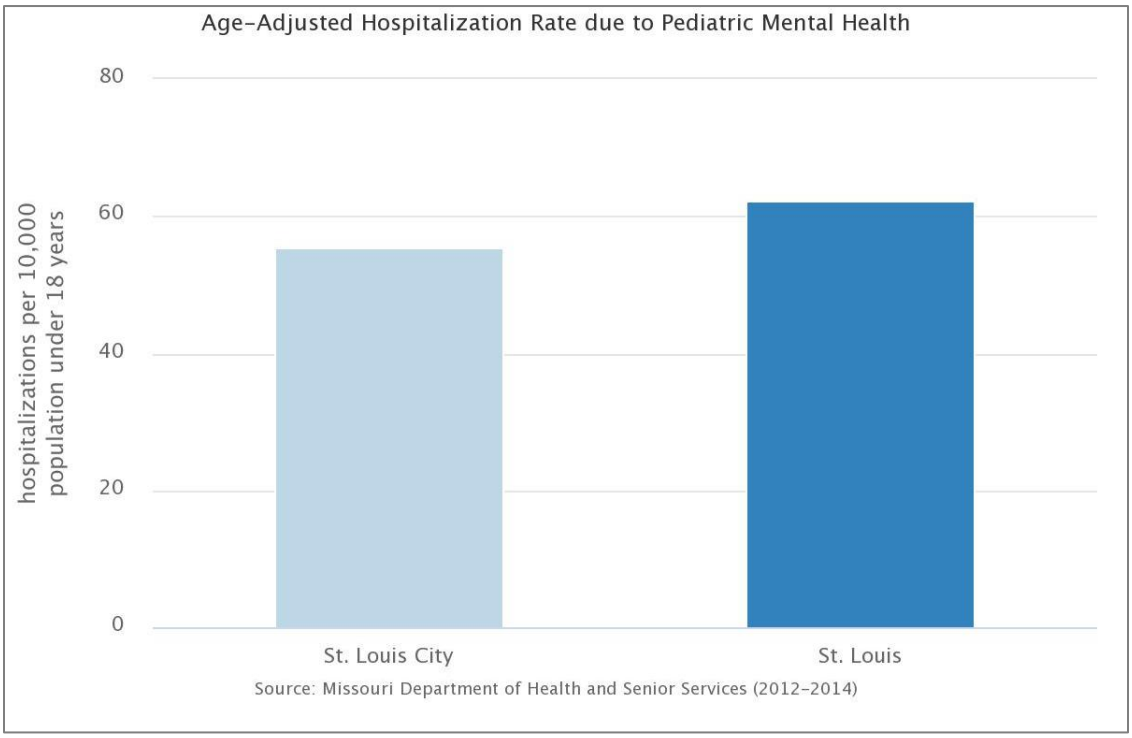


Figure 33. Age-Adjusted Hospitalization Rate due to Pediatric Mental Health Trends, St. Louis City, 2010-2014

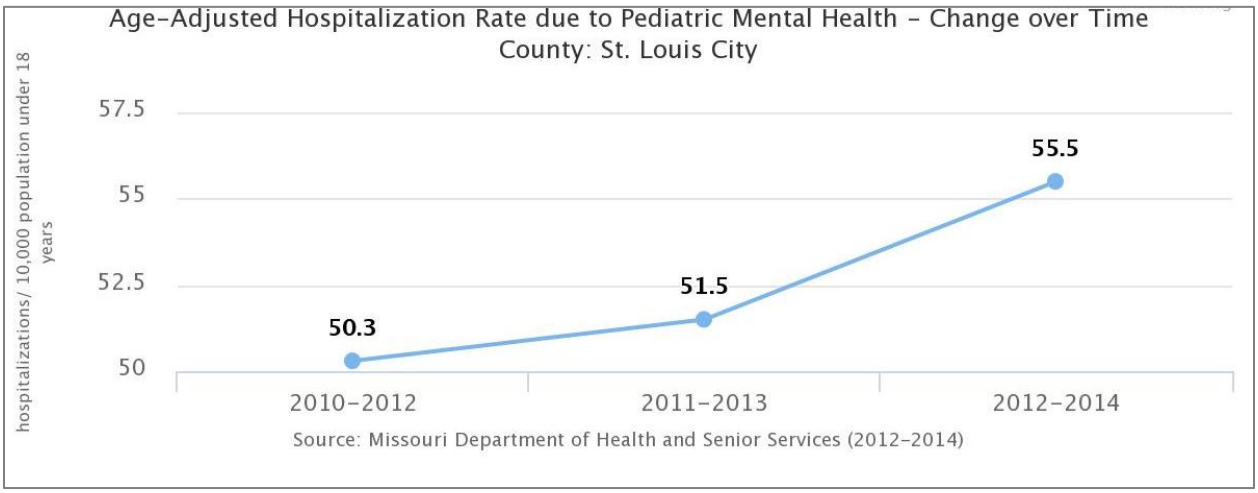
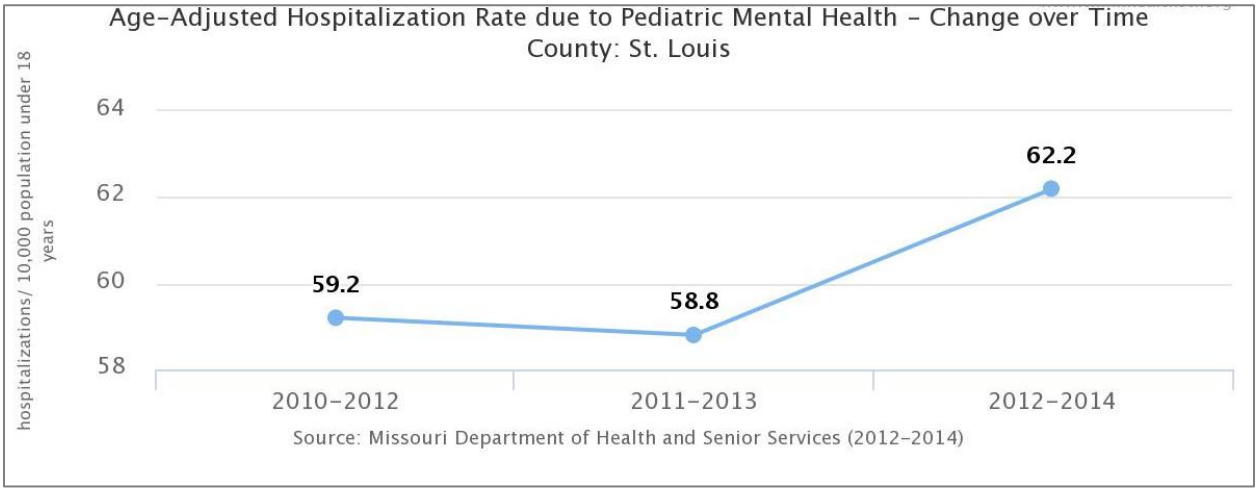


Figure 34. Age-Adjusted Hospitalization Rate due to Pediatric Mental Health Trends, St. Louis County, 2010-2014



Within and across counties, hospitalization rates vary by demographic groups. For both St. Louis County, Black/African-American youth experience hospitalizations at the highest rate of any racial or ethnic category and higher than the overall rate for the population. For both counties, ages 5-11 and 12-14 have the highest rates of hospitalization visits (also present in ER utilization). The rates for these age categories is markedly higher (two times or more) than that of the overall population. Also, in both St. Louis City and County, females experience higher rates of hospitalization.

Table 70. Hospitalization Rate due to Pediatric Mental Health by Demographic Group, St. Louis City and County, 2012-2014

	Age (in years)				Race/Ethnicity				Sex		
	0-4	5-11	12-14	15-17	Asian	Black or African American	Hispanic, any race	White, non-Hispanic	Female	Male	**Overall**
St. Louis County	0.7	122	179.1	29.2	19.5	77.6	31.3	55.4	68.3	56.4	62.2
St. Louis City	-	123.5	122.3	35.2	-	48.7	26.4	67.3	60.5	50.6	55.5

Data is suppressed for St. Louis City's Asian population and individuals 0-4, given small population sizes.

FINDINGS FROM THE ST. LOUIS COUNTY STUDENT SURVEY: TOP BEHAVIORAL HEALTH ISSUES ST. LOUIS COUNTY STUDENTS FACE AT SCHOOL OR IN THEIR COMMUNITY

A representative sample of St. Louis County public school students were surveyed in 2016 and 2017 regarding their BH needs and the issues they experience. St. Louis City students were not included in this sample since the project was focused on the county population of youth. However, regional analysis was conducted with some of the data being more similar to the St. Louis City data than the total sample of students. Future efforts should be focused on assessing the St. Louis City youth on the same BH items as the county population to allow for comparisons to be made.

Out of the 4,253 completed surveys, 2,382 were from high school students, and 1,866 were from middle school students. In the population, St. Louis County middle school students comprise 42% of the total student population, with high school students comprising 58% of the total student population. Based on the 4,253 completed surveys, 44% (1,869) were by middle school students with 56% of surveys completed by high school students. Forty-eight percent (48%) of the completed surveys were from White students, followed by 22% from African American/Black students, 7% selecting "other", 6% Hispanic, and 5% Asian. The racial composition of students completing the survey in each of the four sub-regions varies from the St. Louis County totals, especially in West, South, and North County.

TOP ISSUES MIDDLE SCHOOL AND HIGH SCHOOL STUDENTS FACE AT SCHOOL/IN COMMUNITY BY SUB-REGION

Students were given a list of BH-related issues that they might face at school or in the community, and were asked to identify the top five. This information was analyzed separately for middle and high school students, and is summarized below.

Middle School Student trends (Table 69):

- Bullying/cyber-bullying was one of the top issue across all of the sub-regions, with 61% of students identifying this as a pressing issue.
- Friend/peer relationship, social skills, problem-solving and self-esteem was one of the top two issues across all of the sub-regions with 54% of all students.
- Controlling emotions, anger management, and conflict resolution was identified as the third most prevalent issue by 44% of middle school students, with 50% of North County students dealing with this in comparison to only 34% of South County students, so there are sub-regional differences.
- Anxiety/worrying is a major concern in all of the sub-regions with the exception of North County. In North County, this issue was not as much of a problem as threats of violence or being injured by another peer by 39% of student, and gang violence by 35% of students. Threats of violence or being injured by another peer was also a concern for central county students (31%).

High School Student trends (Table 70):

- There was more sub-regional variation in the top issues high school students face at school or in the community with high school students. However, drug use/abuse was first or second issue in all of the sub-regions, with 60% or more of the students selecting this issue.
- Anxiety/worrying a lot was one of the top issues in all of the sub-regions with the exception of North County. In North County, only 30% of students identified this issue, and instead had bullying/cyber-bullying as its second highest need issue at 50%, followed by gang violence at 46%.
- Friend/peer relationships, social skills, problem-solving and self-esteem (as one issue) was one of most reported issues across all of the sub-regions as well with 49% of all students.
- Depression/being sad a lot was one of the top six issues across St. Louis County, with South County students experiencing this the most at 53%.
- Bullying/cyber-bullying was one of the six issues across all of the sub-regions, with 44% of students identifying this as a pressing matter.
- Controlling emotions, anger management, and conflict resolution was identified as one of the top five issues in North County only.

While this item did not show up in the top five issues, self-harm and/or suicide was identified by 29% of high school students, with 38% of South County students identifying this as an issue. Seventeen percent of middle school students identified self-harm and/or suicide as an issue, so this gets much worse in high school.

Table 69. Middle School Students' Ratings of Top Behavioral Health Issues They Face

	Region				
	Central	South	North	West	Total
Bullying/cyber-bullying	66%	57%	64%	55%	61%
Friend/Peer relationships, social skills, problem-solving, self-esteem	51%	62%	51%	56%	54%
Controlling emotions, anger management, conflict resolution	43%	34%	50%	45%	44%
Anxiety/worry a lot	34%	52%	23%	54%	39%
Feelings of acceptance/belonging	28%	38%	30%	44%	35%
Depression/sad a lot	27%	40%	23%	33%	30%
Unhealthy dating relationships	26%	27%	23%	31%	27%
Online safety	24%	37%	21%	26%	26%
Threats of violence or being injured by another peer	31%	14%	39%	13%	26%
Drug use/abuse	23%	21%	29%	14%	22%
Gang violence	20%	5%	35%	5%	18%
Self-harm and/or suicide	16%	23%	13%	18%	17%
Coping with grief, loss, and/or divorce	15%	20%	14%	17%	16%
Abuse and neglect issues (body safety)	8%	5%	10%	7%	8%
Other	4%	5%	6%	5%	5%
Housing instability/nowhere to live	5%	5%	5%	4%	4%

Table 70. High School Students' Ratings of Top Behavioral Health Issues They Face

	Region				
	Central	South	North	West	Total
Drug use/abuse	64%	60%	63%	63%	63%
Anxiety/worry a lot	53%	58%	30%	65%	51%
Friend/Peer relationships, social skills, problem-solving, self-esteem	51%	47%	42%	54%	49%
Depression/sad a lot	47%	53%	36%	46%	44%
Bullying/cyber-bullying	41%	42%	50%	42%	44%
Feelings of acceptance/belonging	33%	35%	26%	48%	36%
Controlling emotions, anger management, conflict resolution	33%	28%	40%	27%	33%
Unhealthy dating relationships	32%	30%	31%	30%	31%
Self-harm and/or suicide	33%	38%	23%	27%	29%
Gang violence	17%	11%	46%	7%	21%
Threats of violence or being injured by another peer	20%	13%	26%	13%	18%
Online safety	12%	11%	10%	13%	12%
Coping with grief, loss, and/or divorce	11%	12%	11%	11%	11%

Abuse and neglect issues (body safety)	7%	6%	7%	6%	6%
Housing instability/nowhere to live	7%	5%	8%	4%	6%
Other	3%	3%	2%	1%	2%

Source: St. Louis County's Children's Service Fund Needs Assessment Report for Youth – 2016 – Berry Organizational & Leadership Development, LLC survey process.

OTHER FINDINGS

- When asked if they were able to find BH resource information when they needed it, 22% of middle school students could not find the information when they needed it, which is 5% more than the high school student percentage.
- Ten percent more high school students (55%) than middle school students (45%) have not experienced bullying* in the past three months.
- For middle school students, the most prevalent issue they experienced is that they were grouchy, irritable, or in a bad mood (72% dealt with this issue in the past 30 days at least one or more days). Next, 56% of students had one or more days where they had difficulty concentrating on school, with South and West County students dealing with this issue more than Central and North County students. 54% percent of students were sad at least one or more days out of the past 30 days. Anxiety, fear and being worried was an issue present among 50% of middle school students.
- High school students also dealt with being grouchy, irritable, or in a bad mood, where 80% of them had experienced this at least one day out of the past 30. Difficulty concentrating on school was the second highest experienced issue, similar to middle school students, with 69% of students. Being anxious, fearful, or worrying a lot became the third most prevalent issue with 60% of students, followed by 59% of students being sad. 44% of students were angry or unable to control their emotions, or felt hopeless about the future at least one out of the past 30 days.

BARRIERS YOUTH FACE:

- Across both grade levels, students are experiencing the same four barriers when attempting to access BH services.
- *For middle school students:*
    - Fear of getting treated differently by peers/friends if they need these services (25%).
    - Not wanting others to know they have a mental health-related need (21%).
    - Their own lack of information on resources or their awareness of resources that are available (17%).
    - Not being able to get an appointment when needed (17%).
- *For high school students:*
    - Not wanting others to know they have a mental health-related need (29%), followed by (28%)
    - Fearing that they might get treated differently by peers/friends if they need these services (28%).
    - Their own lack of information on resources or awareness of available resources (23%).
    - Not being able to get an appointment when needed (19%).

SUBSTANCE USE

The availability of county-level data on substance use and abuse is also limited. Because of this, it is important to review some of the general population data that is available about alcohol and drug use (from the 2017 Behavioral Health Profile).

In 2014, St. Louis City had 198 DWI arrests, 902 liquor law violations and 435 drug-related arrests. The manufacture of methamphetamine has been particularly problematic for Missouri however, the number of lab seizures have dropped throughout the last decade. Specifically, Missouri has gone from 2,788 in 2004 to 1,045 in 2014. St. Louis County had 105 methamphetamine laboratory seizures in 2004 and 102 in 2014. St. Louis City had only 9 seizures in 2016. This should be interpreted cautiously due to the variations inherent in law enforcement.

In 2014, St. Louis City residents had a total of 241 alcohol-related and 392 drug-related hospitalizations. In addition, there were 1,630 alcohol-related and 1,010 drug-related emergency room visits that did not include a hospital stay.

In 2015, 3,459 individuals in St. Louis City were admitted into Substance Abuse Treatment Programs. Heroin was the primary drug of choice for 1,436 of these individuals. A total of 691 were primarily due to alcohol, with 699 due to marijuana. The next highest primary drug problem was cocaine with 358 individuals. Of the 3,459 individuals admitted, only 114 were youth under the age of 18, which has decreased by 54% since 2009. Youth under 18 years old made up 3.3% of the total number of individuals who were admitted to a substance abuse treatment program in 2015 (Table 71).

Table 71. City Youth Admitted into Substance Abuse Treatment Programs*

Age Ranges	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	% of total 2015	Diff.	% Ch.
Under 18 years old	249	234	191	137	149	143	114	3.3%	-135	-54.2%
General Population Total	3,941	4,038	3,648	3,387	3,166	3,370	3,459		-482	-12.2%

Division of Behavioral Health: Substance Abuse and Compulsive Gambling Admissions developed for the Status Reports on Missouri's Substance Abuse and Mental Health Problems.

MISSOURI STUDENT SURVEY – 2016 – ST. LOUIS COUNTY STUDENT SAMPLE - KEY FINDINGS TO BE GENERALIZED TO THE ST. LOUIS CITY STUDENT POPULATION

The Missouri Student Survey can provide estimates for youth in or near St. Louis County who attend the public schools. This survey is administered in even-numbered years to 6th through 12th grade students in participating school districts. St. Louis City schools do not participate in this process.

For the 2016 Missouri Student Survey, the full sample involved 94,486 students after adjustment and data cleaning tasks. The grade range was 6 to 12, with an average age of 14.67. The statewide random sample (tied to MO reported data) included 3,397 students. The sample was evenly represented by males (47.7%)

and females (52.3%), which is similar to the state's gender distribution (49% males and 51% females), and the St. Louis County sample.

Perception and patterns of use for cigarettes is a primary area of the student survey because of the associated health risks. On every item relating to cigarettes, the St. Louis County youth are improving. The average age of first use has increased by almost a year, only 11.8% reported lifetime use, with 4.3% using in the past month. Since 2008, there has been an 11.9% decrease in the percentage of students who report they have one or more friends who smoke cigarettes (currently reported for 24.9% of students). So overall, there are many positive changes occurring with youth cigarette use in St. Louis County. However, in the last few years, there is a 5.3% increase in the percentage of youth reporting they have used electronic cigarettes in their lifetime (20.6%), yet past month use has decreased slightly, with a reported 10.7% for 2016.

Youth who use alcohol are at greater risk of developing abuse problems later in life. An estimated 54% of youth in St. Louis County believe that it would be easy to get alcohol, but this item is one of the only items that showed a negative trend with alcohol for these youth. The average age of drinking has increased from 12.8 in 2008 to 13.5 in 2016, and 21.8% less youth have used alcohol in their lifetime than in 2008 (reported at 33.5% of youth). The monthly use of alcohol has also declined by roughly 12% with a reported 17% for 2016. There are 43% of students who report they have one or more peer who consumes alcohol, but this is a 12% decrease from the 55% reported in 2008. Overall, trends with alcohol use among youth are improving.

An alarming item was the average age of first use for inhalants, which was 10.9. This age has decreased from 11.5 years old reported in 2010 for St. Louis County youth. However, only 2.7% reported that they had used an inhalant in their lifetime, with only 1.1% in the past month.

Trends with recreational prescription drug use are also important to monitor. We are seeing more students reporting lifetime prescription drug misuse (12.7%), and 8.6% reported misusing prescription drugs in the past month in comparison to only 5.9% of the 2008 student sample. The prescription drugs that are most likely to be misused by youth are pain medications, where 13.2% of youth reported misuse in the past year. Prescription drug misuse has a more negative perception by youth and their peers and parents than alcohol, cigarettes, and marijuana. Prescriptions drugs are viewed as almost as risky as illicit drugs, which include heroin, crack, and cocaine.

Marijuana use seems to be of less concern to students, their peers, and their parents over the past few years, but there are still 75% of youth who believe it is wrong or very wrong, and 90% of their own peers believing the same. With that being stated, the average age of first use has increased to 14.4 in 2016 from 13.1 in 2008, which is a very positive trend for the St. Louis County youth. There are 19.9% of youth who report using marijuana in their lifetime with 11.3% using it in the past month. Lifetime use has decreased over time, with past month use increasing from 2008 to 2016. Sixty-four percent (64%) of the youth believe marijuana is a great or moderate risk in comparison to 91% of youth for other illicit drugs.

Interestingly, 87% of youth perceive synthetic drugs to be of moderate or great risk. Youth distinguish risk differently for alcohol with no defined dosage (67% as a moderate or great risk), and drinking alcohol five or more drinks at a time, once or twice a week (83% as moderate or great risk). Cigarettes at 87.5% are almost as high as other illicit drugs as well. Lifetime drug use is decreasing and at one of the lowest reported percentage for the following drugs: chew use (3.7%), cigarette use (11.8%), club drug use (1.2%), cocaine use (1.1%), hallucinogen (2.0%), heroin (.3%), methamphetamine (.3%), and synthetic drug use.

Another area of focus is on the ease of availability assessments where alcohol and over the counter drugs are reported as the most easily accessible by more than 50% of students. Fifty-five percent of youth report over

the counter drugs as being easily accessible, yet only 1.8% of youth report past month youth. Fifty-four percent of youth report alcohol as easily accessible, and this is the item with the highest report past month use at 16.6%. The full summary of this information is provided in the St. Louis County Youth-focused Needs Assessment.

In 2016, St. Louis County youth were doing better than the Missouri youth sample on 60% of the items (75 total items). St. Louis County youth had 4% or greater differences with Missouri youth on only 18 items. The item that represented the largest difference of 12.3% between St. Louis County and Missouri students was for enforcement of gun laws. There were 73.9% of St. Louis County students who reported that gun laws would be enforced in comparison to 61.7% of Missouri students. ***The areas where St. Louis County youth were performing better than Missouri related mostly to perception and harm of alcohol, enforcement of laws, school safety, and cigarette use.*** There was no difference between the Missouri sample and St. Louis County sample on 5.6% of the items (seven items).

RACIAL TRENDS AND COMPARISONS FOR THE 2016 MISSOURI STUDENT SURVEY ITEMS

The Missouri Student Survey data is provided by the three racial categories of White, Black, and Hispanic, and in comparison, to the state percentage and St. Louis County percentage for each item in 2016. Per item (or row), the racial category or region highlighted green represents the one that was doing the "best" (highest or lowest respective percentage). The category highlighted red represents the one that was doing the "worst" (highest or lowest respective percentage) out of all the comparisons in 2016. If the difference between the "best" or red box and "worst" or green box in each row is 8% or greater, an asterisk (*) can be found in the "Significance" column. These will be considered significant for this paper's purposes. This symbol, ~ is being used if the difference was between 6-7.9%. These items require attention and are noted throughout the findings detailed in the next few pages, and by section. Items are coded by relevance in the table, and their code names are provided in parentheses behind each heading below so that the reader can easily find these items in Table 77 (p185).

Oppositional Behavior (Behavior) and Bullying (Bully and BullyV)

- There were greater percentages of Black (23.3%) and Hispanic (22.7%) students who ignored rules in comparison to White (15.9%) students. Black (16.7%) and Hispanic (14.9%) students were also at higher percentages for being oppositional in comparison to White (8.9%) students. Approximately 10% of Black students had been suspended in the past 3-months in comparison to 2% of White students.
- There was a significantly higher percentage of Black students who engaged in emotional (62.5%) and physical bullying (25.2%) of others than White and Hispanic students. While not significant, a higher percentage of White students than other students engaged in bullying online (20.5%) and in rumor spreading (27%).
- *White students had the highest percentage (62.2%) of those who were victims of emotional bullying. Black students had the lowest percentage at 54.7%, which is still considered high. Black students had the lowest percentage (19.7%) who had been a recent victim of bullying online or via cell phone. Both Hispanic (27%) and White (26.5%) students were at much higher percentages for this type of bullying than Black students*. While not a significant difference, Hispanic students had higher percentages who were victims of physical bullying (23.5%), rumor spreading (47.1%), and being a victim of any bullying at school in the past year (significant; 28.8%)

Depression (D)

- *In five out of the six items assessing depression, there was a greater percentage of Hispanic students who were depressed than White and Black students.* This included, student had an eating disruption (23%), felt hopeless (16%), had school/work disruption (32%), had sleep disrupted (27%), and they were sad (24%). The only item where this did not occur was with students' ratings of irritability, where 37% of Black students reported, which was the highest and significantly different from the 27% of White students.

Suicide, Self-Harm, and Fighting (Harm)

- Covering all of the suicide and self-harm items, Hispanic students had the highest reported numbers. 17% had seriously considered suicide in the past year. The only item with a significant difference was for self-injury where 23.2% of Hispanic students reported in comparison to only 13% of Black students.
- There was a significantly higher percentage of Black students (28.3%) who engaged in fighting in the past year in comparison to all of the other racial and regional comparisons.

Weapons (Weapon)

- *A matter of concern with weapons was that 18.9% of Black students reported that their peers carry a gun, which was significantly higher than all other regional and racial comparisons.*
- Enforcement of gun laws was rated highest by White students at 77% in comparison to the state at 62%.

Cigarette and Electronic Cigarette Trends (C and EC)

- In every comparison, St. Louis County was doing better than the state on the cigarette items covering use and perception. There was a significantly higher percentage of county youth (39.5%) who believe cigarette use is enforced than the 29.7% of Missouri students.
- A significant difference was found where 90.3% of White student rated smoking a pack of cigarettes a day as being moderate or great risk in comparison to only 78.8% of Black students. Black students had the lowest ratings of cigarette use in comparison to White and Hispanic students, and in comparison to the state.
- White and Hispanic students had significantly higher percentages than Black students who had used electronic cigarettes in their lifetime, in the past month, and who could easily get them.

Drug Trends (Drugs)

- Most of St. Louis County students' method of access to drugs was noted as coming from a family member (3.8%) or a friend (1.7%). Six percent of Black students got drugs from their family, with 3% of Hispanic students getting drugs from their friends. These groups are the outliers for access.
- *The drugs that were most likely to be reported as misused in the past year were pain medications (13%) and other prescription medications (10%). There were significantly higher percentages reported for pain (20%) and other prescription (15%) medications with Black students than other groups of students, especially White students.*
- When students were asked to give their reasons for misusing prescription medications, the highest percentages were to reduce or manage pain (4.6%), help them sleep (2.9%), help with stress reduction (2.5%), and help them feel better or happier (2.2%). Across the ten potential reasons for prescription misuse, Hispanic students were higher than the St. Louis County and Missouri total percentages in nine of the comparisons.

Alcohol (A) Trends

- Including 22 alcohol-related items, Black students had the "best" percentages on 12 of the items; Hispanic students had the "worst" percentages on eight of the items. The more prominent findings include:
  - 46.2% of White students had one or more peers who drink alcohol in comparison to only 34.5% of Black students.
  - 27.3% of Black students have used alcohol in their lifetime in comparison to 38.2% of Hispanic students.
  - 19% of White students have consumed alcohol at least one day in the past month in comparison to only 10% of Black students. Further, 58% of White students said alcohol is easy or very easy to get in comparison to only 43% of Black students. White students had the highest percentages for past month alcohol use, past two weeks binge drinking, and peer alcohol use.

Marijuana (M)

- With the 16 marijuana-related items, the state performed better than St. Louis County students on twelve of the items. Black students and with many of the items, Hispanic students, reported more use, and have perceptions of marijuana that it is not as risky or harmful as the general population of students in the County and in Missouri. Many of these comparisons were significantly different from the state percentages, especially for lifetime marijuana use (23.6% of Black students in comparison to 15.2% of MO students). There were 45.5% of Hispanic students who reported marijuana being easily available in comparison to only 27.1% of Missouri students.

Over the Counter (OTC) Drugs and Prescription Drugs (Script)

- *White students had a significantly higher percentage of students (58.3%) that said OTC drugs were easily available in comparison to only 45.6% of Black students. There were also significant differences between these groups on their perception of harm about OTC and prescription drug misuse. Seventy-two percent (72%) of Black students rated OTC misuse as moderate or great risk in comparison to 82% of White students. Seventy-eight percent (78%) of Black students rated prescription misuse as moderate/great risk in comparison to 90% of White students. Similar results were also noticed with perception of harm about synthetic drugs, which would suggest the necessity for education to this student population so that the harms of these drugs can be shared.*
- *Black students had higher percentages who reported lifetime (7.5%) and past month (3.6%) OTC drug misuse, and lifetime (16.8%) and past month (12.2%) prescription misuse.*

Manage Life (Healthy)

- Hispanic students had the lowest reported percentage at 72.4% who had an adult in their life they could turn to when things feel overwhelming.
- Both Black (65.8%) and Hispanic (67.9%) had significantly lower percentages who know where to go in their community to get help in comparison to White students (77.2%).

School and Parent Support (School)

- Both Hispanic (69.5%) and Black (70.5%) students had significantly lower percentages of students than Missouri (78.4%) students who reported that they experienced no discrimination in student treatment. Both of these groups also had the lowest percentage agreeing that rules are enforced fairly.

- Hispanic students had the lowest percentage at 66% who reported that their parents consult them when making decisions and parents notice and comment on good work (significantly different from other racial groups in county and the state).
- Black students had the highest percentage (81.4%) that noted teachers noticed and commented on their good work; which was significantly higher than the state rate of 73.2%.
- Items relating to school safety showed that black students had significantly less students at 83.1% than White students at 91.5% rating it as safe or very safe.

GRADE TRENDS AND COMPARISONS FOR THE 2016 MISSOURI STUDENT SURVEY ITEMS

The Missouri Student Survey data is provided for each of the grade levels assessed, and in comparison to the state percentage and St. Louis County percentage for each item in 2016. Per item (or row), the grade highlighted red represents the one that is doing the "worst" (highest or lowest respective percentage) out of all the grades. This identifier was used to highlight when the item peaks or is at its highest or lowest amount across grades. For many of the items relating to drug and alcohol use, you would expect 11th and 12th grade students to be highlighted red. Therefore, findings that are atypical will be the only ones noted in the narrative section below. The same coding was used for the grade trends as was found with the racial trends. The rating scale options that are tied to the percentages shown are provided in the last column.

- For many of the items assessing perception of harm of various substances, 6th grade students had the lowest percentage assessing them as a moderate/great risk. This included having 1 or 2 drinks of alcohol nearly every day, (74%), having 5 or more drinks of alcohol 1-2 times per week (81%), consuming one or more packs of cigarettes per day (86%), other illicit drugs (88%), over the counter drug misuse (77%), prescription drug misuse (83%), and synthetic drugs (78%).
- The same percentage (19.6%) of 8th and 12th grade students had been with a driver under the influence for at least one day out of the past month, which is more than 5% greater than the Missouri percentage. This is an item that needs attention in the St. Louis County region.
- Forty percent of 11th grade students believed it is okay to cheat, which remained at 38% for seniors in high school. This percentage jumped by almost 10% from 10th to 11th grade.
- The same percentage of 8th, 9th, and 11th grade students agreed that they were oppositional (12.5%). Seniors were close at 12.2%.
- 9th grade students had the highest percentage who bullied online or via cell phone (24.8%) and who spread rumors (28.7%) at least one time in the past three months, and who were victims of online or cell phone bullying (28.9%), emotional bullying (64.1%), and rumor bullying (46.6%). Sixth grade students had the highest percentage who physically bullied others (18.5%), and who were victims of physical bullying (29.6%) at least one time in the past three months, and 33.6% who were a victim of bullying at least one time in the past year.
- Sixty grade students were also at the highest percentages for fighting once or more in the past year (22.3%) and fighting with injury (3.2%).
- All of the depression items peaked in 11th grade.
- All of the suicide-related items peaked in 11th grade, with 12.3% who planned a suicide, 18% seriously considered it, 6.9% attempted suicide, and 1.8% attempted suicide resulting in an injury (in the past year). Self injury peaked in 10th grade with 19.6% attempting self-injury in that year.
- Chew use jumped from 4.8% of 10th graders to 9% of 11th graders in 2016. Club drug and cocaine use also spiked in 11th grade to 3.3-3.4% for both (from 1% or less in 10th grade).

- A higher percentage of middle school students get drugs from family members than would be expected. Almost 5% of 8th graders said they get drugs from family members. More of the high school students get drugs from their friends.
- The highest percentage of other prescription medication misuse (unidentified) was found with 6th graders at 16.6% (at least one time in the past year). Almost 16% of 8th graders had misused pain medications at least once in the past year, which was the highest percentage across all of the grades. Anxiety medication misuse was the highest at 5.7% with 11th graders. Sleeping meds were misused the most by 8th graders at 6.5%.
- 6th graders had the highest percentage of school days missed due to safety concerns (6.5% missed one or more days in the previous year).

BEHAVIORAL HEALTH RESPONSE DATA ANALYSIS: TRENDS FOR THE 2015 ST. LOUIS COUNTY YOUTH CASES AND FY2017 ST. LOUIS CITY YOUTH CASES

Data was provided to BOLD, LLC to analyze trends for the 2015 St. Louis County youth cases (age 20 and under) calling into the Behavioral Health Response (BHR) St. Louis County Youth Connect hotline. The St. Louis City summary information (provided in pdf format to BHN, and subsequently to BOLD, LLC) covered three quarters of a year from July of 2016 through March 2017. Here are comparative findings between these two regions for the data that was available.

BHR YOUTH CASES

St. Louis County Youth BHR Cases in 2015

BHR handled 2,128 cases in 2015 for St. Louis County youth, where 49% (1,046) were females and 50% (1,055) males, with 1% not identified (27 cases). Here is a breakdown of those cases across the various sub-regions.

- North County (NC)= 1,070 youth - 50% of the total cases
- Central County (CC)= 557 youth- 26% of the total cases
- South County (SC)= 246 youth- 12% of the total cases
- West County (WC)= 219 youth – 10% of the total cases

Sixty-four percent (64%) of the cases were youth age 10 to 18, with 38% of the cases being youth age 15 to 18. Less than 4% of the cases were children under the age of six.

Table 107: Age Ranges of 2015 BHR Cases

Age Ranges	%	#
Age 0 to 2	1%	13
Age 3 to 5	3%	72
Age 6 to 9	12%	259
Age 10 to 14	28%	595
Age 15 and 18	38%	806
Age 19 and 20	11%	242
Unknown	7%	141

St. Louis City Youth BHR Cases in FY 2017 Q1-3 (July 2016 through March 2017)

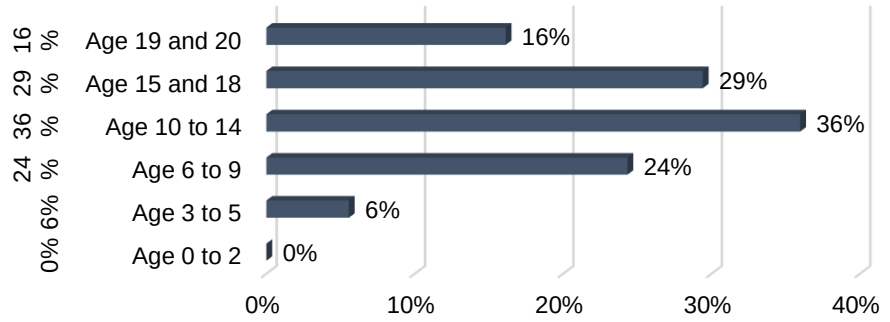
During this period of time, BHR handled 475 cases representing St. Louis City youth

ASSESSMENT OF RISK

BHR staff assess cases as being high risk (based on specific criteria of being suicidal, past or current, engaging in self-harm or self-injurious behavior) or low to no risk, which is an important distinction to make when assessing the percentages of cases that were linked within two or fourteen days.

St. Louis County - There were 571 high risk cases, which equates to 27-28% of the total number of cases (where risk was assessed). Figure 40 shows the percent of youth in each age range that were high risk. Thirty-six percent (36%) of the 10-14 year old cases were high risk, followed by 29% of the youth age 15-18, and 24% of the 6-9 year old children. Less than 6% of youth age 3-5 were at risk, with 0% of the youth age 0-2 at risk.

Figure 40. Age Ranges - Percent that are High Risk - St. Louis County



St. Louis City -There were 209 out of the 475 callers or 44% that were considered high risk cases in comparison to 27-28% of the St. Louis County cases (high risk cases = 571 out of 2,128 total cases).

ASSESSMENT OF PRIMARY PROBLEMS FOR 2015 ST. LOUIS COUNTY BHR CASES (NO COMPARISON WITH ST. LOUIS CITY DATA)

Five primary problems make up 88% of the 2,128 BHR cases (where known problem was assessed). The top five primary problems were:

1. **Childhood/Adolescent problems** – 35%
2. **Non-Acute Mental Health needs** – 22%
3. **Housing** – 15%
4. **Currently Suicidal** – 9%
5. **Education and Assistance with Referral** – 7%

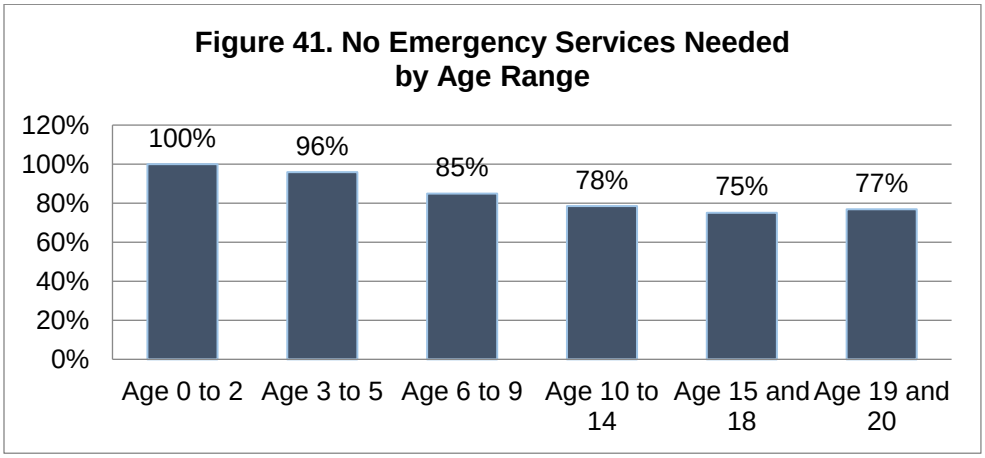
Childhood adolescent problems, mental health needs, and cases where youth are currently suicidal were in the top five problems across all of the sub-regions in St. Louis County as well (see Table 108).

ANALYSIS OF EMERGENCY SERVICES NEEDED

St. Louis County - 80% of the 2015 BHR cases did not require emergency services, which included admission to a psychiatric or medical unit, or an emergency visit (of the valid 2,103 cases). There were 5% of the cases (113 youth) that required admission to a psychologist/psychiatric unit, with 6% of cases (126 youth) requiring an ED visit for psychological services.

St. Louis City – 87% or 436 of the 499 reported cases did not require emergency services. There were 4.4% of the cases (33 youth) that required admission to a psychologist/psychiatric unit, with 6.8% of cases (34 youth) requiring an ED visit for psychological services.

The percentage of cases in each age range where no emergency services were needed is provided in Figure 41. Seventy-five percent of youth age 15 to 18 did not need emergency services, which was the lowest among all of the age ranges. This age range had 14% (114 youth) being admitted to a psychological/psychiatric unit or needing a visit related to a psychological/ psychiatric issue. Fifteen percent (15%; 88 youth) of the cases in the 10 to 14 age range required these psychological/psychiatric-related services as well. Overall, 12% of the cases, where this information was collected, required these types of services, representing 237 total youth.



LINKAGES

St. Louis County - BHR staff assess cases as being high risk (based on specific criteria of being suicidal, past or current, engaging in self-harm or self-injurious behavior) or low to no risk, which is an important distinction to make when assessing the percentages of cases that were linked within two or fourteen days. In Table 114, the total number and percentage of cases and their primary problem were assessed for those linked to a service within 2 days, and then by 14 days. Overall, 60% of the total cases were linked to services within 2 days, and 64% within 14 days.

St. Louis City – 65.7% of callers (312 callers out of 475) received linkage from the linked services they received as a result of the intake call. There were 68% of callers who wanted the linked services' information.

Within each of these primary problem types, there was a rather high number of cases where no data was available, so it is important to focus on the number of youth that fall in the "no" column or the "% Not Linked in two and 14 days" columns shown in Table 114. Overall, 117 out of the 2,128 youth did not get linked to services within two days, which is 5% of all cases. However, 34% of these cases, or 733 youth, are unknown

for this item. The largest number of youth who did not get linked to services within the 2 or 14-day window were dealing with the generalized “childhood/adolescent problems”, which may require more time to connect with services. More than half of these unknown cases have noted barriers that will be explored in the next section.

High Risk Cases -St. Louis County- Cases that were identified as high risk were analyzed for their linkage to a service within two and 14 days as well (see Table 115). Eighty-six percent (86%) of the high risk cases were linked to services within two days of calling, and 89% were linked within 14 days. Not counting the youth with no information, only 21 youth (3.7%) were not linked to a service within two days, and two youth (.4%) within 14 days. Data was mined specifically for these high risk cases to determine what barriers were experienced without knowing what happened to the youth where no data (which represented 10.3% of the high risk cases) was available. The barriers experienced by these high risk cases will be explored shortly.

High Risk Cases -St. Louis City – There were 80% of the high risk cases (169 out of 209) in St. Louis City who wanted to be linked to services within 14 days, with 167 of them who were linked (99% of those who agreed to follow-up service).

BARRIERS FOR CASES THAT WERE NOT SERVED OR LINKED

St. Louis County -There were 433 cases or 20% of youth that experienced barriers, with 508 total barriers noted for these cases. Eighty percent (80%) of the cases had no identified barriers. It is important to note that for the 2,128 BHR cases, insurance was a barrier for only two of them, finances/funding for two cases, and transportation for four cases (when looking at all of the barriers noted by the caller/client). These three barriers are linked to only .2% of the total 2015 cases. Ninety-nine youth or 5% declined follow-up or referrals from the BHR staff. Fifty-six cases (3% of these cases) stated that services were not needed during the follow-up call, with twelve cases needing services that were not available. The largest barrier was not being able to verify or re-connect (contact) the client associated with the case, which represented 12% of cases. Perhaps additional contact information should be gathered during intake to increase the likelihood of contacting these youth, but it is more likely a result of these youth not wanting to be contacted.

	Central	North	South	West	St. Louis County
% with Barriers	19%	21%	17%	16%	20%
# with Barriers	107	230	43	36	**433**
Total Cases	557	1070	246	219	2128

St. Louis City – There were 179 cases or 38% of youth that experienced barriers in St. Louis City. Similar to St. Louis County, lack of insurance, finances, and transportation were barriers for less than four total callers/clients. The largest barrier was once again not being able to verify or re-connect (contact) the client associated with the case, which represented 25% of cases; 4% declined follow-up; with 3% of guardians declining referrals upon the follow-up call. Almost 3% of services were not needed upon follow-up.

HIGH RISK CASES WITH BARRIERS

St. Louis County - Previously, high risk youth were assessed for the percentage that were linked within two and 14-days, with no data available for 59 of those youth, who had experienced a total of 68 barriers. An

estimated 10% of high risk calls had a barrier. Overall, 7.5% of high risk youth were not able to be verified or contacted, followed by a combined 3.5% who declined follow-up of any kind. Not one of the barriers listed by the high-risk cases was that the services that were needed were unavailable. Insurance and funding were noted by one client each, with four youth not needing services any longer.

St. Louis City – Approximately 21% of high risk callers experienced a barrier, with 17% of these youth not able to be verified or contacted during the follow-up call, 1.4% who declined follow-up and 2.5% who declined referrals.

HOW CALLER LEARNED ABOUT BHR

St. Louis County - Callers were asked how they that heard about BHR, with 20% from the school or teachers, 9% from agency workers, 3% from a friend, 2.4% through green card, 2.2% through police, and 2.1% through North Central Community Health Center (NCCHC). There were 33% classified as other, with this information not analyzed in greater detail.

St. Louis City – Here is a breakdown of how these callers heard about the call line; 44% from the school or teachers, 10% from agency workers, 4.9% through green card 2.5% from a friend, 1.7% from family, and 1.5% through police. There were 33.6% classified as other, with this information not analyzed in greater detail.

EASTERN REGION BEHAVIORAL HEALTH ACCESS TO CARE SURVEY DATA

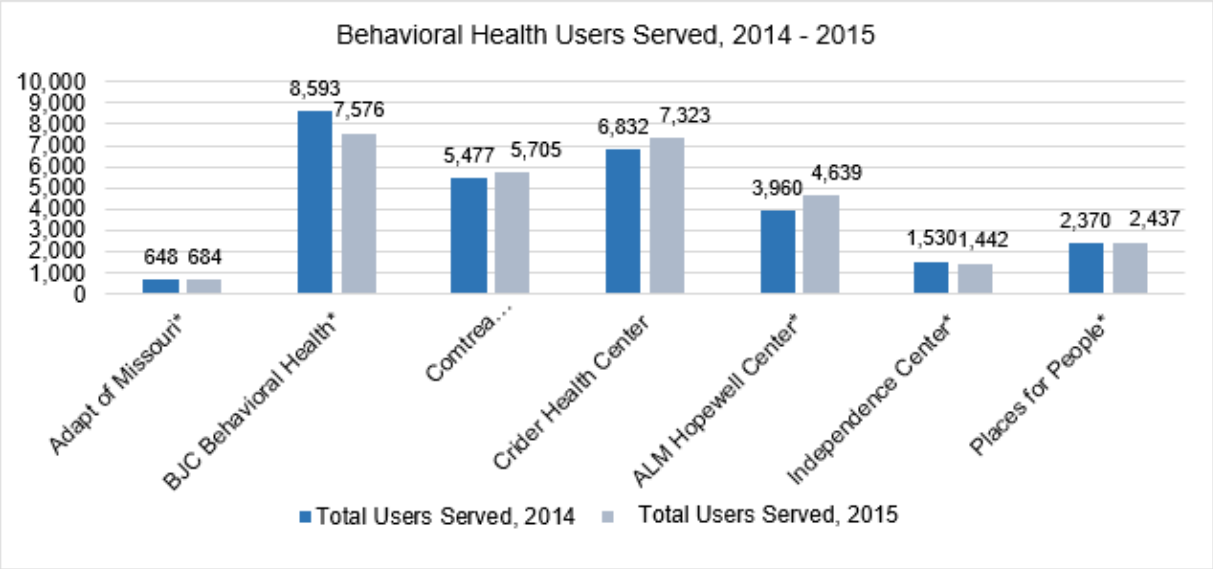
The St. Louis Regional Health Commission's (RHC) annual Access to Care Data Book details safety net primary care, specialty care, and emergency department provider operating statistics. BHN developed the inaugural "Eastern Region Behavioral Health Access to Care Survey" in 2015 to obtain calendar year 2014 data from Eastern Region mental health and substance use safety net providers. This process is continuing and trends first became available in the most recent report, with calendar year 2015 data.

This section reviews detailed self-reported, operating statistics of reporting community-based BH safety net providers (community mental health and substance use treatment) and safety net hospitals with inpatient psychiatric services in the Eastern Region of Missouri (St. Louis City and Counties of Franklin, Jefferson, Lincoln, St. Charles, St. Louis and Warren). BH includes mental health and substance use care for all ages, throughout the lifespan. Safety net providers included are area hospitals with inpatient psychiatric services, Department of Mental Health Administrative Agents and Affiliates and state-funded substance use treatment providers with the widest array of services for the general population in the Eastern Region. Self-reported data for this section of the report has been collected and verified by the BHN, with the exception of primary care data provided by local community health centers which is collected and validated by RHC. Historical data from 2005 is sourced from the Regional Health Commission's "Eastern Region Public Behavioral Health System: Utilization of Services" report, while historical data from 2007-2010 stems from the RHC's "MPC Regional Psychiatric Capacity Analysis and Recommendations" report.

COMMUNITY-BASED BEHAVIORAL HEALTH: COMMUNITY MENTAL HEALTH CENTERS

BH safety net community mental health providers+ served 29,806 users in 2015, remaining stable in 2015, as compared to the 29,410 users served in 2014. BJC BH and Independence Center saw a decrease in number

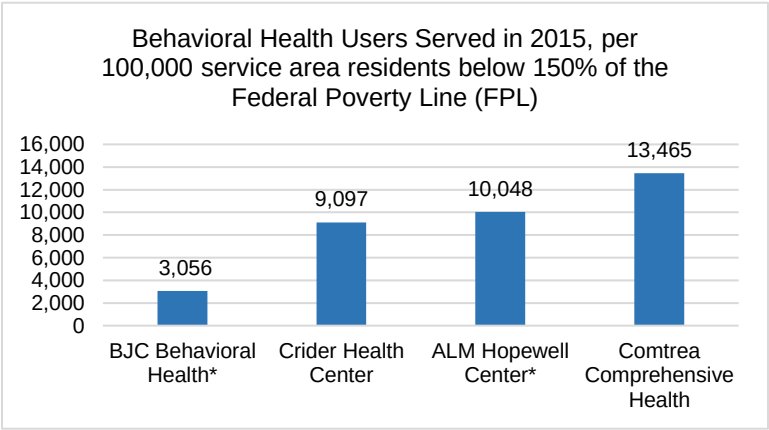
of users served (12% and 6%, respectively), while users served at all other community mental health centers either increased or remained stable.



Missouri Department of Mental Health's administrative agents have service catchment areas. Administrative agents' rate of serving the population below 150% of the Federal Poverty Line (FPL) within their designated service areas varies significantly by agency.

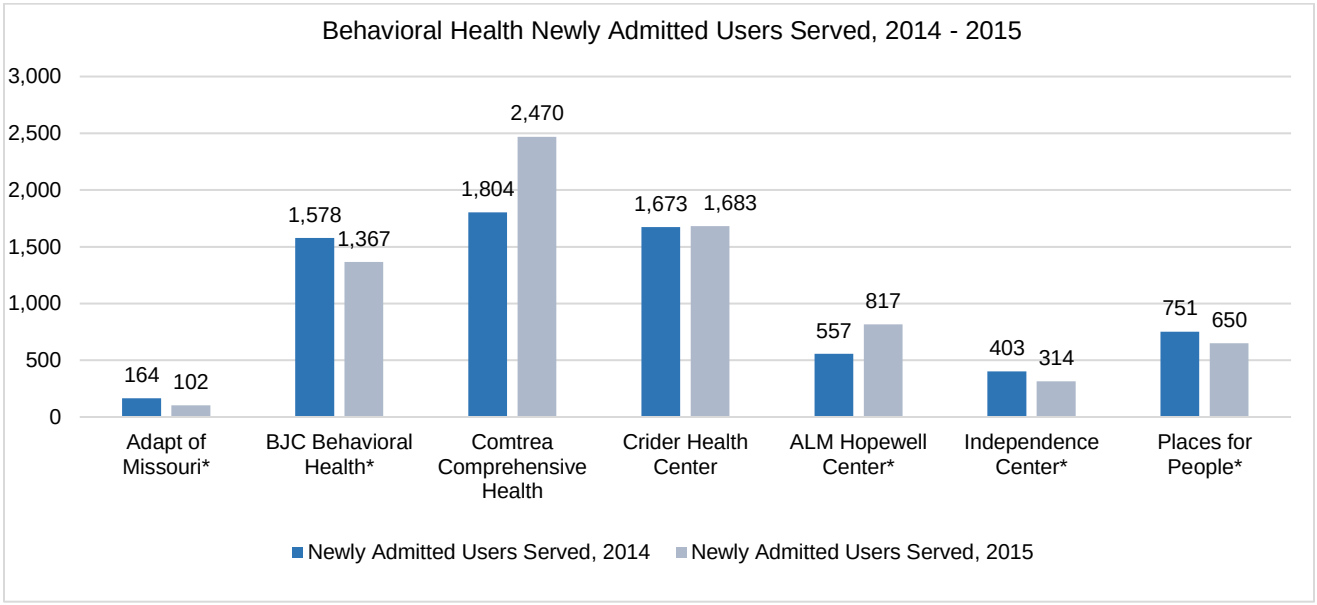
In addition to being served by DMH administrative agents BJC BH and ALM Hopewell, a portion of St. Louis City and County users are served by affiliate agencies (Adapt of Missouri, Independence Center and Places for People).

When combining service at both administrative and affiliate agencies, the rate of St. Louis City and County residents served in 2015 was 5,706 patients per 100,000 residents below 150% of the FPL.



BH safety net community mental health providers newly admitted 7,403 users in 2015. Newly admitted users served at BH safety net agencies increased by 7% (nearly 500 additional users) in 2015 as compared to the 6,930 new users served in 2014. Newly admitted users served accounted for 25% of overall users served in 2015.

Newly admitted users decreased slightly at Adapt of Missouri, BJC BH, Independence Center and Places for People, while newly admitted users at all other community mental health centers either increased or remained stable.

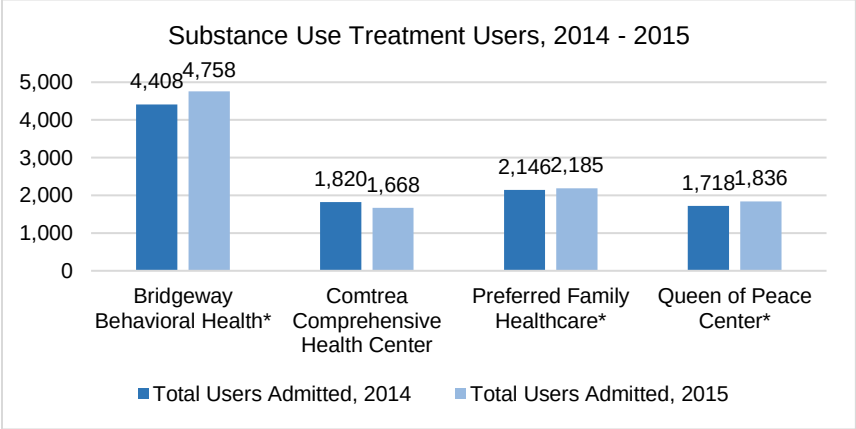


COMMUNITY-BASED BEHAVIORAL HEALTH: SUBSTANCE USE TREATMENT

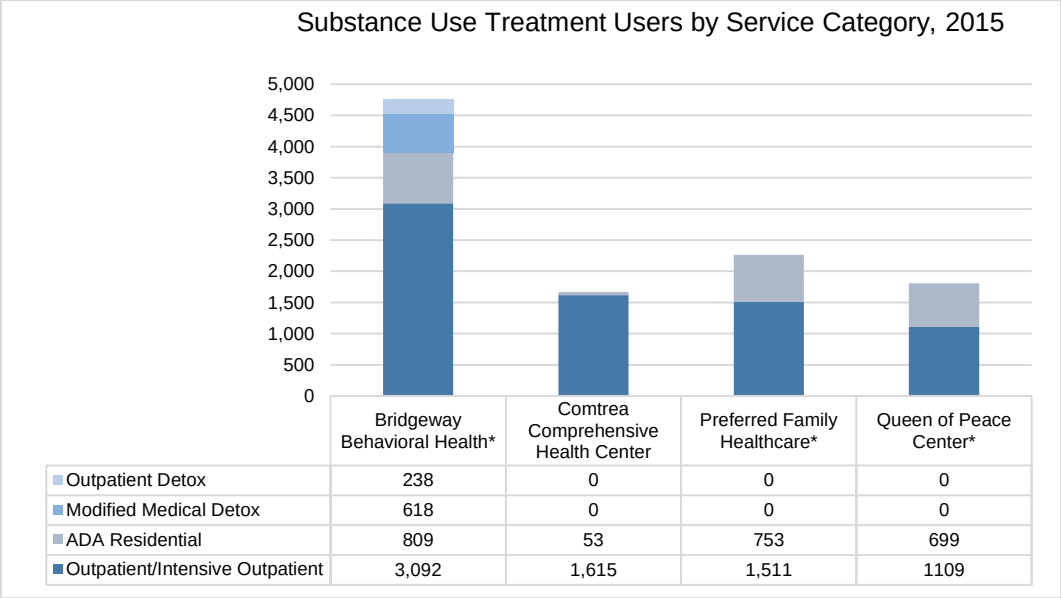
State-funded substance use treatment providers in the Eastern Region served 10,447 treatment users in 2015.

Substance use treatment users admissions remained stable in 2015, as compared to the 10,092 users served in 2014.

Service mix varies by substance use treatment provider. Bridgeway Behavioral Health provides detox, residential and outpatient services. Comtrea Comprehensive Health, Preferred Family Healthcare and Queen of Peace Center provide outpatient and residential services.



Service mix varies by substance use treatment provider. Detox and residential user volumes reflect that state-funded substance use treatment capacity is limited.



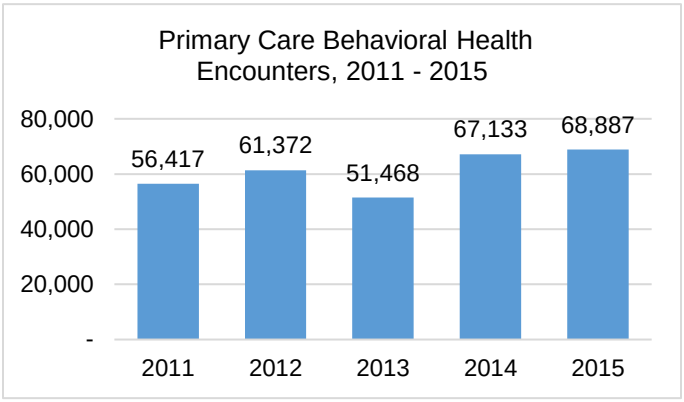
	Bridgeway Behavioral Health*	Comtrea Comprehensive Health Center	Preferred Family Healthcare*	Queen of Peace Center*
Outpatient Detox	238	0	0	0
Modified Medical Detox	618	0	0	0
ADA Residential	809	53	753	699
Outpatient/Intensive Outpatient	3,092	1,615	1,511	1109

Bridgeway Behavioral Health is the only state-funded modified medical detox provider in the Eastern Region of Missouri, serving over 600 admissions with 16 dedicated detox beds. Additionally, medical detox is privately available at only three hospitals in the region—BJC's Christian Hospital, SSM Health's DePaul Hospital and St. Clare Hospital.

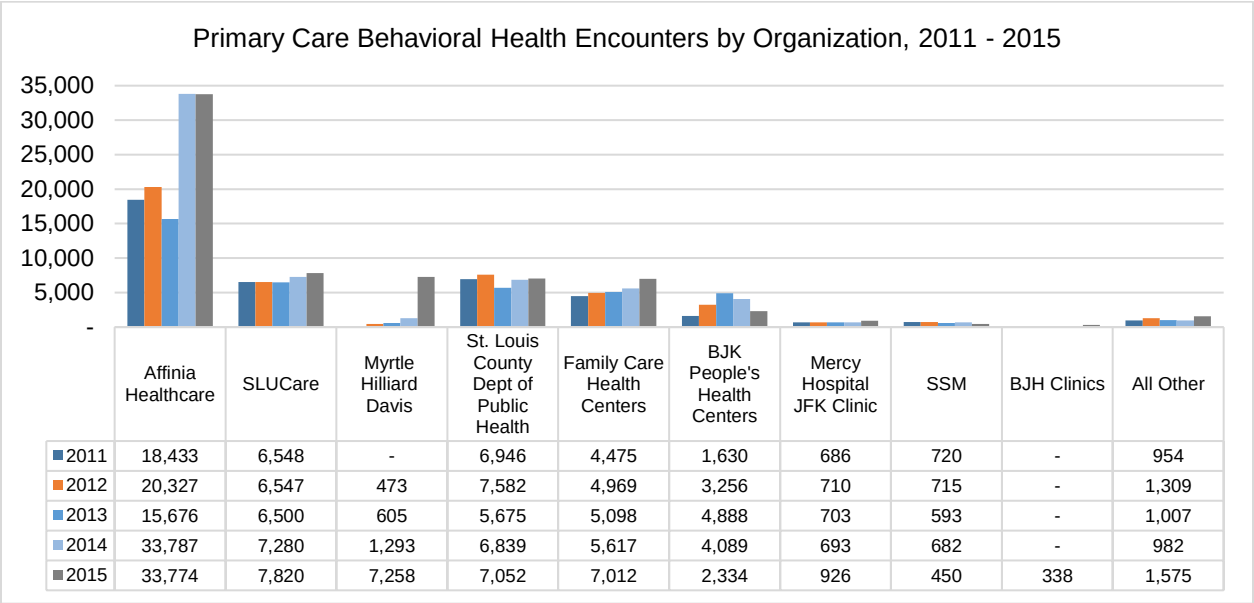
Note: Only services delivered by the four largest state-funded substance use treatment providers with the widest array of services for the general population within the Eastern Region are listed. Bridgeway Behavioral Health and Preferred Family Healthcare are reflected separately for 2015 and merged on January 1, 2016.

PRIMARY CARE

BH encounters at safety net primary care providers have increased by 22% since 2011. BH encounters at safety net primary care providers remained relatively stable over the past year.



BH encounters have increased at three safety net primary care organizations providing BH services. The three primary care organizations with increases in BH encounters over the past year include: Myrtle Hilliard (461%), Mercy JFK Clinic (34%) and Family Care (25%). BH encounters decreased at BJK People's and SSM by 43% and 34%, respectively, over the past year.

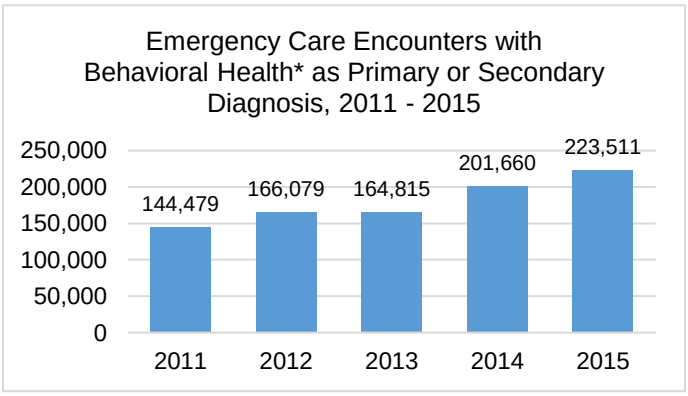


	Affinia Healthcare	SLUCare	Myrtle Hilliard Davis	St. Louis County Dept of Public Health	Family Care Health Centers	BJK People's Health Centers	Mercy Hospital JFK Clinic	SSM	BJH Clinics	All Other
2011	18,433	6,548	-	6,946	4,475	1,630	686	720	-	954
2012	20,327	6,547	473	7,582	4,969	3,256	710	715	-	1,309
2013	15,676	6,500	605	5,675	5,098	4,888	703	593	-	1,007
2014	33,787	7,280	1,293	6,839	5,617	4,089	693	682	-	982
2015	33,774	7,820	7,258	7,052	7,012	2,334	926	450	338	1,575

Note: "All Other" category includes the SPOT and St. Luke's Pediatric Care Center. STL County DPH contracts with Family Mental Health Collaborative to provide BH services. Encounters above represent BH services provided at STL County DPH clinics, as well as services provided through their Family Mental Health Collaborative. Affinia contracts with the Salvation Army to provide substance abuse services. In 2014, their model changed to provide more group sessions which in turn increased capacity for BH services. Myrtle Hilliard Davis increased capacity for BH services in 2014 and 2015 by hiring licensed clinical social workers. The "SSM" category includes St. Mary's Health Center and Glennon Care Pediatrics. Data for SSM's Danis Pediatrics is included in SLUCare's data, as this clinic is serviced by SLUCare providers. Additional BH counseling services are available at BJK People's during one day each week. Those encounters are not included in the data above as patients are not billed for those services.

EMERGENCY CARE

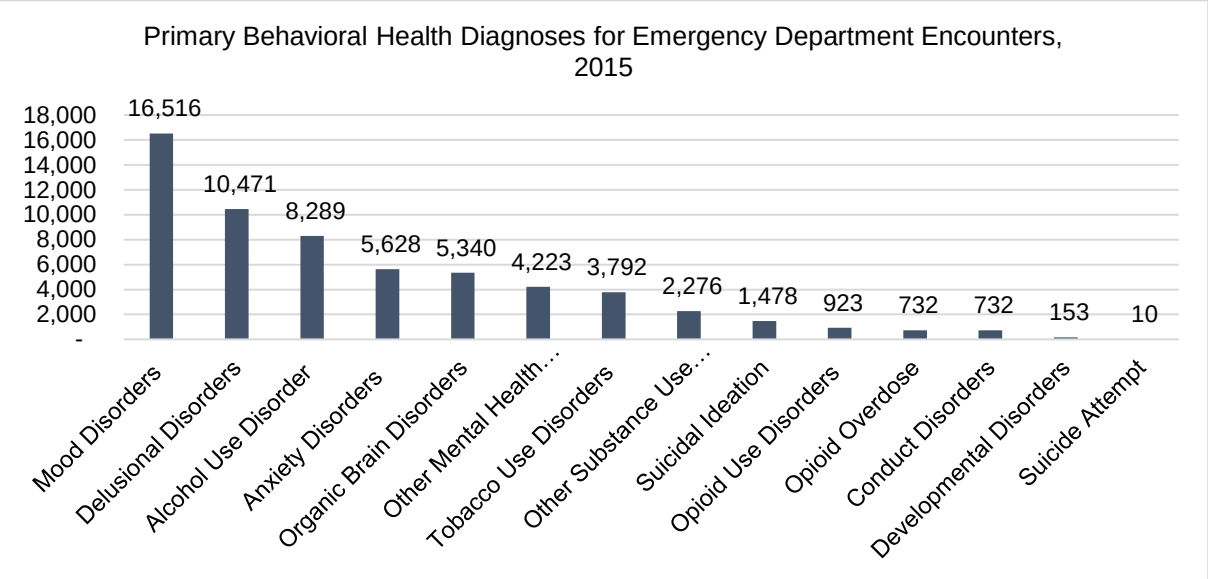
Emergency department encounters with BH diagnoses have increased by 11% over the past year and account for 32% of total emergency department encounters in 2015.



BH emergency department encounters have increased by 55% over this five year period.

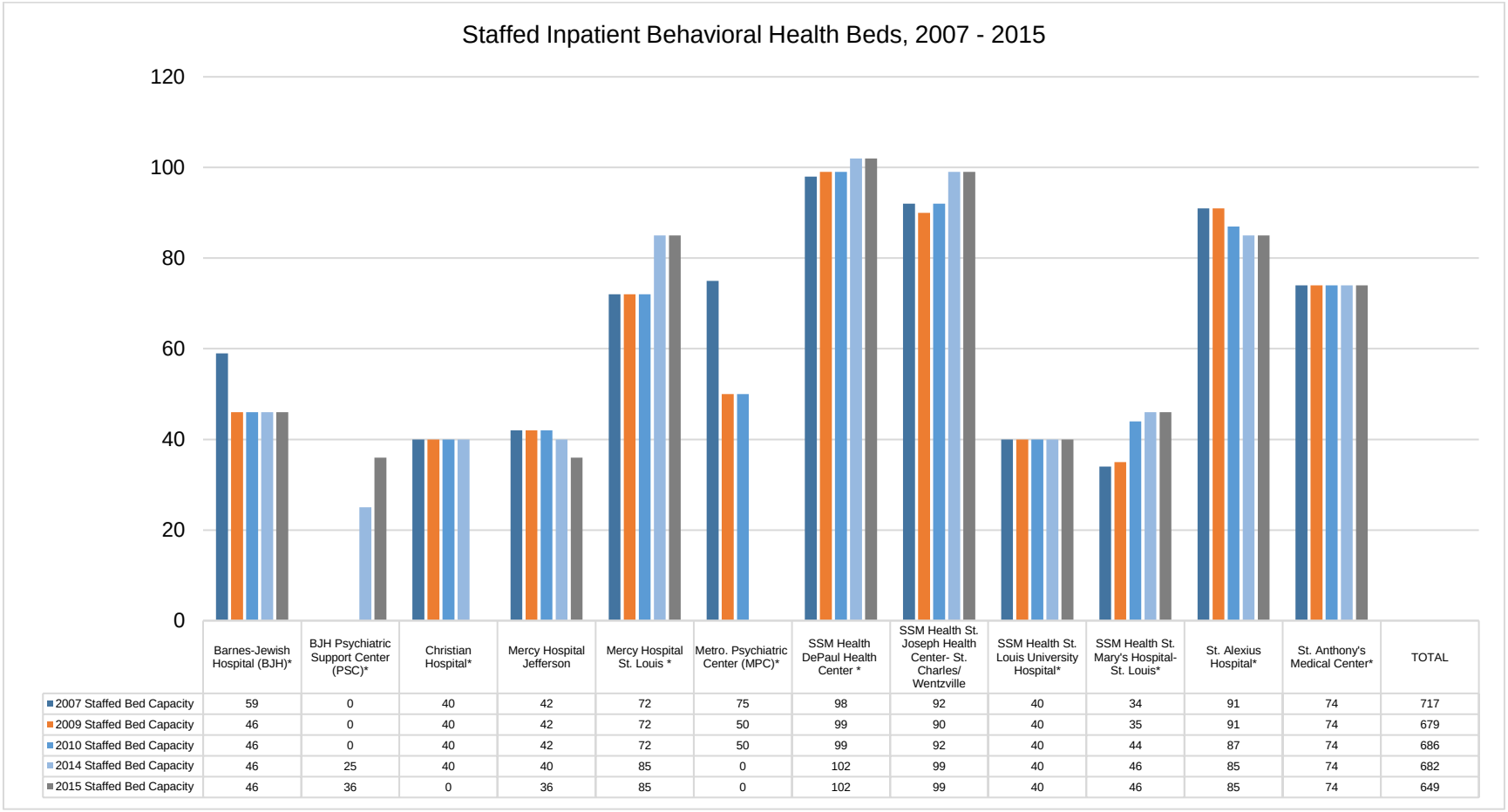
Tobacco use, mood and anxiety disorders make up 63% of all primary and secondary emergency department BH diagnoses in 2015. Of note, tobacco use, often coded for cessation or treatment purposes makes up 30% percent of these diagnoses.

Among primary diagnoses only, mood disorders (representing 27% of all BH primary diagnosis), schizophrenia/delusional disorders (representing 17% of all BH primary diagnosis and alcohol use disorders (representing 14% of all BH primary diagnosis) are the main BH diagnoses presenting to St. Louis area emergency departments.



INPATIENT CARE

Between 2014 and 2015 inpatient BH safety net hospital staffed bed capacity decreased by 33 beds, or 5% (from 682 to 649 total staffed beds). Inpatient staffed beds decreased by 10% as compared to 2007.



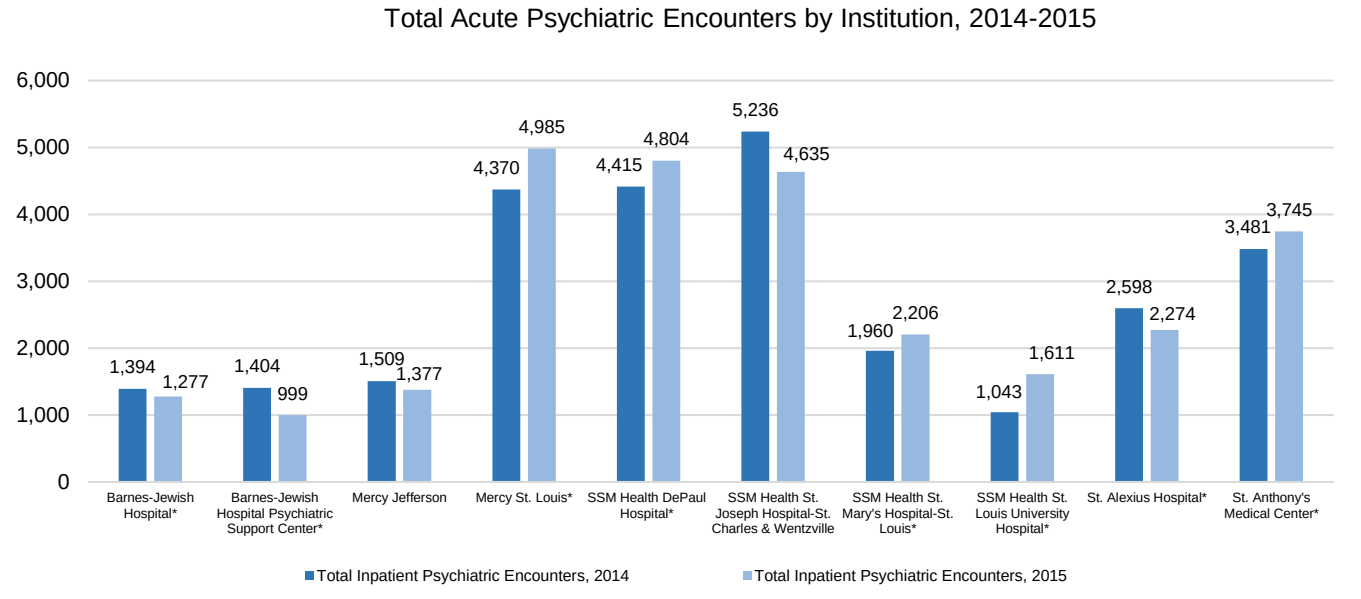
	Barnes-Jewish Hospital (BJH)*	BJH Psychiatric Support Center (PSC)*	Christian Hospital*	Mercy Hospital Jefferson	Mercy Hospital St. Louis *	Metro. Psychiatric Center (MPC)*	SSM Health DePaul Health Center *	SSM Health St. Joseph Health Center- St. Charles/ Wentzville	SSM Health St. Louis University Hospital*	SSM Health St. Mary's Hospital- St. Louis*	St. Alexius Hospital*	St. Anthony's Medical Center*	TOTAL
2007 Staffed Bed Capacity	59	0	40	42	72	75	98	92	40	34	91	74	717
2009 Staffed Bed Capacity	46	0	40	42	72	50	99	90	40	35	91	74	679
2010 Staffed Bed Capacity	46	0	40	42	72	50	99	92	40	44	87	74	686
2014 Staffed Bed Capacity	46	25	40	40	85	0	102	99	40	46	85	74	682
2015 Staffed Bed Capacity	46	36	0	36	85	0	102	99	40	46	85	74	649

Note: Data reflects community hospitals that provide acute psychiatric services, as well as Metropolitan Psychiatric Center (MPC), a former state-run hospital. MPC ceased services in July 2010. Psychiatric Stabilization Center, later renamed Psychiatric Support Center (PSC), opened at MPC's former site in January 2012. As of April 2015, Christian Hospital's 40 psychiatric beds were closed. As part of this 2015 transition, BJC HealthCare took over operations of PSC and expanded PSC's capacity to 50 licensed beds, opening April 2015 (with 36 staffed beds). Of note, Christian Hospital has since expanded outpatient resources to include extensive BH services and intensive outpatient programming.

Inpatient BH staffed safety net hospital bed capacity varied by hospital and population. In 2015, total staffed beds declined by 33 beds across adult and geriatric populations. In total, 108 beds are available through safety net community hospitals in the St. Louis region.

Hospitals with Inpatient Psychiatric Services	Staffed Bed Capacity ADULT	Staffed Bed Capacity GERIATRIC	Staffed Bed Capacity ADOLESCENT	Staffed Bed Capacity CHILD	Total Staffed Bed Capacity
Barnes-Jewish Hospital* (BJH)	36	10	0	0	46
BJH Psychiatric Support Center*	36	0	0	0	36
Christian Hospital*	0	0	0	0	0
Mercy Hospital Jefferson	24	12	0	0	36
Mercy Hospital St. Louis *	56	16	13 combined		85
SSM Health DePaul Health Center *	60	0	22	20	102
SSM Health St. Joseph Health Center-St. Charles	0	22	0	0	22
SSM Health St. Joseph Health Center-Wentzville	46	0	31	0	77
SSM Health St. Louis University Hospital*	24	16	0	0	40
SSM Health St. Mary's Hospital-St. Louis*	36	10	0	0	46
St. Alexius Hospital*	64	21	0	0	85
St. Anthony's Medical Center*	52	0	22	0	74
TOTAL	434	107	108		649

While acute psychiatric encounters remained stable overall in 2015, inpatient psychiatric staffed bed capacity has declined by 5% since 2014.



THEMATIC RECOMMENDATIONS AND SUPPORTIVE KEY FINDINGS

What follows are thematic recommendations that emerged from the findings across the three methods of data collection informing this Report: 1) Regional Reports; 2) Qualitative Data; and 3) Quantitative Data—all gathered and analyzed by the Behavioral Health Network of Greater St. Louis (BHN) and our sub-contracted partners, BOLD, LLC and Silver Arrow Strategies. A synopsis of key findings from each method can be found in the three respective sections of this Report (respectively starting on p20, p33, p45). BH is a broadly applied term that encompasses needs and services for mental health (MH) and/or substance use (SU) concerns, at all levels of severity and points on the service continuum.

Through the source information, BHN sought insights regarding the following aspects of St. Louis' youth BH system to inform recommendations: Resources/Assets, Barriers/Gaps, and Opportunities. BHN identified where the data conceptually reinforced each other, usually emphasized in all three sources, and developed major thematic recommendations regarding community response to youth BH needs. Each recommendation theme is followed by a brief explanation and a sampling of key findings which informed the prioritization of that theme to the status of a recommendation. There are insightful recommendations and findings in each of the three source sections of this Report, which were not elevated to the level of thematic "Recommendation." While important, they were not listed here due to less strong resonance throughout the three categories of source information.

The "opportunities" described under each recommendation were particularly guided by responses in the qualitative data and the regional reports. These opportunities offer general and specific programmatic approaches and populations of need, which would actualize the Recommendation theme. Of note, these recommendations should be viewed in tandem, allowing for interplay among the various thematic categories, as components link together to create the youth BH care system. The recommendations and opportunities below are not listed in a priority order.

1. RECOMMENDATION: TRANSFORM BEHAVIORAL HEALTH (BH) SERVICES TO BE OPTIMALLY ACCESSIBLE TO YOUTH

Enhance access to programs and services; Re-organize to increase responsiveness in service "gap" areas; Integrate follow-up and case management. Invest in system level disconnects and sustainable policies and care integration that can have sustainability.

Select Supporting Data:

- Across the regional reports and qualitative groups/interviews, a lack of access to psychiatry, particularly pediatric psychiatrists was cited as a key St. Louis gap areas.
- All of the qualitative stakeholder groups noted a desire for additional programs and services targeting BH, with the most common including Psychiatry access, Therapy programs that support the family (family therapy, parental therapy/support), substance use and prevention supports, and programs for special populations. Multiple stakeholders noted the need for more accessibility in the form of centralized community and BH resources, walk-in facilities with open intake hours or same day access for appointments (particularly medication management). For those with severe needs or co-morbidities, more facilities for longer-term or respite care were desired, particularly by BH providers.
- 20% of the BHR County cases, and 13% of the City cases required emergency services upon the intake call. Eleven percent of both (11%) the county and City youth required psychiatric and/or psychological services. Fifteen to 18 year olds in the county had the highest percentage at 25% who needed emergency services (N = 114).
- Across the board, regional reports and analyses offered data demonstrating a lack of capacity and shortage of providers for BH services. A planning group focused on BH for the St. Louis County CHIP indicated that the public health department lacks adequate resources to address MH, and high ED utilization for certain MH related conditions may indicate access barriers to inpatient, ambulatory and/or

crisis services. (8) [23] Specific references to funding limitations, wait times for appointments that extended past one month (5, 7), high numbers of youth BH clients (7) and unserved youth provided hard evidence of demand outpacing provider capacity in both St. Louis City and County. (2) Specific services identified as requiring additional capacity included crisis intervention and suicide prevention services (2), counseling, psychiatry including evaluations, respite services and community/home/school based programs.

- Substance Use: Youth identified drug availability and use as a key issue impacting them, their peers and the community (e.g. repeatedly discussed by all age youth in qualitative sessions and top BH issue expressed by high school students in Missouri Student Survey); Although St. Louis City data was not available, statewide the need for SU prevention beginning at an early age is widely recognized. In Missouri, SU onset typically occurs before the age of 14.
- While acute psychiatric encounters remained stable overall in 2015 (page 147), inpatient psychiatric staffed bed capacity decreased by 5% (33 beds) in 2015, as compared to 2014. Much of this decline (a net loss of 29 beds) took place in St. Louis County, subsequent to the Christian Hospital inpatient psychiatric service closure (page 146).

Opportunities to Transform Behavioral Health (BH) Services to be Optimally Accessible to Youth:

- Address Broad Barriers to access - Transportation and location of services; Address distrust of providers, negative past experiences with BH services, and stigma roadblocks for families and youth.
- Improve follow-up activities for youth who transition to a new or different program or service.
- Expand specialty services, specifically to include: respite, counseling (especially family counseling), home-based services, intensive outpatient programs/treatment, 24/7 crisis access/response service, inpatient supports, longer-term care/case management/follow-up (especially post-crisis), etc.
- Enhance care coordination within and across agencies and systems to improve access and engagement.
- Expand evaluation and psychological/psychiatric testing and services, respite care; and expand prevention and after-care services (in addition to the early intervention and treatment services currently funded).
- Address the shortage of psychiatric care providers. Approaches could include: Invest in supports to primary care providers to manage the care of patients with mild to moderate BH needs; Engage Advance Practice Nurses (APNs); Employ tele-psychiatry to augment BH care teams.
- Funding contracts require some level of care coordination and/or contributions to a sustainable BH safety-net infrastructure, beyond direct service delivery.
- Improve shared information/ communication between agencies to strengthen care coordination, including. between levels of BH care (e.g. inpatient hospitalization to outpatient services).
- Develop clear discharge protocols that manage exit from more intensive services.
- Expand options for SU treatment/supports and related-prevention activities.
- Increase free or low-cost options for BH services; Increase families' insurance access and reduce cost of services and medications.
- Support primary care integration with BH care, to include co-location and integration within service providing organizations as means to allow patients to move along a more collaborative continuum of care (e.g. CMHCs and primary care).

[23] Source Regional Reports and analyses are cited per the numbers assigned in Appendix A, p156

2. RECOMMENDATION: INVEST IN FAMILY SYSTEMS APPROACHES AND CAREGIVER SUPPORTS TO ADDRESS YOUTH BH

Services for youth BH needs must be integrated with and understanding that the youth cannot be understood in isolation, but rather as a part of their family, [24] and that providers must attend to caregivers' needs.

Select Supporting Data:

- Family-focused Services/intergenerational approaches are insufficient. Often, providers are not funded to work with the whole family or to overcome the challenges of working with multiple family members. While supports may be affordable or accessible to youth, uninsured youth caregivers with needs experience great difficulty in accessing and receiving services.
- High rates and numbers of neglect cases shows the need for family counseling, parent education, and family involvement in services. Linked to Juvenile Law Violation offenses, neglect had the highest number of offenses out of all categories with 596 for 2014, and is the only offense that increased by 5% in number of offenses from 2004 to 2014. From the quantitative data for substantiated cases of child abuse and neglect, neglect made up the majority of cases in both St. Louis City (45% or 90 out of 229) and St. Louis County (51% of 418 out of 819).
- Youth, caregivers, and providers vocalized need for training and supports on how to respond effectively to youth BH issues and provide youth support.
- BH stigma reduction needed. Stigma was one of the main fears of both middle and high school students if they needed BH assistance.
- Qualitative data showed that a higher percentage of youth and adults in the City report inadequate social support than surrounding areas (Community Reports).

Opportunities to Invest in Family Systems Approaches and Caregiver Supports to Address Youth BH:

- Fund services that allow for intergenerational approaches and caregiver specific services to improve caregivers' ability to recognize and manager BH issues with their youth. Invest in family systems approaches.
- Invest in resources to provide BH supports/treatment to caregivers in need of services.
- Integrate Family Support Providers (peer mentors) to assist families and caregivers.
- Facilitate caregivers' awareness and navigation of available services and resources.
- Increase the availability of family counseling.
- Improve digital / online information about available services, and ensure it includes eligibility parameters to minimize future accessibility issues and frustration of the family and youth.
- Strengthen caregivers' general parenting skills and knowledge, including understanding developmental milestones.

3. RECOMMENDATION: STRENGTHEN THE SERVICE PROVIDING COMMUNITY'S RESPONSIVENESS (BH AND NON-BH PROVIDERS)

Enhance service agencies and providers to be better equipped to respond to community youth BH needs, regardless of care setting or sector. Improve approaches to transitions of care for youth with agency/provider expertise, coordination, and collaboration.

Select Supporting Data:

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[24] Kerr, Michael E. "One Family's Story: A Primer on Bowen Theory." The Bowen Center for the Study of the Family. 2000. http://www.thebowencenter.org.

- All provider types (interviewed for the qualitative section) expressed the need for enhanced care coordination within and across agencies and systems to improve access and engagement, noting they sometimes have difficulty with warm hand-offs and client transitions between services, often due to limited cross-agency infrastructure, key contacts, or logistical barriers. Poor communication between providers and a lack of follow-up on cases on both ends of a referral were highlighted as contributing factors.
- From the regional reports where more than 50+ St. Louis BH agency Executive Directors were surveyed about the greatest roadblocks they face that hinder provision of services, with the prioritized response or 23% reporting the need for more quality staff, with an additional 4% specifying the lack of child psychiatrists and mental health treatment providers and counselors.
- Once they made a referral, providers noted difficulties following-up with a case referral, with particular barriers around confidentially/privacy policies.
- The main barrier noted for the 25% of St. Louis City BHR callers (representing 119 youth) and 12% for St. Louis County (representing 255 youth) was not being able to verify or re-connect (contact) the client associated with the case, which represented 12% of cases. This barrier was identified by the BHR staff who were unable to reach a caller during follow-up procedures.

Opportunities to Strengthen the Service Providing Community's Responsiveness (BH and non-BH providers):
- Invest in a linkage & referral data-informed network—details of available community programs/services and how families can access them. Make eligibility restrictions/requirements more transparent.
- Foster provider collaboration across care sectors and care settings.
- Investigate funding strategies that support flexibility and address geographic boundaries for funding and service delivery (i.e. City/County boundary barriers).
- Establish stronger "front doors" for families to know about BH services options and assistance to access care.
- Strengthen providers' capacity to support client/family navigation of the service delivery system, especially across primary care and BH care settings.
- Leverage technology to improve communication, enhance care coordination, and strengthen regional data reporting.
- Invest in BH workforce development-- Build community expertise around specific needs, approaches (i.e. EBP) and populations; Expand the number of BH providers in the region.
- Support BH-service providing organizations to increase their organizational cultural competence.

4. RECOMMENDATION: RESPOND TO YOUTH EXPERIENCES OF TRAUMA

Violence, traumatic experiences, and toxic stress can have a devastating impact on youth, affecting their physical, emotional, cognitive, and social development. Trauma encompasses a range of adverse childhood experiences. Of note, community violence is a special consideration in St. Louis City and a key trigger for BH needs in the region. Services and supports are needed to be available and tailored to these environmental realities.

Select Supporting Data:
- The St. Louis City rate of violent deaths to teens (ages 15-19), is at a rate of 108 deaths per 100,000 youth is more than double the statewide rate of 49 and St. Louis County's rate of 42.
- Qualitative date indicated there is limited BH support offered to families and children who experience trauma (separate from crime victims services).
- Students engaging in self-injury has increased over time with 4.1% more students responding "yes" in 2016 (16.5%) than 2012 (12.5%). Self-injury peaked in 10th grade with 19.6% attempting self-injury in that year.
- 79% of homeless adults in St. Louis City reported having at least one traumatic experience before the age of 19. 17.9% of St. Louis City youth are currently homeless, putting them at risk of more trauma.
- 39% of St. Louis City children (0-17) are in poverty in comparison to 26% of the general population. Overall, 39.3% of the city youth age 0-17 are in poverty in comparison to 20.4% for Missouri youth.

- 44% (209 out of 475) of the St. Louis City BHR clients (calls made by or on behalf of youth) were considered high risk in comparison to 27-28% of the St. Louis County cases (571 out of 2,128 total cases), where high risk designation is based on criteria if youth is suicidal, either in past or currently, or has engaged in self-harm or self-injurious behavior.
- Violent offenses within Juvenile Law Violation Referrals for St. Louis City made up the majority of the law violation offenses with 413 recorded for 2014. However, this declined by 59% from 999 referrals made in 2004. However, neglect referrals putting youth at risk of trauma increased by 5% over time for St. Louis City youth, and represents the area with the highest number of offenses at 596.

Opportunities to Respond to Youth Experiences of Trauma:
- Increase the trauma-informed competency of organizations and trauma-expert practitioners in the community.
- Expand trauma-focused services and targeted case management.
- Increase specialized services for survivors of trauma, with attention to demographic differences (e.g. racial and grade-level) to respond to youth who are at highest risk of experiencing trauma with the least supports and access to BH services and programs.
- Assess factors that may have led to a decline in violent juvenile law violation offenses to replicate best practices.

5. RECOMMENDATION: INCREASE EARLY IDENTIFICATION OF BH VULNERABILITY AND PROVIDE EARLY INTERVENTION

Foster BH intervention earlier in the life- and disease-course. Enable assessment of BH needs and expedite youth access to services and to promote an understanding of youth needs.

Select Supporting Data:
- Regional reports showed that in the Fall of 2016, one of the largest providers of psychological evaluation services for youth in the St. Louis region had 15% of youth (counted at one time as 247 youth in St. Louis County only) who needed this service put on a waitlist. Waitlist times ranged from 15-19 weeks.
- Needs emerge in early childhood and often go un-addressed, until school-age; Schools then particularly see the ramifications of these needs
- Qualitative data reflected a wide sense that there is limited access to services until a crisis takes place.

Opportunities to Increase Early Identification of BH Vulnerability and Provide Early Intervention:
- Increase diagnosis and evaluation availability and accessibility (esp. in St. Louis City), to improve early identification and treatment of BH needs.
- Increase early childhood screenings (esp. in St. Louis City; worsens for youth age 10+).
- Increase screenings in medical and other settings for BH needs. Include BH screening for children 0-5 and parents (mothers and fathers) during perinatal care.
- Expand access to Individualized Education Plan (IEP) assessments, advocacy, and support (esp. in St. Louis City).
- Establish earlier intervention / screening / connection to services for BH issues in children through primary care.

6. RECOMMENDATION: INVEST IN SCHOOL-BASED CAPACITY TO ADDRESS BH NEEDS

Bolster the infrastructure and reach of schools for BH prevention, awareness, skill building, and connection to needed treatment.

Select Supporting Data:

- School-based or -associated health provision can provide access to needed BH services. Youth and caregivers vocalized school as a key intervention point opportunity and support for young people, with opportunity for fostering trust by training school staff. BH services in schools provided by external partners with expertise show strong promise, based on established programs; this includes those services tied to physical health supports. Qualitative respondents expressed that they experience limited access to in-school BH services, both provided by schools and in partnership with external entities (esp. in St. Louis City—in public and charter schools)—that it doesn't exist or is too difficult to access. Schools face significant competing demands to focus on education, while addressing BH service needs directly or with limited funds to support external services.
- The top BH issues youth face in school include bullying/cyber-bullying (66% of middle school and 44% of high school students); "friend/peer relationships, social skills, problem-solving, and self-esteem" (54% of middle school and 49% of high school students), Threats of violence or being injured by another peer was an issue for 39% of North County middle school students, with gang violence identified by 35% of middle school students, and 46% of high school students.
- Select Indicator Data Trends in Schools: St. Louis City Public Schools experienced a 2% increase in high school dropouts between 2004-2015 to 11.7%. This is 9.6% higher than the state rate of 2.1% and 9.9% higher than St. Louis County's rate of 1.8%. This has, however, declined from its peak of 17% in 2011. St. Louis Public Schools' rate of disciplinary incidents (3%) is more than double the statewide rate (1.3%), however this has significantly improved from the peak rate of 6% in 2009. School-related truancy juvenile law violation referrals in St. Louis City outpace St. Louis County three to one despite the considerable population size difference.
- Services/programs that may be offered at/or near school need to be sensitive to BH stigma and youth fear of their peers' perceptions. 46% of middle school students and 57% of high school students either don't want their friends knowing they have a BH need, or fear that they might get treated differently by their peers for having this need, so this needs to be handled delicately by the schools and providers. Providers should explore if the targeted clients prefer services be delivered on site or offsite.

Opportunities to Invest in School-Based Capacity to Address BH Needs:

- Evaluate the current efforts in the Mental Health First Aid trainings for teachers and staff to determine gains in knowledge, skill, and application, in addition to assessing remaining gaps in training focused on youth behavioral health. Then, invest in BH support for teachers and school staff to include supports beyond training—ongoing skill development to identify and respond to generalized BH needs of students (see supporting data above). Support implementation of mandated reporter training for teachers and other professionals.
- Invest in more BH counseling and surveillance within the schools to address youth treatment needs (i.e. depression, anxiety, emotion-control, SU, etc.). Have BH specialists in public elementary, middle and high schools (regardless of whether they are school counselors or contracted/external BH specialists).
- Implement school-based MH awareness, trauma screening, fighting/violence remediation (see student survey data).
- Explore opportunities for effective education, screening, and response to bullying in schools and impact on youth BH.
- Strengthen trauma-informed schools and districts by providing ongoing / incremental evidenced-based trauma-informed training and support to administrators, teachers, families, and students, including support for secondary trauma. Build upon and enhance / increase existing work.
- Look for additional opportunities for school-based reimbursement for BH services delivered in the school.

7. RECOMMENDATION: INCREASE BH ENGAGEMENT BY ADDRESSING SOCIAL DETERMINANTS OF HEALTH / ENVIRONMENTAL STRESSORS

Significant BH and physical health improvements can be gained by mobilizing innovative approaches to addressing social determinants of health, including intentional collaborations with other sectors of care.

Select Supporting Data:

- Transportation and location of services is a top barrier identified by families and providers.
- Homelessness - transient families and homelessness are all identified as factors that influence ability to stay in school and access and engage in BH services, particularly with services divided by regional catchment areas and funding sources.
- Select Indicator Data Trends in Social Determinants:
    - Stability of Housing – Housing and Urban Development (HUD) indicates high risk of instability for those who spend 30% or more of their income on housing. There were 6.3% more renters in St. Louis City (48.2%) than Missouri who had gross rent costs of 30% or more of their household (HH) income (MO rate = 41.9%). Fifty-seven percent of St. Louis City households are made up of renters. In 2015, 31% of St. Louis City residents spent 30% or more of their income on housing, compared to 24% statewide.
    - Income – While median household income increased by 35% in St. Louis City 2004-2015 (to $35,681 in 2015), this is the lowest median household income compared to all neighboring Missouri counties and is $12,000 lower than the state.
    - Poverty - Poverty in youth is outpacing youth population growth. In 2015, 39% of youth in St. Louis City lived in poverty as compared to 26% of the St. Louis City total population. Compared to national, state, and county comparisons, St. Louis City has a higher rate of youth 0-17 in poverty and 5-17 in poverty.
    - Number and Percentage of Children in Single-Parent Households: The St. Louis City percentage is by far the highest in 2017 at 60% with St. Louis County next highest at 34.9%.
    - Youth Needing Financial Support: 72% of St. Louis City children are on food stamps, and 94.6% enrolled in the Free/Reduced Price lunch program.
- Health care and social assistance organizations are more densely situated in St. Louis City, but not all are conveniently located to help consumers with multiple health and socio-emotional issues.
- There is a heavy demand for children and youth services in far north St. Louis neighborhoods (zip codes 63137 and 63147) and in far south St. Louis neighborhoods (zip code 63118). This is quantified by the high number of youth and the shortage of available services in those areas.

Opportunities Increase BH Engagement by Addressing Social Determinants of Health / Environmental Stressors:

- Address youth's / families' basic needs through partnerships and alignment with the social service sector to promote access, health, wellness, and equity.
- Decrease access barriers by increasing transportation of youth and families to and from services; improve the location of services to better meet youth/family needs; and/or provide more sites or places where people can access services.
- Help more families gain insurance.
- Address families' housing instability.
- Address basic needs as part of youth BH care planning (e.g. via flexible funding).

8. RECOMMENDATION: FOSTER POSITIVE YOUTH SOCIAL DEVELOPMENT (PYD)

Support intentional efforts to provide opportunities for youth's positive community engagement and activities for personal empowerment (i.e. interests, skills, and abilities) and recreation, via programs designed to optimize developmental progress. [25]

[25] *"Positive Youth Development in the U.S.: Research Findings on Evaluations of Positive Youth Development Programs". Retrieved April 9, 2014.*

Select Supporting Data:

- Select Indicator Data Trends in Youth Community Engagement and Employment:
  - 14.2% of the St. Louis City population ages 16 to 24 is neither employed nor in school. This is higher for African Americans at 24.9%.
  - St. Louis City consistently has higher unemployment than St. Louis County, the state of Missouri and the US. Of note, generally, the unemployment rate for adults living with mental illness is three to five times higher than for those living without a mental illness.
  - The St. Louis City school's disciplinary rate of 2.0 (2016) was more than double the Missouri rate of 1.3, with the out-of-suspension rate for the city at 2.8 per 100 students in comparison to the Missouri rate of 1.0.
  - St. Louis City has the 3rd highest percentage of disconnected African American youth among 25 major metropolitan areas at 25%.
- Qualitative date indicated respondents' experience / perception that there is limited affordable and accessible recreational activities (esp. after school programming and during the summer day), and limited opportunity for positive community involvement, especially for teens.
- From the regional reports, six percent (6%) of the 54 surveyed BH service providers in the St. Louis region identified the need for teen/pre-teen recreational and after-school activities (the sixth highest reported need)

Opportunities to Foster Positive Youth Development:

- Increase youth skill building for independent living, including healthy relationships. Foster positive self-concept among youth.
- Increase Positive Youth Development (PYD) programming that is future-focused. Increase activities to build knowledge and job-readiness skills, promote career awareness, and develop social responsibility and leadership skills.
- Promote youth employment opportunities for meaningful work (e.g., fair wages) to financially and emotionally empower youth.
- Provide safe places for youth during evenings, weekends, and summer.
- Expand prevention, promotion, education and early intervention programs which support youth resilience and yield better recovery trajectories.

ALERT: PRIORITIZE SUPPORTS FOR VULNERABLE POPULATIONS

It is recommended, that within all of the thematic priorities, the data calls for an investment in responsiveness to the BH care needs of particular populations, due to inequities in available BH services in general and those tailored to vulnerable populations' unique needs. Some of these populations might represent a smaller portion of the youth population, yet with high needs. Populations in great need include the following (see quantitative and qualitative data), as some of these are a small portion of the youth population with high needs and some are a large portion of the youth population:

- Youth with co-occurring substance use (SU) disorder.
- Youth with co-occurring Intellectual/Developmental Disabilities (IDD) and BH needs.
- Youth with co-morbid BH and physical health needs.
- Youth who have experienced violence or trauma.
- Transition-age youth. Including those transitioning from adolescence to young adulthood, aging out of foster care system, and aging-out/emancipated minors with severe needs.
- Early childhood (Children ages 0-5) populations are repeatedly the smallest population served per provider report.
- Juvenile justice-involved youth.
- Child welfare system-involved youth.
- Youth who are homeless or housing unstable.
- Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) youth.
- English Language Learners.

Select Supporting Data:

- There was broad concern, in the qualitative sessions, that our region has limited provider capacity or expertise to deliver needed services for youth with specific needs.
- Select Indicator Data Trends in IDD Populations: St. Louis City experienced a 34% increase in young children (ages 3 to pre-k) with a developmental delay and 138% increase in autism diagnoses 2007-2016 (421 diagnoses for 2016), and a 119% increase in children with a speech impairment (included 725 children for 2016). St. Louis County experienced a 14% increase in young children (ages 3 to pre-k) with a developmental delay and 92% increase in autism diagnoses 2008-2016.
- Select Indicator Data Trends in Youth Homelessness: For 2016, 17.9% of youth in St. Louis City Public Schools were noted as homeless, a 215% increase in the number of reported students who were homeless between 2009-2016. Poverty rates have increased steadily for all of the age ranges of youth in St. Louis City.
- Select Indicator Data Trends in Juvenile Law Violation Referrals: St. Louis City experienced a marked decrease in juvenile law violation referrals for ages 10-17 between 2004-2015 (a decline of 47%). This peaked at a rate of 115.6 per 1,000 youth in 2006 and has dropped to its lowest rate of 43 per 1,000 youth. Violent offense referrals decreased by 59% between 2004-2015 in St. Louis City, while St. Louis County experienced a 30% decrease. In both counties, violent offenses continue to make up the majority of violations.
- Select Indicator Data Trends in Child Welfare: Approximately 1% of St. Louis City children were referred to family court for reasons related to abuse, neglect and/or custody disputes, nearly equal to the proportion in the county with a notable difference in the number of referrals attributed specifically to neglect.

Opportunities to Prioritize Supports for Vulnerable Populations:

- Prioritize supports for vulnerable populations.
- Recognize that there are specific needs of the identified populations and different barriers to access services.

APPENDICES

APPENDIX A. COMMUNITY REPORT REFERENCES

1. Project LAUNCH Environmental Scan

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APPENDIX B. QUALITATIVE QUESTION SET SAMPLE

Sample Community Participant Session Domains and Questions

DOMAIN ADDRESSED	SAMPLE QUESTIONS
THINKING ABOUT HEALTH	Prompt: What makes a community healthy?
	Follow-up Probe: Engage all your senses as you think about a healthy community. What do you see? What do you hear? What is there? What isn't there?
	Follow-up Probe: Now consider children, teens and young adults—what defines a healthy community for young people? Does this change your definition? How so? What additions or changes would you make?
	Prompt: What are the biggest health concerns facing our community?
	Follow-up Probe: What contributes to these health issues? What are barriers to being healthy in our community?
	Follow-up Probe: Now consider children, teens and young adults—what defines a healthy community for young people? Does this change your definition? How so? What additions or changes would you make?
RESOURCES/ASSETS	Prompt: Thinking about youth mental health and wellbeing, where do youth and families of youth currently go for help? What resources or programs are available for youth and families of youth within the community?
	Follow-up Probe: Let's say a parent noticed their child was having trouble with depression or self-esteem. Where could that parent go to seek help for their child?
	Follow-up Probe: Let's say a teenager needed help with substance abuse. Where could he/she go for help?
	Prompt: What youth mental health and wellbeing needs are being met in the community?
	Follow-up Probe: How are these needs being met?

BARRIERS/WEAKNESSES	Prompt: For caregivers/parents, what makes it difficult to access community resources for substance use and mental health for children and youth?
	Prompt: Is there anything additional that makes it difficult for youth to access community resources for mental health and wellbeing (especially for themselves)?
	Follow-up Probe: What would make it easier to access community resources for such needs?
	Prompt: What youth mental health and wellbeing needs are not being met in the community?
	Follow-up Probe: What are your thoughts on why these needs are not being met?
	Follow-up Probe: Is there anything that would make it easier to access these community resources?
	Follow-up Probe: What happens because these needs are not being met?
OPPORTUNITIES	Prompt: What additional resources or programs would be helpful to address mental health and substance use needs of youth in the community?
	Prompt: Is there anything additional that makes it difficult for youth to access community resources for mental health and wellbeing (especially for themselves)?
	Follow-up Probe: What could there be more of? What could there be less of?
	Prompt: Are there any additional recommendations or suggestions you would like to make regarding the youth mental health and wellbeing resources within the community?

APPENDIX C. DETAILED KEY INFORMANT (KI) INTERVIEW CONTRIBUTIONS (BY STAKEHOLDER TYPE)

RESOURCES/ASSETS				
Key Informant (KI) Sector	**Met Needs/Accessible Resources**	**Provider Strengths**	**Broader Community Strengths**	**Successful linkage/referral**
Juvenile Justice	**Increased availability of programs/services** • Substance abuse treatment programs • BH residential programs • Outpatient therapy options • Intensive in-home family therapy • Shelter care services • Psychological evaluations and assessments • Individual counseling programs • Mentoring programs • More evidence-based treatments • Access to some psychiatry services **Specific community agencies/services that work well**	**Provider expertise** • Providers who deal with unique issues of delinquent youth • Those who are trauma aware **Provider service quality** • Providers with a holistic view to treatment **Provider accessibility** • Provider accessibility **Providers that reduce barriers** • Intensive in-home services **Provider expertise** Provider expertise/understand unique needs of clients	**Recreational Activities** • Recreational activities for youth **Youth Development Programs** • Workforce development programs • Academic support/tutoring	**Provider service quality** • Providers with a holistic view to treatment • Provider engagement • Provider persistence **Providers that reduce barriers** • Transportation assistance • In-home services **Provider relationships/collaborations** • Good communication between agencies • Direct/Warm hand-off **Provider accessibility** • Provider accessibility (i.e., short waitlist) **Providers that reduce barriers** • Providers that offer barrier reduction (i.e., transportation, home-based services) • Providers with an easy process, flexible hours • Transportation assistance • In-home services

RESOURCES/ASSETS				
Key Informant (KI) Sector	**Met Needs/Accessible Resources**	**Provider Strengths**	**Broader Community Strengths**	**Successful linkage/referral**
	Barrier reduction/Increased access • Facilities with open intake hours/walk-in services			
Youth Development	**Increased availability of programs/services** • Accessibility Community Mental Health Centers through formal partnerships **Specific community agencies/services that work well** • Specific community agencies/services (esp. St. Louis County special school district) • The Spot • Social workers in schools (esp. St. Louis County) • BHR for crisis services	**Increased agency collaboration** • Cross-agency direct care staff very willing to work together for clients (staffing and identifying/providing resources)	N/A	**Provider relationships/collaborations** • Direct/Warm hand-off • Comprehensive community resource list of BH providers **Provider accessibility** • Provider accessibility (i.e., short waitlist) **Providers that reduce barriers** • Providers with an easy process, flexible hours

RESOURCES/ASSETS				
Key Informant (KI) Sector	**Met Needs/Accessible Resources**	**Provider Strengths**	**Broader Community Strengths**	**Successful linkage/referral**
Child welfare/ Violence prevention	**Increased availability of programs/services** • Increased availability of specialized services for referrals • More evidence-based treatments • Psychological evaluations and assessments • Access to group therapy **Increased provider expertise** • More organizations focused on youth domestic/sexual violence • Increase in trauma-informed providers **Barrier reduction/Increased access** • Provider access to students at school **Specific community agencies/services that work well**	**Provider coordination/follow-up** • Increased agency coordination • Electronic medical records • Increase in youth therapeutic services **Provider service quality** • Provide holistic support for clients • Attempts at barrier reduction **Provider expertise** • Provide consultations/ guidance on treatment plan	**Youth Development Programs** • Academic support/tutoring • Youth development/ employment programs • Becoming a more trauma-informed community **Collaborative community relationships** • Identification of family support networks within the community • Collaborative relationships with law enforcement • Collaborative relationships with hospitals/providers	**Provider relationships/collaborations** • Having a community presence • Relationships with providers/schools • Partnerships and collaborations with other BH resources (e.g., DMH, SOC) **Providers that reduce barriers** • Streamlined system/Easy to navigate **Provider service quality** **Provider accessibility** • Provider availability

RESOURCES/ASSETS				
Key Informant (KI) Sector	**Met Needs/Accessible Resources**	**Provider Strengths**	**Broader Community Strengths**	**Successful linkage/referral**
Physical Health	**Increased provider expertise** • Increase in trauma-informed providers • Strong, accessible agencies working in specific areas **Barrier reduction/Increased access** • Integration of psych services in hospital/primary care setting **Increased availability of programs/services** • Greater internal services and addition of team approach (PCP, psychiatry consult, BH consultants, psychologist, Community health worker) to meet BH needs • Follow-up/case management support for BH clients • External resources for expert therapy (for those insured or with	**Provider expertise** • Provide consultations/expertise to help clients **Providers that reduce barriers** • Some providers have increased outreach • Being flexible with trauma patients • Shifts towards allowing cross-agency attendance at appointments (e.g. case manager in physical health to attend BH services) **Increased agency collaboration** • Cross-agency direct care staff very willing to work together for clients (staffing and identifying/providing resources) • Shared value of team approach and respective agency role/expertise **Provider service quality** • Internally engaging family-system in approach • Internally outreaching family-system in approach	**Recreational Activities** • Recreational activities for youth **Collaborative community relationships** • Engagement of teachers or BH-focused school contact in treatment	**Provider relationships/collaborations** • Personal relationships with providers • Direct/warm hand-off **Providers that reduce barriers** • Agencies that go-to intake • Agencies that facilitate warm hand-offs • Responsive to where clients are at (physically and motivationally) and flexible to client needs

RESOURCES/ASSETS				
Key Informant (KI) Sector	**Met Needs/Accessible Resources**	**Provider Strengths**	**Broader Community Strengths**	**Successful linkage/referral**
	Medicaid, ages 3 and up) • Medication access (for those with Medicaid) • Children's services access for those in County • Developmental Disability/Autism screenings for children under 10 (above age 10 accessible for county only) • Students bussed into County from St. Louis City have strong school-based supports • Access to parenting program • Assessments and evaluations	• Increased trauma-informed approaches to care		
Housing/ Social Service	**Specific community agencies/services that work well** **Increased availability of programs/services** • Slight improvement on accessibility of youth assessments	**Provider coordination/follow-up** • Provider communication and follow-up **Provider service quality** • Those who provide intensive case management	N/A	**Provider relationships/collaborations** • Coordination of care **Providers that reduce barriers** • Assisting clients with system navigation

RESOURCES/ASSETS				
Key Informant (KI) Sector	**Met Needs/Accessible Resources**	**Provider Strengths**	**Broader Community Strengths**	**Successful linkage/referral**
	Increased provider expertise • Great expertise of youth-focused agencies to handle issues unique to youth **Increased availability of programs/services** • More BH staff in schools			
Schools	**Increased availability of programs/services** • After school programming • A fair number of therapists are accessible to serve students • Shift from disciplinary approach for BH needs • Social work services and wrap-around • Ability to develop IEPs and 504 plans to address specific needs of child • Some school outreach to home and family, including prior to school starting • Trainings for teachers	**Providers that reduce barriers** • Some providers will facilitate in-home counseling services **Provider expertise** • Specialized therapy services (e.g. CBT, trauma informed)	**Increased awareness of BH needs** • Increased community awareness about BH needs • Schools designed for specific population needs **Collaborative community relationships** • Increased collaboration b/w community partners addressing BH (RECAST, FORECAST, Community Matters, etc.)	**Providers that reduce barriers** • Providers who take several forms of payment • Offer transportation assistance and/or provide in-home services **Provider accessibility** • Diminished wait time for service connection

RESOURCES/ASSETS				
Key Informant (KI) Sector	**Met Needs/Accessible Resources**	**Provider Strengths**	**Broader Community Strengths**	**Successful linkage/referral**
	Barrier reduction/Increased access • Nursing staff available in the school **Increased provider/agency expertise** • Trauma informed services training for staff • More organizations focused on youth domestic/sexual violence **Increased agency collaboration** • Deputy Juvenile Officers are assigned to several elementary schools to assist with Truancy • Learning collaboratives w/ community partners			

RESOURCES/ASSETS				
Key Informant (KI) Sector	**Met Needs/Accessible Resources**	**Provider Strengths**	**Broader Community Strengths**	**Successful linkage/referral**
Transition-Age Youth	**Specific community agencies/services that work well** • Mental Health First Aid • Trauma-focused CBT/Trauma training awareness	**Provider expertise** • Community capacity building through greater training (e.g. trauma)	**Increased awareness of BH needs** • Awareness of growing need for assessment and community placement/in-home support across systems (e.g. juvenile justice) • Shared goal to have supports and leverage expertise brought into collaborations across systems • Shift towards strengths-based approaches (incl. positive youth justice, positive youth development, etc.)	

BARRIERS					UNMET NEEDS
Key Informant (KI) Sector	**Coordination Barriers**	**Internal Barriers**	**External/Additional Barriers**	**Family Roadblocks**	**Needs Not Being Met**
Juvenile Justice	**Lack of specialized services/Provider expertise** • Availability of specialized services **Provider accessibility/availability** • Provider capacity/accessibility **Provider coordination/follow-up** • Coordination of care • Follow-up difficult after referral **Program/Service restrictions** • Client burden/responsibility • Therapy cannot be conducted during school hours **Family/Youth Engagement** • Ability to provide effective in-home services • Parental support/engagement/advocacy • Ability to locate/follow-up with families • Youth engagement	**Identification of services** • Knowledge of BH services/Providers • Need more contracted service providers **Operations barriers** • Limited capacity for psychiatry services	**Funding Barriers** • Limited provider/program funding **Program/Service restrictions** • Program/service restrictions • Provider fee structure	**Transportation/Service location** **Financial barriers** • Lack of insurance/Cost of services • Inability to meet basic needs **Family barriers** • Parental support/engagement/advocacy **Access to providers/services** • Provider accessibility • System navigation • Access to in-home services • Program restrictions **Family Engagement** • Personal barriers (e.g., childcare, language) • Stigma	**Accessible Programs/Services** • Family-centered therapy • Services for youth with specialized needs (e.g., MRDD, sexual behaviors) • 24/7 crisis access/response service • More residential/inpatient programs • Access to psychiatric services • Early interventions (birth to age 3) • Long-term case management **Care Coordination** • Transitional care post-intervention • Continuity of care • Long-term case management **Trauma** **Specific BH/MH disorders** • Anger/aggression **Environmental stressors** • Toxic environment • Lack of parental/peer support • Unmet basic needs

BARRIERS					UNMET NEEDS
Key Informant (KI) Sector	**Coordination Barriers**	**Internal Barriers**	**External/Additional Barriers**	**Family Roadblocks**	**Needs Not Being Met**
Youth Development	**Program/Service restrictions** • Confusion in funding sources and covered services • Problems arise in establishing funding for services (leads to delays, reduces engagement) **Provider accessibility/availability** • Cost of services if clients do not qualify for reduced cost or have insurance/safety-net coverage (esp. St. Louis City) • Cost of medications and spend-down barriers • Turnover of staff at partner agencies **Provider-to-Provider coordination/follow-up** • Limited communication and awareness of what each other do/can provide • Lack of uniform training	**Identification of services** • Knowledge of BH services/Providers • Awareness of available resources and constant change of resources **Operations barriers** • Capacity (staff and client load) to address BH needs	N/A	**Financial barriers** • Lack of insurance/Cost of services **Family barriers** • Stigma of getting help **Access to providers/services** • Knowledge of available resources • Availability/wait times for crisis supports • Cost of services if clients do not qualify for reduced cost or have insurance/safety-net coverage (esp. St. Louis City) • Cost of medications and spend-down barriers **Stigma/Past Experience** • Negative past experience with services • Willingness of guardians or families to support engagement in services (fear of losing benefits, stigma) **Transportation/Service location**	**Accessible Programs/Services** • Crisis follow-up services • Need for braided services • School-based supports (esp. St. Louis City) • Pre-employment programming/Life skills development (have for DD population, not for BH) • Poor access to affordable, community BH services (esp. St. Louis City) • Lack of walk-in facilities for BH needs **Supports for special populations** • Lack of support for youth with severe needs in schools • Limited ability to outreach, engage and meet needs of difficult to engage youth **Barrier reduction** • Transportation **Trauma**

BARRIERS					UNMET NEEDS
Key Informant (KI) Sector	**Coordination Barriers**	**Internal Barriers**	**External/Additional Barriers**	**Family Roadblocks**	**Needs Not Being Met**
Child welfare/ Violence prevention	**Family/Youth Engagement** • Parental consents • Transportation **Provider accessibility/availability** • Limited number of resources available **Lack of specialized services/Provider expertise** • Finding services for older youth (14+) • Provider understanding of older youth needs • Provider expertise with extreme behaviors • Provider assistance with treatment plans	**Operations barriers** • Number of staff • Space • Limited capacity • Competition for qualified staff due to resources **Identification of services** • Knowledge of BH services/Providers • Need creative solutions for assisting clients Rely on expertise of providers/specialists to determine treatment	**Program/Service restrictions** • Limitations/Restrictions on program funding	**Transportation/Service location** **Financial barriers** • Cost of services **Family barriers** • Family support/Parental engagement • Knowing when to seek help **Access to providers/services** • Availability of services (i.e., LGBTQ programs) • Access to in-home family therapy • Provider accessibility • Knowledge of available resources	**Accessible Programs/Services** • Not enough child psychiatrists • Need more prevention programs • Services for ages 16-18: academic support • Need more trauma-focused services (CITY) • Limited counseling services for youth • Few resources for the LGBTQ community • Available services for older youth (14+) or those with extreme behaviors • Resources for children with limited developmental functioning **Housing Supports** • Housing for youth with behavioral issues • Safe housing options • Services for ages 16-18: transitional housing **Barrier reduction** • Access to programs for the underinsured

					Trauma • Those who are healing from trauma **Specific BH/MH disorders** • Depression • Substance Abuse • Youth with problematic sexual behavior
	BARRIERS				**UNMET NEEDS**
Key Informant (KI) Sector	**Coordination Barriers**	**Internal Barriers**	**External/Additional Barriers**	**Family Roadblocks**	**Needs Not Being Met**
Physical Health	**Provider coordination/follow-up** • Coordination with providers (time) **Lack of specialized services/Provider expertise** • Lack of MH interpreters • Poor culture competency/sensitivity to unique populations (esp. racial minorities, LGBTQ youth) • Not trauma informed nor positive youth development informed • Limited ability to serve BH and physical health needs--comorbidity awareness and treatment **Provider accessibility/availability**	**Operations barriers** • Time • Staffing • Fee structure/billing • Capacity (staff and client load) to address BH needs **Training** • Pediatric staff not trained in MH procedures **Program/Service restrictions** • Funding of supports by county	**Funding Barriers** • Limited provider funding **Collaboration Barriers** • Not seeing other entities (e.g. physical health) as part of BH care (not invited to the table) **Policy Barriers** • Regional divisions	**Transportation/Service location** • Transportation **Financial barriers** • Inability to meet basic needs **Family barriers** • Parental support/engagement/advocacy • Personal barriers (e.g., childcare, language) • Community violence/crime **Unstable housing and residency based services** **Access to providers/services** • limited resources to get to multiple places for appointments, care coordination • Length of waits	**Environmental stressors** • Safety issues/concerns • Resources to meet basic needs **Psychiatry access** • Pediatric psychiatry access • Addressing wait times (leverage triage and screening before getting to a psychiatrist) **Coordination** • Need for Coordination between IP and OP treatment **Supports for special populations** **Daytime youth supports** • Positive youth development programming during the day— job

	• Access to current provider resource list/Provider availability • Complex navigation/complex intake process • Limited choices—esp. important for teens • Demand outpaces capacity, esp. in St. Louis City • Limited capacity and long wait lists for BH services **Provider-to-Provider coordination/follow-up** • Coordination with providers (time) • School communication difficult (timing) • HIPAA compliance concerns arise with cross-collaborations **Varying Provider Approaches** • Differences in treatment philosophies and approach, esp. for trauma-informed care			• Requirements for documentation first, treatment second • "let's see if you qualify" "let's see what we can do" rather than "let's see what we can do" • Limited choices—esp. important for teens • Complex navigation/complex intake process	training and opportunities, recreation • Intensive treatment, job training and opportunities, recreation **Early identification and treatment** **Psychiatry access** • Pediatric psychiatry access **School-based supports** **Family-focused services/Intergenerational**
Housing/ Social Service	**Provider-to-Provider coordination/follow-up** • Warm hand-offs • Follow-up difficult after referral	**Operations barriers** • Funding • Limited capacity	**Program/Service restrictions** • Lack of standardization in program requirements	**Transportation/Service location** • Transportation • Location of services **Financial barriers** • Cost of services	**Accessible Programs/Services** • Child psychiatrists • Limited number of resources/programs • Limited capacity of existing resources

	Lack of specialized services/Provider expertise • Provider understanding of unique needs when working with minors **Provider accessibility/availability** • Agencies aren't always accessible • Provider capacity • Access to current provider resource list/Provider availability **Program/Service restrictions** • Residential restrictions of services/Homeless clients • Inconsistent restrictions across agencies • Parental consents		• Difficult to promote coordination of care • Lack of consistency across funding sources	**Access to providers/services** • Residential restrictions of services (homeless clients) • Parent/Caregiver access to treatment • Availability of services (i.e., LGBTQ programs) **Family barriers** • Parental engagement • Coordination of care • Intensive case management	• Services for LGBTQ • Intensive case management services **Barrier reduction** • Transportation **Housing Supports** • Supportive housing services **Trauma** • Trauma-related issues (PTSD)

BARRIERS					UNMET NEEDS
Key Informant (KI) Sector	**Coordination Barriers**	**Internal Barriers**	**External/Additional Barriers**	**Family Roadblocks**	**Needs Not Being Met**
Schools	**Lack of specialized services/Provider expertise** • Lack of understanding as to school regulations/laws that govern education **Provider-to-Provider coordination/follow-up** • Overall lack of follow-up with students/families post-referrals, no static data capture to realize outcomes. **Provider accessibility/availability** • Long wait lists • Fragmented service array • Limited provider access and capacity • Cost • Limited collaboration between schools and providers • Schools in need of expert supports outside of school	**Internal communication/ coordination** • Communication b/w schools as to services offered • Duplicative services w/in the same schools **Competing Demands** • Schools are being asked to provide services that have historically not been offered (e.g. clinics, therapy) • School priority is on education • Limited dollars, resources and power to effectively meet BH needs • Stigma	**Transportation/Service location** • Transportation barriers **Policy Barriers** • Lack of understanding as to School regulations/laws that govern education • Stigma **Funding Barriers** • Limited funding to access need services constrains capacity for schools to meet needs • State budget allocations do not meet all the needs of schools and programs are then cut • Insurance does not cover school-provided services (e.g. Speech Therapy) • Cuts to Parents as Teachers	**Transportation/Service location** • Transportation **Access to providers/services** • Long wait lists • Lack of access to treatment services due to socio-economic status **Stigma/Past Experience** • Willingness of families to engage • School may approach family regarding need, however charter school is optional and family may transfer	**Accessible Programs/Services** • Family centered services, counseling • Bi-lingual therapists • Poor access to affordable, community BH services • Limited access to in-school BH services, esp. in St. Louis City • Support to families and children for trauma or transitions that take place outside of school **Earlier Intervention** • Limited Access to Service until Crisis takes place • Need emerges in early childhood and when not addressed, schools are seeing the ramifications **Teacher support** • Training and skills to respond and de-escalate Support for secondary trauma **Provider expertise** • Cultural competency • Trauma informed policy

		Navigation Barriers • Limited awareness of services in families and school community			**Psychiatry access** • Pediatric psychiatry access **Youth development** • Affordable recreational activities/after school programming; mentors **Cultural competency**
BARRIERS					**UNMET NEEDS**
KI Sector	**Coordination Barriers**	**Internal Barriers**	**External/Additional Barriers**	**Family Roadblocks**	**Needs Not Being Met**
Transition-Age Youth	**Provider-to-Provider coordination/follow-up** • Working across providers and systems and seeing added value and role of each entity **Varying Provider Approaches** • Differences in philosophies and approach, esp. for families and TAY	**Operations barriers** • Level of severity needed to receive services is high • Access and coordination between youth and adult services within and across agencies • Delays for adult services • Disconnect of serving developing TAY in adults systems	**Financial barriers** • Adults are less eligible for safety-net services • Funding doesn't transition well across youth and adults systems • Limited funding, esp. for family-focused services **Policy Barriers** • Need to pathologize to provide services • Funding focuses on traditional services (fit families to services rather than fit services to families)	**Transportation/Service location** • Parent Transportation **Financial barriers** • Adults are less eligible for safety-net services **Family barriers** • Competing demands (jobs, etc.) • Basic and Housing needs unmet **Stigma/Past Experience** • Negative past experience with services	**Housing** **Barrier reduction** • Basic needs/poverty supports **Programs/Services** • Child psychiatrists/prescribers • Respite • Natural support development • Family-focused services/Intergenerational approaches • School-based supports **Supports for special populations** • Co-occurring substance use and mental health clients • Co-occurring developmental disability and BH clients

					Psychiatry access **Substance Use Treatment** **Youth Development Opportunities** • Accessible pro-social community opportunities **Family-focused services/Intergenerational approaches**

OPPORTUNITIES			
Key Informant (KI) Sector	**BH Resources/Programs**	**BH Community Actions**	**Broader Community actions**
Juvenile Justice	**Long-term case management** • Continuity of care **Increase/Develop Novel Programs and Services** • 24/7 crisis access/response service • Long-term case management • Medication management clinics **Enhance System Access** • Open access/Walk-in facilities **Increase/Develop Novel Programs and Services** • More psychiatrists • Mobile outreach services • Long-term case management services	**Foster Community Collaboration/Integration** • More BH services in schools • One-stop centers/embed BH into current services **Increase access to current programs** • Increase service accessibility (existing program capacity) • More flexibility for provider engagement activities • Increase access to current programs	**Transportation initiatives** • Improved transportation **Youth Development Opportunities** • Workforce development programs/job readiness training • Affordable youth development programs **Assistance with basic needs** • Affordable housing
Youth Development	**Increase/Develop Novel Programs and Services** • Prevention services • Better BH assessments • Pre-vocational/ Life skills training programs • "Open door" Resource center for navigation to BH services and addressing other need **Enhanced System Access** • Better referral system • Open access/Walk-in facility	**Increase access to current programs** • Fewer eligibility restrictions for programs **Improve provider collaboration** • Improve agency collaboration **Community Collaboration/Integration** • Stronger partnerships between providers/community and universities to meet workforce development needs	**Assistance with basic needs** • More resources to help with basic needs (i.e., housing, food, etc.) **Transportation initiatives** • Develop transportation supports **Youth Development Opportunities** • Pre-vocational training programs • Daily living skills programs • Future-focused positive youth development programs

OPPORTUNITIES			
Key Informant (KI) Sector	**BH Resources/Programs**	**BH Community Actions**	**Broader Community actions**
Child welfare/ Violence prevention	**Increase/Develop Novel Programs and Services** • More prevention programs • Child psychiatrists available to consult • Child therapy programs • More holistic services • intensive treatment facilities • Facilities that work with severe needs • Provider consultation service to help w/ treatment plan • Access to more individual therapy options	**Increase access to current programs** • Increase program capacity **Greater Awareness of BH needs** • Increase media attention on BH issues/Community buy-in **Community Collaboration/Integration** • Connecting BH services and Family courts to serve delinquent youth **Expand Provider Expertise** • Enhancement in trauma-informed therapists	**Transportation initiatives** • Improved transportation **Youth Development Opportunities** • More youth mentoring programs • Efforts to keep youth in schools **Foster Community Collaboration/Integration** • Regional healthcare fund **Assistance with basic needs** • More youth housing options
Physical Health	**Increase/Develop Novel Programs and Services** • More psychiatry services • Family therapy programs • Family-focused services/Intergenerational approaches • Parental support programs **Leverage existing successful programs/services** • Leverage IHN's CRC model for IP and OP links--Have model, just needs to be expanded • School based services based on strong school partnerships • Greater integration of BH and primary care services **Enhance System Access** • Community resource list • Central intake phone number	**Expand Provider Expertise** • MH training for pediatric primary care staff • Invest in 19-24 TAY, without applying adult models • Develop more "on-ramps" to meet folks where they are at and refer/work to get needs met (open windows when doors close) **Community Collaboration/Integration** • Stronger partnerships and coordination within the system • Meaningfully engage marginalized youth in planning and treatment • Collaboration with school supports in treatment	**Foster Community Collaboration/Integration** • Provider networking • City/County coordination **Youth Development Opportunities** • Affordable youth development programs • Preventing abuse and neglect, as well as negative behaviors/outcomes for youth through day time programming **Funding Transformation** • Breakdown silos for planning and funding—fund cross-agency support • Increase turnaround time on grants Fund planning/planning period at grant onset

OPPORTUNITIES			
Key Informant (KI) Sector	**BH Resources/Programs**	**BH Community Actions**	**Broader Community actions**
Housing/ Social Service	• **Increase/Develop Novel Programs and Services** Better resources for suicide treatment/prevention • More services for those with developmental disabilities • Intensive clinical case management	**Improve provider collaboration** • Coordination of regional funding for services • Centralized place to coordinate all providers **Increase access to current programs** • Fewer program restrictions **Expand Provider Expertise** • More youth serving providers becoming trauma-informed	**Assistance with basic needs** • Better housing programs • More housing options **Community Collaboration** • Coordinated efforts of the philanthropic community
Schools	**Increase/Develop Novel Programs and Services** • Increase number of therapists in school system • Increase in-home services	**Increase access to current programs** • Offer sliding scale and/or accept various forms of payment **Greater Awareness of BH needs** • Provide more education / raise awareness about youth BH needs **Community Collaboration/Integration** • Partnerships with external providers • Shared accountability with community to meet BH needs • Community Collaboration to allow providers to address needs identified in school screenings early childhood population **Shift towards prevention/early intervention** • Earlier intervention, esp. for young children • Substance youth	**Transportation initiatives** • Improve transportation **Assistance with basic needs** • More community partners providing for student/family basic needs **Community Collaboration** • Partnerships with external providers • Shared accountability with community to meet BH needs **Increased programming** • Positive Youth Development, esp. for older youth • Support Parent as Teachers **Support for teachers** • Support and Train teachers

OPPORTUNITIES			
Key Informant (KI) Sector	**BH Resources/Programs**	**BH Community Actions**	**Broader Community actions**
			Funding Transformation • School-drive design and use of resources • Reduction in competing demands of funders
Transition-Age Youth	**Increase/Develop Novel Programs and Services** • Family-focused services/Intergenerational approaches • Developing natural supports • Improve BH assessments/screening and subsequent documentation • Targeted outreach • Improve service accessibility (including locations and system complexity/navigation) **Leverage existing successful programs/services** • Leverage Healthcare Home/nurse care models	• **Community Collaboration/Integration** Develop partnerships to expand and engage with non-clinical/community opportunities	**Youth Development Opportunities** • Funding support for developing community supports • Accessible pro-social community opportunities (located near youth)

APPENDIX D. ADDITIONAL ST. LOUIS CITY INDICATOR TABLES

Table 72. Number of Youth - 0-17 in Poverty

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff	% Ch.
St. L City	31,445	32,521	33,437	28,427	30,232	31,594	26,898	25,315	27,775	27,318	27,003	24,414	-7,031	-22%
St. L County	30,875	28,818	29,581	26,865	26,908	32,011	32,338	37,633	39,912	36,018	30,191	30,716	-159	-1%
MO	253,884	262,608	267,968	257,404	263,006	291,359	293,856	308,390	310,382	303,923	289,287	277,687	23,803	9%

Table 73. Number of Youth - 5-17 in Poverty

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff	% Ch.
St. L City	20,227	22,536	22,798	18,771	20,643	21,205	17,483	16,324	18,399	18,149	18,442	16,385	-3,842	-19%
St. L County	18,297	18,555	19,279	16,847	16,375	20,905	20,654	25,199	26,589	24,488	20,483	21,155	2,858	16%
MO	158,877	170,436	173,091	160,841	165,418	186,019	186,633	201,231	205,173	203,216	192,099	187,316	28,439	18%

Source: U. S. Census Bureau; American Community Survey and SAIPE

Table 74. Percentage of Youth - 0-17 in Poverty - County, State, and National Comparisons

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.
Franklin County	12.6	13.0	12.6	12.6	12.3	15.2	19.3	13.8	19.1	16.0	16.2	16.3	3.7
Jefferson County	12.1	14.1	11.0	12.2	11.0	12.7	15.7	16.6	14.2	14.6	14.9	13.6	1.5
Lincoln County	13.6	14.5	13.8	13.1	14.4	16.1	15.2	19.2	17.2	17.1	20.8	15.4	1.8
St. Charles County	6.9	6.2	6.2	5.7	6.6	6.8	7.2	7.8	9.3	8.3	8.9	7.8	0.9
St. Louis City	36.5	38.6	37.7	33.0	35.3	40.7	40.7	38.2	42.0	43.1	42.9	39.3	2.8
St. Louis	13.2	12.5	12.6	11.7	12.0	13.9	14.0	16.6	17.8	16.2	13.7	14.0	0.8
Warren County	14.5	14.1	14.7	13.1	14.8	18.3	20.2	20.7	19.4	18.9	19.4	18.8	4.3
Missouri	18.5	19.5	19.3	18.4	18.9	20.7	21.0	22.3	22.6	22.2	21.3	20.4	1.9
United States	17.8	18.5	18.3	18.0	18.2	20.0	21.6	22.5	22.6	22.2	21.7	20.7	2.9

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

Table 75. Percentage of Youth - 5-17 in Poverty –County Comparison

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Diff.
Franklin County	10.9	11.7	11.4	10.6	10.6	13.9	17.3	13.1	16.5	14.8	15.1	14.9	4.0
Jefferson County	9.9	11.9	9.2	10.5	9.3	11.1	13.2	15.0	13.0	12.9	13.1	12.4	2.5
Lincoln County	11.9	12.8	12.4	11.7	12.0	14.3	13.7	17.6	15.8	16.1	19.3	14.2	2.3
St. Charles County	6.0	5.2	5.1	5.2	5.5	6.1	6.0	6.6	8.2	7.9	7.9	6.9	0.9
St. Louis City	34.5	38.7	36.6	31.2	34.3	40.5	38.6	36.6	41.5	43.0	44.1	39.8	5.3
St. Louis County	10.7	10.9	11.0	9.9	9.9	12.3	12.0	14.9	16.0	14.9	12.6	13.1	2.4
Warren County	12.5	12.6	12.4	11.2	13.1	15.7	17.2	19.3	18.3	16.7	16.5	17.8	5.3
Missouri	16.3	17.6	17.3	16.0	16.6	18.6	18.5	20.1	20.6	20.5	19.5	18.9	2.6
United States	16.2	17.0	16.7	16.4	16.5	18.2	19.8	20.8	21.0	20.8	20.4	19.5	3.3

Source: U. S. Census Bureau; American Community Survey and SAIPE

Table 76. Racial breakdown of the St. Louis County Behavioral Health Youth Survey - 2016

	Central		South		North		West		St. Louis County	
White	729	47%	798	73%	90	10%	422	63%	2039	48%
African American/Black	510	33%	87	8%	706	79%	98	15%	1401	33%
Hispanic	158	10%	44	4%	14	2%	19	3%	235	6%
Asian	45	3%	74	7%	13	1%	76	11%	208	5%
Other	107	7%	81	7%	61	7%	48	7%	297	7%
American Indian or Alaskan Native	16	1%	8	1%	7	1%	3	0%	34	1%
Native Hawaiian or other Pacific Islander	1	0%	1	0%	3	0%	3	0%	8	0%
Total	1566	100%	1093	100%	894	100%	669	100%	4222	100%
Blank	6		8		10		2		26	
Grand Total	1572	37%	1101	26%	904	21%	671	16%	4248	

Table 77. Racial Trends of the Missouri Student Survey St. Louis County Student Sample and Missouri Comparisons								
Code	**Item**	**White STL**	**Black STL**	**Hispanic STL**	**Missouri**	**St. Louis**	**Sign.**	**Rating Scale**
A	Age of First Use – Alcohol	13.7	13.0	12.9	13.4	13.5		Average
A	Ease of availability - alcohol	58.1%	42.8%	56.0%	50.7%	53.9%	*	Very Easy/Sort of Easy
A	Lifetime alcohol use	36.0%	27.3%	38.2%	35.3%	33.5%	*	Yes
A	Lifetime alcohol use (times)	34.6%	25.4%	36.4%	33.2%	32.0%	*	1+ Times
A	Past month alcohol use	19.0%	10.1%	16.0%	14.2%	16.6%	*	1+ Days
A	Past month driving under the influence	2.8%	1.4%	3.4%	2.4%	2.4%		1+ Days
A	Past month riding with a driver under the influence	18.8%	17.9%	19.2%	14.3%	18.4%		1+ Days
A	Past two weeks binge drinking	7.8%	2.7%	6.8%	5.6%	6.5%		1+ Times
A	Peer alcohol use	46.2%	34.5%	45.1%	45.1%	42.8%	*	1+ Friends
A	Peer perception of coolness of alcohol use	26.8%	21.8%	28.0%	24.8%	25.2%	~	Pretty Cool or Very Cool
A	Perception of enforcement - alcohol	39.6%	38.8%	37.9%	34.0%	39.7%		yes or Yes!
A	Perception of friends feelings on student alcohol use	81.3%	76.4%	75.4%	76.2%	80.3%		Wrong or Very Wrong
A	Perception of harm - alcohol (1 or 2 drinks nearly every day)	78.3%	72.3%	78.1%	70.8%	76.9%	~	Moderate or Great Risk
A	Perception of harm - alcohol (5 or more drinks once or twice a week)	84.7%	78.9%	83.5%	78.5%	83.3%		Moderate or Great Risk
A	Perception of harm - alcohol (no dosage)	66.2%	65.8%	69.5%	66.2%	66.2%		Moderate or Great Risk
A	Perception of parental feelings on student alcohol use (1-2 drinks nearly every day)	96.4%	94.3%	94.9%	94.2%	95.9%		Wrong or Very Wrong

Code	Item	White STL	Black STL	Hispanic STL	Missouri	St. Louis	Sign.	Rating Scale
A	Perception of parental feelings on student alcohol use (no dosage)	81.4%	88.3%	80.7%	83.1%	83.3%	~	Wrong or Very Wrong
A	Perception of wrongness - alcohol (1 or 2 drinks nearly every day)	90.0%	91.1%	89.7%	86.8%	90.3%		Wrong or Very Wrong
A	Perception of wrongness - alcohol (5 or more drinks once or twice a week)	90.2%	93.5%	89.7%	88.8%	91.0%		Wrong or Very Wrong
A	Perception of wrongness - alcohol (no dosage)	65.8%	75.9%	68.8%	68.2%	68.6%	*	Wrong or Very Wrong
A	School alcohol use	0.8%	1.1%	1.0%	1.2%	0.9%		1+ Days
A	Student perception of peers having one or two alcoholic drinks nearly every day	27.3%	27.5%	28.8%	29.8%	27.3%		Neither or Somewhat Disapprove
Behavior	Student believes it is ok to cheat	20.8%	21.8%	23.8%	20.8%	21.0%		Agree or Strongly Agree
Behavior	Past 3 month school suspension	2.3%	10.2%	4.7%	4.5%	4.2%	~	1+ Times
Behavior	Student ignores rules	15.9%	23.3%	22.7%	18.7%	17.8%	~	Agree or Strongly Agree
Behavior	Student is oppositional	8.9%	16.7%	14.9%	12.3%	10.9%	~	Agree or Strongly Agree
Behavior	Days skipped or cut	21.1%	33.9%	32.7%	29.0%	24.3%	*	1+ Days
Bully	Past 3 month bullying online or via cell phone	20.5%	19.3%	16.9%	16.5%	19.9%		1+ Times
Bully	Past 3 month emotional bullying	58.4%	62.5%	56.5%	54.0%	59.1%	*	1+ Times
Bully	Past 3 month physical bullying	9.7%	25.2%	16.7%	15.3%	13.6%	*	1+ Times
Bully	Past 3 month rumor spreading	27.0%	24.0%	25.8%	22.7%	26.2%		1+ Times
BullyV	Past 3 month victim of bullying online or via cell phone	26.5%	19.7%	27.0%	23.1%	24.7%		1+ Times
BullyV	Past 3 month victim of emotional bullying	62.2%	54.7%	60.2%	58.8%	60.2%	~	1+ Times
BullyV	Past 3 month victim of physical bullying	17.2%	20.7%	23.5%	21.1%	18.2%		1+ Times
BullyV	Past 3 month victim of rumor spreading	43.3%	43.5%	47.1%	45.1%	43.3%		1+ Times

Code	Item	White STL	Black STL	Hispanic STL	Missouri	St. Louis	Sign.	Rating Scale
BullyV	Past year victim of bullying at school - version 2	28.1%	20.3%	28.8%	28.8%	26.2%	*	1+ Times
C	Age of First Use – Cigarettes	13.7	11.8	12.9	12.7	13.2		Average
C	Ease of availability - cigarettes	44.8%	38.4%	44.4%	46.0%	42.8%	~	Very Easy or Sort of Easy
C	Lifetime cigarette use	12.2%	11.1%	16.3%	17.6%	11.8%	~	Yes
C	Past month cigarette use	4.7%	3.1%	6.1%	6.2%	4.3%		1+ Days
C	Peer perception of coolness of cigarette use	6.6%	7.7%	10.1%	9.1%	6.8%		Pretty Cool or Very Cool
C	Peer smoking cigarettes	25.9%	22.7%	29.2%	29.4%	24.9%	~	1+ Friends
C	Perception of enforcement - cigarettes	38.1%	35.1%	39.5%	29.7%	37.7%	*	yes or Yes!
C	Perception of friends feelings on student cigarette use	85.4%	85.2%	83.6%	81.6%	85.5%		Wrong or Very Wrong
C	Perception of harm - cigarettes (1+ pack per day)	90.3%	78.8%	86.0%	85.1%	87.5%	*	Moderate or Great Risk
C	Perception of parental feelings on student cigarette use	95.5%	93.9%	93.2%	92.8%	95.1%		Wrong or Very Wrong
C	Perception of wrongness - cigarettes	90.6%	92.4%	90.1%	88.4%	91.1%		Wrong or Very Wrong
Ch	Lifetime chew use	4.6%	1.0%	3.4%	9.4%	3.7%	*	Yes
Ch	Past month chew use	1.8%	0.4%	2.0%	3.7%	1.4%		1+ Days
Cl	Lifetime club drug use	1.4%	0.5%	2.0%	0.8%	1.2%		Yes
Co	Lifetime cocaine use	1.3%	0.4%	2.0%	0.9%	1.1%		Yes
D	Depression scale - Student eating disruption	17.6%	20.4%	23.1%	21.6%	18.4%		Often or Always
D	Depression scale - Student feels hopeless	11.7%	11.5%	16.0%	13.5%	11.7%		Often or Always
D	Depression scale - Student irritable	26.8%	36.6%	31.1%	33.4%	29.1%	*	Often or Always
D	Depression scale - Student school work disruption	26.8%	26.1%	31.5%	29.5%	26.5%		Often or Always
D	Depression scale - Student sleeping disruption	20.0%	26.2%	26.5%	24.7%	21.5%	~	Often or Always

Code	Item	White STL	Black STL	Hispanic STL	Missouri	St. Louis	Sign.	Rating Scale
D	Depression scale - Student very sad	20.1%	19.1%	23.5%	22.7%	19.8%		Often or Always
Drugs	Method of Rx Access: A family member gives or sells it to me	3.1%	6.0%	4.7%	4.3%	3.8%		Endorsed
Drugs	Method of Rx Access: A friend gives or sells it to me	2.0%	0.8%	3.1%	1.9%	1.7%		Endorsed
Drugs	Method of Rx Access: A stranger gives or sells it to me	0.3%	0.5%	0.7%	0.3%	0.4%		Endorsed
Drugs	Method of Rx Access: Buy it online	0.1%	0.5%	0.7%	0.2%	0.2%		Endorsed
Drugs	Method of Rx Access: I take it without permission	1.4%	1.3%	2.4%	1.8%	1.4%		Endorsed
Drugs	Method of Rx Access: Other	0.9%	2.9%	1.4%	1.5%	1.4%		Endorsed
Drugs	Past Year Misuse Other Rx medication	8.2%	15.0%	12.2%	11.6%	10.0%	~	1+ Times
Drugs	Past Year Misuse Pain medication	11.0%	20.3%	14.9%	12.9%	13.3%	*	1+ Times
Drugs	Past Year Misuse Sedatives / anxiety medication	3.1%	1.8%	4.1%	2.9%	2.7%		1+ Times
Drugs	Past Year Misuse Sleeping medication	4.3%	7.0%	5.8%	6.0%	5.0%		1+ Times
Drugs	Past Year Misuse Stimulants	3.9%	2.8%	4.1%	2.9%	3.6%		1+ Times
Drugs	Reason given for Rx Misuse: Curiosity	1.2%	0.8%	2.7%	0.8%	1.1%		Endorsed
Drugs	Reason given for Rx Misuse: To fit in with friends	0.4%	0.5%	0.0%	0.1%	0.4%		Endorsed
Drugs	Reason given for Rx Misuse: To have a good time	1.6%	0.8%	2.0%	1.2%	1.4%		Endorsed
Drugs	Reason given for Rx Misuse: To help me feel better or happier	2.1%	2.4%	3.1%	2.3%	2.2%		Endorsed
Drugs	Reason given for Rx Misuse: To help me sleep	2.6%	3.9%	4.7%	3.7%	2.9%		Endorsed
Drugs	Reason given for Rx Misuse: To help with stress reduction	2.5%	2.2%	3.0%	2.7%	2.5%		Endorsed
Drugs	Reason given for Rx Misuse: To help with weight loss	0.8%	0.9%	1.4%	0.4%	0.8%		Endorsed
Drugs	Reason given for Rx Misuse: To improve academic performance	1.2%	0.6%	2.4%	0.8%	1.1%		Endorsed
Drugs	Reason given for Rx Misuse: To increase my energy	1.4%	1.2%	2.4%	1.3%	1.4%		Endorsed

Code	Item	White STL	Black STL	Hispanic STL	Missouri	St. Louis	Sign.	Rating Scale
Drugs	Reason given for Rx Misuse: To reduce and-or manage pain	3.8%	7.0%	5.8%	5.0%	4.6%		Endorsed
EC	Ease of availability - electronic cigarettes	48.0%	34.0%	44.4%	43.2%	44.1%	*	Very Easy or Sort of Easy
EC	Lifetime electronic cigarette use	22.8%	14.8%	24.7%	22.5%	20.6%	*	Yes
EC	Past month electronic cigarette use	12.6%	5.9%	11.9%	10.6%	10.7%	~	1+ Days
EC	Peer perception of coolness of electronic cigarette use	15.4%	13.5%	16.7%	17.0%	14.9%		Pretty Cool or Very Cool
EC	Perception of harm - electronic cigarettes	62.8%	59.3%	60.8%	59.4%	62.1%		Moderate or Great Risk
EC	Perception of wrongness - electronic cigarettes	77.9%	85.0%	78.0%	79.1%	79.9%	~	Wrong or Very Wrong
Ha	Lifetime hallucinogen use	2.5%	0.5%	3.8%	1.1%	2.0%		Yes
Harm	Past year fighting	12.4%	28.3%	18.3%	17.3%	16.3%	*	1+ Times
Harm	Past year fighting with injury	1.5%	4.5%	3.7%	2.6%	2.3%		1+ Times
Harm	Past year planning suicide	9.0%	10.2%	11.0%	9.9%	9.4%		Yes
Harm	Past year seriously considering suicide	13.5%	11.8%	16.8%	13.9%	13.3%		Yes
Harm	Past year attempting suicide	4.6%	7.6%	8.2%	6.3%	5.5%		1+ Times
Harm	Past year suicide with injury	1.0%	1.2%	2.0%	1.3%	1.0%		Yes
Harm	Self-injury	17.3%	13.1%	23.2%	17.9%	16.5%	*	Yes
He	Lifetime heroin use	0.3%	0.3%	0.7%	0.2%	0.3%		Yes
Healthy	Student feels optimistic about their future	83.1%	79.0%	77.5%	80.6%	82.0%		Agree or Strongly Agree
Healthy	Student feels that they handle stress in a healthy way	65.1%	63.1%	63.3%	61.4%	64.6%		Agree or Strongly Agree
Healthy	Student has adults in their life to turn to when things feel overwhelming	81.0%	75.9%	72.4%	76.6%	79.6%	*	Agree or Strongly Agree

Code	Item	White STL	Black STL	Hispanic STL	Missouri	St. Louis	Sign.	Rating Scale
Healthy	Student knows where to go in their community to get help	77.2%	65.8%	67.9%	70.7%	74.2%	*	Agree or Strongly Agree
I	Age of First Use – Inhalants	11.4	9.9	10.9	10.9	10.9		Average
I	Lifetime inhalant use	2.4%	3.7%	3.4%	2.8%	2.7%		Yes
I	Past month inhalant use	0.8%	1.9%	1.0%	1.0%	1.1%		1+ Days
M	Age of First Use – Marijuana	14.6	13.8	13.9	14.1	14.4		Average
M	Ease of availability - marijuana	42.3%	45.3%	45.5%	37.1%	42.5%	*	Very Easy or Sort of Easy
M	Lifetime hookah use	11.1%	16.6%	16.6%	9.7%	12.5%	~	Yes
M	Lifetime marijuana use	19.1%	23.6%	23.4%	15.2%	19.9%	*	Yes
M	Past month hookah use	4.5%	7.1%	7.8%	3.4%	5.2%		1+ Days
M	Past month marijuana use	11.1%	12.8%	12.9%	7.0%	11.3%		1+ Days
M	Peer perception of coolness of marijuana use	26.1%	32.4%	30.6%	24.9%	27.4%	~	Pretty Cool or Very Cool
M	Peer smoking marijuana	40.7%	42.5%	41.2%	35.3%	40.6%	~	1+ Friends
M	Perception of enforcement - marijuana	51.2%	45.8%	48.5%	44.9%	50.2%	~	yes or Yes!
M	Perception of friends feelings on student marijuana use	68.6%	60.3%	67.1%	71.9%	67.0%	*	Wrong or Very Wrong
M	Perception of harm - marijuana	65.8%	55.4%	65.1%	63.5%	63.6%	*	Moderate or Great Risk
M	Perception of parental feelings on student marijuana use	90.3%	89.8%	90.4%	91.8%	90.4%		Wrong or Very Wrong
M	Perception of parental feelings on student marijuana use (once or twice a week)	93.8%	91.1%	92.2%	93.5%	93.3%		Wrong or Very Wrong
M	Perception of wrongness - marijuana (no dosage)	74.5%	73.9%	72.5%	79.1%	74.7%	~	Wrong or Very Wrong
M	Perception of wrongness - marijuana (once or twice a week)	79.2%	76.3%	76.9%	81.2%	78.7%		Wrong or Very Wrong

Code	Item	White STL	Black STL	Hispanic STL	Missouri	St. Louis	Sign.	Rating Scale
M	School marijuana use	1.2%	2.1%	3.4%	0.8%	1.5%		1+ Days
Meth	Lifetime methamphetamine use	0.3%	0.2%	0.7%	0.3%	0.3%		Yes
OLD	Ease of availability - other illicit drugs	14.9%	16.3%	17.2%	13.9%	15.2%		Very Easy or Sort of Easy
OLD	Peer other illicit drug use	15.2%	8.0%	16.3%	10.6%	13.3%		1+ Friends
OLD	Perception of harm - other illicit drugs	93.1%	83.8%	90.1%	90.9%	90.7%		Moderate or Great Risk
OLD	Perception of wrongness - other illicit drugs	96.1%	95.4%	96.2%	97.0%	95.9%		Wrong or Very Wrong
OTC	Ease of availability – over the counter drugs	58.3%	45.6%	52.2%	51.7%	54.9%	*	Very Easy or Sort of Easy
OTC	Lifetime over the counter drug misuse	3.7%	7.5%	6.1%	4.7%	4.6%		Yes
OTC	Past month over the counter drug misuse	1.2%	3.6%	3.1%	2.2%	1.8%		1+ Days
OTC	Perception of harm - over the counter drug misuse	82.0%	71.7%	81.2%	77.6%	79.5%	*	Moderate or Great Risk
OTC	Perception of parental feelings on student over the counter drug misuse	98.0%	93.2%	95.9%	96.1%	96.8%		Wrong or Very Wrong
OTC	Perception of wrongness - over the counter drug misuse	93.1%	90.6%	92.2%	92.3%	92.5%		Wrong or Very Wrong
Parents	Parents check on students homework	85.5%	83.9%	82.7%	79.3%	85.1%	~	Agree or Strongly Agree
Parents	Parents consult student when making decisions	74.9%	71.5%	66.0%	71.1%	74.0%	*	Agree or Strongly Agree
Parents	Parents notice and comment on good work	74.9%	71.5%	66.0%	83.5%	74.0%	*	Agree or Strongly Agree
Safety	Perception of school safety	91.5%	83.1%	84.0%	85.8%	89.3%	*	Agree or Strongly Agree
Safety	Days missed due to safety concerns	4.0%	7.4%	6.8%	5.9%	5.0%		1+ Days
School	No discrimination in student treatment	75.9%	70.5%	69.5%	78.4%	74.3%	*	Agree or Strongly Agree

Code	Item	White STL	Black STL	Hispanic STL	Missouri	St. Louis	Sign.	Rating Scale
School	Rules are enforced fairly	74.4%	63.4%	66.4%	65.3%	71.6%	*	Agree or Strongly Agree
School	School notifies parents with praise	45.7%	45.4%	44.7%	39.3%	45.8%	~	Agree or Strongly Agree
School	Teachers notice and comment on good work	79.2%	81.4%	78.0%	73.2%	79.6%	*	Agree or Strongly Agree
Script	Ease of availability – prescription drugs	28.2%	29.1%	31.4%	27.7%	28.4%		Very Easy or Sort of Easy
Script	Lifetime prescription drug misuse	11.3%	16.8%	14.3%	14.3%	12.7%		Yes
Script	Perception of friends feelings on student prescription drug misuse	88.7%	82.5%	85.4%	87.7%	87.2%	~	Wrong or Very Wrong
Script	Perception of harm – prescription drug misuse	89.7%	78.3%	87.7%	86.3%	86.8%	*	Moderate or Great Risk
Script	Perception of parental feelings on student prescription drug misuse	96.9%	92.9%	94.6%	94.9%	95.9%		Wrong or Very Wrong
Script	Perception of wrongness - prescription drug misuse	94.3%	92.4%	92.8%	93.9%	93.8%		Wrong or Very Wrong
Script	Past month prescription drug misuse	7.4%	12.2%	10.9%	10.0%	8.6%		1+ Days
Synth	Ease of availability - synthetic drugs	26.3%	25.5%	30.1%	21.9%	26.1%		Very Easy or Sort of Easy
Synth	Lifetime synthetic drug use	1.4%	1.4%	1.4%	1.8%	1.4%		Yes
Synth	Past month synthetic drugs	0.4%	0.7%	0.7%	0.3%	0.5%		1+ Days
Synth	Perception of harm - synthetic drugs	89.6%	79.2%	86.9%	88.4%	87.1%	*	Moderate or Great Risk
Weapon	Past month weapon carrying at school	2.1%	3.0%		4.0%	2.3%		1+ Days
Weapon	Past year victim of weapon threat at school	4.3%	7.3%	7.1%	7.4%	5.1%		1+ Times
Weapon	Peer gun carrying	5.7%	18.9%	8.5%	10.0%	8.9%	*	1+ Friends
Weapon	Perception of enforcement - guns	77.0%	64.2%	69.9%	61.7%	73.9%	*	yes or Yes!

Source: Missouri Student Survey Data provided to Berry Organizational & Leadership Development LLC to analyze by racial categories collected. Note: * = > 8% difference between high and low values across all comparisons. ~ = 6-7.9% difference between high and low values across all comparisons.

Table 78. Grade Trends of the Missouri Student Survey St. Louis County Student Sample and Missouri Comparisons											
Code	**Item**	**6th**	**7th**	**8th**	**9th**	**10th**	**11th**	**12th**	**MO**	**STL**	Rating Scale
A	Age of First Use – Alcohol	NA	NA	NA	NA	NA	NA	NA	13.4	13.5	Average
A	Ease of availability - alcohol	22.6%	31.6%	45.7%	61.9%	71.1%	76.1%	76.7%	51%	54%	Very Easy/Sort of Easy
A	Lifetime alcohol use	10.4%	13.3%	21.4%	34.8%	46.6%	54.3%	64.7%	35%	34%	Yes
A	Lifetime alcohol use (times)	8.5%	11.5%	19.7%	32.7%	45.3%	53.5%	63.9%	33%	32%	1+ Times
A	Past month alcohol use	2.5%	3.6%	7.7%	15.3%	24.2%	31.2%	39.5%	14%	17%	1+ Days
A	Past month driving under the influence	0.2%	0.4%	0.5%	0.8%	3.4%	6.3%	7.2%	2%	2%	1+ Days
A	Past month riding with a driver under the influence	15.9%	18.7%	19.6%	18.9%	16.5%	19.3%	19.6%	14%	18%	1+ Days
A	Past two weeks binge drinking	0.4%	0.6%	1.6%	5.0%	8.6%	14.0%	19.1%	6%	6%	1+ Times
A	Peer alcohol use	8.5%	13.8%	27.5%	51.0%	62.8%	71.7%	76.8%	45%	43%	1+ Friends
A	Peer perception of coolness of alcohol use	6.0%	7.6%	15.6%	26.1%	39.1%	46.3%	45.9%	25%	25%	Pretty Cool or Very Cool
A	Perception of enforcement - alcohol	62.7%	56.9%	43.3%	32.2%	29.0%	22.7%	24.5%	34%	40%	yes or Yes!
A	Perception of friends feelings on student alcohol use	91.3%	91.1%	86.1%	78.5%	73.8%	66.1%	69.6%	76%	80%	Wrong/Very Wrong
A	Perception of harm - alcohol (1 or 2 drinks nearly every day)	74.1%	76.6%	77.0%	78.2%	77.1%	75.6%	79.1%	71%	77%	Moderate/Great Risk
A	Perception of harm - alcohol (5 or more drinks 1-2x week)	81.2%	84.3%	85.7%	83.6%	82.9%	81.9%	83.0%	79%	83%	Moderate/Great Risk
A	Perception of harm - alcohol (no dosage)	70.7%	72.1%	69.4%	65.7%	63.5%	60.2%	58.8%	66%	66%	Moderate or Great Risk
A	Perception of parental feelings on student alcohol use (1-2 drinks nearly every day)	98.2%	97.9%	97.0%	95.4%	96.0%	95.1%	91.5%	94%	96%	Wrong or Very Wrong
A	Perception of parental feelings on student alcohol use (no dosage)	95.2%	94.0%	89.2%	84.0%	79.8%	73.9%	61.5%	83%	83%	Wrong or Very Wrong

Code	Item	6th	7th	8th	9th	10th	11th	12th	MO	STL	Rating Scale
A	Perception of wrongness - alcohol (1 or 2 drinks nearly every day)	97.2%	96.4%	94.5%	89.6%	86.6%	82.3%	82.2%	87%	90%	Wrong or Very Wrong
A	Perception of wrongness - alcohol (5 or more drinks 1-2x a week)	98.0%	97.3%	95.6%	92.3%	87.7%	82.0%	80.0%	89%	91%	Wrong or Very Wrong
A	Perception of wrongness - alcohol (no dosage)	92.6%	89.7%	79.1%	66.4%	56.4%	46.5%	39.1%	68%	69%	Wrong or Very Wrong
A	School alcohol use	0.2%	0.1%	0.4%	0.3%	1.5%	1.7%	2.4%	1%	1%	1+ Days
A	Student perception of peers having 1 or 2 alcoholic drinks nearly every day	12.9%	14.7%	23.1%	33.6%	33.7%	38.6%	38.2%	30%	27%	Neither or Somewhat Disapprove
Behavior	Student believes it is ok to cheat	4.8%	6.6%	13.3%	21.5%	31.3%	39.7%	38.3%	21%	21%	Agree or Strongly Agree
Behavior	Student ignores rules	12.2%	11.5%	17.1%	19.0%	16.9%	24.8%	25.0%	19%	18%	Agree or Strongly Agree
Behavior	Student is oppositional	9.0%	8.0%	12.5%	12.5%	9.4%	12.5%	12.2%	12%	11%	Agree or Strongly Agree
Behavior	Past 3 month school suspension	5.6%	5.5%	7.2%	2.8%	3.4%	3.2%	1.8%	4%	4%	1+ Times
Behavior	Days skipped or cut	23.0%	24.7%	24.4%	20.4%	23.6%	24.4%	31.0%	29%	24%	1+ Days
Bully	Past 3 month bullying online or via cell phone	12.1%	14.5%	20.1%	24.8%	23.5%	22.5%	22.6%	16%	20%	1+ Times
Bully	Past 3 month emotional bullying	45.9%	51.5%	59.6%	64.4%	67.4%	66.3%	61.4%	54%	59%	1+ Times
Bully	Past 3 month physical bullying	18.5%	15.8%	18.3%	12.6%	11.3%	9.3%	8.2%	15%	14%	1+ Times
Bully	Past 3 month rumor spreading	25.5%	24.6%	27.4%	28.7%	27.7%	24.3%	24.6%	23%	26%	1+ Times
BullyV	Past 3 month victim of bullying online or via cell phone	19.2%	21.6%	25.2%	28.9%	26.5%	26.3%	24.8%	23%	25%	1+ Times
BullyV	Past 3 month victim of emotional bullying	59.0%	59.4%	61.8%	64.1%	59.6%	56.5%	58.8%	59%	60%	1+ Times
BullyV	Past 3 month victim of physical bullying	29.6%	23.5%	23.0%	16.6%	10.6%	11.1%	9.8%	21%	18%	1+ Times
BullyV	Past 3 month victim of rumor spreading	46.3%	44.3%	43.7%	46.6%	41.8%	40.4%	37.7%	45%	43%	1+ Times

Code	Item	6th	7th	8th	9th	10th	11th	12th	MO	STL	Rating Scale
BullyV	Past year victim of bullying at school	33.6%	30.6%	28.7%	25.6%	22.2%	21.5%	18.6%	29%	26%	1+ Times
C	Age of First Use – Cigarettes	NA	NA	NA	NA	NA	NA	NA	12.7	13.2	Average
C	Ease of availability - cigarettes	14.0%	19.3%	31.0%	45.1%	56.9%	65.0%	79.6%	46%	43%	Very Easy or Sort of Easy
C	Lifetime cigarette use	3.1%	4.2%	8.0%	11.0%	15.0%	21.6%	24.3%	18%	12%	Yes
C	Past month cigarette use	0.9%	1.4%	2.3%	4.1%	4.9%	8.1%	10.0%	6%	4%	1+ Days
C	Peer perception of coolness of cigarette use	4.3%	5.4%	6.4%	6.1%	8.6%	9.4%	8.8%	9%	7%	Pretty Cool or Very Cool
C	Peer smoking cigarettes	13.0%	12.8%	16.3%	23.8%	33.0%	36.5%	45.7%	29%	25%	1+ Friends
C	Perception of enforcement - cigarettes	63.4%	57.0%	41.8%	31.6%	27.3%	16.7%	17.8%	30%	38%	yes or Yes!
C	Perception of friends feelings-student cigarette use	93.6%	93.7%	90.6%	86.4%	80.8%	76.6%	72.2%	82%	86%	Wrong or Very Wrong
C	Perception of harm - cigarettes (1+ pack per day)	85.5%	87.1%	87.9%	87.9%	86.8%	86.1%	90.5%	85%	87%	Moderate or Great Risk
C	Perception of parental feelings on student cigarette use	98.3%	98.2%	96.4%	95.0%	95.1%	93.4%	88.5%	93%	95%	Wrong or Very Wrong
C	Perception of wrongness - cigarettes	97.7%	97.1%	94.5%	90.4%	88.6%	85.4%	81.5%	88%	91%	Wrong/Very Wrong
Ch	Lifetime chew use	0.9%	0.7%	1.4%	2.3%	4.8%	9.0%	8.7%	9%	4%	Yes
Ch	Past month chew use	0.2%	0.2%	0.2%	1.1%	1.9%	3.5%	3.7%	4%	1%	1+ Days
Cl	Lifetime club drug use	0.2%	0.3%	0.4%	0.7%	1.0%	3.4%	3.0%	1%	1%	Yes
Co	Lifetime cocaine use	0.4%	0.2%	0.4%	0.4%	0.7%	3.3%	3.0%	1%	1%	Yes
D	Depression scale - Student eating disruption	14.0%	14.1%	16.9%	20.0%	19.7%	24.2%	21.6%	22%	18%	Often or Always
D	Depression scale - Student feels hopeless	7.4%	7.5%	10.8%	13.2%	13.3%	17.7%	13.9%	13%	12%	Often or Always
D	Depression scale - Student irritable	20.4%	21.3%	29.7%	31.6%	32.1%	38.6%	33.4%	33%	29%	Often or Always
D	Depression scale - Student school work disruption	17.4%	18.6%	23.6%	27.5%	31.5%	37.3%	34.1%	29%	26%	Often or Always

Code	Item	6th	7th	8th	9th	10th	11th	12th	MO	STL	Rating Scale
D	Depression scale - Student sleeping disruption	18.6%	17.3%	19.2%	21.2%	24.3%	26.0%	26.5%	25%	22%	Often or Always
D	Depression scale - Student very sad	13.8%	14.0%	18.6%	21.9%	22.5%	26.2%	23.9%	23%	20%	Often or Always
Drugs	Method of Rx Access: A family member gives or sells it to me	3.7%	4.0%	4.8%	4.1%	3.9%	3.1%	2.9%	4%	4%	Endorsed
Drugs	Method of Rx Access: A friend gives or sells it to me	0.3%	0.4%	0.8%	1.8%	2.6%	3.5%	3.6%	2%	2%	Endorsed
Drugs	Method of Rx Access: A stranger gives or sells it to me	0.1%	0.1%	0.2%	0.2%	0.3%	1.1%	0.7%	0%	0%	Endorsed
Drugs	Method of Rx Access: Buy it online	0.1%	0.1%	0.2%	0.1%	0.5%	0.3%	0.1%	0%	0%	Endorsed
Drugs	Method of Rx Access: I take it without permission	0.6%	1.2%	1.5%	1.2%	2.5%	1.2%	1.5%	2%	1%	Endorsed
Drugs	Method of Rx Access: Other	2.6%	2.0%	1.6%	0.9%	0.6%	0.9%	1.0%	1%	1%	Endorsed
Drugs	Past Year Misuse Other Rx medication	16.6%	12.8%	11.2%	7.3%	8.3%	7.7%	5.8%	12%	10%	1+ Times
Drugs	Past Year Misuse Pain medication	12.1%	14.9%	15.6%	13.4%	12.4%	14.1%	10.3%	13%	13%	1+ Times
Drugs	Past Year Misuse Sedatives / anxiety medication	1.0%	1.4%	1.6%	2.6%	4.3%	5.7%	3.6%	3%	3%	1+ Times
Drugs	Past Year Misuse Sleeping medication	4.7%	5.6%	6.5%	5.4%	4.6%	4.0%	3.2%	6%	5%	1+ Times
Drugs	Past Year Misuse Stimulants	1.1%	1.5%	2.3%	3.0%	5.1%	6.6%	6.9%	3%	4%	1+ Times
Drugs	Reason given for Rx Misuse: Curiosity	0.4%	0.7%	0.8%	0.7%	2.0%	2.0%	1.5%	1%	1%	Endorsed
Drugs	Reason given for Rx Misuse: To fit in with friends	0.1%	0.4%	0.3%	0.5%	0.5%	0.8%	0.3%	0%	0%	Endorsed
Drugs	Reason given for Rx Misuse: To have a good time	0.1%	0.4%	1.0%	1.0%	2.3%	3.2%	2.5%	1%	1%	Endorsed
Drugs	Reason given for Rx Misuse: To help me feel better or happier	1.3%	1.6%	2.3%	2.4%	2.5%	3.0%	2.7%	2%	2%	Endorsed

Code	Item	6th	7th	8th	9th	10th	11th	12th	MO	STL	Rating Scale
Drugs	Reason given for Rx Misuse: To help me sleep	2.6%	2.8%	3.5%	2.7%	4.0%	3.2%	2.3%	4%	3%	Endorsed
Drugs	Reason given for Rx Misuse: To help with stress reduction	1.0%	1.5%	2.1%	2.6%	4.1%	3.5%	3.0%	3%	2%	Endorsed
Drugs	Reason given for Rx Misuse: To help with weight loss	0.2%	0.7%	0.6%	1.1%	1.7%	0.9%	0.4%	0%	1%	Endorsed
Drugs	Reason given for Rx Misuse: To improve academic performance	0.1%	0.6%	0.7%	0.9%	2.1%	1.3%	2.1%	1%	1%	Endorsed
Drugs	Reason given for Rx Misuse: To increase my energy	0.6%	0.9%	1.2%	1.2%	2.2%	2.0%	2.1%	1%	1%	Endorsed
Drugs	Reason given for Rx Misuse: To reduce and-or manage pain	4.0%	5.5%	5.9%	4.5%	4.6%	4.2%	3.0%	5%	5%	Endorsed
EC	Ease of availability - electronic cigarettes	10.9%	16.9%	31.8%	48.2%	61.2%	71.1%	80.8%	43%	44%	Very Easy or Sort of Easy
EC	Lifetime electronic cigarette use	4.0%	5.3%	13.5%	21.5%	30.1%	39.8%	38.5%	22%	21%	Yes
EC	Past month electronic cigarette use	1.5%	2.8%	6.4%	10.8%	18.0%	22.1%	18.8%	11%	11%	1+ Days
EC	Peer perception of coolness of electronic cigarette use	5.4%	8.5%	13.0%	15.9%	21.4%	24.1%	19.8%	17%	15%	Pretty Cool or Very Cool
EC	Perception of harm - electronic cigarettes	72.8%	74.2%	64.1%	59.8%	52.0%	49.1%	56.8%	59%	62%	Moderate or Great Risk
EC	Perception of wrongness - electronic cigarettes	94.8%	93.8%	86.6%	78.0%	70.5%	64.0%	64.3%	79%	80%	Wrong or Very Wrong
Ha	Lifetime hallucinogen use	0.3%	0.3%	0.4%	1.0%	3.8%	4.3%	5.3%	1%	2%	Yes
Harm	Past year fighting	22.3%	16.8%	20.5%	15.3%	13.3%	13.9%	10.9%	17%	16%	1+ Times
Harm	Past year fighting with injury	3.2%	1.9%	2.7%	2.1%	2.8%	1.7%	1.9%	3%	2%	1+ Times
Harm	Past year planning suicide	6.2%	6.3%	9.0%	10.9%	10.6%	12.3%	11.6%	10%	9%	Yes
Harm	Past year seriously considering suicide	9.0%	9.9%	12.3%	14.0%	15.5%	18.0%	15.8%	14%	13%	Yes
Harm	Past year attempting suicide	5.0%	4.5%	6.0%	6.1%	5.2%	6.9%	5.2%	6%	6%	1+ Times

Code	Item	6th	7th	8th	9th	10th	11th	12th	MO	STL	Rating Scale
Harm	Past year suicide with injury	0.6%	0.6%	1.2%	1.3%	0.9%	1.8%	1.0%	1%	1%	Yes
Harm	Self-injury	12.4%	13.3%	15.6%	18.1%	19.6%	18.9%	18.9%	18%	17%	Yes
He	Lifetime heroin use	0.2%	0.1%	0.2%	0.3%	0.2%	0.5%	0.9%	0%	0%	Yes
Healthy	Student feels optimistic about their future	84.2%	82.6%	80.7%	80.5%	81.1%	81.0%	84.2%	81%	82%	Agree or Strongly Agree
Healthy	Student feels that they handle stress in a healthy way	71.5%	70.3%	64.2%	60.3%	60.5%	60.8%	63.6%	61%	65%	Agree or Strongly Agree
Healthy	Student has adults in their life to turn to when things feel overwhelming	86.0%	84.6%	78.3%	78.1%	75.5%	75.3%	77.5%	77%	80%	Agree or Strongly Agree
Healthy	Student knows where to go in their community to get help	81.3%	77.5%	73.7%	74.0%	68.1%	71.0%	71.9%	71%	74%	Agree or Strongly Agree
I	Age of First Use – Inhalants	NA	NA	NA	NA	NA	NA	NA	10.9	10.9	Average
I	Lifetime inhalant use	2.6%	3.1%	3.0%	2.2%	2.3%	3.6%	2.6%	3%	3%	Yes
I	Past month inhalant use	1.8%	1.4%	1.4%	0.7%	0.7%	0.8%	0.7%	1%	1%	1+ Days
M	Age of First Use – Marijuana	NA	NA	NA	NA	NA	NA	NA	14.1	14.4	Average
M	Ease of availability - marijuana	7.8%	12.6%	27.9%	47.7%	65.5%	73.1%	76.6%	37%	43%	Very Easy or Sort of Easy
M	Lifetime hookah use	2.0%	2.2%	6.6%	9.8%	18.0%	23.8%	31.3%	10%	12%	Yes
M	Lifetime marijuana use	1.5%	3.0%	9.6%	16.8%	29.9%	41.1%	48.6%	15%	20%	Yes
M	Past month hookah use	1.0%	1.2%	3.1%	3.9%	7.4%	10.2%	12.0%	3%	5%	1+ Days
M	Past month marijuana use	0.6%	1.7%	5.2%	9.4%	17.2%	24.2%	27.2%	7%	11%	1+ Days
M	Peer perception of coolness of marijuana use	6.9%	11.0%	20.5%	26.5%	42.6%	47.9%	46.9%	25%	27%	Pretty Cool or Very Cool
M	Peer smoking marijuana	7.4%	12.5%	27.0%	46.8%	62.5%	68.3%	73.2%	35%	41%	1+ Friends
M	Perception of enforcement - marijuana	77.3%	70.6%	54.2%	43.9%	36.5%	30.1%	30.6%	45%	50%	yes or Yes!
M	Perception of friends feelings on student marijuana use	92.7%	89.8%	78.4%	67.5%	49.0%	40.9%	37.5%	72%	67%	Wrong or Very Wrong

Code	Item	6th	7th	8th	9th	10th	11th	12th	MO	STL	Rating Scale
M	Perception of harm - marijuana	81.8%	81.5%	72.1%	63.7%	51.5%	43.8%	40.9%	64%	64%	Moderate or Great Risk
M	Perception of parental feelings on student marijuana use	98.2%	97.1%	94.4%	90.0%	88.9%	84.4%	76.9%	92%	90%	Wrong or Very Wrong
M	Perception of parental feelings on student marijuana use (once or twice a week)	98.5%	98.0%	95.5%	92.5%	92.4%	89.8%	84.3%	93%	93%	Wrong or Very Wrong
M	Perception of wrongness - marijuana (no dosage)	95.9%	94.0%	84.4%	74.5%	60.9%	52.7%	49.8%	79%	75%	Wrong or Very Wrong
M	Perception of wrongness - marijuana (once or twice a week)	96.6%	94.8%	87.4%	78.3%	68.6%	59.2%	57.6%	81%	79%	Wrong or Very Wrong
M	School marijuana use	0.1%	0.3%	0.7%	1.3%	2.8%	2.6%	3.2%	1%	1%	1+ Days
Meth	Lifetime methamphetamine use	0.3%	0.1%	0.2%	0.2%	0.2%	0.7%	0.2%	0%	0%	Yes
OLD	Ease of availability - other illicit drugs	3.7%	5.0%	8.2%	14.4%	22.1%	29.5%	29.4%	14%	15%	Very Easy or Sort of Easy
OLD	Peer other illicit drug use	2.3%	4.0%	6.9%	11.4%	21.6%	26.0%	27.9%	11%	13%	1+ Friends
OLD	Perception of harm - other illicit drugs	87.5%	89.7%	91.3%	91.4%	91.2%	90.6%	93.6%	91%	91%	Moderate or Great Risk
OLD	Perception of wrongness - other illicit drugs	98.6%	98.0%	96.7%	96.2%	94.3%	92.7%	93.4%	97%	96%	Wrong or Very Wrong
OTC	Ease of availability – over the counter drugs	29.1%	38.9%	51.3%	60.6%	65.1%	70.9%	74.4%	52%	55%	Very Easy or Sort of Easy
OTC	Lifetime over the counter drug misuse	4.4%	3.8%	4.8%	3.9%	3.9%	5.4%	6.7%	5%	5%	Yes
OTC	Past month over the counter drug misuse	1.8%	1.6%	2.0%	1.4%	1.9%	1.2%	2.5%	2%	2%	1+ Days
OTC	Perception of harm - over the counter drug misuse	76.9%	78.8%	79.8%	78.4%	79.5%	77.3%	85.6%	78%	79%	Moderate or Great Risk
OTC	Perception of parental feelings on student over the counter drug misuse	97.0%	97.6%	96.0%	96.7%	97.0%	97.6%	95.7%	96%	97%	Wrong or Very Wrong

Code	Item	6th	7th	8th	9th	10th	11th	12th	MO	STL	Rating Scale
OTC	Perception of wrongness - over the counter drug misuse	95.0%	94.8%	93.3%	92.1%	90.2%	89.3%	91.3%	92%	92%	Wrong or Very Wrong
Parents	Parents check on students homework	94.5%	91.3%	87.1%	86.6%	82.4%	80.9%	69.8%	79%	85%	Agree or Strongly Agree
Parents	Parents consult student when making decisions	79.0%	79.1%	72.2%	73.5%	71.1%	72.2%	69.1%	71%	74%	Agree or Strongly Agree
Parents	Parents notice and comment on good work	79.0%	79.1%	72.2%	73.5%	71.1%	72.2%	69.1%	83%	74%	Agree or Strongly Agree
Safety	Days missed due to safety concerns	6.5%	5.0%	5.2%	4.9%	5.0%	4.3%	3.7%	6%	5%	1+ Days
Safety	Perception of school safety	89.1%	89.5%	88.1%	88.7%	90.1%	89.8%	90.7%	86%	89%	Agree or Strongly Agree
School	No discrimination in student treatment	83.8%	81.0%	76.7%	72.9%	69.9%	67.5%	65.6%	78%	74%	Agree or Strongly Agree
School	Rules are enforced fairly	80.7%	77.2%	68.0%	73.5%	69.1%	64.4%	65.1%	65%	72%	Agree or Strongly Agree
School	School notifies parents with praise	58.3%	57.8%	48.3%	41.7%	38.3%	33.3%	38.1%	39%	46%	Agree or Strongly Agree
School	Teachers notice and comment on good work	81.7%	82.3%	80.0%	77.8%	75.9%	78.6%	80.6%	73%	80%	Agree or Strongly Agree
Script	Ease of availability – prescription drugs	15.9%	20.3%	29.0%	30.6%	31.8%	38.7%	35.7%	28%	28%	Very Easy or Sort of Easy
Script	Lifetime prescription drug misuse	10.7%	11.3%	12.7%	11.2%	14.3%	15.1%	14.9%	14%	13%	Yes
Script	Perception of friends feelings on student prescription drug misuse	91.8%	92.6%	90.2%	87.7%	85.1%	77.2%	82.0%	88%	87%	Wrong or Very Wrong
Script	Perception of harm – prescription drug misuse	82.8%	85.6%	87.4%	88.7%	85.8%	85.5%	90.9%	86%	87%	Moderate or Great Risk
Script	Perception of parental feelings - student prescription drug misuse	96.6%	97.3%	95.2%	95.7%	95.2%	95.5%	95.3%	95%	96%	Wrong or Very Wrong
Script	Perception of wrongness - prescription drug misuse	96.1%	96.1%	95.2%	94.2%	91.2%	89.2%	92.9%	94%	94%	Wrong or Very Wrong
Script	Past month prescription drug misuse	7.7%	9.1%	9.1%	7.5%	9.4%	9.4%	8.2%	10%	9%	1+ Days

Code	Item	6th	7th	8th	9th	10th	11th	12th	MO	STL	Rating Scale
Synth	Ease of availability - synthetic drugs	20.0%	23.1%	25.7%	28.9%	27.0%	30.7%	28.0%	22%	26%	Very Easy or Sort of Easy
Synth	Lifetime synthetic drug use	2.2%	1.3%	1.0%	0.9%	0.6%	2.3%	1.7%	2%	1%	Yes
Synth	Past month synthetic drugs	1.1%	0.7%	0.4%	0.3%	0.0%	0.4%	0.2%	0%	0%	1+ Days
Synth	Perception of harm - synthetic drugs	78.4%	82.3%	86.7%	87.8%	89.9%	91.4%	94.9%	88%	87%	Moderate or Great Risk
Weapon	Past month weapon carrying at school	1.5%	1.5%	2.3%	2.1%	3.0%	4.3%	2.4%	4%	2%	1+ Days
Weapon	Past year victim of weapon threat at school	6.2%	5.5%	6.8%	5.4%	4.6%	3.4%	3.3%	7%	5%	1+ Times
Weapon	Peer gun carrying	4.6%	5.6%	9.8%	9.3%	9.4%	11.2%	13.2%	10%	9%	1+ Friends
Weapon	Perception of enforcement - guns	83.1%	81.6%	74.8%	74.1%	67.8%	64.6%	67.0%	62%	74%	yes or Yes!

APPENDIX F. ADDITIONAL BHR DATA TABLES

Table 108: Regional Analysis of Primary Problems for 2015 BHR Cases

	CC		NC		SC		WC		Total	
Primary Problems	#	%	#	%	#	%	#	%	#	%
Abuse/Neglect	7	1%	7	1%	4	2%	1	0%	22	1%
Access to and/or Problems with Psychiatric Medications	10	2%	21	2%	4	2%	2	1%	37	2%
Acute Psychiatric Crisis	20	4%	*53*	*5%*	*20*	*8%*	*17*	*8%*	110	5%
Alcohol/Drug	8	1%	13	1%	5	2%	5	2%	31	1%
Bullying	2	0%	8	1%	0	0%	1	0%	11	1%
Childhood/Adolescent Problems	*176*	*32%*	*403*	*38%*	*92*	*37%*	*71*	*32%*	*745*	*35%*
Currently Suicidal	*47*	*8%*	*82*	*8%*	*27*	*11%*	*29*	*13%*	*185*	*9%*
Domestic Violence	1	0%	3	0%	0	0%	0	0%	4	0%
Education and Assistance with Referral	*50*	*9%*	49	5%	15	6%	*16*	*7%*	*141*	*7%*
Family Problems	8	1%	19	2%	8	3%	8	4%	44	2%
GLBTQ Related Concerns	1	0%	2	0%	1	0%	0	0%	4	0%
Housing	*109*	*20%*	*174*	*16%*	*22*	*9%*	13	6%	*323*	*15%*
Non Acute Mental Health Needs	*118*	*21%*	*236*	*22%*	*48*	*20%*	*56*	*26%*	*471*	*22%*
Grand Total	557		1070		246		219		2128	
Note: Top five in each region are in bold and italics.										

Table 111: Regional Analysis of Emergency Types – St. Louis County

	CC		NC		SC		WC		Total	
	#	%	#	%	#	%	#	%	#	%
Admission to Unit - Medical	0	0.0%	4	0.4%	0	0.0%	3	1.4%	7	0.3%
Admission to Unit - Psych	20	3.6%	61	5.7%	11	4.5%	21	9.6%	113	5.4%
ED Visit - Medical	7	1.3%	12	1.1%	1	0.4%	4	1.8%	24	1.1%
ED Visit - Psych	27	4.8%	70	6.5%	11	4.5%	18	8.2%	126	6.0%
No Emergency Services	445	79.9%	840	78.5%	214	87.0%	157	71.7%	1674	79.6%
(blank)	58	10.4%	83	7.8%	9	3.7%	16	7.3%	159	7.6%
Grand Total	557		1070		246		219		2103	

Table 114. All Cases – Linkage within 2 days and 14 days by Primary Problem Type

	No	Yes	No Data	Total	% Linked in 2 days	% Not Linked in 2 days	No	Yes	No Data	Total	% Linked in 14 days	% Not Linked in 14 days
Abuse/Neglect	2	11	9	22	50%	9%		13	9	22	59%	0%
Access to and/or Problems with Psychiatric Medications	2	21	14	37	57%	5%	1	22	14	37	59%	3%
Acute Psychiatric Crisis	1	80	29	110	73%	1%		81	29	110	74%	0%
Alcohol/Drug	6	12	13	31	39%	19%		18	13	31	58%	0%
Bullying		5	6	11	45%	0%		5	6	11	45%	0%
Childhood/ Adolescent Problems	54	443	248	745	59%	7%	16	481	248	745	65%	2%
Currently Suicidal	6	133	46	185	72%	3%		139	46	185	75%	0%
Domestic Violence		4		4	100%	0%		4		4	100%	0%
Education and Assistance with Referral	9	53	79	141	38%	6%	5	57	79	141	40%	4%
Family Problems	1	28	15	44	64%	2%		29	15	44	66%	0%
GLBTQ Related Concerns	1	2	1	4	50%	25%		3	1	4	75%	0%
Housing	6	230	87	323	71%	2%	2	234	87	323	72%	1%
Non Acute Mental Health Needs	29	256	186	471	54%	6%	4	281	186	471	60%	1%
Total	117	1278	733	2128	60%	5%	28	1367	733	2128	64%	1%

Table 115. High Risk Cases – Linkage within 2 days and 14 days by Primary Problem Type

	No	Yes	No Data	Total	% Linked to w/in 2 days	No	Yes	No Data	Total	% Linked w/in 14 days
Access to and/or Problems with Psychiatric Medications		6		6	100%		6		6	100%
Acute Psychiatric Crisis		43	8	51	84%		43	8	51	84%
Alcohol/Drug		3	1	4	75%		3	1	4	75%
Bullying		4		4	100%		4		4	100%
Childhood/Adolescent Problems	9	168	16	193	87%	1	176	16	193	91%
Currently Suicidal	6	128	16	150	85%		134	16	150	89%
Domestic Violence		3		3	100%		3		3	100%
Education and Assistance with Referral	1	9		10	90%	1	9		10	90%
Family Problems		9	2	11	82%		9	2	11	82%
GLBTQ Related Concerns		1		1	100%		1		1	100%
Housing		19	1	20	95%		19	1	20	95%
Non Acute Mental Health Needs	5	98	15	118	83%		103	15	118	87%
Grand Total	21	491	59	571	86%	2	510	59	571	89%

Table 116. Initial Barriers of All Cases

Barriers	#	%
Unable to verify/contact	260	12.2%
Declined follow-up	64	3.0%
Services not needed	56	2.6%
Declined referrals-guardian	19	0.9%
Declined referrals-client	16	0.8%
No services available	12	0.6%
Transportation	3	0.1%
Finances/Funding	2	0.1%
Insurance	1	0.0%
Barriers	433	20.3%
No Barriers Identified	1695	79.7%
Total	2128	

Table 117. Total Barriers of the High-Risk Cases

Barriers	#	%
Declined follow-up	9	1.6%
Declined referrals-client	2	0.4%
Declined referrals-guardian	8	1.4%
Finances/Funding	1	0.2%
Services not needed	4	0.7%
Unable to verify/contact	43	7.5%
Insurance	1	0.2%
Total	68	11.9%

Note: 59 separate cases assessed high risk with barriers; 68 total barriers identified