CHAPTER 7:
ENHANCED MENTAL HEALTH & SUBSTANCE ABUSE SERVICES STRATEGY

7.1 INTRODUCTION TO STRATEGY

Child welfare agencies routinely struggle to provide timely and appropriate assessment and treatment for clients with mental health and/or substance abuse needs. For up to 70% of children entering out-of-home care, parental drug and/or alcohol abuse is the primary reason for the child's removal. Children with parents who receive little or no treatment for their substance abuse needs are less likely to be reunified, and their parents are more likely to have their parental rights terminated (McWey, Henderson, & Tice, 2006).

Compounding the needs of their parents, children in foster care have been found to have more mental health issues than children in the general population. These issues may be due to abuse and/or neglect as well as to the impact of removal from the home and placement in care. Children in the child welfare system are also at an increased risk of not receiving the services necessary to address their needs; less than half of child welfare agencies assess all children entering care for mental health issues (Kerker & Dore, 2006). A child with untreated mental health needs is likely to change placements more frequently, as well as ultimately need more intensive resources such as hospitalization or incarceration.

Within their efforts to meet the mental health and/or substance abuse needs of children and their parents, child welfare agencies often encounter barriers such as the following:

- Caseworkers are not adequately trained to provide assessments;
- Community providers often lack knowledge specific to working with a child welfare population;
- Clients often have co-occurring mental health and substance abuse needs, making treatment more complex;
- Clients often fail to comply with treatment regimens;
- Children often lack an advocate; a dispersion of responsibility leaves no one in charge;
- ASFA timelines pressure providers/families to complete services more quickly than is clinically recommended;
- Financial and eligibility barriers do not allow for adequate treatment or choice of treatments;
- Community providers are few in number and are sometimes of low quality;
- Collaboration among client service providers is inconsistent;

- Providers often have long waiting lists for particular services.

Like other child welfare agencies, Ohio PCSAs recognize the pivotal role played by mental health and substance abuse (MHSA) services in improving outcomes for the children and families they serve. In order to address some of the barriers noted above, three of the ProtectOhio demonstration counties opted to use Waiver flexibility to enhance MHSA services. These three counties -- Belmont, Lorain, and Muskingum - have been recently joined by two expansion counties, Hardin and Coshocton, yielding five counties for the MHSA strategy.

Unlike the ProtectOhio strategies of FTM, Supervised Visitation, and Kinship, the MHSA strategy is not an intervention which is precisely defined and uniformly implemented across participating counties. Rather, each county has identified its specific needs and implemented targeted interventions. Although the specifics of each intervention for these five counties vary in practice, the purpose of implementation is consistent: to improve and accelerate access to mental health and substance abuse services. In theory, more timely, targeted, thorough, and convenient assessments and services will lead to better outcomes for children and families.

Evaluation of each participating county entails a pre-post study. The study team will identify two groups: a pre-strategy group entering ongoing services at least two years before implementation of enhanced services, and a post-strategy group entering services at least one year after full implementation. Each group will consist of cases that were open to ongoing services for least 90 days. The study team will gather data from case record reviews, and will supplement that information with outcome data drawn from state-level data systems. The timing of data collection is dependent on strategy implementation dates for each county.

The first participating county to fully implement its MHSA enhancements was Lorain County Children Services (LCCS). We describe below LCCS' MHSA initiative and report the evaluation findings.

7.2 LORAIN COUNTY EVALUATION

Prior to 1999, families in Lorain County, Ohio, with mental health and/or substance abuse treatment needs were experiencing long waiting lists for treatment. In addition, agency staff considered many outside providers to be under-qualified and not responsive to or respectful of the needs of families being served by child welfare.

Since the beginning of flexible funding under the ProtectOhio Title IV-E Waiver, LCCS has made significant changes to their client assessment services for mental health and substance abuse treatment.

- In 1999, LCCS implemented in-house assessment services for adults with drug and alcohol issues, hiring experienced and credentialed staff. Currently, the alcohol and drug unit has a supervisor and two staff members who provide assessments and connect clients with treatment providers. This unit is also able to provide in-home assessments.
- In 2001, LCCS implemented the Extended Casework Services unit which provides mental health assessments for children entering out-of-home care. This unit currently has

one supervisor and one staff member who provide comprehensive assessments. This unit also occasionally accepts referrals for assessments on children who are in kinship settings or who remain at home.

For both units, the goals are to provide high-quality and timely assessments and to work successfully with outside providers. By completing their own assessments, Lorain County feels they have a more complete picture of what a family needs for a successful outcome.

Interviews with Lorain County staff indicate firm belief that the new MHSA initiative has had a positive impact. They generally voice the view that in-house resources have improved and accelerated access to assessment and treatment. In particular, staff report that waiting lists have mostly been eliminated, treatment episodes have been shortened, and cases have been closing sooner. This study offers some hard evidence which adds depth and texture to the staff perspective.

7.2.1 Sample

7.2.1.1 Process Study: Case Record Reviews

In 2005, HSRI staff reviewed the case records of a random sample of child welfare cases receiving ongoing services from LCCS. The sample included two types of cases:

- Pre-implementation cases: family cases that opened for ongoing services during federal fiscal year 1997 (FFY 1997[1])

- Post-implementation cases: family cases that opened for ongoing services during FFY2002 or 2004

These time periods reflect the dates when the new LCCS assessment units began full operation. The pre-implementation time period occurs two years before the first unit was established, to assure that these "pre" cases were not affected by the development of the new units. The post-implementation period occurs well after the second unit was established, to allow time for the new practices to become standard practice. Two separate periods were used, 2002 and 2004, to better represent the ongoing maturation of the program. In addition, because nearly all cases opened for child welfare services in Lorain County have a substance abuse issue, a mental health issue, or both, the sampling frame consisted of all cases that opened during the specified time periods. In the course of the case record review, HSRI dropped only a few cases from the sample because they appeared to have neither of these issues.

Table 7.1 describes the sample. HSRI obtained case record data from a total of 93 families. Each of these 93 families had from one to six family members involved with the case, resulting in a sample of 191 individual persons. Of these individuals, 49% were parents, 42% were children, and 9% were other adults. This group of 191 people is used for the Process Study.

For each person, the study team gathered on up to nine "events," defined as an interaction with child welfare that resulted in an assessment, referral, or service for a substance abuse or

[1] FFY 1997 runs from October 1, 1996 through September 30, 1997.

mental health issue. A total of 310 events were recorded over the entire sample. Most individuals had one or two events, with only 13% of the sample involved in three or more.

Fifty-nine percent of the sample had at least one mental health event, 25% had at least one substance abuse incident, and 17% had at least one of each.

Table 7.1: Lorain County MHSA Sample Description

	# of individuals	% of total individuals
Pre-Implementation of In-House Services	76	40
Post-Implementation of In-House Services	115	60
At least one Mental Health service need	111	60
At least one Substance Abuse service need	47	25
Both Mental Health & Substance Abuse needs	33	17
Individual is: Parent	93	49
Child	80	42
Other	18	10
At least one intervention incident recorded	191	100
Two or more intervention incidents recorded	67	34
Three or more intervention incidents recorded	24	13
Total	191	100%

7.2.1.2 Outcome Study: FACSIS Data

For the outcome study, the study team uses a slightly different sample. Adults were dropped from the sample, as outcome data was not available for them. At the same time, some children were added. These children were children who were living in the home at the time a family member received a service, but who did not have service (case record) data. They may or may not have received a service. This included all siblings except those who had been adopted, had aged out, or had gone to independent living. In addition, ten children with service data were not included in the outcome study because their FACSIS identification numbers could not be matched with their case record information.

The resulting outcome sample consists of 155 children. In the “pre” families, there were 76 children living in the home during the period when parent(s) and/or some children received mental health and/or substance abuse services. In the “post” families, there were a total of 79 children present during this period.

Table 7.2 shows the difference between the samples for the Process Study and the Outcome Study.

Table 7.2: Sample Differences for Outcome Study			
	Process Data (individuals with service data from case records)	**Outcome Data (individuals and family members with data available from FACSIS)**	**Both Types of Data (individuals with service data and outcome data)**
Children	80	155	70
Adults	111	-	-
Total Individuals	191	155	70

7.2.2 Data Collection Process

7.2.2.1 Primary Data: Process Study

Through review of family case records, HSRI collected primary data on parents and children. Data from case records was entered into Excel spreadsheets. Information collected from case records for the 191 people in the process study included:

- dates of case openings and closings
- reasons for case openings and closings
- dates of birth of all children in a family
- family members needing services
- case dispositions
- assessment and referral dates and locations
- service dates
- diagnostic labels
- treatment results

We gathered these categories of information for several reasons: to accurately identify family members, to comprehensively identify services offered and completed, and to establish timelines for case events.

7.2.2.2 Secondary Data: FACSIS Data

Data obtained from the state FACSIS system for each of the 155 children in the outcomes study included:

- child abuse and neglect (CAN) report dates
- number of CAN reports
- disposition of CAN reports
- adjudication results
- hearing results
- dates of placement(s)
- placement resource types
- types of exits from placement

These categories of information were selected in order to align with LCCS' goals of reducing (a) the amount of time cases are open, (b) the amount of time children are spending in placement, and (c) the number of substantiated incident reports subsequent to case opening.

7.2.3 Results

7.2.3.1 Process Study Results

To analyze the data from the case records, the study team created an analysis file with coded information from the Excel spreadsheets. The most pertinent information from this file were event dates, such as case opening and closing dates, and dates of referrals and assessments. Where dates were available, we calculated the period of time that elapsed between particular events. In an ideal trajectory, a child welfare client with a mental health and/or substance abuse need would have a case opening, receive an assessment and a referral, begin and complete treatment, and have a case closing. In our sample, many clients were missing one or more dates from their trajectories. For analysis purposes, the evaluation team made the assumption that a missing date meant that the event did not occur. Finally, one of the challenges of the case record review was missing client identification information for a small number of cases—making it difficult to determine which particular family member might have received the service. These issues resulted in variation in the numbers of cases available for each analysis.

In analyzing the case records data, the study team focused on two paths of inquiry: access to assessments and services, and length of time between case events.

Assessments & Services: Tables 7.3 to 7.5 show the percentage of clients who received an assessment and/or completed treatment. Table 7.3 indicates that, among children in the post group, a much larger percentage received an assessment than did children in the pre group, 73% compared to only 37%. The percentage of parents receiving an assessment was identical for the pre group and the post group, 41%.

Table 7.3: Was There an Assessment?

Group	Assessment?	Parents	Children	Both
Pre Group (n=76)	Yes	41%	37%	39%
	No Evidence	59%	63%	61%
Post Group (n=115)	Yes	41%	73%	57%
	No Evidence	59%	27%	43%

Table 7.4 shows how many clients had evidence of treatment completion in their case record. Each person was coded as "completed treatment", "non-compliant" or "other". Clients coded as non-compliant began services but did not complete them. Other service endings included: "never followed through with referral", "case closed before the end of treatment", "referred elsewhere", and "services still ongoing". Service compliance rates are noticeably higher for the post group, 24% compared to 16%.

Table 7.4: How did Services End?		
	Pre (n=76)	Post (n=110)
	%	%
Completed Treatment	16	24
Non-compliant	25	14
Other	59	63
Total	100	100

*percentages are for combined groupings of mental health/substance abuse treatment and parents/children

The data in Table 7.4 masks differences between parents and children, and differences between MH service recipients and those receiving SA services. Table 7.5 focuses on MH treatment experiences, separately presenting data on parents and children. Although the numbers of clients are quite small (for example, only one parent in the pre group had evidence of completed mental health treatment), it appears that a greater percentage of both adults and children are completing mental health services after the implementation of in-house assessments, and this contrast is greater for MH treatment than for all services together (refer back to Table 7.4). Table 7.5 also shows that, among MH clients, the difference is much more dramatic for parents, with 34% of post group parents completing treatment compared to 11% in the pre group.

Table 7.5: How did Mental Health Services End for Parents and Children?				
	Parents		Children	
	Pre (n=19)	Post (n=35)	Pre (n=32)	Post (n=39)
	%	%	%	%
Completed Treatment	5	34	9	20
Non-compliant	21	11	31	10
Other	74	60	60	70
Total	100	100	100	100

Time Between Case Events: Among the goals of enhanced MHSA services in Lorain County is to accelerate access to assessment and treatment and to close cases more quickly. To explore the extent to which this happened, the study team obtained certain dates from the case records. These dates were related to mental health and/or substance abuse treatment and included (in typical chronological order): date of case opening, date of assessment referral, date of assessment, date of assessment write-up, date of service referral, date of service start, date of service end, and date of case closing. Table 7.6 presents average time periods between these key events.

Table 7.6: How Many Days Passed Between Case Events?				
	Pre Group		Post Group	
Time Period	Avg. Days	N	Avg. Days	N
Case Open to Case Close*	606	76	262	78
Assessment to Case Close*	445	27	177	31
Service Start to Case Close*	394	43	194	40
Case Open to Assessment	142	24	154	54
Case Open to Service Start	212	38	165	57
Service Start to Service End	170	32	92	45

*statistically significant difference (ANOVA)

Although many of these dates were inconsistently recorded, reducing sample sizes for some events, the available information suggests that time periods between certain case events were shorter for the post group than for the pre group. Three of these time periods show statistically significant ANOVA differences between the two groups. The average number of days from case opening to case closing was dramatically shorter for the post group than for the pre group, 262 compared to 606 days. The time from the date of assessment to case closing was also shorter, with an average of 445 days for the pre group and an average of 177 days for the post group. Finally, the period of time from the start of services to case closing was 394 days for the pre group and 194 days for the post group. The other three time periods displayed in Table 7.6 also show differences between the two groups, but these differences are not statistically significant.

7.2.3.2 Outcomes Study Results

The purpose of the outcomes study was to examine if enhanced MHSA services lead to greater child safety and/or less time in out-of-home care. Data analysis of FACSIS data consisted of computing frequencies of events such as incidents and placements, and calculating the period of time between elapsed events in order to determine how long cases were open, how long children were in placement, and timing of incident reports.

The study team merged into one file the data from both the case record files and the FACSIS files, in order to link children who received services with their corresponding FACSIS information.

Safety: Data to examine child safety consists of child abuse/neglect incident (CAN) reports. Across the pre and post groups, a total of 86 children had 105 child abuse and neglect reports during the target period. The "target period" is defined as case opening to one year after case closing for each case. Table 7.7 shows the proportion of each group which experienced a CAN report. Post group children were more likely to have a CAN report during the target period.

Table 7.7: How Many Children had a New CAN Report?		
	N	**% of each group with a report**
Pre group	31	41%
Post group	55	70%
Totals	86	-

Table 7.8 indicates the dispositions of these CAN reports. Sixty-one percent of the 43 pre group reports were either substantiated or indicated, compared to 78% of the post group reports. Although the number of children is small, it is notable that not only were children in the post group more likely to have a new report, but reports in this group were more likely to have a finding of substantiated or indicated.

Table 7.8: What was the Disposition of these Reports? (n=105 reports)						
	Pre		**Post**		**Totals**	
	N	%	N	%	N	%
Substantiated	14	33%	27	44%	41	39%
Indicated	12	28%	21	34%	33	31%
Unsubstantiated	12	28%	9	15%	21	20%
Other*	5	11%	5	8%	10	10%
Totals	43	100%	62	100%	105	100%

*includes: couldn't locate, case resolved, missing disposition

Possible explanations for this trend include:

- Clients coming to the attention of LCCS have more abuse and neglect concerns than they have had in the past;
- Assessment workers are more likely to open a case with a substantiated or indicated report, knowing that the agency has increased ability to respond to borderline needs;
- LCCS staff are looking more closely at the needs of the family, confident that resources are available to address these needs;
- Clients receiving in-house services are more likely to have intensified and sustained contact with service providers who make reports.

The study team may be able to explore these possibilities in later years of the evaluation.

Time in Care: For analysis of children's time in placement, at the study team examined placements for 29 children who had one or more placement episodes during the target period (case opening to one year after case closing) (Table 7.9). Although 39 children had at least one episode, ten children from the post group were removed from the analysis because they had placements that were ongoing when we received the FACSIS file. The average number of placement/custody days for these 29 children was 346 days.

Table 7.9: Average Length of Time in Placement		
	N	**Average # of placement days***
Pre	19	402.53
Post	10	237.20
Total	29	345.52

* across all episodes during target period

Although the numbers of children are too low for the differences in days to reach statistical significance, the post group shows a lower average time in placement.

<u>Placement/Custody Exit Types:</u> Table 7.10 shows the various types of exits from care. Of the 29 cases with completed placements during the target period, a total of 39 episodes resulted in an exit from care.

Table 7.10: Exits from Care			
Exit Type	**Group***	**Number of Exits**	**% of exits**
Reunification	Pre	11	52%
	Post	11	61%
Relative	Pre	4	19%
	Post	5	28%
Adoption	Pre	1	5%
	Post	2	11%
Other Agency	Pre	3	14%
	Post	-	-
Emancipation	Pre	2	10%
	Post	-	-

*Total Pre Episodes = 21; Total Post Episodes = 18

It appears that the post group has slightly higher percentages of exits to reunification and relative care. However, since the numbers of children involved are very small, this result should be viewed as a topic for further exploration rather than as a conclusion.

7.2.4 Summary and Conclusions

The evaluation of Lorain County's enhanced MHSA services had some encouraging results. Collection and analysis of case record and outcome (FACSIS) data from 93 families suggested that *since implementation of enhanced services*:

- More children are receiving assessments
- More clients have evidence in their case record of treatment completion
- Cases are closing more quickly
- The time between assessment and case closing is getting shorter
- The time between the start of services and case closing is also getting shorter
- More children have additional substantiated or indicated CAN reports while their cases are open or during one year after closing
- Cases opened after implementation of enhanced services have fewer placement days

Many of these results may simply reflect an overall agency trend towards closing cases more quickly. However, evaluation evidence suggests that the efforts of the LCCS Alcohol & Drug and Extended Casework Services units have expedited services for families and are making practical differences in case resolution.

For further evaluation, it would be useful to obtain a larger sample so we can examine more children who received assessments and/or services. A larger sample would allow a more accurate look at group differences on outcomes such as CAN reports and exit types, as well as an opportunity to look at additional outcomes such as re-entry into care. In addition, a larger sample size would allow examination of outcomes by treatment diagnoses and results. We also recommend more consistent recording of data in the case record or in a corresponding database, particularly dates of case events which are not available in FACSIS such as assessments, referrals, and services.

7.3 EVALUATION IN OTHER PARTICIPATING COUNTIES

The evaluation has not yet begun for the other four PCSAs participating in the MHSA strategy. In Spring 2006, the evaluation team conducted telephone interviews with Muskingum and Belmont County staff regarding the specifics of their interventions. A timeline has been developed for case record reviews and data analysis which allows for the full effect of service implementation.

We describe below initial information about the model that has been implemented by Belmont and Muskingum counties. Details of the approaches being taken by the two expansion counties, Hardin and Coshocton, have not yet been compiled.

7.3.1 Belmont County

Belmont County has made two enhancements to its MHSA program:

- In January 2005, Belmont County implemented a Family Drug Court involving the PCSA, the county juvenile court, and a local health center. The cooperation of these three agencies allows families to receive parenting classes, individual and group therapy, drug and alcohol testing, progress incentives, and enhanced case management.

- In Fall 2004, Belmont changed its provider of mental health evaluations for parents and children, with the goal of improving their turnaround time as well as their quality.

Interviews with Belmont County staff indicate that these implementations have resulted in more frequent contact with clients and a quicker decision timeline. Waiver funding has allowed Belmont to devote one worker, with a lower caseload, to drug and alcohol cases, as well as pay for mental health evaluations and provide compliance rewards for families.

Expected outputs and outcomes for Belmont County include:

- ✓ More productive collaboration with service providers
- ✓ More successful at getting participants clean and sober
- ✓ Increased follow-up with clients receiving services
- ✓ Services are established more quickly
- ✓ Reports from providers arrive more quickly
- ✓ Cases close more quickly

7.3.2 Muskingum County

Muskingum County has made enhancements in two areas:

- Between 1998 and 2000, Muskingum County implemented the "Options" program, which provides assessments, group treatment, and individual treatment to clients with drug and alcohol issues. This program includes a component of specialized home visits for drug screenings.
- During the same period, Muskingum added two staff to provide mental health assessment and treatment services; a psychologist who provides evaluations and reviews reports completed by other providers and a home-based counselor who provides behavior modification for clients with mental health needs.

Interviews with Muskingum County staff indicate that services have been expedited, frequency of contact has increased, and families are more comfortable participating in evaluation and treatment. Waiver funding has assisted Muskingum County with all MHSA services by allowing for "up-front" spending for their psychologist, as well as for drug-testing kits used on home visits.

Expected outputs and outcomes for Muskingum include:

- ✓ Services are established more quickly
- ✓ Increased consistency of services
- ✓ Increased frequency of services
- ✓ Increased consistency of random drug screenings

- ✓ Expedited decisions regarding best approach to case management
- ✓ Expedited permanency
- ✓ Reduced recidivism
- ✓ Cases close more quickly

7.4 NEXT STEPS AND CHANGES TO EVALUATION PLAN

The next steps for the evaluation of MHSA enhancements will be case record reviews in Muskingum and Belmont. Case record reviews will be conducted in Muskingum in mid-2007, with data analysis beginning in late 2007. Case record reviews will be conducted in Belmont in mid-2008, with data analysis beginning in late 2008.

As part of the overall ProtectOhio site visits, all demonstration and comparison counties will be interviewed regarding mental health and substance abuse services.

At this time, only one change to the evaluation plan for MHSA services bears mention: The study team will be using a pre/post evaluation design in each of the strategy counties, so case record reviews will not need to be conducted in comparison counties.