CHAPTER 6:
ENHANCED MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

6.1 INTRODUCTION

One of the most critical needs of families involved with child welfare agencies is access to mental health and alcohol and drug addiction services. The need for these services is significant. Evidence suggest that between one-third and two-third of families in the child welfare system are affected by substance abuse disorders[1]. Frequently, such addictions co-occur with mental health issues. In terms of mental health issues, up to 80% of children who enter foster care have serious problems with mental health (Simms, Dubowitz, & Szilagyi, 2000), as compared to 18 to 22% of children in the general population (Roberts, Attkisson, & Rosenblatt, 1998). Given this level of need, mental health and substance abuse services (MHSA) are considered a "core" element in the continuum of child welfare services and are critical to the PCSA's ability to effectively serve children and their parents.

Unfortunately, child welfare agencies have limited success in assuring that their clients access MHSA services in their communities. The Child Welfare League of America (CWLA) estimates that while two-thirds of parents involved in the child welfare system need addiction treatment, child welfare agencies can provide treatment services for less than one-third. The availability of mental health services is also limited: while the need is estimated at 80%, "only 23% of children who are in foster care for at least 12 months receive mental health services" (National Survey of Child and Adolescent Well-Being, 2003). This scarcity of mental health and substance abuse (MHSA) services arises from an overall strain on the MHSA care system, a service system that has experienced significant funding cuts, resulting in long wait lists and fewer providers.

Ultimately, the availability of MHSA services in a community significantly influences the ability of the child welfare agency to address the needs of its clients and ensure the long-term safety of children in the child welfare system. Children whose families do not receive appropriate treatment for alcohol and other drug abuse are more likely to enter foster care, remain in foster care longer, and re-enter foster care once they have returned home, than are children whose families do receive treatment. A similar effect is experienced if a child's mental health issues go untreated: such a child is likely to change placements more frequently, as well as ultimately need more intensive resources such as hospitalization or other in-facility treatment (CWLA, 2010). If child welfare agencies are able to encourage the development and improvement of MHSA services within their communities, PCSAs will have some of the tools needed to be more successful at decreasing placements and establishing permanency for children in their care.

[1] National Center on Substance Abuse and Child Welfare. *Research, Fact Sheets, Statistics*. Retrieved from http://www.ncsacw.samhsa.gov/resources/resources-research.aspx.

6.1.1 Background on the Mental Health and Substance Abuse (MHSA) Strategy

Since the beginning of ProtectOhio, the evaluation team has explored the hypothesis that waiver flexibility would enable demonstration counties to enhance the continuum of services accessed by child welfare clients, compared to comparison counties. The team hypothesized that waiver flexibility would, in particular, facilitate development of innovative and alternative approaches to meet family needs through collaboration with local MHSA providers or increased services offered directly by the PCSA. During the first waiver period, research revealed the following patterns related to mental health services:

- 2000 evaluation data suggested that demonstration counties were slightly more likely to judge local mental health services as being insufficient than were comparison counties (75% compared to 50%). There was little difference between demonstration and comparison counties in terms of availability of addiction services (HSRI, 2000, page 127).
- When data on specific service insufficiency (2001) was matched with information on new service development (2002), demonstration counties were substantially more likely to fill the identified mental health service gap with a new program: four of the seven demonstration sites who had indicated insufficient outpatient child psychology services described the creation of new programs, compared to none of the six comparison sites; and five of the six demonstration counties with insufficient child outpatient counseling established new services, compared to only one of seven comparison sites (HSRI, 2003, page 59).
- Nonetheless, in 2003 interviews, demonstration PCSAs were slightly more likely to report that families had difficulty accessing mental health counseling services and medication/somatic services; in other core mental health service areas,[2] the two county groups reported similar levels of difficulty for families (HSRI, 2003, page 62).

By the end of the first waiver, it was evident that demonstration counties had yet to fully capitalize on the flexibility of the waiver to enhance MHSA services in their communities. Consequently, during the waiver bridge period, as the Consortium began to discuss the preferred program focus for the second waiver period, enhancements to mental health and addiction services came to the fore. Although all 14 PCSAs contributed to the decision to include MHSA as a waiver strategy, only four counties committed to using Waiver flexibility for this purpose.

MHSA Strategy Counties:

Belmont
Coshocton
Lorain
Muskingum

In contrast to the other ProtectOhio strategies, the MHSA strategy is a loosely-defined intervention, which varies across the participating counties, reflecting each site's most pressing concern. However, the purpose of this strategy is consistent in all sites: to improve and accelerate access to MHSA services, with the underlying thesis that more timely, targeted, thorough, and convenient assessments and services will lead to better outcomes for children and families.

[2] Ohio's six required mental health service areas include counseling, assessment, medication/somatic, partial hospitalization, crisis and community support.

Central Hypothesis

The premise of this strategy is that the four counties would use waiver flexibility to enhance availability of MHSA services either in their broader communities (i.e. through closer collaboration or formalized agreements with local providers) or within their own agency (i.e. creating MHSA staff positions within the PCSA). Four key hypotheses guide evaluation efforts in exploring the impact and success of this MHSA strategy: Compared to the 14 non-strategy demonstration counties and the 17 comparison counties, the four strategy counties will exhibit the following characteristics:

- MHSA needs will be better assessed and addressed;
- MHSA services will be of better quality and more available and timely; and
- Collaborations between MHSA service providers and PCSAs will be stronger (e.g., collaborative meetings, interagency agreements).

And, when comparing the current performance of strategy counties to their pre-strategy performance:

- Families will have better outcomes (e.g., shorter lengths of stay, less recidivism of abuse and neglect, and fewer reentries into substitute care) leading to decreased placements and quicker permanency for children in their care.

6.1.2 Evaluation Methods

HSRI used a variety of data collection methods to explore the effectiveness of MHSA service enhancements. These methods provide unique insights into the implementation and outcomes of each county's MHSA strategy.

- In-person and telephone interviews. During the winter of 2008, the study team interviewed all 35 participating ProtectOhio counties by phone to gather information about the waiver in general. Administrators in the four strategy counties were interviewed again in the spring regarding agency processes and service enhancements. Follow up interviews were later conducted by phone to gain a deeper understanding of their efforts to improve MHSA services.
- PCSA survey. In summer 2009, the study team asked PCSA administrators to complete a brief electronic survey regarding their perceptions of the MHSA service array available to their clients. Thirty-four of 35 PCSAs completed the survey. A copy of this survey is included in Appendix B.9.
- Provider survey. Also in summer 2009, in an effort to further understand the broader MHSA service system in each of the 35 ProtectOhio counties, the study team developed an electronic survey that was completed by a total of 123 providers, a response rate of 78%. It is important to note that this sample of MHSA service providers is in no way representative of the universe of providers that exist in each county. Rather, survey respondents are a self-selected sample of providers identified by PCSAs. As such, their responses provide a unique perspective on county MHSA service systems and how they interact with PCSAs and the children and families they serve. A copy of this survey is included in Appendix B.10.
- Case Record Reviews. From 2005 to 2009, the study team visited each of the four strategy counties to review case records and collect primary data on parents and children receiving

services both before and after implementation of the strategy. The purpose of these reviews was to explore the variety and timing of MHSA services received by sampled PCSA families.

6.1.3 Organization of Chapter

This chapter summarizes the findings from our evaluation of the MHSA strategy according to system-level and individual-level outcomes. In Section 6.2, we explore the broad MHSA service delivery system in all 35 evaluation counties, examining differences between demonstration and comparison counties and describing the context within which four MHSA strategy counties implemented their service enhancements. In Section 6.3, the study team describes how each of the four strategy counties enhanced the array of MHSA services available to child welfare clients within their community. In Section 6.4, we examine survey and case record review findings to explore the impact of the waiver on the quality and sufficiency of MHSA services in the community and on individual families served by the child welfare agency.

6.2 MHSA SERVICE DELIVERY SYSTEM IN DEMONSTRATION AND COMPARISON COUNTIES

The study team hypothesized that in demonstration counties, and particularly in strategy counties, flexible funding available under the waiver would influence community MHSA services; specifically, MHSA services will be more available, timely, and of higher quality. To determine whether these outputs occurred, the study team explored the capacity of the MHSA service delivery system in each of the 35 evaluation counties. Using data from the PCSA interviews, provider survey, and PCSA survey, this section describes differences between demonstration and comparison counties on three major aspects of local MHSA service systems: the availability and quality of services, the structure of service provision, and the process PCSAs employ to access services for their clients.

6.2.1 Availability and Quality of MHSA Services

PCSAs were asked to indicate whether mental health and addiction services for youth (ages 0 to 18) and adults are available in-county, out-of-county, or not at all. Responses indicate that a wide range of mental health services are highly available to PCSA clients, with no differences between demonstration and comparison counties (Table 6.1).

Table 6.1: Percent of PCSAs Reporting Availability of Mental Health Services (n=34*)

	Youth	Adults
Assessments, Psychological evaluations, Individual and family counseling, Hospitalization/psychiatric care	100% (34)	100% (34)
Inpatient/ residential females	100% (34)	97% (33)
Inpatient/ residential males	100% (34)	97% (33)
Group counseling	94% (32)	94% (32)
In-home services	85% (29)	82% (28)

**Thirty-four of 35 counties completed this section of the survey.*

Outpatient addiction services (Table 6.2) are slightly less available than mental health services, with minimal differences between the two county groups. When services are not available in county, PCSAs rely on providers in neighboring counties to serve their clients.

Table 6.2: Percent of PCSAs Reporting Availability of Outpatient Addiction Services (n=33*)		
	Youth	**Adults**
Assessments	97% (32)	100% (33)
Individual Counseling	100% (33)	100% (33)
Group Counseling	97% (32)	100% (33)
Detoxification	88% (29)	97% (32)
Intensive Outpatient	85% (28)	91% (30)
Methadone Administration	70% (23)	85% (28)
Drug Court	73% (24)	73% (24)
In-home Services	55% (18)	61% (20)

**Thirty-three of 35 counties completed this section of the survey.*

While PCSAs report no difference between the two county groups regarding availability of outpatient addiction services, slight differences are evident in the availability of residential services (Table 6.3). PCSAs slightly more often report these services are available in demonstration sites than in comparison sites.

Table 6.3: Differences in Availability of Residential Services Between County Groups		
	Demonstration counties (n=17*)	**Comparison counties (n=16*)**
Adult Residential females with children	94% (16)	63% (10)
Youth Residential females with children	76% (13)	44% (7)
Youth Residential males with children	53% (9)	31% (5)

**One demonstration and one comparison county did not complete this section of the survey.*
Note: Regarding Adult Residential males with children, there is no difference between the county groups (53% in demonstration counties, 44% in comparison counties).

Although the data are not conclusive, it appears that providers in demonstration counties are targeting inpatient service gaps more frequently than comparison counties. This may be a response to an increase in the number of families with substance abuse issues receiving child welfare services acknowledged by some PCSAs during telephone interviews. Further examination may offer insight into this difference and whether new services were created to address a particular service demand.

The study team also surveyed MHSA service providers to determine the amount of services available to all individuals and families within each ProtectOhio county. Providers were asked to indicate whether the amount of mental health services and substance abuse services available is adequate, less than adequate, or more than adequate to meet the service demand. Consistent with findings from the PCSA survey, providers report that the amount of MHSA services available is generally adequate to meet the service demand.

In addition to availability of services, the provider survey explored quality of services. Local service providers were asked to judge the quality of mental health and addiction services as poor, fair, good, or excellent. Overall, providers in both demonstration and comparison counties give high marks to mental health and substance abuse services for all age groups. Sixty to eighty percent of providers rate the quality of mental health services as good to excellent; this is true for age-specific services and overall. Similarly, 50-70% of providers rate substance abuse services as good to excellent.

In summary, PCSAs and MHSA service providers in all 35 ProtectOhio counties report a wide range of quality mental health and addiction services available to the children and families they serve with no differences in availability of mental health services between demonstration and comparison counties. Only one notable difference was found: for female youth and adults, residential addiction services appear to be more available in demonstration than comparison counties.

6.2.2 Structure of MHSA Service Provision

Child welfare agencies engage in a variety of practices to obtain MHSA assessment and treatment services for their clients. These practices include: (a) utilizing various resources to help their clients pay for MHSA services when necessary, (b) engaging in direct contracts or other types of agreements with service providers to prioritize or exclusively serve their clients, and (c) communicating regularly with providers regarding mutual clients. It was hypothesized that, in an effort to better address the MHSA needs of PCSA clients, demonstration counties would work more closely with providers to enhance the way MHSA services in the community are provided and more quickly address the needs of PCSA families. Interview and survey data reveal how PCSAs and service providers interact to deliver needed services to children and their parents. Differences between demonstration and comparison counties are highlighted below.

6.2.2.1 Use of Resources to Pay for MHSA Services

In an effort to understand how local MHSA service providers are reimbursed for assessment and treatment services delivered to children and parents, the study team asked local providers to identify sources of payment for services provided to PCSA clients. As described in Table 6.4, providers rely primarily on Medicaid and funding from local mental health recovery boards. For families without Medicaid eligibility or private insurance, providers typically offer sliding fee scales. Similarly, PCSAs maintain that the cost of services is not a barrier for their clients and the agencies tend to pay for services for non-insured families using funds from TANF, grants, contracts, or other sources. There are no statistically significant differences between demonstration and comparison counties in the sources of payments for MHSA services.

Table 6.4: Payment sources for services provided to PCSA clients			
	Agencies in Demonstration Counties (n=59)	**Agencies in Comparison Counties (n=43)**	**All agencies (n=102)**
Direct contract	39% (23)	42% (18)	40% (41)
Medicaid	93% (55)	88% (38)	91% (93)
Client self-pay	54% (32)	70% (30)	61% (62)
TANF/PRC	24% (14)	35% (15)	28% (29)
Private insurance	56% (33)	56% (24)	56% (57)
County MH Recovery Boards	76% (45)	56% (24)	75% (76)
Family & Children First Councils	19% (11)	21% (9)	20% (20)
Grants	42% (25)	30% (13)	37% (38)

6.2.2.2 MHSA Service Agreements

In an effort to learn more about how PCSAs access MHSA services for their clients, the study team asked PCSAs to describe the type of contracts or agreements in place with local providers. Responses indicate that PCSAs engage in a variety of formal and informal practices to provide assessments and treatment services to their clients.

Regarding assessments, almost half of participating PCSAs (46%) have direct contracts with providers, and another 23% provide assessment services in-house. The remaining PCSAs refer their clients to area service providers without a formal contract in place. Demonstration and comparison counties differ somewhat in how they provide assessments (Table 6.5). Slightly more comparison counties report that they provide these services through direct contract. It is notable that that three of the four strategy counties provide assessments and/or treatment services in-house with the purpose of making these services more accessible to their clients. These services are provided either on-site or in the family home.

Table 6.5: Provision of MHSA Assessments		
	Direct contracts	**In-house**
PCSAs in Comparison counties (17)	59% (10)	18% (3)
PCSAs in Demonstration counties (18)	33% (6)	28% (5)
PCSAs Overall (35)	46% (16)	23% (8)

For treatment services, about half of PCSAs have contracts with community providers to serve their clients, with no differences between the two county groups. When contracts are not in place, some PCSAs report the use of payment agreements or Memoranda of Understanding to provide certain services to their clients or to prioritize child welfare cases. Consistent with this finding, about one-third

of providers across the two county groups report that they have formal or informal agreements with PCSAs in place to prioritize services to children and their parents involved in the child welfare system.

6.2.2.3 Communication with MHSA Service Providers

To determine whether communication with service providers was better under the waiver, the study team explored the frequency and strength of PCSA interactions with service providers. We found that, in addition to payment agreements, direct contracts, and formal or informal agreements, PCSAs communicate regularly with community service providers to ensure MHSA services for their clients.

PCSAs across both groups of counties agree that regular communication with community providers regarding mutual clients is an integral factor in accessing services for their clients. Overall, about half of PCSAs report strong communication between agency staff and community providers with no differences between the two county groups (50% of demonstration sites, 65% of comparison sites). PCSAs attribute this strength to regularly scheduled interagency meetings and frequent informal communication. Results of the provider survey are consistent with these findings. While we might expect that the waiver encourages this type of communication in demonstration counties, findings suggest that there is no difference between demonstration and comparison counties.

In a question regarding the frequency of communication with PCSAs, providers were asked to indicate how frequently their staff communicates with child welfare staff. As illustrated in Table 6.6, providers across both groups of counties are most likely to communicate informally with child welfare agency staff. When looking at other forms of communication, written report are more likely to always be used, compared to attendance at other meetings; once again this finding was found to be statistically significant. There were no differences between the two county groups.

Table 6.6: Frequency of Provider Communication with PCSAs Regarding Individual Clients

	Always	Sometimes	Never
Informal Communication (email, phone, unscheduled in-person contact)	59% (72)	42% (52)	0%
Written reports submitted on a regular basis	43% (53)	50% (62)	7% (9)
Attendance at child welfare agency meetings	26% (32)	60% (74)	15% (18)
Attendance at multi-agency case reviews or meetings	26% (32)	63% (78)	11% (14)

Similarly, in a survey question asking providers to rate the quality of interagency communication at the management or planning level as needs improvement, adequate, or very good, almost half said this communication is “adequate” with no differences between the two county groups (45% of demonstration sites, 51% of comparison sites). Quality of communication is especially high in strategy counties where almost two-thirds of providers report communication is “very good.” While we expected interagency communication to be rated higher in demonstration sites, this finding suggests that PCSAs in MHSA strategy counties enhanced communication with providers to improve client access to services.

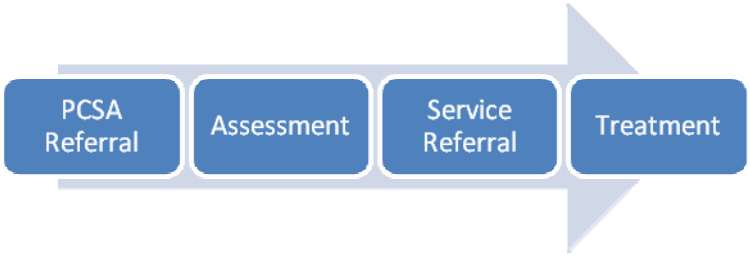
In summary, differences in the structure of MHSA service provision between the two county groups are minimal. PCSAs and community service providers in both county groups collaborate on several levels to provide needed services to children and their parents involved in the child welfare system. Formal and informal contracts or other agreements ensure service prioritization and/or delivery to PCSA clients, utilization of various resources secures payment for services, and regular interagency communication maintains the structure necessary for successful service delivery.

Despite these commonalities, a few findings support the hypothesis that the waiver has helped PCSAs to make MHSA services more available to PCSA clients. For example, a greater number of PCSAs in demonstration and strategy counties use Waiver funding to provide services in-house, increasing access to needed services. Likewise, demonstration and strategy counties are able to use Waiver and other funds to help clients pay for services. Finally, it appears that in strategy counties, communication between providers and PCSAs is stronger than in other counties. It is unclear if the strong relationship enabled the development of new service arrangements, or vice versa, but it does appear that strategy counties have been able to positively influence the array of MHSA services for their clients.

6.2.3 Process of MHSA Service Provision

As described above, PCSAs and community providers work together on several levels to provide quality mental health and addiction services to child welfare clients. The study team hypothesized that, under the Waiver, MHSA services would be more available and timely in demonstration counties. In theory, demonstration counties would use flexible Waiver funding to expedite the process of service provision to reduce wait times between referral and assessment or the start of services. This process typically begins during intake at the child welfare agency when families are initially assessed to determine whether a MHSA issue is present. Detection of such issues triggers a series of events that lead to treatment: (a) PCSA referral, (b) assessment, (c) service referral, and (d) treatment (Figure 6.1). Each step in this process is briefly described below.

Figure 6.1: Process of MHSA Service Provision



In general, PCSAs refer clients experiencing MHSA issues for appropriate assessment. As indicated by interview and survey data, some PCSAs refer clients automatically, for example, when individuals are under age 18, when there is a drug conviction, or when there is a court filing. About a quarter of PCSAs provide assessments in-house, with no differences between the two county groups. Others provide clients with verbal or written referrals to community providers.

Thirty of 35 PCSAs (86%) report their clients are able to receive an assessment within 30 days of receiving a referral, with no differences between the two county groups. Notably, three of the four

strategy counties use waiver funding to provide MHSA assessments in-house, and all strategy counties report their clients receive assessments within 30 days of referral.

After the assessment is completed and MHSA issues are confirmed, clients typically receive a service referral to begin treatment. The assessment provider usually sends assessment results to the PCSA caseworker. Ninety percent of PCSAs across both county groups report they receive results within 30 days. PCSAs attribute this quick turnaround time to strong communication with providers. Further, when assessments are provided in-house, as in strategy counties, or when agencies communicate regularly with providers, caseworkers are able to receive results "almost immediately."

About three-quarters of PCSAs report that clients are typically able to enter treatment within 30 days of receiving a referral, with no differences between the two county groups. Speed to service is attributed to the provision of in-house assessments, formal service agreements or contracts with providers, and regular communication between PCSAs and service providers regarding mutual clients.

Once treatment begins, ideally, caseworkers and service providers collaborate to support children and their parents through treatment. Interagency agreements facilitate this process. For example, Belmont County's strategy hinges on a formal agreement with the juvenile court and a community substance abuse service provider. This agreement involves one PCSA caseworker that manages all child welfare cases with substance abuse issues. This person works closely with the service provider to support clients involved in the drug court program. In turn, the provider serves all families that go through the program. Over one-third of providers in each county group report similar agreements with PCSAs to prioritize services to individuals and families involved in the child welfare system, effectively reducing barriers to services.

Both PCSAs and community service providers employ multiple strategies to reduce service barriers and increase client engagement in and completion of services. Transportation is a barrier frequently acknowledged by both PCSAs and providers. Almost all PCSAs (94% in demonstration sites, 100% in comparison sites) provide transportation assistance in the form of gas cards, rides, public transportation passes, or contracts with local transportation agencies to help their clients receive needed services. Likewise, community providers commonly assist their clients with transportation (39%). Table 6.7 lists other forms of support that PCSAs and community providers offer to their clients to help them access treatment and achieve case plan goals.

Table 6.7: Support Offered to Increase Client Engagement in and Completion of Treatment		
	PCSAs	**Providers**
Childcare assistance	✓	✓
Help scheduling appointments	✓	
Pay for services	✓	
Provide pre-treatment services (when there is a wait)	✓	
Frequent communication between agencies	✓	✓
Frequent communication with clients		✓
Interagency collaboration regarding mutual clients	✓	✓
Staff available flexible hours		✓
Provide In-home services	✓	✓
Employ a tracking system to ensure follow up with clients		✓

In summary, both PCSAs and providers work together to facilitate timely and appropriate assessments and treatment for children and their parents. While the study team expected MHSA services would be more available and timely in demonstration counties, no notable differences emerged between the two groups of counties. Most PCSAs in both demonstration and comparison counties report that clients are able to access assessment and treatment services within 30 days. Likewise, PCSAs and providers across groups of counties actively support clients to complete treatment. In this process, both PCSAs and providers are sensitive to time to assessment and treatment services, and respond accordingly. They also acknowledge barriers to services and work both together and in parallel to support their clients through the treatment process.

6.2.4 Strengths and Barriers to Meeting MHSA Needs

In an effort to understand the issues that county child welfare agencies experience in accessing MHSA services for their clients, the study team interviewed administrators and supervisors of all 35 participating PCSAs by phone regarding the strengths and weaknesses of their county MHSA service system as it relates to the children and families they serve. PCSAs were asked to discuss factors that may help or hinder their efforts to access mental health and addiction services. Topics that emerged from these discussions include: (a) gaps in MHSA services, (b) provider expertise in serving child welfare clients, and (c) accountability.

6.2.4.1. Gaps in MHSA Services

Most PCSAs (89%) report at least one service gap in their local MHSA service systems with no difference in the number of gaps reported between county groups. Two demonstration and two comparison PCSAs report no gaps in these services. The most frequently reported gaps relate to specialized addiction services.

- Ten counties report gaps in detoxification (six demonstration counties, four comparison counties);

- Six counties report gaps in methadone and other drug administration (two demonstration counties, four comparison counties);
- Five counties report gaps in residential addiction treatment (one demonstration county, four comparison counties).

PCSAs also note insufficiencies in a wide variety of specialized services needed in certain counties (e.g., juvenile sex offender treatment, play therapy, crisis services).

6.2.4.2 Service Provider Expertise in Serving Child Welfare Clients

Community MHSA providers that serve child welfare clients may or may not understand how the children's services system operates, have specialized skills, or understand the unique issues that child welfare clients typically experience. Overall, 38% of PCSAs (with no differences between county groups) report a lack of providers with specific training relevant to the needs of child welfare clients. For example, several respondents note that they struggle to find therapists that can effectively address issues regarding sexual abuse, post-traumatic stress, separation issues, attachment and bonding, and placement and adoption issues. A quarter (26%) say community providers have expertise in some areas, yet they lack in others, with no differences between county groups.

Slightly more than one a third of respondents (35%) report that provider expertise is sufficient. Forty-four percent of PCSAs in demonstration counties report provider expertise is a strength compared to a quarter of PCSAs in comparison counties (25%). PCSAs attribute this strength to the availability of therapists with specific training (e.g., Master's degree in social work, attachment and bonding issues), collaboration during treatment team meetings regarding mutual clients, and provider willingness to learn and accommodate the needs of child welfare clients. For example, providers in Portage County repeatedly invite the PCSA to conduct staff trainings at their agencies.

Despite lack of provider expertise in some areas, more than half of PCSAs (58%) believe the community service system has the capacity to effectively meet the treatment needs of their clients. This is especially true in demonstration counties where 80% of PCSAs perceive the overall efficacy of services as a strength, compared to 43% of PCSAs in comparison counties.

6.2.4.3 Accountability

Most county agencies employ strategies to ensure client accountability. Overall, over half of PCSAs (59%) count their ability to hold their clients accountable as a strength. This is especially true in comparison counties where slightly more PCSAs (69%) report this as a strength, compared to 46% of demonstration PCSAs. PCSAs report most leverage when their clients are receiving child welfare services through a court order and when reunification is a goal in the case plan. Additionally, caseworkers frequently communicate with providers regarding whether individuals are receiving treatment and intervene when clients miss appointments with a mental health or addiction service provider. Many providers terminate treatment after an individual misses a certain number of appointments. When necessary, the PCSA can file for a court order to ensure that they complete treatment.

Overall, PCSAs engage in a wide variety of practices to improve access to MHSA services for their clients. The study team examined the impact of the waiver on local MHSA service systems in each of the 35 ProtectOhio counties by examining differences between demonstration and comparison sites

regarding the availability and quality of services, the structure of service provision, and the process PCSAs employ to access services for their clients. While we expected to see differences between demonstration and comparison sites on these three aspects of MHSA service systems, minimal differences between the two county groups emerged. Briefly, PCSAs in demonstration counties are more likely to:

- Provide MHSA services in-house, using waiver funding;
- Help clients pay for services, using waiver funding;
- Report sufficiency of provider expertise in serving child welfare clients; and
- Report the overall efficacy of services as a strength.

While these differences are notable in demonstration counties, it is unrealistic to expect that the MHSA strategy, or even the broader waiver effort, would significantly impact the wider MHSA care system. Despite limited findings that point to improvements in local MHSA service systems, MHSA service enhancements implemented in the four strategy counties show some promise in affecting individual-level outcomes. These efforts are described below.

6.3 ENHANCED MHSA STRATEGY IN FOUR DEMONSTRATION COUNTIES

In order to assure more timely and successful assessment and treatment for their clients, the MHSA strategy counties (Belmont, Coshocton, Lorain, and Muskingum) used waiver flexibility in a variety of ways to enhance services in their communities. This section describes the service enhancements made in each of these counties, and provides a cross-site description of targeted population, service changes, beneficiaries, and impact on the agency and families served.

The first participating county to fully implement its MHSA service enhancements was Lorain County Children's Services (LCCS). LCCS funded these enhancements during the first ProtectOhio Title IV-E Waiver providing flexible funding to PCSAs from October 1997 through September 2002. Belmont and Muskingum counties entered into the strategy under the second waiver, which began January 2005. Prior to 2005, these counties were already taking steps to address the MHSA needs of their clients. In 2007, Coshocton County joined the MHSA strategy.

6.3.1. Belmont County

Belmont County began taking steps to address the mental health and addiction needs of their clients before receiving waiver funds. During fall of 2004, Belmont contracted with a new mental health service provider to improve the quality and timeliness of assessments for adults and children. They also entered into an agreement with the juvenile court and a local service provider to create a family drug court.

Prior to 2005, a high percentage of Belmont County families involved in the child welfare system were not successfully completing addiction treatment. Traditional outpatient counseling services experienced high recidivism rates, and strategies used to hold individuals accountable to their treatment plans were ineffective.

Since the beginning of the second waiver, Belmont County has made additional enhancements to their services for families with substance abuse treatment needs.

- In January 2005, Belmont collaborated with the county juvenile court to create the Family Dependency Treatment Court. This program utilizes an existing court contract with a local substance abuse agency to provide assessments and treatment services for clients receiving court-ordered services. Belmont County refers court-ordered cases identified at intake to the contracted service provider for assessment and screening into the drug court program.
- Using waiver funds, Belmont County PCSA hired one caseworker to manage drug court cases and work with the addiction service provider, who attends all drug court meetings. The PCSA also hired two special service aides to provide clients transportation to drug court meetings, and individual and group counseling appointments.
- Belmont County also used waiver funds to purchase SCRAM units to hold clients receiving addiction services accountable. Participants wear these units around their ankles. The units detect alcohol consumption and provide immediate ongoing reports to the caseworker.

The purpose of these enhancements is to establish timely substance abuse assessments and treatment, increase follow-up with families receiving services, improve collaboration and communication with service providers, help families become clean and sober, and close cases more quickly. By cooperating with the Juvenile Court and the local service provider, Belmont County is better able to support families to complete addiction treatment and hold their clients accountable to their treatment plans.

Interviews with Belmont County staff indicate their firm belief that these service enhancements have had a significant impact on outcomes of families experiencing substance abuse issues; most individuals that complete the program become clean and sober and are able to change their lives and keep their families intact.

6.3.2 Coshocton County

Coshocton is the most recent ProtectOhio County to join the MHSA strategy, beginning implementation of their service enhancements in 2007. They enhanced addiction services in response to an increase in the number of families with substance abuse issues on their caseloads. In doing so, they also addressed transportation and other barriers families experience in accessing and completing addiction treatment offered in the community.

Prior to 2007, in-home services were not available and clients were expected to access addiction treatment without agency support or accountability measures. In response to these issues, the PCSA utilized waiver funds to enhance services to families experiencing substance abuse issues.

- In 2007, Coshocton County PCSA contracted with a local substance abuse agency to hire a part-time team of two counselors to provide addiction assessments, treatment, and random drug screens to clients in their homes. Counselors and caseworkers work closely together to provide support to families to complete treatment.

The purpose of this enhancement is to provide timely substance abuse assessments and services that are flexible and responsive to family needs, increase client accountability to their treatment plan, and increase the frequency and consistency of agency contact with clients. Interviews with Coshocton

County staff indicate that the enhancements enabled the agency to increase the effectiveness and timeliness of substance abuse services.

6.3.3 Lorain County

Prior to 1999, families in Lorain County 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 first ProtectOhio Title IV-E Waiver, LCCS has made significant changes to their client assessment services for mental health and addiction treatment.

- In 1999, LCCS implemented in-house assessment services for adults with substance abuse issues, hiring experienced and credentialed staff. Currently, the substance abuse 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 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 than before enhancements were implemented.

6.3.4 Muskingum County

Although Muskingum County Children's Services (MCCS) entered the MHSA strategy in 2005, the agency had already made mental health and substance abuse service enhancements under the first waiver in two areas:

- Between 1998 and 2000, MCCS implemented the "Options" program, which provided assessments, group treatment, and individual treatment to clients with substance abuse issues. The program also included specialized home visits for drug screenings.
- During the same period, MCCS 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.

Prior to these enhancements, children and families experienced extended waits for mental health and substance abuse services. The services available were not timely or flexible enough to meet the

needs of families receiving child welfare services. Waiver funding assisted MCCS with all MHSA services by allowing for "up front" spending for their psychologist, as well as for drug-testing kits used during home visits. Muskingum used the second waiver to build on these enhancements.

- In 2003, MCCS contracted with Muskingum Valley Educational Services (MVES), to hire an in-house psychologist to provide mental health assessments and treatments to children and families.
- The Options program continued under the second waiver until 2007, when the substance abuse caseworker was called to military duty. Funds were not available to maintain the program.
- In 2009, MCCS contracted with Six County Mental Health Services to provide on-site treatment to pre-school-age children and their families involved with social services. This collaboration provided anger management, parental support, and additional group therapies for children and families. Since then, this program has expanded to serve families of school-age children.
- In July 2009, the County juvenile court contracted with the MCCSs' in-house psychologist to provide assessments and treatment to children residing in the juvenile detention facility.

The purpose of MCCS' service enhancements is to prevent out-of-home placement by addressing the MHSA service needs of children and families. The PCSA's objectives include reducing wait times by establishing timely services, increasing the consistency and frequency of services, increasing the consistency of random drug screenings, expediting case management decisions, especially regarding permanency, reducing time to case closure, and reducing recidivism.

Additionally, a collaborative agreement with a local service provider complemented these enhancements. In 2009, Avondale Youth Center collaborated with Thompkins Center Mental Health Services to provide on-site group therapies for children and families. This agreement advanced MCCS's focus on addressing the MHSA needs of clients by making services accessible to more families.

Interviews with agency staff indicate that service enhancements have had a direct impact on the agency's ability to reduce placement days, prevent placement days, and keep children from returning into the system. Note that effects of Muskingum's enhancements implemented after 2004 are not included in the case record review (Section 6.4.2.4).

6.3.5 Synopsis of MHSA Enhancements across Strategy Counties

The four MHSA strategy counties made several service enhancements to help the children and families they serve access quality mental health and addiction services. Although the specifics of these enhancements vary across counties, they were implemented with the intention of contributing to better outcomes for children and families. Several common themes are evident across MHSA service enhancements in the four participating counties (Table 6.8):

- All MHSA strategy counties directed service enhancements to the assessment process.
- Some counties enhanced treatment as well.
- All four counties acknowledge an increase in substance abuse issues among the families they serve and subsequently targeted addiction services.

- Three counties improved access to services – more services are provided by PCSA staff, by contractors at the PCSA, or in the home.

Table 6.8: Focus on Enhanced MHSA Services				
	Belmont	**Coshocton**	**Lorain**	**Muskingum**
Substance abuse services	✓	✓	✓	✓
Mental health services	✓		✓	✓
Assessment	✓	✓	✓	✓
Treatment	✓	✓		✓
Adults	✓	✓	✓	✓
Children			✓	✓
Services at PCSA or in home		✓	✓	✓

6.4 CASE-LEVEL IMPACT OF MHSA STRATEGY

As illustrated by the enhancement efforts of the four counties described above, the MHSA strategy is built upon the premise that strategy counties will utilize the flexibility of the waiver to improve access to MHSA services for the children and families they serve. PCSAs might improve access by working with local providers to ensure timely access to quality assessment and treatment services, or by building internal capacity to provide MHSA services within the child welfare system. In investigating the impact of these efforts, this section examines the case-level impact of this strategy on families receiving MHSA services in the four strategy counties.

6.4.1 Case Record Review Methodology

To assess how these targeted efforts influenced the experience of PCSA clients at the individual-level, HSRI conducted a case record review (CRR) in each of the MHSA strategy counties. The purpose of the CRR was to gather detailed information at the case-level about what MHSA services were provided to a sample of child welfare clients, how quickly these services were provided, and subsequent events the families experienced in the child welfare system.

CRR Data Collected

- 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

The CRR methodology entails a pre-post study. The evaluation study team identified two groups of families involved in the child welfare system: a pre-strategy group entering ongoing services at least two years before the implementation of the county's enhanced services, ensuring that 'pre' cases were not

affected by the development of the new efforts. A post-strategy group was selected to include cases that began receiving ongoing services at least one year after full implementation, to allow time for the new practices to become standard practice. Each group consists of cases that were open to ongoing services for at least 90 days. The timing of data collection is dependent on strategy implementation dates for each county (Table 6.9).

While the CRR methodology provides a rich examination of the experiences of individual families, the method is limited due to the number of cases on which data was collected. The study team spent several days in each county reviewing case files. This process was very labor intensive, and despite the hours spent reviewing files, documentation of the provision of mental health and addiction services was difficult to find. Even within a single county, evidence of an individual being referred to, assessed, or treated by a MHSA service provider was found in a variety of locations, and very often only noted in the case notes. For this reason, the findings from the CRR must be viewed with caution as the sample sizes ("n") are often very small, and it is likely that there are instances when MHSA services were provided, but the study team did not find evidence in the case record. This implies that the results reflect not only service delivery, but also the quality of PCSA documentation.

To identify cases for the case record review, the study team used FACSIS and SACWIS data to identify family cases opened to ongoing services in both the pre- and post-time periods. Table 6.9 provides an overall sense of the number of cases reviewed.

Table 6.9: Children in Case Record Review Sample

	Belmont		**Coshocton**		**Muskingum**	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**
Time period	Oct 2002 to Sept 2004	After Jan 1, 2006	May 2004 to April 2006	July 2007 to Jan 2009	Oct 1995 to Sept 1996	Oct 2003 to Sept 2004
Child	69	44	96	69	79	92
Any need			34% (33)	45% (31)	51% (40)	50% (46)
With any MH need	94% (65)	100% (44)	31% (30)	43% (30)	47% (37)	48% (44)
With any AOD need	33% (23)	20% (9)	7% (7)	6% (4)	5% (4)	10% (9)
With both MH & AOD need	28% (19)	20% (9)	4% (4)	4% (3)	1% (1)	8% (7)
Parent	55	52	76	59	51	51
Any need			58% (44)	71% (42)	71% (36)	84% (43)
With any MH need	85% (47)	90% (47)	43% (33)	59% (35)	59% (30)	78% (40)
With any AOD need	78% (43)	73% (38)	33% (25)	37% (22)	14% (10)	41% (21)
With both MH and AOD need	64% (35)	63% (33)	18% (14)	25% (15)	6% (4)	35% (18)

Lorain County is not included in Table 6.9 because the Lorain County CRR was conducted during the first half of the second waiver and the analysis was described somewhat differently; a full description of

the Lorain sample is included in Table 7.1 of the HSRI Interim Evaluation Report (2007, page 159). The following bullets provide an overview of the Lorain CRR sample.

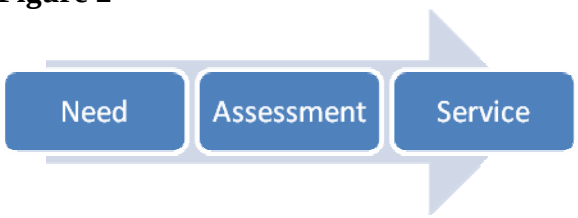
- Pre-implementation cases opened for ongoing services between July 1996 and June 1997.
- Post-implementation cases opened for ongoing services between July 2001 and June 2004.
- Of the Lorain sample, 49% are parents and 42% are children
- Sixty percent of the individuals in the Lorain sample had at least one mental health need; 25% have at least one substance abuse need, and 17% have both mental health and substance abuse needs.

6.4.2 Service Provision and Speed to Service

During the course of the CRR visits to each of the four strategy counties, HSRI staff reviewed case record files for evidence of any indication of need for mental health or addiction services. Then, staff documented if any assessment or treatment service was provided, allowing the study team to examine differences between pre- and post- cases. This also enabled the study team to explore if MHSA needs were more often addressed in strategy counties after the enhanced MHSA model was implemented. In particular, two methods were used to examine the CRR data.

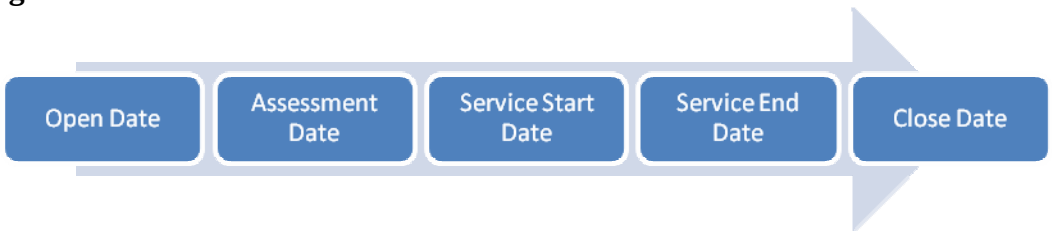
First, the study team examined what services were provided to individuals with mental health and/or addiction needs. In particular, the study team explored whether, for each case sampled, a need for MHSA support was determined, an assessment was conducted, or a treatment service was provided (Figure 2).

Figure 2



Second, the study team examined the time between events. In particular, to assess improvements in the timeliness of supports to clients in need of MHSA services, the study team reviewed case records in search of dates from which time calculations could be made. These include (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. Then, these dates were collapsed to create five key points in time for each individual with a MHSA need (Figure 3).

Figure 3



This analysis is constrained by the limited number of children (or cases) where dates could be located. In many cases, the study team could find evidence of service provided, but dates were difficult

to locate. Likewise, in some cases, dates were not in sequential order and thus more dates were lost. Therefore, as noted before, it is important to understand that these findings are illustrative rather than representative, due to the small number of cases included here. Further research is needed to determine if similar trends are still evident with larger samples.

The following sections provide an overview of the four strategy counties. For each county, we provide a quick recap of service enhancements, then provide the data around services provided, as well as timeliness of services. In the analyses that follow, asterisks (*) denote statistically significant differences found between pre and post sample groups. In all instances where statistical significance was found, a ⍰ was used and significance was set at $p < .05$.

6.4.2.1 Belmont

Belmont County enhanced client access to MHSA services in two ways: the PCSA worked with a local mental health agency to improve the timeliness of assessments for children and adults, and the PCSA developed a Family Dependency Treatment Court to help support families in achieving and maintaining sobriety (Section 6.3.1).

Table 6.10 presents the findings regarding the ability of PCSA clients to receive assessments and services as needed. While there appears to be a minimal difference for the child population, a significant difference was found for parents, who more often receive in-house psychological assessments; treatment services for both groups are provided at similar rates (51%). For parents in this sample, PCSA efforts to improve the availability of assessments appear to have been successful.

Table 6.10: Belmont Mental Health Need, Assessment, Services

	Pre	Post	Change of > 10%
CHILDREN			
Total Children with Identified Need	65	44	-
Assessment Received	31% (20)	20% (9)	-11%-
In-House Psychological Assessment Received	8% (5)	9% (4)	-
Service Received	74% (48)	82% (36)	-
Assessment and Service Received	25% (16)	18% (8)	-
PARENTS			
Total Parents with MH Identified Need	47	47	-
Assessment Received	66% (31)	53% (25)	-13%
In-House Psychological Assessment Received*	6% (3)	40% (19)	+34%
Service Received	51% (24)	51% (24)	-
Assessment and Service Received	40% (19)	28% (13)	-12%

In terms of providing Belmont County clients with access to substance abuse assessment and treatment, data enable us to examine differences for parents but not for children. While data were gathered for children, the total sample was too small: 23 children in the pre-sample, and nine children in the post-sample, had an indentified substance abuse need. For parents, larger numbers had an identified need, and we found a notable difference in service provision between the pre- and post-

groups (Table 6.11). Not surprisingly, parents in the post-group were much more likely (+14%) to participate in drug court – the service was not available prior to the waiver. In addition, a larger proportion of parents received treatment services in the waiver period than earlier. These findings support the belief of agency staff that parents are now more able to complete treatment, change their lives and keep their families intact.

Table 6.11: Belmont Substance Abuse Need, Assessment, Services for Parents			
	Pre	**Post**	**Change of >10%**
Total Adults with Identified Need	43	38	-
Participated in Drug Court	7% (3)	21% (8)	+14%
Assessment Received	72% (31)	76% (29)	-
Service Received*	19% (8)	39% (15)	+20%
Assessment and Service Received	19% (8)	24% (9)	-

Table 6.12 presents average time periods between these key events for cases with mental health needs. Notably, the time between events is significantly longer for cases in the pre-period than in the post-period. The most striking difference is the decrease in length of time from case opening to case closure, 684 days for cases prior to the waiver strategy compared to only 334 days during the waiver. Overall, Belmont County clients with mental health needs served during the strategy period appear to experience shorter times to closure than those in the pre-group.

In examining the average time span for receipt of substance abuse services, similar patterns are apparent. As Table 6.12 indicates, for individuals with a need for substance abuse treatment, the length of time from case open to case close is over a year shorter for the post-case than the pre-cases, averaging 743 vs. 350 days. Unfortunately, so little date information was available in the substance abuse cases that we are unable to provide any further analysis of the time between events for cases with a substance abuse need.

Table 6.12: Belmont Mental Health Case Events				
	Pre Group		**Post Group**	
Time Period	**Avg. Days**	**N**	**Avg. Days**	**N**
Cases with Mental Health Need				
Case Open to Case Close *	684	110	334	70
Assessment to Case Close *	514	35	264	19
Service Start to Case Close *	572	41	271	13
Case Open to Assessment	233	39	134	27
Case Open to Service Start	222	43	126	22
Service Start to Service End	339	22	271	9
Cases with Substance Abuse Need				
Case Open to Case Close *	743	62	350	34

Key findings for Belmont County suggest that, compared to pre-strategy cases:

- More post-group parents receive psychological assessments, from providers located in-house;
- More post-group parents participate in the Family Treatment Drug Court;
- More post-group clients receive addiction treatment services;
- The time between case opening and case closing for post-group cases is significantly shorter (by almost a year) for clients with mental health and similarly for those with substance needs;
- For post-group clients with mental health needs, the time between assessment and case closure, as well as between service start and case closure, is also significantly shorter.

6.4.2.2 Coshocton

Coshocton County entered into the strategy much later than the other three counties, beginning their enhanced efforts in 2007 and focusing solely on addiction services. Their primary objective was to address barriers parents were facing in accessing and completing substance abuse treatment in the community. In particular, the PCSA contracted for substance abuse counselors to provide home-based substance abuse assessments and treatment, as well as drug-testing.

In the Coshocton County CRR, pre-cases opened between June 2004 and May 2006, while post-cases opened between July 2007 and January 2009. While the sample size for children was too small for analysis, Table 6.13 presents the findings for addiction services provided to parents in Coshocton.[3] In this table, it is notable that there is little difference between the pre- and post- groups; however, it is also notable that it appears that enhanced services were provided to both the pre- and post- groups. In further exploration, we discovered that, while cases opened and closed in the pre-timeframe, they may have received some of the enhanced addiction services. In other words, some pre-cases may have reopened to address substance abuse issues inadequately addressed when initially presented.

Table 6.13: Coshocton Data on Substance Abuse Need, Assessment, and Services for Parents

	Pre	Post	Change of > 10%
Total Parents with Identified Need	25	22	-
MHSA Participant	88% (22)	82% (18)	-
Drug Screen	76% (19)	77% (17)	-
Assessment Received	36% (9)	41% (9)	-
Service Received	88% (22)	82% (18)	-
Assessment and Service Received	20% (5)	32% (7)	-

[3] While data were collected for children in this CRR, these finding are not presented as the number of children/youth needing substance services are so small.

In examining the time between case events for individuals in the post-group, cases closed an average of 82 days earlier, compared to the pre-group (Table 6.14). While this difference is smaller than in Belmont County (393 days), it is significant.

Table 6.14: Coshocton Substance Abuse Case Events

Time Period	Pre Group		Post Group	
	Avg. Days	N	Avg. Days	N
Case Open to Case Close*	321	118	239	51
Assessment to Case Close	266	3	248	2
Service Start to Case Close	280	6	264	3
Case Open to Assessment	56	3	72	6
Case Open to Service Start	115	7	69	10
Service Start to Service End	112	7	112	8

While findings for Coshocton County suggest that the enhanced substance abuse services resulted in shorter case episodes, further work on the services data is needed to clarify whether the pre-cases were also affected by the new interventions.

6.4.2.3 Lorain

The case record review in Lorain County was conducted in 2005. Complete findings from the analysis of this data are available in the Interim Evaluation Report (Kimmich, et al., 2007, Chapter 7). To recap these findings, Lorain County Children Services implemented in-house assessment services for adults with substance abuse issues, as well as developed an Extended Casework Services unit which provides mental health assessments for children entering out-of-home care. Findings suggest that since the implementation of enhanced services, more children are receiving assessments and more clients have evidence in their case record of treatment completion.

Additionally, time periods between certain case events are shorter for the post group than for the pre group. Three of these time periods show statistically significant ANOVA differences between the two groups.

- Cases are closing more quickly;
- The time between assessment and case closing is shorter;
- The time between the start of services and case closing is also shorter.

6.4.2.4 Muskingum

Muskingum County began to enhance MHSA services under the first Waiver, focusing on increasing the availability and quality of both mental health and substance abuse assessments and treatment services through contracts and internal capacity building. In the second waiver, the agency focused on ensuring and expanding the availability of mental health services, while their addiction efforts were

discontinued because funds were not available to maintain the program. Note that more recent enhancements occurred after the completion of this case record review.

Muskingum County CRR findings indicate that this focus has a significant impact on the availability of both mental health and addiction services for children and adults. Table 6.15 indicates marked improvements in the receipt of mental health assessment and treatment services for both children and adults. While the sample sizes are not large, the percentage increases in this table are notable.

Table 6.15: Muskingum Mental Health Need, Assessment, Services			
	Pre	**Post**	**Change of > 10%**
CHILDREN			
Total Children with Identified Need	37	44	-
Assessment Received	16% (6)	23% (10)	-
In-House Psychological Services Received	0	55% (24)	55%
Service Received*	24% (9)	57% (25)	33%
Assessment and Service Received	11% (4)	20% (9)	-
PARENTS			
Total Parents with Identified Need	30	40	-
Assessment Received*	13% (4)	43% (17)	30%
In-House Psychological Assessment Received	0	65% (26)	65%
Service Received*	13% (4)	70% (28)	57%
Assessment and Service Received*	3% (1)	43% (17)	40%

As Table 6.16 indicates, in terms of services to help adults[4] address addiction issues, Muskingum County is providing many more services across the full spectrum of addiction services, including the capacity to provide assessment and treatment when there is a need. It is important to note that the sample size in this analysis is very small, making these findings illustrative rather than representative of a trend in increasing availability.

[4] Children and youth are not included in this analysis due to the small sample size: pre- 4 case, post-9 cases.

Table 6.16: Muskingum Substance Abuse Need, Assessment, Services			
	Pre	**Post**	**Change of > 10%**
PARENTS			
Total Parents with Identified Need	10	21	-
Home-based services	0	71% (15)	71%
Home drug testing*	0	52% (11)	52%
In-house psychologist	0	38% (8)	38%
Assessment Received	10% (1)	38% (8)	18%
Service Received*	20% (2)	76% (16)	56%
Assessment and Service Received*	0	38% (8)	38%

Finally, in terms of the timeliness of MHSA services, significant differences exist between pre- and post-cases for mental health services (Table 6.17). Again, the sample sizes are relatively small, but suggest that, especially for length of case episode, Muskingum County is addressing case needs in shorter amounts of time: post-cases are ending an average of 168 days earlier than pre- cases.

Table 6.17: Muskingum Mental Health Case Events				
Time Period	**Pre Group**		**Post Group**	
	Avg. Days	**N**	**Avg. Days**	**N**
Case Open to Case Close*	473	63	305	72
Assessment to Case Close*	643	9	282	31
Service Start to Case Close*	381	18	162	16
Case Open to Assessment	295	10	67	37
Case Open to Service Start	168	18	90	17
Service Start to Service End	202	7	155	3

Table 6.18 presents some interesting findings in terms of time periods for cases in need of addiction services. Of the four strategy counties, Muskingum is the only place where it appears the length of case episode (open to close) is not shorter for pre-strategy cases compared to post-strategy cases. While this difference is not statistically significant, Muskingum's trends do not mirror those found in other counties. This may be a result of the county's discontinuation of the Options addiction services program due to staff and resource constraints.

Table 6.18: Muskingum Substance Abuse Case Events				
Time Period	Pre Group		Post Group	
	Avg. Days	N	Avg. Days	N
Case Open to Case Close	285	13	357	22
Assessment to Case Close	320	2	301	11
Service Start to Case Close	223	4	269	12
Case Open to Assessment	50	2	61	15
Case Open to Service Start	81	3	86	15
Service Start to Service End	101	2	118	13

In summary, the CRR findings indicate that strategy counties have successfully enhanced MHSA services available to child welfare clients and have impacted the experience of PCSA clients at the case-level. In particular, it appears that:

- For all MHSA strategy counties except Coshocton, when an enhanced service was implemented, there was a notable improvement in the delivery of assessment and/or treatment services, when comparing pre- to post- cases.
- In all three counties with mental health interventions, there was an increase in assessment and treatment services for parents. In one MHSA strategy county, more assessments were provided to children with mental health needs.
- Regarding substance abuse services, parents received more assessments in one MHSA strategy county, and more treatment services in another MHSA strategy county.
- The three strategy counties with mental health enhancements showed a significant decrease in timeframes from case opening to closure for mental health cases.
- Three of the four strategy counties experienced a significant decrease in case length for substance abuse services.

These findings indicate that MHSA counties have been able to increase access to assessment and treatment services for PCSA clients. Based on the description of how these services were enhanced, it appears that efforts to contract directly for particular services or create services within the child welfare agency have been successful.

6.5 SUMMARY

Four demonstration counties chose to participate in the MHSA strategy because their ability to assist their clients to address mental health and substance abuse issues was inadequate. As a result, parents were unable to complete case plans and children remained in the care of the child welfare agency. MHSA strategy counties believed that by improving the availability of MHSA services, clients would receive adequate treatment services, and ultimately, cases would be closed more quickly and

safely. To accomplish this shift, PCSAs realized the need to work with community providers to improve access and quality of MHSA services in their communities.

This study indicates that overall, there are few differences between demonstration and comparison counties in terms of the availability and quality of MHSA services, suggesting that the waiver effect was not strong enough to significantly influence the broad service delivery system in these counties. However, findings from the case record review indicate that the MHSA strategy counties enhanced particular services to address the specific needs of their clients. While these findings are exploratory in nature, it appears that MHSA strategy counties used waiver flexibility to provide needed services more quickly to their clients. The benefits of this outcome are supported by extensive research, which purports the effectiveness of MHSA treatment. When individuals with mental health and/or substance abuse issues receive needed services, individuals are better positioned to complete their case plans in a timely manner and ultimately experience less involvement with child welfare agencies.

Efforts to enhance MHSA services in the four strategy counties appear to have had a positive impact on client access to timely and quality assessments and treatment. Each MHSA county used flexible waiver funding to strengthen relationships with key community providers, expediting access to assessments and addiction services, especially for parents. If Waiver funding ends, reduced resources will affect these agencies' ability to maintain enhancement efforts at current levels. While these PCSAs report that they will explore multiple resources and relationships to maintain as many services as possible, they concur that the impact of losing waiver funding would be dramatic.

Belmont: If waiver funding ends, reduced resources will affect the child welfare agency's ability to address the substance abuse needs of the families they serve. The PCSA will explore multiple resources and relationships to maintain as many services as possible. Continuation of the enhancements will rely on a firm commitment from the juvenile court and local service provider.

Coshocton: If Waiver funding ends, staff believe they will be able to continue some components of their service enhancement; however, their contract with the local substance abuse service agency to provide services in-home will be affected.

Muskingum: Without continued flexible funding provided by the Waiver, MCCS will not be able to continue the level of services to children and families present under the waiver. "The impact would be devastating to children and families as well as to the staff, who have come to rely on the services to help children and families on their caseloads."