CHAPTER 3: SPECIAL TOPICS FROM THE PROCESS IMPLEMENTATION STUDY

3.1 INTRODUCTION

In the course of the Waiver evaluation, the Process Study team explored numerous aspects of county child welfare practice. To provide a context for several key areas relevant to participant outcomes, this chapter explores several topics that have been identified by the study team as significant in county efforts to decrease placement days and increase positive outcomes for children.

In Year 5, the evaluation team selected four topics to pursue in-depth with the Waiver counties. These topics include: prevention, mental health, court referrals and interagency collaboration. The following bullets offer a brief description of why these topics were chosen; a more detailed discussion of these topics forms the basis of this chapter.

Chapter 3 Topics:
- ✓ Service Array:
  Prevention
  Mental health services
- ✓ Court Referrals
- ✓ Interagency Collaboration

- The availability of prevention and mental health services is critical to a PCSA's ability to appropriately serve its clientele. The challenge for child welfare administrators is to have ready access to "core services," those typically and frequently needed, as well as to encourage the creation of innovative, alternative approaches to meet individual and unique child and family needs.
- Throughout the evaluation the study team has considered the relationships between juvenile court and PCSAs. The court is often viewed as the most important entity that can affect the ability of the PCSA to reduce placement days, because the court has the ability to commit children to the agency with or without its concurrence.
- The Process Implementation study team has included interagency collaboration in each year's data collection effort for two reasons. First, child welfare does not exist in a vacuum. It must rely on the services and supports of other community agencies, particularly the juvenile court and the mental health system. To the extent that these systems do or do not work collaboratively with child welfare, they can affect the ability of the child welfare system to achieve its desired outcomes. Second, the fiscal flexibility offered by the Waiver gives the child welfare agency more opportunity to address or support community-wide issues, including prevention, and can affect how other systems see child welfare and their willingness to collaborate with the child welfare agency. Figure 3.1 highlights the eight evaluation outcomes discussed in this chapter.

The following chart shows the counties targeted for telephone interviews in Year 5. All evaluation counties were interviewed on the topic of mental health services, while only selected counties were interviewed by the evaluation team for the other topic areas.

Table 3.1: Year 5 Telephone Interview Topics and Counties Interviewed

Interview Topic: Mental Health	Interview Topic: Court Referrals	Interview Topic: Prevention
Counties Interviewed:	Counties Interviewed:	Counties Interviewed:
All 14 demonstration and 14 comparison counties were interviewed about this topic	Belmont Clark Greene Lorain Muskingum Portage Richland Stark Allen Butler Hocking Scioto Summit Warren	Belmont Clark Fairfield Greene Lorain Muskingum Miami Scioto Wood

3.2 SERVICE ARRAY

In traditional managed care, the phrase "care criteria" refers to the standards used to determine what services can be provided, or a list of allowable services. In child welfare, the pertinent concern is making available a comprehensive array of services that increase a PCSA's ability to serve its clientele appropriately. The challenge for child welfare administrators is to have ready access to "core services," those typically and frequently needed, as well as to encourage the creation of innovative, alternative service approaches to meet individual and unique family needs.

The following section summarizes findings from the first four years of the evaluation and presents the results of additional data collection and analysis in Year 5.

3.2.1 Summary of Evaluation Findings from Years 1-4

Over the course of the evaluation, the study team has refined its central hypothesis as new and more specific data were gathered. The initial hypothesis was that flexible funds would mean demonstration counties would expand their service array to cover all basic needs, more so than would the comparison counties. Site visit teams explored the availability of each of a list of services that might be provided directly by a PCSA, provided under contract to PCSA, or provided by a community partner (see Exhibit 3.1).

The study team found little difference between demonstration and comparison counties on the basic array of services. Most counties, demonstration and comparison alike, were increasingly focusing on service provision at the "front end" of the system, sponsoring more prevention-oriented activities in the community, and providing more home-based services to intact families with children at risk of placement. Accompanying these

preventive efforts, counties were also using creative approaches to screening and assessing children and families referred because of alleged abuse or neglect.

For the second year of the Waiver evaluation, the team recognized that data on the availability of an array of services did not account for differences in the amount or quality of the services of each type. While most counties had some services available in every category, there was great variation in how well the service met the need. In the absence of any estimate of service need, the study team refined its hypothesis, suggesting that flexible funding enabled demonstration counties to adjust the volume and quality of services, resulting in more service sufficiency.

In Year 2 and Year 3 of the evaluation, the team explored service insufficiency. Insufficiency in any particular service is defined based on the "typical" experience workers and supervisors have with accessing the service, and includes (a) frequent delays in obtaining the service, (b) usually not having the service available in the geographic area where it is needed, and/or (c) the service typically being of inadequate quality.[1]

[1] For more detail on methods used to gather the information, see *Third Annual Report,* Section 2.2.1, September 2001.

Exhibit 3.1: List of Services Examined in Each County Throughout the Evaluation

Placement Services

- Foster Family Care (PCSA)
- Foster Family Care (network)
- Therapeutic/Specialized Foster Care (PCSA)
- Therapeutic/Specialized Foster Care (network)
- Adoptive Homes
- Group Care
- Residential Treatment

Mental Health Services

- Child Mental Health In-patient
- Child Mental Health Out-patient
- Psychologist Services
- Counseling
- Adult Mental Health In-patient
- Adult Mental Health Out-patient

Substance Abuse Services

- Adolescent Substance Abuse In-patient
- Adolescent Substance Abuse Out-patient
- Adult Substance Abuse In-patient
- Adult Substance Abuse Out-patient

Prevention Services to Children and Birth Families

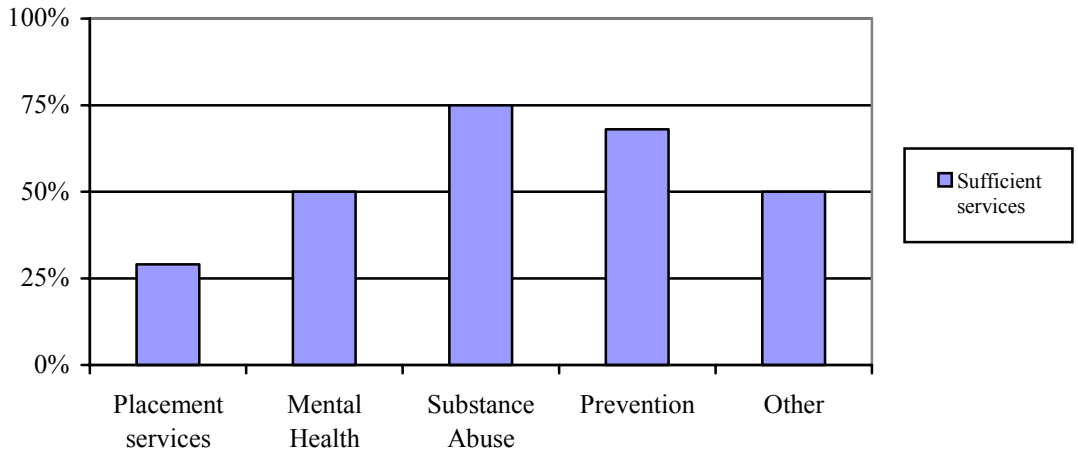
- Short-term intensive intervention with family
- Teaching parenting skills, family dynamics, child developmental stages
- Mentoring and/or providing home management and parenting (e.g., Homemaker/ parent aid)
- Counseling and support to family and child
- Providing information services, advice to families and facilitating family networking (e.g., family resource center)
- Non-curricular services and supports offered at school locations for students and their families (e.g., school-based)

Other Services

- Teaching teens daily living skills, financial management, college prep, etc. (e.g., independent living)
- Assessment and intervention for children aged 0-3 (e.g., early intervention)
- Non-traditional educational options for children with special needs (e.g., alternative education)
- Services by court, law enforcement, etc. to meet needs of adolescents to prevent placement (e.g., adolescent diversion)
- Transportation

Analysis revealed small differences between demonstration and comparison counties, with demonstration counties noting slightly less sufficiency in prevention services and mental health outpatient services. Figure 3.2 shows the percentage of all counties judging a majority of the services within each grouping as being sufficient. Placement services were least often ranked as sufficient, with only about a quarter of the counties (4 demonstration and 4 comparison) reporting that a majority of their placement services were sufficient. This is not surprising, given that the PCSAs need high quality and convenient placement options to be available, even if the agency is working to reduce its reliance on placement. Substance abuse services and preventive services were most consistently rated as sufficient, with two-thirds or more of the counties judging a majority of the services in each category as being sufficient. For mental health services and the remaining category of "other" services, approximately half the counties said most of the specific services in the category were sufficiently available.

Figure 3.2: Percentage of Counties Judging Majority of Services Within A Service Group Sufficient (n=28)



Mental Health Services

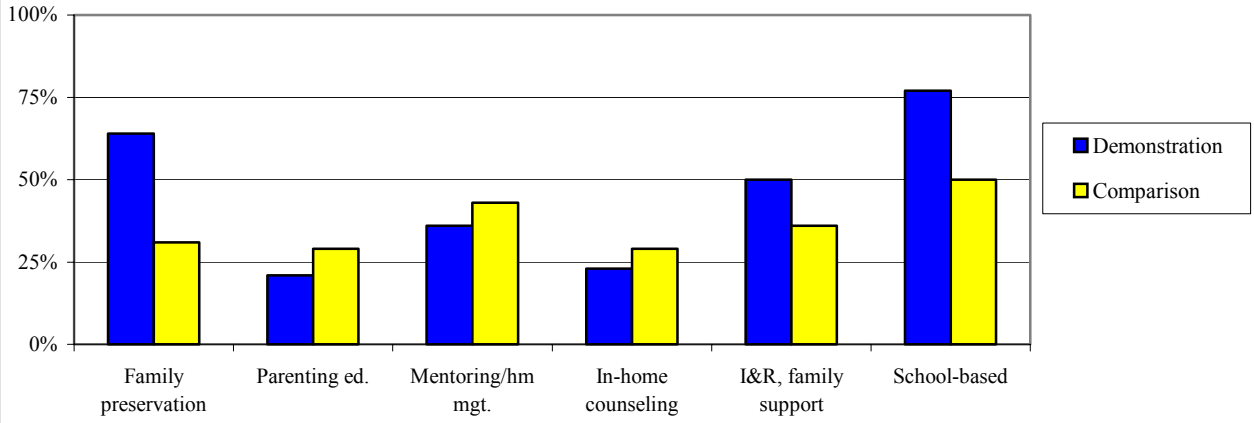
The Year 2 evaluation data suggested that demonstration counties were slightly less satisfied with the sufficiency of their mental health services overall than were comparison counties. In Year 3, the pattern remained true for inpatient services for both children and adults, but fewer demonstration counties than comparison counties deemed outpatient services for children and adults as being insufficient (43% of demonstration sites versus 50% of comparison sites). This difference may reflect the attention that some demonstration counties have given to child mental health services during Year 3 – the three demonstration counties who judged outpatient mental health services to be sufficient in Year 3 reported having new mental health services, including in-home therapeutic services, wraparound services for families with mental health issues, in-home respite, and creating an in-house mental health assessment unit.

Prevention Services

In addition to placement, mental health and substance abuse services, child welfare agencies use a number of preventive services to meet the needs of children and families. Although half of the evaluation counties judged this group of other services to be sufficient, additional information gathered in Year 3 suggests that the sufficiency of the services within the group varies (Figure 3.3). On average, counties reported that the availability and quality of family preservation and school-based services were insufficient.

The sense of insufficiency of the school-based programs may reflect the relative lack of

Figure 3.3: Insufficiency of Prevention Services

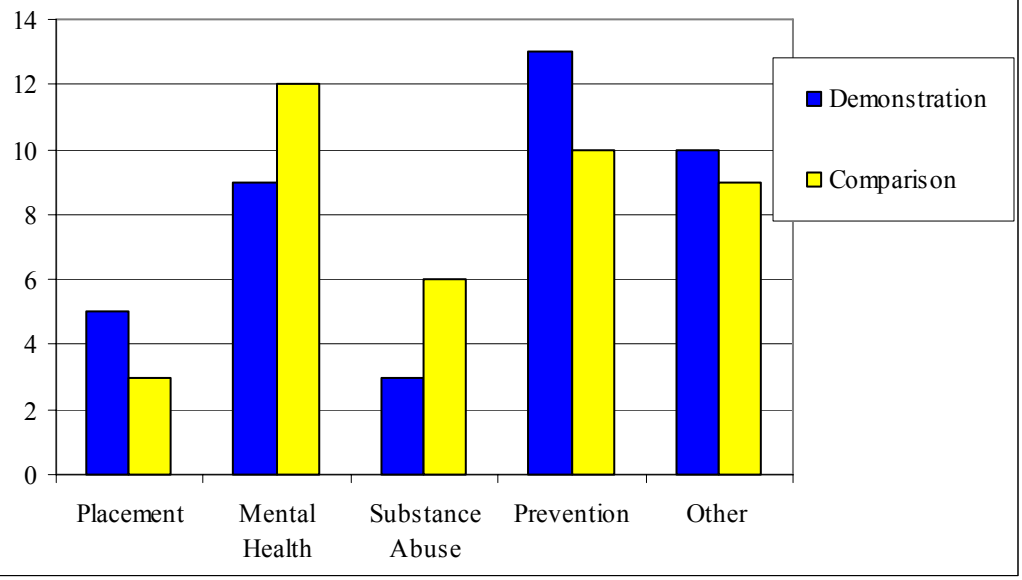


connection between schools and PCSAs; some interviewees acknowledged that there might be such services but they were not aware of them. Regarding the family preservation insufficiency, almost two-thirds of the demonstration counties judged short-term family intervention services to be insufficient, while the reverse was true in the comparison counties. It is interesting to note that counties that have worked the hardest to expand this type of service are sometimes the very ones who cite its insufficiency, because they realize they still do not have enough to go around. Another possible explanation for the insufficiency is that the push for earlier intervention and permanency decisions engendered by HB484 and the Waiver may have increased demand for intensive interventions. For example, when asked whether the PCSA was approaching in-home service delivery differently in light of HB484, many demonstration counties noted that they were attempting more than ever before to "front-load" services in their intervention with a family to prevent placement and to impress upon the family the urgency of the situation. As the counties have become more aggressive about placement prevention, perhaps the true gaps in non-placement services are revealed.

New Services

Data gathered from Year 3 and Year 4 indicate that both demonstration and comparison counties actively developed new services, showing fairly comparable development with two exceptions (Figure 3.4). First, slightly more demonstration counties created services with a preventive focus. Data gathered from family focus groups in Year 4 are indicative of the shift PCSAs made to provide more in-home, preventive services. The vast majority of families who participated felt that the PCSA has helped them by providing assistance in accessing services and financial resources. Examples of assistance

Figure 3.4: Range of New Services Created in Year 4



included: paying rent and utility bills, transportation, day care, or legal services, buying goods like furniture and diapers, providing parenting classes as well as other classes to teach needed skills, providing access to homemakers and case aides, and to programs to help with drug and alcohol issues Second, comparison counties created slightly more mental health services. Examples of these new services include: in house assessment units, partial hospitalization programs, in-home counseling/therapy and behavioral support to foster and adoptive homes.

Summary: Little distinguishes demonstration counties from comparison counties in their assessment of the sufficiency of the service spectrum in their counties. Most counties generally find placement services to be insufficient. On the other hand, although the numbers are less dramatic, many counties are generally satisfied with the overall availability of non-placement services provided by the PCSA itself and other agencies. Demonstration counties appear to be more dissatisfied with the availability of mental health and particular prevention services (e.g. family preservation and school-based

services) that would assist them in reducing placement days and establishing permanency plans, however, demonstration counties were slightly more likely to create more new prevention services in Year 4.

3.2.2 Year Five Explorations and Findings

Even though both groups of counties face similar insufficiencies, it remained unclear whether or not demonstration counties were better able to respond to service gaps. To what extent do the demonstration counties target their new service development to specific areas where insufficiencies exist? And, if such targeting occurs more often in demonstration sites than in comparison counties, is it simply due to their having access to flexible IV-E dollars, or do the demonstration counties also have partners who are more willing to help provide services to the child welfare population, thereby enhancing their ability to fill service gaps more effectively?

Research Approach

In Year 5, the study team undertook two distinct activities to find answers to these questions. First was a re-analysis of earlier data to determine the extent to which counties targeted their new service development to areas of service insufficiency, particularly in the areas of preventive and mental health services. In this analysis, the team matched specific services noted as insufficient to specific new services created. For prevention, the team looked at services defined as "non-placement other" in previous reports: short term family intervention, parenting skills training, mentoring to birth parents, family counseling, information and referral services, and non-curricular school-based activities. For mental health, the team reviewed the six Medicaid-required community-based mental health services: counseling and psychotherapy services, diagnostic assessment/evaluation, medication/somatic services, partial hospitalization, crisis intervention, and community support services. The second task was to gather new information from a select group of counties. Table 3.1 above lists the counties interviewed regarding the development of prevention services; finally, all counties were interviewed concerning mental health services.

Prevention. In selecting counties for the prevention interviews, the study team chose to focus on the counties who were deemed as most likely to be active in the prevention arena, so that interviews would generate maximum information about prevention activities. All counties were classified according to two dimensions: (1) extent of new spending on "other child welfare" (see Chapter 4) and (2) degree of commitment to prevention. The change in other child welfare expenditures includes new spending other than foster care board and maintenance,[2] calculated as a percentage of total child welfare expenditures. To determine the degree of commitment to prevention, the team reviewed site visit data from past years concerning counties' reform strategies. PCSA administrators who consistently stated they were focusing on prevention were recorded as

[2] Other child welfare spending includes expenditures for county program and administrative staff and family and community-based services.

having an explicit commitment to prevention.[3] Using the two factors, the study team created four groups of counties. (See below for discussion of the groups. Also, Appendix V-6 presents the data underlying the creation of the groups).

The study team conducted interviews with top-level administrators and supervisors in a subset of these counties,[4] The team asked three questions: how the agency funded particular prevention activities; what population they targeted for their prevention activities; and what particular factors helped or hindered the process of becoming more prevention focused. It is important to note that patterns observed here are not necessarily representative of all demonstration and comparison counties because the number of counties interviewed is so small and because the study team deliberately chose counties that were most active in prevention.

The interviews explored six key preventive services that have been highlighted consistently throughout the Waiver evaluation. These services include:

- Short-term family intervention
- Parenting skills training
- Mentoring to birth parents
- Family and child counseling
- Information services and advice
- Non-curricular school-based activities

Mental Health. In exploring mental health services, the study team conducted telephone interviews with all 28 ProtectOhio counties. The interviews were divided into two sections: the first focused on the six ODMH community mental health services, and the second on general issues surrounding mental health in the county. Table 3.2 lists the six services.

Table 3.2: The Six Mandated ODMH Community Mental Health Services
1. Counseling and psychotherapy services
2. Diagnostic assessment and evaluation
3. Medication and somatic services
4. Partial hospitalization
5. Crisis intervention
6. Community support services

[3] Commitment to prevention is derived from the *Fourth Annual Report*, Section 2.3, September 2002.
[4] All Group One and Group Two counties participated in the telephone interviews with the exception four counties due to the number of other interviews/site visits those counties were participating in.

Key questions focused on the availability and quality of services and the creation of new services. In addition, PCSAs were asked to assess timely access to mental health services and to comment on any increase in service capacity relative to need.

The following sections present the findings for these two service categories, first the results of the re-analysis of data and then highlights of new information collected during telephone interviews.

Findings Regarding Targeting of New Prevention Services

The study team examined counties that identified insufficient prevention services in Year 3 to determine whether they created a new service to fill the particular service gap. As Table 3.3 indicates, 12 demonstration sites and nine comparison sites had identified at least one insufficient prevention service in Year 3. Of the 37 service insufficiencies identified by these 12 demonstration counties, in 20 instances the county created a new service of that particular type (54%); by contrast, only ten of the comparison counties' 28 insufficiency (36%) were targeted by new service development. Consistent with this finding, more than twice as many demonstration counties (nine) as comparison counties (four) appeared to be targeting their new services.

Table 3.3: Number of Service Insufficiencies in Year 3 and Creation of New Service in Year 4

	Demonstration	**Comparison**
Y3 number of counties having insufficient prevention service	12	9
Y3 count of all insufficient prevention services across those counties	37	28
Y4 number of new prevention services created in the area of insufficiency	20	10
Created new services as a percent of insufficient services	54%	36%
Number of counties who targeted services (counties were defined as targeting if they created services for at least half of their reported service insufficiencies)	9	4

Examples of PCSAs that seem to be targeting services include:

- Greene County reported creating new services for five out of six insufficient services. For example, Greene reported expanding their family preservation program and adding more social workers in local schools.
- Stark County reported creating new services for three out of four insufficient services. Stark now has CARE teams in the Fairless school district. This collaborative effort includes: teachers, a mental health therapist, alcohol and drug mentor, representative from the sheriff's department, family mentor, tutors, and after school programming to assist families in greatest need.
- Summit County created new services for three out of five insufficient services. They have developed several programs to prevent placement such as the reconfiguration of their Family Preservation Unit into a Short-term Intensive Services Unit, which takes families who do not meet the criteria for ongoing services but who still need help. Summit also created a "Grandparents on the Rise" program, a support and information-sharing group.
- Montgomery County created new services for three out of four service insufficiencies. They now have a Crisis Response Team for children who witness domestic violence and have added parenting classes.

This analysis has some limitations, as questions for new services were open ended so the study team may have missed some counties who created new prevention services but did not report them. In addition, counties may have developed new preventive services in earlier years of the Waiver, which would not be included in this analysis. Nonetheless, the findings suggest that demonstration counties are somewhat better at targeting their new services to fill particular gaps in the prevention arena.

Findings from the Prevention Interviews

As described above, the study team focused its exploration of prevention on counties deemed most active in that service area, using a categorization based on data gathered in prior years of the evaluation. As Table 3.4 shows, demonstration sites tend to more often have new spending above the median level, and are more likely to have enunciated prevention as a reform theme, so they are more often classified in Group One and Group Two.

Table 3.4: Prevention Groups[5]				
New spending on non-foster care	Strong Theme		No Strong Theme	
	Demos	Comps	Demos	Comps
Above the median	Group One		Group Three	
	6	1	3	2
Median or below	Group Two		Group Four	
	3	2	1	8

Each of the four groups is characterized below:

- *Group One:* Six demonstration counties and one comparison county showed a large increase in new spending on non-foster care activities and were explicit that their counties sought to develop preventive services as a reform strategy. Three of these counties showed the highest increase in new non-foster care spending over the Waiver period. In general, Group One PCSAs reported that they created more preventive programming through enhancing collaborative efforts as well as through their own service offerings. A larger proportion of Group One counties reduced placement days than did other groups, which may explain their ability to shift funds to non-placement services. Perhaps reflecting the funding shift, in Y3 this group of counties judged the availability of preventive services to be relatively good.
- *Group Two:* Three demonstration counties and two comparison counties reported that they were moving towards preventive services as a system reform effort; however, fiscal data did not clearly reflect this change. This group of counties was at or below the median in new non-foster care spending. Most Group Two counties have seen increases in placement days, which may explain the lack of ability to shift funds to non-foster care services. Some of these counties attribute the rise in placement days to harder to serve families and an increase in permanent custody cases. Perhaps due to their limited ability to increase non-foster care spending, this group of counties reported having less sufficient preventive services than did Group One.

[5] One demonstration and one comparison counties had incomplete fiscal data so they could not be categorized in this table.

- *Group Three:* Three demonstration counties and two comparison counties appear to have made relatively large increases in expenditures for non-foster care; however, they did not enunciate a strong commitment to prevention as a system reform effort. Four out of five Group Three counties reported creating new prevention services during Year 4 of the evaluation. Perhaps more important, none of these counties faced substantial increases in placement days; indeed, only one saw a slight increase. This suggests that they had the resources to shift to non-foster care areas. As a group, these counties tend to have the most sufficient array of preventive services, which may go a long way to explain their lack of explicit commitment to enhance prevention.
- *Group Four:* One demonstration county and eight comparison counties did not explicitly pursue prevention as a system reform effort and increased their non-foster care spending to a lesser extent than was typical. Like Group Three counties, these PCSAs may well have pursued prevention initiatives in the past such that by Year 4 of the evaluation, prevention was a lesser priority for them. Indeed, the smaller growth in non-foster care spending suggests such an attitude. All but two of these counties saw an increase in placement days. As a group, these counties tended to have less sufficient prevention services

The presence of more demonstration counties in Groups One and Two appears to offer support for the hypothesis that demonstration counties gave more explicit attention to developing preventive services during the Waiver period than did comparison counties, whether through an explicit recognition of prevention as a goal or through actual commitment of new resources to non-placement activities. This difference may reflect demonstration counties' greater awareness of the need to curtail placement costs.

Given the distinctions among the four groups of counties, the study team deemed it most worthwhile to look more closely at those PCSAs most active in prevention, as defined by Groups One and Two. How does the greater focus on prevention come about? And does it yield better results for children, families and communities? The study team conducted interviews with a subset of these counties,[6] including four demonstrations and one comparison from Group One and two demonstrations and two comparisons from Group Two, for a total of nine counties (Table 3.5).

It must be noted that this analysis faces some challenges. First, counties may have a tendency to categorize a wide range of services/programs as "preventive" making the term difficult to define operationally. Second, the data used to group counties on their commitment to prevention is qualitative and was collected by different interviewers, so there maybe some variation in the depth and breadth of the information. These data are further compromised by the fact that a county that already had shifted its program toward prevention might legitimately exclude prevention from its characterization of current reform focus. Third, the telephone interviews conducted in Year 5 only covered counties

6 All Group One and Group Two counties participated in the telephone interviews with the exception of three counties due to the number of other interviews/site visits those counties were participating in.

in either Group One or Two; therefore, the interview sample is not meant to be representative of all counties in the evaluation. Indeed, the numbers are too small to support a comparison between demonstration and comparison counties. Nonetheless, this analysis is useful in providing insight into how counties that are most active in prevention have made it happen. Clearly, having flexible funds, through the IV-E Waiver or other sources, is one element, but it is more complex than that, since not all demonstration counties are active in developing preventive services and some comparison counties (without benefit of the Waiver) *are* active.

Table 3.5: Counties Chosen for Year 5 Interviews

	Demonstration	**Comparison**
Group One	4 of 6	1 of 1
Group Two	2 of 3	2 of 2

The data show that most of the nine PCSAs make broad use of their prevention services. Most counties indicated that they use all six of the services for open cases, to prevent the need to place a child, and, similarly, they use them for at-risk families and children, to prevent the need to open the case to formal PCSA services.

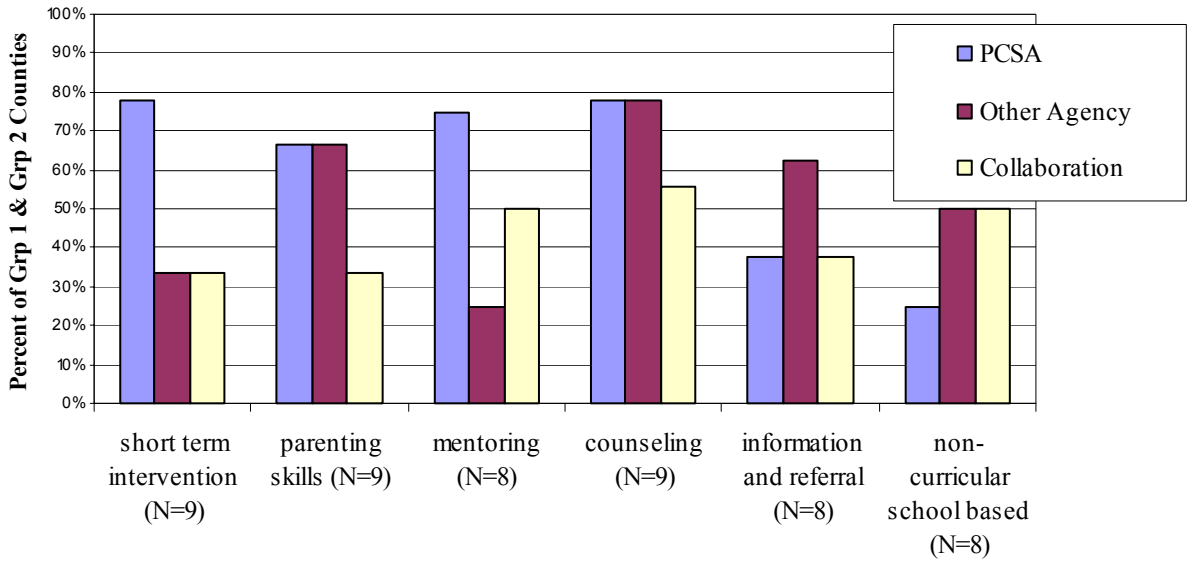
In terms of funding sources for prevention, three-quarters of the counties report funding three of the services with their own funds, including short-term family intervention, mentoring to birth parents, and family and child counseling (Figure 3.5). Funding for counseling also appears to come equally from other agencies in the community, as does funding for parenting skills training. Not surprisingly, funding for information services and advice comes from multiple sources, including collaborative ventures, since it is a service that broadly benefits the community. A similar pattern is evident in funding for school-based activities, often funded through collaboration with Juvenile courts, schools, and Family and Children First Councils.

Above and beyond the six prevention services specifically explored in the interviews, counties reported using a range of other services to prevent the placement of a child. These included hard goods and services, mediation services, custody review teams, alcohol and drug staff in schools, respite and child care programs, domestic violence emergency teams, kinship support, juvenile court programs such as court liaisons, juvenile court diversion, and a collaborative planning body. Most of these services were also available to at-risk families and youth in the general community.

Given that prevention services, as well as other categories of service, are not able to meet all the needs of children and families served by the PCSAs, the study team asked about additional services that counties needed to prevent children from being placed out of the home. The services noted most frequently are dual diagnosis services for families with mental illness and substance abuse or mental retardation/developmental disabilities, and substance abuse services for adults and teens. Consistent with these findings, the caseworker focus groups conducted in Year 4 revealed that workers see the lack of therapeutic foster care options and supportive services, such as mental health and in-home services, as impeding their ability to return children home or to move them to less restrictive placements.

In exploring the factors that enhance prevention activity, most counties (seven of the

Figure 3.5: Funding for Prevention Services



nine) indicated that a belief in or commitment to prevention was important in facilitating their county's focus on prevention. Only three counties—all demonstration—stated that flexible funding was important. By contrast, when respondents were asked about factors impeding county efforts toward prevention, the most frequent responses were: lack of funding (five counties); an increase in more difficult cases, thus draining resources that might be used for prevention (three counties); and lack of services such as in-home or community-based therapists with expertise in child abuse and neglect or for dual diagnosis patients (two counties).

Summary: Demonstration counties appear to be targeting their new preventive service development to areas of specific need and were a more active subset of counties in shifting towards prevention then comparison counties. The interview data suggests that, among the counties most active in prevention (including both demonstration and comparison counties), prevention services generally appear to be offered both to families

in open cases and to families that are at-risk of entering PCSA services. Counties tended to use their own funds to pay for about half of the services, with other agencies and collaboration helping to fund the other half.

Findings Regarding Targeting of New Mental Health Services

The Process Implementation Study team hypothesized that demonstration counties will be more likely than comparison counties to develop mental health services to fill service gaps due to the flexibility provided by the IV-E Waiver. This may be especially true for outpatient/home-based services because such services directly decrease the need for out-of-home placements. In the targeting analysis, two services are explored: child outpatient psychology and child outpatient counseling. Table 3.6 shows that four out of seven demonstration counties created new outpatient child psychological services in Year 4, after indicating it to be insufficient in Year 3, while only one out of six comparison counties did the same. Further, five demonstration counties out of six indicating child outpatient counseling services were insufficient in Year 3, developed new child outpatient counseling services in Year 4, while no comparison counties did the same.

Table 3.6: Demo vs. Comp Counties: Insufficient Outpatient Services in Year 3 and New Outpatient Services in Year 4

County	Year 3 Insufficiency Outpatient Child Psychology	Year 4 New Outpatient Child Psychology	Year 3 Insufficiency Outpatient Child Counseling	Year 4 New Outpatient Child Counseling
Demonstration	7	4	6	5
Comparison	6	0	7	1

Some demonstration counties were particularly attentive to filling mental health service gaps. Three demonstration counties created new services for both outpatient psychology and child outpatient counseling after indicating service insufficiencies in the previous year, while no comparison counties filled both service insufficiencies. Although the data are not conclusive, it appears that demonstration counties were targeting mental health outpatient service insufficiencies more frequently than comparison counties.

Findings from Mental Health Interviews

To further explore the improved availability and quality of core mental health services, the Process study team conducted brief telephone interviews with top-level administrators or supervisors in all 28 counties. Core mental health services are defined as Ohio's six community mental health services (Table 3.2). The Medicaid Community Mental Health Program requires that these services be available to all Medicaid-eligible clients who meet the State's medical necessity criteria for each service. Most community mental

health agencies, within available funding, provide the same services to both Medicaid and non-Medicaid eligible clients based on the same medical necessity criteria.

The study team hypothesized that, in spite of the requirements of Medicaid law that services be offered equally statewide, demonstration counties will be more likely to provide core mental health services due to the flexible funding afforded by the Waiver. More specifically, the demonstration counties will be more likely to have shorter waits for service and PCSAs will perhaps contribute more funding towards mental health services to fill service gaps in the community mental health system.

The interview data revealed that the six core mental health services tend to be provided to individuals in all counties, with the exception of partial hospitalization programs. Two demonstration counties report that they do not have access to partial hospitalization, and one demonstration county and five comparison counties report limited access to partial hospitalization services.

For most counties, the mental health board appears to be fulfilling its mandate through paying the Medicaid match for each of the six core services (Table 3.7). Little variation is evident among the services. Overall, it appears that Mental Health Boards in the demonstration counties are not more likely to pay Medicaid match, covering 59 services compared to 57 for comparison counties. Slightly more comparison PCSAs reported paying the match for assessment and evaluation services. Demonstration PCSAs were slightly more likely to share with the mental health board the cost for match for community support services. In some counties, both the mental health board and the PCSA pay for services. This situation, where both agencies pay for a service, is most likely to occur when PCSAs use both private providers and providers funded under the mental health board. Often this funding method is used to reduce wait lists or to provide access to specialized services such as treatment for adolescent sex offenders.

Of the counties where all six services were provided (13 demonstration and 13 comparison sites), slightly more demonstration counties than comparison counties reported that the mental health board pays the Medicaid match for all six services. In seven demonstration and five comparison counties, the non-federal match for all core services is paid by the mental health board, perhaps demonstration PCSAs can better support other local activities with their flexible money.

The substantial extent to which mental health boards are paying the Medicaid match for core mental health services is clearly related to the availability of local mental health revenues. Most counties, 11 demonstration and 11 comparison, have mental health levies. Eight demonstration counties and nine comparison counties have a separate levy for mental health.

Table 3.7: Who Pays the Medicaid Match for MH Services?[7]						
	MH Board		**PCSA**		**PCSA and MH**	
MH Service	*demo*	*comp*	*demo*	*comp*	*demo*	*comp*
counseling	9	9	3	3	2	1
assessment	10	8	2	5	2	1
medication	11	10	2	3	1	1
partial hospitalization	10	8	2	3	0	1
crisis	12	11	1	2	1	0
community support	7	11	1	1	3	0
Totals	59	57	11	17	9	4

Demonstration counties are slightly more likely to report that some groups have difficulty accessing core mental health services (Table 3.8). Four demonstration counties reported that some groups have difficulty accessing counseling and psychotherapy services while two comparison counties reported the same; and three demonstration counties reported that some groups have difficulty accessing medication services. In both demonstration and comparison counties, these groups included: individuals without private insurance who are not eligible for Medicaid; families who were not currently receiving PCSA services (i.e. not an open case), or limited providers who accept Medicaid.

The substantial extent to which mental health boards are paying the Medicaid match for core mental health services is clearly related to the availability of local mental health revenues. Most counties, 11 demonstration and 11 comparison, have mental health levies. Eight demonstration counties and nine comparison counties have a separate levy for mental health.

[7] Cells may not total to 28 counties for each service category, some counties indicated that they did not know who funded the service or they did not provide the service; therefore the question was not applicable.