Draft Report

Shared Outcomes for Mental Health & Child Welfare Partnership

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Background

The Kansas Mental Health Child Welfare Steering Committee has developed a Statewide Partnership Plan for how the child welfare and mental health systems will coordinate services to create a seamless array of services for children and their families served by both systems.[1] In addition to the numerous practical details of daily practices, the Partnership Plan articulates the goal of establishing a common set of outcomes for children who concurrently receive services from the child welfare and mental health systems.[2] . It is anticipated that increased coordination between child welfare and children's mental health will result in better outcomes for children and their families. Likewise, establishing shared outcomes is seen as a way of recognizing common goals and encouraging better coordination of services for children and their families toward achieving those goals.

The first section of this report is a policy level analysis describing the approach for outcome measurement in both systems, analyzing similarities and differences, and discussing options for establishing shared outcomes. The second section of this report will provide results from an initial analysis of some of the shared outcome measures that were identified for which data were available. The last section will outline proposed next steps for establishing a process for monitoring shared outcomes and other key aspects of the Mental Health and Child Welfare partnership identified in the statewide Partnership Plan.

[1] The Child Welfare Mental Health Partnership Plan completed its final draft on February 12, 2007. It was a culmination of several years of discussions and negotiations between representatives of child welfare (state and provider) and mental (SRS HCP and CMHC's). Given the major changes in the administration of mental health services in Kansas, the Plan was not formally adopted.

[2] Technically, the term "outcome" refers to a measure of client/consumer change (i.e. status, behavior, attitude). This report will use the term as it is more commonly used which also refers to performance measures for meeting of a service standard (e.g. timely access to services).

Shared Outcomes for Mental Health and Child Welfare Partnership

In an effort to inform the development of shared outcome measures for the Mental Health Child Welfare (MH-CW) Partnership, this section of the report examines existing outcomes and indicators established in both service systems, analyzes these outcomes (e.g. similarities, differences, data availability), and outlines options for establishing an outcomes measurement system. The ideal set of shared outcomes would optimally strive to use measures that:

- Are the same as or similar to already existing outcomes in either service system;
- Can efficiently be computed (e.g. use existing data);
- Focus on consumer changes more than service processes;
- Both service systems view as having a reasonable level of influence in achieving;
- Are methodologically sound (e.g. valid, reliable); and
- Provide a standard or goal that represents a reasonable level of improvement.

Outcomes in Children's Mental Health

The children's mental health system in Kansas has established five outcomes for services to children that are assessed as having a Serious Emotional Disturbance (SED) and receiving Community Based Service (CBS). A case level dataset is submitted monthly by Community Mental Health Centers which is used to develop the Client Status Report (CSR) disseminated to SRS and CMHCs quarterly[3]. Table 1 below provides the major indicators tracked. Performance that is 10% or more below the state average on a given indicator is noted in the Client Status Report.

[3] Reports can be seen at the following URL: http://www.srskansas.org/hcp/MHSIP/pdf/State%20-%20All%20FY06Q2.pdf

Table 1: Children's Mental Health Outcome Indicators

Outcome	Indicator
Permanent Home	Percent of children in a permanent home with biological or adoptive parents, relative, guardian, or other approved caretaker. This measure excludes children in out of home placement who are also in either JJA or SRS custody.
Without Law Enforcement	Percent of children without arrests and whose parents have not been contacted (regarding the youth) by law enforcement. This measure excludes all children under JJA custody or supervision.
Clinically Significant CBCL Scores	Percent of children with at least one of four CBCL scores that is clinically significant, thereby indicating an at-risk functional status.
A, B, or C Performance	Percent of children averaging C or above grades. This measure excludes children with educational placement of not in school, not applicable, or preschool.
Regular Attendance	Percent of children attending school 90-100%. This measure excludes children with educational placement of not in school, not applicable, or preschool.

The above five outcomes and indicators are reported for each Community Mental Health Center. However, a wide range of other data on children served by CMHCs is also reported in the CSR report providing more in depth information of these outcomes and the status of children being served (see examples below). These data are reported statewide and each CMHC is provided their data for the client population served by that CMHC.

1. Current residential living status (percent and days in status)
    - Institutional, Substantially Restrictive, and Surrogate Home
    - Movement table showing changes in residential living status from beginning of the quarter to the end of the quarter
2. Juvenile Justice and Law Enforcement Status
    - Children with arrests, children whose parents were contacted by law enforcement, children without arrests or law enforcement contact
3. Child Behavior Checklist Scores
    - Competence, problem, internalizing, externalizing

4. Educational Statistics
    - Not in school (expelled/drop out), Special Education classroom, Regular classroom with special education support, regular classroom
5. Academic Performance
6. School Attendance
7. Other school performance
    - IEP's, 504 Plans, excused and unexcused absences, truancy charges, in-school suspensions, out-of-school suspensions
8. Exit status
    - Residential living, educational placement, clinically significant CBCL scores, juvenile justice status

Outcomes in Child Welfare

Contracts with Child Welfare Community Based Providers (CWCBP) specify 22 outcome indicators (see Table 2 below). These outcomes are relevant to all contracted services including Family Preservation, Foster Care and Adoption services. Data for most of these indicators are computed using a case level database (FACTS) maintained by SRS. Others are computed less often using data from case reads on a random sample of cases by SRS quality assurance staff. Data are reported on a monthly basis in a report called Portraits and is published on the Internet.[4]

The outcomes and their indicators listed below will likely change in FY 2008 due to changes at the federal level. The federal government has established a new set of outcomes that will drive the Child and Family Services Review (see Attachment A). The major outcomes of

[4] See Portraits on the SRS website: http://www.srskansas.org/CFS/datareports07.html

permanency, safety, and well-being have remained the same, but the indicators have changed substantially. The three most significant changes are:

- Fifteen outcome indicators are collapsed into four composite scores using a statistical analysis methodology provided to states.
- An expanded list of federal outcome indicators from six to fifteen with an increased emphasis on permanency for children in care for longer periods of time; and
- Some improvements in measurement methodology using more entry cohort measures (although some exit measures were retained)

Table 2: CWCBP Outcome Indicators

Outcome	Indicator
Children are Safe	▪ 93.9% of children will not experience recurrent maltreatment ▪ 96% of children will not experience maltreatment during (90 days) or after (365 day) of being engaged in Family Preservation Services ▪ 99.43% of children will not experience maltreatment by a foster parent or employee facility ▪ 95% of children will not experience maltreatment after reintegration, guardianship or adoption
Positive Family Relationships	▪ 75% of children will be placed with either relative, sibling, or in same school as prior to removal ▪ 90% of children will have placement in family like setting ▪ 90% of youth leave custody with one positive role model contractor data
Children Demonstrate Age Appropriate Development	▪ 90% of youth in out of home placement will increase life skills ▪ 50% of children maintain academic performance equal to or greater than the time of entry into care
Children's Education Needs are Met	▪ 90% of children have regular school attendance
Children Achieve Permanency	▪ 76.2% of children reintegrated will be reintegrated in 12 months ▪ 32% of children adopted will be adopted in 24 months ▪ 86.7% of children in OOH less than 12 months will have 2 or fewer placements. ▪ 91.4% of children will not re-enter custody ▪ 95% of children will have timely permanency hearings
Effective Supports and Services	▪ 95% of children will have goals that meet their needs ▪ 95% of families engaged in FPS services
Individuals Live and Receive Services in Least Restrictive Setting	▪ 90% of children will have placement in family like setting ▪ 90% of children served are without negative law enforcement contact
Customers Involved in Case Planning	▪ 85% of adults and youth over age 14 respond that services were provided using family centered principles ▪ 60% of families report enhanced capacity to meet needs
Program Requirements are Met	▪ 50% of stakeholders report services provided enhance families capacity to meet child's needs

The new quantitative federal measures computed from the state's database continue to be devoid of child or family well-being outcome measures. Child and Family Well-Being measurement is largely measured in a qualitative review of case records due to the importance of the nuances of individual cases and the difficulty of operationalizing such terms as "adequate" or "timely". They also tend to reflect service response. The following are examples of this: 1) Children receive adequate services to meet their physical and mental health needs; 2) Children receive appropriate services to meet their educational needs; and 3) Child and family involvement in case planning. Adequacy of services and involvement in case planning are not as amenable to quantitative measurement.

Proposal of the Steering Committee on Shared Outcomes

At its November 29, 2006 meeting the MH-CW Steering Committee members identified four major content areas as priority needs for families in child welfare and mental health to be successful. For each area, the members identified possible outcomes/indicators using a variety of sources, including the shared outcomes identified by the Child Welfare CEO's. These content areas identified were reflected in the meeting notes as follows but the details were not finalized:

1. Access to mental health services
    a. A treatment service (excluding an assessment) will be provided to a child within 2 weeks of referral to CMHC. **OR**
    b. Track AIMS data on time from referral to intake and intake to first service **and/or**
    c. Have all CW kids be considered urgent unless they are in the emergent category. However, this would require emergent to be 3 working days instead of 72 hours.

2. Stability

    a. 80% of the children in out of home care shall have 2 or fewer placement moves (or settings?) from the point of referral for services to the CMHC.

    b. 91.4% of children who have not been removed from their home and who have been referred for CMHC services by a Family Preservation contractor will remain stable in their home for 12 months following referral for services.

    c. 90% of children in SRS custody who receive mental health services will be maintained in a family-like setting (the least restrictive environment.)

3. Timely Permanency (shorten length of stay in out of home care)

    a. 76% of children will be released from custody for reason of reunification within 12 months of removal.

    b. 32% of children will be released from custody for reason of adoption within 24 months of removal.

4. Maintain permanent home

    a. 91.4% of children who have been reintegrated or adopted after being placed out of home and who have been referred for CMHC services by a CW/CBS provider will not reenter out of home care within 12 months following referral for services.

    b. NEW – creating an outcome related to CW assisting MH during aftercare when families are resistant to engaging mental health services.

Analysis and Discussion of Current Outcomes

Population for Shared Outcomes

Outcomes and service response goals for each system are based on different but overlapping sets of children. Children's Mental Health outcomes are currently based on the population of children identified as having a Serious Emotional Disturbance in need of Community Based Services (SED/CBS). Child Welfare outcomes are based on children and families that receive Family Preservation or Reintegration/Foster Care regardless of their mental health status.

There was general agreement from the Steering Committee that shared outcomes will be based on shared cases. Shared cases were operationally defined as children who receive mental health services any time during the time they were in out-of-home care (foster care). Another shared population identified was children who received mental health services while also receiving Family Preservation services. These children could be receiving minimal mental health services or be in the SED/CBS population. Outcomes for each system would continue to be computed just as they are but shared outcomes would be identified and reported based on this shared service population.

Common Outcomes

While the outcomes and indicators for the two systems are different in how they are operationalized, there are outcomes that are similar in concept as follows (see Table 3):

- Children living in a permanent home is a common outcome. Mental health calls it "Permanent Home" and child welfare calls it "Permanency". Child welfare has many indicators related to permanency largely measuring time to achieving and maintaining

permanency. While placement stability is not considered permanency, it is a child welfare measure reflecting permanency while in placement and is often seen as ultimately contributing to timely permanency.

- School performance is a common outcome. Mental health reports on grades (C or better) and attendance (0-2 absences, 3-5, or 6+). Child welfare looks at maintaining grades while in foster care, and regular school attendance. Mental health gathers this data only on the SED with CBS population and the child welfare data is very limited and only collected through a limited number of case reads. While this is a common outcome area, data are not available to compute a shared outcome.
- Living in the least restrictive environment is a common measurement taken. Mental health looks at "residential living status" and child welfare looks at placement in "family like setting" (non-residential care). Mental health reports on percent of children in each of three levels of restrictiveness on a specific day and also reports percent of days in each level. Children who are not in one of the three levels of restrictive care are in the "permanent home" category shown above. Although residential living status details are not one of the five broad mental health outcomes, they are regularly reported in the CSR.

Table 3: Common outcomes in Children's Mental Health and Child Welfare

Common Outcome (or reported performance)	Children's Mental Health Outcomes	Child Welfare Outcomes
Permanency	Permanent Home	Timely Permanency (reunification, guardianship, and adoption) Maintain permanency upon discharge or completion of services Placement Stability
School Performance	Grades (C average) Attendance (0-2 absences, 3-5, or 6+)	Maintain grades Regular attendance
Living in least restrictive environment	Residential status	Living in family like setting (non-residential)

Data Availability

To measure and report shared outcomes, data will need to be collected and accessible. There are at least three options:

1. Link databases already in use (i.e. FACTS, AIMS, and MMIS). The capacity to link databases exists. KU has been doing this for research projects on a limited basis over the last several years. There is a common ID between FACTS and MMIS. A common ID has recently been added to AIMS. Table 4 below shows the availability of the initial set of outcomes identified by the Steering Committee.

Table 4: Analysis of Data Availability

Outcome	Subject of Indicator	Data Currently Available	Data Not Currently Available
Access to Mental Health Services	Time from MH referral to start of first service after intake assessment		No
	Time from CW referral to MH intake		No
	Time from intake to first service	Yes	
	Initial referrals to CMHCs meeting access standards (urgent, emergent or routine)	Yes	
Stability	Few placement settings while in foster care	Yes	
	Children maintained in a permanent home following Family Preservation	Yes	
	Children maintained in a family like setting (non-residential) while in foster care	Yes	
Timely Permanency	Timely reunification	Yes	
	Timely adoption	Yes	
Maintain permanent home	Maintained in a permanent home after achieving permanency	Yes	

2. Modify existing databases to gather needed data. Outcome data for mental health is generally limited to the SED/CBS population. If educational status (grades and attendance) is identified as a shared outcome, either additional data will need to be collected on non-SED/CBS children, or modifications in data being gathered by child welfare will need to be made.

3. Randomly selected cases can be reviewed. To adequately address some of the outcomes for which data are not currently collected in databases and to get at outcomes that require a more qualitative approach a case review process could be implemented. Some have suggested that this could be a peer review process where both mental health and child welfare staff collaborate to review a set of cases on a periodic basis (e.g. annually).

The Steering Committee limited its thinking on shared outcomes to more quantitative types of measurement. However, some outcomes and service quality standards may be more effectively measured through qualitative review of cases. Expansion in this area could get to such things as family involvement; coordination of service planning; adequacy of services, services to parents of children in care, and others. Case review can also be used to gather more quantitative data when data are not available in databases currently.

Standards

Neither child welfare nor children's mental health has outcome data for the shared population upon which to base a standard (performance goal). Child welfare has very specific outcome standards but they apply to their general population. The children with mental health needs, however, may indicate a more difficult to serve sub-population. Thus an argument can be made that in order for child welfare to meet their outcomes, they could have lower performance on this sub-set of cases overall. However, another argument can be made for keeping the

standard the same regardless of their level of severity, with the thinking that enhanced, coordinated service provision can help meet the desired outcomes.

Selection of Measures

When selecting shared outcomes it will be important to select good quality indicators. Two of the draft outcomes considered by the Steering Committee are based on children exiting foster care. It is widely recognized in the research community that these are poorly constructed measures for several reasons. First, a child has to reach the outcome in order to be counted. Permanency measures based on whether children are reunified or adopted do not account for the children that leave child welfare due to less desirable outcomes (e.g. aging out, transfer to JJA). Second, placement stability measures that use 2 or fewer placement settings as defined by the federal government do not take into account the length of time a child has been in out of home care. Third, point in time measurement of placement in residential treatment also has its weakness that can be overcome by accounting for days of service.

Selecting a shared outcome could involve accepting one of the existing outcomes being monitored. Alternately or additionally, a shared outcome could be one that is unique to the partnership, thus developed specifically to monitor the performance of coordinated service efforts. As shared outcomes are developed, it would be desirable to choose indicators that have the highest level of validity to the well-being of children being served. Choosing an indicator because it is required by either the federal or state government is perhaps understandable, however, this would be an opportunity to step outside of those requirements to develop measures that are more reflective of the true status of shared clients.

Additionally, it would be important to review the list of the four main content areas identified by the committee and make sure no additional areas need to be added. For example,

placement proximity to home is often identified as important and may be a good addition to this list of measures.

Options for Future Direction

The development of shared outcomes is an empty promise unless there is a means of collecting and reporting such data. Since no reports currently existed for this shared population, the MH-CW Steering Committee considered options for future measurement of shared outcomes at its January 10, 2007 meeting. It was suggested by KU researchers that an incremental approach be used so that: 1) existing data can be used to compute some of the indicators under consideration to help set the baseline and the standard; 2) plans be put in place for establishing additional or improved outcomes measurement methods at a later time; and 3) develop a process for producing the reports in a regular and consistent manner. KU researchers provided committee members with the following options for next steps at this January meeting:

Option 1:

One option involved adopting the initial list of outcomes and indicators with or without standards that came out of the November 29th meeting for which data exist. Outcomes that have existing data could be computed by linking mental health and child welfare databases. This could be done by SRS or by exploring the possibility of using the resources of a current SRS-KU Task Order. The goal would be to compute and report these outcomes using existing databases over the next 4-6 months. Since not all of the indicators can be computed, a task force could be formed to establish a mechanism to collect such additional data as needed.

The advantage of this option is that the initial stages of this could be done relatively quickly. The disadvantage is that some of the outcome indicators are based on measures that are

methodologically weak. Secondly, it may be important for there to be a level of general acceptance of these outcomes for them to be sustained and supported. Since these indicators are largely child welfare indicators, discussion would be needed on what mental health indicators might need to be added. This option is the most expeditious and provides a good starting point.

Option 2:

The Steering Committee could accept the list of outcomes developed out of the November 29th meeting in principle, examine actual performance data for the major outcomes for those outcomes that have existing data, and modify the measures and/or standards based on research of historical performance. Just as stated in Option 1, SRS or possibly KU through modification of an existing Task Order could analyze existing data and report such to the Steering Committee. Such analysis could report performance on the same and additional/improved outcome indicators to the extent that data are available. This would assist in developing operational definitions of indicators and possible standards of performance based on this population. See Table 5 for what general outcomes and types of indicators could be examined.

Secondly, CMHCs could be asked to gather data on a randomly selected set of common cases to measure the following Service Response (process) measures that cannot be computed using existing databases. This survey would look at time from referral to initiation of mental health services, time from referral to intake, and other important process or quality standards deemed important. Then recommendations could be developed to incorporate these data into existing databases to monitor these services standards on an ongoing basis.

Table 5: Analysis of outcomes with available data

Outcome Area	Types of Indicator
Access to Mental Health Services	Time from intake to first service Initial referrals to CMHCs meeting access standards (urgent, emergent or routine)
Stability	Children have placement stability
Timely Permanency	Time to achieve permanency (permanent home) • Reunification • Adoption
Maintain permanent home	Maintained in a permanent home after achieving permanency (leaving foster care) Children are maintained in a permanent home following Family Preservation services
Living Status	Maintained in a family like setting (non-residential)

Option 3:

This option would incorporate Option 2 and take it a step further by adding a peer-led case review process. A case review system could be developed that could provide feedback on outcomes and service response measures for which there is no data or are best measured by a qualitative review. This would include the content of the review, selection of cases, frequency of review, and who would conduct the review. As pointed out above, case reviews can be used to gather more qualitative information such as family involvement; coordination of service planning; adequacy of services, services to parents of children in care, and others. Likewise, case reviews can gather quantitative data that is not routinely collected in databases and reported (e.g. meeting access standards of urgent, emergent, or routine) at both intake and ongoing. A workgroup could be established to help develop this and could potentially be supported by KU through the SRS-KU contract.

The Committee endorsed the use of existing data for computing measures identified for which data were available. It was hoped that having actual data would help with making decisions about what outcomes to use and what standards to set. The Steering Committee voiced interest in all three options, in that they build on each other. While advantages were noted on the case review process outlined in Option 3, members thought it needed to be coordinated with existing reviews.

Mental Health and Child Welfare Shared Outcomes Analysis

Analysis of existing data was completed and presented at the April 3, 2007 MH-CW Steering Committee meeting. This analysis presented a limited set of outcomes and some additional analysis for which data were available.

Methodology

Data were merged and analyzed from four data sets to provide baseline information to the Mental Health – Child Welfare Steering Committee for use in developing shared outcomes. A brief description of the data sets is provided, followed by the methodology used for the analyses.

Background Data Sets

1. **FACTS** – FACTS is a child welfare data set maintained by SRS – Children and Family Services. It captures information on each child in out-of-home placement. In addition to basic demographics, it includes among other variables, the date and reason for removal, the county of origin, the number and types of placements, when the child was returned home and the type of placement to which the child was returned. FACTS data was provided for children in foster care between July 1, 2002 and June 30, 2006.
2. **Medicaid Management Information System (MMIS)** data – this data set provides information on each service billed to Medicaid for each child. The Medicaid number for the children included in the FACTS data set was sent to SRS-HCP along with the removal date and the discharge date, which together defines the child welfare episode. MMIS data was searched to identify if one of the mental health services listed below beyond the 90801 (or initial mental health intake) was provided during that child welfare episode. The data set provided for this analysis was a simple "yes" if any mental health

service was provided, regardless of the frequency, intensity, or provider, or "no" if no mental health service was recorded in MMIS during that child welfare episode.

3. **Automated Information Management System (AIMS)** data – this data set provides case level data collected by each Community Mental Health Center (CMHC) for individuals receiving services through that center. AIMS data includes many variables for each episode that the individual received services, including admission and discharge data, diagnosis, and chronicity level. For this project, information from the FACTS data set was used to create the AIMS ID. The AIMS IDs for the children in the FACTS data set were sent to SRS-HCP along with the removal date and the discharge date for each child welfare episode. For each episode, the "highest" level of chronicity was recorded, grouped as follows:

   Level One – Chronicity 6 (SED/CBS) was established at some point – this is considered the highest level
   Level Two – Chronicity 4 or 5 (SED but not CBS) was established at some point – this is the 2nd level
   Level Three – Chronicity 7 or 8 (Not SED or unknown) – this is the third level
   Level Four – There was no AIMS match (I.e., the child did not receive mental health services through a CMHC during the episode) – this is the lowest level

   For the children in levels one through three, data were also provided on whether or not one of the mental health services listed below beyond the 90801 (or initial mental health intake) was recorded in AIMS during that child welfare episode. Although CMHCs are not required to record service data in AIMS, some centers do record service data here so it provides another source of information. Additionally, there are some services that are provided but cannot be billed in all circumstances, such as parent support. These services may be identified through this data set.

4. **Statewide Contractor Reimbursement Information & Payment Tracking System (SCRIPTS)** data – this data set is maintained by SRS – Child and Family Services. When child welfare contractors provided a service (or sub-contracted out for the service), they submitted an encounter to SCRIPTS, which SRS-CFS then used to claim federal reimbursement. These claims were not entered into MMIS but were recorded in this system instead. The Client IDs from the FACTS data set were used, along with the removal date and the discharge date, to identify whether or not a mental health service was provided, past the 90801 (or initial intake) during the child welfare episode. Once again, it was recorded as a simple yes or no.

The following were the mental health services codes[5] included in these analyses:

- Individual Therapy – 90805, 90806, 90807, 90808, 90810, 90812, 90826
- Family Therapy – 90847
- Group Therapy – 90853
- In Home Family Therapy – Y9111
- Pharm Management – 90862
- Case Management – Y9117, Y9118
- Attendant Care – Y9119, Y9544
- Psychosocial Group – Y9565
- Wraparound – Y9700
- Parent Support – Y9702
- Respite Care – Y9703

Creation of Final Data Set

The three mental health data sets – MMIS, SCRIPTS, and AIMS – were merged into the main FACTS data set, using common IDs among the various data sets. The time frame from

[5] Most of the codes switched to HIPAA codes in January of 2004. Both the old and new/HIPAA procedure codes were used for identifying the services.

August 2002 through June 2006 was used as there was a problem with mental health data for July 2002.

Using the county where the child was residing upon removal from the home, variables were created for each episode to show the following information for that county: which CMHC served that county, the population density (frontier, rural, densely-settled rural, semi-urban or urban), and its SRS region and judicial district. It is important to note that the child may not have been placed in the same county from which he/she was removed. Therefore, even when mental health services were provided, they may not have been provided by the CMHC serving that county. However, since placement data was not recorded, analyses by CMHC were conducted using the home county as a base.

Two additional variables were created to identify mental health involvement. First, a variable was created to show whether a mental health service was recorded in any of three data sets – AIMS, MMIS, or SCRIPTS – for each child welfare episode. The values for this variable were a simple yes or no, indicating whether or not mental health involvement occurred.

Using the "mental health involvement" variable described above, a second variable was created to group each child welfare episode into one of the following four options:

Group 1: A MH service was provided and the highest chronicity was SED/CBS at some point during the child welfare episode

Group 2: A MH service was provided and the highest chronicity was SED but not CBS during some point during that child welfare episode

Group 3: A MH service was provided and the chronicity was either Not SED or there was no AIMS match (e.g., a service was provided by someone other than the CMHC)

Group 4: No MH service past the 90801 was recorded (note: it is possible that the child had AIMS Chronicity information but if there was no MH service information, the child was in this last group.)

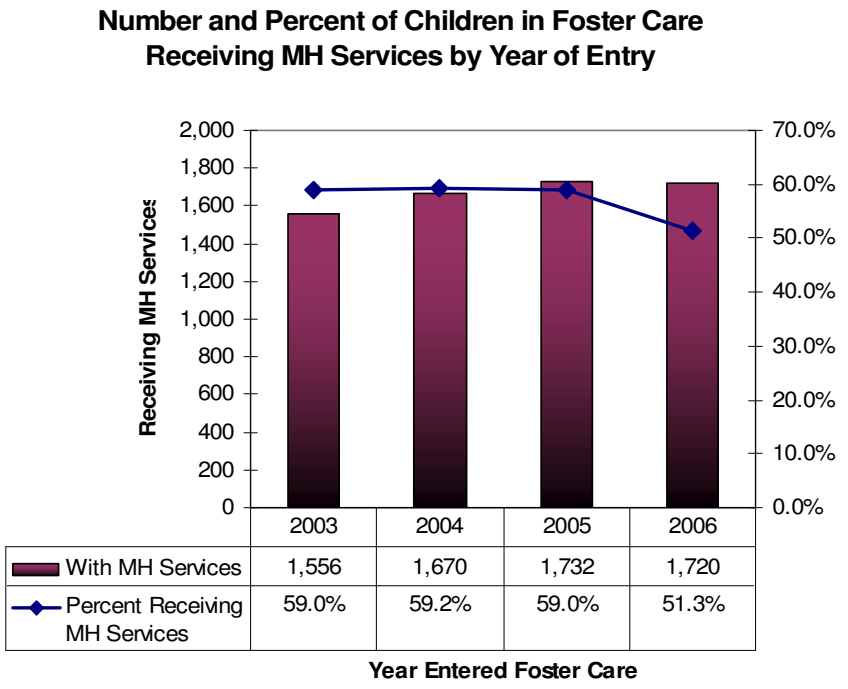
Policy Notes

There were several policy changes during this four year time period related to how mental health service were paid and thus, where they were recorded. Prior to FY06, SRS-CFS paid the child welfare contractors a set amount of money per child each month to serve that child who was in SRS custody and in an out-of-home placement. Those services included mental health and behavior management services which were typically paid for through the medical card. To prevent providers from billing the medical card, a block was placed on the child's medical card that rejected claims for those types of services should they pass through the MMIS. As child welfare contractors provided a service (or sub-contracted out for the service), they submitted an encounter to SCRIPTS, which CFS then used to claim federal reimbursement. The only mental health services that would appear in MMIS during this time period were for those children who were eligible for SED/CBS services or children in the adoption contract. If a child needed mental health services but was not in one of the latter two groups, the contractor could choose to pay a CMHC for the service. In this scenario, the service would appear in SCRIPTS, not MMIS. Child welfare providers noted two exceptions to this statement: first, if the child welfare provider had qualified individuals on staff and therefore, they could provide the services directly; and second, if the child was seeing a non-Medicaid provider prior to entering custody and the judge ordered those services to continue, the child welfare provider would have paid for those services directly.

On July 1, 2005 (the start of FY06), mental health services came out of the child welfare contracts. So beginning with that date, all children in custody had their mental health services paid through their medical card. Thus any medical or mental health services should be recorded in MMIS during this time and would not appear in SCRIPTS.

Findings

Incidence of Mental Health Services Provided to the Foster Care Population



Findings:

For children entering foster care:

- The number of children receiving MH services has remained about the same in the last three years studied (FY 2004-2006)
- The percentage of children entering foster care that received MH services was at 59% from FY 2003-2005 but decreased substantially in FY 2006

NOTE: Percent reported for FY 2006 may have been affected by the fact that children entering in FY 2006 would have had less time in which to receive mental health services.

Percent Children in Foster Care by Severity Groups And Year of Entering Care

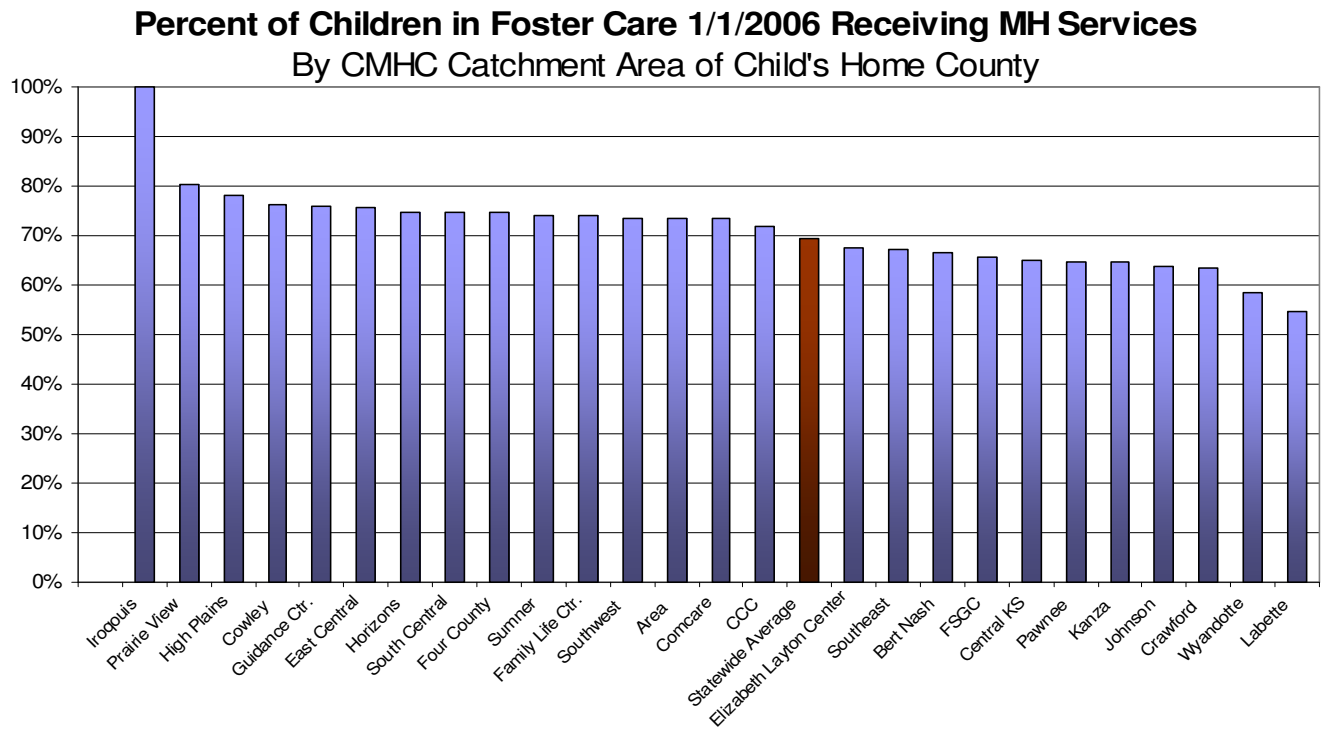
	FY 2003	FY 2004	FY 2005	FY 2006 (see note)
SED w/ CBS	25.4%	26.8%	25.9%	19.5%
SED no CBS	9.7%	11.0%	12.7%	11.5%
No SED	23.8%	21.4%	20.4%	20.3%
No MH Services	41.0%	40.8%	41.0%	48.7%
Total	100.0%	100.0%	100.0%	100.0%

NOTE: Percents reported for FY 2006 are likely affected by the fact that children entering in FY 2006 would have had less time in which to receive mental health services.

Findings:

- The percent of children in foster care qualifying as SED/CBS decreased in FY 2006 while children "SED no CBS" and "Not SED" but receiving services showed little change.
- Percent of children in foster care not receiving MH services grew in FY 2006 even though the numbers provided MH services was about the same (see chart above).

NOTE: Percents reported for children entering foster care in FY 2006 receiving MH services may have been affected by the fact that children entering in FY 2006 would have had less time in which to receive mental health services.

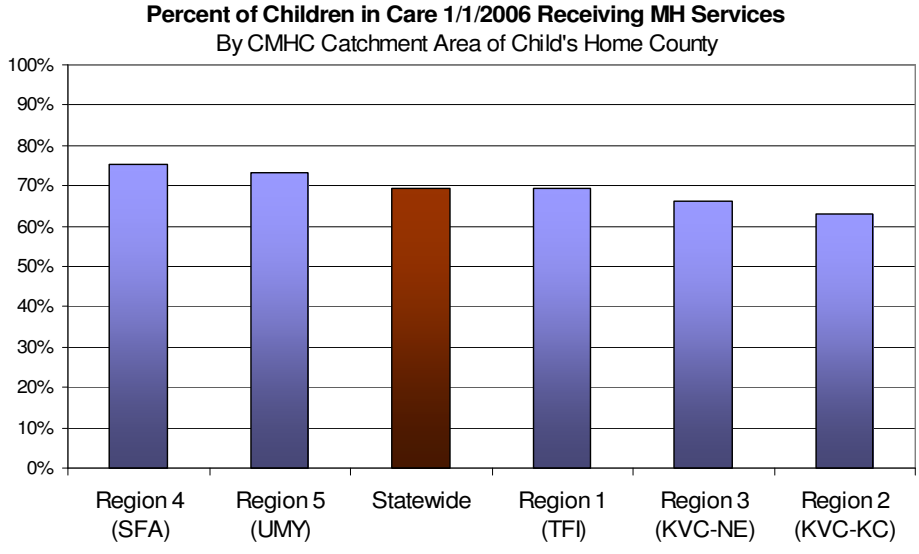


Findings: (see Attachment B)

Of children that were in foster care on January 1, 2006 in each of the CMHC catchment areas:

- The percent receiving MH services ranged from 80% in Prairie View to 54% in Labette areas.

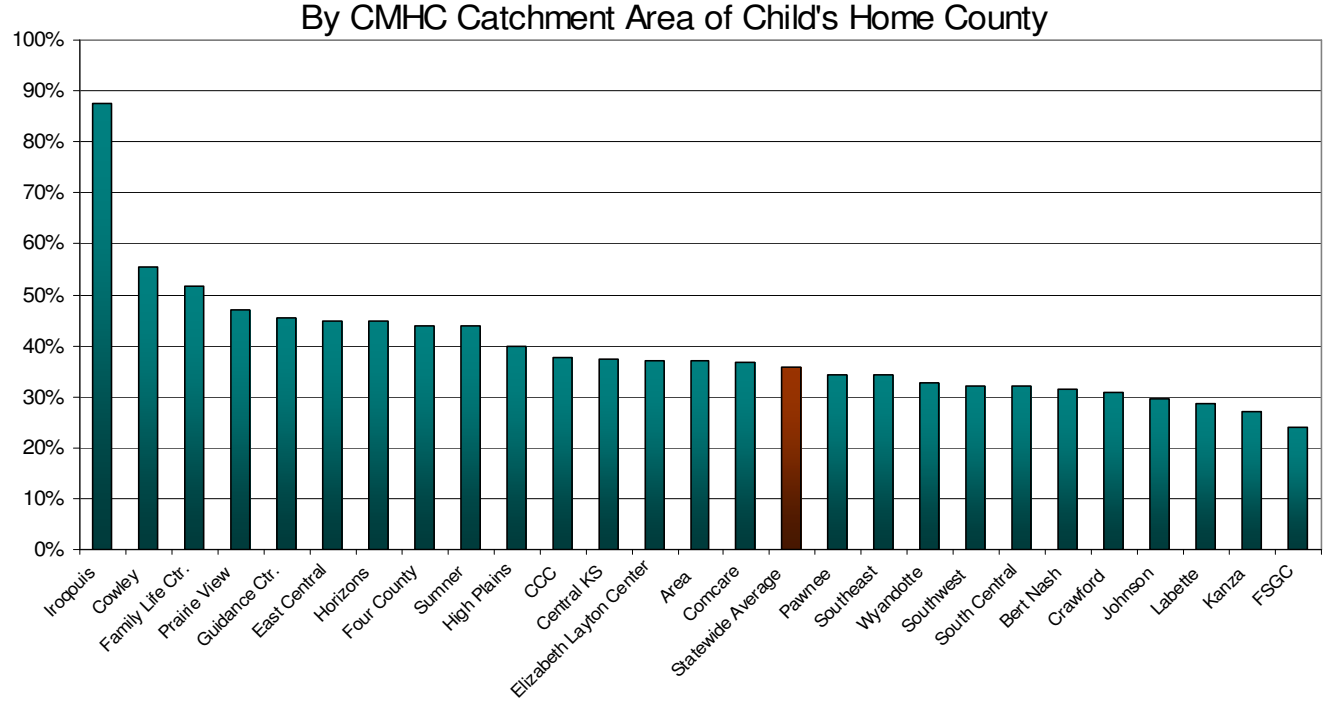
NOTE: Iroquois CMHC area had too few children in foster care to draw any conclusions.



Findings: (see Attachment C)

Of children in foster care on January 1, 2006:

- The percent receiving MH services was highest in SRS Region 4 West (76%) and lowest in SRS Region 2 KC Metro (63%).

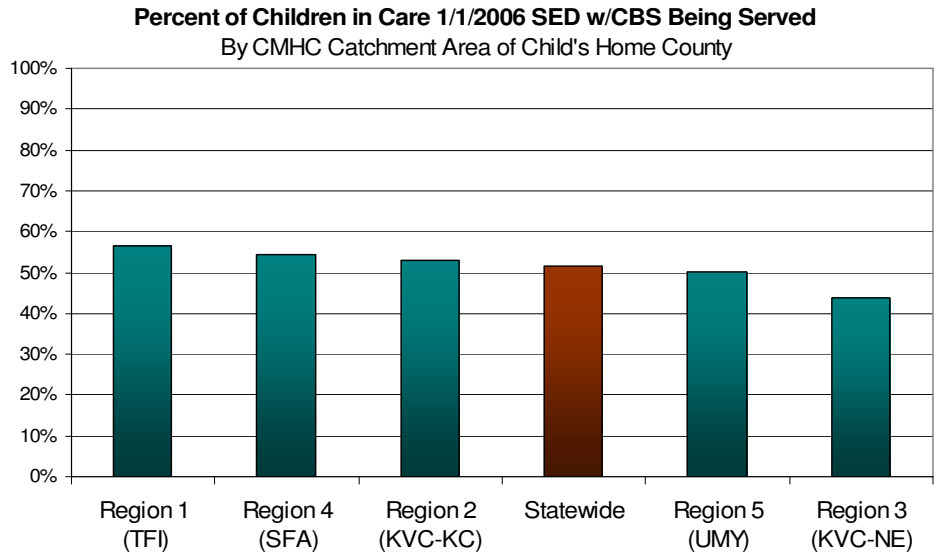


Findings: (see Attachment B)

Of children that were in foster care on January 1, 2006:

- The percent of the foster care caseload classified as SED/CBS ranged from 56% in Cowley CMHC to 24% at Family Service and Guidance (less than half the incidence than Cowley).

NOTE: Iroquois CMHC area had too few children in foster care to draw any meaningful conclusions.

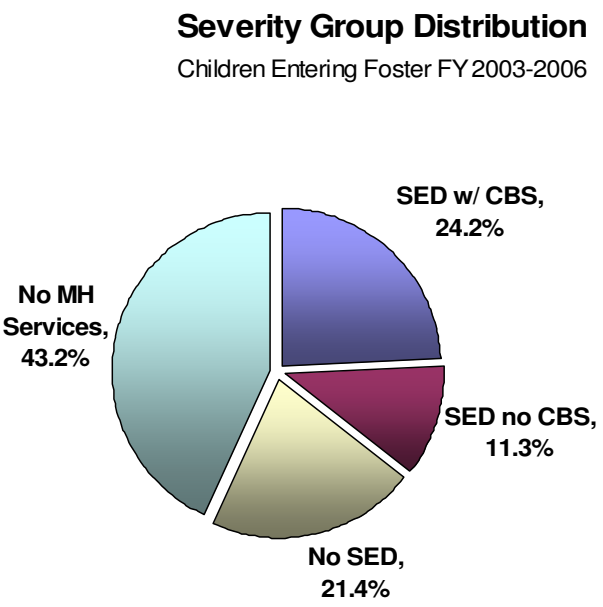


Findings: (see Attachment C)

Of children in foster care on January 1, 2006:

- The percent of the foster care caseload that was SED/CBS ranged from 56% in SRS Region 1 Southeast to 44% in SRS Region 2 KC Metro.

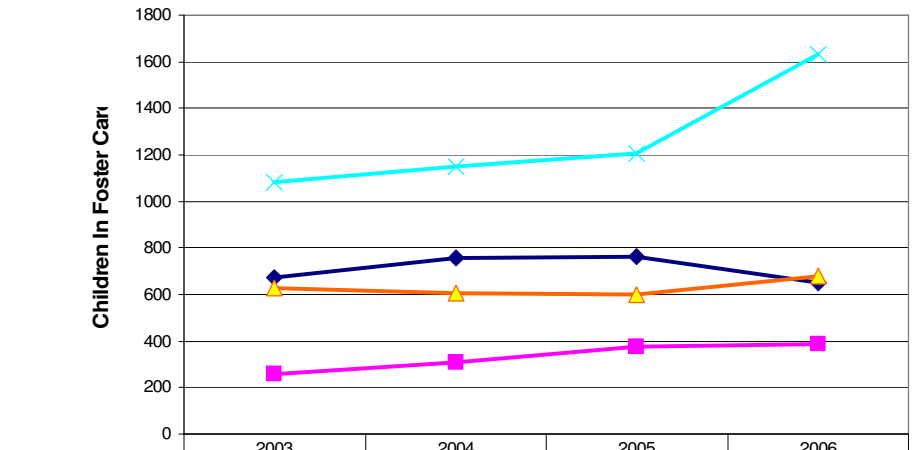
Severity Group Distribution



Findings:

Of all the children who entered foster care over the four years studied:

- 43% received no mental health services while in care.
- 24% of children were classified as SED/CBS
- 11% received services were SED but without CBS
- 21% of children in care who received Mental Health services were not SED.



	2003	2004	2005	2006
SED w/ CBS	671	755	760	652
SED no CBS	257	311	373	387
No SED	628	604	599	681
No MH Services	1082	1152	1205	1631

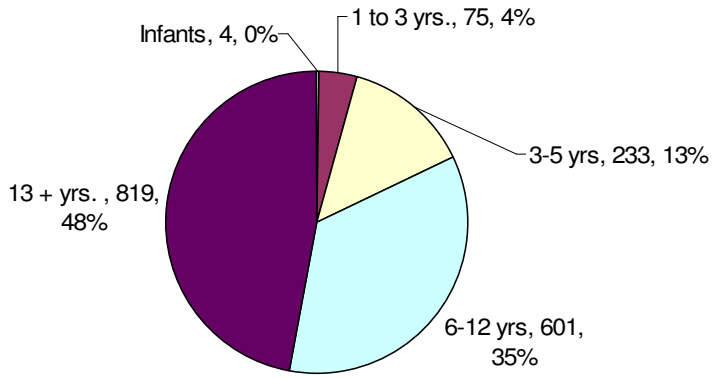
Findings

Of all the children who entered foster care over the four years studied:

- The number receiving MH services increased from 1,556 in FY 2003 to 1,720 in FY 2006
- The number not receiving MH services increased from 1,082 in FY 2003 to 1,631 in FY 2006
- The largest gain in number of children receiving MH services among severity groups was SED no CBS.
- Fewer numbers in the SED/CBS group were served.

Age Distribution

Age Distribution of Children Entering Foster Care in FY 2005 Who Received Mental Health Services

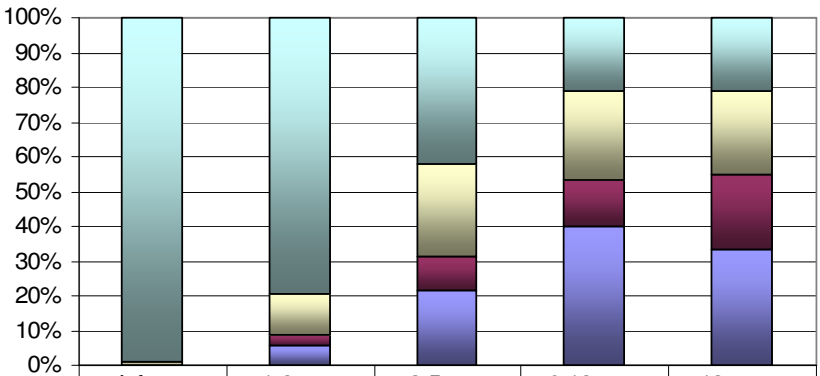


Findings:

Of children who entered foster care in FY 2005 and received MH services:

- Nearly half of those receiving MH services were adolescents.
- Very few (79) children under the age of 3 received MH services.
- 35% were ages 6-12 and 13% were ages 3-5.

Percentage of Children in Foster Care by Age and Severity Groups (Children Entering FC in FY 2005)



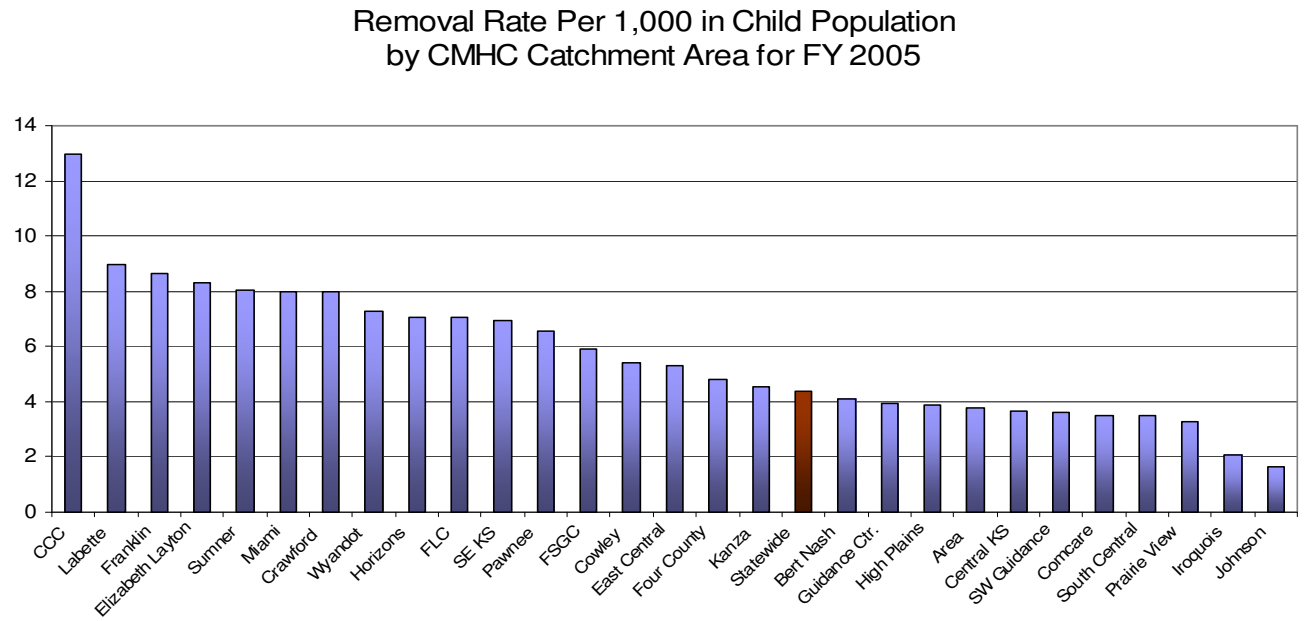
	Infants	1-2 yrs.	3-5 yrs.	6-12 yrs.	13+ yrs.
No MH Services	99%	80%	42%	21%	21%
No SED	1%	12%	27%	26%	24%
SED no CBS	0%	3%	9%	13%	22%
SED w/ CBS	0%	5%	22%	40%	34%

Findings

Of children entering care in FY 2005:

- Nearly 80% of children 6 years of age or more received MH services.
- Close to 60% of the 3-5 age group received MH services compared to 20% for 1-2 yrs and 1% for infants.
- The highest proportion of SED/CBS within age groups was the 6-12 years.
- 13 years or more, 22% were in the SED no CBS but receiving services, proportionally higher than the other age groups.

Out-of-Home Removal Rates

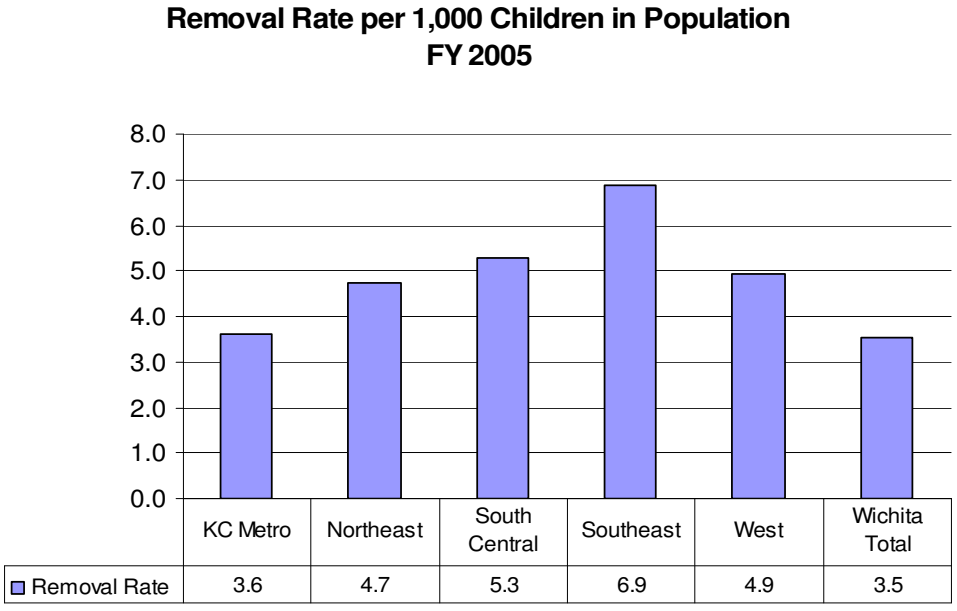


Findings: (see Attachment D)

- Rates of removal varied greatly across the state in FY 2005 from 13 per 1,000 in the child population from the CCC catchment area to 1.7 per 1,000 from Johnson County CMHC catchment area.

NOTES:

- Removal rates are based on the number of removals in FY 2005 per 1000 in the child population
- Children in foster care were assigned to mental health centers based on their permanent residence rather than where they were placed or receiving services.

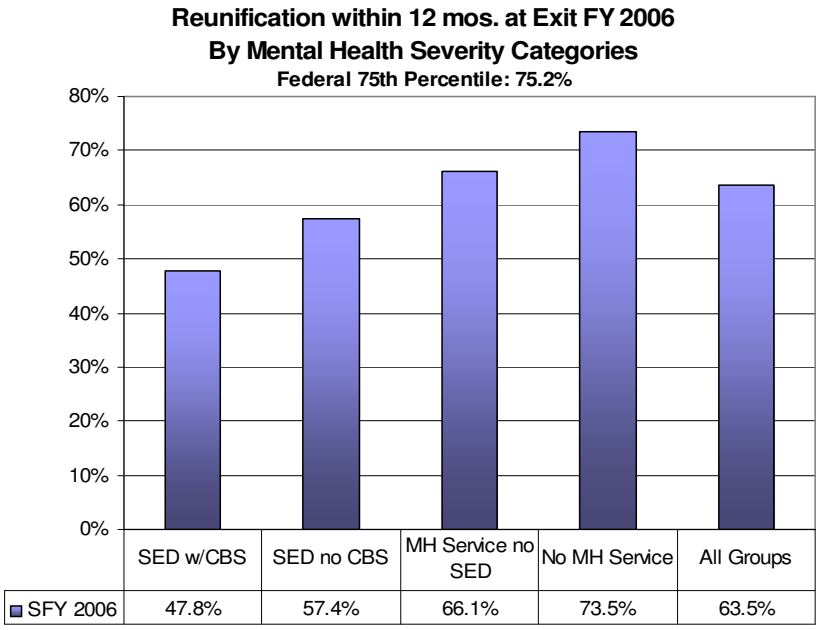


Findings

For children placed in foster care (removed) in FY 2005

- The rate at which children were removed per 1,000 in the child population ranged from 3.5 in Sedgwick (Wichita) to 6.9 in the Southeast SRS Region, nearly twice the rate.

Outcome Performance: Reunification

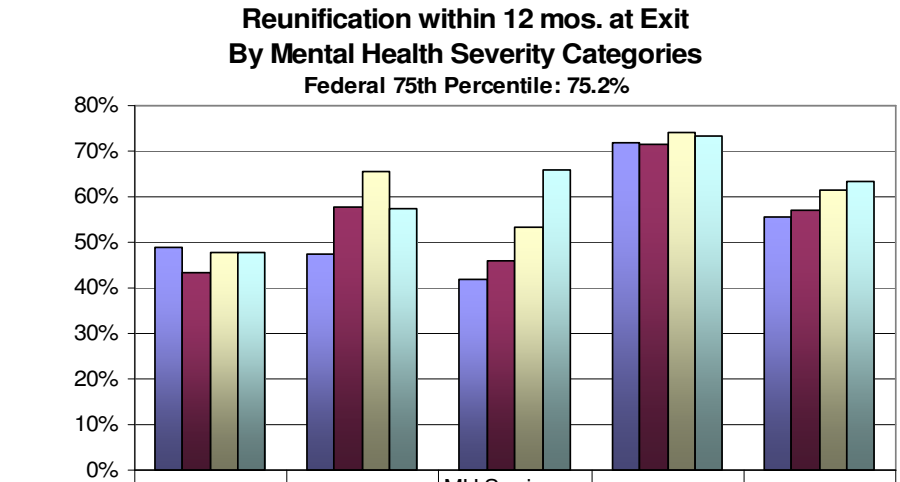


Findings

Of the children exiting to reunification (in FY 2006), the percent achieving reunification in within 12 months

- Was the lowest for children identified as SED/CBS
- Was highest (best) for children who did not receive any mental health service

NOTE: See Attachment E for results by CMHC for FY 2006

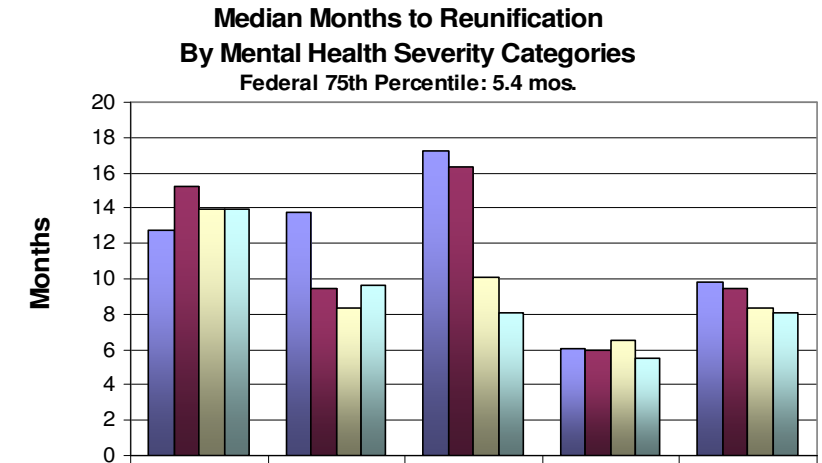


	SED w/CBS	SED no CBS	MH Service no SED	No MH Service	All Groups
SFY 2003	48.90%	47.50%	41.70%	72.00%	55.70%
SFY 2004	43.40%	57.80%	45.80%	71.60%	57.20%
SFY 2005	47.90%	65.40%	53.40%	74.20%	61.40%
SFY 2006	47.80%	57.40%	66.10%	73.50%	63.50%

Findings:

Of the children exiting to reunification (by year of exit), the percent achieving reunification in within 12 months:

- Increased statewide each year
- Was consistently the lower for children identified as SED/CBS
- Was the highest (best) for children who did not receive any mental health service
- Substantially increased (better) for children who received MH services but were not SED

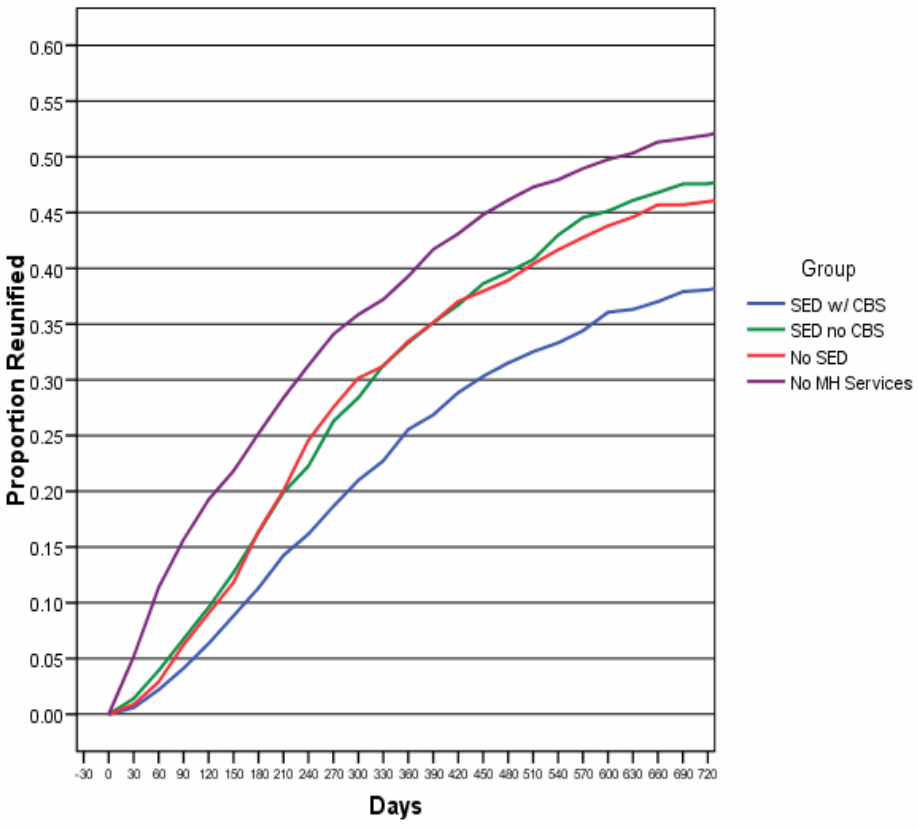


	SED w/CBS	SED no CBS	MH Service no SED	No MH Service	All Groups
SFY 2003	12.8	13.8	17.3	6.0	9.8
SFY 2004	15.2	9.5	16.4	6.0	9.4
SFY 2005	14.0	8.3	10.1	6.5	8.4
SFY 2006	14.0	9.6	8.1	5.6	8.1

Findings

Of the children exiting to reunification (by year of exit), the median number of months in care at exit:

- Declined (improved) each year over the four years studied.
- Improved the greatest for children receiving MH services but not SED
- Was the lowest (best) for children that did not receive MH services.
- Increased (got worse) for children SED/CBS after FY 2003 but improved from FY 2004 to FY 2005 and 2006

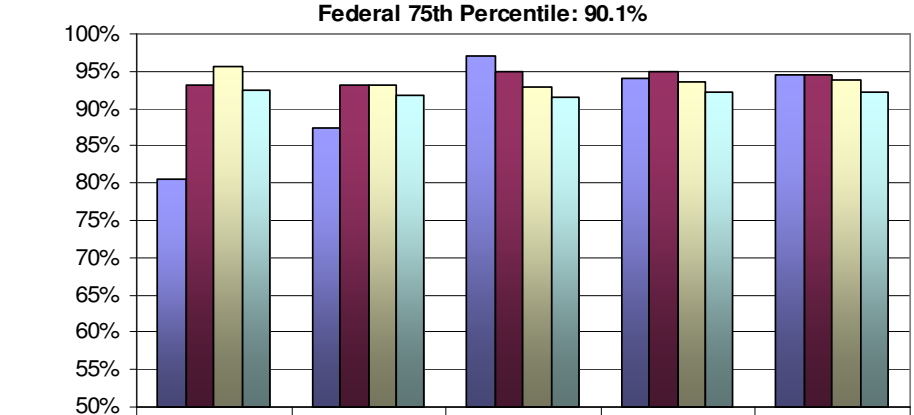


Findings

The proportion of children achieving reunification by time to reunification (in 30 day increments)

- Was best (higher proportion over time) for the children in foster care with no MH services.
- Was longest for children assessed as SED/CBS
- Was about the same for children receiving MH services assessed as not SED and children SED no CBS

Outcome: Maintain Permanency (no re-entry in foster care)



	SED w/CBS	SED no CBS	MH Service no SED	No MH Service	All Groups
SFY 2003	80.60%	87.50%	97.00%	94.10%	94.60%
SFY 2004	93.20%	93.20%	94.90%	94.90%	94.50%
SFY 2005	95.60%	93.20%	93.00%	93.60%	93.90%
SFY 2006	92.40%	91.70%	91.60%	92.30%	92.10%

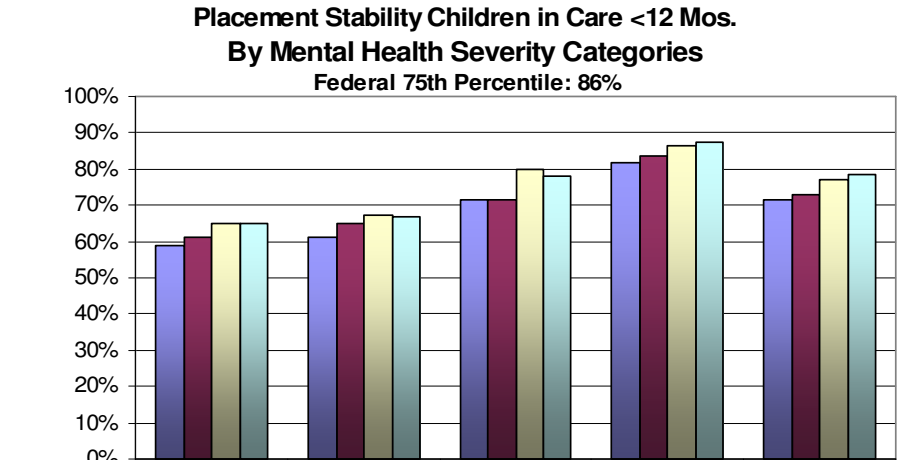
Findings:

For children exiting foster care, the percent for which permanency was maintained (no re-entry)

- Declined slightly (worse) each of the four years but well over federal expectation.
- Was about the same for all MH severity groups in 2006

NOTE: See Attachment F for results by CMHC for FY 2006

Outcome: Placement Stability



	SED w/CBS	SED no CBS	MH Service no SED	No MH Service	All Groups
SFY 2003	58.70%	61.10%	71.70%	82.00%	71.60%
SFY 2004	61.30%	65.00%	71.30%	83.70%	73.10%
SFY 2005	65.00%	67.40%	79.90%	86.50%	77.00%
SFY 2006	64.80%	66.60%	78.00%	87.40%	78.30%

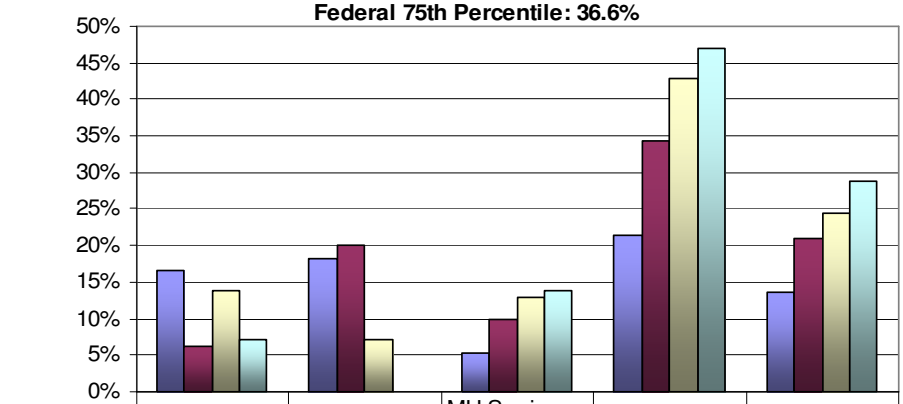
Findings

For children in care less than 12 months as of the last day of each federal fiscal year, the percent with two or fewer placements:

- Improved each year over the four years for all children in foster care.
- Improved each year for all MH severity groups.
- Was the lowest for children receiving MH services identified as SED/CBS and SED no CBS.

NOTE: See Attachment G for results by CMHC for FY 2006

Outcome: Adoption



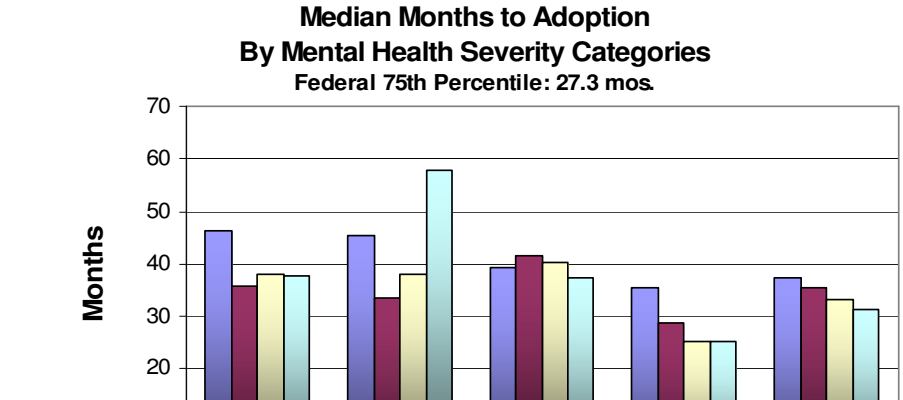
	SED w/CBS	SED no CBS	MH Service no SED	No MH Service	All Groups
SFY 2003	16.70%	18.20%	5.30%	21.50%	13.60%
SFY 2004	6.30%	20.00%	9.90%	34.40%	21.00%
SFY 2005	13.80%	7.10%	13.00%	42.90%	24.50%
SFY 2006	7.10%	0.00%	13.80%	46.90%	28.90%

Findings

For children adopted each year, the percent that were adopted in less than 24 months:

- Improved overall each year over the four years
- Improved the most and was the highest for children that did not receive MH services.
- Was zero percent for children SED no CBS (small n or 10).
- Was the lowest in FY 2006 for children identified as SED/CBS

NOTE: See Attachment H for results by CMHC for FY 2006



	SED w/CBS	SED no CBS	MH Service no SED	No MH Service	All Groups
SFY 2003	46.5	45.4	39.2	35.4	37.5
SFY 2004	35.7	33.6	41.4	28.7	35.6
SFY 2005	38.2	37.9	40.3	25.3	33.4
SFY 2006	37.8	57.9	37.5	25.2	31.4

Findings

For children adopted each year, the median number of months to adoption:

- Improved each year over the four years for all children.
- Improved the most and was the lowest (best) for children that did not receive MH services.
- Was the highest (worst) for children identified as SED no CBS.

Discussion of Data Analysis

Prevalence of MH Services in Foster Care Population

Of those children entering foster care in the four years studied (FY 2003-2006) 57% received mental health services during the time they were in foster care. Consistently over the last three years (FY 2004-2006) around 1,700 of the children entering foster care (FC) each year received mental health services while in care. For children entering care in FY 2006, there was a decrease in percentage of children that received MH services, however, the number of children receiving mental health services was about the same as the prior two years. With more children entering foster care in FY 2006 the lower percentage receiving MH services could be an artifact of children not being in care long enough for the data to capture those services compared to children entering in prior years.

In addition to analyzing mental health service participation rates by the year children entered foster care (entry cohorts), researchers looked at the percentage of children in foster care on January 1, 2006 to measure the prevalence of children in care who had received MH services while they were in care. This point-in-time analysis revealed that 69.3% of children in foster care had received mental health services. This analysis yielded a somewhat higher percentage than the entry cohort analysis because the point-in-time analysis would have a larger proportion of children in foster care for longer periods of time.

Using the point in time measure, researchers noted substantial differences in MH service participation rates among mental health center catchment areas[6] (ranging from 54% to 80%) and Child Welfare Provider regions (ranging from 63% to 76%). Attachment B provides the participation levels for each CMHC for each severity group. A greater disparity between CMHCs was noted for rates of SED/CBS (24% to 56%). Child welfare providers ranged from 44% (Region 2, KC Metro) to 56% (Region 1, Southeast Kansas).

[6] Children in foster care were reported by the mental health center catchment areas based on the child's county of permanent residence not county in which they were placed.

Severity levels were analyzed for their prevalence in the foster care population. The three categories where children received MH services: 24.2% were SED/CBS, 11.3% were SED w/no CBS, and 21.4% were not SED (totaling the 57% presented above). Note that this also includes infants and toddlers.

MH service participation rates looked quite difference for the various age categories. For children entering care in FY 2005, close to 80% (FY 2005) of Adolescents (over 13) and ages 6-12 years received MH services. Nearly 60% of pre-school children (ages 3-5 years) received MH services. Of all children entering care in FY 2005, 34% of the adolescents and 40% of the 6-12 year age group were in the SED/CBS category. Nearly half (48%) of the foster care population receiving MH services were adolescents.

Foster Care Removal Rates

Out-of-home removal (foster care) rates were calculated per 1,000 in the child population. While foster care placement is a more complex phenomena, a removal rate can be seen as an indicator of foster care prevention efforts of which CMHCs can play an important role. Rates for SRS Regions ranged from 3.5 per 1,000 in the Wichita Region to 6.9 in the Southeast Region. Wide variance was also noted between mental health catchment areas ranging from 1.7 per 1,000 child population in Johnson County to 13 per 1,000 in the CCC (Great Bend) area.

Outcomes: Reunification

Four outcomes were calculated for children in foster care who received MH services: timely reunification, maintain permanency (no-re-entry), placement stability and timely adoption. Outcome measures were reported by severity groups. Researcher sought to provide the most recent data the measure would reasonably allow. Three different approaches to measuring timely reunification were used, and two measures were used for timely adoption.

The SED/CBS population consistently showed the lowest rates of timely reunification. For children with SED/CBS exiting to reunification, only 48% achieved reunification in 12 months compared to 64% for all children in foster care. The SED/CBS severity group consistently took longer to reunify than all other groups receiving MH services as well as those not receiving MH services (74%). There was little change in this outcome for this group over the four years studied. In addition to reunification in 12 months (based on children exiting), the same patterns showed up in "median months to reunification" measure, and the event history (survival) analysis based on entry cohorts. The event history analysis showed that 75% of SED/CBS children were still in foster care one year after entering care.

Given that the SED/CBS group is the highest severity level, the lower timely reunification results are not surprising. At the same time, it would appear that the more intensive services provided by CBS are not offsetting the additional challenges surrounding these children and their families in achieving timely reunification at rates equal to that of other children in foster care.

Outcome: Maintain Permanency

Once children achieve permanency (e.g. reunification, guardianship, adoption), very few re-enter foster care. Kansas substantially exceeds federal expectations on this measure. This is also true for the SED/CBS population. There were very few differences between the severity groups measured on this outcome and were within 1% of each other in FY 2006. Permanency was maintained for the SED/CBS in FY 2006 in 92.4% compared to 92.1% for all children leaving foster care. In contrast to the reunification rates, MH services may be offsetting the greater needs of this population.

Outcome: Placement Stability

Placement stability (2 or fewer placement settings) was measured only for children in foster care less than 12 months. The higher the severity level the less placement stability. In FY 2006, the following percent of children achieved stability by severity group: SED/CBS 64.8%, SED no CBS 66.6%, MH

service no SED 78%, and No MH Services 87.4%. Overall, placement stability improved over the four years studied and this pattern was similar in each severity level.

Outcome: Adoption

Adoption was measured by looking at those children who were adopted. One measure used the percent of children adopted in less than 24 months while the other used a median months to adoption. In general, children receiving MH services were far less likely to achieve timely adoption than children not receiving mental health services. In FY 2006 children adopted achieved adoption in less than 24 months as follows: SED/CBS (7.1%), SED No CBS (0%), MH Service no SED (13.8%) and No MH service (46.9%).

Most importantly, it appears that children SED/CBS or SED no CBS are not getting adopted. Over the four years studied (FY 2003-2006), only 79 of the 2,329 adoptions (5.6%) were children that were SED/CBS. Comparatively children identified as SED/CBS comprise 24.2% of the foster care population. The same is true for children identified as SED no CBS who represent 11.3% of the foster care population but only 2.0% of the children adopted. These disparities are concerning.

These results show limitations of the adoption measures for use as a shared outcome. Twenty of the twenty-six mental health center catchment areas had fewer than 10 adoptions for children that received mental health services during FY 2006. These numbers are so small that it is difficult to draw any meaningful conclusions. Likewise, one of the peculiarities of the adoption and reunification measures is that children have to achieve the outcome of adoption or reunification in order to be counted by the measure (referred to as exit measures). Entry cohort measures, particularly used in event history analysis, offer a more realistic measure of outcomes.

Proposed Next Steps

The Partnership Plan represents a positive step forward in improving mental health services to a significant at-risk population - children and families that have come to the attention of Child Welfare in Kansas. The stated goal is to create a seamless service delivery system so that these children and families receive core required medically necessary mental health services. Now that the key components to partnering have been identified, a natural next step centers on the development of quality assurance activities to determine to what extent partnering is occurring around this shared consumer population.

The Plan articulates procedural aspects to service coordination, agency level coordination, and expected outcomes. A listing of the specific terms in the Partnership Plan that could be subject to measurement (see Attachment I) was reviewed at the April 3, 2007 Steering Committee meeting. This listing also includes which of two methods could be used for monitoring or evaluation each item. For direct consumer service items, either case review or data analysis were indicated as possible methods, and for administrative or agency coordination, either on-site review or data analysis was indicated.

There is much detail stated in the Partnership Plan on case level coordination covering such procedures as: referral; case/treatment planning; assessment; and communications both formal (e.g. reports) and informal (e.g. child updates). Roles and responsibilities were explicated for each of these areas of service coordination for cases. To adequately determine if these procedures are being followed would largely require a review of case records. The Steering Committee has stated a preference for limiting the number of items to be monitored given the other outcomes that are already being monitored and that adherence to these procedures be integrated into existing quality assurance systems as appropriate.

The Partnership Plan articulates a number of outcomes and criteria for accessing timely services. Further the Plan states that a set of shared outcomes would be developed based on an analysis of

outcomes for which there was available data. If implemented, this may be the first time anywhere in the country that these traditionally separate social service systems establish a set of shared outcomes for a set of children concurrently served in order to reinforce this important partnership.

This report provides information that can be used to inform the development of a set of shared outcomes and key performance indicators for the partnership between children's mental health and child welfare in Kansas. Both a policy level analysis of existing outcomes and a baseline analysis of a preliminary set of outcomes as identified by the Steering Committee has been provided in this report. Data are also presented on the rate at which children in foster care receive mental health services.

Proposed Next Steps

The Steering Committee has expressed interest in the ongoing measurement and analysis of this shared population of children with a specific focus on outcomes and key indicators for timely access to services. Adherence to a very limited set of procedures for case level coordination has been discussed for integration in existing quality assurance systems. The following are proposed next steps for establishing and reporting on shared outcomes, key service response measures, and other aspects of partnering:

1. Decide what outcomes and key service responses should be tracked on an ongoing basis that provides data on the effectiveness of the partnership.
2. Develop indicators and operational definitions for measuring various aspects identified in the Partnership Plan utilizing existing data to the extent data are or could be available.
    a. KU researchers would work with agency staff to define data requirements for selected indicators and data extracts needed to report on the outcomes and indicators chosen.
3. If data are not available for selected indicators, make recommendations on the modification of electronic databases or other data gathering mechanisms to secure needed data.

4. Make recommendations on alternative methods of evaluating other aspects of the Partnership Plan that are not possible within existing data or not amenable to quantitative analysis (e.g. revisions of existing quality assurance protocols, conduct surveys).
5. Analyze data and provide Partnership Status Reports as data become available.
6. Make recommendations to establish an ongoing mechanism for reporting ongoing performance of the mental health and child welfare partnership.

Further, it is proposed that the Steering Committee oversee the development of this system for accountability. The formation of a technical workgroup with people that are particularly knowledgeable of existing data (i.e. data definitions, quality of data), measurement, and creating data extracts would also inform this proposal.

The Steering Committee will meet on June 8, 2007 to review these proposed next steps designed to reinforce this important partnership for children and families in Kansas.

ATTACHMENT A
New Federal Child Welfare Outcome Indicators and Data Composites

Children are Protected from Abuse and Neglect

Of all children who were victims of a substantiated or indicated maltreatment allegation during the first 6 months of FY 2004, what percent were not victims of another substantiated or indicated maltreatment allegation within the 6-months following that maltreatment incident?

Of all children served in foster care in FY 2004, what **percent** were not victims of a substantiated or indicated maltreatment by a foster parent or facility staff member during the fiscal year?

Permanency Composite 1: Timeliness and Permanency of Reunification

Of all children discharged from foster care to reunification in FY 2004 who had been in foster care for 8 days or longer, what percent were reunified in less than 12 months from the date of the most recent entry into foster care? (This includes the "trial home visit adjustment.")

Of all children discharged from foster care to reunification in FY 2004 who had been in foster care for 8 days or longer, what was the median length of stay (in months) from the date of the most recent entry into foster care until the date of reunification? (This includes the "trial home visit adjustment.")

Of all children entering foster care for the first time in the second 6 months of FY 2003 who remained in foster care for 8 days or longer, what percent were discharged from foster care to reunification in less than 12 months from the date of the first entry into foster care? (This includes the "trial home visit adjustment.")

Of all children discharged from foster care to reunification in FY 2003, what percent re-entered foster care in less than 12 months from the date of discharge?

Permanency Composite 2: Timeliness of Adoptions

Of all children who were discharged from foster care to a finalized adoption in FY 2004, what percent were discharged in less than 24 months from the date of the most recent entry into foster care?

Of all children who were discharged from foster care to a finalized adoption in FY 2004, what was the median length of stay in foster care (in months) from the date of the most recent entry into foster care to the date of discharge?

Of all children in foster care on the first day of FY 2004 who were in foster care for 17 continuous months or longer, what percent were discharged from foster care to a finalized adoption before the end of the fiscal year?

Of all children in foster care on the first day of FY 2004 who were in foster care for 17 continuous months or longer, what percent became legally free for adoption (i.e., a termination of parental rights was granted for each living parent) in less than 6 months from the beginning of the fiscal year?

Of all children who became legally free for adoption (i.e., a termination of parental rights was granted for each living parent) during FY 2003, what percent were discharged from foster care to a finalized adoption in less than 12 months of becoming legally free?

Permanency Composite 3: Achieving permanency for children in foster care for long periods of time

Of all children who were discharged from foster care in FY 2004 and were legally free for adoption (i.e., there was a termination of parental rights for each living parent), what percent were discharged to a permanent home prior to their 18th birthday? A permanent home is defined as having a discharge reason of adoption, guardianship, or reunification (including living with relative).

Of all children in foster care for 24 months or longer on the first day of FY 2004, what percent were discharged to a permanent home prior to their 18th birthday and by the end of the fiscal year? A permanent home is defined as having a discharge reason of adoption, guardianship, or reunification (including living with relative).

Of all children who exited foster care with a discharge reason of emancipation prior to their 18th birthday or who reached their 18th birthday while in foster care, what percent were in foster care for 3 years or longer?

Permanency Composite 4: Placement stability

Of all children in foster care in FY 2004 who were in foster care for (a) 8 days or longer and (b) less than 12 months, what percent had two or fewer placement settings?

Of all children in foster care in FY 2004 who were in foster care for at least 12 months but less than 24 months, what percent had two or fewer placement settings?

Of all children in foster care in FY 2004 who were in foster care for at least 24 months, what percent had two or fewer placement settings?

Attachment B

Foster Care Caseload on January 1, 1006
By Mental Health Involvement and Severity Levels

Children from Mental Health Center Catchment Area	Received Mental Health Services			No MH Services	Total In Care	Total Received MH Services	% FC Caseload Received MH Services	% CW Caseload SED w/CBS
	SED w/CBS	SED No CBS	No SED					
Area	85	27	57	61	230	169	73.5%	37.0%
Bert Nash	32	16	20	34	102	68	66.7%	31.4%
Central KS	35	7	19	33	94	61	64.9%	37.2%
CCC	81	12	61	60	214	154	72.0%	37.9%
Cowley	35	2	11	15	63	48	76.2%	55.6%
Crawford	31	15	18	37	101	64	63.4%	30.7%
Four County	57	13	27	33	130	97	74.6%	43.8%
Elizabeth Layton Center	66	21	33	58	178	120	67.4%	37.1%
High Plains	53	26	25	29	133	104	78.2%	39.8%
Iroqouis	7	0	1	0	8	8	100.0%	87.5%
Johnson	110	52	74	135	371	236	63.6%	29.6%
Kanza	13	8	10	17	48	31	64.6%	27.1%
Horizons	128	43	43	72	286	214	74.8%	44.8%
East Central	66	20	25	36	147	111	75.5%	44.9%
Guidance Ctr.	79	28	25	42	174	132	75.9%	45.4%
Pawnee	63	28	28	65	184	119	64.7%	34.2%
Prairie View	48	9	25	20	102	82	80.4%	47.1%
Comcare	448	120	327	325	1220	895	73.4%	36.7%
South Central	24	7	25	19	75	56	74.7%	32.0%
Southeast	53	20	31	51	155	104	67.1%	34.2%
Southwest	17	9	13	14	53	39	73.6%	32.1%
Wyandotte	197	63	93	250	603	353	58.5%	32.7%
Labette	22	6	14	35	77	42	54.5%	28.6%
Family Life Ctr.	28	4	8	14	54	40	74.1%	51.9%
Sumner	39	11	16	23	89	66	74.2%	43.8%
FSGC	150	146	113	213	622	409	65.8%	24.1%
Statewide Average	1967	713	1142	1691	5513	3822	69.3%	35.7%

Attachment B (continued)

Percent of Foster Care Caseload on 1/1/2006 Receiving Mental Health Services From Highest Percentage to Lowest

Table A
Percent Children in Foster Care Receiving MH Services

Mental Health Center Catchment Area	% of FC Caseload Receiving MH Services
Iroqouis	100.0%
Prairie View	80.4%
High Plains	78.2%
Cowley	76.2%
Guidance Ctr.	75.9%
East Central	75.5%
Horizons	74.8%
South Central	74.7%
Four County	74.6%
Sumner	74.2%
Family Life Ctr.	74.1%
Southwest	73.6%
Area	73.5%
Comcare	73.4%
CCC	72.0%
Statewide Average	**69.3%**
Elizabeth Layton Center	67.4%
Southeast	67.1%
Bert Nash	66.7%
FSGC	65.8%
Central KS	64.9%
Pawnee	64.7%
Kanza	64.6%
Johnson	63.6%
Crawford	63.4%
Wyandotte	58.5%
Labette	54.5%

Table B
Percent Children in Foster Care SED w/CBS Receiving MH Services

Mental Health Center	% of FC Caseload SEDw/CBS
Iroqouis	87.5%
Cowley	55.6%
Family Life Ctr.	51.9%
Prairie View	47.1%
Guidance Ctr.	45.4%
East Central	44.9%
Horizons	44.8%
Four County	43.8%
Sumner	43.8%
High Plains	39.8%
CCC	37.9%
Central KS	37.2%
Elizabeth Layton Center	37.1%
Area	37.0%
Comcare	36.7%
Statewide Average	**35.7%**
Pawnee	34.2%
Southeast	34.2%
Wyandotte	32.7%
Southwest	32.1%
South Central	32.0%
Bert Nash	31.4%
Crawford	30.7%
Johnson	29.6%
Labette	28.6%
Kanza	27.1%
FSGC	24.1%

Attachment C

Percent of Foster Care Caseload on 1/1/2006 Receiving Mental Health Services From Highest Percentage to Lowest

Children from Mental Health Center Catchment Area	Received Mental Health Services			No MH Services	Total In Care	Total Received MH Services	% FC Caseload Received MH Services	% CW Caseload SED w/CBS
	SED w/CBS	SED No CBS	No SED					
Region 1 (TFI)	299	82	149	235	765	530	69.3%	56.4%
Region 2 (KVC-KC)	461	169	239	506	1375	869	63.2%	53.0%
Region 3 (KVC-NE)	300	206	181	352	1039	687	66.1%	43.7%
Region 4 (SFA)	459	136	246	273	1114	841	75.5%	54.6%
Region 5 (UMY)	448	120	327	325	1220	895	73.4%	50.1%
Statewide	1967	713	1142	1691	5513	3822	69.3%	51.5%

Table A
Percent Children in Foster Care Receiving MH Services

CWCBSP	% of Caseload
Region 4 (SFA)	75.5%
Region 5 (UMY)	73.4%
Statewide	69.3%
Region 1 (TFI)	69.3%
Region 3 (KVC-NE)	66.1%
Region 2 (KVC-KC)	63.2%

Table B
Percent Children in Foster Care SED w/CBS Receiving MH Services

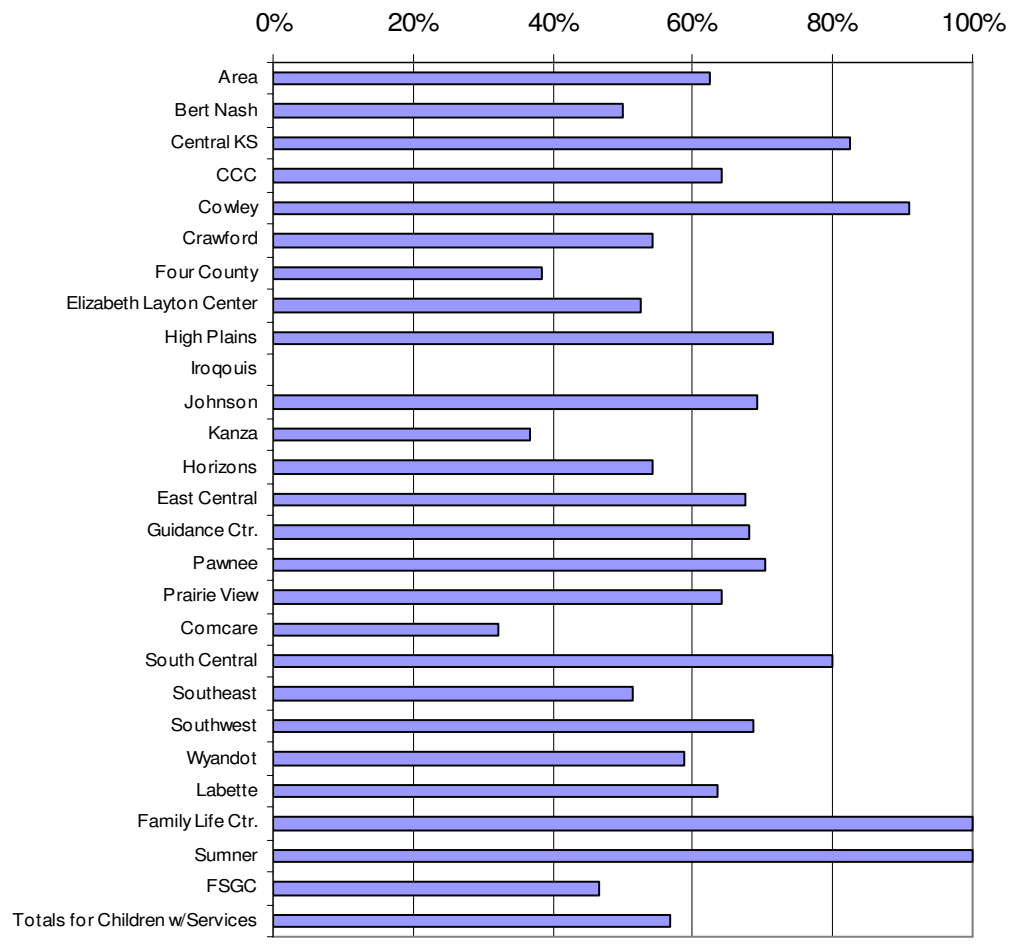
CWCBSP	% of Caseload
Region 1 (TFI)	56.4%
Region 4 (SFA)	54.6%
Region 2 (KVC-KC)	53.0%
Statewide	51.5%
Region 5 (UMY)	50.1%
Region 3 (KVC-NE)	43.7%

Attachment D

Foster Care Removal Rates Per 1000 in Child Population by CMHC Catchment Center

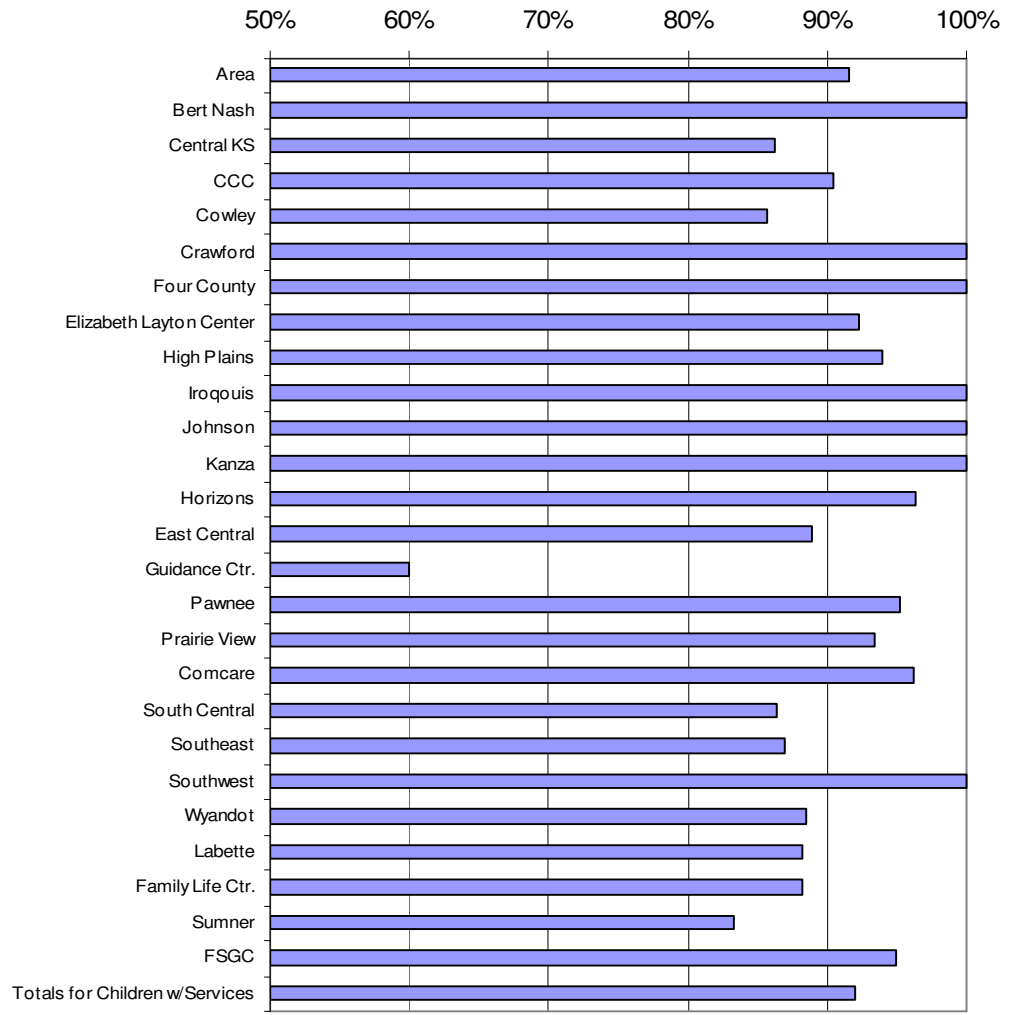
7/1/04 Census Est. Child Pop (17 and under)	CMHC Catchment Area	# of all Removal Episodes 2005	2005 All Removal Episode Rate per 1,000 child pop	# of NAN Removal Episodes 2005	2005 NAN Removal Episode Rate per 1,000 child pop	# of A/N Removal Episodes 2005	2005 A/N Removal Episode Rate per 1,000 child pop
34152	Area	128	3.7	37	1.1	91	2.7
19599	Bert Nash	80	4.1	30	1.5	50	2.6
11418	CCC	148	13.0	63	5.5	85	7.4
21039	Central KS	77	3.7	44	2.1	33	1.6
126187	Comcare	445	3.5	129	1.0	316	2.5
8717	Cowley	47	5.4	13	1.5	34	3.9
8280	Crawford	66	8.0	29	3.5	37	4.5
19981	East Central	106	5.3	52	2.6	54	2.7
14112	Elizabeth Layton	117	8.3	35	2.5	82	5.8
5396	FLC	38	7.0	18	3.3	20	3.7
12053	Four County	58	4.8	31	2.6	27	2.2
41863	FSGC	248	5.9	78	1.9	170	4.1
26544	Guidance Ctr.	104	3.9	53	2.0	51	1.9
21808	High Plains	85	3.9	57	2.6	28	1.3
21114	Horizons	149	7.1	87	4.1	62	2.9
2390	Iroquois	5	2.1	3	1.3	2	0.8
127012	Johnson	210	1.7	185	1.5	25	0.2
10338	Kanza	47	4.5	17	1.6	30	2.9
5363	Labette	48	9.0	28	5.2	20	3.7
1974	Pawnee	13	6.6	4	2.0	9	4.6
17585	Prairie View	58	3.3	36	2.0	22	1.3
15397	SE KS	107	6.9	55	3.6	52	3.4
15715	South Central	55	3.5	28	1.8	27	1.7
6465	Sumner	52	8.0	19	2.9	33	5.1
11564	SW Guidance	42	3.6	21	1.8	21	1.8
43966	Wyandot	320	7.3	122	2.8	198	4.5

Attachment E



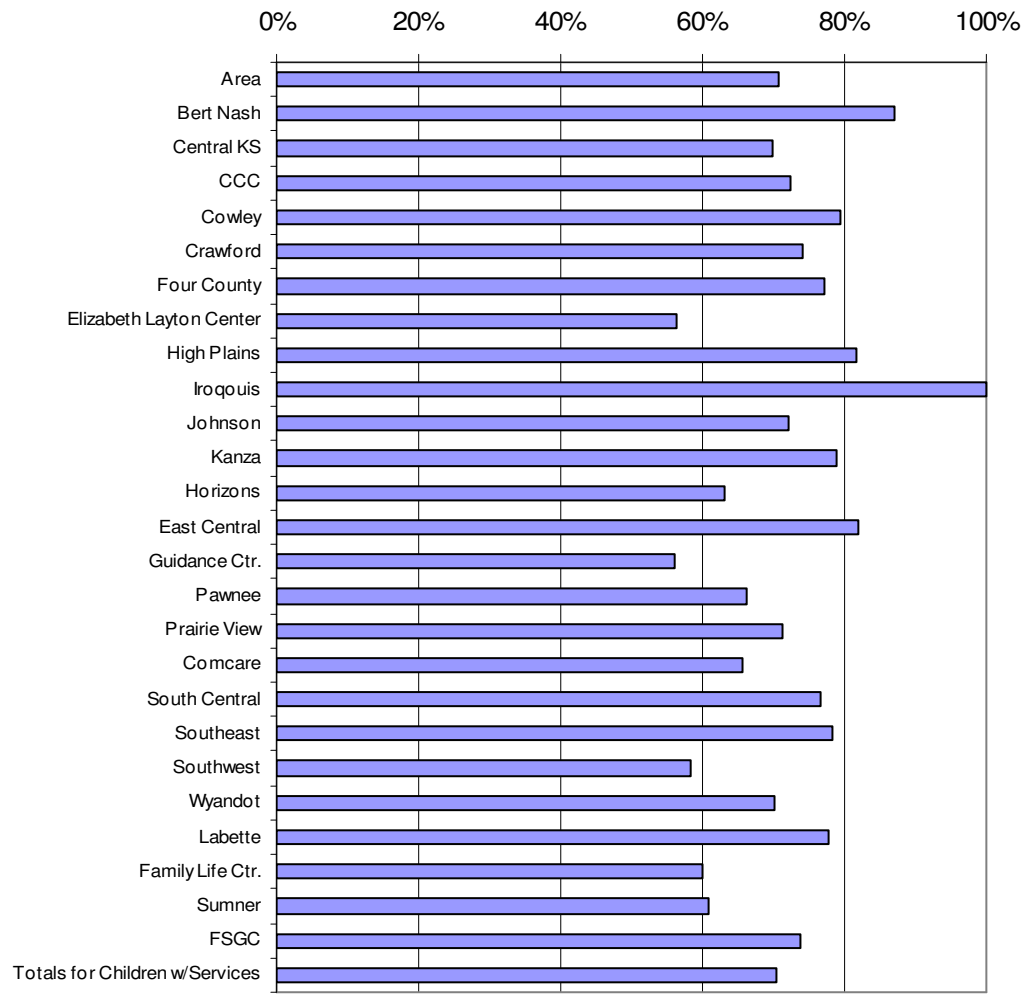
	Reunified	Less than 12 mos.	% < 12 mos.
Area	40	25	62.5%
Bert Nash	8	4	50.0%
Central KS	17	14	82.4%
CCC	53	34	64.2%
Cowley	11	10	90.9%
Crawford	24	13	54.2%
Four County	13	5	38.5%
Elizabeth Layton Center	40	21	52.5%
High Plains	42	30	71.4%
Iroqouis	1	0	0.0%
Johnson	52	36	69.2%
Kanza	19	7	36.8%
Horizons	59	32	54.2%
East Central	46	31	67.4%
Guidance Ctr.	25	17	68.0%
Pawnee	27	19	70.4%
Prairie View	25	16	64.0%
Comcare	143	46	32.2%
South Central	20	16	80.0%
Southeast	37	19	51.4%
Southwest	16	11	68.8%
Wyandot	68	40	58.8%
Labette	11	7	63.6%
Family Life Ctr.	8	8	100.0%
Sumner	5	5	100.0%
FSGC	71	33	46.5%
State Total	881	499	56.6%

Attachment F



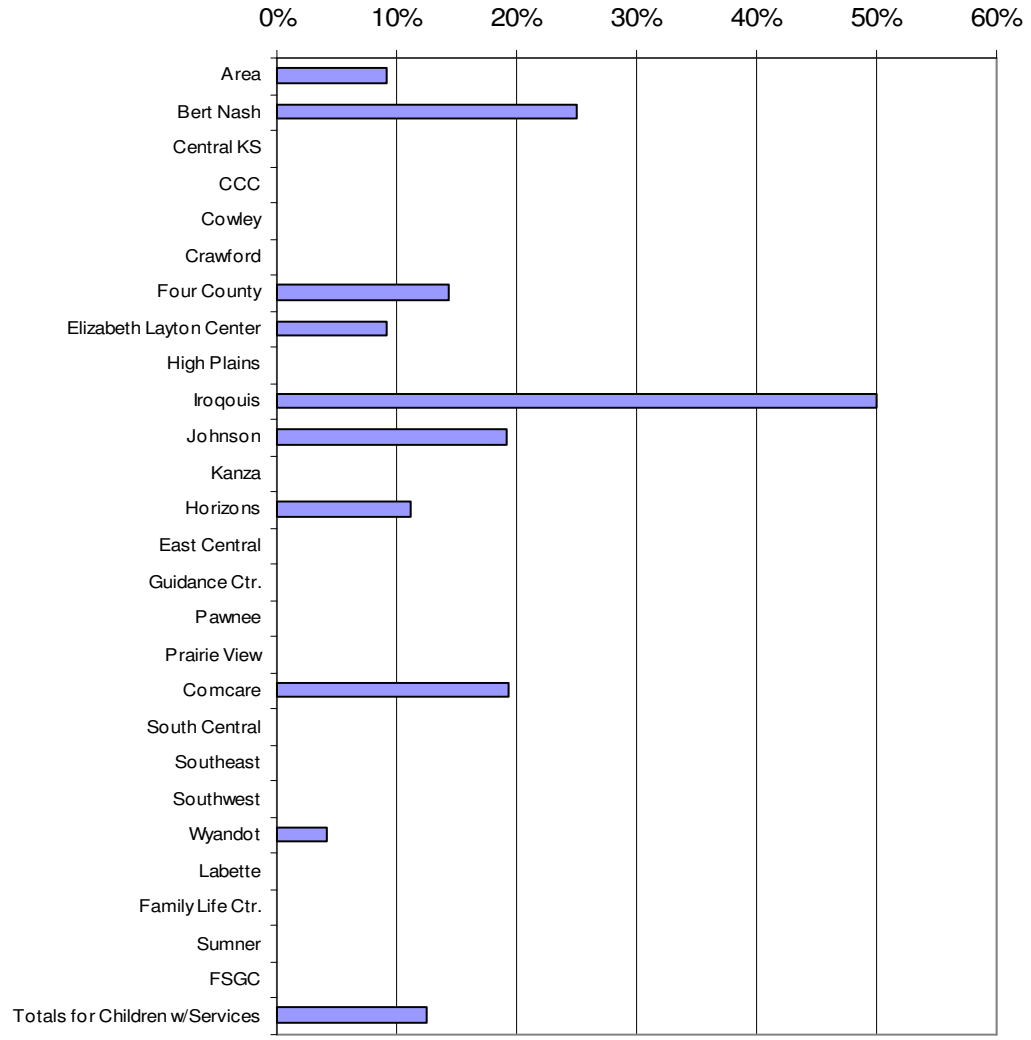
	Discharges	No Re-entry	% No Re-entry
Area	71	65	91.5%
Bert Nash	16	16	100.0%
Central KS	29	25	86.2%
CCC	42	38	90.5%
Cowley	14	12	85.7%
Crawford	19	19	100.0%
Four County	27	27	100.0%
Elizabeth Layton	13	12	92.3%
High Plains	33	31	93.9%
Iroqouis	1	1	100.0%
Johnson	46	46	100.0%
Kanza	4	4	100.0%
Horizons	54	52	96.3%
East Central	63	56	88.9%
Guidance Ctr.	30	18	60.0%
Pawnee	42	40	95.2%
Prairie View	30	28	93.3%
Comcare	159	153	96.2%
South Central	22	19	86.4%
Southeast	61	53	86.9%
Southwest	17	17	100.0%
Wyandot	61	54	88.5%
Labette	17	15	88.2%
Family Life Ctr.	17	15	88.2%
Sumner	18	15	83.3%
FSGC	60	57	95.0%
State Total	966	888	91.9%

Attachment G



	In Care	2 or fewer Settings	% 2 or fewer
Area	123	87	70.7%
Bert Nash	23	20	87.0%
Central KS	43	30	69.8%
CCC	109	79	72.5%
Cowley	39	31	79.5%
Crawford	58	43	74.1%
Four County	57	44	77.2%
Elizabeth Layton	62	35	56.5%
High Plains	93	76	81.7%
Iroqouis	2	2	100.0%
Johnson	118	85	72.0%
Kanza	19	15	78.9%
Horizons	127	80	63.0%
East Central	89	73	82.0%
Guidance Ctr.	89	50	56.2%
Pawnee	86	57	66.3%
Prairie View	59	42	71.2%
Comcare	284	186	65.5%
South Central	43	33	76.7%
Southeast	83	65	78.3%
Southwest	24	14	58.3%
Wyandot	127	89	70.1%
Labette	36	28	77.8%
Family Life Ctr.	25	15	60.0%
Sumner	46	28	60.9%
FSGC	172	127	73.8%
State Total	2036	1434	70.4%

Attachment H



	Adopted	< 24 mos.	% < 24 mos.
Area	11	1	9.1%
Bert Nash	4	1	25.0%
Central KS	1	0	0.0%
CCC	5	0	0.0%
Cowley	1	0	0.0%
Crawford	4	0	0.0%
Four County	7	1	14.3%
Elizabeth Layton	11	1	9.1%
High Plains	1	0	0.0%
Iroqouis	2	1	50.0%
Johnson	26	5	19.2%
Kanza	0	0	0.0%
Horizons	27	3	11.1%
East Central	1	0	0.0%
Guidance Ctr.	5	0	0.0%
Pawnee	9	0	0.0%
Prairie View	6	0	0.0%
Comcare	98	19	19.4%
South Central	2	0	0.0%
Southeast	2	0	0.0%
Southwest	0	0	0.0%
Wyandot	24	1	4.2%
Labette	5	0	0.0%
Family Life Ctr.	0	0	0.0%
Sumner	5	0	0.0%
FSGC	6	0	0.0%
State Total	263	33	12.5%

Attachment I
Framework for Evaluating MH-CW Partnership

Item to be Evaluated	Case Reviews	Data Analysis
Placement in least restrictive environment • Developmentally and clinically appropriate	**X**	**X**
Placement proximity		**X**
Bio parents, resource and permanency receive needed MH services	**X**	**X**
MH services provided in-home	**X**	

Access targets
• Emergent: (X% in X hours)
• Urgent (X% in X hours)
• Routine:
  • Assessment: (X% in X hours)
  • Treatment: (X% in X hours)
		X

CWCBSP screen children for MH and refer within 3 days	**X**	
Scheduling appointment protocol: • Send pages one and two Request for Initial MH form • At time of referral or by knowledgeable adult - Consent to treat; completed releases; financial forms; and medical or insurance card. • First appointment – knowledgeable person (phone or in person); social history; case plan; CINC petition; service team members contacts; journal entry for orders of MH services.	**X**	
Initial Assessment: • Accompanied by adult • Knowledgeable adult available • Information for intake 48 hrs. in advance	**X**	
Initial MH treatment report within 5 working days (2 days for emergent) with SED determination	**X**	**X**
MH treatment plan completed in 30 days (w/appropriate services to be provided) • Invited participants list • How services will support permanency plan	**X**	**X**
Treatment plan review every 90 days including key people in child's life and CWCBSP (must attend)	**X**	**X**
CWCBSP invites MH to child welfare case planning meetings (one must attend)	**X**	
Ongoing communication: • Child specific - who needed to participate in future appointments; child's progress at school, home and community; • Regular MH updates through the Service Utilization Report to CW • Frequent telephone and email contact – returned within 2 working days	**X**	

Item to be Evaluated	Case Reviews	Data Analysis
Contractual agreement among CMHCs and Associate Providers to exchange information and releases	**X**	
Transfer of cases assistance both within catchment area and between mental health centers	**X**	
Placement Moves • CW provide notice to MH in advance if possible for planned moves and within 48 hrs of unplanned move s • CW complete release of information with referral to new provider • Prior MH will coordinate care with new team in 48 hours of notification • Upon releases of information secured by CW, new MH contact home MH to notify child from its catchment area is receiving services, discuss coordination of services	**X**	
MH will complete clinical eligibility for SED Waiver	**X**	
Psychiatric appointments Knowledgeable adult available for all psychiatric appointments • information on previous medications and treatment available at initial appointment • CW notified when changes made in medications	**X**	
MH will respond to MH-related crises and CW respond to foster care related crisis or emergencies	**X**	
MH develop a prevention and crisis plan • Input from case stakeholders • Identify triggers, supports • Specify contacts for crisis • If screens in for hospital but is not available, CW and MH develop a plan to support the child	**X**	
At first entry MH will provide CW • Initial diagnoses • Services the child well receive • Treatment goals • List of medications	**X**	
Quarterly MH will provide to CW • List of services provided during time period • Treatment progress update/review • Attendance rating w/ narrative on why not attending • Diagnosis changes • Treatment plan changes and copy of treatment plan	**X**	
Interim reports if needed between quarterly • CW provide 10 day notification • If court needs in less than 10 days CW notifies MH same day • MH will provide information requested by court within time set	**X**	

Item to be Evaluated	Case Reviews	Data Analysis
CW will provide updated case plans within 10 days	**X**	
Inpatient Care/PRTF • MH provide liaison services to facilitate discharge planning • MH (CBST) family meetings held • CW notified • Ongoing work to facilitate timely discharge • Discharge plan in place at discharge	**X**	**X**
Discharge planning from MH services • CW coordinates changes in case plan to transition or terminate MH services • When permanency achieved, CW and MH will assist family secure resources to continue needed services	**X**	
Family Involvement • Parents asked for their input and assigned tasks and responsibilities • Involvement in treatment processes • Resource family asked for input and involved in therapy as appropriate • MH and CW identify needed MH services for biological parents if reunification is plan • MH and CW MH services needed for family in general • Coordinate MH services between treatment of child and family regardless of distance from placement	**X** **(Parent interviews, focus groups, or surveys)**	

Administrative and agency coordination	On-Site Review	Data
CW and MH Quarterly meetings to discuss administrative and case issues	X	
MH and CW share regularly update contact lists, email addresses, phone numbers, emergency contact numbers	X	
Designate one main contact person responsible for coordination of written and verbal information	X	
Use informal dispute resolution before formal	X	
Quality Assurance • CSR data on CW population • Problem solving Steering Committee • Involvement of MH and CW staff as needed • Use of resolution process • Track following Statewide Partnership Plan • Training and evaluation • Data tracking regarding all outcomes, benchmarks and access points	X	X

Other Analysis	Case Review	Data Analysis
Shared outcomes • Timely reunification • Timely adoption • Placement stability • Maintain permanency (no-re-entry • School attendance • Grades • Least restrictive environment		X
Timelines of MH services (See Figure 1 below) A. Time from removal to first referral to MH B. Time from first referral to intake? C. Time from intake to service (new or transfer cases)? D. Time from referral to services (new case, open case or transfers)? E. Time from placement in a new CMHC and referral to the CMHC?		X

Figure 1: Monitoring Partnership Plan Timelines