



THE LOUIS DE LA PARTE FLORIDA MENTAL HEALTH INSTITUTE



A Study of the Child Welfare Prepaid Mental Health Plan (CW-PMHP) Final Report

Amy Vargo, M.A.
Patty Sharrock, M.S.W.
Patricia Robinson, Ph.D.
Roger Boothroyd, Ph.D.
Sharon Lardieri, M.S.W.
Frank Reyes, A.A.
Rhonda Ort, B.A.
Mary Armstrong, Ph.D.



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**The Louis de la Parte
Florida Mental Health Institute**

University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807

For more information, call 813-974-5356
or visit the Website: <http://fmhi.usf.edu>

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List of Acronyms

ACF	Administration for Children and Families, US Department of Health and Human Services
AHCA	Agency for Health Care Administration
ASFA	Adoption and Safe Families Act
BHOS	Behavioral Health Overlay Services
CBC	Community-Based Care
CBCL	Child Behavior Checklist
CW	Child Welfare
CW-PMHP	Child Welfare Prepaid Mental Health Plan
DCF	Department of Children and Families
FCCBHN	Florida Coalition for Children Behavioral Health Network
HCFA	(Federal) Health Care Financing Administration
ITN	Intent to Negotiate
LTD	Limited
MCO	Managed Care Organization
NAMI	National Alliance on Mental Illness
PA	Prior Authorization
PMHP	(Medicaid) Prepaid Mental Health Plan
PMPM	Per Member Per Month
RFP	Request for Proposals
SD	Standard Deviation
SIPP	Statewide Inpatient Psychiatric Program
SPOC	Single Point of Contact

A Study of the Child Welfare Prepaid Mental Health Plan (CW-PMHP) Final Report

Executive Summary

In 2004, the Florida Legislature authorized Community-Based Care Lead Agencies to provide mental health services through a managed care organization to children who are in the child welfare system. This initiative represents a major and much anticipated shift in the way mental health services are financed for the child welfare population. Although the Child Welfare Prepaid Mental Health Plan (CW-PMHP) was just recently implemented, it is important to begin evaluation efforts early in the process to inform stakeholders of strengths and challenges in the system to aid in improvement of ongoing implementation work.

The purpose of this report is to provide an update on the implementation status of the CW-PMHP, which began implementation on February 1, 2007. Semi-structured interviews were conducted with national, state and local-level stakeholders in Citrus and St. Johns Counties. In addition, this report provides baseline data on access to mental health services for children in out-of-home care in St. Johns and Citrus Counties. The study will expand to include a more urban population over the coming months.

The CW-PMHP is being implemented via a contract AHCA awarded in 2006 to The CBC Partnership, which is an entity comprised of Magellan (a managed care organization [MCO]) and Community-Based Care of Seminole (a child welfare lead agency), as general partners and additional Community-Based Care lead agencies as limited partners. Despite an initial delay in implementation, the CW-PMHP is operating in several areas of the state and children are being served through this new managed care arrangement. It should be noted that this implementation is not really a statewide initiative in that Areas 1, 6, and 10 are currently excluded from the CW-PMHP.

Implementation Analysis

Findings indicate that AHCA and The CBC Partnership have worked closely to establish provider networks and work through eligibility issues. The majority of stakeholders generally felt that the transition to managed mental health care occurred more smoothly than anticipated. Initially, several providers were hesitant to join the network due to lack of information and uncertainty regarding managed care initiatives. However, both AHCA and The Partnership worked jointly to alleviate these concerns.

Communication mechanisms are in place to support frequent and ongoing dialogue between AHCA and The Partnership. Stakeholders indicated that The Partnership subcontracting with The Florida Coalition for Children for a full time position of State Project Director was extremely helpful in coordination efforts. The Partnership also has two staff assigned to different areas of the state to meet

with local CBCs and providers to help respond to problems and provide technical assistance. In addition, Magellan has employed two individuals who have personal experience with the child welfare system who are available to work with local families as well as providers in fostering the principles of recovery and resiliency. Trainings continue to be held with local-level agencies that have facilitated consistent communication about how the plan will operate.

Stakeholders also noted that there seemed to be better accountability for the mental health services that were being provided. Child welfare staff have more opportunity for input into treatment planning and an increased awareness of the services children and youth are receiving. The CBCs are provided feedback from the MCO as to the services that have been authorized and provided. Providers indicated that the provision of mental health services has not changed since pre-Plan implementation, including the way comprehensive assessments are done or the way in which families (including foster families) are involved in treatment planning.

A commonly identified challenge in implementation was having accurate and timely eligibility files. There are apparently significant discrepancies in the numbers of children in the HomeSafenet system and those that are shown as eligible in the Medicaid files. Receiving accurate eligibility information is complicated by the fact that children are enrolled and dis-enrolled as they enter and exit different parts of the treatment system (e.g., the SIPP or BHOS) or as they enter and exit care. The impact of these challenges has reportedly delayed the process of obtaining prior authorizations for services and the receipt of treatment. In addition, inordinate amounts of time and staff resources are reportedly being spent on reconciling these issues.

In terms of cost savings to the state, most stakeholders believed that because of the initial reductions that were taken by the state when the capitation rate was established and the fact that there is more accountability for the services being provided that the state would save money initially. There were some concerns, however, about long-term savings because of the high level of needs in the child welfare population. At least one respondent noted that there is a growing awareness of the gaps in the systems and another pointed out that more resources may be necessary in order to address the diverse needs of this population.

Mail Survey Analysis

Regarding findings from the foster parent mail survey, results were less than positive. While only Citrus and St. Johns Counties were sampled for this particular report, at least some of the issues that emerged (e.g., the need for child care and transportation) were consistent with findings from other Medicaid studies that the Florida Mental Health Institute (FMHI) has conducted regarding the delivery of children's mental health services. The majority of foster parents indicated that they had not been informed about the Child Welfare Prepaid Mental Health Plan or that the funding for mental health services for children in their care had changed. While foster parents reported no service gaps regarding foster children's physical health and vision services, some gaps were reported between service needs and mental health services. Additionally, foster parents reported being relatively satisfied with

the physical health services their foster child had received but only “somewhat to moderately satisfied” with mental health services.

When foster parents were asked to rate the adequacy of aspects of their children’s care, none of the domains (access to care, information needs, case managers/mental health providers, quality of care, coordination of care, cultural competency, and financing) received positive ratings. Specific to quality of care, foster parents expressed concern regarding their ability to choose mental health service providers, with the adequacy of mental health screenings and assessments, and the timeliness in which these screenings are conducted. Regarding the financing of mental health services, foster parents were concerned about the adequacy of the system’s funding, their own access to funds to pay for foster children’s mental health services, and the adequacy of foster children’s mental health benefits. Foster parent concerns specific to coordination of care centered on the adequacy of the amount of information shared across systems (i.e., schools, child welfare and mental health) and the adequacy of service coordination.

Additional areas of concern voiced by foster parents included access to services, the need for more information, and adequacy of child welfare case managers and mental health providers. Regarding access to care, problems identified were the lack of available of public transportation, lack of available childcare, inability to reach mental health providers by telephone, and an inability to obtain mental health services for their foster children when needed. While providers are not contractually obligated or singularly responsible for providing these services, effort should be made to explore how to collectively respond to these barriers. Regarding the need for more information, foster parent concerns related to need for access to foster children’s health records, need for clarification of policies related to mental health services for foster children, need for training on behavioral health strategies that can be used in the home, and enhanced education on mental health issues in foster children. Issues specific to child welfare case managers and mental health providers included child welfare case managers’ lack of knowledge of the mental health needs of foster children, their inability to manage assigned caseloads, and the inadequacy of child welfare case managers’ training. Foster parents were somewhat more positive regarding the consistency with which foster children see the same mental health provider and the seriousness with which mental health providers take foster parents’ concerns.

Policy Recommendations

The following policy recommendations resulted from this study:

- The state should continue to explore the possibility of establishing “presumptive eligibility” for Medicaid for children in the child welfare system to ameliorate the problems related to the timely establishment of their eligibility.
- Every effort should continue to be made to resolve the problems with matching the HomeSafenet database and the Medicaid eligibility files. Once an accurate eligibility file is established it should be made available to providers on a timely basis.

- Consideration should be given to further integration of services such as the Statewide Inpatient Psychiatric Programs (SIPP) and Behavioral Health Overlay Services (BHOS) into the CW-PMHP to promote better coordination of care and reduce system fragmentation.
- Efforts should be made to keep other managed care plans informed as children exit the CW-PMHP so that assignment to the correct plan can be determined and communicated to providers.
- Continued efforts need to be made to keep families (including foster families and other caregivers) informed about the CW-PMHP (i.e., how it affects procedures for children being able to access mental health services, information on how to appeal decisions, etc.) and to provide opportunities for them to have a voice in its operation.
- There should be an increased focus on enhancing relationships with direct providers, providing training and technical assistance as needed and checking with them periodically to obtain their perspectives on “how things are going,” to obtain suggestions on ways to improve determinations of eligibility, prior authorization processes, streamlining billing, etc.
- Increased efforts should be made to insure that stakeholders at a local level (including the courts and school system) are informed about the CW-PMHP, specifically how managed care is impacting providers and services available to children.
- Roles and responsibilities among all stakeholders (SPOC, DCF, Magellan, etc.) should continue to be clarified. For example, the duties each SPOC carries out versus Magellan staff.
- Efforts should be made to insure that current levels of communication linkages among stakeholders do not diminish over time so that the current momentum and levels of understanding about the CW-PMHP are maintained.
- Since access to child care and transportation services were noted as barriers to foster parents accessing care for their foster children and providers are not contractually obligated or singularly responsible for providing these services, efforts should be made to explore how the system could respond to these barriers.
- Since the adequacy and timeliness of foster children’s mental health screenings was a concern to foster parents, efforts to ensure that mental health screenings are completed in a timely manner and that foster parents are informed of their results are needed to help minimize these concerns.
- Improved efforts to better communicate with foster parents concerning the health and mental health needs of foster children in their care, including greater access to the health records of foster children would be helpful.

Background

Many children entering the child welfare system are found to be at-risk for developmental, emotional, and behavioral problems that require intervention. In a recent survey of youth with completed child welfare investigations, 47.9% were determined to have clinically significant emotional or behavioral problems (Burns et al., 2004; also see Appendix A for a detailed review of the literature on mental health prevalence rates for children in child welfare). Access to mental health services for this population has also been problematic. For example, only 25% of Burns' sample was found to have received specialty mental health services after one year in care.

In the last decade, the State of Florida has enacted several reform efforts to better meet the needs of children in the child welfare system. These efforts include the outsourcing of child welfare services through the use of a lead agency design, implementation of the first statewide Title IV-E Waiver providing flexibility for foster care funds and the authorization of privatized child welfare organizations to provide mental health services. This section of the report provides a brief overview of these initiatives.

Florida's Child Welfare System

In 1996, the Florida Legislature mandated the outsourcing of child welfare services through the use of a lead agency design, known as Community-Based Care (CBC) (s. 409.1671, F.S.). The intent of the statute was to strengthen the commitment and oversight of local communities for caring for children and reunifying families, while increasing the efficiency and accountability of service provision. The responsibilities of lead agencies were to:

- Coordinate, manage, and provide all child protective services in their communities;
- Cooperate with child protective investigations;
- Ensure the capability to serve all children referred and ability to provide continuity of care for these children;
- Ensure that child protective staff are trained to Department of Children and Families (DCF) standards; and
- Achieve federal and state outcome and performance standards for child protective services.

The following year, the Florida Legislature mandated statewide expansion of this model, and in 1999 it further revised the State's child welfare statutes in order to bring Florida into compliance with the new federal Adoption and Safe Families Act (ASFA). In July 1999, DCF issued a CBC Implementation Plan, which provided a blueprint for incorporating ASFA goals as Florida's child welfare system continued to transition to the new community-based system of care model. Currently, all of Florida's 67 counties have transitioned to this model, with 20 lead agencies throughout the state holding contracts with DCF to provide child welfare services.

Florida's IV-E Waiver

In 2006, the State of Florida received federal approval for the first statewide waiver providing flexibility for foster care funds. The Administration for Children and Families (ACF) U.S. Department of Health and Human Services authorized the five-year waiver under Title IV-E of the Social Security Act, allowing Florida to demonstrate that flexibility in funding would result in improved services for families.

The new IV-E Waiver, implemented October 1, 2006, has significant potential to impart benefits to families and improve child welfare system efficiency and effectiveness through greater use of prevention services and in-home supports offered throughout all stages of contact with families. Waiver implementation is expected to result in increased flexibility of IV-E funds that have historically been earmarked for out-of-home care services. The new flexibility would allow these funds to be allocated toward services to prevent or shorten child placements into out-of-home care.

In addition, consistent with the Community-Based Care model, it is expected that the new flexibility of funds will be used differently by each lead agency, based upon the unique needs of the children and families served in each local community. It is expected that Waiver implementation will lead to changes in or expansion of the existing child welfare service array for many, if not all, of the lead agencies. These changes in practice are expected to positively affect child outcomes, including child permanency, safety, and well being.

Over the life of the Title IV-E demonstration project, it is expected that fewer children will need to enter out-of-home care, resulting in fewer total days in out-of-home care. Therefore, costs associated with out-of-home care are expected to decrease following Waiver implementation, while costs associated with prevention and in-home services will increase, although no new dollars will be spent as a result of waiver implementation (Vargo et al., 2006).

Florida's Medicaid Managed Mental Health Care Plans

Florida's Agency for Health Care Administration (AHCA) first implemented the Medicaid Prepaid Mental Health Plan (PMHP) in Area 6 in 1996. The PMHP was a result of a 1915(b) waiver from the Federal Health Care Financing Administration (HCFA). In 2001, the PMHP demonstration was expanded to Area 1, which includes four counties (Escambia, Santa Rosa, Okaloosa, and Walton) in the Florida panhandle. Also in 2001, an HMO began providing community mental health services in Escambia and Santa Rosa Counties. The PMHP was expanded to Areas 5 (Pasco & Pinellas counties) and 7 (Brevard, Orange, Osceola, and Seminole counties), effective August 1, 2005. Further expansion in Areas 2, 3, 4, 8, 9, and 11 occurred in 2006. With the exception of AHCA Areas 1 and 6, children within HomeSafenet, Florida's child welfare database, were excluded from other managed care programs prior to CW-PMHP implementation.

Florida's Child Welfare Prepaid Mental Health Plan

During 2001-2004 lead and provider network child welfare agencies advocated with the Legislature to exclude children in the child welfare system from any managed care program. At the point that it was determined that all mental health services would soon be provided under managed care, however, the Florida Coalition for Children requested a specialty carve-out design for the child welfare population.

In 2004, the Florida Legislature authorized CBC Lead Agencies to provide mental health services through a managed care organization to children who are in the child welfare system and eligible for Medicaid. According to the original RFP, this new Child Welfare Prepaid Mental Health Plan (CW-PMHP) is a “comprehensive mental health plan under contract with the Agency for Health Care Administration on a prepaid, capitated basis to provide mental health services to Medicaid eligible children and adolescents with open cases for services in the HomeSafenet database.”

Early in 2006, the Florida Coalition for Children formed a Behavioral Health Network Board (FCCBHN) to craft a response to AHCA's RFP 0603 for a Child Welfare Prepaid Mental Health Plan. During an ITN process, FCCBHN partnered with Magellan Behavioral Health of Florida, Inc. as their managed care partner and a Memorandum of Agreement was drafted regarding roles and responsibilities. AHCA awarded the contract to this CBC Partnership, LTD (referred to in this document as “The Partnership”), which is now comprised of Magellan and Community-Based Care of Seminole as general partners and additional lead agencies as limited partners. Implementation of the CW-PMHP began February 1, 2007. This initiative represented a major shift in the way mental health services were financed for the child welfare population.

The purpose of this study is to focus on the mental health needs of children in foster care receiving Medicaid-funded mental health services through the CW-PMHP carve-out. There were two components to the first year's analysis: an implementation analysis sub-study and a mail survey sub-study. Together these components provide an in-depth assessment of the current status of the mental health needs of children in foster care in St. Johns and Citrus Counties, as well as a baseline examination of this newly implemented CW-PMHP. An interim report was submitted in June 2007. The current report offers a complete presentation of year one findings, conclusions, and policy recommendations from the implementation analysis and mail survey sub-studies.

Methods

Implementation Analysis Methods

Due to the relatively recent start date of the CW-PMHP (February 1, 2007), this implementation analysis sub-study was designed to capture the early experiences of the various stakeholders that had a role in the development and operation of the CW-PMHP in this first year.

Implementation refers to a purposeful set of processes “designed to put into practice an activity or program of known dimensions” (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005, p.5). In this instance, the “program of known dimensions” is the application of managed care strategies to Florida’s mental health services that are financed by Medicaid. These strategies are organizationally and functionally complex. They are also embedded in complex service and political environments that are difficult to appreciate, yet impact the way they function. This implementation analysis sub-study strives to describe not only the plan as it is being implemented, but the contexts in which it operates, by detailing the financial, structural, and clinical aspects of the managed care arrangements. These domains have been identified as having potential impact on access to services, service utilization, costs and quality of care for managed mental health care recipients. Ridgely and associates (2002) designed a conceptual model for examining critical elements of managed behavioral health care arrangements which includes contextual factors such as the characteristics of enrolled populations and Medicaid plans, structural aspects such as organizational characteristics of managed care organizations (MCOs) and the compositional features of network providers, procedural aspects of care such as utilization management, financial and risk arrangements of and between MCOs and service providers, and clinical management. Pincus, Zarin, and West (1996) identified similar elements relevant to the relationships between plans and service providers in a study on the impact of managed care: organizational and contractual relationships, financial arrangements, and procedural arrangements.

Utilizing the framework of these domains, the implementation analysis sub-study obtained the unique perspectives of representatives from the state agencies that had a role in the conceptualization and development of the initial request for proposals, statewide advocacy and provider organizations, the MCO, staff of The Partnership as well as members of the Operating Committee, the Community-Based Care Lead Agencies, and service providers, regarding the organizational, structural, financial, and operational aspects of Medicaid’s managed mental health care plan for Florida’s child welfare population.

The information obtained through this sub-study helps to inform other aspects of the overall evaluation and to provide AHCA and other relevant stakeholders with an understanding of the complex organizational structures and functions of this managed care initiative. The implementation analysis sub-study also helps highlight program strengths as well as identify potential barriers to the successful implementation of this financing strategy.

Primary Evaluation Domains

This sub-study employed a combination of methods to obtain data regarding the implementation of the CW-PMHP under the following domains:

- Organizational structures
- Financial structures and funding strategies
- Implementation (including facilitators and barriers)
- Communication
- Relationships
- Roles and relationships
- Service delivery
- Management information systems
- Outcomes

During FY06-07 and the first quarter of FY07-08, the implementation sub-study focused on early implementation planning and processes as well as the current status of mental health service provision for the child welfare population. The goal was to collect information that would inform our understanding of the CW-PMHP as it became fully operational.

Participants

During March and April of FY06-07, seven telephone interviews were conducted with state-level administrators from the Agency for Health Care Administration, the Florida Department of Children and Families, representatives from advocacy and trade organizations, and the Substance Abuse and Mental Health Corporation. An additional telephone interview was conducted with a nationally recognized expert on managed care arrangements in child welfare. In August and September of 2007, project staff conducted nine telephone interviews with mid-level and local-level stakeholders that included administrators from Magellan (the MCO), as well as The Partnership and the Operating Committee, Community-Based Care lead agencies, and mental health providers in St. Johns and Citrus Counties. These two counties were chosen because they have very similar numbers of children in foster care, but represent very different community-based systems (e.g., organizational type, funding level, and performance outcomes). An urban area will be added to the FY07-08 study in order to include an area of the state with a more complex service delivery system. Information regarding this latter county will be included in the 2008 year-end report.

Instrumentation

For the interviews with state-level stakeholders, a protocol was developed to assess the following domains: CW-PMHP implementation, roles and relationships, communication among stakeholders, and anticipated outcomes. A primary goal of those interviews was to obtain an understanding of the pre- and early implementation relationships and activities related to the CW-PMHP. For the interviews with representatives from mid-level system organizations such

as The Partnership and the MCO, the protocols were revised to include the additional domains of organizational structures, service delivery, management information systems, financial structures and funding strategies. The same protocol was subsequently used for interviews with local-level representatives from the Community-Based Care lead agencies and mental health providers in St. Johns and Citrus Counties. These additional domains were incorporated to help further understand the actual structures, management, and operation of the CW-PMHP. All interviews were audio-taped (with permission of the interviewees) and extensive notes were taken during the interviews. In addition to the interviews, documents such as presentation handouts, provider and beneficiary handbooks, and the scope of work required in the initial RFP were also reviewed.

Data Analysis

Qualitative content analysis of interview data was performed by study team members relevant to the areas of interest noted earlier and is presented according to the following themes in this report: organizational structures, financial arrangements, implementation issues, communication among stakeholders, relationships, roles and responsibilities, service delivery, management information, and anticipated outcomes.

Mail Survey Methods

Mail survey techniques have been used for a long time across different settings with varying results (Kanuk & Berenson, 1975). In this evaluation of Florida's Child Welfare Prepaid Mental Health Plan, the use of surveys has the advantage of being able to easily access all of the foster parents serving foster children in the counties of interest. The use of mail surveys permits an assessment by foster parents of the mental health services available to foster children irrespective of whether or not the children have needed or used these services. Given that the majority of evaluations include only recipients of care, foster children who may need service, but for whatever reasons experience difficulty accessing care, are excluded. Population-based mail surveys, however, permit the monitoring of the service needs and well-being of all foster children, irrespective of whether they use services. The mail survey techniques used in the evaluation of the CW-PMHP are patterned after those developed and successfully implemented for the past ten years in the Louis de la Parte Florida Mental Health Institute's evaluation of Florida's Medicaid managed mental health care programs. Overall, the response rates in this long running evaluation have ranged between 35% and 50% over multiple administrations. Although these response rates are lower than one would ideally like, the rates are substantially higher than those reported in other studies involving similar populations (Barrilleaux, Phillips, & Stream 1995; Brown & Nederend, 1997; Rohland & Rohrer, 1996).

Primary Evaluation Questions

The mail survey component of the CW-PMHP evaluation is intended to address the following four basic questions from the perspective of active foster parents.

1. What are the self-reported health, mental health, and substance abuse needs of foster children in St. Johns and Citrus counties?
2. How satisfied are foster parents in St. Johns and Citrus counties with the services their foster children have received?
3. What issues impact foster parents' ability to access health and mental health services for their foster children?
4. To what extent are foster parents in St. Johns and Citrus counties aware of the CW-PMHP?

Sample

While the original plan was to obtain the names and addresses of foster parents in St. Johns and Citrus counties from the state's HomeSafenet information system, difficulties emerged related to obtaining permission to access this information. Given this, plans were made to acquire contact information for foster children enrolled in the state's Medicaid eligibility files. However, examination of these addresses raised concerns about the adequacy and accuracy of these addresses. Ultimately, foster parents' contact information was requested and obtained directly from the Community-Based Care lead agencies in St. Johns and Citrus Counties. In total, the names and addresses of 68 active foster parents were obtained from the lead agencies in these two counties (Citrus=27, St. Johns=41). Given the small number of foster parents serving in these counties, it was decided to mail a questionnaire to every foster parent in both counties.

Instrumentation

During the 2006-2007 contract year with the Florida Agency for Health Care Administration, a questionnaire was developed for use in a mail survey of foster parents to obtain their perspectives regarding the mental health needs of their foster children and to document their experiences in accessing mental health services. The questionnaire was fashioned after the children's version of the mail survey used by Louis de la Parte Florida Mental Health Institute in their evaluation of Florida's Medicaid managed mental health care programs. However, questions specific to issues of children in the foster care system were added. Construction of the questionnaire involved a review of the professional literature regarding the mental health needs and service use of children in the child welfare system and the barriers that foster parents experience in attempting to obtain mental health services for their foster children. In addition, a focus group (Krueger, 1994, 1998) was conducted with 12 foster parents in Polk County to obtain their first-hand accounts regarding the mental health needs of foster children and their ability to access needed services. A questioning route was drafted for the focus group that consisted of a primary question in addition to follow-up probes. The questions included:

1. What are your perceptions of the mental health needs of foster children?
2. What has been your previous experience in accessing mental health services for your foster children?

3. What recommendations would you offer for designing a questionnaire to obtain foster parents' views about these issues?

Information from the literature review and the focus groups was used to draft a questionnaire, which was first reviewed by the project team members and then sent to the lead agencies in St. Johns and Citrus Counties for their review and comment.

Questionnaire Content

The questionnaire contained a total of 97 questions. Ten of the survey items related to respondents' experience and roles as foster parents. Five questions focused on the demographic characteristics of the survey respondents. More importantly for this study, 28 questions addressed foster children's health-related (e.g., mental, physical, dental, substance abuse) needs, service use, and satisfaction as perceived from the foster parent perspective.

Additionally, seven questions were included on the survey regarding the cultural competence of mental health services. Three questions focused on unsuccessful foster placements and solicited information on what supports, if any, might have been helpful in preventing the disruption. Finally, two questions concerned foster parents' knowledge of the recent changes in the funding of mental health service delivery for children in the child welfare system (i.e., CW-PMHP). An open-ended question was included on the questionnaire to solicit foster parents' recommendations regarding the availability and quality of mental health services for foster children. Foster parents' responses to this question are listed in Appendix B.

The majority of the questions (42 items), however, asked foster parents about various issues which they might have experienced and which could impact their capacity to access mental health services for their foster children. As previously noted, these items were developed based on a review of the professional literature and a focus group conducted with current foster parents. The 42 items were clustered into seven domains that were frequently cited in the literature and also emerged during the focus group. The domains consisted of: 1) access to care (13 items), 2) information needs (8 items), 3) case managers/mental health providers (10 items), 4) quality of care (3 items), 5) coordination of care (3 items), 6) cultural competency (2 items), and 7) financing (3 items). Some of the literature supporting the inclusion of each of these domains is briefly summarized below.

Rationale for Inclusion of the Survey Content Domains

The following review provides a brief summary of the literature related to the major content domains included in the foster parent mail survey. The literature base related to child welfare has a long history and is quite extensive. Given this, the following synthesis is not intended to be all encompassing, but is rather to support the inclusion of the survey content domain previously described.

There is an extensive literature base focused on issues related to access to care for children in the child welfare system that supports its importance for inclusion as a domain in the survey. One aspect of this domain relates to adequacy of available mental health service providers. Burns and associates (2004) noted

a shortage of “...well-trained mental health professionals” (p. 968) as a major barrier to mental health care for foster children. Several other studies highlighted the need for increased numbers of child psychologists (Raghavan et al., 2006; Semansky & Koyanagi, 2004). Another facet related to access concerns the types of services that are available. Semansky and Koyanagi (2004) conducted focus groups with foster parents who reported a “...need for more intensive in-home services...” (p. 25) Similarly, Klee, Soman, and Halfon (1992) argued the need for a broader spectrum of mental health services for foster children than is currently available. Hochstadt, Jaudes, Zimo, and Schachter (1987) stressed the need for comprehensive, consistent, and specialized services while Schneiderman, Connors, Fribourg, Gries, and Gonzales (1998) highlighted the need for a “menu” of services ranging from short-term theme-oriented groups to more long-term trauma-focused services. Additionally, Kerker and Dore (2006) stressed the importance of innovative programs and the need for offering more evidenced-based programs. In addition to the services provided to foster children, a number of authors have stressed the need for support services directed toward foster parents (see Hochstadt, et al., 1987). A study on the recruitment and retention of foster parents in Florida (Lawton and Rhea Chiles Center for Healthy Mothers and Babies, 2000) found that “respite care and childcare were consistently noted as important retention issues, especially in rural areas” (p. 17).

A number of investigators have examined and stressed the importance of information needs of foster parents. For example, Simms and Halfon’s (1994) review of the health care needs of children in out-of-home care concluded with a series of recommendations intended to improve the delivery of comprehensive health care for this population. One recommendation focused on the need for improved management of health care information. They described and recommended the expanded use of “medical passports” that were currently used in several states. These medical passports were held and maintained by foster parents and provided “...a much needed link among all parties involved in the child’s care” (p. 516). This sentiment was echoed by Chernoff, Combs-Orme, Risley-Curtiss, and Heisler (1994) who concluded, “More energy should be invested in developing systems for documenting and communicating the health problems and health histories of foster children in placement” (p. 599). Other investigators have also argued the need for centralized medical and psychosocial records for foster children (Hochstadt et al., 1987). In addition to access to foster children’s health records, training for foster parents has been reported as a measure for meeting their information needs. Kerker and Dore (2006) recommended training foster parents to enhance their ability to identify potential mental health problems. Simms, Dubowitz, and Szilagyi (2000) noted that foster parents could be trained to assist in the treatment of mental health problems by implementing specific behavior management programs. These studies highlight the importance of access to and sharing of information related to foster children’s mental health needs and of providing foster parents with information on how to better deal with challenging behaviors. Given this literature, a domain focused on information needs was included in the questionnaire.

The important role that case managers and mental health providers have regarding foster children's access to and receipt of mental health services has been clearly documented in the literature. Stiffman, Chen, Elze, Dore, and Cheng (1997) described how these individuals serve as gatekeepers related to foster children's access to care. Simms, et al. (2000) described the important role and responsibility of health care professionals in ensuring that foster children receive needed mental health services. Thompson and Fuhr (1992) reported a need for increased training of case managers regarding the identification of emotional and psychological disturbances among children in the child welfare system. In addition to roles and training needs of providers, factors such as caseload size and turnover have been reported as significant contributors to the failure of foster children to receive mental health services (Schor, 2005). A recent report from the Government Accountability Office (2006) noted that 35 states reported the inability to recruit and retain child welfare case workers as one of their three major challenges. This same report noted that more than half of the states reported "dissatisfaction with the average number of cases per worker, administrative responsibilities of caseworkers, and the effectiveness of caseworker supervision" (p. 14). A recent Florida report (Office of Program Policy Analysis & Government Accountability, 2006) concluded that the changes under community-based care have resulted in lower caseloads and position vacancy rates for case managers, but that starting salaries are lower and that staff turnover has increased. These studies emphasize the critical need for an experienced, well-trained, and stable child welfare workforce and support the importance of obtaining foster parents' perceptions regarding these workforce issues as part of the CW-PMHP evaluation.

Quality of care, particularly comprehensive assessment and improved evaluation and screening of children in child welfare, has often been studied. Schneiderman, et al., (1998) proposed an idealized framework for the delivery of mental health services to children in foster care, the first component of which focused on an early and comprehensive mental health screening and assessment. Hochstadt et al., (1987) argued for the early medical and psychosocial screening of all children entering foster care. The need for early, comprehensive, and universal mental health screening of foster children has been echoed by numerous other investigators (Chernoff et al., 1994; Kerker & Dore, 2006; Leslie et al., 2005; Shin, 2005; Stein, Evans, Mazumdar, & Rae-Grant, 1996).

The importance for coordination of care in the provision of mental health services for children in foster care has been a frequently studied and discussed issue. Burns and associates (1995) documented that multi-sector involvement was a "significant phenomenon" among many children receiving mental health services and stressed the need for service integration. Similarly, Schneiderman et al., (1998) called for the integration of mental health services with other social services for children in the child welfare system. Hochstadt et al., (1987) stress the need for system linkages and coordination given the special and high-risk needs of foster children. In a more recent article, Burns et al., (2004) argued that strong linkages are needed between the mental health and child welfare systems and highlighted some of the policy and cultural differences between these systems that

serve as barriers to coordination. A report from Mathematica (Rosenbach, 2001) on meeting the health care needs of foster children through Medicaid concluded that there is a strong need for a “broad-based concept of care coordination” (p. 8) that includes public health, child welfare, mental health, schools, and juvenile justice. Clearly these studies support the importance of including coordination of care as a domain in the CW-PMHP evaluation.

The importance of providing culturally competent services is supported by the racial and ethnic disparities that have been consistently documented among foster children’s receipt of mental health services. Based on her review of the literature, Staudt (2003) concluded that the “race was the most consistent ‘nonneed’ predictor of service use” (p. 199) among children in foster care, noting that Caucasian children had higher rates of mental health service use compared to African American and Latino foster children. More recently, Kerker and Dore’s (2006) review produced the same conclusion. Not surprisingly, these conclusions are consistent with many published studies. For example, Stahmer et al., (2004) found that Black children were only half as likely to receive mental health services as white children. Burns et al., (2004), Garland and Besinger (1997), and Kolko, Seleyo, and Brown (1999) all found that Caucasian foster children were more likely to receive mental health services compared to foster children of color. The reduced access to mental health care among minority foster children supports the need to assess the cultural competency of Florida’s mental health delivery system.

Financing has been an often-researched issue in the delivery of public sector services. This is also true among studies examining the receipt of health and mental health services by children in the child welfare system. For example, Rosenbach (2001) highlighted the adverse impact on access to care among foster children associated with discontinuities in health care coverage. The problems created through categorical and inflexible service funding also have been frequently documented and reported in the literature (Kerker & Dore, 2006; Schor, 2005; Simms et al., 2000). Based on their review of the literature, Kerker and Dore (2006) concluded that “...providers are not adequately reimbursed for serving this population which results in few opportunities for obtaining care” (p. 144).

Data Collection and Analysis

For the mail survey, a highly systematic and structured approach to survey design and follow-up similar to those recommended by Dillman (1978) and Salant and Dillman (1994) was utilized. When completed, a total of five separate mailings will have been conducted. The first mailing consisted of a pre-notification postcard informing the foster parents in St. Johns and Citrus Counties that a study examining foster children’s mental health care service needs was being conducted and that they would receive a questionnaire in the mail in about a week. One week later a second mailing was conducted. This mailing included a personalized cover letter explaining the purpose of the study, that respondents would be paid \$10.00 for returning a completed questionnaire, and information about the days and hours of operation of the toll-free telephone number along with the questionnaire. A toll-free number was provided so that

the foster parents surveyed could contact the project team to get any questions answered or to complete the questionnaire over the telephone. A pre-addressed stamped return envelope also was included in the mailing. One week later, a postcard reminder was sent to each foster parent who had not yet responded. This reminder emphasized the importance of the study and again included information on the toll-free telephone number foster parents could call. Two weeks after this postcard reminder was mailed, a fourth mailing containing a cover letter, questionnaire, and return envelope was mailed to each non-respondent. This mailing has just been completed. A fifth and final mailing will be sent via certified mail to individuals who have not responded four weeks from the most recent mailing. As with the second and fourth mailings, foster parents will receive a personalized cover letter, questionnaire, and a pre-addressed, stamped return envelope. As recommended by Dillman (1978), first class postage is being used on both the outgoing and return envelopes of each mailing and address correction is requested from the post office so that the mailing database can be updated. These mailing procedures are based on the findings of a feasibility study conducted to assess the validity of using mail survey procedures with a Medicaid-enrolled population. The findings from this feasibility study are summarized in Boothroyd and Shern (1998). Prior to initiation of any mailing activities, all survey procedures and materials were reviewed and approved by the University of South Florida's Institutional Review Board to ensure that the rights of all study participants were fully protected.

The analyses of data derived from the mail survey are largely descriptive in nature and are intended to address the four basic evaluative questions associated with this component. Domain scale scores were calculated by averaging respondents' ratings across the number of items within each domain. Selected comparative (i.e., inferential) analyses were performed to contrast the responses of foster parents in St. Johns and Citrus Counties.

Findings

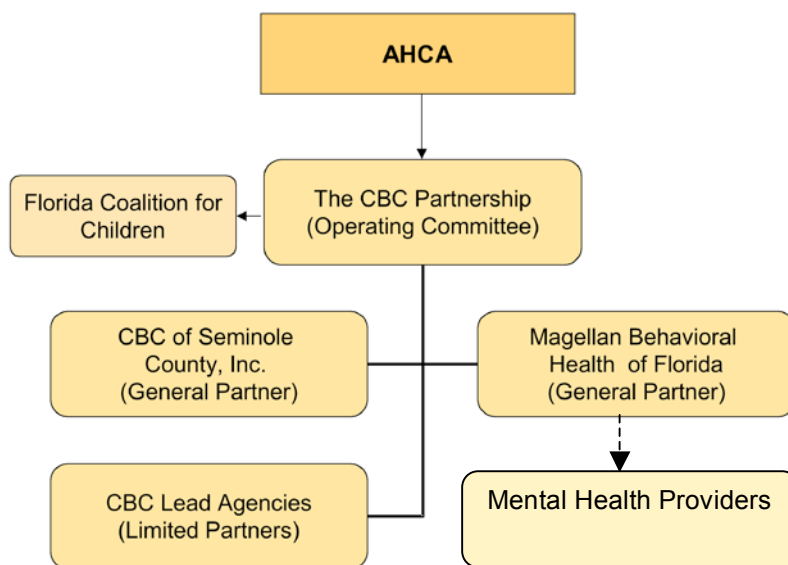
Implementation Analysis Findings

The following findings are based on themes that emerged during the semi-structured interviews with national, state, mid and local-level stakeholders regarding implementation of the Child Welfare Prepaid Mental Health Plan.

Organizational Structure

The CW-PMHP was structured to be comprised of either a single CBC lead agency or several CBC lead agencies who could act alone or in partnership with a managed care organization to provide all the Medicaid mental health services for children in the child welfare system. In December 2005, the Agency for Health Care Administration issued a Request for Proposal (RFP) to select the vendor for the new managed care plan. The Florida Coalition for Children Behavioral Health Network (FCCBHN) was formed to begin work on the response to the RFP and through an Intent to Negotiate (ITN) process, selected Magellan, a behavioral health managed care organization, as their managed care partner. When it was determined that FCCBHN was ineligible to respond to the RFP, they formed the Community-Based Care Partnership, Ltd. that was ultimately selected by AHCA as the vendor for the CW-PMHP in August 2006. The CBC of Seminole County was identified as the general partner that would work with Magellan as the representative for the other lead agencies in Florida and serve as the primary liaison/contract manager with AHCA. The Florida Coalition for Children hired the State Project Director and other staff to administer the CW-PMHP, which most interview respondents agreed is now operational. Figure 1 shows the organizational structure for the CW-PMHP.

Figure 1
CW-PMHP Organizational Structure



Community-Based Care agencies across Florida provide input into the governance decisions through the CBC of Seminole County and an Operating Committee established to approve provider networks, rates and methodology, clinical policies, work flows, and to address quality of care issues as well as provide a venue for stakeholder input. The Operating Committee is comprised of 50% CBCs and 50% Magellan staff.

Financial Arrangements

The financing arrangement between the Agency for Health Care Administration and The Partnership is a capitation rate, based upon rates established by AHCA and published in the RFP. These actuarially-certified rates are predicated upon previous years' billings (FY02-03 and FY03-04) as identified in AHCA's fee-for-service billing files for covered services for different age bands (under 1 year, 1-5 years, 6-13 years and 14-20 years) trended forward. Each AHCA Area of the state in which the PMHP is operating (Areas 2-5, 7-9, and 11) has a unique rate established for the different age groups of children and youth. According to the rates published in the amendment to the original RFP, for children under the age of 1, the rates range from \$4.99 per member per month (PMPM) in Area 3 to \$9.19 PMPM in Area 7. For children between the ages of 1-5, the rates range from \$32.82 PMPM in Area 3 to \$60.44 PMPM in Area 7. The rates for children in the 6-13 age category range from \$241.06 PMPM in Area 3 to \$443.90 PMPM in Area 7 and the rates for 14-20 year olds range from \$249.02 PMPM in Area 3 to \$458.57 PMPM in Area 7. While it is clear that there is variation in the rate structure, with Area 3 consistently having the lowest rates and Area 7 having the highest, according to AHCA, the current rates being paid for all AHCA Areas are based on an average PMPM until such time the differential rates can be entered into their data systems.

As noted earlier, the variation in established rates is related to the historical billings for the population covered by the CW-PMHP. However, further exploration is needed to better understand the basis of the variations in historical billings. AHCA anticipates that future rates will be established based upon encounter data currently being collected from the managed care organization.

From the capitation received from AHCA, there is a \$2 million allocation for the hiring of administrative staff and the Single Point of Contact (SPOC) staff within the CBCs. Of the \$2 million, \$500,000 is contracted to the Florida Coalition for Children to employ the staff, including the State Director who is responsible for administering the CW-PMHP. The remaining \$1.5 million is contracted to the CBCs to employ the Single Point of Contact staff. The amount contracted to each CBC is determined by the number of children they had in care as of December 31, 2006.

The MCO receives a percentage of the capitation for its operations and contracts with its networks of providers on a fee-for-service basis. The fees that are paid are generally based upon the previously established Medicaid fee-for-service rates. When Medicaid recently increased some of their rates, the MCO passed those increases on to their providers, but was unsure about continuing to

do so with future Medicaid rate increases. When asked about timely payments for services rendered, one provider indicated that they were not aware of any difficulties in receiving prompt payment by the MCO. Another provider indicated that while timely payment was not a problem, they would like to see an improvement in the rates offered by the MCO.

Implementation Issues

Early in the study, an interview was conducted with a national expert on managed care arrangements in child welfare to facilitate a better understanding of the issues that often surface when states implement managed care plans in a child welfare system. From the national stakeholder perspective, a “successful” implementation is best judged from the point of view of the children, families and the front-line caseworkers. Birth and foster families and caseworkers should experience such things as:

- Easy access to an array of easy-to-navigate services that specifically serves their specialized needs
- Children remain covered for needed services even when their Medicaid eligibility status changes due to such things as a placement change
- Services are provided in a culturally sensitive way, particularly for individuals where English is not their first language (e.g. materials in Spanish, translators available when needed, etc.)

The national expert also stressed the importance of providers being supported and trained and that one should also be able to note changes in the child’s behavior. This national perspective served as a helpful guidepost for interviews with state-level stakeholders in Florida, particularly as they related to identifying communication linkages, understanding relationships that have been forged, and portraying the process of defining roles and responsibilities.

Mid and Local-Level Interviews

Agencies at the mid and local levels were asked about the major challenges and successes that they have had in implementing managed mental health care for the child welfare population. Most respondents referred to the challenges associated with having accurate and timely eligibility files as the major concern. There are apparently significant discrepancies in the numbers of children in the HomeSafenet system and those that are shown as eligible in the Medicaid files. Receiving accurate eligibility information is complicated by the fact that children are enrolled and dis-enrolled as they enter and exit different parts of the treatment system (e.g., the Statewide Inpatient Psychiatric Programs [SIPPs] or Behavioral Health Overlay Services [BHOS]) or as they enter and exit care. The impact of these challenges has reportedly delayed the process of obtaining prior authorizations for services and the receipt of treatment. In addition, inordinate amounts of time and staff resources are reportedly being spent on reconciling these issues.

Another challenge that was identified was the learning that needed to occur as the child welfare system became engaged with the mental health treatment system. As one respondent noted “This is a child welfare agency and a lot of

people don't [sic] and have never been involved with children's mental health... There are certain things that you can and can't do." Similarly, one respondent noted that an ongoing challenge has been with the court systems where judges are ordering care that is not reimbursable by Medicaid or that is not included in the CW-PMHP, such as psychiatric evaluations.

In terms of the successes that agencies have experienced, respondents cited that the transitions to managed mental health care went more smoothly than anticipated. They also noted that there seemed to be better accountability for the mental health services that are being provided. Child welfare staff reportedly have more opportunity for input into treatment planning and were more aware of the services that the children and youth are receiving.

Communication

State-Level Interviews

In contrast to the large amount of information and communication present when Medicaid Reform was on the horizon, state-level respondents reported a general sense that there was less communication with many of the relevant stakeholders about the implementation of the CW-PMHP, particularly at the local family level. On a positive note, the current State Project Director with the Florida Coalition and almost all of the individuals with AHCA, Magellan, and DCF, who were originally involved in the development and implementation discussions regarding the CW-PMHP remain in their roles. This continuity has greatly facilitated consistency in messages being conveyed.

Overall communication was also acknowledged to be difficult due to different perspectives and different levels of understanding among stakeholders. As one respondent stated: "Magellan knows about managed care, but not child welfare. Lead agencies and DCF know child welfare but not managed care..."

According to the national expert, one needs to inform families how the system is intended to work so one can later provide feedback on the service delivery process. In this same vein, it is critical to provide education very early into the process to all stakeholders about how the implementation is going to work. However, state-level respondents reported that it appeared that families had no real voice during the planning stages, and had been provided little to no information as to how the CW-PMHP would affect them. At least one respondent observed that there had been a noted lack of "frantic" phone calls from parents expressing concerns about the CW-PMHP. However, he attributed this to the likelihood that families were not sufficiently engaged and informed about the CW-PMHP and its implications for them and their child's treatment, rather than an indication that things were going smoothly.

In general, state-level stakeholders reported not receiving information or "official" communication about the CW-PMHP implementation until just prior to or after the February 1, 2007 implementation date. Important stakeholders such as the court system had also been apparently absent from early planning, and implementation. This lack of involvement may result in judges ordering treatment that may not be funded.

The national expert also stated that lack of supports for providers is a barrier to successful implementation (i.e. difficult billing process, difficulty in authorization, no real Q & A for providers that is supportive of services, etc.). In addition, mention was made that since the IV-E Waiver is in place in Florida, there needed to be clear guidelines for all concerned to provide clarity as to which funding service is responsible for paying for what service.

Interviews with state-level stakeholders revealed that efforts to communicate information to the provider community regarding the CW-PMHP implementation were less than adequate. For example, one respondent stated that The Partnership began holding regional meetings to discuss the rollout just three days prior to the February implementation date. It also appeared that communication efforts might not have been as coordinated as they could have been. Challenges associated with providers communicating with an MCO contract manager working from home via email and receiving requests for identical information from different people across the country were also noted. Additional challenges mentioned were confusion in billing procedures and cost shifting that was occurring between service categories.

At the time of the interview, one respondent acknowledged that the implementation was in the very early stages, and much of the providers' current attention to the CW-PMHP had been diverted by difficulties already being encountered in the field related to Medicaid reform and the presence of other managed care arrangements in the state.

Even though there has been little or no reported communication with family members, a number of communication linkages have reportedly been put in place among those responsible for implementation, and to some extent, with other community stakeholders. Interviews conducted with individuals at the community level have confirmed these earlier reports.

- More than one respondent mentioned that overall communication improved when The Partnership sub-contracted with the Florida Coalition for Children for the position of State Project Director.
- Early in the implementation, The Partnership went to AHCA area offices across the state to conduct provider training and held meetings with DCF and AHCA Area staff to let them know about the process and what would be occurring. This was in addition to routine AHCA meetings and on-site reviews and conference calls. The Partnership took this extra step in order to discuss transition issues, customer service information, and so that stakeholders could place a face with a name.
- Work groups with representatives from the CBC of Seminole, Magellan, the subcontractor from the Florida Coalition, and AHCA conduct weekly conference calls and regularly identify issues that need to be resolved. Based on these calls, this work group promulgated a series of "Question and Answer" documents that are disseminated to applicable stakeholders.
- AHCA has a bi-weekly two-hour telephone meeting with all contract managers for all the managed care plans where the CW-PMHP is discussed.

- The Partnership has contracted with local CBC organizations to have a Single Point of Contact position responsible for facilitating communication, with the CW-PMHP and to keep the CBC abreast of what is happening with a specific child. These Single Point of Contact positions are seen as the “problem-solvers” in the system.
- The Partnership holds a Single Point of Contact conference call every week where they discuss such things as medical necessity criteria and other issues related to CW-PMHP implementation.
- According to one respondent, Magellan has also hired regional representatives that local stakeholders can go to with questions about the CW-PMHP Plan.
- Advisory Group meetings hosted by the local AHCA Area representative are held every three months in eight local geographic areas throughout the state. These meetings have included The Partnership, CBC lead agencies, NAMI, Mental Health Planning Councils, the Florida Community Action Council, etc. Missing from the list of invitees to date has been the Florida State Foster and Adoptive Association.
- There was at least one meeting with representatives from school districts to engage their participation in the implementation process and solicit their involvement in signing collaborative agreements. However, AHCA staff and others were struck by the lack of understanding that school staff had about managed care in general, and particularly about how the CW-PMHP implementation was going to affect their providers.

Mid and Local-Level Interviews

Representatives from The Partnership (including the MCO) and the Operating Committee reported that they have made great efforts to communicate and problem-solve with the important stakeholders at the local level as the plan has been implemented. Specifically, the State Director was identified as being a key person in helping to maintain open communication among the stakeholders. As noted earlier, as the CW-PMHP plan has progressed there have been, and continue to be, regularly scheduled conference calls with AHCA contract managers and CBC Single Point of Contact staff. The Partnership also has two staff assigned to different areas of the state to meet with local CBCs and providers to help respond to problems and provide technical assistance. In addition, Magellan has employed two individuals who have personal experience with the child welfare system who are available to work with local families as well as providers in fostering the principles of recovery and resiliency. Also, trainings continue to be held with local-level agencies that have facilitated consistent communication about how the plan will operate.

Relationships

State-Level Interviews

One respondent reflected the belief that a significant role for the managed care organization was to be cost conscious, while the lead agencies’ perspective is that they are to ensure that individual children receive the care they need. It was

reported that in the beginning months of implementation there were new limits placed on services to children that did not exist under the former fee-for-service arrangements with Medicaid, thereby restricting providers' ability to meet the needs of their clients.

The national expert cited the importance of making the implementation "provider friendly" so that providers feel involved, valued, and supported with ongoing training and technical assistance. This is necessary so that children and families in the child welfare system have access to an array of quality evidence-based practices that specifically target their specialized needs (i.e., having a sufficient number of providers that understand abandonment issues, treat trauma, etc.).

Stakeholders representing providers expressed frustration that early in the implementation, providers were given little information about the implementation and how it would work. This, combined with a general skepticism about managed care, reportedly resulted in an early reluctance by providers to sign contracts when solicited by The Partnership, particularly in several key geographic areas of Florida. There was also uncertainty about how the multi-disciplinary teams were going to operate in concert with the Single Point of Contact responsibilities.

The early reluctance of providers to sign contracts with The Partnership, as well as The Partnership's lack of understanding about the significance of certain missing key niche providers, apparently combined to create a strain in relationships between AHCA and The Partnership. This occurred when AHCA denied The Partnership's December 2006 request to initiate implementation because of AHCA's conclusion that the provider network was not adequate and did not insure sufficient access to services.

Mid and Local-Level Interviews

Respondents at the local and mid levels reported that the relationships among the various parties involved in the Plan have been enhanced by the open communication that has been fostered by The Partnership as the CW-PMHP has progressed. The knowledge and experience of the State Director and other staff members as well as their commitment to the successful implementation of the CW-PMHP were also identified as being important to good working relationships. The Partnership has continued to work with local community agencies and providers by providing trainings and technical assistance as well as to address specific problems that have been encountered. For example, in one instance where an assessment for a child was needed but the provider was unable to accommodate the need on a timely basis, the State Director was able to intervene in such a way that an appointment was scheduled for the next day. There also have been presentations by The Partnership to other important stakeholders such as the judges, which have helped to explain the new CW-PMHP plan. One provider noted, however, that they have had little contact with The Partnership, except as follow-up to the training conducted in January and would like to see more communication between The Partnership and other local stakeholders, such as the schools.

Roles and Responsibilities

State-Level Interviews

According to our interviews, entities, such as AHCA and The Partnership, who were most closely involved in drafting the original Request for Proposal and ultimately responsible for implementing the Child Welfare Prepaid Mental Health Plan, have reportedly experienced the least confusion in defining their roles and responsibilities. In contrast, community groups like NAMI Florida, the Substance Abuse and Mental Health Corporation, and the State Foster and Adoptive Parent Association reported that they played no role in the original planning and have only learned about the implementation through informal sources, such as having someone on their staff serving as a board member in a related organization.

With The Partnership assuming many new roles and responsibilities, AHCA staff began meeting bi-weekly to discuss their roles and responsibilities and to identify areas that are now The Partnership's responsibilities.

As late as December 2006, prior to the revised projected January 2007 implementation date, The Partnership and DCF reported role confusion in terms of how the responsibilities of the Single Point of Contact (formerly known as the Single Point of Assessment) and multidisciplinary staffings were going to be handled. In a meeting between AHCA, The Partnership, and DCF staff, AHCA confirmed that the intent of the RFP was to shift the SPOC responsibility for initial assessments and multi-disciplinary team staffings from DCF to The Partnership. This information reportedly came as a surprise, not only to The Partnership, but also to DCF who had been heavily invested in that role for quite some time. This shift in thinking resulted in The Partnership having to strategize about how best to accomplish the transition of these responsibilities, and also raised questions from DCF in terms of what their role would entail after implementation. Reportedly, it was AHCA's perspective that DCF would retain a very critical role in monitoring children and families' access to needed services, but many DCF staff were still uncertain about their future roles as evidenced by general questions that have surfaced regarding their future job responsibilities and implications for their funding. Examples of such questions included "For all those things that I used to do, what am I going to do now? What does this mean about our job? What does this mean about our funding?"

The national expert stressed that there needs to be clarity about eligibility, including having a smooth process for dealing with changes in a child's Medicaid eligibility, so that there is continuity of services when eligibility changes. There also needs to be clarity about how referrals are made and information about the specific roles of all stakeholders. In her opinion, if this is not done, there is a risk that referrals to providers will slow down and everyone will revert to "business as usual."

Interestingly, one of the earliest and still most significant challenges in implementation has been determining a child's eligibility for the CW-PMHP. The CW-PMHP initially experienced major problems when early reports regarding the number of children in HomeSafenet who were receiving Medicaid was discrepant with the Medicaid files by as many as 15,000 children. The fact that not all counties within Florida are currently covered in this "statewide" implementation further contributes to the confusion over roles and plan eligibility. Managed care plans in

Areas 1 and 6 already had children in foster care included in their plans and are not part of the CW-PMHP. Also, Area 11 is not yet fully implemented. This structure poses particular eligibility difficulties when a child moves from a CW-PMHP county to a non-CW-PMHP county. Negotiations are still underway as to how best resolve this issue.

Apparently absent from discussions about eligibility and service provision have been other HMO companies (e.g. Amerigroup and Harmony Behavioral Health), who need to know when a child is no longer eligible for their services and when they become re-eligible. Providing a clear pathway for families and caseworkers to follow when there is a conflict about approval for services and the need to have a person whose job it is to resolve problems when they occur were also noted by the national expert as important.

As noted earlier, the Single Point of Contact position that is paid for by The Partnership and is co-located at the CBC serves to facilitate communication and is responsible for keeping the CBC Partnership abreast of what is happening with a specific child. Since it is early in implementation, it is unclear how effective this structure will be when there are conflicts about approvals for services and resolution is needed.

Mid and Local-Level Interviews

Most respondents agreed that the roles and responsibilities of the various components of the Plan (e.g., The Partnership, the Operating Committee, CBCs) were clear and that any role confusion is being addressed as it arises. The one issue that related to who would be responsible for the Single Point of Contact appears to have been resolved. However, there is clearly variation among the CBCs in the way it is carried out in different areas. Similarly, the methods by which prior authorizations are obtained for certain mental health services in the areas also reportedly vary. In some instances, the CBCs have preferred that the mental health provider obtain prior authorizations for services by contacting the MCO directly, others have required that the providers go through the CBC to seek approval. The Partnership has provided for this flexibility at the local level in terms of how various functions are carried out.

Service Delivery

Mid and Local-Level Interviews

Issues related to determining who is eligible for Medicaid services continue to be problematic. There apparently is still no final resolution to the difficulties in cross matching the Medicaid files with the HomeSafenet database and children are not showing as eligible for Medicaid. This reportedly creates delays in services by providers who are reluctant to proceed with providing services without assurances of being paid. It was reported that efforts are continuing at the state level to resolve this major concern.

According to documentation from the MCO, prior authorizations (PA) are required for only certain services, which include: inpatient services, psychological testing, children's targeted case management, psychosocial rehabilitation services, and

respite care. Requests for these types of services must go through the CBCs and their Multi-Disciplinary Teams rather than directly to the MCO. Routine services such as outpatient care do not require prior authorizations from the MCO. One provider noted however, that one of their major challenges for them has been not receiving authorizations for certain levels of services that they believe are needed for the child.

Mid and local-level respondents reported that the means by which children access services really have not changed since before implementation of the CW-PMHP; however, the CBCs reported having more input into the child's care and treatment as well as having a better understanding of what mental health services are actually being provided. The CBCs are provided feedback from the MCO as to the services that have been authorized and provided. Providers indicated that the provision of mental health services also has not changed since pre-Plan implementation, including the way comprehensive assessments are done or the way in which families (including foster families) are involved in treatment planning. Providers indicated, however, that they were given treatment guidelines in their contract with the MCO, especially as they relate to the determinations of medical necessity.

Management Information Systems

Local and mid-level respondents were asked about any changes they have had to make regarding their management information systems in order to accommodate the implementation of the CW-PMHP. The Partnership noted that they are beginning to make changes that will include the development of software to help providers know in real time what placements are currently available across the state in order to facilitate appropriate placement decisions.

In terms of the data that is provided back to the CBCs, they get a weekly report from the MCO that details the services that have been authorized for their children and on a monthly basis they receive a report on the claims that have been paid for all services rendered. An emerging problem that was identified, however, was related to the fact that the child welfare system and the mental health system cannot always share information.

Anticipated Outcomes

State-Level Interviews

State-level interviewees were asked for their opinions on the capacity of the CW-PMHP system to help local communities identify and meet the mental health needs of the children and families served, whether or not the new system would result in a cost savings to the state, and what other system changes should occur as a result of the CW-PMHP.

Because the CW-PMHP was still in the early stages of implementation, respondents could not say definitively whether or not the new system would assist communities in identifying and meeting the mental health needs of children in the child welfare system and their families. However, all but one respondent were generally hopeful that this would occur. Two concerns mentioned by two different respondents were the uncertainty of having sufficient funds to meet children's identified needs and the lack of training assistance provided by DCF and AHCA.

State-level stakeholders appeared to be split in their opinions about whether or not the CW-PMHP system would result in economic savings. Three respondents reportedly did not believe such a cost savings would occur, citing the high service utilization of children in the child welfare system and the fact that they cannot be put on a waiting list. A suggestion was also made that there would be no long-term cost savings until financial incentives are offered to provide preventive care. Two respondents said that a cost savings would result because capitation rates would ensure lower costs; however, if funding limits were instituted for lower levels of care, it was expected that service utilization at higher levels of care would increase. The remaining interviewees were unsure about any resulting cost savings.

Regarding other possible system changes believed to result from the CW-PMHP, there were both positive opinions and concerns reported. Concerns included inadequate capitation rates, the reduction of available service funding due to administrative costs associated with managed care organizations, insufficient resources and access to services, increasing tension between CBCs and mental health providers in meeting children's needs, the exclusion of Statewide Inpatient Psychiatric Programs (SIPPs) from capitation, generating "another silo" resulting in more fragmentation of the child welfare system, and the need for a major system reform. Positive opinions focused on the opportunity to identify inefficient elements of the service system, the hope that CBCs would take a more active role in ensuring access to services and the possibility of developing more community-based services to improve access, the hope for improved integration between treatment plans and permanency planning, and the hope for a greater focus on family-directed care and early intervention.

Other respondent comments related to implementation of the CW-PMHP included the belief that there could have been much better use of the media, indicating that providing too little information can have a negative impact on stakeholders. One respondent also noted the divergence of systems and rules for children within the child welfare system due to the exclusion of certain areas of the state from the CW-PMHP. Another interviewee reported concerns about the failure of the CW-PMHP to integrate physical health and mental health care for the child welfare population and the possibility of cost shifting between health plans by classifying care under a non-capitated diagnosis. On a more positive note, it was mentioned that the CW-PMHP will allow The Partnership more flexibility in the creation of new services to meet children's needs.

Mid and Local-Level Interviews

Respondents at the mid and local levels were also asked about the outcomes that might be anticipated from the implementation of the CW-PMHP. Some of the positive outcomes that were cited were that children in the child welfare system were being better served by the mental health system than in the past because of improved access and more accountability. As one respondent noted "...we can go to providers and say, we've got this many kids that need this type of service, can you provide it? If they say no, we can go to Magellan and ask them to find us a provider." In terms of saving the state money, most believed that because of the initial reductions that were taken by the state when the capitation rate was

established and the fact that there is more accountability for the services being provided that the state would save money initially. There were some concerns, however, about long-term savings because of the high level of needs in the child welfare population. At least one respondent noted that there is a growing awareness of the gaps in the systems and another pointed out that more resources will be needed to address the diverse needs of this population.

Mail Survey Findings

Response Rate

Of the 68 foster parents surveyed in the two counties, 34 completed surveys have been returned at this point in time (after the follow-up postcard reminder). At the writing of this report, the second complete mailing had just been conducted and the final complete mailing is yet to be completed. The 34 completed surveys represent an unadjusted response rate of 50%. When adjusted for incorrect addresses and individuals who were no longer foster parents, the adjusted response rate is 52%. Given the mailing process is still underway, the results summarized below reflect the preliminary findings from this survey.

Characteristics of Responding Foster Parents

The ages of the 34 foster parents who have responded to date ranged from 34 to 71 years, averaging 50 years old (SD = 10 years). In terms of gender, 76% of the respondents were female. None of the respondents were Hispanic or Latino. Respondents were mostly white (85%) with 12% indicating they were Black/ African American. One respondent (3%) indicated they were Asian or Pacific Islander. Slightly over two-thirds (68%) of the respondents were foster parents serving St. Johns County, while the remaining 32% were foster parents serving Citrus County.

Experience and Current Involvement as a Foster Parent

On average, respondents had served as foster parents for 5.14 years (SD = 5.8 years). However, their level of experience was quite varied ranging from six months to 30 years.

With respect to the type of foster care respondents provided, 74% indicated they were non-relative foster homes, 41% were adoptive homes, 15% were approved non-relative caregivers, and 11% were non-relative family shelter homes. Two respondents (6%) indicated being relative foster homes, one foster parent (3%) an approved relative caregiver, and two foster parents (6%) reported being a non-relative medical foster home (note: respondents could select more than one response). In terms of the ages of children they served, 44% of the foster parents reported serving infants, 71% served youth, and 24% served adolescents. In addition, 12% reported housing foster children with medical needs (note: respondents could select more than one response).

At the time the survey was conducted, 26% of the respondents indicated that they currently had no foster children in their homes, 29% reported one child, 33% indicated two children, 6% had three children, and 6% stated that they

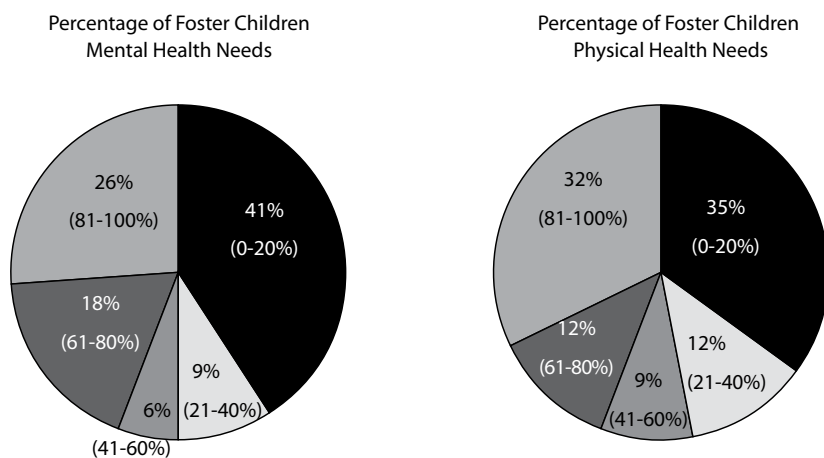
currently had four children. Approximately 29% of the foster parents reported currently having at least one child diagnosed with a developmental disability.

Two foster parents (6%) were brand new foster parents and reported never having a child in their care over the past five years, 21% reported having 1-3 children, 15% had 4-6 children, 18% had 7-9 children, one foster parent (6%) reported having 10-12 children, while the plurality (34%) reported fostering 12 or more children over the past five years. In terms of foster children’s lengths of stay, the majority of foster parents (74%) reported that a typical stay extended between one and four years.

Foster Children’s Health-related Needs and Service Use

Foster parents were asked to estimate the percentage of foster children that they had cared for over the past five years who needed physical health and/or mental health services. These data are summarized in Figure 2. Foster parents’ estimates regarding the percentage of foster children who needed mental health services were quite varied. Forty-one percent indicated that 20% or less of the foster children they had provided care to over the past five years needed mental health services. In contrast, 26% of the foster parents estimated between 81% and 100% of the children in their care needed mental health services.

Figure 2
Estimated Foster Children’s Physical and Mental Health Need



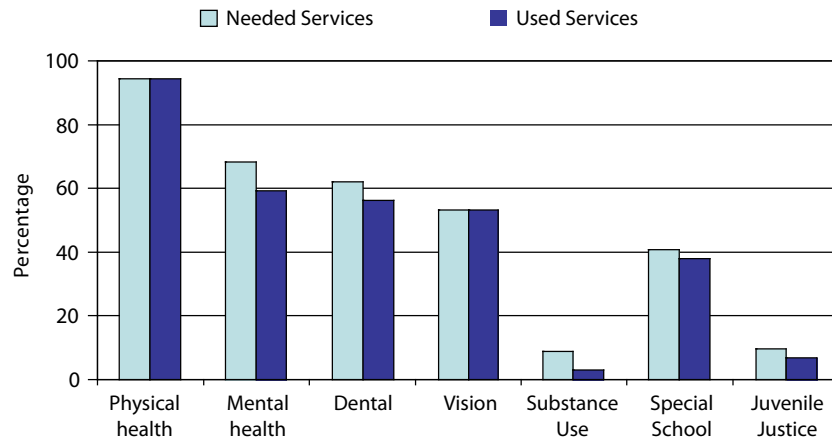
Similar findings were obtained regarding foster children’s needs for physical health services. Thirty-five percent of the foster parents reported that 20% or less of the foster children they had cared for during the past five years needed physical health services. In contrast, 32% of the foster parents estimated that between 81 and 100% of the children in their care needed physical health services.

Foster parents were also asked to think of a current foster child (or their most recent foster child if none were currently in the home), and to indicate if that child needed and used a variety of other services (e.g., physical, mental, dental, vision, substance use, school-based, juvenile justice). These results are summarized in Figure 3. As is shown in this figure, foster parents reported no identified service

gaps (i.e., reported need equaled reported use) regarding foster children’s physical health and vision services. Overall, 94% of the foster parents reported their foster child needed physical health services and all reported their child had used these services. Foster children’s need for vision services was reported by 53% of foster parents and again all of them indicated their children had received dental services.

In contrast, some gaps were reported between service needs and use for mental health, substance use, specialized school services, and juvenile justice. For mental health, 68% of the foster parents indicated their child needed mental health services, while only 59% reported their foster child received these services. The need for dental services was reported by 62% of the foster parents while 56% had received some care. Nine percent of the foster children were reported to need substance abuse services and one-third of these children were reported to have used these services. Foster children’s need for special school-based services was reported by 41% of the foster parents and these services were used by 38% of the children. Finally, a need for juvenile justice services was reported by 9% of foster parents and received by two-thirds of these children.

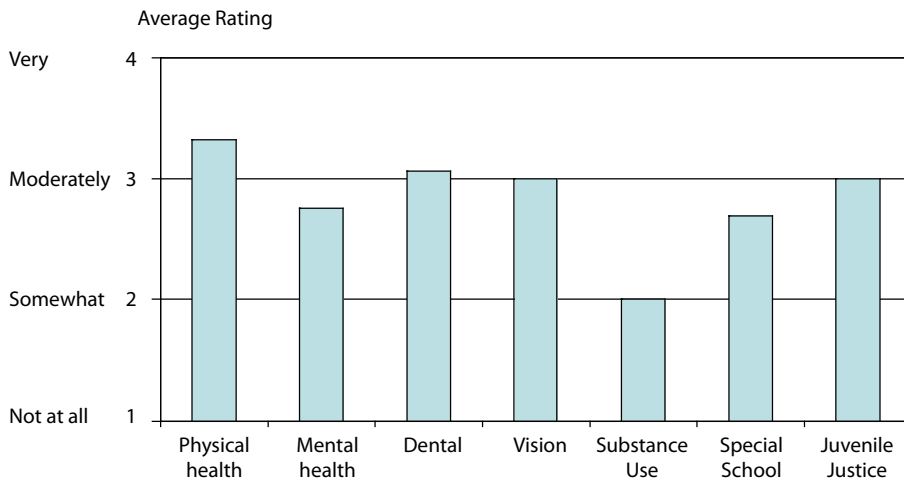
Figure 3
Foster Children’s Service Needs and Use



Foster Parents’ Satisfaction with Services

Foster parents were asked to assess their level of satisfaction with the various health-related services their foster children had received. These results are summarized in Figure 4. In general, foster parents’ level of satisfaction with the services their foster children had received fell in the “somewhat” to “moderate” range. Foster parents gave the highest rating to physical health services that foster children had received. Mental health and school-based services received similar “somewhat to moderately satisfied” ratings. Foster parents’ satisfaction with substance abuse services was rated poorest, however, few foster children were reported in need of these services.

Figure 4
Satisfaction with Services Received

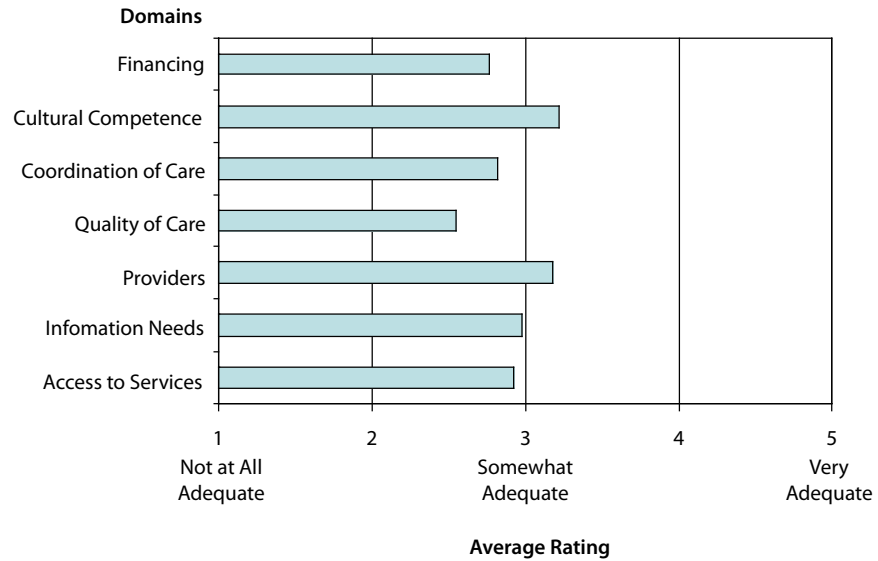


Issues Impacting the Care of Children in Foster Care

Foster parents were asked to rate the adequacy of 42 areas that can impact their ability to access mental health services for their foster children. For presentation purposes, item scores were reverse coded from those in the actual questionnaire so that higher scores would reflect a more positive assessment by foster parents. The five-point Likert-type scale ranged from 1 = “Not At All Adequate” to 5 = “Very Adequate.” These items are categorized into seven domains that are summarized in Figure 5. In addition, individual item responses and the percentage of foster parents rating the item below “somewhat adequate” are summarized in Appendix C.

In five of the seven domains (Access to Services, Information Needs, Quality of Care, Coordination, and Financing), foster parents’ average ratings across the items fell below the “somewhat adequate” level while their ratings in the other two areas (Case Managers & Mental Health Providers and Cultural Competence) were at the “somewhat adequate” level. None of the seven domains assessed received very positive ratings. Foster parents gave the lowest rating to the three items assessing quality of care (Mean = 2.55; SD = 1.03). Foster parents’ ratings on the three financing items ranked second lowest (Mean = 2.75; SD = 1.07). The three items assessing coordination of care received the third lowest rating by foster parents (Mean = 2.82; SD = .98). The 13 items assessing access to services (Mean = 2.92; SD = .84) and eight items focused on information needs (Mean = 2.98; SD = 1.01) received similar ratings from foster parents. The two domains rated at the “somewhat adequate” level included the ten items regarding child welfare case managers and mental health providers (Mean = 3.18; SD = 1.00) and the three items assessing cultural competence (Mean = 3.22; SD = 1.07). Independent t-tests were used to compare the responses of foster parents from St. Johns and Citrus Counties on each of the seven domains and no statistically significant differences were found on any domain.

Figure 5
Issues Impacting Care



Foster parents rated nine of the 13 items within the access to care domain below “somewhat adequate.” Specific areas in which foster parents raised concerns related to the availability of public transportation (Mean = 1.74; SD = 1.61) and availability of child care (Mean = 2.36; SD = 1.22). The adequacy of other support services (Mean = 2.84; SD = 1.11) was also poorly rated. Foster parents’ poor assessments regarding their ability to access a mental health specialist (Mean = 2.87; SD = 1.18) and their ability to reach mental health providers by telephone (Mean = 2.83; SD = 1.26) also raise cause for concern.

Foster parents reported serious concerns with half of the eight items within the information needs domain, rating each of these items as well below “somewhat adequate.” The greatest concern related to their need for access to foster children’s health records (Mean = 2.34; SD = 1.28). The need for this type of information also emerged during a focus group with foster parents in which it was stated that they “often receive children with no information about the child, have no knowledge of what has happened to the child previously such as any mental, medical, and past experience (abuse) issues.” The parents recommended that foster children’s records be maintained at a known centralized location so they can access them. It was also noted that “children show up with pills and foster parents have no knowledge of why these particular pills are being taken by the child.” Foster parents expressed a need for clarification of policies related to mental health services for foster children (Mean = 2.60; SD = 1.25). Foster parents also reported having training needs including the need for training on behavioral health strategies that they could use at home (Mean = 2.78; SD = 1.31) and enhanced education on mental health issues in foster children (Mean = 2.74; SD = 1.24).

With respect to specific items within the child welfare case managers and mental health provider domain, foster parents gave below “somewhat adequate” ratings to child welfare case managers’ ability to managed assigned caseloads (Mean = 2.72;

SD = 1.25) and to their knowledge of the mental health needs of foster children (Mean = 2.80; SD = 1.30). Foster parents also raised some concerns regarding the adequacy of child welfare case managers' training (Mean = 2.97; SD = 1.27). These concerns are consistent with many of the issues raised during a focus group conducted with foster parents during the development of this questionnaire. Foster parents indicated their child welfare case managers "lacked knowledge of the mental health system" and "did not have enough time to address mental health issues with them because they usually only see children and foster parents for 20 minutes a month." Foster parents provided somewhat more positive ratings regarding the consistency with which foster children see the same mental health provider (Mean = 3.85; SD = 1.08) and the seriousness with which mental health providers take foster parents' concerns (Mean = 3.68; SD = 1.22).

As previously noted, the three items assessing quality of care received the poorest average rating of any of the seven domains. Each of the three items was rated substantially below the "somewhat adequate" rating. Foster parents raised serious concerns with their ability to choose mental health service providers (Mean = 2.34, SD = 1.17), with the adequacy of mental health screenings and assessments (Mean = 2.66; SD = 1.04), and the timeliness in which they are conducted (Mean = 2.66; SD = 1.20). Choice emerged as an issue during the foster parent focus group with one parent stating that they had "...no choice of the facilities available and that there were only two facilities that foster children could go to if Medicaid was to pay for them." Other foster parents cited concerns that "children are not diagnosed properly," that there is a "lack of compatibility of services" with many foster children's needs, and a "need for more focus on therapy and less on medication."

Foster parents rated coordination of care as the third lowest domain, rating two of the three items well below "somewhat adequate." These two items focused on the adequacy of the amount of information shared across systems (i.e., schools, child welfare and mental health) (Mean = 2.70; SD = 1.09) and the adequacy of level of coordination of services provided across these systems (Mean = 2.71; SD = 1.24). Communication issues also arose during the focus group, with one foster parent noting that "communication problems exist within the system, between placements, and among case workers." This concern was exacerbated as one foster parent noted, because "no individual is likely to have all the information" that is necessary to provide adequate care to a foster child.

The two items assessing cultural competence received the highest overall rating of any domain – slightly above "somewhat adequate." Foster parents assessed the cultural sensitivity of the service providers (Mean = 3.31; SD = 1.14) and the availability of ethnically diverse service providers (Mean = 3.14; SD = 1.12) as "somewhat adequate." It should be noted that the majority of the foster parents who responded were Caucasian (86%) however, we do not know about the demographics of the children in their care. In addition, one respondent reported that they "encountered prejudice against Black/Hispanic children with some providers."

Foster parents' overall assessment of the mental health financing domain was rated the second worst with each of the three items being rated well below "somewhat adequate." Foster parents reported the adequacy of the system's funding for mental

health services (Mean = 2.68; SD = 1.19), the adequacy of foster children's mental health benefits (Mean = 2.79; SD = 1.11) and their own access to money to pay for foster children's mental health services (Mean = 2.86; SD = 1.16).

Foster Parents' Knowledge of the Child Welfare Prepaid Mental Health Plan

Foster parents were asked if they were aware that the mechanism for funding mental health services for children in the child welfare system had been recently changed. Overall, only 18% of the respondents reported that they knew about this change; however, differences in foster parents' awareness seemed dependent on the county in which they served. None of the 11 responding foster parents serving Citrus County reported they were aware of this change, while 26% of the 23 responding foster parents serving St. Johns County reported they knew of these changes. Of the foster parents who had been informed of the CW-PMHP, 33% reported that they learned of this change through the child welfare case manager, 33% received a letter from the state or lead agency, and 33% reported they heard about it at a foster parent meeting.

Disrupted Placements

Foster parents were asked if they ever had to have a child removed from their home and if so, why, and what services and/or supports might have prevented the disrupted placement. Over half of the respondents (58%) reported that they requested to have a foster child removed from their home. The reasons foster parents most frequently cited regarding why a foster child had to be removed focused on the foster child's behaviors. Sample responses included "behavioral issues that I could not receive help with," "child became violent and went into a rage," "child's behavior related to other children in the home," "disruptions made life difficult for other children in home," and "the brother was abusing the sister." When asked if the availability of any services or supports might have prevented the failed placement, 29% cited access to intensive treatment, 29% reported access to intensive in-home behavioral services, 15% wanted more practical help/advice from the child welfare agency, 15% cited 24-hour emergency services, 12% reported more contact with the case manager, 9% indicated the availability of respite care, and 9% cited a higher board rate (note: respondents could select more than one response).

Discussion & Policy Implications

A few limitations should be noted prior to interpretation of findings. First, the CW-PMHP itself was implemented less than a year ago, and in some areas of the state, is just now being implemented. Second, although the counties included in this study to date have different lead agency organizational structures and levels of child welfare funding, both communities are rural. Thus, findings cannot be generalized to the entire State. The next evaluation report will include a metropolitan area. Finally, although the response rate to the mail survey was high, due to the rural nature of the counties included in the current report, the total sample is small.

Findings indicate that AHCA and The CBC Partnership have worked closely to establish provider networks and work through eligibility issues. The majority of stakeholders generally felt that the transition to managed mental health care went more smoothly than anticipated. Initially, several providers were hesitant to join the network due to lack of information and uncertainty regarding managed care initiatives. However, both AHCA and The Partnership worked jointly to alleviate these concerns.

Communication mechanisms are in place to support frequent and ongoing dialogue between AHCA and The Partnership. Also, trainings continue to be held with local level agencies and many court judges that have facilitated consistent communication about how the plan will operate. Conversely, when foster parents were asked if they knew of the Child Welfare Prepaid Mental Health Plan, or that the funding for mental health services for children in their care had changed, the majority of foster parents said no.

The Partnership and lead agencies should improve efforts to better communicate with foster parents concerning the health and mental health needs of foster children in their care, and increased access to the health records of foster children would be helpful. Continued efforts need to be made to keep families (including foster families) informed about the CW-PMHP and to provide opportunities for them to have a voice in its operation. All parties should work to ensure that current levels of communication among stakeholders do not diminish over time so that the current momentum and levels of understanding about the CW-PMHP are maintained.

Participants also noted that there seemed to be better accountability for the mental health services that were being provided. Child welfare staff have more opportunity for input into treatment planning and are more aware of the services that the children and youth are receiving. Behavioral health providers though, indicated that the provision of mental health services also has not changed since pre-Plan implementation, including the way comprehensive assessments are done or the way in which families (including foster families) are involved in treatment planning. However, this may also be a reflection of the fact that providers felt they were doing a good job prior to implementation of the CW-PMHP. The Partnership should increase its focus on enhancing relationships with direct providers, providing training and technical assistance as needed and checking

with them periodically to obtain their perspectives on “how things are going,” to obtain suggestions on ways to improve determinations of eligibility, prior authorization processes, streamline billing, etc.

When foster parents were asked to rate the adequacy of aspects of their children’s care, none of the seven domains received very positive ratings. The quality of care domain was rated the lowest. Specifically, foster parents expressed concerns regarding their ability to choose mental health service providers, with the adequacy of mental health screenings and assessments, and the timeliness in which these screenings are conducted. Efforts to ensure that mental health screenings are completed in a timely manner and that foster parents are informed of their results could help minimize these concerns. The domain of coordination of care came in third lowest, with foster parent concerns centering on the adequacy of the amount of information shared across systems (i.e., schools, child welfare and mental health) and the adequacy of the level of coordination of services.

A commonly identified challenge in implementation of the CW-PMHP was having accurate and timely eligibility files. Every effort should continue to be made to resolve the problems with matching the HomeSafenet database and the Medicaid eligibility files. Once an accurate eligibility file is established it should be made available to providers on a timely basis. Receiving accurate eligibility information is complicated by the fact that children are enrolled and dis-enrolled as they enter and exit different parts of the treatment system, e.g., the SIPP or BHOS, or they enter and exit care. The impact of these challenges has reportedly delayed the process of obtaining prior authorizations for services and the receipt of treatment. In addition, inordinate amounts of time and staff resources are reportedly being spent on reconciling these issues. Consideration should be given to further integration of services such as SIPP and BHOS into the CW-PMHP to promote better coordination of care and reduce system fragmentation. In addition, efforts should be made to keep other managed care plans informed as children exit the CW-PMHP so that assignment to the correct plan can be determined and communicated to providers.

Another implementation challenge has to do with child welfare and mental health’s interface with the court system, where judges are ordering care that is not reimbursable by Medicaid or that is not included in the CW-PMHP, such as psychiatric evaluations. The Partnership and child welfare lead agencies should continue their efforts to educate the court and school systems about the CW-PMHP.

In terms of saving the state money, most believed that, because of the initial reductions that were taken by the state when the capitation rate was established and the fact that there is more accountability for the services being provided, the state would save money initially. There were some concerns, however, about long-term savings because of the high level of needs in the child welfare population. At least one respondent noted that there is a growing awareness of the gaps in the systems and another pointed out that more resources will be necessary in order to address the diverse needs of this population.

Additional areas of concern voiced by foster parents included access to services, the need for more information, and adequacy of child welfare case managers and mental health providers. Regarding access to care, problems identified were the lack of available of public transportation, lack of available childcare, inability to reach mental health providers by telephone, and an inability to obtain mental health services for their foster children when needed. While providers are not contractually obligated or singularly responsible for providing these services, effort should be made to explore how to collectively respond to these barriers. Regarding the need for more information, foster parent concerns related to need for access to foster children's health records, need for clarification of policies related to mental health services for foster children, need for training on behavioral health strategies that can be used in the home, and enhanced education on mental health issues in foster children. Issues specific to child welfare case managers and mental health providers included child welfare case managers' lack of knowledge of the mental health needs of foster children, their inability to manage assigned caseloads, and the inadequacy of child welfare case managers' training. Foster parents were somewhat more positive regarding the consistency with which foster children see the same mental health provider and the seriousness with which mental health providers take foster parents' concerns.

Next Steps for the Evaluation

This year, the Implementation Analysis sub-study will continue to focus on the implementation of the CW-PMHP, the various roles and relationships that stakeholders had in the early phases of implementation, as well as communication about the new plan. Due to the smaller size of the child welfare populations in St. Johns and Citrus Counties, an urban population will be added to the study in order to include an area with a larger child welfare population. Interviews with the Community-Based Care Lead Agencies and local mental health and child welfare providers in the urban area will begin in the second quarter of FY07-08.

An initial mailing of the mail survey will also be conducted with foster parents in this urban area. The names and addresses of foster parents will be solicited from the Lead Agency in this county. Depending on the number of foster parents serving this county, a decision will be made to either survey all foster parents or to sample a subgroup of foster parents.

In addition to continuing research activities within these two study components, a third component was added to the FY07-08 contract – a Quality of Care sub-study. The overall objective of the Quality of Care sub-study is to examine the experiences of families and providers involved in court-ordered in-home cases in the CW-PMHP relevant to the following six domains:

- access to services
- adequacy of service array
- consumer engagement (e.g., family-driven services and respect for youth and families)
- appropriateness of services
- evidence-based programs and practices
- child outcomes

This will be accomplished through the use of semi-structured interviews and focus groups. Separate protocols will be developed for each population in order to capture the unique experiences of each group.

References

- Armsden, G., Pecora, P. J., Payne, V. H., & Szatkiewicz, J. P. (2000). Children placed in long-term foster care: An intake profile using the Child Behavior Checklist/4-18. *Journal of Emotional and Behavioral Disorders, 8*(1), 49-64.
- Barrilleaux C., Phillips S., & Stream, C. (1995). *Florida Medipass evaluation report*. Tallahassee, FL: Policy Science Center, Florida State University.
- Blumberg, E., Landsverk, J., Ellis-MacLeod, E., Ganger, W., & Culver, S. (1996). Use of the public mental health system by children in foster care: Client characteristics and service use patterns. *Journal of Mental Health Administration, 23*(4), 389-404.
- Boothroyd, R. A., & Shern, D. L. (1998, January). *Assessing the feasibility of using mail survey methodology with Medicaid enrollees: A summary of a pilot study for the member survey*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.
- Brown, J. A., & Nederend, S. E. (1997). *Locating and surveying Medicaid and AFDC beneficiaries: CAHPS field test experience to date*. Santa Monica, CA: RAND, (DRU-1664-AHCPR).
- Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M. & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*(3), 147-159.
- Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youth involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(8), 960-970.
- Chernoff, R., Combs-Orme, T., Risley-Curtiss, C., & Heisler, A. (1994). Assessing the health status of children entering foster care. *Pediatrics, 93*(4), 594-601.
- Clausen, J. M., Landverk, J., Granger, W., Chadwick, D., & Litrownik, A.. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies, 7*(3), 283-296.
- Dillman, D. A. (1978). *Mail and telephone surveys: The total design method*. New York, John Wiley & Sons, Inc.
- Dubowitz, H., Zuravin, S., Starr, R. H., Feigelman, S., & Harrington, D. (1993). Behavior problems of children in kinship care. *Journal of Developmental and Behavioral Pediatrics, 14*(6), 386-393.
- Fanshel, D., & Shinn, E. B. (1978). *Children in foster care: A longitudinal investigation*. New York, NY: Columbia University Press.
- Farmer, E. M. Z., Burns, B. J., Chapman, M. V., Phillips, S. D., Angold, A., Costello, E. J. (2001). Use of mental health service by youth in contact with social services. *Social Services Review, 75*(4), 606-624.
- Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).
- Garland, A. F., & Besinger, B. A. (1997). Racial and ethnic difference in court referred pathways to mental health services for children in foster care. *Youth Services Review, 19*(8), 651-666.

- Garland, A. F., Hough, R. L., McCabe, K. M., Yeh, M., Wood, P. A., & Aarons, G. A. (2001). Prevalence of psychiatric disorders in youths across five sectors of care. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(4), 409-418.
- Government Accountability Office (2006, October). *Child welfare: Improving social service program, training, and technical assistance information would help address long-standing service level and workplace challenges: Report to the Ranking Minority Member, Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives (GAO-07-75)*. Washington, DC: Author. Retrieved September 26, 2007 from <http://www.gao.gov/new.items/d0775.pdf>.
- Halfon, N., Berkowitz, G., & Klee, L. (1992a). Children in foster care in California: An examination of Medicaid reimbursed health services utilization. *Pediatrics*, 89(6 Pt2), 1230-1237.
- Halfon, N., Berkowitz, G., & Klee, L. (1992b). Mental health utilization by children in foster care in California. *Pediatrics*, 89(6 Pt 2), 1238-1244.
- Halfon, N. G., Mendonca, A., & Berkowitz, G. (1995). Health status of children in foster care: the experience of the center for the vulnerable child. *Archives of Pediatric Adolescent Medicine*, 149(4), 386-392.
- Hansen, R. L., Mawjee, F. L., Barton, K., Metcalf, M. B., & Joye, N. R. (2004). Comparing the health status of low-income children in and out of foster care. *Child Welfare*, 83(4), 367-380.
- Hefflinger, C. A., Simpkins, C. G., & Combs-Orme, T. (2000). Using the CBCL to determine the clinical status of children in state custody. *Children and Youth Services Review*, 22(1) 55-73.
- Hochstadt, N. J., Jaudes, P. K., Zimo, D. A., & Schachter, J. (1987). The medical and psychosocial needs of children entering foster care. *Child Abuse and Neglect*, 11(1), 53-62.
- Hulsey, T. C., & White, R. (1989). Family characteristics and measures of behavior in foster and nonfoster children. *American Journal of Orthopsychiatry*, 59(4), 502-509.
- Kanuk, L., & Berenson, C. (1975). Mail surveys and response rates: A literature review. *Journal of Marketing Research*, 12(4), 440-453.
- Kavaler, F., & Swire, M. R. (1983). *Foster-child health care*. Lexington, MA: Lexington Books.
- Kerker, B. D. & Dore, M. M. (2006). Mental health needs and treatment of foster youth: Barriers and opportunities. *American Journal of Orthopsychiatry*, 76(1), 138-147.
- Klee, L., Soman, L. A., & Halfon, N. (1992). Implementing critical health services for children in foster care. *Child Welfare*, 71(2):99-111.
- Kolko, D. J., Seleyo, J., & Brown, E. J. (1999). The treatment histories and service involvement of physically and sexually abusive families: Description, correspondence, and clinical correlates. *Child Abuse and Neglect*, 23(5), 459-476.
- Krueger, R. A. (1994). *Focus groups: A practical guide for applied research (2nd ed)*. Thousand Oaks, CA: SAGE Publications.
- Krueger, R. A. (1998). *Developing questions for focus groups (Focus Group Kit, no. 3)*. Thousand Oaks, CA: SAGE Publications.
- Lawton and Rhea Chiles Center for Healthy Mothers and Babies (2000). *Florida foster care recruitment and retention: Perspectives of stakeholders on the critical factors affecting recruitment and retention of foster parents: Phase I of a two-part study Commissioned by the Department of Children and Families*. Tampa, FL: Author. Retrieved September 27, 2007 from <http://www.teamfla.org/downloads/FCAPRptFINAL7-31-00.pdf>.

- Leslie, L. K., Gordon, J. N., Meneken, L., Premji, K., Michelmore, K. L., & Ganger, W. (2005). The physical, developmental, and mental health needs of young children in child welfare by initial placement type. *Journal of Developmental & Behavioral Pediatrics, 26*(3), 177-186.
- Litrownik, A. J., Taussig, H. N., Landsverk, J. A., & Garland, A. F. (1999). Youth entering an emergency shelter care facility: Prior involvement in juvenile justice and mental health systems. *Journal of Social Service Research, 25*(3), 5-19.
- McIntyre, A., & Keesler, T. Y. (1986). Psychological disorders among foster children. *Journal of Clinical Child Psychology, 15*(4), 297-303.
- McMillen, J. C., Zima, B. T., Scott, L. D., Auslander, W. F., Munson, M. R., Ollie, M. T., & Spitznagel, E. L. (2005). Prevalence of psychiatric disorders among older youths in foster care system. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(1), 88-95.
- Moffatt, M. E., Peddie, M., Stulginkas, J. L., Pless, I. B., & Steinmetz, N. (1985). Health care delivery to foster children: A study. *Health and Social Work, 10*(2), 129-137.
- Office of Program Policy Analysis & Government Accountability (2006). *Child welfare system performance mixed in first year of statewide community-based care (Report No.06-50)*, Tallahassee, FL: Author. Retrieved September 27, 2007 from <http://www.oppaga.state.fl.us/reports/pdf/0650rpt.pdf>.
- Pilowsky, D. (1995). Psychopathology among children placed in family foster care. *Psychiatric Services, 46*(9), 906-910.
- Pincus, H.A., Zarin, D.A., & West, J.C. (1996). Peering into the 'black box': Measuring outcomes of managed care. *Archives of General Psychiatry, 53*(10), 870-877.
- Raghavan, R., Leibowitz, A. A., Andersen, R. M., Zima, B. T., Schuster, M. A., & Landsverk, J. (2006). Effects of Medicaid managed care policies on mental health service use among a national probability sample on children in the child welfare system. *Children and Youth Services Review, 28*(12), 1482-1496
- Ridgely, M.S., Giard, J., Shern, D., Mulkern, V. & Burnam, M.A. (2002) Managed behavioral health care: An instrument to characterize critical elements of public sector programs. *Health Services Research, 37*(4), 1105-1123.
- Rohland, B. M., & Rohrer, J. E. (1996). Evaluation of managed mental health care for Medicaid enrollees in Iowa. *Psychiatric Services, 47*(11), 1185-1187.
- Rosenbach, M. (2001, March). *Children in foster care: Challenges in meeting their health care needs through Medicaid (Policy Brief series)*. Princeton, NJ: Mathematica Policy Research Institute. Retrieved May 2007, from http://www.emq.org/press/docs/foster_care_brief.pdf.
- Salant, P. A., & Dillman, D. A. (1994). *How to conduct your own survey*. New York, NY: John Wiley & Sons, Inc.
- Schneiderman, M., Connors, M. M., Fribourg, A., Gries, L., & Gonzales, M. (1998). Mental health services for children in out-of-home care. *Child Welfare, 7*(1), 29-40.
- Schor, E. L. (2005). Developmental and behavioral services and child welfare. *Pediatrics, 117*(2), 591.
- Semansky, R. M., & Koyanagi, C. (2004). Obtaining child mental health services through Medicaid: The experience of parents in two states. *Psychiatric Services, 55*(1), 24-25.
- Shin, S. H. (2005). Need for and actual use of mental health services by adolescents in the child welfare system. *Children and Youth Services Review, 27*(9), 1071-1083.

- Simms, M. D., Dubowitz, H., & Szilagyi, M. A. (2000). Health care needs of children in the foster care system. *Pediatrics*, *106*(4 Suppl), 909-918.
- Simms, M. D., & Halfon, N. (1994). The health care needs of children in foster care: A research agenda. *Child Welfare League of America*, *73*(5), 505-524.
- Stahmer, A. C., Leslie, L. K., Hurlburt, M., Barth, R. P., Webb, M. B., Landsversk, J., & Zhang, J. (2004). Developmental and behavioral needs and service use for children in child welfare. *Pediatrics*, *116*(4), 891-900.
- Staudt, M. M. (2003). Mental health service utilization by maltreated children: Research findings and recommendations. *Child Maltreatment*, *8*(3), 195-203.
- Stein, E., Evans, B., Mazumdar, R., Rae-Grant, N. (1996). The mental health of children in foster care: A comparison with community and clinical samples. *Canadian Journal of Psychiatry*, *41*(6), 385-391.
- Stiffman, A. R., Chen, Y. W., Elze, D., Dore, P., & Cheng, L. C. (1997). Adolescents' and providers' perspectives on the need for and use of mental health services. *Journal of Adolescent Health*, *21*(5), 335-342.
- Swire, M. R., & Kavalier, F. (1977). The health status of foster children. *Child Welfare*, *51*(10), 635-653.
- Thompson, A. H., & Fuhr, D. (1992). Emotional disturbance in fifty children in the care of a child welfare system. *Journal of Social Service Research*, *15*(3/4), 95-112.
- Vargo, A. C., Armstrong, M., Jordan, N., Kershaw, M. A., Pedraza, J., Romney, S., et al. (2006). *Florida's IV-E Waiver Demonstration evaluation plan*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute.
- Wolkind, S., & Rutter, M. (1973). Children who have been "in care": An epidemiological study. *Journal of Child Psychology and Psychiatry*, *14*(2), 95-105.

Appendix A: Mental Health Prevalence Rates among Children in Foster Care

Citation	Sample			Method Used	Results/Rates
	Age	Size	Description		
Armsden, Pecora, Payne, & Szatkiewicz (2000)	4 to 18 years old average age 10.5 years old (SD=3.1)	362	children from 13 states served in long-term family foster care by The Casey Family Program	CBCL – caregiver form	11% borderline & 20% clinical on internalizing 10% borderline & 28% clinical on externalizing 10% borderline & 30% clinical on total problem
Blumberg, Landsverk, Ellis-MacLeod, Ganger, Culver (1996)	0 to 16 year old average age was 5.41 years old (SD=4.63)	1,352	participants in the Foster Care Mental Health Study, selected from adolescents referred to the Hillcrest Receiving Home in san Diego County	at least one episode in the mental health system	17.4% also had involvement with the mental health system
Burns, Phillips, Wagner, Barth, Kolko, Campbell, & Landsverk (2004)	2 to 14 years old	3,803	data from the National Survey of Child and Adolescent Well-being	children CBCL-2-5 caregiver report children CBCL 6-10 caregiver or teacher report children 11-older combined caregiver, teacher, and youth reports	47.9% scored in the clinical range adolescent 65.7% pre-schoolers 32.3%
Chernoff, Combs-Orme, Risley-Curtiss, & Heisler (1994)	0 to 19 years old average age was 7.5 years old	1,407	children entering the Baltimore City department of Social Services	health exams completed at entry into foster care (mental health status screening was completed on 77% of children 3 or older n≈775)	36.2% had a history of behavioral problems 14.8% suicide ideation 6.9% homicidal ideation
Clausen, Landsverk, Granger, Chadwick, & Litrownik (1998)	0 to 17 years old	267	children from 3 California counties	one or more standardized measures including the CBCL-Parent Report, Piers-Harris Self-Concept Scale, & Vineland Adaptive Behaviors Scales	50.0% San Diego 42.5% Monterey 46.7% Santa Cruz
Dubowitz, Zuravin, Starr, Feigelman, & Harrington (1993)	2 to 16 years old	346	children in kinship care under the supervision of the Baltimore City Department of Social Services	CBCL – Parent Report	42% of boys in clinical range 28% of girls in clinical range (expected is 10% in a general pediatric population)
Fanshel and Shinn (1978)	Birth to 12 years old		New York City children placed in non-treatment foster settings in 1966	Vineland Adaptive Behavior Scale and the Louisville Behavior Checklist	11% to 40% depending on age and measure used. Children “have a large number of behavioral problems often associated with psychiatric disorders” (pg. 53)

Citation	Sample			Method Used	Results/Rates
	Age	Size	Description		
Farmer, Burns, Chapman, Phillips, Angold, Costello (2001)	9, 11, 13 years old	132 foster care subgroup	data from the Great Smokey Mountain study – a rural region in the southeastern US. Children were randomly selected from public schools	Child and Adolescent Psychiatric Assessment	5.6% had a diagnosis 35.4% had an impairment 37.5% had SED
Garland, Hough, McCabe, Yeh, Wood, Aarons (2001)	12 to 18 years old	426 in child welfare subgroup	children engaged child welfare system in San Diego, CA.	Diagnostic Interview Schedule for Children	41.8% met diagnostic criteria for a least one study disorder
Halfon, Berkowitz, & Klee (1992)	0 to 18 years old	27,446	foster children using Medi-Cal mental health services during 1988	expenditure data from California's Medi-Cal program	children in foster care accounted for 41% of user of mental health services although they only represented 4% of the enrolled population
Halfon, Mendonca, & Berkowitz (1995)	children younger than 12, preference for younger than 6 years old average age 3.1 years old	213	children referred to long-term foster care by the Alameda County (CA) Department of Social Services	systematic chart reviews	60% emotional problems 51% relationship problems 54% coping problems 29% behavioral problems
Hansen, Mawjee, Barton, Metcalf & Joyce (2004)	birth to 18 years old	226	foster children seen between 8/98 and 2/99 at the Foster Health Care Program (Sacramento, CA)	abstracted medical charts	42.2% behavior problems 17.6% aggressive or destructive behavior 10.1% attention deficit disorders 1.5% self-injurious behavior
Heflinger, Simpkins, & Combs-Orme (2000)	2 to 18 years old	254	random sample of children in foster care, kinship care, group residential facilities, and state institutions through the Children's Program Outcome Review Team in Tennessee	CBCL	34% of the children were reported as having significant behavior problems (23% in clinical range; 11% borderline)
Hochstadt, Jaudes, Zimo, & Schachter (1987)	10 days to 17 years old	149	children entered foster care during 1984 in Cook County, IL	Louisville Behavior Checklist and the Vineland Adaptive Behavior Scale	11% to 40% depending on age and measure used. "significant number of behavioral problems, far in excess of that expected in the general population" (pg. 58)
Hulsey & White (1989)	average age 5.8 years old	65 in the foster care subgroup	children in the Baltimore city foster care program	CBCL	children in foster care had significantly higher CBCL score compared to non-foster care children
Kavalier & Swire (1983)	0 to 15 years old	668	in foster care in New York City for at least one year		70% had moderate to severe mental health problems

Citation	Sample			Method Used	Results/Rates
	Age	Size	Description		
Leslie, Gordon, Meneken, Premji, Michelmore, & Granger (2005)	3 months to 5 years 11 months average age 2.9 years old	1,542	admitted to San Diego's sole emergency shelter/receiving facility	documented mental health diagnoses in children's child welfare and medical records	8.7% had a mental health diagnosis 7.8% were recommended for more in-depth evaluation
Litrownik, Taussig, Landsverk, & Garland (1999)	11 to 17 years old	295	children and youth entering an emergency shelter care facility Serving the central and southern regions of San Diego County	children and youth self-reports	43.1% of children reported receiving counseling and 10.5% report admission to a psychiatric hospital
McIntyre & Keesler (1976)	4 years, 11 months to 18 years, 9 months old	158	foster children in east Tennessee	CBCL	48.7% manifested clinical psychological disorders on the narrow-band index
McMillen, Zima, Scott, Auslander, Munson, Ollie, & Spitznagel (2005)	17 year olds average age 16.99 (SD=.09)	373	youth in foster care from eight Missouri counties in and around St. Louis	Diagnostic Interview Schedule	61% had at least one psychiatric disorder during their lifetime 37% met criteria for a psychiatric diagnosis during the past year
Moffatt, Peddie, Stulginkas, Pless & Steinmetz (1985)	under 2 to 18 year old	subsample of 35	foster children served between 1968 and 1970 by a large social services agency in Montréal Quebec	CBCL	13% in the clinical range 29% abnormal range 10% known psychiatric problem
Pilowsky (1995)	Birth to 18 years olds across the 13 studies	1,997 across the 13 studies	varied across the 13 studies	review and analysis of the published literature between 1974 & 1994 "most studies have used the Achenbach's CBCL to estimate the prevalence of psychopathology" (pg. 908)	25% to 63% across the 13 studies depending on age group and method used to determine impairment
Schor (2006)	0-22 year old	387	random sample of foster children enrolled in the Chesapeake Health Plan	medical record reviews	37%
Shin (2005)	16.5 to 17.5 year old	113	foster youth from a large mid-western state	Mental Health Inventory (MHI) and Medicaid paid claims	MHI scores for foster children were significantly higher than for youth in a general population 40% conduct disorder 32% depressive disorders 32% adjustment disorders 19% anxiety disorder 13% ADHD 9% bipolar 8% schizophrenia 50% had used mental health services (10 times more likely than general population youth)

Citation	Sample			Method Used	Results/Rates
	Age	Size	Description		
Stahmer, Leslie, Hurlburt, Barth, Webb, Landsversk, & Zhang (2004)	1 to 71 months old	2,813	data from the National Survey of Child and Adolescent Well-being	CBCL and Vineland Adaptive Behavior Checklist	among 0-2 year olds, 6.2% had adaptive behavior problems while 25.7% had behavioral needs among 3-5 year olds, 14.9% had adaptive behavior problems, 31.9% had behavioral needs, 8.2% had social skill deficits
Stein, Evans, Mazumdar, & Rae-Grant (1996)	4 to 16 years old	248 in the foster care group	wards of the London, Ontario and Middlesex Children's Aid Society	Standardized Clinical Information System - parent and teacher forms (an adaptation of the CBCL)	"clinical scores of the CAS group [foster care children] were much closer to those of the clinical group than the community norm" (pg. 389)
Swire, & Kavalier (1977)	1 to 15 years old	179	5 boroughs of NYC and western Nassau County	direct clinical evaluation	35% judged to have "moderate impairment" 35% "marked-to-severe" impairment
Thompson and Fuhr (1992)	6 to 18 years old	50	random sample of foster children from an urban child welfare agency	CBCL, Eysenck Personality Questionnaire, Children's Depression Inventory	72% of the sample rated by social worker as displaying emotional disturbance 56% recommended for counseling 60%-80% had pathology depending on the cut-off score used
Wolkind & Rutter (1973)	10 to 11 year old		school children from the Isle of Wright and an inner London borough	teacher questionnaire developed by Rutter (1967)	

Appendix B: Foster Parents' Open-ended Responses

What recommendations do you have regarding the availability and quality of mental health services for foster children?

St. Johns County

- > Access to the psychiatrist is inadequate- need more psychiatrists. There is a need for programs during school vacations as well as summer school vacation for children with mental health challenges. There is a need for therapists who are male. There is a need for therapists who are minorities.
- > I just started getting referrals for mental health/ behavioral services. So far, headed in the right direction but the process is slow. Some questions regarding mental health I could not answer as it did not apply to my case yet.
- > I think they do the best. What they need is more funding.
- > I am unable to make recommendations at this time because the child has not been placed with me.
- > It would have been helpful to have an updated list of the services available including phone numbers, addresses, and names of the people available. Trying to find any service has been difficult. Mental health and medical were the easiest by far!
- > For my family, services have been timely and helpful. This has not always been the case with other families in the system. Our mental health and social work professionals need to be educated in the area of attachment disorder as this is a huge problem in the foster care community. These children are frequently misdiagnosed and not properly cared for. Increasing awareness and educating the social work/ mental health communities would be a huge benefit to foster children and the families trying to help them.
- > I have not had a lot of experience with mental health because most of my children are too young. Most of my knowledge comes from medical services and stories from other foster parents on mental health.
- > So long as county mental health employees are not allowed, unwilling to opine on re-unification out of fear of legal liability- they should stop seeing the children! This is an abomination and against ethical justice and any decent licensed therapist. Send the kids to therapists who are not restrained by such fears. What's happening now is not in children's best interests. I know this as a therapist and a guardian ad litem. Call me should you like to discuss further. Cell phone is above.
- > The system seems to disregard the foster parents. In order to get an appointment MHS, FIP needs to make it. I state this since I attempted to make an appointment and it is four weeks and it has not been done yet- both case worker and super notified seven times.
- > Not enough support or services available to help manage children. I believe all foster children should be receiving mental health care. They should not be moved from a loving foster home to a relative to save the state money!
- > Need availability outside of St. Johns County mental health system to private and/or other non-profit counselors. Just as case managers are way overloaded, so are mental health staff and so availability is difficult. Need more phone follow-up with counselors. Counselors may see child regularly for some time but then disruption happens in schedule, but counselor does not personally follow-up with foster parent or case manager. Case managers have fewer children so they can spend more time in homes observing and being available for conversation with foster parents. They may see things that foster parents have not noticed.
- > St. Johns mental health providers that I have used were very good and seemed to care for the children. It was only lack of information about the progress of the child that I didn't like too well. It went to the Department of Children and Families.

- > There is a conflict of interest between our CBC (family integrity program, FIP) and St. Johns County Mental Health- both county run. They don't make decisions on the child's needs and permanency for the child. It's what's best for FIP and their bottom line. Dr. (Name redacted) of St. Johns County Mental Health is about pushing drugs to the children. That is her cure all, with little or no regard to therapy or specialized help. We need a therapist who is specially trained in treating children with attachment disorders. Furthermore, we need FIP and its team members (starting from the top with [Name redacted]) to educate themselves on attachment disorders. We are among the highest quality of foster parents, who have put our heart and soul into the children who come into our home are sadly giving up our foster care license due to the high level of frustration and lack of support we received from FIP. Our hearts will always be with the children of our community. Please help us in an effort to help them.
- > No choice of mental health workers. My child didn't like hers so it was a waste of time. I was there nothing got done, months of nothing.
- > It seems to me as if case workers are overloaded. As a result, it is difficult for foster parents to get assistance until the foster child is in "crisis." Usually by then, it is too late to save the placement. The child then gets moved into another home that is unprepared for the behaviors and needs for the child. Once the "honeymoon" period is over in this next home, the child begins having similar issues. But caseworkers do not respond adequately, with proper treatment and services until it is too late. My recommendations are better preparation for foster parents, better mental health providers, and (*the key*) much better coordination and team work between caseworkers, mental health, and foster parents. Thank you!

Citrus County

- > This system is so broken- there are too many agencies involved- nobody wants to step on anyone's toes- the children are suffering severely due to the lack of services offered in Citrus County and none willing to treat kids below 6 years of age.
- > I only request babies, had 2 to 4 year olds. My foster children had no mental problems. One had eye and 2 had speech problems. Biggest problem is finding DR in Citrus County to accept Medicaid. Also take too long to get Medicaid number. Had one child 3 months and never received Medicaid # at all.
- > Need information on services availability and how to determine when a child needs those services. We currently know nothing about mental health services. All case workers have been very concerned for the children, but have too much paperwork and too many cases to do all that is expected of them.
- > I have been a foster parent for a while you do not hear from the worker if something is wrong or right. I have not received a call in 3 months. Do not know why?
- > They spend too much time training foster parents on parenting and attention deficit- I had an African American child and I had to take her to a hairdresser just to find out what kind of shampoo to use in her hair. They need to offer more diversity in their training. They need to hire more people to lessen caseloads. Also, I haven't dealt much with using mental health services.
- > I would like doctors close to where I live and services specific to the child's needs. Also to be able to talk to someone who is knowledgeable in that area.

Hernando (serving St. Johns County)

- > I have not had a child that has had to go to a mental health services. Just early steps and physical therapy.

Appendix C: Individual Item Responses

Domain/Item	N	Average Rating ¹	Standard Deviation	Percentage Below "Somewhat Adequate"
Access				
1. Availability of various physical health services for foster children.	34	3.12	1.63	27%
2. The office hours of your foster children's mental health care provider(s).	29	3.31	1.17	21%
3. The location of my foster children's mental health care provider(s).	30	3.43	1.38	27%
4. Ability to obtain a mental health specialist for my foster children when it is necessary.	31	2.87	1.18	29%
5. Availability of public transportation to my foster children's mental health provider(s).	27	1.74	1.61	70%
6. Availability of social support for foster parents.	31	2.87	1.15	32%
7. Length of time needed to get a mental health appointment.	32	3.00	1.78	31%
8. Number of treatment sessions available to my foster children.	29	3.28	1.07	27%
9. Ability to obtain mental health service referrals.	29	3.21	1.35	31%
10. Availability of support services (e.g., respite care, child care).	32	2.84	1.11	34%
11. Ability to get an appointment with my foster children's mental health care provider.	30	3.00	1.14	30%
12. Ability to get through to your foster children's mental health provider(s) when I call.	29	2.83	1.26	38%
13. Access to child care (if needed) for other children at home so that your foster children can keep their mental health appointments.	25	2.36	1.22	52%
Information				
14. Training on behavioral strategies to address specific problems in the home and community.	32	2.78	1.31	41%
15. Availability of information on your foster children's medications.	29	3.62	1.12	17%
16. Availability of information about foster children's physical health and mental health status.	32	3.00	1.16	28%
17. Your knowledge of foster children's mental health needs.	31	3.23	1.23	19%
18. Your knowledge of how to access mental health services for my foster children.	31	3.52	1.06	16%
19. Availability of mental health education for foster parents.	31	2.74	1.24	39%
20. Clarity of the policies related to mental health services for foster children.	30	2.60	1.25	43%
21. Access to the health records of your foster children.	32	2.34	1.28	59%
Case managers/Mental health providers				
22. Ability of your child welfare case manager to manage their assigned case load.	32	2.72	1.25	34%
23. Child welfare case managers' knowledge of the mental health needs of foster children.	30	2.80	1.30	40%
24. Adequacy of my child welfare case managers' training.	29	2.97	1.27	41%
25. Frequency with which you talk with my child's welfare case manager.	33	3.27	1.26	21%
26. Continuity of foster children's child welfare case managers.	31	2.97	1.20	32%
27. Consistency with which your foster children see the same mental health provider from visit to visit.	26	3.85	1.08	11%
28. How serious mental health providers take foster parents' concerns.	28	3.68	1.22	14%
29. How serious child welfare care case managers take foster parents' concerns.	32	3.28	1.40	31%
30. Your involvement in the mental health services planning for my foster children.	29	3.10	1.11	28%
31. Frequency with which you meet with your child welfare case manager.	32	3.56	1.19	22%

Domain/Item	N	Average Rating ¹	Standard Deviation	Percentage Below "Somewhat Adequate"
Quality of Care				
32. Amount of choice in mental health services providers.	29	2.34	1.17	44%
33. Completion of mental health assessments in a timely manner.	29	2.66	1.20	41%
34. Adequacy of early screening and assessment among foster children.	32	2.66	1.04	41%
Coordination				
35. Coordination of children's services among school, child welfare, and mental health professionals.	31	2.71	1.24	39%
36. Amount of communication among school, child welfare, and mental health professionals.	30	2.70	1.09	40%
37. Stability of foster children's placements.	31	3.13	1.20	23%
Cultural Competence				
38. Availability of ethnically diverse service providers.	29	3.14	1.12	28%
39. Cultural sensitivity of service providers.	29	3.31	1.14	21%
Financing				
40. Adequacy of the funding devoted to mental health services in foster care.	28	2.68	1.19	50%
41. Availability of money to pay for my foster children's mental health services.	29	2.86	1.16	35%
42. Adequacy of the mental health care benefits for foster children.	29	2.79	1.11	38%

¹ Item scores were reverse coded so that higher scores reflect a more favorable assessment.

- 1 = "Not At All Adequate"
- 3 = "Somewhat Adequate"
- 5 = "Very Adequate"