Behavioral Health Provider Capacity to Address Key Child Welfare Outcomes among Parents with Behavioral Health Issues

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BACKGROUND

The overall goal of this project was to investigate the capacity of behavioral health providers contracting with Big Bend Managing Entity (Circuits 2 and 14) in north Florida to effectively address behavioral health issues among parents involved in the child welfare system. In addition, the project sought to determine the training and system-level needs required to improve the ability of behavioral health providers to serve parents’ behavioral health needs. Specific parental behaviors that directly affect child well-being, safety, permanency, and risk of future child abuse and neglect were examined in this pilot project. A mixed-method, longitudinal approach was used to achieve the project goals. Phase 1 (Fall 2016 – Fall 2017) and Phase 2 (Fall 2017 – Fall 2018) of this project aimed to identify and address the gaps and needs for behavioral health integration among behavioral health providers and child welfare personnel.

A systematic review and analysis of child welfare records was conducted during Phase 1. Focus groups were also held with behavioral health providers in the primary Medicaid-serving behavioral healthcare center and child welfare case providers within the Circuit 2 Managing Entity and the results analyzed. These case record reviews and focus groups revealed that behavioral health providers perceived the need for further training to understand how to effectively work with and increase the motivation of parents involved in the child welfare system, especially parents who were affected by mental health disorders and trauma. Case records reviewed revealed that most parents sampled had significant and relatively high rates of substance use, interpersonal violence, and other trauma history, as well as mental health and medical problems. In many cases, there was substantial co-occurrence of these risk issues. Most parents were referred for multiple services, but there was inadequate information of service follow through. It is evident from both the qualitative and quantitative results that parental engagement in evidence-based treatments for mental health and substance abuse is problematic and indicates a need for improvement. Phase 1 results also revealed that child welfare personnel perceived that they had limited use or knowledge of utilizing evidence-based screening tools to detect parental behavioral health issues.

To address perceived training needs based on qualitative data from Phase 1, the project piloted a training for behavioral health providers and child welfare personnel that focused on evidence-based approaches to the detection of parental substance abuse and mental health issues. The training was feasible to deliver in a one-day format and substantially increased knowledge in the domains covered in the training as rated by child welfare case managers. This report presents results of Pilot Phase 2, which focused more specifically on behavioral health providers’ capacity and determined their training and system-level needs to effectively address behavioral health issues in parents involved in Circuits 2 and 4 of the child welfare system.

METHODS OVERVIEW

All main behavioral health provider outlets in Circuits 2 and 14 were identified through stakeholder meetings. Qualitative interviews via focus groups and semi-structured interviews were completed with purposefully sampled behavioral health leadership staff, supervisors, and therapists (n = 29). Interview guides were developed to address the research questions outlined above. Behavioral health providers were asked to enumerate their training experiences and practices in addressing parental behaviors that directly affect risk for poor child welfare outcomes, as well as protective factors. Key questions based on principles of grounded theory were developed, and thematic analyses were performed.

A training based on the behavioral health qualitative data analyses was devised and piloted. The goal of the training was to strengthen the capacity of behavioral health providers to specifically address parental behaviors that influence child welfare outcomes.

On the child welfare side, data from Phase 1 conducted in FY 2017-18 were used to identify sources of information and documentation routinely collected to determine parental behavioral health needs and specific parental protective capacities. In particular, a sample of Caregiver Protective Capacity Forms was examined for a six-month period from Circuits 2 and 14.

Qualitative Study

In-depth qualitative interviews were conducted to explore behavioral health providers’ experiences and capacity to address parental behavioral health needs.

With assistance from the Big Bend Community-based Care (BBCBC) lead agency, behavioral health providers serving clients in Circuits 2 and 14 were recruited. Providers were contacted by a member of the project team about the project and, for those who were interested in participating in the project, interviews or focus groups were scheduled.

We developed interview guides to address the first three research questions, and conducted a total of 10 semi-structured focus groups and individual phone interviews, including 23 behavioral health providers, between the dates of December 2017 and January 2018.

Behavioral health providers were asked to describe their training experiences and practices in addressing parental behaviors, to discuss training related to working with child welfare clients, and to discuss current practices for assessing parents’ behavioral health and parental capacities.
How does someone involved in the child welfare system come to funded through a contract?

In Phase 2, the primary focus was on the Caregiver Capacity Assessment as this is a primary method used by DCF to assess various domains of caregiver capacity and functioning over time. In Phase 2, the primary focus was on the Caregiver Capacity Assessment completed by child welfare personnel during the course of the caregiver’s child welfare involvement.

In order to further examine the adequacy of current practice in determining specific parental behaviors that directly link to child safety, a half-day training curriculum was developed. In June 2018, the Florida State University research team provided a three-hour behavioral health training entitled, Behavioral Health and Child Welfare Practice Integration, to contracted providers in the Circuit 2 and 14 catchment area. Forty-three providers attended the training. The purpose of the training was to provide a child welfare practice model framework for delivering behavioral health services to parents with children in the child welfare system. The training focused on providing participants an overview of the child welfare system, an understanding of primary focal areas, and processes.

Training components included:
1) The child welfare practice model
2) Defining maltreatment
3) Understanding danger threats
4) In-home safety criteria
5) Safety management
6) Caregiver protective capacities
7) Child/family functional assessments
8) A-Z questions for behavioral health providers (addresses questions from “How does someone involved in the child welfare system come to my attention?” to “Once I’m working with a child welfare involved client, who do I share information with?”)

This training was designed for behavioral health providers who work outside of the child welfare system but receive referrals for child welfare-involved clients. The training was designed to specifically address the following questions:

1) Does participating in the training increase knowledge of training content?
2) What are participants’ perceptions of the training?
3) In what ways do participants feel that the training could be improved?

Pre-post training content knowledge test data suggest that behavioral health providers can identify the challenges of providing behavioral health services to child welfare recipients; however, integrating their practice methods and processes with Florida’s child welfare practice model components requires a change in practice and perspective. Participants were asked to rate the usefulness of the training on several domains on a scale of 1 (“not useful”) to 4 (critical to our work). Overall, mean scores 3.50 ± 0.6 for relevance of training material for your work and 3.58 ± 0.6 for overall satisfaction with the workshop (n = 29). Therefore, the training was feasible and well received.

Results

The interviews produced a rich data set with several emergent themes. This section summarizes themes that were most salient and relevant to our initial research questions. We identified content related to six themes.

Theme 1: Beyond Parental Behavioral Health Needs
Behavioral health providers frequently mentioned client needs that extended beyond that of behavioral health services during interviews. Needs that centered around case management services and life management skills training were most often repeated.

Theme 2: Detection and Assessment
Providers were asked to describe the methods they used to assess parents’ behavioral health needs and parenting capacities.

Theme 3: Parental Behavioral Health Needs
Providers reflected on common presenting issues of their clients, treatment approaches, and the use of evidence-based practices.

Theme 4: Parent Relevant Case Planning and Treatment
Content in this theme surrounds the relevancy of case plans to parents’ needs, skills, and capacities. Parental engagement and other factors impacted the ability to implement case plans and provide effective treatment thought to meet parents’ most pressing behavioral health needs.

Theme 5: System Issues
This theme was the most salient in terms of the number of emerging subthemes and references. Within this theme, providers discussed the ability of services to meet the needs of parents, a lack of collaboration/coordination of services for parents receiving services from more than one system or agency, and the quality and adequacy of communication with DCF. Many of the issues overlapped with subthemes within other categories.

Theme 6: Training and Training Needs
Participants reflected on how they learned about the child welfare system, discussing both formal and information training and educational experiences. This led to discussions of gaps in training and identification of training needs.

For more detailed information on the subthemes, see the full report at https://ficw.fsu.edu/research-evaluation/parental-behavioral-health-services-integration-child-welfare.

TRAINING DEVELOPMENT AND RESULTS

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Quantitative Study

In order to further examine the adequacy of current practice in determining specific parental behaviors that directly link to child safety, permanency, and well-being outcomes, including risk for future child welfare referrals, this part of the project investigated the caregiver protective capacity assessment. In order to accomplish this, a child welfare case record review, extraction, and analysis was conducted using the same records that were examined in Phase 1 of the study (Fall 2016 – Fall 2017). Whereas Phase 1 focused specifically on any information in the case record that pertained to the behavioral health needs, referrals and follow through with behavioral health referrals, Phase 2 sought to provide information on the Caregiver Capacity Assessment completed by child welfare personnel during the course of the caregiver’s child welfare involvement. In Phase 2, the primary focus was on the Caregiver Capacity Assessment as this is a primary method used by DCF to assess various domains of caregiver capacity and functioning over time.

Funded through a contract with the Florida Institute for Child Welfare
Analysis
A final sample of 202 cases in the Florida Safe Families Network (FSFN) through the Department of Children and Families (DCF) was examined and 171 cases that had at least one valid record were extracted. Four forms were used to extract the information: FFA-Initial (FFA-I), FFA-Ongoing (FFA-O), Progress-Update 1, and Progress-Update 2. It is possible that the information on some of the four forms was missing.

The main questions for the caregiver capacity domains are the same in all four forms. However, FFA-I used 2-level scales ("Yes"/"No") ("Unknown" was classified as missing during the data cleaning process due to the small amount). The FFA-O and Progress-Update 1 & Progress-Update 2 used an identical form and a 4-level scale (A/B/C/D). The FFA-I is completed by the child protection investigator while the forms for the FFA-O and Progress-Update 1 & Progress-Update 2 are completed by the ongoing case manager. Per the Florida Department of Children and Families, the criteria for scores "A" and "B" can be equivalent to the answer of "Yes" in Form 1, and scores "C" and "D" can be equivalent to the answer of "No" in each of the three forms. In child welfare practice, an "A" or "B" is equivalent to the caregiver meeting the specific capacity assessed, and a "C" or "D" means that the caregiver did not meet that specific capacity domain.

Results
The caregiver capacity domains for which changes over time were statistically significant. The timeframes for each subsequent are not consistent across participants or time but represent each assessment that was conducted with the parent.

In order to use the maximum information to include the initial assessment using the form, FFA-I, we uniformed the 4-Level scales from the other 3 forms by matching Score "A" and "B" to "Yes" in Form 1, and Score "C" and "D" to "No". Therefore, we can examine the change in each domain in a broader scale with 2-levels ("Yes"/"No"). Due to the possibility of missing information at any point of time in a case, we looked at a broader change by comparing the first available record no matter which form served as the first, and the last available record no matter which form observed as last. In this analysis, only those cases with at least two records were included so that each case had a first and a last record, which resulted in 142 cases.

Overall, 6 out of 19 domains had a significant change towards improvement and 13 of 19 did not show a statistically significant change over time. For the 2-level scale, 4 out of 19 domains showed a statistically significant change over time towards improvement, and 15 domains did not show improvement over time. While these results suggest that most of the caregiver Capacity domains were not rated in the case records as having improved over time, this finding should be interpreted with caution as the Caregiver Capacity Assessment has not been validated.

DISCUSSION AND POLICY RECOMMENDATIONS
All conclusions and recommendations should be considered preliminary in light of the fact that this pilot study had a limited sample size and was conducted within two specific circuits in Florida (2 and 14).

Overall, this project aimed to 1) assess behavioral health providers’ capacities; and 2) identify training and system-level needs regarding behavioral health providers’ abilities to effectively address the behavioral health needs of parents involved in the child welfare system. In addition, the project gathered information from the child welfare case records, specifically focusing on assessments of caregiver functioning and capacities and changes over time in these assessments. Examining these issues could result in a greater understanding of how specific parental behaviors that directly affect the current and future well-being, safety, and permanency of children are detected and treated. This could be useful for child welfare case managers and supervisors by improving their training to better detect behavioral health issues, and refer to appropriate services. In particular, focus groups and semi-structured interviews of behavioral health providers and supervisors in Circuits 2 and 14 were conducted to pilot a training program to increase the behavioral health providers’ capabilities to address parental behaviors that affect a child’s well-being. In addition to the qualitative interviews, a sample of Caregiver Protective Capacity forms were examined. This, in turn, could provide additional insight in identifying the current capacity and gaps of behavioral health and child welfare providers in identifying factors that result in the risk of future and worsening involvement or concerns regarding child safety, well-being, and permanency. For example, if the Caregiver Capacity Assessments are relied upon on the child welfare side to determine caregiver improvement over time, but the behavioral health providers treating the parent are unaware of those caregiver capacity assessments, then it is clearly an important system-level disconnect of vital information. Indeed, the project found that, in most cases, behavioral health providers were unaware of the caregiver capacity assessments and results that were being used on the child welfare side for decision making.

Qualitative interviews with behavioral health leadership staff members, counselors, and supervisors were conducted to identify the types of training experiences and practices they received to address parent behaviors that directly and negatively affect the well-being of a child. Common issues described by the behavioral health providers included a lack of coordination or consistency in the quality of communication across the different roles and systems in the child welfare team. In addition to case plans with unrealistic expectations for the parents, this absence of consistent communication between child welfare personnel and behavioral health providers resulted in frequent misalignment of behavioral health care for the parent and the child welfare case plan. Behavioral health providers also mentioned that clients’ needs frequently included a varying degree of case management services and training for life management skills. Providers expressed the importance of utilizing relationship building skills to increase parent engagement and the importance of the parents developing social support and the networks after child welfare termination. Behavioral health providers also mentioned a varying familiarity, use, and confidence in formal screening tools to assess the caregiver protective capacities or needs of parents. Especially in rural areas, a lack of available services to meet the clients’ needs was identified. The focus groups and interviews provided insights on the behavioral health providers’ desire to receive further training on the child welfare system and roles, effective screening tools and therapeutic interventions for parents involved in the child welfare system, practice models and outcomes, and the universal training on the safety methodology.

Preliminary Recommendations Based on the Qualitative Findings to Consider
1) Provide cross-system training on the child welfare system for all providers (especially behavioral health providers) and professionals who serve child welfare-involved families.
2) Increase access to behavioral health services for parents who are involved in the child welfare system, most often funded through Medicaid. This may involve reallocating funding, identifying new funding streams, providing incentives for existing and new providers to take Medicaid clients, and ensuring these services are accessible (e.g., providing transportation services or offering appointments outside of usual business hours).
3) Create mechanisms to promote communication and collaboration between providers that are serving the same families. This may include monthly or bi-monthly meetings that are built into the case plan (e.g., monthly family team meetings). Develop and possibly require documentation of the meetings.
Streamline and monitor the referral to service process to ensure parents are receiving assessment and needed behavioral health care in a timely manner.

Promote a shift in the practice orientation from a child welfare to a family welfare system. This expanded focus recognizes the centrality of parental health, well-being, and economic and social stability to successful service outcomes. This shifting perspective is more consistent with recent federal policy that places greater emphasis on prevention, and is of particular importance for increasing rates of successful reunification and to prevent future re-entry into care. This can be spearheaded through initiatives lead by the Department of Children and Families, community-based care lead agencies, and cross-systems trainings.

Promote greater consistency in trainings to facilitate greater uptake of evidence-based and evidence-informed practices. Effective uptake of evidence-based practices takes time, but committing to ensure providers are using evidence-based or evidence-informed practice will help ensure that child welfare and behavioral health providers have the skills needed to provide effective services. This may also include engaging in additional evaluation of services, assessing both service processes and outcomes.

Provide cross-system trainings on validated screening tools that are manageable to implement, can be used to inform case plans, and facilitate communication across providers and agencies that are working with the same families.

Engage in efforts to properly validate the Caregiver Protective Capacity Form to ensure its reliability and validity, and to facilitate its potential to increase efforts to improve the protective capacities of child welfare-involved parents.

Provide training for case managers and behavioral health providers in engagement strategies such as motivational interviewing. There was a clear recognition that parents were not always aware of the specific details and rationale for their case plans. In addition, parental motivation to engage in behavioral health care was seen as a major challenge. Parents often had difficulty following up and following through with treatment and all other aspects of their case plan.

Preliminary Recommendations Based on the Quantitative Findings to Consider for Training and System Changes for Behavioral Health Providers

1) There is a need and desire from the behavioral health providers in the regions studied for accurate and reliable information about the child welfare system, including the child welfare outcomes (safety, well-being, and parental behavioral health issues related to permanency).

2) Increase behavioral health providers’ knowledge of the assessments and other tools (such as treatment plans) used in child welfare, including the caregiver capacity form, as these assessments are being used to guide parental decisions in the child welfare system.

3) Behavioral health providers indicated the need and desire for additional training in evidence-based approaches to behavioral health treatment, especially among substance abuse providers.

4) Coordination between behavioral health providers, child welfare case managers, and other parties (e.g. courts) is a challenge—information exchanged between behavioral health and child welfare is inconsistent.

5) Across both Phase 1 and 2 of the study, it is clear that regular team meetings involving the behavioral health providers, case managers, and the parent would be extremely beneficial and should be reimbursable time. This type of case coordination would assist in aligning the behavioral health treatment plans with child welfare case plans.

6) Pilot trainings just scratch the surface. We recommend adapting pilots based on the results and expanding the content and audience. All trainings must be customized to each region in Florida. Child welfare behavioral health providers are willing to integrate parental caregiver capacities into their treatment planning process but need cross training to understand the purpose and intent.

Specific Behavioral Health Issues and Training Implications for Behavioral Health Providers

1) Specific case management needs were consistently seen across Phases 1 and 2 of the project as most helpful, impactful, and appreciated by the families. These needs included access to support networks, housing, financial support, resources, and employment services.

2) There was a clear need to target specific parenting behaviors, such as anger / impulse control, trauma-interventions (beyond trauma informed), evidence-based treatment for psychiatric disorders including access to quality medication management.

3) Interventions to help with parental engagement / buy in, including motivational interviewing, and getting all parties on same page to help with parent awareness and involvement with their case plans.

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