RESEARCH REPORT

Enhancing Parental Behavioral Health Services Integration in Child Welfare

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Executive Summary

The overall goal of this project was to identify gaps and to pilot approaches related to the integration of behavioral health interventions for child welfare-involved adult caregivers. Gaps in detection and intervention for parental behavioral health issues in child welfare were examined using a mixed methods approach. Specific goals and activities of the project included:

1. focus groups with child welfare case and behavioral health providers to determine perceived influences on effective detection and intervention for parental behavioral health and needs for training in that arena
2. pilot trainings to determine feasibility and initial effectiveness based on focus group data
3. reviews of 212 case records to determine whether and how parental behavioral health needs, referrals, and referral follow-up were noted
4. interviews of a sample of child-welfare involved parents to determine feasibility of contacting and collecting behavioral health information from parents, including rates of behavioral health and service needs using validated measures (N = 20).

Qualitative data obtained from focus groups revealed challenges to connecting parents with effective behavioral health services. Common issues identified among focus group participants were related to lack of parent motivation to participate in services a limited use or knowledge of evidence-based screeners, and challenges with communication and service coordination across systems. Trainings that were developed and delivered based on focus group results highlighted the need for further training for case managers to better understand how to effectively: 1) address motivation in parents; 2) work with trauma-affected parents; and 3) use screeners to detect behavioral health issues in parents. The training was feasible, and resulted in high satisfaction ratings and a significant increase in post-test scores of knowledge in each of the domains.

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Executive Summary (continued)

Results of case record reviews and family interviews showed that most parents in our sample had significant and relatively high rates of substance use, interpersonal violence and other trauma history, as well as mental health and medical problems. 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. The pilot training in effective engagement approaches (i.e. Motivational Interviewing) was feasible and well received by the child welfare case managers. Based on this pilot study, we recommend that additional targeted training and attention be placed on the engagement of parents and families in evidence-based treatment for mental health and substance use disorders. Based on family interviews and record reviews, it is highly likely that the type and intensity of behavioral health services are not aligned with the prevalence, co-morbidities, chronicity, and severity of behavioral health disorders seen in this population. Our study found no indication that best practice psychiatric treatment guidelines were in place for any parent.

Providing behavioral health services for parents is an essential component of child welfare practice. There is a need for child welfare-involved parents to receive timely assessments, screenings, and referrals to appropriate behavioral health services and resources. An integrated approach to services is necessary among all providers serving child welfare-involved parents. Recommendations for future work in this area include training for case managers on the use of screening tools and evaluating behavioral health outcomes with child welfare-involved parents; piloting and evaluating joint trainings between different service providers to improve communication and coordination between and among service agencies. In addition, much more coordination is needed with behavioral health providers. It is clear that case records do not include information related to behavioral health treatment and treatment follow through that aligns with best practice behavioral health treatment.

Project Description

There are disproportionately high rates of mental health and substance use (i.e. behavioral health) disorders among caregivers involved in the child welfare system. Parents with behavioral health needs are at greater risk for repeated child welfare involvement. Based on the research literature, parents with behavioral health issues are not likely to be adequately screened, appropriately assessed, referred, or engaged in evidence-based (EB) behavioral health treatment. Studies have shown that improvement of behavioral health outcomes in parents improves child behavioral and other health outcomes, as well as improves reunification and overall family functioning outcomes.

The overall goals of this project were to identify gaps and to pilot approaches related to the integration of behavioral health interventions for child welfare-involved adult caregivers (18 and older). Additionally, the project sought to develop, implement, and test the feasibility and initial outcomes of training to improve detection, engagement and intervention for parental behavioral health needs in child welfare. Gaps in detection and intervention for parental behavioral health issues in child welfare were also examined using a mixed methods approach.

The specific aims of this pilot project were to:

1. Determine gaps and opportunities for improved behavioral health integration among child welfare personnel within the Circuit 2 Managing Entity (Big Bend Community Based Care, BBCBC) as well as among the behavioral health clinicians at the primary Medicaid-serving behavioral health center in the region (Apalachee Center). Using qualitative methodology, we identified and analyzed themes related to needs and opportunities in training, care referral and coordination, and clinical and Child and Family Services Review (CFFR) outcomes. We also conducted a systematic review, extraction, and analysis of child welfare records in order to supplement qualitative data by identifying gaps in tracking and use of information collected and documented by child welfare personnel.
2. Pilot a training for child welfare professionals and community behavioral health clinicians in evidence-based approaches to detection and intervention for parental mental health and substance abuse, based on qualitative data. The focus was on detection of primary parental risk issues, motivational interviewing for engagement, and referrals with monitoring and support. Outcomes included uptake and fidelity to training, as well as preliminary training outcomes.
3. Determine the feasibility of interviewing child welfare-involved families. Pilot interviews were designed to determine preliminary rates of behavioral health disorders of parents involved in the child welfare system using validated behavioral health measures.

Qualitative Study

Focus groups were conducted with child welfare and behavioral health staff in order to address the following research questions:

RQ1. What are the perceived pathways and barriers in detecting and connecting child welfare-involved parents with needed behavioral health services?

RQ2. What additional training and other supports would improve the capacity of child welfare case managers to better address parental behavioral health integration?

Three focus groups were conducted with the providers from the following agencies in Tallahassee, Florida.

Apalachee Center

Located in Leon County, the Apalachee Center is a behavioral health facility offering residential and outpatient mental health services. The Apalachee Center is the primary facility serving Medicaid clients in the Big Bend region. The job roles and responsibilities of the focus group participants ($N = 4$) at the Apalachee Center included therapy and counseling, supervision, and administrative duties. The focus group meeting took place on September 1, 2016.

Children's Home Society

Children's Home Society (CHS) is a community-based care (CBC) lead agency with locations throughout Florida. CHS offers a variety of services to address the needs of vulnerable children and families, including dependency case management services. Job roles and responsibilities of the CHS focus group participants (*N* = 5) included supervisory and administrative duties, providing service referrals, and treatment planning. The focus group took place on October 10, 2016.

DISC Village

DISC Village offers a variety of behavioral health programs to individuals in the Big Bend Region. Dependency case management services are provided through DISC Village's Children and Families department, through a partnership with the Department of Children and Families (DCF, Department). Focus group participants (*N* = 4) from DISC Village reported that their job roles and responsibilities included case management, supervision, independent living, and providing in-home services, service referrals, and counseling and therapy. The focus group meeting was held on October 17, 2016.

Methods and Procedures

Approval was obtained from the Florida State University Institutional Review Board prior to data collection. The investigators developed an initial interview guide and was edited by the entire research team and iteratively modified based on each focus group conducted. Interview guide queries and probes centered on several topics including:

- participants' roles and functions at their agencies
- perceptions of gaps and opportunities related to their ability to detect and address parental behavioral health
- recommendations for future training of case workers to better prepare them for integrating parental behavioral health care into their work
- other influences on parental behavioral health integration

At the beginning of each focus group, participants signed a consent form and agreed to be audio recorded. Open-ended questions were asked in an unstructured format meant to elicit information about the overarching themes of pathways and barriers experienced by providers when connecting child welfare-involved parents with behavioral health services. No form of compensation was offered to participants. Each focus group was held at the service agency and lasted approximately one hour. One member of the research team served as the primarily facilitator while at least one other member of the team took notes and assisted as needed. All focus groups were recorded and transcribed verbatim. Four independent coders created lists of initial, proposed codes. Codes were then discussed and refined using expert consensus.

Audio recordings were manually transcribed by undergraduate research assistants who were trained and supervised by a project research associate. A coding process similar to the constant comparison analysis method (Glaser & Strauss, 1967; Glaser, 1978, 1992) was used. In the first stage, four members of the research team independently analyzed each transcript, grouped the data into smaller units, and attached a descriptor code to each unit (i.e., excerpt). These descriptor codes were then grouped into overarching (i.e. "parent") themes.

The refined list of codes was validated by assigning them to each excerpt from the transcripts by two independent coders. Agreement among the code assignments was calculated and found to be acceptable (over 80% agreement). Final coded transcript excerpts were entered into NVivo (Version 11), a qualitative data analysis software. The process deviated slightly in the third stage from the traditional approach, in which coders develop smaller themes that are specific to the content of each separate focus group (Strauss & Corbin, 1998). However, because CHS and DISC Village are both agencies providing dependency case management services, the responses of these two focus groups were collapsed into a larger group that was renamed Case Managers, whereas the Apalachee Center group was renamed Behavioral Health Providers.

Each of the research team members developed sub-themes. The results of each team member were compared and a master list was created based on the parent themes and the associated sub-themes with the highest interrater agreement. These parent themes were entered into NVivo as parent nodes, and the sub-themes were entered as child nodes.

Analysis

A matrix table was created to obtain frequency counts of the parent and child nodes, between and across the different groups. Exemplar quotes were also selected to provide rich descriptions of the themes, distinguishing between those that were either unique to only one group or that were frequently identified between both groups.

In response to the research questions, the following themes and sub-themes were identified that provided information that were unique to case managers or behavioral health providers or common to both. The majority of the focus group discussions concentrated around three major themes: parental motivation and buy-in; assessments and screenings; and communication and coordination of services. Specific overarching and sub-themes are provided below.

Theme 1: Parental Motivation/Buy-In

- Sub-theme: Family Engagement
- Sub-theme: No Service Follow-through
- Sub-theme: Non-Compliant Parent

Theme 2: Assessments and Screenings

- Sub-theme: Use of Assessments and Screeners
- Sub-theme: Improved Service Matching
- Sub-theme: Training to Guide Service Matching

Theme 3: Communication and Coordination

- Sub-theme: Inter and Intra-agency Communication
- Sub-theme: Legal Issues
- Sub-theme: Misalignment of Timelines

Results

Theme 1: Motivation/Buy-In

The overall theme of Motivation/Buy-In was used for responses that addressed how motivated a parent was to engage in services related to child welfare and/or behavioral health, as well as the degree to which they felt they needed such services. The results demonstrated that the theme of Motivation/ Buy-In was common to both groups; however, specific issues were unique to the different service provider groups, as indicated by the breakdown of sub-themes between the two groups. Figure 1 presents the number of times each sub-theme was referenced in the focus group transcripts.

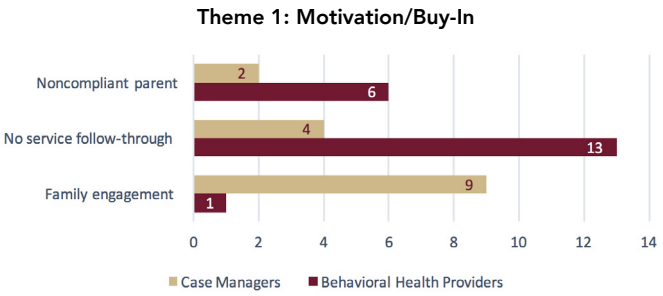

Figure 1. *Division of Motivation/Buy-In Sub-themes by Case Managers and Behavioral Health Providers*

Sub-theme: Family Engagement

The sub-theme of Family Engagement was mentioned nine times by case managers and once by behavioral health providers. Case managers reflected on their perceptions of the importance of engaging parents in services under challenging circumstances including lack of parental motivation and views on the usefulness of services and unresolved trauma.

As one case manager stated:

"And we'll talk to the parents. I mean, the parents are the ones who are on the case plan. So, we'll get their buy-in as well, if they even think this assessment is useful for everybody who's playing a role in the case."

Another case manager reflected on challenges with engaging families:

"I think also, like a lack of rapport. Because, like, sometimes our families are just not motivated. Because it's like, your kid was removed. We're here to help you. Like, how are we going to work together to help you? So, like, building that rapport, and their lack of motivation…"

Another case manager reflected on the role of unresolved trauma:

"And for us it's difficult when we have these parents that, we get to the point, what can we do or say to get them motivated? They're staring at us with a blank stare and I know it's trauma, it's trauma because this this particular mom I know she had history and stuff that happened to her in the past, but how do I make her talk about it, I can't make her. But she, this is her what, third go around in the system. I mean what do I do? I'm at a loss with this particular mom because she's doing just enough for me to close the case out. She got her kids back but she did just enough to get her kids back. Even though one is still in the system which,"y'all can raise her and she can come back when she's 18". And those are the ones I'm torn with because like I said I can't make them do anything."

Sub-theme: No Service Follow-Through

The sub-theme No Service Follow-Through was used when focus group participants spoke about situations when child welfare-involved parents did not take actions towards completing services that were recommended or required for them by case managers or behavioral health providers. In contrast to Family Engagement, the sub-theme No Service Follow-Through was found to be more salient among behavioral health providers, who mentioned it 13 times, while case managers spoke about it 4 times. Behavioral health providers expressed their frustration with working with child welfare-involved parents who did not follow through with their services, despite being offered assistance in removing barriers to such services. Case managers reflected on the need for continued participation in services even after the case plan is officially closed. In both groups, participants commented that without involvement of the Department, parents were often reluctant to follow-through in treatment. As one behavioral health provider stated:

"But even still, you know, when it comes to following up with a doctor here, even if we provide some transportation… it doesn't happen. It doesn't happen."

Another behavioral health provider reported:

"And, you know, any of these families aren't getting services or aren't following through. But realistically, if at some point a parent can be held, you know, responsible, for something… maybe at that point they should have a DCF involvement a bit longer than their 45 days because they just showed they can't follow through without somebody on their—on their back about it."

Case managers also elaborated on this issue:

"I think it's like, the lack of after-care planning if that makes sense. Because once we're done with the families, like after post reunification, we hope that the family will continue services. Now at that time it's not mandated and not court ordered. So they feel once the department is out, they're out. They don't have to continue services. Well, you know obviously we know that ongoing treatment is needed. So I think it's like, the lack of an after-care plan for the families and probably not knowing where to seek those services, because I mean we can provide them… our community center information but how many of our families are actually going to go out there in the community and say hey, I have an issue, help me?"

Sub-Theme: Non-Compliant Parents

The sub-theme Non-Compliant Parents was used when focus group participants referenced parents who did not comply with their service plan requirements with DCF and subsequent involvement with behavioral health providers. The sub-theme of Non-Compliant Parents was mentioned six times by behavioral health providers, and twice by case managers. As one behavioral health provider stated:

"… I've noticed that a lot of the kids I work with are learning the habits of not showing up to appointments from their parents. I've got one in specific that I can think of right now who, um, he's more than happy to meet with me, he's 17, you know it's fine, but mom ditches on all the appointments, and being a minor I can't meet you at the house by yourself…So it's coming in that I'm seeing as they become adults, well then they stop showing up to appointments because, well that's what they learned as a child–how not to show up. So I'm kinda seeing…"

When asked "What is your experience with trying to help parents receive behavioral health services?", one case manager replied:

"They're in denial or unwilling to do it."

This was illustrated by another case manager who quoted a parent's views on receiving services:

"'I don't have any mental health issues so I don't need any help.'"

Theme 2: Assessments and Screenings

The overall theme of assessments and screenings were meant to capture participants' responses that addressed the use of, need for, and attitudes towards assessments and screening tools. The theme of Assessments and Screenings and its sub-themes (Improved Service Matching and Training to Guide Service Matching) were all found to be unique to the case managers. Only the sub-theme Use of Assessments and Screeners was mentioned between both groups. Figure 2 presents the number of times each sub-theme was referenced in the focus group transcripts.

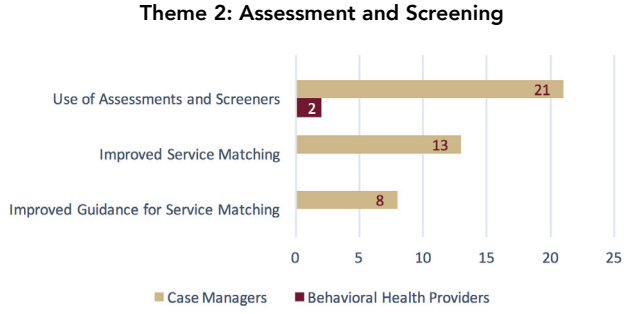

Figure 2. *Division of Assessments and Screenings Sub-themes by Case Managers and Behavioral Health Providers*

Sub-theme: Use of Assessments and Screeners

The sub-theme Use of Assessments and Screeners refers to discussion about screenings and assessments that are used by case managers and behavioral health providers.

Case managers indicated that the existing tools available to them focused primarily on the children and did not help them adequately identify the needs of parents. This is captured in the following discussion between a research team member and three case managers during a focus group:

Participant 3: "The thing is the CBHAs[1] are for the kids but the parents don't get it and I don't even know if the CBHAs use any standardized assessment."

Participant 4: "Yeah I don't think…"

Research team member: "It just asks about parental health history."

Participants 3 & 4: "Yeah, yeah."

Research team member: "And we didn't find much information in it about the parent."

Participant 3: "Yeah and sometimes they're okay but there's really nothing where a parent comes in and gets like a standardized screening."

Participant 6: "Unless it's with a sexual abuse case and then they go to CPT and have those um…"

Participant 3: "Yeah they'll get a psych social…"

Participant 6: "But it's not in depth."

Behavioral health providers mentioned using a combination of various screeners as part of the intake and clinical skills to determine the needs of the client as indicated by one provider:

"Yeah we use uh preliminary uh preliminary assessment yeah, suicide assessment, uh, help me here… uh FARS[2], um mental health, health forms, um medical questionnaire, umm ISAM"

Another provider added:

"But then you kinda use your case management clinical skills to figure out "What do these guys need?"

"So at that point you know it's sort of like, I'll just use the term "screening triage" just kinda get a sense of what's going on and what kinds of services they might need, and, and it sounds like the goal, if they have a mental health issue, would be to get them in for a psychiatric evaluation?"

Sub-theme: Improved Service Matching

The sub-theme Improved Service Matching was used when focus group participants spoke about situations in which the proper use of and/or knowledge about screening and assessment tools would help them to provide more appropriate service referrals for parents. Case managers discussed this sub-theme 13 times.

"Trying to figure it out [the needs of the parent] and not wanting to get it wrong, because you have this entire family. You have this child that needs their parents, and it's your job to help that child and the parents. But it doesn't do any body any good—it's actually an injustice if you don't know exactly what you're helping for and what you're looking for."

"I think it [the use of screenings among case managers] would be beneficial on both ends, on the parents and as well as on the, um, child welfare workers because that way we would be able to better assist that family. We would know exactly this mom's needs because it was more than just a guess."

[1] CBHA refers to the Comprehensive Behavioral Health Assessment, an assessment that is used by the state child welfare agencies in Florida.

[2] FARS refers to the Functional Assessment Rating Scale (Ward & Dow, 1994).

Sub-theme: Training to Guide Service Matching

The sub-theme Training to Guide Service Matching was used to denote times when focus group participants expressed a desire to receive additional information about screening and assessment tools to guide their service recommendations for parents. This theme was mentioned eight times during our discussions with case managers. Case managers expressed views that assessment and screening tools were important to making referrals and developing services plans, but also noted a lack of training to help them differentiate between different types of instruments and their use. Further, case managers' comments also reflected a lack of knowledge on the difference between screening and assessment.

"I think one piece we never–and I can't remember the last time we even had a training on this–what the different assessments test for. So yes, we're social work majors. Well, not all of us. Some of us are social work majors, some of us are mental health, you know, majors and things of that nature. But I think it's imperative, if we are case managers making recommendations with the collateral information that we have, we need to know what's the difference between a psychological, psychiatric, long-term parenting evaluation, bonding assessments."

Theme 3: Communication/Coordination

The overall theme of Communication/Coordination was used whenever focus group participants spoke about issues of communication, including inter-agency issues, as well as those between co-workers and between providers and families. The subtheme of Inter/Intra-agency Communication was found to apply to both case managers and behavioral health providers but the subthemes of Misalignment of Timelines and Legal Issues were unique to case managers. Figure 3 presents the number of times each of the sub-themes were referenced between both groups.

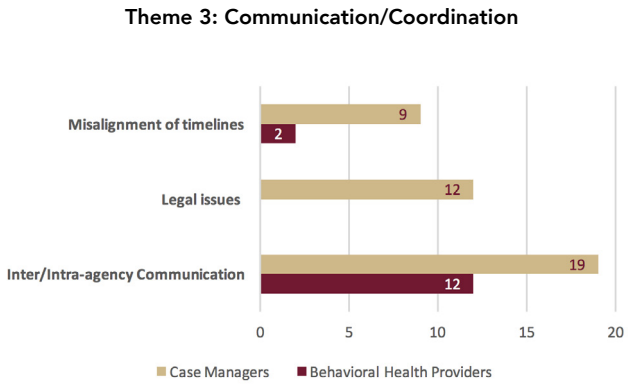

Figure 3. *Division of Communication/Coordination Sub-Themes by Case Managers and Behavioral Health Providers*

The discrepancy in these sub-themes may be explained by differences in the professional roles of case managers and behavioral health providers. For example, the sub-themes Legal Issues and Misalignment of Timelines both deal with issues more commonly faced by case managers, for whom regular job duties include attending court proceedings and ensuring deadlines for permanency are met. In addition to communicating with court officials and attorneys, case managers often are regularly called upon to work closely with a broad variety of professionals from different fields in order to coordinate services for children and families. In this respect, case managers may be required to have a greater quantity of interactions with inter-agency service providers than do behavioral health providers. The sub-theme Need for Teamwork was most often mentioned by case managers in regard to their professional communications with child protective investigators (CPI), which is a relationship that behavioral health providers are unlikely to encounter.

Sub-theme: Inter and Intra-Agency Communication

This sub-theme was used to denote all communications issues within and across agencies. A case manager described improving communication between DCF and case management:

"And I think other providers are like now understanding what we're looking for and now is able to talk our lingo because in the beginning—like before, they [DCF] was just giving us reports and we're like okay guys, we have an outcome that we need to achieve and this is what it needs to look like so I think they're stepping into the case management world a little bit more and seeing you know the behaviors we're looking for and, and it's on both ends because now you have a provider talking to the, um, parent, you know, what change are we looking for this time? We're talking to the parent you know, what change, so everybody's in sync so I feel like that's helping the families a little bit better."

Another case manager noted the important of teamwork between DCF case manager and CPIs:

"They [families] don't separate us. We are one system. Which we are, we're DCF. So that's important, even within our own agency, that we work as a team it works the same way when we're engaging with families".

One behavioral health provider mentioned wanting more communication and contact with DCF when working with the same clients:

"I think both agencies, let's say us and DCF, I think we need more communication, between the two, um, hands on providers, whether it's a therapist, with their case manager or their CPI as a not a case manager as a CPI with DCF, um, so more um global contact between the two so and then that the uh, maybe even be uh be seen together with the client because that's something that we don't do".

Sub-theme: Legal Issues

The Legal Issues sub-theme was used whenever focus group participants discussed issues of communication and coordination of a legal nature, such as interactions with parents' attorneys and the judicial system. Their comments suggest a desire for greater collaboration and balance in decision-making than what may be occurring. A case manager described her interaction with a parent's attorney:

"Because lots of times the parents' attorneys—like I've said before—will be like…well I've been – have heard this comment before in the courtroom… "I've been doing this for 14 years and know what this parent needs. She has to do A, B, C, and D."

Like, those are words from a parent's attorney's mouth."

Another case manager elaborated on this dynamic by stating:

"Ideally, I think we're supposed to come to the table with the families, with any service providers that are there, with collaterals, and come up with a case-plan task all together as a team. Um, I can't say that's actually how it works out yet. Um it is usually the attorneys, so CLS, the parent's attorneys, the Guardian ad Litem (GAL), and then case manager, supervisor, and then usually a GAL supervisor at the table thinking "this is what mom and dad needs". And lots of times the parent's attorney will actually come to the table well we'll do this and this but not this. And that's how it really plays out."

Sub-theme: Misalignment of Timelines

Misalignment of Timelines was a sub-theme used to describe all issues related to state-mandated timelines regarding permanency, and their impact on communication, coordination, and continuity of behavioral services for child welfare-involved parents. A case manager described the conflict between state-imposed timelines and providing appropriate services by stating:

"Our job is to move as expeditiously as possible, but we need to be treating or rectifying why this kid came into care, and making those parents understand why their kid was in care. How did they get here is not just because, you know, I had a bad day, and you know it's, we really want to get to the root of the problem.… so, they won't come back and when we come to a situation where we're throwing services at people and rushing stuff, nine times out of ten they come back."

A behavioral health provider discussed the limitations of the current timeline in which child welfare cases are typically allowed to be open:

"Problem is a lot of times we'll get a lot of those referrals at the end of the time they're going to close the case out. Um, because they technically can't have the case closed unless they have some type of recommendations in place, uh, to follow through with what the client either needs."

Summary of Findings from Focus Groups

In summary, both case managers and behavioral health providers expressed believing in the importance of engaging parents in services and the need for behavioral health services, specifically. However, providers reported experiencing a lack of motivation among parents and difficulty in establishing rapport. Parents' on-going trauma, mental health, and substance abuse warranted the need for behavioral health services, while at the same time contributed to the difficulty in motivating parents to follow through on referral and participants in behavioral health treatment. Providers noted that parents were unlikely to follow through in treatment with DCF as an external reinforcement, and that parents continued to need aftercare treatment, but often stopped participating once the case closed. Others noted a need for longer service duration to allow for more time for parents to receive behavioral health services and for an aftercare plan to support continuity of care. Child welfare providers reported that parents are regularly screened for behavioral health issues and felt screeners would be beneficial to enhance service planning. Behavioral health providers reported using functional and risks assessments/screeners at intake along with clinical judgement. It was less clear whether validated mental health assessments or screeners are being used as part of standard procedure. In general, providers on both sides recognize the importance of teamwork and express that more collaboration within and between provider agencies would be beneficial.

Integrating Behavioral Health Services in Child Welfare System Pilot Training

Based on themes identified from focus groups and from meeting with BBCBC and Apalachee Center leadership staff, a pilot training curriculum and format was developed. Two full-day trainings were conducted using the developed curriculum (one with BBCBC and one with Apalachee Center). Pre and post knowledge and skills tests were developed based on training content by the investigators, as were training feedback forms. One full-day training was held on January 18, 2017 at the BBCBC at the Leon Services Building. This training included modules on:

- Overview of trauma-informed care and working with trauma-affected parents
- Self-care for helping professionals
- Assessment and screening- guidance and use
- Addressing family motivation/engagement
- Communication/coordination with the behavioral health system
- Feedback for training improvement

Attendance: There were 41 training participants from BBCBC, CHS, and DISC Village, including case managers, supervisors, trainees, and interns.

Pre-training Knowledge Assessment: Of the 41 attendees, 36 completed the pre-training knowledge assessment, which consisted of multiple-choice questions related to the content to be presented in the training. These assessments were scored, resulting in a mean score of 41.45 percent correct, a maximum score of 69.23 percent and a minimum score of 7.69 percent correct.

Post-training Knowledge Assessment: Of the 41 attendees, 28 completed the post-training knowledge assessment, which contained the same questions in the same order as the pre-training assessment. There was an improvement in scores as the resulting mean score was 53.57 percent correct with a maximum score of 92.31 percent and a minimum of 15.38 percent.

Table 1. *Pre and Post-test Training Results for Case Management Staff*

KNOWLEDGE ASSESSMENT	MEDIAN SCORE (%)	MAXIMUM SCORE (%)	MINIMUM SCORE (%)
Pre-test (*N* = 36)	41.45	69.23	7.69
Post-test (*N* = 28)	53.57	92.31	15.38

Professional Quality of Life Scale (PROQOL): As a part of the training module on self-care for helping professionals, participants were given several standardized self-care self-assessments and encouraged to develop a self-care plan. Of the 41 attendees, 30 returned their PROQOL assessments, which were scored with the following results:

Level of Compassion Satisfaction: 70 percent (21 participants) reported "average" levels of compassion satisfaction, while 30 percent (9 participants) reported "high" levels of compassion satisfaction.

Level of Burnout: 63.33 percent (19 participants) reported "average" levels of burnout, while 36.67 percent (11 participants) reported "low" levels of burnout.

Level of Secondary Traumatic Stress: 46.67 percent (14 participants) reported "average" levels of secondary traumatic stress, while 53.55 percent (16 participants) reported "low" levels of secondary traumatic stress.

Training Evaluation: Of the 41 attendees, 25 completed the training evaluation which asked participants to rate the training on a scale of 1-4 (with 1 = poor; 4 = excellent). The mean scores for each question are reported below:

- Relevance of the material to their work: 3.56
- Quality of instruction and training ability: 3.56
- Organization and flow of the workshop: 3.4
- Opportunity for discussion and questions: 3.72
- Expertise and level of knowledge of the instructor: 3.76
- Overall satisfaction of the workshop: 3.52

A second full-day training was held on January 20, 2017 at the Apalachee Center for behavioral health providers. That training included modules on:

- Special issues in working with child welfare involved parents
- Overview of trauma-informed care and education of parents on trauma
- Addressing family motivation/engagement
- Overview of Dialectical Behavioral Therapy
- Overview of other trauma-informed therapy approaches
- Feedback for training improvement

Attendance: There were 10 training participants from the Apalachee Center including care managers, case managers, a senior case manager, a supervisor, and a clinical supervisor.

Pre-training Knowledge Assessment: Of the 10 attendees, 10 completed the pre-training knowledge assessment, which consisted of multiple-choice questions related to the content to be presented in the training. These assessments were scored, resulting in a mean score of 31.82 percent correct, with a maximum score of 63.64 percent and a minimum score of 0 percent correct.

Post-training Knowledge Assessment: Of the 10 attendees, 10 completed the post-training knowledge assessment which contained the same questions in the same order as the pre-training assessment. There was an improvement in scores as the resulting mean score was 44.55 percent correct with a maximum score of 72.72 percent and a minimum of 18.18 percent.

Table 2: *Pre and Post-test Training Results for Behavioral Health Providers*

KNOWLEDGE ASSESSMENT	MEDIAN SCORE (%)	MAXIMUM SCORE (%)	MINIMUM SCORE (%)
Pre-test (*N* =10)	31.82	63.64	0
Post-test (*N* = 10)	44.55	72.72	18.18

Training Evaluation: Of the 10 attendees, 9 completed the training evaluation which asked participants to rate the training on a scale of 1-4 (with 1 = poor; 4 = excellent). The mean scores for each question are reported below:

- Relevance of the material to their work: 3.56
- Quality of instruction and training ability: 3.56
- Organization and flow of the workshop: 3.4
- Opportunity for discussion and questions: 3.72
- Expertise and level of knowledge of the instructor: 3.76
- Overall satisfaction of the workshop: 3.52

Follow-up Training

In order to assess trainee perspectives on the baseline training content in the weeks following the training and in preparation for the follow-up training, a survey was developed and sent to all training participants in April 2017. The goal of the survey was to assess training participants' perspectives on: 1) the usefulness of the modules of the baseline training they received; and 2) their needs and preferences for additional content to be covered in a follow-up training. The BBCBC staff training coordinator assisted in sending a Qualtrics Survey via email. A total of 13 participants responded to the survey. Respondents were asked about specific modules that were covered in the January 18, 2017 training and what additional training, if any, would be desired in each of the areas. Participants were asked about whether they would like additional content related to: 1) knowledge and skills in specific modules; 2) background information in each of the modules; and/or 3) skills practice in each of the modules. Respondents were also asked to provide open-ended information on additional topics they saw as important for improving parental behavioral health integration. Participants reported no additional topics.

Results of the survey regarding the participants' interest in receiving additional content on specific topics in the modules are depicted in Table 3.

Table 3: *Survey Results*

TOPIC	KNOWLEDGE AND SKILLS	BACKGROUND	SKILLS PRACTICE
Trauma-informed care and working with trauma-affected families	77%	77%	70%
Addressing family motivation and engagement	92%	92%	92%
Assessment and screening for parental BH	92%	85%	92%
Self-care for professionals	93%	92%	92%

As can be seen from Table 3, the majority of survey respondents requested additional knowledge and skills, background information, and skills practice in each of the training modules (trauma-informed care, addressing motivation, assessment and screening in parental behavioral health, and self-care for professionals) three months post-baseline training. Based on these results, a follow-up training was developed and conducted on July 18, 2017 at the BBCBC. A total of 15 participants attended, including many of those who attended the baseline training in January. The training modules included:

- Skill building - Working with Trauma-Affected Parents
- Motivational Interviewing: Building Rapport Through Use of Motivational Interviewing
- Screening - Guidance and Use
- Self-Care and Mutual Peer Support

Attendance: There were 15 child welfare case managers.

Pre-training Knowledge Assessment: Of the 15 attendees, all 15 completed the pre-training knowledge assessment, which consisted of multiple-choice questions related to the content to be presented in the training. These assessments were scored, resulting in a mean score of 75.15 percent correct, with a maximum score of 90.91 percent, and a minimum score of 54.55 percent correct.

Post-training Knowledge Assessment: Of the 15 attendees, 11 completed the post-training knowledge assessment which contained the same questions in the same order as the pre-training assessment. There was an improvement in scores as the resulting mean score was 85.12 percent correct with a maximum score of 100 percent and a minimum of 54.55 percent.

Table 4: *Pre and Post-test Training Results for Case Manager Follow up Training*

KNOWLEDGE ASSESSMENT	MEDIAN SCORE (%)	MAXIMUM SCORE (%)	MINIMUM SCORE (%)
Pre-test (*N* =15)	75.15	90.91	54.55
Post-test (*N* = 11)	85.12	100	54.55

Training Evaluation: Of the 15 attendees, 10 completed the training evaluation that asked participants to rate the training on a scale of 1-4 (with 1 = poor; 4 = excellent). The mean scores for each question are reported below:

- Relevance of the material to their work: 3.60
- Quality of instruction and training ability: 3.50
- Organization and flow of the workshop: 3.40
- Opportunity for discussion and questions: 3.70
- Expertise and level of knowledge of the instructor: 3.50
- Overall satisfaction of the workshop: 3.40

Quantitative Study

Child Welfare Electronic Records Data Extraction

In order to identify the ways in which parental behavioral health issues are detected, notated, and tracked, we conducted a comprehensive review of child welfare case records. Based on discussion with BBCBC leadership, the following criteria were used to identify potential cases to be included in the data extraction:

- Children ages 0-17 (no older children who have aged out of the foster system and are continuing to receive services for independent living)
- Cases in two counties
- Cases with families receiving services in the home AND cases where the families are receiving services with the children sheltered outside the home
- All cases opened within a three-month window, beginning twelve months prior to the commencement of data extraction. This allowed for observation of a full cycle of services throughout the course of the open case. Thus, cases included are those opened (or reopened, as some of these families have prior history with the Department) between December 2015 and February 2016.

This yielded an initial pool of 802 available cases for extraction. However, once this list was adjusted to consolidate cases with multiple children (who were each listed separately) and adoption cases, the list of potential cases to be extracted was reduced to 456. In the process of exploring the records for data extraction, some cases were unable to be used due to various reasons:

- records that we were unable to view due to their categorization as "restricted access"
- records with immediate termination of parental rights due to egregious abuse or neglect
- cases that are not categorized specifically as adoption cases, but were found upon exploration to have already progressed beyond the termination of parental rights and to be adoption cases
- other cases where the parents (for whatever reason) were no longer part of the case plan

Records Extracted: A total of 212 records were successfully extracted and entered into a secure database. The database included completely de-identified data and therefore contained anonymous data.

Records Extraction Data Entry and Fidelity Checks: A database was developed and tested to enter data collected. For the first 100 records, every fifth record was double extracted and compared to check for data interpretation fidelity. For the second 100 records, every tenth record was double extracted and for all remaining records, every twentieth record. A comparison of the double extracted records was conducted and an 88 percent rate of agreement between three researchers was found.

Results

Analyses of the child welfare case record extraction data included summarization of dates related to the primary Alleged Perpetrator (AP) identified in the case record. Frequencies of the following data on the primary AP are presented in the tables below: demographic information, medical conditions, any information noted on parental (AP1) mental health, substance abuse, current interpersonal violence, or any other trauma-history. The tables also include percentages of referrals for mental health, substance abuse, interpersonal violence, and other trauma history. All open-ended information on the behavioral health referral outlet and any information on behavioral health referral follow-up was coded into categories. Percentages of those codes are also presented in the tables below.

Table 5: *Overall Sample Characteristics*

VARIABLE	MEAN (SD) OR %
Child age	6.7 (4.9)
Parent age	32.6 (8.2)
Number of children in home	1.8 (1.3)
Number of adults in home	1.6 (.72)
Number of previous FSFN cases	4.1 (3.6)
Child Gender	
Male	56
Female	44
Parent Role	
Mother	92
Father	5
Other	3
Parent Race	
White	63
Black	34
Other	3
Parent Ethnicity	
Hispanic	3
Non-Hispanic	97
Parent Education	
Grade school	22
High school/GED	48
Some college/skill training	26
Bachelor level	5
Parent Employed (yes)	35.9
Parent Medical Problems	
Yes	58
No	42

Table 6: *Primary Parent Mental Health (MH) Information*

VARIABLE	PERCENTAGE
Mental Health disorder noted by BBCBC[1]	
Yes	45
No	55
If yes, what diagnosis	
Depression	57
Anxiety	49
Bipolar	48
Schizophrenia	18
Other	65
MH screening tool used (yes)	0
MH referral made:	
Yes	99.3
No	.7
Lifetime MH history noted:	
Yes	66
No	34
Referral-service type:	
Parenting psych evaluation	.2
Parenting class	2.4
Parent/child psychotherapy	1.9
Psychological evaluation	1
Individual/family counseling	1.9
No service type reported	4.7
Mixed/unspecified	10.4
Missing referral service type information	72
Referral follow-up information:	
Completed/compliant	13.3
Not compliant/incarcerated	4.2
Not compliant/not incarcerated	27.2
Completed evaluation; no follow up	9.2
Currently engaged in services	42.5
Missing follow up information	43.4

[1] This variable included any mental health disorder noted anywhere in the record

Table 7: *Primary Parent Substance Use (SU) Information*

VARIABLE	PERCENTAGE
Current SU noted by BBCBC:	
Yes	72
No	28
If yes, what subtance	
Amphetamine	44
Marijuana	44
Alcohol	30
Prescription drugs	29
Cocaine/crack	26
Heroin	.007
Other	26
SU referral made:	
Yes	95
No	5
Lifetime SU history noted:	
Yes	89
No	1
Referral to:	
SU service	100
Referral follow-up information:	
Completed/compliant	7.1
Engaged in services / negative drug screen	12.7
Evaluation but no follow up	4.7
Incarcerated	6.6
Continuing to use, but engaged in services	8
Continuing to use, not engaged in services	6.1
Non-compliant; no info on current use	15.6
Missing follow-up information	38.7

Table 8: *Parent Other Psychosocial Risk*

VARIABLE	PERCENTAGE
Current interpersonal violence (IPV):	
Yes	77
No	23
IPV referral made:	
Yes	85
No	16
Lifetime IPV:	
Yes	86
No	14
Parent history of trauma[1] (yes)	41
Sexual	.02
Physical	61
Neglect/emotional	22
Witness violence	29
Other	34

[1] Any trauma other than current interpersonal violence

Frequencies of Co-occurring Behavioral Health and Associated Referrals

The rates of co-occurring behavioral health needs were calculated for the primary parent (primary Alleged Perpetrator) by summing the co-occurrence of either mental health, substance abuse, interpersonal violence or other trauma-related history. In addition, the percentages of referrals to one or more behavioral health services were calculated. Nearly half of the records had noted some indication of a mental health problem (based on various sources of information). Most commonly noted were mood and anxiety disorders.

Table 9: *Behavioral Health Issues Noted and Referrals*

VARIABLE	PERCENTAGE
1 BH issue noted	7.6
2 BH issues noted	26.4
3 BH issues noted	33.5
4 BH issues noted	22.6
5 BH issues noted	9.4
6 BH issues noted	.5
No service referral	19.3[1]
Referral to 1 service	12.7
Referral to 2 or more services	68
Referral to 3 or more services	49.7
Referral to 4 or more services	31.3
Referral to 5 or more services	17

[1] Percentages add up to > 100% due to the fact that each level is aggregated across individuals

Summary of BBCBC Case Record Review

As can be seen from the tables, the majority of primary Alleged Perpetrators were mothers. The rates of multiple open child welfare cases were relatively high, with an average of more than four previous Florida Safe Families Network (FSFN) cases (SD = 3.6). Only one-third of parents had more than a high school education, and 35 percent had some indication of employment in the case record. Nearly 60 percent of parents had a major medical condition noted in the case record. The percentage of those parents who were receiving proper medical care is unknown. The vast majority of cases had notations related to an indication of substance abuse, including a lifetime history of mental health (66%) or substance abuse (72%). Record reviews also revealed very high rates of current interpersonal violence (77%) and history of physical and sexual abuse and other forms of trauma. Although rates of referral for mental health, substance abuse, and violent history were quite high (up to 100% for substance use), rates of follow-through with parental services was highly variable. For example, 13 percent of parents were noted in the chart as having completed referred services for mental health, and 7 percent for substance use. However, a relatively large percentage of records did not include any information (i.e. missing information) on referral follow through (43% missing for mental health and 39% for substance use referral follow-up). Analyses also revealed substantial missing information in the records related to the type and location of service referral for mental health, with 72 percent of the records missing referral outlet information. Of the notated service referral outlets, there was little indication that parents were being referred to, or followed through, with evidence-based psychiatric or substance use disorder treatment. Of note, 92 percent of parental records had notations of co-occurring or co-morbid behavioral health or psychosocial risk (i.e. interpersonal violence or other trauma). Parents with co-occurring or co-morbid behavioral health issues likely require intensive interventions that are known to be effective. Record reviews did not show clear evidence that services received were aligned with what is known about effective intervention for behavioral health and psychosocial risk. In addition, the majority of parents were referred to multiple services, often at different locations:

- nearly 70 percent were referred to two or more services
- nearly 50 percent were referred to three or more services
- 30 percent were referred to four or more services
- 17 percent were referred to five or more services

In summary, record reviews showed that most parents in the sample had significant and relatively high rates of mental health, substance use, interpersonal violence, and other trauma history, as well as medical problems. Most had multiple cases open with DCF. Most parents were referred for multiple services, but there was inadequate information regarding service follow-through by the parents.

Family Interviews

Methods

In order to examine rates of parental behavioral health issues using validated measures, a sample of parents receiving services through BBCBC was contacted and interviewed. All procedures were approved by the FSU Institutional Review Board. A list of potential families to contact for interviews was sent to the BBCBC representative using the same inclusion criteria as the record extraction portion of the study. The BBCBC representatives vetted the families to ensure that these were families who were willing to participate and were currently in contact with their case managers, and ensured that the families were made aware of the possibility of being contacted by FSU researchers and that their participation would not affect their case. A total of 25 families agreed to be contacted, and a total of 20 (80%) families completed interviews. The BBCBC returned a final list of families that they recommended that FSU researchers contact. Interviews were conducted over the telephone and took approximately 20 minutes to complete. After a written consent form was completed, validated screening measures for a DSM-V psychiatric diagnosis and alcohol and substance misuse was utilized, as well as questions regarding satisfaction with services. Families were remunerated $50 for their time.

Results

Table 10: *Parental Demographics (Interviewed sample = 20)*

VARIABLE	MEAN (SD) OR %
Parent age	33.1 (6.8)
Parent role	
Mother	70
Father	25
Other	5
Number of other children in home	2.7 (1.2)
Parent race	
White	80
Black	20
Health Insurance	
None	50
Medicaid	30
Private	20
Education	
Grade school	10
High school or GED	40
Some college / skills	40
Bachelor degree	10

Table 11: *Parental Behavioral Health Risk*

VARIABLE	PERCENTAGE
Used alcohol or drugs	
Yes	45
No	55
Ever had a drinking or drug problem	
Yes	65
No	35
Ever diagnosed with depression	
Yes	60
No	40
Ever diagnosed with anxiety	
Yes	55
No	45
Family History of MH condition	
Yes	79
No	21
Ever had treatment for MH condition	
Yes	70
No	30
Current PHQ-9 above 10	
Yes	25
No	75
Current GAD7 above 10	
Yes	30
No	70

Based on the Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD), a validated screening tool for substance use disorders, 30 percent (*N* = 6) of parents interviewed scored above a cutoff of 4.

Parents also completed the DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: Adult Version, which includes validated screening domains for a number of psychiatric disorders. The percentages of positive screening rates for twelve psychiatric domains are listed in Table 12. A positive screen on each domain indicates the need for further psychiatric diagnostic assessment.

Table 12: *Psychiatric Disorders*

Domain	Percent (N = 20)
Depression	30
Anger	25
Mania	40
Anxiety	45
Somatic symptoms	25
Psychosis	15
Sleep Problems	45
Memory	5
Repetitive thoughts and behaviors	25
Dissociation	10
Personality functioning	25
Substance use	65

Summary of Family Interviews

As can be seen from the tables, the sample of families interviewed reported relatively high rates of psychiatric disorders based on validated screening measures. For example, the rates of families who scored above the cut-off score on the depression (PHQ-9) and anxiety (GAD7) measures were nearly double the rates found in general primary care samples of age-matched new mothers. Rates of psychiatric risk including severe, persistent illnesses such as bipolar disorder, psychosis, mood and anxiety disorders were also found to be substantially higher than the expected prevalence based on community samples. The results also reveal related problems that likely require medical or behavioral intervention, including problems related to sleep disturbance (45%), anger (25%) and dissociation (10%). Risk for substance use disorders was most commonly reported (65% based on the DSM-5 symptom measure). These results clearly indicate the need for thorough psychiatric diagnostic assessment, and based on assessment results, intensive psychiatric and psychological treatment.

Discussion

The aim of this study was to identify gaps, barriers, and opportunities related to increased access and integration of behavioral health services for parents who are involved with the child welfare system. This study included four related components, each serving a unique purpose in shedding light on issues and recommended strategies for facilitating greater behavioral health integration for child welfare-involved parents. Results provide preliminary evidence supporting that behavioral health issues are prevalent among parents receiving child welfare services in Circuit 2. Based on the review of case files and discussions with case managers, efforts to detect behavioral health issues in parents are limited as is the use of screening tools. Although data from the sample of case files showed rates of referrals for services were high, information regarding the type of services parents were referred to and uptake were mostly unavailable. Scores on behavioral health assessments from follow-up interviews with families suggests disproportionally high rates of behavioral and psychiatric conditions among those contacted, many of whom continued to experience significantly elevated symptoms. Further research is needed to identify what services parents are receiving and how referral decisions are made.

Behavioral health issues are prevalent among parents who are involved with the child welfare system and are a major factor that impact child and family outcomes. Despite longstanding recommendations for utilizing a family-centered practice approach in child welfare, and an increasing amount of research supporting the effectiveness, such approaches have yet to be fully actualized in the field. Child well-being and successful reunification cannot be achieved without ensuring that parents receive proper screening, assessment, and evidence-supported treatment to address behavioral health issues that are often the underlying contributors to incidents of child maltreatment and involvement in the system. Further, without proper behavioral health intervention, risk for recurring maltreatment and re-entry into the child welfare system are high. Efforts toward widespread achievement of the federal child welfare outcomes of safety, permanency, and well-being will require a perspective shift in child welfare from child-focused to family-focused, where effectively meeting parental behavioral health and other needs are treated as integral components of the service plan where reunification is the goal.

Focus group interviews with case managers and behavioral health providers provided insights around some of the challenges of connecting parents with effective behavioral health services. Common issues identified among focus group participants related to challenges with parent motivation to participate in services, a limited use or knowledge of evidence-based screeners, and challenges with communication and service coordination across systems. Current policies mandating expedited services and time-limits on case plans allows only a brief period of time for case managers and providers to address issues with engagement and motivation and may result in reduced incentive for parents to continue with treatment once the case is closed, despite a continued need. The focus group results imply that additional training on specific client engagement skills, such as Motivational Interviewing, are needed and desired. Results also imply that evidence-based screening tools that can assist case managers in determining the primary behavioral health treatment need would enhance the efficiency of making referrals and in engaging the parent.

Record reviews showed that most parents in the sample had significant and relatively high rates of mental health, substance use, interpersonal violence and other trauma history, as well as medical problems. Most had multiple cases open with DCF. Most parents were referred for multiple services, but there was inadequate information of service follow through by the parents. This may be due to missing information in the case file, or missing information from the parent, or both. It is evident from both the qualitative and quantitative results that parental engagement in evidence-based treatments for mental health and substance abuse is not occurring and there is an obvious need for improvement. The pilot training in effective engagement approaches (i.e. Motivational Interviewing) was feasible and well received by the child welfare case managers. Based on this pilot study, we recommend that additional targeted training and attention be focused on the engagement of parents and families in evidence-based treated for mental health and substance use disorders. Based on family interviews and record reviews, it is highly likely that the type and intensity of behavioral health services are not aligned with the prevalence, co-morbidities, chronicity, and severity of behavioral health disorders seen in this population. For example, for major depressive disorder and anxiety disorders, best practice treatment includes at least six months of medications in combination with evidence-based psychotherapy, including adherence monitoring and support. More serious and persistent psychiatric disorders such as bipolar or psychotic disorders require longer and more intensive treatment and monitoring. Our study found no indication that best-practice psychiatric treatment guidelines were in place for any parent.

The results from the pre and post-training evaluation of the pilot training provide preliminary evidence of the need for further training for case managers to better understanding and effectively addressing motivation in parents, working with trauma-affected parents, and how to use screeners to detect behavioral health issues in parents. Follow-up training validated the perceived utility of the specific training content. The majority of participants responded to a follow-up survey and indicated that case managers would like additional information and skills practice in each of the four modules. Pre-post test scores at the follow-up training showed significant improvement and training evaluation scores were in the very good to excellent range.

Further training in the use of Motivational Interviewing, trauma-informed care, and in the use of evidence-based screeners may help provide case managers with additional practical skills shown to be effective to increase client engagement, reduce risk for re-traumatization, and increase detection of behavioral health issues—an essential step to ensuring parents receive treatment that meets their specific needs. However, given the preliminary nature of this study, further research is needed to determine more specific or additional training needs and effective approaches for child welfare providers.

Project Description

Providing behavioral health services for parents is an essential component of child welfare practice. There is a need for child welfare-involved parents to receive timely assessments and screenings and referrals to appropriate behavioral health services and resources. An integrated approach to services is necessary among all providers serving child welfare-involved parents. Recommendations for future work in this area include:

- training case managers on the use of screening tools and evaluating behavioral health outcomes with child welfare-involved parents
- piloting and evaluating joint trainings between different service providers to improve communication and coordination between and among service agencies.

In addition, much more coordination is needed with behavioral health providers. It is clear that case records do not include information related to behavioral health treatment and treatment follow-through that is in line with best practice for behavioral health treatment.

There is also a need to explore the opportunity to develop or expand "aftercare planning" for families once they are "discharged" from the system. This was a need brought up in the focus groups and aftercare planning could help address the needs of the parents who reported continued mental health symptoms during the family interviews.

Based on data from this pilot project, DCF may consider offering trainings on behavioral health screening tools, including how to use them to detect behavioral health risk and service needs, and how to interpret results in order to make referrals. The record extraction revealed that no mental health screening tools were used. Results also suggest that trainings include motivational interviewing to address concerns and gaps identified during focus groups related to family engagement, compliance, buy-in, and follow through.

Communication gaps must also be addressed. We learned from focus groups that communication problems are an issue among agencies, with DCF, with legal teams, with parents, and among coworkers. This may be addressed through offering additional trainings on communication, more built-in opportunities throughout the process to communicate or discuss cases, and/or improved chart documentation to support better communication among various people working with a family. It is possible that adding specific fields in case records that allow for clear documentation of parental behavioral health history, risk, referral needs, and follow-up information would facilitate consistent documentation and improve communication.

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