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Caregiver involvement in behavioural health services in the context of child welfare service referrals: a qualitative study

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Abstract

Human service agencies serve a growing number of adults with behavioral health needs. Despite these agencies' key role in identifying need and facilitating services, many individuals do not receive care or end services prematurely. Few studies have explored the experiences of families referred to behavioral health services by such agencies or the extent to which families' perceptions of service need align with those of treatment providers and frontline workers. This study presents findings from a qualitative study of caregivers involved with child welfare agencies who were referred to behavioral health services. Researchers reviewed agencies' case records and conducted in-depth interviews with 16 caregivers, 9 child welfare caseworkers, and 12 behavioral health treatment counselors. Findings suggest that when deciding to engage in services, caregivers weigh not only their individual and family behavioral health needs but also potential agency intervention, including loss of child custody. Many professionals reported that involvement with a child welfare agency hindered the caregiver's disclosure of behavioral health care needs. Implications for managers and practitioners are discussed.

Keywords

Behavioral health; child welfare; caregivers; service use

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INTRODUCTION

In the US, human service agencies serve a growing number of adults with behavioral health treatment needs due to mental illness and/or substance abuse. Despite agencies' key role in identifying these needs and facilitating appropriate services, about half of adults with behavioral health needs do not receive care. Among those who start services, one out of every five clients stop attending counseling sessions without the service provider's agreement and with a significant amount of the individual's relief and/or recovery goals left unmet (Swift et al., 2012). This pattern is concerning as evidence shows that clients who start and finish treatment in agreement with the service provider are better able to recover, express satisfaction with services, and ultimately regain or improve their ability to function at home and/or work (Barrett et al., 2008, Klein et al., 2003, Luchansky et al., 2000).

Behavioral health services (hereafter referred to as 'service use') include both inpatient and outpatient mental health and substance use-related treatment. These services have been shown to reduce future child maltreatment, by addressing caregiver stress and improving communication among family members (Chaffin et al., 2004). However, individual characteristics such as gender, age, race/ethnicity, healthcare insurance status, and the initial emotional distress level experienced by the individual during the service referral have been associated with variation in service use (Barrett et al., 2008, Edlund et al., 2002, Thormahlen et al., 2003, Adeponle et al., 2007, Green et al., 2002). Interpersonal dynamics between the client and the service provider, such as the development of a collaborative and trustful relationship referred to as therapeutic alliance (Martin et al., 2000), can also influence clients' use of services (Baldwin et al., 2007, Björk et al., 2009, Sanders and Roach, 2007). Client dissatisfaction with services (Björk et al., 2009) and perceptions of negative service outcomes (Klein et al., 2003, Lampropoulos, 2010) can result in premature termination of services and wasted limited mental health resources (Barrett et al., 2008).

Much of the current literature has focused on mental health service use among self-referred individuals and those referred by primary healthcare providers. However, the behavioral healthcare needs of many adults are identified and services facilitated by human service agencies such as child welfare. Few studies have examined how caregivers experience the service referral and the therapeutic process within the context of child welfare involvement, or how these processes are characterized by the professionals involved with the families. Given the involuntary involvement of most families with child welfare agencies, it is important to understand caregiver and professionals' dynamics and how their potentially differing views about service need may impact the referral process and ultimately caregiver service use. In this study, caregiver is defined as the adult with legal guardianship or responsibility of a child such as the biological parent or a relative.

In general, child welfare agencies are responsible for receiving reports of suspected child maltreatment and, when warranted, conducting an investigation or assessment (Office on Child Abuse and Neglect et al., 2003). As part of that initial process, investigative caseworkers assess family needs and identify behaviors and conditions about the child, caregiver, and family that may contribute to risk of child maltreatment. When service needs are identified, child welfare caseworkers facilitate access to services as a way to ensure

children's safety and well-being (Child Welfare Information Gateway., 2008). These services may or may not be court-ordered or part of a case service plan.

Despite caseworkers' efforts, a high number of caregivers who are referred to behavioral health services by caseworkers do not engage in services. Research on families involved with child welfare indicates that only about half of caregivers identified with a behavioral healthcare need receive some type of service (Mennen and Trickett, 2007, Dolan et al., 2012). This service gap is troubling because caregiver behavioral health care needs can contribute to child maltreatment (Barth, 2009, Traube, 2012, Chuang et al., 2013). Children of caregivers with behavioral health problems are also more likely to experience emotional and behavioral problems in adolescence and early adulthood (Ashman et al., 2008).

The level of family engagement with the Child Protective Services (CPS) agency influences how accurately service plans address family members' needs and ultimately whether families benefit from available services (Nilsen et al., 2009). Guided by the conceptual framework of the engagement process in CPS agencies (Staudt, 2007), we conceptualize caregiver engagement as the result of negotiated understandings stemming from social interactions with professionals. Specifically, professionals' use of engagement strategies are expected to influence caregivers' attitudes toward services, and motivation to engage in open discussions about their needs and to follow up on a referral to behavioral health services. Engagement strategies used by professionals that address the treatment relevance and acceptability, external barriers to treatment, beliefs about treatment and that foster a positive therapeutic alliance with the caregiver are expected to influence their motivation and actions toward higher engagement in services (Staudt, 2007).

Understanding how caregivers experience these interactions with professionals and how caregivers experience behavioral health services when child welfare has been the referral agency is relevant for two main reasons. First, given the nature of families' initial involvement with the child welfare agency behavioral service referrals may be perceived by some caregivers as involuntary (Chapman et al., 2003). Second, it is possible that a perceived negative relationship with their child welfare caseworker influences caregivers' willingness to accept a service referral.

Purpose and research questions

This paper presents findings from a qualitative study describing the experiences of caregivers involved with child welfare who were referred to behavioral health services. The purpose of this study is to provide a comparison of caregiver and professional views about service need and the impact of child welfare as the referral source on service engagement. In this study, behavioral health care counselors included psychiatrists, therapists, and/or alcohol and other drug (AOD) licensed caseworkers.

This study has two distinctive features. First, researchers gathered detailed information from caregivers involved with child welfare through face-to-face interviews in their homes. Second, this information was compared with accounts provided by caseworkers and counselors involved with each family and from reviews of agencies' case records. These multiple sources of information on a single case allowed us to explore the perceptions of

caregivers' need for services, the service referral process made by a caseworker, and how each actor assesses the helpfulness of those services when provided. Thus, we sought to answer the following research questions:

1. How did caregivers describe their perceived need for the services recommended to them by the caseworker?
2. How did caregivers characterize their experiences with services?
3. Were caseworker and counselor characterizations of the caregivers' service need aligned with caregivers' own experiences?

METHOD

Data are drawn from a larger study funded by the National Institute of Mental Health (NIMH) to identify how case management affected behavioral healthcare engagement and outcomes for families involved with U.S. child welfare agencies. This study was a subsample of the NIMH case study in that these analyses focused exclusively on the caregivers, rather than on processes attendant to children's needs. The principal investigator's IRB oversaw the data collection after full board review and the study's privacy protections were developed in consultation with an ethicist experienced in designing studies relating to maltreatment.

The study focused on families whose children remained in the home (i.e., in-home) after the initial child welfare investigation because in general this population comprises the majority of families (61%) receiving services from child welfare (Childrens Bureau., 2012), and because at this juncture service(s) may prevent removal of the child from the home. Behavioral health services are defined in this study as: a) in-patient services or residential programs: 24-hour services delivered in a licensed hospital setting that provide clinical intervention for mental health or substance use diagnoses, or both or b) out-patient services provided in an ambulatory care setting such as a mental health center or substance use disorder clinic, faith-based setting, practitioner's office or at an individual's home (Gifford, 2013).

We interviewed each participant using a semi-structured interview protocol comprised of questions addressing service need, service referral and service experiences. Examples of questions from the caregiver protocol include: "What services did the agency recommended to you", "What did you do to get the recommended mental health/substance abuse treatment/services?" and "How did the child welfare agency help you get the mental health/substance abuse treatment they recommended?". Caregiver interviews lasted an average of 33 minutes and those with professionals lasted an average of 26.5 minutes. Caregivers received a gift card for their participation. The participating professionals received a gift card if allowed by their agency.

The sample selection criteria were: 1) the family was receiving in home services at the time of the study or within the prior six months, 2) the social worker perceived a behavioral health care need for the family, 3) the social worker did not believe the family's participation in the study would create a risk for any family members. In part because of prior research

showing comparable risk regardless of substantiated maltreatment (Leiter et al., 1994), and in part because the definition of substantiation differs across states, this was not a factor in study inclusion.

Sampling and recruitment procedures

Caregiver recruitment was implemented using a three-stage process (See Figure 1). First, caseworkers who volunteered to participate in the study were asked to identify three to six families in which at least one person had a mental health or substance use–related need. Each caseworker gave the study's recruitment materials to each caregiver; explained that the study was completely voluntary; and that he or she could mail a return post card to the principal investigator if interested in participating. The principal investigator then completed informed consent with one or two families, depending on how many families the caseworker reported approaching. The principal investigator mailed a gift card to the other caregiver volunteers, explaining that not all volunteers could be included.

Study participants' privacy was protected through a combination of strategies. First, the researchers only learned identities of families who volunteered. Second, the researchers did not tell caseworkers the names of any caregivers except those selected to participate. Hence, caseworkers did not know which of the non-participating families were excluded by the researchers versus those who chose not to participate. Third, researchers did not share anything disclosed by any given participant with any other participant. Finally, reports to agencies were reviewed by a social worker not involved with the study to ensure that no one could infer the identities of any families from any descriptions therein.

Child welfare agency characteristics—As shown in Table 1, all families sampled received services from one of three child welfare agencies. All three agencies provide case management services to between 100 to 200 families investigated by child welfare each year. Two of the agencies are located in a single, Midwestern state. The first of these agencies, “Christian Services,” is a large, private agency providing child welfare services for much of the state. The second, “Big City Social Services,” is a smaller agency providing services in a single urban area. The third agency, “County Services,” is a smaller agency providing services in a small urban area in the Appalachian region.

Child welfare caseworkers—Researchers approached a total of 24 caseworkers and 9 of these agreed to participate in the study. Participating caseworkers had slightly larger caseloads (i.e., by 1.7 cases) than those who did not participate. The nine participating caseworkers had an average of 8.4 years of experience at their agency, with a wide range (1.2 - 15.6 years). Less than half had a degree in social work; most were non-Hispanic White; and all were female.

Caregivers—Sixteen caregivers in 11 families participated in the study. The average caregiver age was 31 years old. Participants included individuals of White and African American race and Latino ethnicity. Five of the participating caregivers were single mothers and one was a single father. All of the families were struggling financially due to a lack of

regular income. Half of the participating families were involved with child welfare for the first time and one case was court-involved.

Behavioral health care counselors—With the caregivers' permission, a total of 12 counselors were interviewed regarding provision of services to families. For mental health providers, we interviewed individual and family counselors and a psychiatrist. For substance use treatment providers, we interviewed a volunteer leader in a faith-based sobriety support program, an AOD supervisor, and one worker providing inpatient services.

Following caregiver authorization, we first interviewed their caseworker or a colleague familiar with the case. In addition, we collected demographic information from caregivers and history of the child welfare case and professional background information from service providers. All participants were asked about their understanding of the caregiver's behavioral health needs and how they would characterize the caregiver's service experiences. The team also reviewed each family's child welfare and, when applicable, behavioral treatment records. These records provided specific facts and perceptions that study participants did always remember by the time of the interviews. All but one caregiver allowed access to their child welfare and clinical records.

Data analysis

All interviews were transcribed word-for-word and reviewed by one of the interviewers to ensure accuracy. Four interviews were conducted in Spanish and translated into English by a native Spanish speaker. Identifying information from transcripts and child welfare or behavioral health case records was replaced with pseudonyms, and all transcripts were redacted. All study files were uploaded into an Atlas.ti (qualitative software) database. Data analysis was started early in the data collection process to pursue emerging ideas as needed (Rubin and Rubin, 2005, Miles et al., 2013).

Data coding started with the creation of descriptive codes related to each child and caregiver's behavioral health needs, service use, and outcomes. Data analysis then transitioned from descriptive to more interpretative coding. A codebook was developed for interpretative themes with detailed definitions. We used an iterative comparative coding process in which team members coded separately and then met to discuss those codes, identify discrepancies, and reach mutual agreement. We then compared those selected themes to prior published studies in the area of study to identify patterns or new information that could lead to additional codes. Codes were revised, dropped, and added throughout this process. These iterations continued until each individual caregiver was fully analyzed by the team.

Second, participants were divided by groups—caregivers, caseworkers, and counselors and emerging themes were compared within and across groups. Data was condensed using tables to identify patterns across groups (Yin, 2003). We used memos throughout the coding process to document reflective remarks, the frequency and timing of events, and emerging similarities across participants' accounts (Allison, 1999, Miles et al., 2013).

Several strategies were implemented to achieve credible, dependable, and confirmable findings. All research team members reviewed interview transcripts and child welfare and service treatment records. Interviews and case record review provided a comprehensive view of each participant's experiences of services. Researchers used reflexivity throughout data coding and analysis (Krefting, 1991). When participants had differing accounts of service need and experiences with services, child welfare and clinical records were used to corroborate verifiable facts like dates and behavioral health diagnoses (Miles et al., 2013). Conflicting individual experiences of events were preserved because each account was considered to be the meaningful reality for that individual (Corbin and Strauss, 2007). The final codebook developed in this study is available upon request.

RESULTS

Common themes that emerged within and across groups of participants related to the engagement process. These are presented and examples illustrated through quotations. The following three themes emerged from caregivers' accounts of their experiences: (a) perceived voluntarism of services, (b) perceived need for services, and (c) therapeutic alliance. Although the individual accounts related to the first two themes overlap, we present them separately to provide more detailed information on each theme.

First theme: Caregivers perceive service referrals as involuntary

In general, there is some degree of non-voluntarism when a caregiver is involved with a child welfare agency. Certain requirements must be met to ensure the child's safety before the case can be closed and agency involvement terminated. If services are recommended to a caregiver as part of the agency's service plan, participation in those services may or may not be necessary to satisfy case requirements.

Caregivers—Most caregivers responded to the child welfare service referral in pragmatic terms. Caregivers' acceptance of a caseworker referral served as a strategic action to deal with their agency involvement in three different ways. First, caregivers accepted services suggested by the caseworker to avoid losing custody of their child(ren) or as a way to reunite family members. A young mother expressed it this way:

[The child welfare agency] came into my life and said 'you either go into treatment or we're taking your child' and my butt was at [the treatment facility] the next morning.

Second, service use was seen by caregivers as a way to expedite the reunification of all family members because this service requirement was part of the family's safety plan. Another caregiver explained:

So, I agreed to go to [substance abuse] treatment and part of the safety plan was if I go to treatment, I could be alone with the kids and I think that's why I did it.

Finally, caregivers accepted services as a way to end the agency's involvement in the family's life. One mother summarized this point bluntly when describing why she accepted intensive substance abuse treatment:

To get them off our backs.

Sometimes, caregivers learned over time that services were more voluntary than they had initially believed:

I found out after I had finished that treatment was an option, it wasn't that I had to do it. But, I thought that I had to do it and it was mandatory.

The underlying assumption for these caregivers appears to be one of little discretion about whether they can refuse services without jeopardizing the outcomes of their child welfare case. Decisions related to both their child welfare case and behavioral health service referrals seem to overlap as part of one complex reality for these individuals. That is, acceptance of services seemed to be used by individuals as a coping mechanism to minimize any potential future negative repercussions of their involuntary involvement with a child welfare agency.

The link between child welfare involvement and service use was not reported by all interviewed individuals. In fact, two caregivers seemed to feel empowered to decline the services strongly suggested by the caseworker. Their argument for refusing services was similar to the one provided by previous caregivers—to avoid further agency involvement because the presence of professionals in the family's life was seen as intrusive. For instance, one father said:

I don't want [caseworkers] here; I don't want anybody here... I know it's all confidential and everything, but I'd just as soon not be involved in any of it.

Others actively engaged in behavioral health care for as long as they considered necessary, as expressed by this caregiver:

They [children] had enough trauma, too many of these people [counselors and caseworkers] are coming and going in their lives. It was just too hard and I'm not used to that. In our family, we work our own problems out.

For the first case, the caseworker expressed satisfaction with the caregiver's engagement with services up to that point in the case. For the second case, caseworkers focused on achieving case management goals (e.g., housing, parenting skills classes) with the family.

Child welfare professionals—Interviews with child welfare caseworkers and review of child welfare case records made reference to the caregivers willingness to use services influenced further agency action. This theme was also discussed by caregivers as described in the previous paragraphs. One set of records stated it this way:

Full disclosure for not cooperating with services: Court involvement, loss of parental custody of the children.

In addition, despite suggesting a service referral, several caseworkers were aware that the presence of the agency negatively influenced caregivers' willingness to use services. A caseworker with over 15 years of experience in the child welfare field described it this way:

[The caregiver] was afraid of that, you know, 'is this going to go against me, because I need mental health services' ...so she has expressed that concern.

However, not all caseworkers or mental health professionals perceived recommended behavioral health care as coercive.

After we [child welfare agency staff] were involved in the case and the service plan was written, [couples' therapy] was offered. So it is not actually an objective or goal in the service plan to meet that. It was just offered as a supportive intervention.

This agency goal to support families through the referral of services, as expressed by this caseworker, was not reported by most caregivers during their interviews.

Behavioral health care counselors—Similar to the views shared by caregivers and caseworkers, counselors also reported that caregivers' attitudes toward service use were related to their perception that the presence of the child welfare agency in the family's life was not voluntary. An outpatient service counselor described it this way:

She [caregiver] really came in saying 'I want to do this, get this done, and get my child welfare case closed'. And in her particular case, her case is practically closed.

One counselor addressed the issue of fear among caregivers who are referred to services by a child welfare agency as influencing the caregiver's willingness to use services:

[The caregiver] tended to think of us [in-home counseling team] as part of DSS [Department of Social Services], which we went over several times that we were not. And she had a little bit of fear, which was her main motivator I think [to participate in counseling], of child welfare stepping in. I don't think she ever got that we are not DSS, we can't take your kids away.

Counselors did not describe any perceptions that differed from those of caregivers regarding this theme. Also, behavioral health care providers mentioned that engaging in services was often not required by the case but that caregivers did not always understand this.

Second theme: Child welfare agency involvement often prompted caregivers to accept need for services

Accounts of the caregiver's perceived need for services did not emerge as an isolated theme but instead within the context of their child welfare agency involvement.

Caregivers—For most caregivers, the event that brought them in contact with child welfare and the threat of losing custody of their child seemed to prompt caregivers to recognize behavioral health needs in ways they had not previously. One mother shared:

I was in the shelter for a month...I think the shelter was my bottom...and this time they [child welfare agency] said 'you are going to [name of recovery home]' and I did.

For another caregiver, this turning point was related to a perceived life-and-death situation:

Yeah, instead of being out there on the streets. It [substance abuse] won't get you nowhere but dead, and I wouldn't want that so, you know, I'm glad. I am very happy to be there [Inpatient substance abuse treatment facility].

A third caregiver expressed it this way:

I guess for me, it didn't matter if I lost my house, it didn't matter if I lost my car. But lose my kids? That meant I was an addict. So when they [caseworkers] told me they were going to come take them, that meant I had a problem. But up until then, I didn't have a problem.

Caregivers' accounts also shed light on an unintended consequence of child welfare involvement. For several caregivers, the need for counseling was perceived as a way to deal with their involvement with the child welfare agency itself as expressed by this caregiver:

I was stressed out...because they [child welfare agency] wouldn't let us be together and be with our kids at the same time, and all that stuff...it was real stressful. I just needed someone to talk to.

Child welfare professionals—Caseworkers were also aware that sometimes it took both agency involvement and additional precipitating events to prompt caregiver recognition of a need for change:

And after that arrest I think [caregiver] realized that, you know, she really needed the help. And she even gave her children to a relative and said, 'I don't think I should be caring for them until I get some help for myself', and so that was kind of a turning point.

In addition, caseworkers were aware that the presence of a child welfare agency in families' lives could be intimidating for some caregivers and that these dynamics may impact their willingness to disclose their behavioral health needs. One caseworker explained how once caregivers overcome those fears they could be more receptive to the service referral:

Well, [caregiver] was really guarded when we first met her just because she was so afraid she was going to lose her child for telling us the truth and the more we got to know her and the more she understood about our program, she started to open up and kind of understand why we were recommending [substance abuse] residential [treatment].

Behavioral health care counselors—Like the other study participants, counselors were keenly aware that for caregivers with a long history of mental health needs and/or substance abuse, being involved with child welfare often served as a wake-up call. A substance abuse counselor described it:

She [caregiver] reported to us basically a substance use history...she did not have any criminal arrests...she was not experiencing any sort of physical repercussions. So, it made sense that she didn't see it as a problem because technically, until she gave birth to a substance-exposed infant [and was referred to child welfare by hospital personnel], in her mind, it hadn't been a problem.

Similar to caseworkers, one mental health service counselor described in more detail how a family's involvement with a child welfare agency seemed to impact their willingness to disclose information during the therapeutic process:

What'll happen is if they're working with child welfare, they're presenting a very contrived picture of what they want for you to see, and until there's safety, and

there's rapport, and there's a belief that you're not working for child welfare and there's something in it for them, that window doesn't get any bigger. They don't open those shades to see inside.

Third theme: Caregivers and professionals reported that trust fostered therapeutic alliance

Caregivers remained in recommended mental health and substance abuse treatment services not only due to their perceived behavioral health need and the non-voluntary nature of the service referral but also due to their ability to establish a trusting human connection with a counselor. The most common theme related to service engagement across all groups was related to the quality of the personal interactions between the caregiver and the counselor(s).

Caregivers—Most caregivers were able to develop a positive and collaborative relationship with their counselor(s). Two reasons, closely related to the child welfare context, were identified by caregivers as facilitating this type of relationship. The first reason was having a service provider with similar background experiences as the caregiver. The following quote illustrates how a father was able to build a close relationship with his counselor in part due to their similar childhood challenges:

He made me feel welcome...he went through the same stuff when he was younger too so we kind of related in a way, it was like a bigger brother.

The second reason was the counselor's professional style. Most frequently, caregivers underscored the importance of having a counselor who kept his/her word and actively advocated for additional services that they agreed were needed. One caregiver explained it:

If I need something like I'm having a hard time placing (psycho) therapy right now and [the] (substance abuse counselor) is like, 'I'm on it...I will find you the therapy. I will take care of it' because I've been calling and calling and they're not calling me back...I have faith...because anytime they [counselor and caseworker] say something, they do it. "Placing psychotherapy" in this context means identifying a service provider and/or obtaining an appointment over the phone.

Child welfare professionals—From the caseworker perspective, counselors' ability to trust their clients in their recovery process and to feel that they were truly learning during the sessions were identified as key factors that could foster or hinder their engagement with services. These two factors are illustrated by two different caseworkers:

And the counselors agreed that [caregivers] would do okay on their own. And um, I think it really gave them a lot of courage to move forward.

Conversely,

The caregiver often complained about the services at the provider right now...how she perceives them as being not really helping her overcome addiction. You know like finger painting, or watching a movie or putting up Christmas decorations. So she often complains about what she's required to do in intensive services.

Behavioral health counselors—Counselors identified several factors that they perceived as contributing to the quality of the therapeutic relationship. Two of those factors

were similar to what was reported by caregivers and caseworkers regarding the counselor's ability to foster a sense of safety and trust with the caregiver:

[The mother] was saying 'we can start, we can start' [counseling]. Well, let's let [dad] have a chance to develop a little bit of a relationship with [his own therapist]. Because, OK you may feel like I am an ally, but him [dad] might go in there with someone he has met twice...so I think by the time we did that everybody felt like 'OK we are in a safe place, we can do these things.'

Conversely, both this counselor and a substance abuse counselor reported needing at times to be direct, or even harsh, with some caregivers. The counselors phrased it as the caregiver needing 'a reminder...a kick in the butt' and as 'I kind of went a little hard with [caregiver] because she was kind of hardcore...she was difficult.' An in-home counselor referred to his therapeutic style with a mother as 'you don't ever want to sugarcoat anything.'

Finally, an additional in-home counselor identified the role of the provider as being a support to the caregiver while the family was also involved with child welfare as key in fostering a positive therapeutic alliance:

[The caregiver] would come back and tell me 'I want to thank you for just being here,' that's what she would tell me, 'because that in itself would help me out, it would help me with what I was going through.'

DISCUSSION

This study sought to identify factors influencing caregiver engagement in behavioral health services during their involvement with a child welfare agency, including both initially accepting recommended services and sustaining engagement. Three major themes emerged. First, it quickly became clear that the level of voluntarism of service referrals was not clearly understood by caregivers. Several professionals in our study reported that their services were voluntary while acknowledging that the caregivers served by these individuals did not share this understanding. Instead, caregivers often viewed their participation in behavioral health services as involuntary, and necessary for maintaining custody of their children. For many of these caregivers, engaging in behavioral health services was seen as a way to avert negative child welfare action and to end agency involvement sooner. Second, caregivers' perceptions of services as involuntary influenced their willingness to accept a need and/or engage in behavioral health services. It also influenced their views of the caseworkers and behavioral health professionals involved. Finally, the quality of the therapeutic alliance with the professional(s) involved in their case was described as playing a strong role in sustaining engagement in services.

For many caregivers, the motivation to follow up on a service referral was influenced not only by their attitudes toward individual and family behavioral health needs but also by the potential threat of losing custody of their children. It was interesting that the level of voluntarism of service referrals was not always clearly understood by caregivers. Several professionals in our study reported that their services were voluntary while the caregivers served by these individuals did not share this understanding. It is possible that this level of vagueness serves as a way to leverage caregiver cooperation.

Key Implications

Our results also suggest that from an engagement process framework, it is important for professionals to acknowledge that the effectiveness of the engagement strategy may be influenced by how caregivers perceive the agency in terms of potential future action impacting the family unit.

The influence of the engagement strategies used by professionals could be better understood by acknowledging the highly asymmetric relationship between professionals and caregivers, in which caregivers lack information about the child welfare system and power over agency decisions. At the same time, agencies are more likely to achieve their goals of protecting children's safety if the caregivers who are referred to services agree to participate and remain in treatment.

Engagement strategies that help caregivers understand the implications of their decision making for future agency action during and after the service referral process may directly influence caregivers' attitudes toward agency involvement and motivation to seek services. Our results showed that a caregiver's decision not to disclose a service need, despite experiencing emotional distress and/or substance abuse dependency, served as a strategic action to preserve the family unit within the context of child welfare agency involvement process and it was not necessarily linked to the quality of the engagement process with professionals. Engagement strategies that acknowledge caregivers' perceived interests and agendas and those they attribute to the child welfare and counseling agencies may help professionals address these issues early on in the referral process and potentially increase buy-in from families.

The authors acknowledge that caregivers and professionals share a strong common interest in the welfare of the child at the center of this situation. Hence, there is not so much a divergence of goals as of perceptions of what needs to be done to assure the child's well-being. Often parents express an inability to respond differently due to mental illness such as depression or substance abuse dependency as well as due to perceived agency intrusion on their freedom to raise their child as they see fit.

Study participants shared during the interviews that caregivers were still able to develop a positive relationship with the counselor despite perceiving the child welfare service referral as coercive. In addition, the quality of that relationship was cited by participants as a key factor in facilitating caregiver engagement with services. Our findings are consistent with the literature reporting that the development of a therapeutic alliance between an individual and a service provider is associated with service engagement (Lambert and Ogles, 2004, Mullins et al., 2012). This finding of a positive alliance between caregiver and professionals may seem contradictory given the perceived coercive nature of the agency involvement in many of the families' lives. We interpret these results as the result of two related but not necessarily congruent factors influencing the engagement process: the role of the agency as perceived by the caregiver, and the type of engagement strategy used by the professional. That is, we found that although caregivers had a negative perception of the CPS agency they still benefitted from the engagement strategies implemented by professionals that included underscoring treatment relevance and fostering a positive therapeutic alliance with

caregivers (Staudt, 2007). Nonetheless, it may be helpful for professionals who believe behavioral health care services to be voluntary for a caregiver involved with a CPS agency to keep in mind that caregivers may not share that understanding.

Our findings also raise additional and relevant questions for child welfare policy makers and practitioners to consider. For example, do child welfare caseworkers want to be clear with clients that services are voluntary, and risk lack of follow up, when they know that both the caregiver and their child will likely be better off if they participate? And in an effort to meet caregivers needs, is it even feasible for practitioners to assure clients that if they fully acknowledge substance abuse or mental health problems it will not cause additional agency action such as removal of their child(ren)?

We can draw several implications from having multiple perspectives on families' common experiences. First, service engagement by clients who are referred by child welfare agencies can be improved by striking a balance between prioritizing case management needs to develop a sense of safety while also building rapport and honestly communicating child welfare policies. These conditions may make caregivers feel more respected and at ease when disclosing behavioral health needs with their child welfare case. Second, education on why behavioral health services are offered could dispel inaccuracies among caregivers and make them more receptive to services. Third, behavioral healthcare providers have an opportunity to bond with caregivers that caseworkers often do not have, which underscores the importance of inter-agency partnerships. Last, building enough trust between professionals and caregivers while protecting confidentiality will likely allow professionals to build strong teams for these families.

Limitations and future directions

Conclusions should be drawn taking into account the following study limitations. First, this study's sampling was not random. It is possible that caseworkers selected the families perceived to be most cooperative with the agency to participate in the study or that families who opted to participate were more comfortable in general sharing private information than were families who did not volunteer. Also, caregivers were referred by caseworkers who volunteered to participate in our study. Still, caregivers' narratives provided a rich picture of the various issues discussed during the interviews. Second, our findings may not be generalizable to other public service agencies or to other informants.

Despite these limitations, this study's findings provide rich insight into individual experiences related to behavioral health from multiple perspectives. Future studies could identify case characteristics where caregiver refusal of service referral leads and does not lead to further agency action, as well as the impact of caregiver involvement in child welfare service planning on service use. Our findings contribute to both the child welfare and behavioral health service literatures because of the limited understanding of the intertwined nature of family situations, professionals' efforts, and agency and local service contexts (Yin, 2003).

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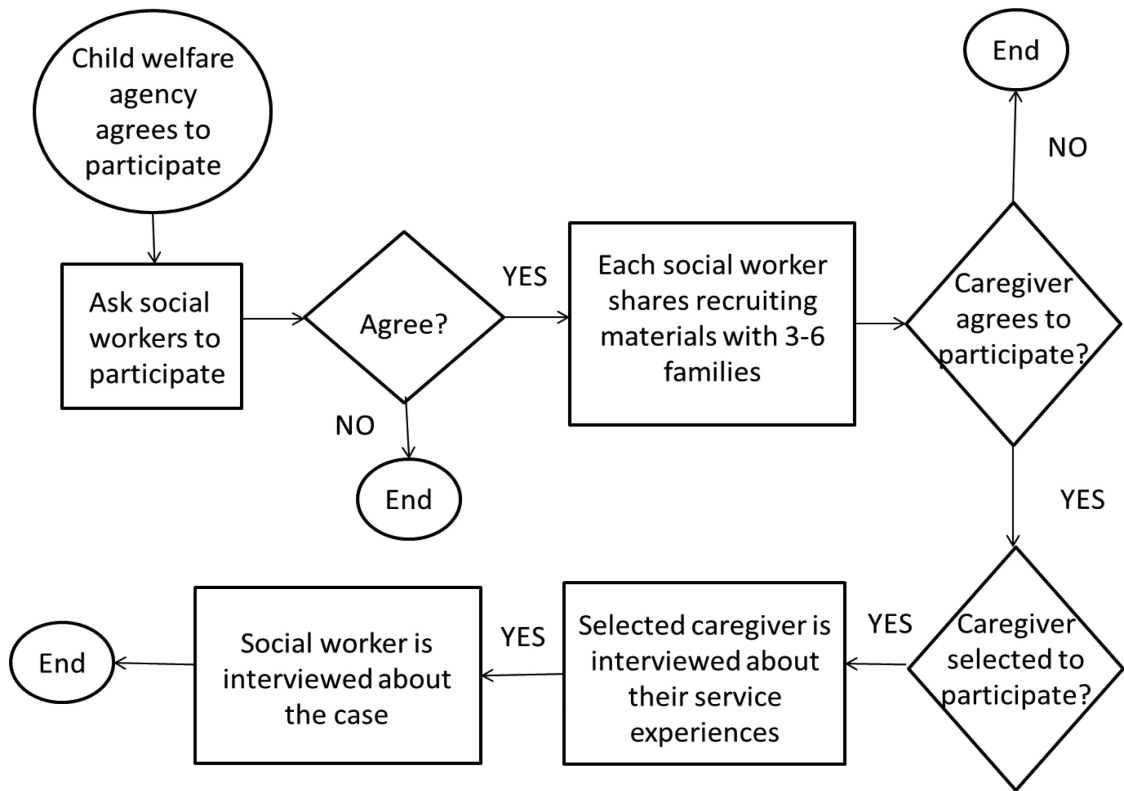


Figure 1.
Study Flowchart for Social Worker and Caregiver Recruitment

Table 1

Overview of the data sources for the study

Site characteristics	Timeline for data collection	Individual interviews / study participants *
Christian Services Private Agency Midwestern Region	April – July 2010	8 caregivers 3 caseworkers 4 counselors
Big City Private Agency Urban site Midwestern area	November of 2011 – April of 2012	4 caregivers 3 caseworkers 2 counselors
County Public Agency Appalachian Region	March – August 2012	4 caregivers 3 caseworkers 6 counselors
Total		37 individuals

* Not all invited caregivers and professionals participated in the study

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