Creating Connections
Phase I Evaluation
Findings from direct service workers in Mental Health and Child Welfare, and Alumni of Foster Care

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Executive Summary: Surveys and Focus Groups with Child Welfare and Mental Health

Creating Connections is a federally-funded project in Washington State (Administration for Children and Families, Children's Bureau Grant #90C01103/01) that aims to increase the social and emotional well-being and improve the developmentally appropriate functioning of children and youth (ages 3-17) in dependent care. This report describes baseline information related to the main goals of the grant and informs planning for project activities. The materials included in this report are general and serve to highlight trends, successes and/or needs that will inform the implementation plan for the final four years of the project.

In the next four years, the project will implement sustainable strategies to connect children and youth with trauma-informed and research-based mental health services (i.e. Evidence or Research Based Practices or EBPs). By 2017, systems will have more confidence that children who come into care with emotional and behavioral health concerns will have their needs identified, and be referred and engaged in the best mental health services available. In turn, this will improve their functioning, and enhance system outcomes in safety, permanency, and well-being.

In the first year of this project, partners from the University of Washington, Children's Administration, the Division of Behavioral Health and Recovery, the Health Care Authority, and others collaboratively designed and conducted focus groups and surveys to collect feedback from frontline workers and alumni of foster care that will serve as a baseline measurement and identify current strengths, challenges, and opportunities for improvement. In this report, we present findings from four different activities:

- Online Survey with Mental Health Therapists (N=148)
- 16 Focus Groups with Social Workers (N=127)
  - Exit Survey with Social Workers (N=118)
- Focus Group with Alumni of Foster Care (N=12)

Results

Strengths: Social workers and therapists reported several strengths within the mental health and child welfare system.

- Across mental health and child welfare there is a **broad pool of experienced service staff**;
- Some areas reported a **diverse service array and availability of evidence and/or research based mental health treatments**;
- There are great examples of **strong, positive working relationships** between mental health agencies and social workers;
- Child welfare and mental health staff are **creative and productive** within occupations that are inherently complex;
- The presence of a **dedicated, jointly funded mental health/child welfare liaison**, is available in one Children's Administration office, is very useful ;
- Within child welfare, the **Child Health and Education Tracking (CHET) Screening Report** is a useful tool to help identify emotional or behavioral concerns;

Needs: Ensuring that the emotional and behavioral health needs (including trauma impacts) of children and youth in out of home care are being accurately identified rests on several system-level needs.

- We need to have ***strong screening tools*** that include trauma impact and accurately identify when a child or youth's behavioral health needs are significant enough that they would benefit from additional behavioral health supports;
- We need a ***strong pathway*** to refer children and youth to appropriate services. This involves having caseworkers with a working knowledge of mental health-related concerns and how to match problems with particular therapeutic interventions;
- We need ***effective services*** available in local communities that address trauma and the emotional and behavioral health symptoms of children and youth in out-of-home care;
- We need ***collaborative case planning*** where child welfare workers and mental health workers coordinate and collaborate in partnership, with efficiency and timely communication; and, most importantly;
- We need ***evidence based progress monitoring***, where youth functioning is regularly tracked using valid and reliable assessments, and stakeholders collaboratively use this information to adjust treatment plans and services to respond to youth progress;
- We need the children and youth in care to be ***healthy and resilient***.

Challenges: Currently, there are several areas of challenge that impact our ability to address these needs. These challenges include:

- While the CHET represents a significant strength in the child welfare system, the information provided by this tool could be greatly enhanced through inclusion of a **screening tool specific to trauma;**
- Currently, there is **limited training on mental health for child welfare workers** including topics such as identifying mental health needs, local mental health services, interpretation of screening tools, and matching needs to services;
- Currently, there is **limited training for mental health workers** on the features of the child welfare system including the culture of foster care and the goals and needs of caregivers and child welfare workers;
- There is **not a consistent strategy to ensure effective communication** between caregivers, child welfare workers, and mental health providers related to child and youth functioning, progress, and movement through the child welfare system;
- There is **some confusion by social work and mental health line staff** related to their ability to coordinate care while complying with HIPAA and other regulations;
- There is **geographic variability** in the existence of evidence-based, research based, or promising mental health services; and
- There is **limited outcome monitoring** related to specific Evidence and Research Based services.

Considerations for moving forward

To address the intersection between the system-level needs and the existing challenges, we recommend considering strategies aligned with *enhancing communication, increasing opportunities for cross-system collaboration, cross-training,* and *community capacity building efforts to support evidence and research-based practices for children's mental health.*

Enhance communication:

- Learn from and expand on existing areas of the state where communication is well established. Develop a consistent cross-system practice guideline for case-level communication and collaboration between mental health and child welfare addressing confidentiality, regulations, and other identified barriers
- Identify additional methods for including biological, kinship, and foster caregivers in treatment planning

Increase opportunities for cross-system collaboration and cross-training:

- For child welfare:
    i. Increase understanding of the mental health needs of children in care and how to link them to appropriate services
    ii. Clarify the process, procedures, and expectations for accessing services at mental health agencies.
- For mental health:
    i. Clarify the process, procedures, expectations of the child welfare system
    ii. Build on the work and resources from the T.R. vs. Dreyfus litigation, EBP legislation, and System of Care Grant.
- Evaluate cross-training opportunities to infuse a consistent, trauma-informed lens across child welfare and mental health.
- Consider co-location of a mental health liaison within child welfare offices

Build community capacity to support evidence and research-based practices for children's mental health:

- Increase availability of trauma-informed, evidence or research-based approaches in the mental health system
- Implement a trauma screen within child welfare to help identify children coming into care who need trauma related mental health services
- Implement evidence-based progress monitoring and assessment to be shared cross-system

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Introduction

Creating Connections is a federally-funded project in Washington State that aims to increase the social and emotional well-being and improve the developmentally appropriate functioning of children and youth (ages 3-17) in dependent care that have emotional and behavioral health needs. A core team of 14 stakeholders guides the project, representing a collaboration across a wide range of partners including veteran parents, families, and youth of the child welfare system, University of Washington (UW), Children's Administration (CA), the Division of Behavioral Health and Recovery (DBHR), the Division of Research and Data Analysis (RDA), the Health Care Authority (HCA), and the Harborview Center for Sexual Assault and Traumatic Stress.

This report represents an effort to collect baseline information related to the main goals of the grant and inform planning for strategic implementation of activities to best meet needs related to serving children and youth in care who have emotional or behavioral health needs. The report findings are general in nature and represent opinions of a subset of people who work in the child welfare and mental health systems. They serve to highlight likely trends, successes and/or needs that will inform the implementation plan for the final four years of the project.

Context for *Creating Connections*

In the four years ahead, the project will implement sustainable strategies to connect children and youth with the appropriate trauma-informed research-based mental health services (i.e. Evidence Based or Research Based Practices [EBPs and RBPs]). The emphasis will be on incorporating trauma screening into the child welfare screening process, increasing access to a broader array of EBPs that are well matched to the foster care population, improving bidirectional communication and information pathways between social workers and therapists, and increasing system capacity to inform service delivery array and support outcome-oriented case planning. The goal is that by 2017, systems will have more confidence that all children who come into care with emotional and behavioral health concerns (particularly those related to trauma) are identified, referred, and engaged in the best services available to improve their functioning and enhance outcomes in safety, permanency, and well-being. In order to accomplish this, the project activities of *Creating Connections* will more closely align screenings, assessments, services, and supports between the child welfare (CW) and mental health (MH) systems. The planning year serves as a time to develop an in-depth knowledge and understanding of the systems the project aims to affect. This project has collaboratively designed and conducted focus groups and survey tools to collect feedback from direct service staff that will serve as a baseline measurement to identify current strengths, challenges, and opportunities for improvement.

When asked what our project name means to you, one youth responded that the name *Creating Connections* means to them: "Making known and introducing new services and opportunities to people- I like it!"

Baseline Information Goals

The *Creating Connections* project planning year (Phase I) work plan includes two deliverables that are directly related to these needs sensing activities:

- Survey therapists in Regional Support Network (RSN) community mental health centers that represent the geographic and cultural differences across WA State, and
- Survey and conduct focus groups with CA social workers and foster youth alumni that are representative of the geographic and cultural differences across WA state

The primary goals of these activities were to understand the pathways through services for children and youth in care who have an emotional or behavioral concern, and to evaluate current mechanisms of communication between social workers and mental health therapists.

Many additional project deliverables were indirectly related to the information received through the surveys, including:

- Document and map existing social worker and mental health screening tools and practices
- Develop method for acquiring organizational readiness and fit data in collaboration with stakeholders
- Implement and analyze measures of organizational readiness and fit
- Determine supports for compassion fatigue in caregivers, social workers and therapists
- Identify strategies to ensure social worker knowledge of available evidence based programs
- Understand and map the range of existing funding streams and access options

Methods

This section is divided into processes and measures for each of the three different stakeholder groups who provided information: mental health therapists, child welfare workers, and youth who are alumni of the foster care system. In this section, we describe how information was gathered across these groups.

Mental health therapists

Data collection process

The collaborative workgroup determined that the optimal way to find diverse voice from a range of mental health therapists across the Washington State was to conduct a statewide survey. The online survey (described below) was conducted between April 29th and May 27th, 2013. Invitations to participate and subsequent survey reminders were sent out via email through three main sources:

1) Washington State RSN contacts, with a request to forward the invitation to their mental health provider agencies,
2) The Washington Community Mental Health Council, with a request to send to their community mental health provider agencies, and
3) Washington State Health Care Authority affiliated providers with contracts to provide mental health services through Fee for Service and Health Options Medicaid managed care

As an incentive, therapists who took the survey could choose to provide contact information and be entered into a drawing to win one of twenty $50 gift cards. In order to maximize participation the invitation was not sent to one centralized list of providers. As a result we do not know how many people received the survey and cannot calculate a response rate.

Measures

The 15-20 minute online survey was developed in collaboration with members of the *Creating Connections* core team. The purpose of the survey was to assess communication and information exchange between the mental health therapists and social workers in the framework of their own specific experiences coordinating care for children and youth in out of home care. Questions covered topics such as: differentiating the needs of foster youth from those youth not in dependent care, identifying the common challenges working with foster children and youth, and identifying challenges associated with, or suggestions for improved communication and collaboration with social workers. See *Appendix A* for a full copy of the original survey. Due to concerns of respondent burden and anonymity, care was taken to keep survey length to a minimum and collect only limited demographic information.

Child Welfare workers

Data collection process

A different data collection strategy was developed for the Child Welfare (CW) system. In order to ensure a diverse range of participants, project stakeholders chose to solicit feedback from field-based social workers in the form of focus groups and exit surveys. CA Headquarters partnered with identified regional mental health leads in each of the three regions in Washington State to help coordinate focus groups (see *Appendix E* for a map of these regions). Decisions about which offices were invited were made in the local regions with the management team, who were also tasked with recruitment of focus group attendees. Social workers, supervisors, and management from 27 of the 48 CA field offices attended one of 16 focus groups and represented a mix of Child Protective Services (CPS), Child and Family Welfare Services (CFWS), Family Voluntary Services (FVS), Child and Health Education Tracking (CHET) staff. The attendees represented a geographic mix of urban, suburban, and rural communities. The identified regional lead attended almost all focus groups and several were also attended by a Division of Behavioral Health and Recovery (DBHR) lead. These meetings were facilitated by a primary facilitator, typically a faculty representative from the UW, and one to two additional core team members. A meeting coordinator took detailed notes that were later supplemented by notes from other facilitators. All facilitator team members attended a one-hour training on conducting focus groups to ensure consistency across meetings. Facilitator teams traveled to the 16 locations between April 30th – May 31st, 2013 to conduct the 1.5 hour long meetings and administer a ten minute exit survey. Subsequent to each focus group, regional leads were provided the coordinator's notes and given an opportunity to provide feedback and ensure that notes were aligned with their understanding of the primary issues being discussed. Each participating office received a $50 gift card.

Measures

Focus group questions were developed in collaboration with members of the *Creating Connections* core team with input from staff internal to their organizations. The questions asked about the steps that are taken to identify children and youth in foster care with mental health needs, the reasons why children or youth who are referred to mental health may not complete an intake or may not engage in services, the types of information social workers received about treatment progress, whether the social workers believed there was an adequate range of services in their community, and additional supports they need to identify, refer, and serve youth with mental health needs. Social workers were asked to use the framework of their own specific experiences in

the past year serving children and youth ages 3-17 in out of home care. They were also asked what types of training or supports would help them to better address the mental health needs of children and youth on their caseloads, and what they thought was the most important area for improvement (See *Appendix B* for the full list of questions). A brief exit survey mirrored several of the discussion questions (see *Appendix C*) and the mental health survey, asking social workers to rank their satisfaction with current processes to connect children and youth with appropriate services. The survey also provided space to write comments they did not say during the discussion.

Youth Voice

Data collection process

The *Creating Connections* project team values the inclusion of children, youth, families, and alumni of the child welfare system in planning and decision making[1]. During our planning year, we greatly appreciate the opportunity to engage with *Passion to Action,* an existing group of foster care youth (who are either currently in care or are alumni of care). The group serves as an advisory board to CA management and staff on practice and policy issues. After an initial introductory meeting, three core team members joined a Passion to Action meeting in early June to conduct a semi-structured focus group to obtain their perspective on the current system's ability to meet their mental and behavioral health needs. Youth underwent a CA-sponsored strategic sharing training prior to the 1.5 hour focus group. Only youth who were over 18 were allowed to participate. Youth under age 18 were provided an alternative activity during this time. Youth were provided a pizza lunch prior to the focus group and a $50 gift card to the group to show appreciation.

Measures

Discussion questions for the 1.5 hour focus group were developed in collaboration with members of the *Creating Connections* core team with input from staff internal to their organizations. *Passion to Action* youth participants received a copy of the discussion questions one month prior to the focus group so that they could be prepared and make an informed choice about whether they wanted to participate. Youth responded to 10 open ended questions such as "What do you think are the most important and helpful things that mental health staff do when children and youth in out of home care start mental health treatment?" and "What do caregivers of children and youth in out of home care need to know to support children and youth's emotional and behavioral needs, including trauma?" See *Appendix D* for full copy of the original discussion questions.

Data Analysis

Quantitative

Analyses for the quantitative portions of the online survey of mental health therapists and the exit survey of social workers consisted of basic univariate descriptive analyses such as calculations of the number and percentage of participants who endorsed categorical responses (e.g. yes, no, don't know), and the average and standard deviations for scale scores. Additionally, scores were analyzed stratifying by Regional Support Network (RSN) and by CA region in order to explore regional differences. Statistical tests for significant differences were

[1] While we continue to explore avenues to include voice from families and foster parents, at the time of this report, we are actively engaging partners to determine the best strategy

not run for the majority of these analyses for two reasons. First, there were an insufficient number of participants within each RSN to permit valid testing. Second, participants in the mental health survey could select multiple counties that they worked in, which resulted in several participants representing multiple regions. Therefore, regional-level results should be interpreted with caution.

Qualitative

Focus-group and open-ended survey questions were analyzed using a content analysis approach. This is a systematic way of uncovering major themes, or patterns of responses that are bounded by conceptual similarity. The evaluation team (four members of UW staff, including two faculty members) had several meetings to review the open-ended responses on the surveys and the detailed notes from the focus groups in order to develop themes and sub-themes for each written segment. The primary themes to be coded were determined through team deliberation. The team coded each of these segments using either Microsoft Excel (open-ended response on surveys) or ATLAS.ti (focus groups) qualitative software. Next, the coding structure was iteratively reviewed in teams of two in order to merge isolated themes into larger categories, or break up categories that were too large into smaller subthemes. This coding structure was then used to process the most significant and consistent themes and summarize them in the results discussed below.

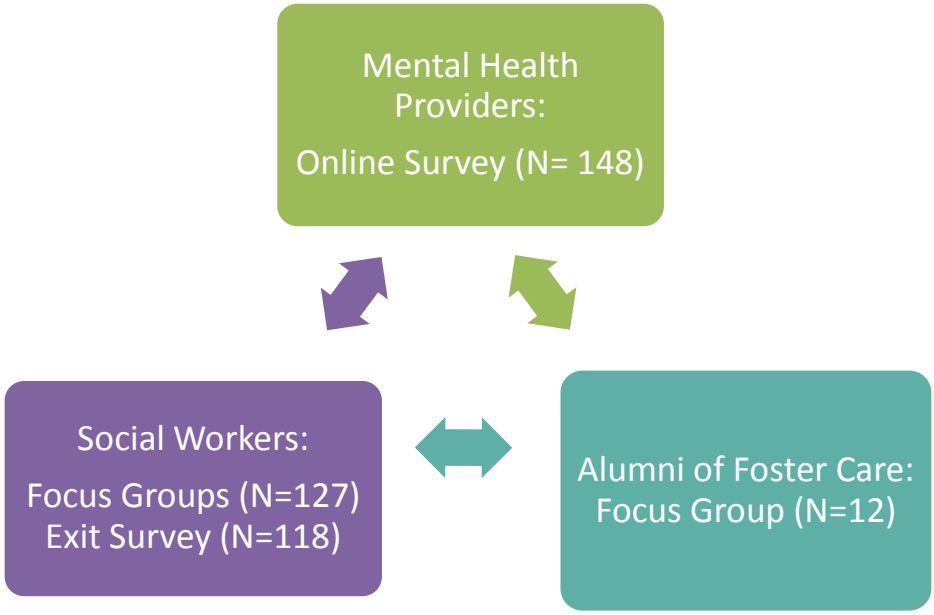
Human Subjects Review and Conflict of Interest Statement

The Washington State Institutional Review Board reviewed three separate proposals for exempt determination requests, all of which were approved due to the fact that these were program evaluation activities. Participants in both surveys and focus groups were not asked personal or sensitive information, and all information collected is presented in aggregate form. No confidentiality records were accessed through any of the above study methods, and any quotations that are used cannot be tied to a specific person or office.

Results

In the following section, we present results from the four different measures (see Figure 1) in the same order as questions were asked. Quantitative responses are displayed as figures in the body of the report, and as tables in Appendix H. For open-ended, qualitative responses, we first describe items that represent the 'stronger' themes (i.e. themes with the highest numbers of participant responses coded as such). Where relevant, perspectives of youth that align with each question are highlighted in the gray boxes with red lettering. The other text boxes (blue writing) feature notable quotes from therapists or social workers, depending on the section.

Figure 1: Data Sources with Sample Sizes



Strengths to Highlight

Every group that was consulted during these activities was extremely enthusiastic about improving the access to mental health services for youth in care. Stakeholders seem to recognize that these systems are complex and respond to intense demands, but are united by their desire to help children and youth. Ideas for improvement were generated across many areas. During data analysis, any ideas or suggestions provided by therapists, social workers, or youth were coded as a separate theme, thus will be reported separately. Here are a few of the strengths we heard from the field:

- **Relationships:** Several social workers described therapists that they enjoyed working with. There were several consistent reasons why particular therapists were highlighted. Social workers endorsed therapists who they met with or talked with regularly, who communicated frequently about treatment progress, who had collaborative working styles, who included the goals of child welfare into treatment, who were creative when working with children and youth (e.g. "The therapist talks about concrete interventions - they come up with new strategies when something else is not working"), who were flexible when providing treatment (e.g. they would provide treatment at schools or in families' homes), and who they believed were effective (e.g. "[The therapist] puts kids back together. Kids will linger in care without her.")
- **Collaboration:** Therapists also described specific social workers who were very effective, for many of the same reasons. For instance, one therapist wrote, "I work with a talented social worker who coordinates exceptionally well." Another therapist reported that they had "very good collaboration" with their social worker.

- **Point in time screening:** Child Welfare offices felt their biggest strength for assessment was the CHET, "CHET screeners are helpful for referrals, information about resources, you're not on your own to figure it out"

Online Survey of Mental Health Therapists

Therapist surveys included 13 questions. Four questions were regarding descriptive characteristics (see Table 1), and the other 9 questions covered content related to communication and collaboration. Questions varied in format; the majority solicited open ended responses, several allowed therapists to check all options that applied with an option to write in 'other' responses (see Figures 2-4), one question asked therapists to rank satisfaction on a Likert scale of one to five (see Figure 5), and one question allowed for other comments and concerns.

Sample

A total of 148 therapists participated in the survey. The responses were not regionally proportional to the size of the counties in which people worked. In particular, there was overrepresentation from people providing services in the Greater Columbia and Spokane RSN regions, and significant underrepresentation from people providing services in King and Pierce RSN regions.[2] Therefore, we provide the characteristics for the raw sample (Table 1), and we weighted the quantitative statewide results to estimate responses as proportional to county populations (Figures 2-5). To see both raw and weighted results for each part of the survey, see Appendix H.

Therapists had been working in children's mental health an average of 13.1 years (median of 11, standard deviation of 9.4), and less than one in ten therapists (6.8%) had ever worked as an employee of CA. A majority of therapists' patients are NOT state dependents. They estimated that about 23% of their caseloads statewide are youth who are state dependent (median of 10, standard deviation of 25.76).

Table 1: Characteristics of Mental Health Survey Participants

	Raw Sample	
Variable	**N=148**	
	n	***%***
Ever worked as employee of Children's Administration		
Yes	*10*	6.8
No	*138*	93.2
Years working in children's mental health	Mean=13.11, SD=9.42, Median=11	
Percent of caseload who are state dependents	Mean=22.90, SD=25.76, Median=10.0	
County in which participant serves clients *(check all that apply-ordered by highest response)*		
King	*16*	10.8
Snohomish	*15*	10.1

[2] See **Appendix F** for a map of RSNs

Pierce	*11*	7.4
Spokane	*45*	30.4
Yakima	*31*	20.9
Kitsap	*8*	5.4
Clark	*10*	6.8
Thurston	*11*	7.4
Whatcom	*10*	6.8
Cowlitz	*8*	5.4
Skagit	*7*	4.7
Lewis	*7*	4.7
Benton	*11*	7.4
Douglas	*11*	7.4
Franklin	*11*	7.4
Stevens	*17*	11.5
Mason	*7*	4.7
Columbia	*6*	4.1
Kittitas	*11*	7.4
Island	5	3.4
Walla Walla	*6*	4.1
Grant	*7*	4.7
Grays Harbor	*5*	3.4
Adams county	5	3.4
Jefferson	*5*	3.4
San Juan	*4*	2.7
Chelan	*8*	5.4
Garfield	*4*	2.7
Clallam	*3*	2.0
Pacific	*5*	3.4
Ferry	*5*	3.4
Pend Oreille	*4*	2.7
Klickitat	*3*	2.0
Skamania	*3*	2.0
Asotin	*3*	2.0
Okanogan	*3*	2.0
Whitman	*2*	1.4
Lincoln	*5*	3.4
Wahkiakum	*1*	0.7

Question 2: "Working with state dependent children and youth can sometimes present challenges that are different than when working with non-dependent youth. What are some of the most difficult challenges specific to working with state dependent youth?"

Communication and Collaboration

The most commonly endorsed challenges of working with dependent youth, comprising more than one-third of total number of unique comments, were an array of issues related to communicating and collaborating, in particular between mental health and the child welfare system. Several respondents noted that the burden of social work sometimes made finding time to communicate difficult. Many noted that it was difficult to connect with social workers, with unreturned phone calls and difficulty obtaining documents requiring signatures such as releases or treatment plans. Others noted that they were not regularly notified when placement changes occurred or when changes to the permanency plan occurred. Several described a lack of shared planning in general. One quote from a participant summarizes several of these challenges: "[Challenges include] getting return phone calls from DCFS social workers, getting DCFS social workers to attend meetings regarding the youth, being informed of when the youth has moved to a different foster home, and DCFS social worker changing course of treatment direction mid-stream without input from the mental health therapist." Others described receiving limited or no case history from social workers and lack of perceived buy-in to treatment plans among stakeholders. Similarly, some said that in their opinion permanency plans were sometimes unrealistic, which they believed lengthened the time until permanent placement.

Several participants described intersystem challenges that went deeper than communication and treatment planning: "The rules and regulations are often inflexible," and "The multiple players involved create confusion and uncertainty." In general, balancing the wants and needs of the variety of stakeholders involved with each child or youth's case was presented as a major challenge.

Many participants described challenges communicating and collaborating with all caregivers, and balancing the needs for including foster parents, biological parents, and kinship caregivers in treatment and planning. Several described difficulty engaging foster parents, with at least one respondent attributing the lack of engagement to the demands faced by foster parents, "foster parents feel overwhelmed with the number of visits, appointments, travel, etc., and are not able to make appointments on a regular basis without support." Four of the twenty-six comments about caregivers specifically referred to biological parents, with two of these describing the challenge of obtaining information about the child from the biological parent. Two described challenges of directly involving biological parents in treatment.

Placement changes, inconsistent adults, emotional challenges, and trust.

Roughly 10-15% of responses described the challenges of working with children experiencing frequent placement changes, and the resulting difficulties associated with the lack of professional or adult consistency. One wrote, "[A challenge is] most of the children have had multiple placements which further exacerbate their ability to trust." Another wrote that, "Lack of permanency, instability makes it difficult to process the trauma underlying behavior issues." They felt that placement changes could disrupt treatment as the therapist would have to re-engage new caregivers and work with the children on new expectations for behavior. This was also related to practical issues like maintaining contact with the child.

Several described the complexity of the cases and how trauma was related to serious emotional concerns that were difficult to address, "[The children have problems related to complex trauma, anxiety, and depression that result in behavioral concerns both at home and school environments because they don't have the skills to process and work through these issues." Several described the difficulties associated from managing

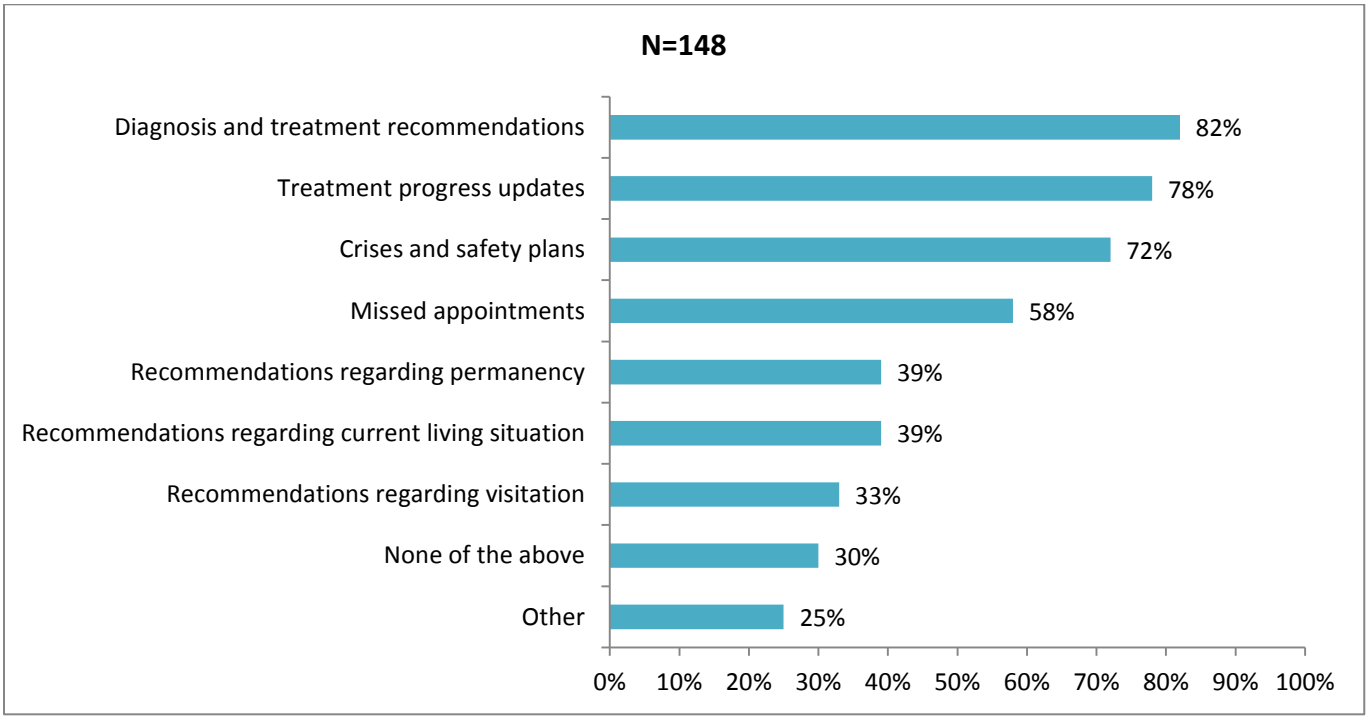
inconsistent and changing adults in the child's life, including biological and foster parents, caseworkers, and changing teachers.

Other

There was a wide array of other themes, each making up less than 5 percent of the overall total number of comments. Some responded that a major challenge was that there was less information about the history of the child to inform treatment planning. Others described problems with transportation to treatment, in particular in rural areas, and similarly, some believed that the lack of financial resources could make treatment more challenging for foster children. A few people mentioned a lack of system capacity to serve foster children with complex mental health needs, including a small pool of specialty trained foster homes and intensive treatment options, and high caseloads for social workers and therapists. Finally, a few described challenges balancing safety with reunification goals, school-related problems, meeting basic needs, motivating youth to participate in treatment, untrained caregivers, supporting families, and insurance.

Question 3: "What types of information do you routinely provide to DCFS case workers about mental health treatment?" (Figure 2)

Check all that apply- ordered by highest response



The most common type of information that therapists report routinely providing to social workers across all CA regions and almost all RSNs was diagnosis and treatment recommendations (82% of therapists statewide). About three fourths of therapists statewide reported regularly providing treatment progress updates and crises and safety plans, but there was more variation across regions and RSNs (see Appendix H for detail). Recommendations about current living situation, permanency, and visitation are regularly provided to social workers at the lowest rates statewide (33-39%). There was considerable variation across these types of information; for example, 73% of therapists that serve the Pierce RSN report sharing recommendations regarding current living situation compared to 32% of therapists who serve the Spokane RSN (See Table 2 in Appendix H).

Question 3 continued: "What <u>other</u> types of information do you routinely provide to CA social workers about mental health treatment?"

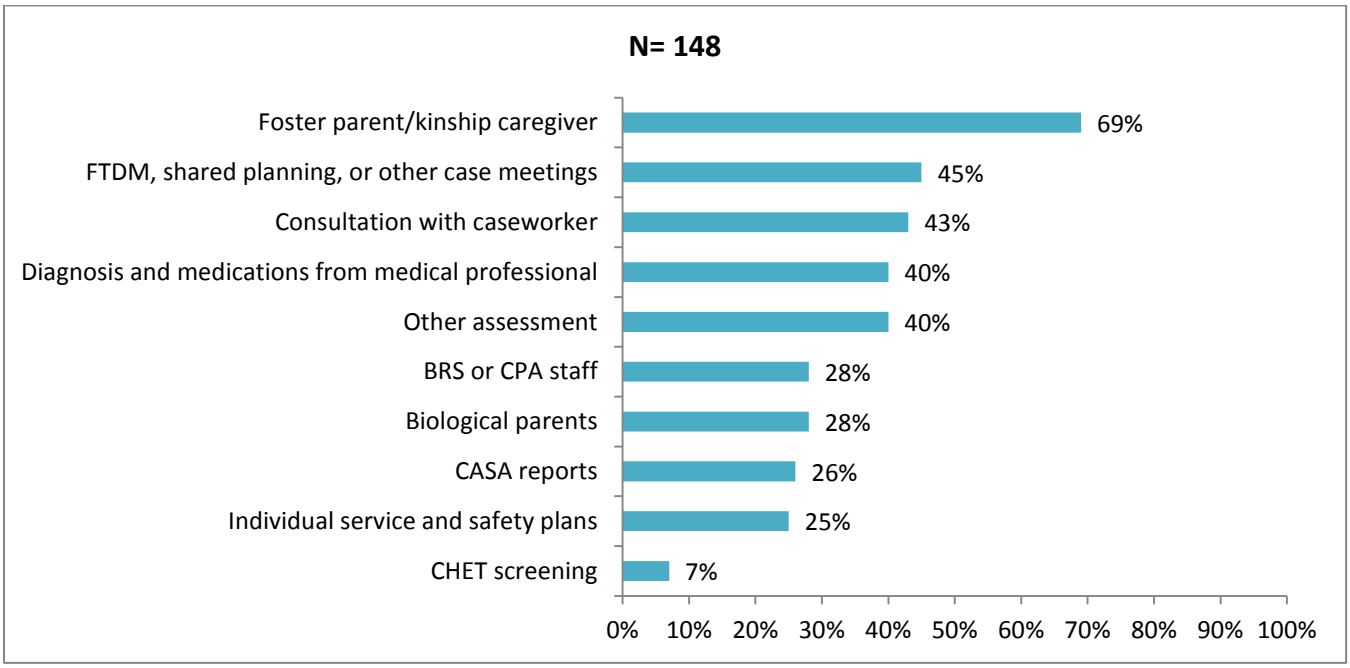
Only 31 therapists (21% of respondents) chose to write in a response to this question under "other". Their responses were wide-ranging and did not coalesce on major themes. Four responded that they provide everything requested by social workers and others, within the limitations of their agency policies and professional ethical codes. In particular, two participants said that they do not provide specific recommendations about placement or permanency decisions, with one of these participants indicating that it is against the ethical code of the American Association of Marriage and Family Therapists[3]. Four participants

[3] We confirmed that the AAMFT ethical code does prohibit therapists from making these types of recommendations.

reported that they make recommendations for additional services; three reported that they provide copies of their treatment plan, and three said that it depends on the case, specifically the age of the child and the relationship with and involvement of the social worker. Other responses included care coordination, client voice, crisis and safety plans, family searches, grades, recommendations about the child's environment, and probation/parole violations.

Question 4: "Of the following sources of information, which do you receive or use regularly to get information about State Dependent children and youth for your case assessment and planning?" (Figure 3)

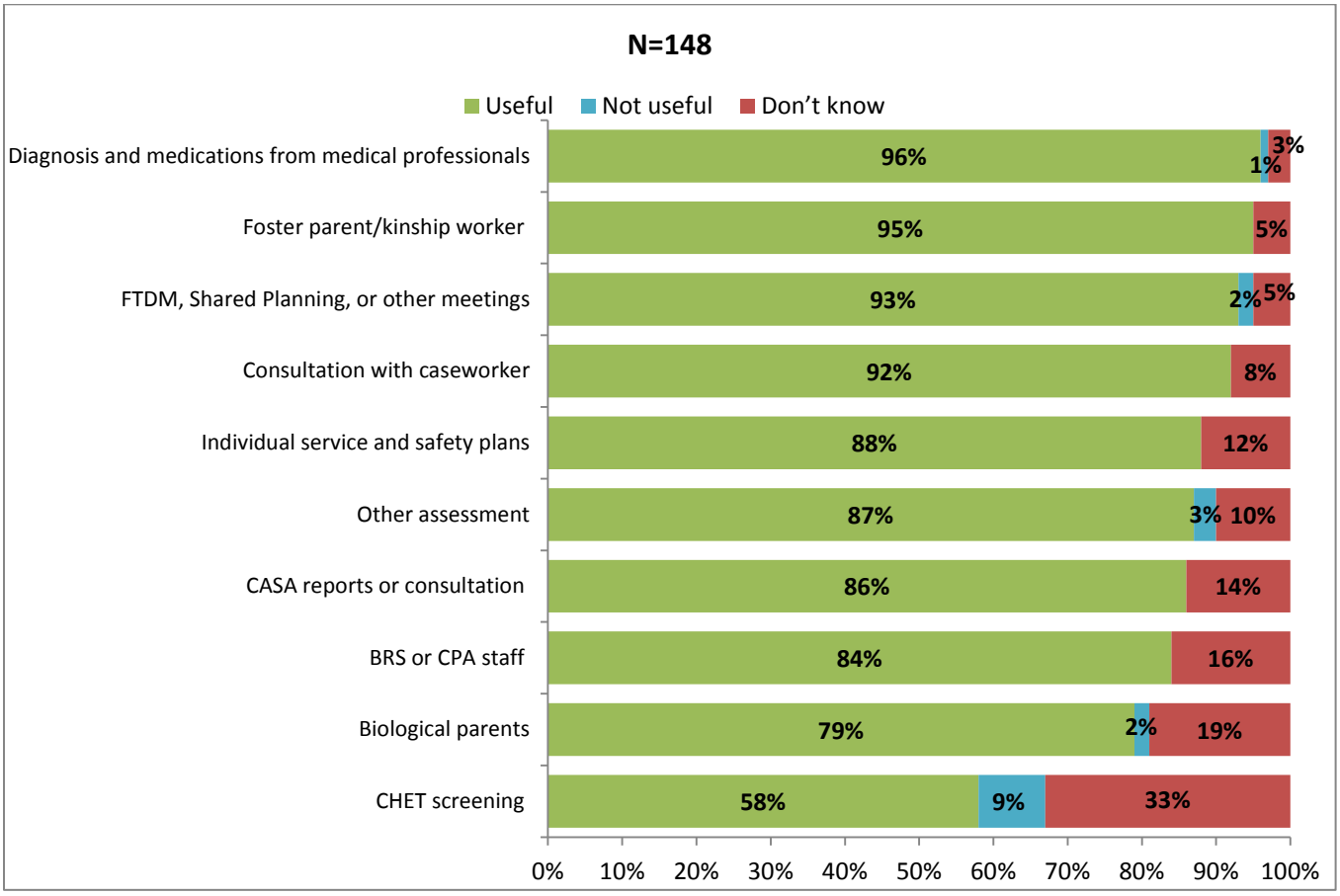
Ordered by highest response



Foster parents and/or kinship caregivers were reported as the most regular source of information used overall for case assessment and planning; over two-thirds (69%) of therapists statewide reported that they regularly receive information from them. This was the highest reported regular source of information across all Regions and all but two RSNs (see Table 4 in Appendix H). The second highest reported regular source of information was FTDMs, shared planning, or other case meetings (45%), while consultation with caseworkers (43%), other assessments (40%), and diagnosis and medications from medical professionals (40%) were reported at similar rates. About one quarter of therapists statewide reported regularly receiving information from biological parents, Behavior Rehabilitation Services (BRS) or Child Protective Services (CPS) staff, Court Appointed Special Advocate (CASA) reports, and Individual Service and Safety Plans (ISSP). The least common source of information for case assessment and planning that was reported as regularly received by the therapists statewide was the CHET Screening Report.

Question 4.2: "Of the following sources of information, which are useful, or, which would be useful if you received them?" (Figure 4)

Ordered by highest response



It was very rare that a therapist reported a source of information was NOT useful. Diagnosis and medications from medical professionals were said to be useful by 96% of therapists, and Foster parent and/or kinship workers were said to provide useful information by 95% of therapists statewide. While the majority of therapists reported each source of information as useful, the lowest rate reported was for the usefulness of the CHET screening (58%). However, these rates varied somewhat by RSN, with a range of 54-100% (see Table 4 in Appendix H). Also worth noting was that only 9% of therapists reported that the CHET screening was not useful, and 33% of therapists did not know if it was useful, indicating that they were not familiar with the CHET.

Question 4.3: "What <u>other</u> sources of information do you receive, use regularly, or would be useful to get information about state dependent children for your case assessment and planning?"

Just over half of therapists provided other sources of information (not listed in Figures 3 and 4) that they use regularly to obtain information about dependent children and youth. The most common source of information reported was information provided from the child or youth's school. Information included verbal reports from teachers and school counselors and academic and behavioral records from the child's teacher or counselor

(including IEP's and/or any educational plans). Therapist reported trying to involve schools in treatment, planning, and interventions as well.

Consultation directly with the child or youth as well as the adults involved in their case also provides valuable historical information for case assessment and planning. Therapists stated many sources they have used to obtain information, such as:

- Other therapists for general assessments, trauma assessments or treatment history
- Private agency case managers for previous placement history
- Physicians for medical history
- Chemical dependency providers for treatment history
- Guardian ad litem's for court updates
- Tribes for cultural context
- Providers who facilitate visitation between the child or youth and parent or family for reports

Therapists frequently mentioned that they seek out consultation with important people involved in the child's life who know the youth personally; such as natural supports, current and previous caregivers, extended family, and church members. As a therapist stated, "Someone that can talk about triggers or frequency of behaviors" can help provide a history of the child or youth and assist with any treatment planning. Consulting directly with the youth was also a strategy several therapists indicated.

Other less mentioned sources of information therapist's use regularly are home visits, observing the caregiver, information provided by the child's child care provider, legal documentation, wrap around documentation, and previous case documentation, including CPS history.

On the other hand, some therapists responded with feedback on types of information that they would like to receive. This includes detailed assessments from providers, court orders, CPS history, historical placement reports, and CA Safety Framework Assessments. Therapists report that they would like to have more opportunity for shared information about the child or youth from social workers directly. One therapist stated, "Information received depends typically on how much effort the clinician makes to get records and call agencies to ensure that records are received."

Youth provided feedback on what mental health therapists need to know about children and youth in out-of-home care to best support them.

The most common feedback was to build on the youth's strengths and realize that it's a balancing act of honoring the child and the progress they want to make in their life.

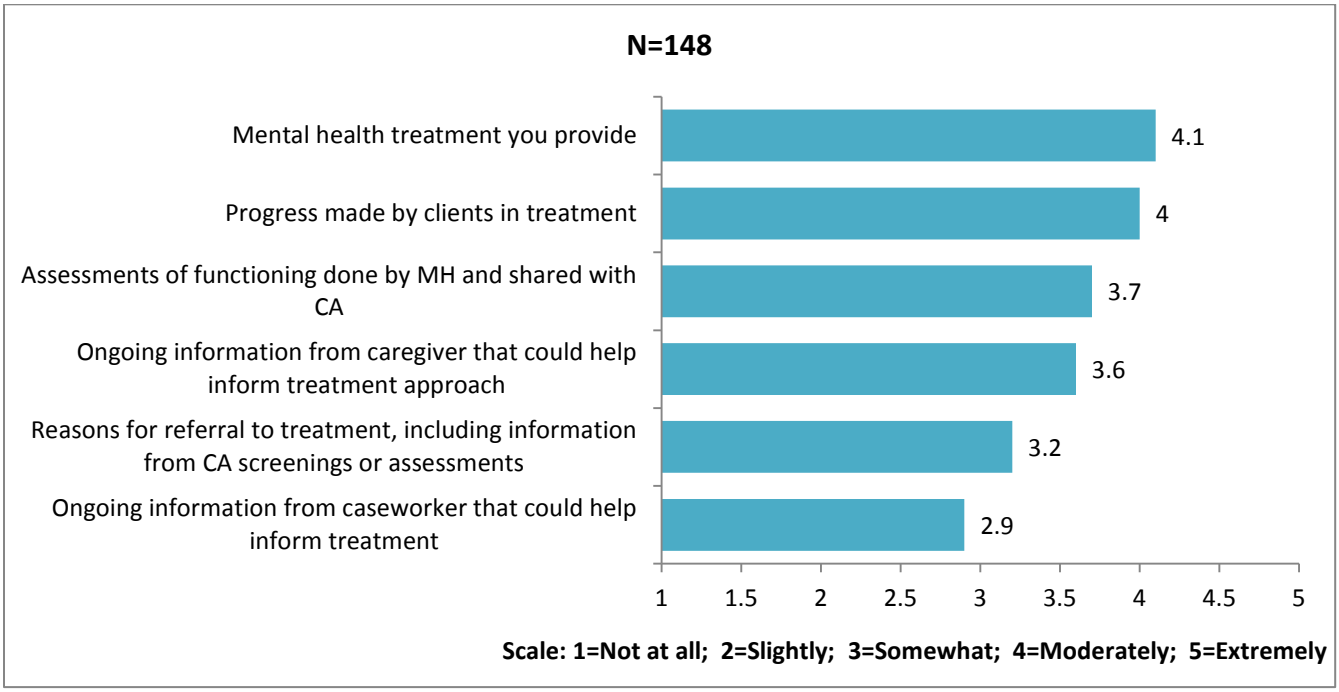
Youth stated they are impressionable; therapists need to tell youth "they are going to succeed!"

Being creative and practicing patience with children and youth will help them be able to open up in therapy, "Recognize a good balance of patience while comfortably pushing the youth."

Building trust will help youth see what responsibilities look like as an adult and will further help them prepare for adulthood.

Question 5: "How satisfied are you with the amount and quality of information and/or process by which information is shared back-and-forth between you/your agency and CA about:" (Figure 5)

Ordered by highest response



Question 5 asked therapists to rank on a scale of 1-5 their satisfaction with the amount and quality of information that is shared back and forth between social workers and themselves, in addition to their satisfaction with the process by which information is shared. Therapists were the most satisfied with the information sharing related to the mental health treatment they provide (4.1) as well as the information sharing related to progress made by clients in treatment (4.0). They were also moderately satisfied with the information sharing related to assessments of functioning done by MH and shared with CA (3.7) as well as the ongoing information from the caregiver that could help inform treatment approach (3.6). Finally, therapists were only slightly satisfied with information sharing related to reasons for referral to treatment, including information from CA screenings or assessments (3.2) and ongoing information from caseworker that could help inform treatment (2.9).

Question 6: "Comments about questions regarding information exchange?"

Roughly one-third of therapists supplied additional comments and questions related to question 7 (not included in Figure 5).

Strengths

Team meetings, flexible services, and frequent communication are mentioned as strengths when working with state dependent children. Therapists explain that often, dependent children and youth have multiple service providers, which can make cross-collaboration difficult. Thus, team meetings in flexible settings can be beneficial for collaboration and assessment planning. One therapist stated that flexible services through other providers were essential for children and youth, "People are typically responsive to any referral for additional

services for the child through home or school settings." Knowledge and frequent communication with the caregiver are also strengths, "Treatment works best when I know the background of the client as well as have weekly contact with a consistent caregiver."

Communication and collaboration

Just under one-third of the comments regarding information exchange listed lack of communication and collaboration as a challenge for case planning and assessment. Responses show that therapists link communication and collaboration with positive treatment outcomes. As one therapists said, "The more collaboration there is, the better the outcome." While email was often expressed as a preferred communication method between mental health and social workers, emails are difficult to send securely to remain HIPPA compliant, "Email would be easiest and more efficient, but I haven't found a way to do that confidentially." Because office availability is limited for both social workers and therapists, phone contact is often sporadic and is not a reliable form of communication. When communication is lacking on a case, therapists report that information sharing becomes difficult, "the more information shared the more helpful we are able to be in supporting the child's progress." Some therapists reported that communication was often "one sided" and felt that there was a strong disconnect between sharing information from the social worker to the therapist. One stated, "communication with CA staff typically happens when I initiate it; rarely do I get proactive calls from CA staff." Some felt that the lack of feedback in response to assessment results hindered communication, "I don't always get feedback on CA's response to assessments done by our agency staff. I don't know how helpful those are to them."

Fourteen percent of therapists indicated that the inconsistencies in communication and collaboration that occur depend on the professional or the case itself. Some cases require extensive communication and collaboration while others do not, "it depends on the specific work and also the level of need for the individual case."

"Communication can be better both ways."

Therapists acknowledge that each child and youth have unique needs that impact the level of communication required, "The more complex the child's symptoms, the higher the need for more information."

This complexity of placement changes was mentioned as a challenge for communication and collaboration, "It often seems like it is hard to provide consistent mental health treatment for these children as there are often frequent disruptions in the foster placements…" Out of county placements make collaboration difficult especially if the child is not placed in the same county as the social worker: "It [collaboration] is almost nonexistent if the child is supervised from a different county than the treatment occurs."

Engagement of adults and other family members in treatment

Three responses from therapists provided their opinion that engagement of adults and other family members in treatment is important for success, "The quality of their treatment is correlated with the other adult figures in their lives that are willing to participate in therapy for the child's best interest." This can be more difficult with adolescents, "Adolescents with co-occurring disorders and grief and loss issues about their family situation are extremely difficult to motivate without some contact with appropriate and supportive family. Providing a healthy connection to family members seems to support them in their treatment goals."

Other

Other themes less often mentioned included a wide variety of comments that impacted the amount and quality of information sharing. Therapists reported being left out of major decisions including placement and school changes and not being aware of all the resources for children and youth within the system can effect case planning. Therapists also believe that social workers may not understand how their role can impact treatment provision. Also, if the therapist a child has prior to coming into care does not accept Medicaid, it could cause a gap in coverage.

Question 7: "What policies and practices currently facilitate communication and collaboration with CA caseworkers?"

Policies and practices that allow operational communication

The most frequent responses were directly related to policies and/or practices that impact communication between social workers and therapists. Forty-one percent of the responses were related to communication. Responses suggest non-specific policies that can be characterized as communication in person, communication by email, and communication by phone.

The most common practice or policy identified by therapists was related to overall communication with CA. This includes providing reports or treatment updates to social workers, ensuring a collaborative process, providing monthly status reviews and progress reports, and "appropriate, ongoing communication between all members of a treatment team." Some therapists suggested strategies to ensure frequency of communication included setting specific times to communicate, making the initial contact, arranging weekly contact at a minimum, and meeting with caseworkers when they attend the first appointment. Other communication responses included obtaining the social worker's contact information at the intake appointment, letters of introduction from the therapist, and obtaining the child or youth's Individual Safety and Supervision Plan (ISSP) and any dependency court records.

Youth reported that they *need help achieving closure,* while at the same time they need help *opening new doors.*

Communication by phone was uniquely mentioned 12 times with examples such as, "regular phone contact," or "weekly phone calls." One therapist commented that they make the initial contact to social workers, "I try to find the number to the caseworker and follow up with them. Rarely do I get a call from them initiating contact." Communication by email was mentioned eight times with examples such as "secure [encrypted] email

communication" and "regular email contact." Many therapists mentioned the need for a way to securely share confidential information via email, "We cannot communicate via e-mail which seems to be a preferred method for CA." Least commonly mentioned were policies and practices that ensured communication in person. One therapist responded that it is common practice to "physically go to CPS office once a month to meet with staff and discuss cases …."

Confidentiality

Appropriately assuring of confidentiality through signed consents was the second most commonly endorsed policy or practice that facilitates communication and collaboration with CA. Releases of information were the most commonly reported documentation required to maintain confidentiality of records. "Signed consents for treatment must be in place before a case is opened, so by policy and practice communication with the caseworker begins on day one. This helps to set the stage for ongoing dialogue and professional coordination with the caseworker."

Shared meetings

Frequent shared meetings with CA staff were described a policy or practice that assists with cross-agency communication and collaboration. Shared meetings also allow for the family and other important people in the child and youth's life to have a voice in decisions and case planning. Therapists view's regarding policies and practices related to shared planning was varied. Some stated that shared planning meetings were social worker initiated, including the use of Family Team Decision Making Meetings (FTDMs), "Agency staff are able to attend any meetings regarding client/family" or an "Invitation to participate in all of the child's staffings." FTDMs were commonly referenced for collaborative contact, "FTDM meetings are useful in establishing collaboration between agencies." While other responses suggested that therapists were responsible for initiating the meeting, "case workers and probation officers [visit] to my office on a weekly basis." School meetings were mentioned as a way to incorporate an educational voice to the shared planning process. There was variation expressed in the frequency of shared planning meeting. Some stated that their practice included bi-weekly or weekly shared planning at a minimum while others stated that there are requirements for monthly or regular treatment team meeting.

"Meetings scheduled and a way to support everyone to feel equal in our common goal of supporting the youth."

Regular progress and treatment reports

Slightly less than 10% of therapists stated that current policies to provide regular progress and treatment reports were helpful to facilitate communication and collaboration. Responses indicate that the regularity with which reports are provided varies from quarterly, to an updated plan every six months, or even updates as needed or recommended. Some of the examples of information included in reports are the outcome of the intake assessment, a copy of the assessment and treatment plan, a plan for services or their continuing progress, any treatment recommendations, a review of the treatment plan and discharge paperwork, or as one stated "My practice is to attempt contact throughout a treatment episode regarding updates as well as in times of significant changes, crisis, or specific needs."

Signatures and Other

Other less mentioned practices and policies include the caregiver attending the intake appointment and any ongoing therapy, court requirements including documentation of legal proceedings, sharing previous mental health or CPS history of the child or youth, and supporting caregivers. "Requiring signatures as the legal guardian" on treatment plans and releases of information were commonly reported as a policy that facilitates communication and collaboration between therapists and social workers.

Question 8: "What could be done to improve communication and collaboration between you and the CA caseworker?"

Collaboration, participation, and shared planning

> *"A collaborative, team approach must be used in treating children and adolescents for consistency of care."*

Close to two in five therapists called for a level of collaboration that goes beyond "frequent contact" to share information. Therapists expressed a desire for more genuine participation by social workers in treatment, with shared planning around goals for supporting a youth through transitional periods as well achieving desired treatment, permanency, safety, and well-being outcomes. Therapists cite family FTDM's and Wraparound meetings as a good example of the kind of shared planning of which they enjoy being part. They appreciate having clear expectations and goals for treatment from the social worker, and a couple therapists suggested having a policy or a new position in place to prioritize a higher level of transparency. Joint trainings are another idea suggested to facilitate a mutual understanding of each other's perspectives.

Regular, frequent, or required contact to share information

A third of the responses to this question focused on the need for more consistent contact with social workers. Some therapists would like required monthly or quarterly check in appointments that are scheduled far in advance. They believe that more regular and frequent contact with the social worker to exchange updates on the youth and their family would make their work less challenging. Therapists describe the current process as a "game of phone-tag" and would like to be informed of pending placement changes, or other important developments in a youth's home or school life. They cite open communication and plenty of notice for in person meetings as facilitators of the level of contact desired. An additional one out of ten therapists expressed that the sharing of more case information improves the communication and collaboration with social workers. The specific information desired includes medical and psychosocial history, court findings, visitation plans, permanency goals, Court Reports, results of home and safety visits, collateral contacts, and details about biological families. Some therapists even suggest a report to be supplied from the social worker at intake or at regular intervals.

> *"It seems that without some standard way for tracking and documenting what has been done, what needs to be done -- The process allows too many places for the child to [fall] thru the cracks and the process inhibits a measurable way to show accountability."*

Smaller caseloads and more staff time

Mental health therapists recognize that social workers have large demands on their time, which hinders their ability to return phone calls, emails, or even initiate contact. Almost one in ten therapists described the thing to do to improve their communication and collaboration with social workers is to ensure social workers have reasonable caseloads and supports so that they can communicate effectively with treatment providers. Therapists also expressed their own large caseloads as obstacles to regular communication. They recognize that the complex needs of many of the children and youth served by both systems increase the demands of cases and can at times be overwhelming. The capacity of both therapists and social workers to devote time to communicating with each other appears to be limited by sheer volume of need.

"My dream? More staff with more time."

Other

There were many responses that did not emerge as major themes yet are noteworthy. A number of therapists mentioned frustrations obtaining signatures on intake paperwork, and obtaining a direct contact phone number for social workers. Challenges with contact are exacerbated with changes in social workers. One therapist would like access to case files, while another wants support linking to caregivers. One response mentioned that CA supervisors need to hold social workers accountable to attendance and communication requirements, while another asks for recognition that mental health service delivery does not allow for reimbursement for travel time, despite the critical need for in home services.

Question 9: "What additional training or support would be helpful for working with CA, foster children, foster parents and/or biological parents?"

Child Welfare System Training

By far the most common training desired by therapists is one that explains the foster care system. Close to one fifth of therapists expressed that they lack understanding and knowledge of the practices, processes, and procedures affecting youth in foster care and their families. The legal process, including termination of parental rights and legal rights of caregivers is a particular point of confusion. Therapists also want a better understanding of timeframes social workers are working with and the different roles within the system.

Therapists would like a "greater understanding of steps in a case and what all is involved in the process to reunite or terminate parental rights."

Collaboration

In light of the need for improved communication and collaboration, it is not surprising that the second most common theme for training was on skills and best practices to effectively collaborate. One suggestion stood out as a way to move forward and build relationships: "I think that it is important to view each other as part of a team and to support each other's efforts. The more we can work together the better. We need to be on the same page so the same trainings, including EBPs, should be made available to staff of both mental health agencies and CA."

Trauma Training

Fifteen therapists mentioned the need for "more trainings on trauma and what that looks like in children of different ages". They assert that caregivers and foster parents, as well as themselves, would benefit from a more trauma-informed system. One therapist mentioned specifically trauma impacts on young children, while another felt there is a lack of adequate training and support to foster parents for understanding the mental health needs of children and youth which increases placement instability.

Mental Health and "system of care" Training

Training for child welfare staff and caregivers on the mental health system was equally as popular as trauma training. This includes topics such as confidentiality guidelines, collaborative treatment approaches, resource options, integration with other services, and the boundaries of what community mental health providers can do. Access to care standards, expectations, and roles in therapy are also mentioned as aspects of the mental health system that cause confusion.

Other

Many therapists had very specific requests around certain EBPs they wanted training on, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), and Motivational interviewing. Others want to know more about what EBPs are appropriate for foster children and youth, how to access and engage biological parents, and how to provide support during transitions. Finally, therapists are curious about therapeutic foster care, safety framework, de-escalation, and how to reduce stigma.

Question 10: "Other final comments or concerns?"

Roughly one in five therapists chose to provide additional comments or concerns. Several therapists expressed confusion around how to measure progress and communicate that progress in a meaningful way. Several therapists mentioned their concern around the length of time it takes to achieve permanency for the youth they have served. Another mentioned the need for ongoing support as youth age out of care. Another called for an increased focus on prevention that is cognizant of population level trends. One therapist mentioned that there is generally a good relationship with social workers with phone communication. Several comments showed appreciation for including mental health in the survey. Some acknowledged that communication and collaboration is a two way street and both parties can improve. One therapist mentioned challenges with serving Medicaid clients: "Considering the limits of my practice, how do I keep connected but not overwhelmed?"

Focus Groups with Social Workers

CA social workers who participated in focus groups were asked to respond to ten broad questions, each generally followed with clarifying prompts. Due to the nature of focus group discussions, not every question was asked in each focus group and questions were not always asked in the same order. Findings are grouped by 8 topic areas that each focus group naturally addressed (to see each question verbatim, see *Appendix B*):

- Identification of mental health needs (question 2)
- Referral to mental health services (question 3)
- Intake into mental health services (question 4)
- Engagement with mental health services (question 5)
- Collaboration and communication among child welfare, mental health, and other stakeholders about ongoing treatment issues (question 6)
- Service issues (question 7)
- Additional training or supports to identify, refer, engage, and serve youth (questions 8 and 9)
- Most important improvements to be made (question 10)

Sample

At the beginning each focus group, principal coordinators recorded workers' responses to the first question (regarding their role and assigned office), as well as observations about gender and race of each worker (see Table 2). The average number of focus group attendees was 7.9 with a median of seven and a range from five to twenty. The majority of social workers who attended the focus groups were identified as female (83%), and White/Caucasian (72%). A wide range of roles was represented in the focus groups. Over one-third of focus group attendees (36.2%) reported their role as Child and Family Welfare Social Workers (CFWS) while 18% called themselves supervisors. CHET social workers and CPS workers represented 7.9% and 7.1% of attendees, respectively. The remaining third of attendees were comprised of diverse roles such as Family Voluntary Services (FVS), Family Assessment and Response (FAR) Lead, and placement coordinators.

Table 2: Characteristics of Social Worker Focus Group Participants

Ordered by highest response

Characteristic	N=127	%	Characteristic	N=127	%
Sex			**Office**		
Female	105	82.7	Spokane	10	7.9
Male	22	17.3	Toppenish	10	7.9
Race			Bellingham	8	6.3
White/Caucasian	92	72.4	OICW	7	5.5
Multiracial	13	10.2	Region 1 Regional Employee	7	5.5
African American	11	8.7	Tri Cities	7	5.5
Hispanic	6	4.7	Tumwater	7	5.5
Asian	5	3.9	Colfax	6	4.7
Role			Port Angeles	6	4.7

CFWS	46	36.2	Smokey Point	6	4.7
Supervisors	23	18.1	Aberdeen	5	3.9
CHET Screener	10	7.9	Kent	5	3.9
CPS	9	7.1	Martin Luther King JR	5	3.9
FVS	4	3.1	Tacoma	5	3.9
Intern	4	3.1	Vancouver	5	3.9
CFWS Indian Child Welfare (ICW)	3	2.4	Wenatchee	5	3.9
Area Administrator (AA)	2	1.6	Bremerton	4	3.1
Adoptions SW	2	1.6	Moses Lake	4	3.1
FAR Lead	2	1.6	Region 2 Regional Employee	4	3.1
Family Reconciliation Services (FRS) / FVS	2	1.6	Clarkston	2	1.6
FTDM Facilitator	2	1.6	Ellensburg	2	1.6
Practicum Student	2	1.6	Region 3 Regional Employee	2	1.6
Program Consultant	2	1.6	Yakima	2	1.6
Other	14	11.2	Other	3	2.4

Identification

Strengths: The Child Health and Education Screening (CHET) Report

Social workers most often reported that a major indicator for identification of mental health needs is the CHET Screening Report. This was mentioned across the state as the best way to identify emotional or behavior concerns when a child/youth first comes into care. CHET Screeners complete the screening report within the first 30-days of out-of-home care using standardized screening tools that provide a clinical cutoff to determine if a referral for follow-up is necessary. CHET Screeners administer the screening tools with caregivers, parents, the child (if age appropriate), other natural supports, schools, family physicians and others to help identify any areas of concern for mental health. "The biggest strength is the CHET," as one social worker stated, as it can help determine if there is a need for any further assessments. "[It] helps with gathering all of the initial information and makes recommendations" to assist the social worker with referrals. Some staff felt the CHET might provide too much

Youth suggested providing caregivers with a quick and easy diagnostic tool to complete at any time that would help provide clinical cut-offs to determine if the child or youth needed therapy

information, or that CHET findings could be presented in a more organized way than the way the report is currently structured.

Strengths: Relationships

Strengths expressed in some offices for identification of an emotional or behavior concern were strong working relationships with mental health therapists and agencies. These relationships allow for quick consultation. As one social worker said, "[I] can call them directly and say 'this is what I am seeing, what do you think?'" Staff felt that the informal relationships helped them do what they thought was best for kids. They emphasized the utility of holding regular meetings to talk about barriers, gaps, and successes. Some offices reported the therapist join them in visiting the child or youth at school or at the caregiver's home, further strengthening the connection between the social worker and therapist.

Challenges to identifying mental health

Challenges in identifying mental health concerns in children and youth was reported second most often, especially identifying trauma. Social workers reported they rely on information shared from parents, the child or youth, school professionals, natural supports, family physicians, probation officers, and others to assist in identification. Social workers expressed that emotional or behavioral concerns can be either under or overstated by caregivers, often times during adjustment periods. This can create a barrier for identification when trying to sort through what information is accurate, "it's hard to sort everything out. Everyone can give a different answer – how do you know what is real?" Often times, children and youth can be hesitant to provide information, "kids might not be ready to share and the information is tough to talk about." Another social worker said that families can be reluctant to provide information about the child's emotional or behavioral concerns. Social workers are uncertain if concerns are because of an environmental issue or if there is a behavior stemming from an untreated mental health condition. Social workers also felt that if there is a documented history of abuse or neglect, behaviors may look similar to something else, which can lead to incorrect identification. Training around identification may help determine any underlying issues as one social worker stated, "[we] assume that all kids are traumatized. [We] never know if they meet the threshold for trauma." Social workers stated they would like more training around identification, stating that referring to mental health is sometimes easier than knowing the unique identifiers for such things, as trauma: "that's why we pay someone else to do it, but we need [the] general knowledge."

"When kids are placed into our custody, that's trauma. It's like a death, a loss. We don't know what the kids are internalizing or dealing with inside."

Social Workers or Other Staff Experience

A little less than 10% of social workers identified the strategy of reaching out to other seasoned social workers or staff with mental health experience for assistance, "Sometimes our knowledge will help determine what is not typical behavior for kids of similar ages." Social workers acknowledged sharing with other staff may help flesh out any concerns or underlying mental health need, "a worker's experience with previous cases can help them identify unusual behavior that may be indicative of a mental health need." Some of the offices reported

strengths of shared planning with experts in mental health, either through previous professions or a mental health liaison located in the office.

Schools and Other Assessments

Other sources of information social workers reported included reading out to schools, "we talk a lot with … the school to help report on the youth's behavior." One social worker suggested collaborating with schools to assist with identification, based on previous history, "there may be a history established at the school that can be of use." Social workers reported that schools maintain records about Individual Education Plans (IEPs) or behavioral health contracts that may alert them to any behavioral problems. Other assessments such as the Global Appraisal of Individual Needs Short Screener (GAIN-SS), the child or youth's medical reports, the CA Family Assessment, any previous medical diagnoses, the Investigative Assessment (IA), or previous assessments from mental health are all sources of information social workers stated they use to help identify emotional or behavioral concerns.

The Child or Youth's Behavior

The child or youth's behavioral was also mentioned as an indication of a mental health need. Assaultive and or sexualized children and youth, self-harming behaviors, hoarding, hygiene, or interactions with others are all externalizing behaviors that social workers noted as a need for a further evaluation. Social workers also listed internalizing cues including vigilance, fearfulness, flat affect, youth who have auditory/visual hallucinations, nightmares, or anxiety. Asking the child or youth directly was also a strategy used; we have to "engage the caregiver, parent, and child, in the child or youth's sleeping patterns, eating habits, and energy levels."

Youth provided feedback that building trust with the therapist is one of the most important parts with any mental health treatment.

One youth stated, "This is me I am sharing about!"

Referral

Perceptions of available services

Nearly one out of five responses from social workers was directly related to the availability of quality services within their communities. Social workers expressed their frustration due to their belief that there are not enough resources in their community to refer foster children or youth who may have significant emotional or behavioral health concerns. While a few counties had plenty of options, other social workers reported that the lack of choice for providers who accept Medicaid would stop them from making a referral. One social worker told us, "They [the community mental health agency] are our only option."

Facilitating the referral

The desire for a flexible referral process was the second highest response from social workers. A minority of social workers reported that they make the referral, but most often request the caregiver to call in order to ensure the time and date will work with the caregiver's calendar. Social workers in one county spoke highly of a system called the "ACCESS line" that facilitates the referral and follows up with the caregiver to ensure the

intake appointment was made. On the other hand, others stated "just make the phone call and accessing the 'screener' is an ordeal".

When the child or youth changes a community mental health agency due to a placement move, social workers reported having problems with the new agency accepting the old agency's referral and having to repeat the paperwork and referral process. One social worker stated, this is the "most difficult thing with referrals is that they're time consuming, depending on who you refer the youth to."

Sometimes social workers reported that when they refer a child or youth for therapy they send copies of a variety of information including the CHET, court report, any prior diagnoses or evaluations, court orders, case notes from FamLink[4], IEP and school records, dependency petition, allegations and referrals to CA. Sometimes this information is shared verbally or faxed, or emailed over. On the other hand, several focus groups made little to no mention of what type of information they include with referrals.

Intake

After referral to mental health services, a child or youth must go through an intake process that involves assessment of the mental health needs of the child, including diagnosis. Participants were asked to describe the strengths and weakness of the intake process.

Communication and Information Provided for the Intake

When asked about supports of and barriers to intakes being completed after a referral is made, communication and information sharing was by far the highest reported theme across the focus groups. This included successful strategies for communication back and forth between social workers, therapists, and caregivers, as well as practices that hindered communication. Communication provided for the intake varied across offices. Although this was rare, one strategy employed by some offices is that the social worker attends the intake appointment with the child, youth, caregiver, and sometimes biological parents, "The [social worker] can bring appropriate paperwork and information, they can make sure that all of the important information is provided to MH provider… it is an outcome that staff want anyways."

Other successful strategies to facilitate communication were reported. One CA office has a mental health liaison as a strategy to help manage the complexity of coordinating services. Social workers reported they can staff cases and have the liaison attend home visits and meetings to provide consultation. One social worker stated that having a mental health liaison available in their office for consultation helps "make the connections … and bridge the gap between professionals and ensure a steady referral and intake process." Workers often mentioned that developing inter-office relationships as a strength making each other accessible for questions and concerns.

One social worker stated having a mental health liaison to consult with can "cut a mile out of the marathon"

[4] FamLink is Washington's Statewide Automated Child Welfare Information System (SACWIS)

Some concerns with communication were also mentioned. Often, social workers reported they provided information to therapists, but did not receive anything in return until they specifically requested it; sometimes the request had to be in writing. Only after they requested the information would they receive "attendance and case notes."

Some social workers spoke of barriers that hindered communication and sharing of information with mental health therapists. While email was often reported as the most efficient way of communicating, it often was seen as a barrier for information sharing, "Some providers won't put anything in email due to concerns about HIPPA." One social worker stated that due to the nature of the work, "the ones who communicate with email get a better response rate" from social workers.

Access to Care

The second most common theme from social workers regarding intake to treatment were a variety of barriers after referral. Social workers in most offices mentioned "access to care standards" had been a challenge. Social workers reported referring children and youth to services, but those children did not receive mental health services because according to the assessment they did not meet the criteria for ongoing therapy. Social workers provided several anecdotes of clients who they felt had very severe needs but who did not receive an appropriate diagnosis. One social worker said, "sometimes [children and youth] don't meet access to care standards. If they don't screen in, that's it." One social worker said that in her opinion, "most often, it is because the client doesn't meet the eligibility criteria [and] will have to be seen by a private provider." Others stated that if the child or youth didn't meet access to care, they will often follow up to provide more substantiating information to ensure the child is accepted for ongoing treatment. A few social workers expressed that they had more success completing referrals to mental health when they used certain language or key phrases.

Intake procedures

Social workers reported challenges with community mental health center's hours of operation. Social workers stated that some agencies have been responsive to requests for more availability of appointments, and created walk-in availability for children and youth, but more often than not, these took longer and were more frustrating to families, "for a walk-in intake, the client must show up at 8am, and wait in the MH office until there is an opening." A few social workers said that they try to attend the intake appointment to ensure communication and information sharing with the therapist. At one office, the RSN contracted agency provider requires that the social workers make the referral, and usually the social workers attend the intake appointment. Those social workers spoke highly of this experience and believed it was valuable for the youth, the foster parent, and the biological parent.

The length of time until the intake varied across the state. Some social workers spoke of intake appointments occurring immediately, while other social worker spoke of wait lists or extended amounts of time until the intake could be arranged, up to "six to eight weeks before you see a therapist." Social workers indicated that some agencies have been responsive to requests for more availability of appointments, that they have even created walk-in availability for children and youth. Although an identified unintended consequence is that adults with serious mental illness are in the waiting room which can be frightening for children and youth. The

same appears true for walk in appointments to see a medical doctor; appointments are on a first-come first-served basis.

Engagement

Once a youth has been accepted to services they must become engaged with treatment in order to truly benefit. Engagement with treatment can be affected by a large amount of factors that social workers shared during the focus groups.

Inflexible or inaccessible services

Social workers highlighted that often times, children and youth in foster care must overcome many potential barriers to attending treatment, thus services must be flexible in order to fully engage youth. The lack of in-home, community-based services that are offered outside traditional office hours becomes yet another obstacle. There is a "small window of time after school" in which youth may already be engaged in extracurricular activities or family visits and caregivers may not be able to leave work to help transport, plus "Everybody wants the 4pm appointment". Especially in rural cases where transportation can take hours, engagement in services can be a major challenge. Social workers expressed frustration in the distances caregivers have to travel to receive treatment, "Some of the families are low income and don't have access to a car, [they] can't afford to do a 45 minute drive into treatment."

Another common theme across groups focused on wait-lists and the extended length of time it takes to obtain services once an intake is completed. One office said that the intake appointment is usually made "three weeks out, then it's another four weeks before the regular appointment can be made." If trying to arrange for a child psychiatrist, the appointment can take months, or as one office stated, "six to nine months" for the appointment. Some spoke of how this impacts their permanency planning when they are unable to report back to the court the progress in treatment due to waiting lists. It was also mentioned that problems exist with cancellation of appointments- either by the therapist or the youth- that aren't promptly rescheduled or communicated to the social workers. One social worker called for "more individualized mental health treatment"; while another said that they need to know how to match youth with effective, local services.

Youth provided feedback the therapy can often be stigmatizing. They want help on building strategies to talk about therapy with peers, friends, and adults. Youth stated they want help building inside stories and outside stories.

Motivation and understanding for children and youth

According to social workers, youth have trouble "connecting" to their providers because they don't have a chance to build rapport. The process of therapy itself can be repetitive; youth have "to tell everyone their story over and over again". Social workers expressed concern that this was re-traumatizing children and youth when talking about the past. Discussions focused on the fact that youth could have had negative experiences with therapy in the past that prevent them from engaging, especially older youth. A bad experience in counseling leads to "taking one step forward but two steps back". Social workers expressed frustration due to their belief that once a youth who is over

13 refuses treatment, there is nothing they can do to convince them that treatment would be useful.

Social workers also explained that the stigma of being in mental health treatment can stop a youth from wanting to engage in services, especially if their engagement will lead to their peers knowing that they are in treatment (i.e. school-based treatment). Likewise, they believed youth rarely come forward to ask for treatment. Several social workers mentioned the need for normalizing and demystifying mental health treatment.

The Role of Caregivers and Families

If caregivers are not seeing changes in a youth's behavior once they have started treatment they may lose confidence that therapy is valuable, according to social workers. They described that caregivers who have multiple youth in therapy need help coordinating services so that it is more convenient. Social workers say that the caregiver's support of treatment is critical in order to get appointments scheduled and make sure youth have transportation. If a therapist doesn't recognize the necessity of engaging caregivers, the lack of cooperation can impact treatment outcomes. Social workers also detailed the need for caregivers that are "mental health savvy" and know how to recognize the needs of youth.

Cultural appropriateness

Youth said they want social workers to match them to the right therapist. This includes appropriate race and gender

Many social workers want to connect youth to a therapist who is of a similar background, gender, or ethnicity in order to "allow youth to be themselves"; however they report that this can be extremely challenging or impossible in some locations. They explained that therapists are often assigned to cases based on availability, and while social workers may request a provider be matched with the youth's background, sometimes those requests were not met. Language barriers can also prevent engagement, if not with the youth, than with their caretakers and families, "[all the] languages are not available. We want more bilingual providers."

Social workers expressed a desire for therapists to understand the culture of foster care itself. Social workers identified that the needs of youth in care are sometimes very different than the needs of youth who live with their families, and therapists who understand "how CA fits into the life of the child or caregiver" can be much more effective at engaging the child or youth.

A final theme that occurred in several offices around cultural appropriateness was the need for therapists that are willing to accommodate cultural traditions and practices, particularly in the Native American and Immigrant communities. Social workers reported concerns that if therapists do not respond to cultural factors they cannot properly treat the child.

Turnover and Consistency

In cases where a youth is changing placements often, "they need consistency with therapy". Social workers say this is hard to achieve for two major reasons; turnover of therapists and multiple placement moves. A youth could be engaged in treatment and then have a placement change can halt forward progress or force youth to

start over with a new therapist. Changes in therapists can be equally as disruptive to a youth's progress; social workers are particularly concerned with the use of interns or inexperienced therapists to treat foster youth. They explained that interns do not last very long, and did not have the skill set or experience necessary to treat complex cases: "if they are a new provider they don't know what they don't know".

Some social workers highlighted the risks of addressing trauma in therapy. They discussed that if the correct foundation has not been built by the therapist and the youth, "trauma work very often destabilizes their day to day functioning, and of course that makes for more psychotropic drugs, more placement changes and more restrictive placements."

Collaboration and Communication around Ongoing Treatment Issues

Focus groups also discussed their interactions with therapists once a youth was engaged in services.

Information Sharing

Communication and information sharing for ongoing treatment issues was by far the most reported theme, and varied across offices. Social workers reported having open lines of communication and information sharing assisted with planning and treatment recommendations. Social workers reported sending case specific information during the referral process, but also consulting the therapist to ensure they kept up to date on changes in the child's life. While some responses reflected strength in information sharing, the majority of responses were focused on barriers to sharing information, "It's a 50/50 if we are going to get a report". Others stated that it can often matter who you are working with, others often stated that it "depends on the therapist". There were also major differences in satisfaction with information depending on the type of service provider; in general, participants believed that information sharing was much more frequent, more useful, and more appropriate when done by CA-contracted community mental health providers as compared to RSN-contracted service providers. This was a common theme across offices.

Social workers reported that information sharing documents often lacked important feedback from the therapist that would help the social worker with ongoing well-being and permanency planning. Staff reported that most often, reports only provided attendance, missed appointments, or brief notes about the child or youth's therapy session. Often times, records had to be requested by the social worker, sometimes more than once, or the office would have to pay for treatment notes by page. At times, social workers need a quick turnaround response from the therapist so they can tend to the current crisis at hand.

Social workers stated they wanted more information from therapists that specifically addressed treatment progress, goals, any steps necessary to take the achieve the goals, and feedback that would assist with their case planning, "we need where [the child or youth] is in treatment so we can inform our permanency planning and other decision making processes." Often social workers expressed their need for reports from therapists to provide to dependency courts for review once every six months.

One social worker reported that cross-learning between social workers and community mental health would be beneficial, "Cross education regarding our roles needs to be understood. MH is looking at privacy; they don't want to have their information taken into court. They want to heal the patient and not have to testify against the client … we need some of that information, but how do we get it?"

For intensive cases, social workers often reported that increased information sharing and planning was required to ensure treatment planning from the therapist aligned with safety goals from the social worker. Social workers reported that when the child or youth was placed out of their county or region, there was a greater need for collaboration between all parties.

Building Relationships and Community

Misunderstanding roles between Mental Health and Child Welfare was often reported as a challenge. One social worker told us "both sides are doing the best they can with the amount of resources available." Social workers expressed that foster children and youth have unique needs that are often times not "typical" of other children or youth their same age. This complexity can increase for therapists when there are multiple stakeholders in a foster child's life. Social workers reported that they would like to be viewed as a co-parent of the child by mental health, and therefore have the level of involvement in treatment and receive the types of information that a parent would. Social workers recognize that it takes "extra effort to build relationships" with providers. These relationships are easier to achieve in close knit, smaller communities. Other strategies include brown bag lunches to build relationships with providers "to be able to align the needs of the kids with the therapist."

Collaboration with Caregivers and Families

Often times, social workers suggested including the caregiver or biological family in therapy to contribute as well to ensure the child or youth "has success in the present moment which can help with long term planning." Social workers explained that caregivers must be relied on to follow up on a referral, complete an intake, and transport children or youth to appointments. Unfortunately this system is not always the most efficient, and true collaboration with caregivers is difficult to achieve; "Even the best parents can't cover all those bases". If a caregiver doesn't fully understand the value of the therapy, they may work against the treatment goals by reinforcing the children not wanting to attend. Social workers also expressed a desire for therapists to involve biological families in therapy, or at least during intake, as kin can elaborate more on a youth's background. They believed that many therapists view their patient in isolation from their biological and/or foster families, and treating the child or youth in the context of their family could achieve better progress towards permanency.

Service Issues

Availability of Quality Services and EBPs

Many social workers were very familiar with of one or two major community mental health agencies in their community. Others mentioned local, private therapists that they preferred and had been using for years. In many offices, social workers could list off a variety of EBPs that were used in their community. They were able to describe where they typically refer youth. However, there were often a range of providers or programs that were available but not being utilized. Social workers described that they lacked ways to remain up to date on all the available services in their community and primarily relied on word of mouth.

Social workers worry that kids are "not getting the best services available". The availability of services varied widely across the three CA Regions. Urban areas have a great deal more options than rural areas. In nearly

every focus group that was not near a metropolitan area, social workers mentioned that there are limited providers in their community that accept Medicaid. In some offices, workers stated that there were no services available at all within their particular county. Many social workers also had the perception that treatment was ineffective, or not working since they aren't seeing the change they expect to see.

Services in community: CMH and Contracted

Social workers reported reaching out to CA contracted providers when they needed a faster turn-around than community mental health could provide, to better meet the needs of the child or youth (due to cultural sensitivity or a language barrier), to refer to a program that has full spectrum of services, greater flexibility of hours and days, and for crisis stabilization services. In general, their attitudes about the effectiveness of services were more positive about CA contracted providers than RSN contracted community based providers. They believed, with some exceptions, that the CA contracted providers were more responsive, more likely to provide detailed information about treatment goals, more likely to include the social worker in determining treatment goals, and better at engaging youth in treatment.

EBPs: Fidelity/Understanding

In some areas, social workers question the fidelity with which EBPs are delivered. They said that while an agency may say they provide a certain EBP, they become skeptical when they cannot see a demonstrable improvement in the child or youth. They also are skeptical that therapists perform adapted versions of EBPs, leaving out important components. On the other hand, social workers reported frustrations with EBPs that have inflexible treatment modalities. Concerns were also expressed about therapists who have recently been trained on an EBP but not had enough experience using it to be able to handle the complex cases of children and youth in foster care. In general, many social workers were proponents of EBPs, however there were also many who did not fully understand their purpose; "when we find EBPs there are a lot of people who aren't ready for that".

Challenges Navigating the System

It was clear from several focus groups that many social workers had difficulty navigating the system: they were not informed of the full service array and had challenges knowing what information to provide with referrals due to a lack of standardization across agencies. In several instances during the focus groups, social workers began sharing information with each other about service issues. Several people mentioned that they tend to rely on Family Preservation Services (FPS) to meet some of youth's needs because of the ease of communication and collaboration, even if they haven't begun offering EBPs yet. Residential treatment, or Children's Long Term Inpatient Program (CLIP) placements were commonly described as extremely difficult to access; "it's like pulling teeth".

Gaps in Service Array

Social workers highlighted other areas in the service array where they perceive gaps, such as trauma-related services, services related to sexual abuse, and services that involve caregivers and/or biological families. In several offices, particularly rural offices, social workers expressed that crisis services were available, and outpatient services were available, but that intensive in-home services (i.e. "mid-range services") were not

available. One worked stated it is hard to find appropriate services for youth with "complex, aggressive behavior".

Additional Training or Supports to Identify, Refer, Engage, and Serve youth

Social workers were asked to describe what types of activities or other supports could help them to identify, refer, engage, and serve children and youth with emotional and behavioral health needs.

Training

Social workers were, in general, enthusiastic about the possibility of additional trainings, and provided their thoughts about the types of trainings that were necessary, the system roles that would benefit from training, and the most essential methods or approaches to training.

> *"Even with everything on our plate, how can we be helpful to our families without the training?"*

Given the major topic of these focus groups, the most endorsed training topics were about mental health and trauma. Several participants felt that they wanted additional training on how to identify mental health concerns in children and youth, when to make referrals, what agencies were available, and how to match agency services or evidence-based practices with the needs of specific youth. Several participants expressed a need for initial and ongoing training about the specific services that were available in their community, their location and availability, and how to refer youth to those services. More generally, several participants wanted training on the mental health system and the roles of the various stakeholders within the system. Many participants also asked for training about trauma and Adverse Childhood Experiences (ACEs), how the two are distinguished, and the consequences of trauma and ACEs on children's development. Similarly, some participants asked that training and support be provided on how to integrate and use the results from trauma screening into their work. Several participants also expressed that training on mental health, trauma, and ACEs would be beneficial for foster parents and kinship caregivers. A few participants also asked for training on Motivational Interviewing techniques and other ways to engage children, youth, and caregivers in order to improve initiation and engagement in treatment. A few also asked for a specific training on attachment disorder.

Youth recommended building a trauma informed system that would not only be beneficial for social workers and therapists, but also for the child or youth, "It would be helpful for everyone involved in a foster youth's life to become trauma informed. [Everyone] helping the youth see the behavior and don't realize it's a symptom of something else."

Several participants emphasized that training should be conducted at their office and during regular office hours, so they would not have to travel. Other participants felt that trainings should be open to the broader community and, in particular, several suggested joint training with mental health in order to understand each other's roles and responsibilities. Similarly, some felt that training for mental health workers about the foster care system, the "nuances of child welfare," and the unique needs of dependent children and youth would be beneficial.

Some participants felt that traditional approaches to training were less effective than more consultative types of approaches. One person suggested regular group case consultation on mental health issues. Another suggested supporting texting and emails to foster parents about identifying mental health issues and using behavior management skills with youth who have behavioral health problems.

Supports

One of the most common additional supports that emerged during the focus groups was a desire to have a dedicated staff person serve as a liaison between Mental Health and Child Welfare. A model for this currently exists in one of the CA offices. This unique position is jointly funded by CA and the local RSN. Several participants in the Tumwater focus group felt that it was invaluable in terms of streamlining access to and understanding of mental health services, and providing a wide array of consultation on mental health issues. One social worker commented that the liaison "cut a mile out of a marathon." Participants at the offices that did not have a liaison emphasized that such a position would be most useful if the person was skilled and knowledgeable about the local resources and needs, and if the person was an active advocate and resource on cases, rather than just providing consultation.

A few participants said that continuous and ongoing screening and assessment would be useful in order to assess children and youth with emergent mental health problems or those who were in a "honeymoon period." Others believed that the CHET screening should be delayed in order to obtain a more valid appraisal of the youth.

Participants stated that it would support their work to engage and serve youth in mental health services if stronger efforts were made to engage and include biological and foster parents in treatment. Similarly, several felt it would be beneficial to provide mental health services that served youth in the home and/or to provide transportation for families, particularly in rural areas. Culturally appropriate services were also seen as a vehicle for engaging and serving families from diverse backgrounds.

Most Important Improvements to be made

Participants were asked to describe the most important improvements to be made in order to help support foster children with mental health and/or trauma-related needs. The training needs described above were the most frequently mentioned, but several other themes also emerged, as described below.

Flexible and Coordinated Services

Flexible and coordinated services that reduce redundancy was frequently mentioned as support for social workers, children and youth, "Redundancy is a huge problem! The families are asked the same questions over and over again through CPS, CHET, and then mental health. If information about their history is already provided to mental health, why do they have to ask again?" Some participants described ways to reduce this redundancy and improve coordination by having social workers attend mental health intake appointments, allowing providers to continue to serve children and youth after they change placements outside of their RSN, having joint case staffings between mental health and child welfare, and easing limitations on the use of technology to communicate between mental health and child welfare. This last point was illustrated by a participant who said, "I can do everything in my life so easily over the internet at home, but when it comes to my job, everything is

just so painfully slow." Others felt that flexible mental health services in terms of location (providing services in the home) and hours (providing services on weekends and in the evenings) would also be important improvements.

Building Community around Addressing Mental Health

Many participants believed that the most important improvement is to build a sense of shared community around addressing mental health. These include some of the ideas previously described, as well as some new ideas: have multi-disciplinary staffings, trainings, and brownbag lunches among mental health and child welfare staff, including caregivers (bio parents and foster parents) in treatment planning and treatment receipt, having "provider fairs" for mental health agencies to attend and describe their services and approach, having shared planning meetings with the wide variety of stakeholders involved in the lives of children with complex needs, building community mental health advocacy centers (some of these already exist), and using the CHET Screening Report and other assessments as a tool to meet with caregivers to discuss the child's strengths and needs.

Information tools

Many participants felt a strength of their system was the diverse array of mental health services available through the RSN and contracted providers. However, a challenge they experienced was navigating these services: knowing what types of services were provided, how they matched children's needs, where and when they were available, and how to access them. Participants asked for some sort of services directory, online or otherwise, that would provide them with this information.

"The multiple players involved creates confusion and uncertainty"

Additionally, some participants felt that a standardized information exchange tool to share information with and receive information from mental health would be beneficial. This included building a secure electronic system that would allow for confidential information to be shared back and forth between social workers and mental health. From mental health, such a tool could streamline reports with information such as the specific treatment plan and treatment goals, progress towards those goals, modality of treatment, the crisis plan, and attendance at sessions. Social workers also desired information about skill development, emotional goals and growth, safety concerns, and visitation, placement, and permanency recommendations. From social workers, such a tool could include information about visitation updates, permanency plans, court orders, CHET screening reports, changes of social worker staff, and more. These tools could be used as part of a telephone exchange between therapists and social workers, or through email or some other means, to facilitate the intake and sharing of ongoing treatment progress.

Youth engagement

Another area that was commonly discussed are tools and supports to increase youth engagement in services. Some of these possible activities were described earlier: training on Motivational Interviewing and flexible and culturally-competent service provision. Additionally, some participants suggested incentives for youth to attend treatment, using treatment modalities that youth respond well to, addressing the age consent laws, training caregivers on ways to motivate youth, and emphasizing peer connections with youth.

Continuum of care

Particularly in rural areas, participants believed that there was not always a continuum of care in terms of available service provision. Some participants stated that there was a need for more intensive services that provided a "middle ground" between outpatient care and inpatient hospitalizations. Others felt that there were not enough (or no) beds available for inpatient care within their community. In several rural communities, participants believed that crisis services were lacking, or that the crisis services that did exist were not responsive to the needs of youth in foster care.

Other

Other, less frequently stated ideas for improvement that have not been mentioned above included: providing flexible funds for purchasing out of county services and other supports, having a standardized intake protocol for mental health agencies, and involving both biological and foster parents in intake assessments in mental health.

Results from the Exit Survey of Social Workers

At the close of each focus group, social workers were asked to complete a one page exit survey (see *Appendix C*) which included an opportunity to write any comments workers did not vocalize during the focus group. There were four questions regarding characteristics, and nine questions that asked workers to rank their satisfaction, comfort, and extent of impact with the current methods for collaborating with and utilizing the mental health system. Nine out of ten (91.3%) of focus group participants responded to the survey.

Sample

Out of 116 social workers who participated in the exit survey after focus groups, 31% had worked as a mental health provider in the past (See Table 3). The largest focus groups were held in Spokane and Toppenish, while the smallest group sizes were in Vancouver and Aberdeen. The two RSNs most represented in the focus groups were Greater Columbia (22.4%) and King (19.0%). Social workers had spent an average of 12.8 years (median of 12.0) working in the field, and an average of 4.9 years (median of 4.0) working in their current position.

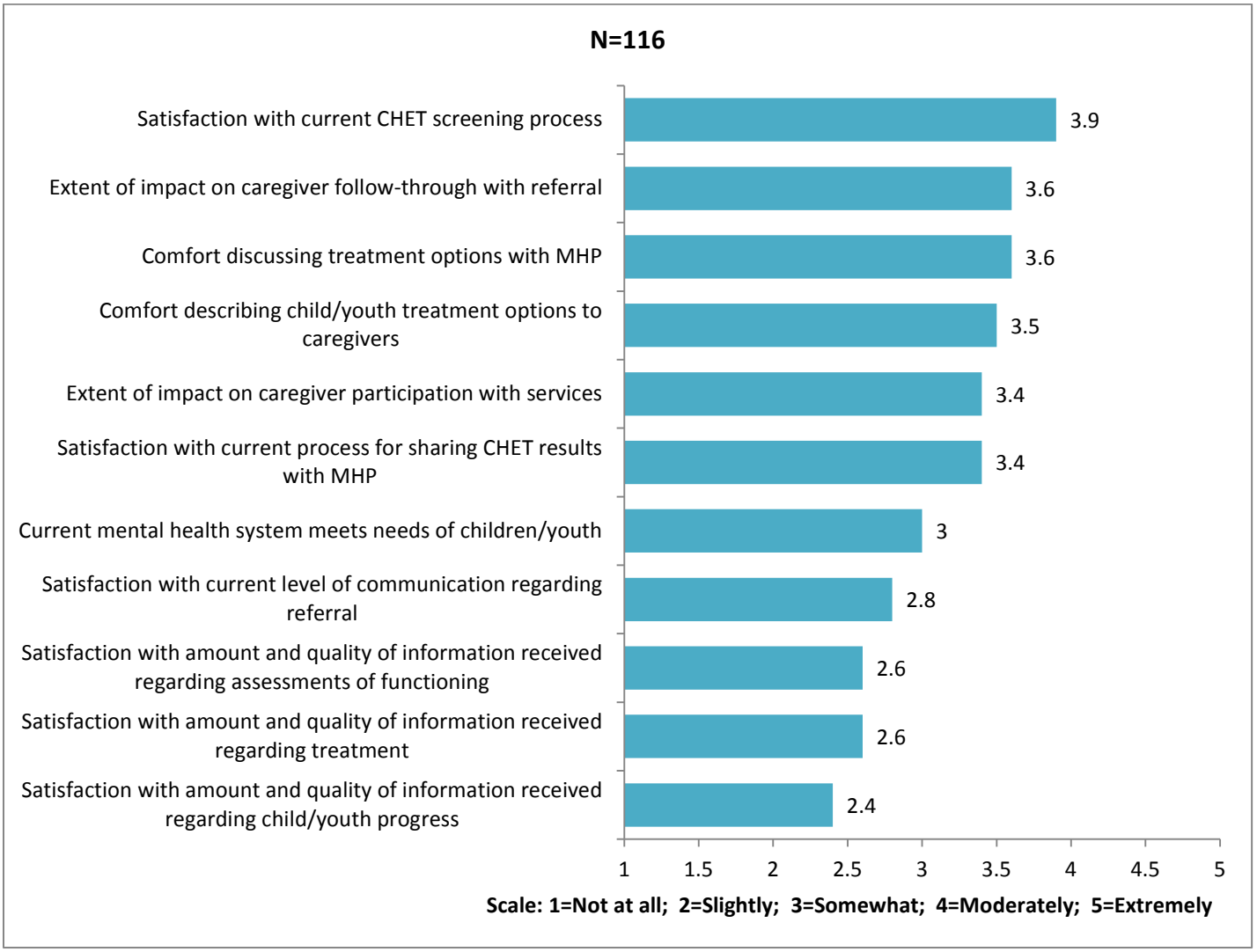
Table 3: Characteristics of Social Worker Exit Survey Participants

Variable	*n=116*	%
Gender		
Male	*19*	16.4
Female	*96*	82.9
Missing	*1*	.9
Have you ever worked as a mental health provider?		
Yes	*36*	31.0
No	*80*	69.0
Office where focus group held (in order of occurrence)		
King South	*8*	6.9
MLK	*7*	6.0
Wenatchee	*6*	5.2

Tumwater	*7*	6.0
Aberdeen	*5*	4.3
Spokane	*14*	12.1
Colfax	*6*	5.2
Bremerton	*5*	4.3
OICW	*7*	6.0
Smokey Point	*6*	5.2
Tri Cities	*7*	6.0
Toppenish	*13*	11.2
Tacoma	*6*	5.2
Vancouver	*5*	4.3
Bellingham	*8*	6.9
Port Angeles	*6*	5.2
Regional Support Networks represented by focus group location (alphabetical)		
Chelan-Douglas	*6*	5.2
Grays Harbor	*5*	4.3
Greater Columbia	*26*	22.4
King	*22*	19.0
North Sound	*14*	12.1
Peninsula	*11*	9.5
Pierce	*6*	5.2
Southwest	*5*	4.3
Spokane	*14*	12.1
Thurston-Mason	*7*	6.0
Timberlands	*0*	0.0
Years working in field	**Mean**= 12.8 **SD**=8.5 **Median**= 12.0	
Years working in current position	**Mean=** 4.9 **SD=** 4.9 **Median=** 4.0	

Figure 6: Quantitative Results from the Social Worker Exit Survey

Ordered by highest response



In the exit survey, social workers were asked to rate their responses on a scale of 1 to 5. The highest rating statewide was regarding satisfaction with the current CHET screening process (3.9). Satisfaction with the current CHET screening process rose to a rating of 4.3 in CA Region 2, which was significantly higher ($p<.05$) than the rating of 3.7 reported in CA Region 1 (see table 8 in Appendix H). Social workers statewide were somewhat comfortable discussing treatment options with providers (3.6) and describing child or youth treatment options to caregivers (3.5). Social workers statewide were less satisfied with the current process for sharing CHET results with therapists (3.4) than they were with the overall screening process. This finding also differed significantly ($p<.05$) between CA Region 2 (3.9) and CA Region 1 (3.1) (see table 8 in Appendix H).[5] Social workers statewide were also somewhat satisfied with the extent to which they can impact caregiver participation with services (3.4) and there was little variation across regions. Social workers responded that the current mental

[5] Note, sample sizes were not large enough to analyze significant differences between RSNs

health system only somewhat (3.0) meets the needs of children and youth. Social workers were only slightly satisfied with the current level of communication regarding referral (2.8), the amount and quality of information received regarding treatment (2.6), and the amount and quality of information received regarding assessments of functioning (2.6). Finally, social workers were the least satisfied with the amount and quality of information received regarding child and youth progress (2.4).

Additional Comments Not Said During Focus Groups

Just over half of social workers who participated in the exit survey wrote additional comments. Half of the comments focused on challenges and needs, many of which reinforced points made during the meeting. Others focused on more unique issues like crises driven communication, the need for more appropriate use of medication, and the need for school involvement in securing successful mental health treatment for the children and youth in foster care.

"The more support we can get and more opportunities to enhance relationships with our partners will lead to better outcomes for all involved."

About one-fifth of comments stressed strengths of the system and presented constructive ideas for improvement, such as better utilization of the ACES study, or "scripts" to use as tools for facilitating referrals. A handful expressed appreciation for the chance to have their voice heard and thanked project staff for taking the time and effort to travel to their offices. Finally, one in ten comments highlight training needs that were also expressed during the focus groups.

Focus Group with Alumni of Foster Care

Creating Connections greatly values the input from alumni of foster care in planning and decision making. Participants in the Passion to Action focus group suggested some major themes on accessing mental health services and building a community of care for youth.

Work together for the sake of the child and youth

"The focus should remain on the child," as one youth told us. With placement moves, quarterly reports, court reports, and more, often the child feels left out in the process. They believe that systems often overlook the child or youth which may injure trust, "Build a bridge of trust and become a friend. There are a lot of other adults in our lives and we do not need another person telling us what's wrong." Youth often feel stigmatized by therapy and need strategies on how to talk about treatment with family and friends. This will help them "re-brand therapy."

Participants said that building trauma informed systems would not only be beneficial for social workers and therapists, but also for the child or youth, "It would be helpful for everyone involved in a foster youth's life to become trauma informed. People [who are] helping the youth see the behavior and don't realize it's a symptom of something else."

Increasing group therapy options and communication between agencies, according to youth, will not only benefit outcomes in treatment, but build up the child's strengths. One youth said they want treatment that will "help us move on."

System and youth summit

Youth suggested holding a summit, where a vast array of stakeholders could engage those who work with foster youth for a joint cross-systems training. Bringing everyone to the table to enhance existing methods of identifying, referring, and obtaining effective and quality services for children and youth could be the emphasis. Youth believed all professionals should hear the successes and tribulations of youth in foster care, including having a youth panel to reflect their voice. Youth felt passionate on having courts involved, as they play a strong role in approving psychotropic medications that have been prescribed by physicians.

Services should empower youth

Participants emphasized that services should be empowering, focused on helping youth develop a capacity to talk about their own mental health experiences, advocate for their own rights, and learn when to ask for help. Youth expressed a strong desire to know what their rights are around their mental health care. One youth told us, "I still don't know what my rights are. What right to privacy do we have?" Youth said they were unsure if they had a choice about whom their counselor was or if they could leave treatment. When transitioning into adulthood, youth want more education around services available as an adult, "Educate youth when they exit foster care they can obtain counseling. You don't have to be alone when you are an adult."

Counselors and therapists should have more treatment options

Participants stated that treatment options for youth should include grief services. They felt that the Partnership Access Line (PAL), a service that physicians can use to obtain medication and psychiatric case consultation, should be open to youth to discuss their own case. Youth reported they need a lot of flexibility and understanding, "A situation may occur when a youth needs to reach the therapist, [agencies should] have availability if the need arises."

Discussion of Integrated Findings

Social workers and therapists reported several strengths within the mental health and child welfare system. Many social workers spoke highly of the Child Health and Education Tracking (CHET) Screening Report as a tool to help identify emotional or behavioral concerns. Other reported strengths within mental health and child welfare include: a broad pool of experienced service staff; diverse service array and availability of evidence based mental health treatments in several counties; several examples of strong, positive working relationships between mental health agencies and social workers; staff who are creative and productive within occupations that are inherently complex; and the presence of a dedicated, jointly funded mental health/child welfare liaison located at one Children's Administration (CA) office. Other strengths noted by the project, though not emerging during the focus groups and surveys, include several major initiatives of the Children's Behavioral Health System that align well with this one, including additional funding for services and workforce development, intensive community education regarding availability and appropriateness of mental health services, increased dependence on data for quality improvement, and accountability. Additionally, WA DSHS has an integrated data

base that is being utilized for a Children's Behavioral Health Dashboard of Child and Youth Functional Performance Indicators.

Collaboration and communication emerged as the most frequent topic from both social workers and therapists. Participants shared a desire for genuine collaborative participation in treatment planning and provision. Participants expressed that collaboration was extremely helpful to improving the services they were providing to children and families. For instance, nearly all therapists rated that much of the information they received from the child welfare system was useful in treatment planning (including consultation with social workers, participation in Family Team Decision Making and Shared Planning meetings, and consultation with foster and kinship parents). Similarly, several social workers spoke highly of mental health agencies and therapists that regularly included them in treatment planning and monitoring. Therapists that had the most direct contact with social workers were often deemed by social workers to be the most effective at helping children and youth achieve better outcomes. . A dedicated mental health and child welfare liaison, jointly funded by CA and the local RSN, was reported as a strength by social workers to help streamline access to and understanding of mental health services, provide a wide range of consultation on mental health issues, and connect child welfare with mental health.

Participants also reported that much work remains to improve case collaboration and communication between child welfare and mental health. For instance, the most commonly endorsed challenge of working with dependent children and youth by therapists was collaborating with the child welfare system. The need for additional focus on collaborative work was echoed by the foster youth alumni, who encouraged professionals to work together in order to best serve the needs of the children and youth. Both the child welfare and mental health systems rated their own efforts towards collaboration and communication highly, yet rated the other system as not very collaborative.

Social workers and therapists expressed confusion and dissatisfaction about the frequency and type of information exchanged between agencies because of a lack of consistent cross-system policy regarding communication and information sharing between mental health and child welfare. Social workers overwhelmingly reported that, in general, CA contracted mental health providers were more likely than RSN contracted community mental health providers to be responsive to their requests, include social workers in treatment planning, focus treatment plans on the goals from the social worker (such as providing reports to court, providing visitation and permanency recommendations), and provide regular and consistent treatment progress updates. There may be system related supports and expectations that make contracted providers more likely to address the needs of child welfare workers.

The benefits and challenges of collaboration were most highly centered on three major areas: assessment, treatment planning, and ongoing monitoring of progress. In terms of assessment, some underutilized strengths could be leveraged to improve collaboration and reduce redundancy. A strength of both systems is the current process for screening and assessment. In fact, social workers gave their highest ratings of satisfaction with the current CHET Screening process. However, mental health therapists reported they infrequently receive a copy of the CHET, and there is no explicit policy to share the CHET (although some offices reported that they suggest the caregiver provide the CHET to the therapist). Both social workers and therapists reported conducting screenings and assessments that included a wide number of the similar collateral contacts: biological parents, caregivers,

teachers, medical records, and court records. Therefore, there is duplication of efforts that could be alleviated through improved communication and sharing of the CHET. Social workers reported that they would not often attend the child or youth's intake or ongoing treatment appointments. Social workers that did report attending spoke very highly of the experience, though it did not seem to translate to increased communication with therapists. There were other gaps in communication following an intake referral; a commonly cited challenge was when a mental health intake assessment would conclude that the child or youth was not in need of treatment when the social worker believed otherwise. Participants reported that collaboration regarding treatment planning was sometimes hindered by different goals between mental health and child welfare. It was reported that mental health treatment goals were more focused on well-being, and less focused on safety and permanency, which is an important emphasis for social workers.

Social workers reported that they often believed they were left out of treatment planning and the development of treatment goals. And, while 72-82% of therapists reported that they routinely provided information to social workers about diagnosis and treatment recommendations, treatment progress, and crisis and safety plans, social workers reported that they did not regularly receive this information, and gave low ratings to their satisfaction with the amount and quality of this information.

In regards to ongoing communication about progress, both parties expressed frustration with issues such as finding time to communicate, and not being included in or notified about important meetings. Social workers noted that they were sometimes not kept abreast of changes to treatment plans, while therapists expressed they were not always notified of changes in living situations. And, as above, participants reported that the types of information shared were often not in line with some of the primary aspects of child welfare. For instance, only one-third of therapists reported regularly providing social workers with recommendations for visitation, living situation, and permanency planning. Additionally, communication around placement changes provide challenges to workers in both systems. Therapists reported placement changes are not communicated while social workers reported that placement moves outside the county could prevent children and youth from maintain their current therapist.

Participants described policy and practice challenges that presented barriers to collaboration, such as HIPPA related restrictions on email communication about cases, ethical codes prohibiting therapist recommendations on safety, visitations, and permanency, court orders that are inconsistent with treatment plans, and service billing restrictions on providing services out of office.

Child welfare participants stressed a need for flexible services that were child or youth directed, met the needs of the family, and were diverse in terms of locations and hours. There was also a desire for flexibility at a higher level, such as the ability to access services outside of a child or youth's home county, or maintain a service when a youth transitions to a new placement.

Training

Also frequently discussed were training opportunities that could be provided through *Creating Connections*. Participants in both child welfare and mental health frequently requested training and additional information about the most relevant aspects of each other's system. In particular, mental health reported they would benefit from increased knowledge about the foster care process (including court orders, goals for permanency,

visitation requirements, etc.) and practice and policies in child welfare. Child welfare reported they would benefit from trainings about children's mental health (in general), the components of effective services, matching effective services to the specific needs of individual children, and identification of trauma impact. Interestingly, a recent survey of a group of Children's Administration staff conducted by Partners for Our Children (Kruzich & Sun, 2013) also found that mental health and trauma-informed child welfare practice were two of the most commonly highly-rated priority areas for training in several regions. Due to the concern about information sharing, a training that could clarify what types of information can legally be shared, as well as what contractual obligations exist that limit the flexibility and accessibility of services would be beneficial for both systems.

Complex systems.

The complexity of the mental health and child welfare system was frequently mentioned as a challenge to addressing mental health needs. Social workers asked for help identifying and coordinating information about the services locally available in their community, including the types of services that agencies offered, how those services matched children and youth's needs, how to access the services, where they are located, and their hours and availability. Participants in child welfare expressed a desire for increased availability of evidence-based practices that specifically meet the needs of children in the child welfare system. They reported these services would be trauma-informed and more likely to incorporate a family focus, especially through the inclusion of biological parents and foster caregivers.

These findings bring to light several important needs in order to ensure that the emotional and behavioral health needs (including trauma impacts) of children and youth in out of home care are being accurately identified. We need to have strong screening tools that include trauma impact and accurately identify when a child or youth's behavioral health needs are significant enough that they would benefit from additional behavioral health support. We need a strong pathway to refer children and youth to appropriate services. This involves having caseworkers with a working knowledge of mental health-related concerns and how to match problems with particular therapeutic interventions. We need effective services available in local communities that address trauma and the emotional and behavioral health symptoms of children and youth in out-of-home care. We need collaborative case planning where child welfare workers and mental health workers coordinate and collaborate in partnership, with efficiency and timely communication. We need evidence based progress monitoring, where youth functioning is regularly tracked using valid and reliable assessments, and stakeholders collaboratively use this information to adjust treatment plans and services to respond to youth progress. And, most importantly, we need children and youth in care to be healthy and resilient.

Limitations

The findings and conclusions of this report should be considered in light of methodological weaknesses. Participants were not a random or representative sample of the population of therapists and social workers. Similarly, some RSN regions participated at much higher rates than others. Measures were self-report and data are not independently verifiable. Only one focus group has been conducted with youth, and no groups have yet been conducted with biological and foster parents. Survey and focus group research questions were determined collaboratively among a variety of system stakeholders, resulting in much more targeted and useful measures; however, during this process we may have omitted important questions due to stakeholder concerns.

Considerations for moving forward

To address the intersection between the system-level needs and the existing challenges, we recommend considering strategies aligned with *enhancing communication, increasing opportunities for cross-system collaboration, cross-training,* and *community capacity building efforts to support evidence and research-based practices for children's mental health.*

Enhance communication:

- Build on and learn from areas that have identified this as a strength
- Develop a consistent cross-system practice guideline for case-level communication and collaboration between mental health and child welfare addressing confidentiality, regulations and other identified barriers
- Identify additional methods for including biological, kinship, and foster caregivers in treatment planning

Increase opportunities for cross-system collaboration and cross-training:

- For child welfare:
    i. Increase understanding of the mental health needs of children in care and how to link them to appropriate services
    ii. Clarify the process, procedures, and realistic expectations for accessing services at mental health agencies.
- For mental health:
    i. Clarify the process, procedures, and realistic expectations of the child welfare system
    ii. Build on the work and resources from the T.R. vs. Dreyfus litigation, EBP legislation, and System of Care Grant.
- Evaluate cross-training opportunities to infuse a consistent, trauma-informed lens across child welfare and mental health.
- Consider co-location of mental health provider within child welfare offices

Build community capacity to support evidence and research-based practices for children's mental health:

- Increase availability of trauma-informed, evidence or research-based approaches in the mental health system
- Implement a trauma screen within child welfare to help identify children coming into care who need trauma related mental health services
- Implement evidence-based progress monitoring and assessment to be shared cross-system

Conclusion

The suggestions for future activities that emerged as a result of the focus groups and surveys with mental health and child welfare line staff were consistent with the original direction for the project as conceptualized in the grant application. In the weeks ahead, the core team will work to synthesize the suggestions from these sources into a coherent and feasible Phase II plan. The core team will continue to engage participants from our needs assessments by providing opportunities to participate in work groups consisting of members that were enthusiastic about assisting our team outline action steps for the identified areas of need.

In addition to using the recommendations from all stakeholders, the Phase II Plan will expand on existing system strengths. The core team plans to align their efforts with new initiatives at the state level that will be implemented during the grant period. For example, the Children's Behavioral Health System is engaged in several major initiatives that are well aligned with the goals of this project. This includes additional funding for services and workforce development, intensive community education regarding availability and appropriateness of mental health services, increased dependence on data for quality improvement, and accountability. In addition, Washington is developing a system-level Children's Behavioral Health Dashboard of Child and Youth Functional Performance Indicators. The diversity of roles and membership in the larger community involved with the project will help ensure that the activities of Creating Connections are aligned well with these activities.

Appendix A: Key Themes in Report

(Listed alphabetically)

Availability of Quality Services and EBPs
Availability of Services
Building Community around Addressing Mental Health
Building Relationships and Community
Challenges for Intake Appointment
Challenges Navigating the System
Challenges to identifying mental health
Child Welfare System Training
Collaboration
Collaboration, participation, and shared planning
Communication and Collaboration
Communication and Information Provided for the Intake
Communication and Information Provided for the Referral
Confidentiality
Continuum of care
Counselors and therapists should have more treatment options to include grief services. Use alternatives to medicine.
Open up the PAL line
Cultural appropriateness
EBP: Availability/Fidelity/Understanding
Engagement of adults and other family members in treatment
Everyone work together for the sake of the child and youth and develop permanent connections between people and agencies.
Flexible and Coordinated Services
Flexible Services
Gaps in Service Array
Ideas for Increased Information Sharing
Inflexible or inaccessible services
Information Sharing
Information tools
Mental Health and "system of care" Training
Motivation and understanding for children and youth
Other
Placement changes, inconsistent adults, emotional challenges, and trust
Policies and practices that allow operational communication
Regular Progress and Treatment Reports
Regular, Frequent, or Required Contact to Share Information
Schools and Other Assessments
Services directed at children and youth should help them develop a capacity to talk about their own mental health experiences, advocate for their own rights, and learn when to ask for help.
Shared Meetings
Signatures and Other
Smaller caseloads and more staff time
Social Workers or Other Staff Experience
Strengths
Supports
The Child or Youth's Behavior
The Role of Caregivers and Families
Training
Turnover and Consistency
Youth engagement
Creation of a Summit where systems can come and talk together

Appendix B: Mental Health Provider Survey

Creating Connections Survey

Thank you for volunteering to complete this survey! It should take about **10 - 20 minutes** to complete. The purpose of this survey is to gather your knowledge and opinions to inform a five-year federally-funded project called '***Creating Connections'***. This project is a collaboration among Division of Behavioral Health and Recovery (DBHR), the University of Washington (UW), and the Children's Administration (CA). The goals of ***Creating Connections*** are **to improve the safety, permanency, and wellbeing outcomes for children and youth in out-of-home care/foster care (State Dependent youth), who also have behavioral health needs, and who may have experienced trauma.**

Your feedback is important for shaping the direction of the project and **improving the collaboration between the mental health and child welfare systems**. Your responses, combined with the responses from CA case workers on similar questions, will be used to improve the **identification** of dependent children and youth with behavioral health needs, improve their **access** to effective trauma-informed mental health services, and **measure and communicate their progress**. We want to hear from you now and throughout the remainder of this project because your perspective will help us **create a strategy** to achieve these goals. We need your contributions so we can **build on existing system strengths**, **fill gaps** and **eliminate barriers** in order to **increase the positive impact you have on their lives.**

Your participation in this survey is **voluntary and confidential.** The results of the survey will be presented as an aggregate and no personal identifiers (name, title, office, etc.) will be tied to the survey. After you complete the survey, you will have the opportunity to enter your email address so we can contact you if you are selected in the **drawing for a $50.00 VISA gift card** (we are providing twenty $50 gift cards.) We will also ask you if you would like to **receive regular updates** on the progress of ***Creating Connections,*** including results of this survey and our other project activities. Entering your email address is optional and will NOT be linked to your responses. While we may use quotes in general, no other identifying information will be maintained and we will not attribute answers to any person.

There are no wrong responses – only helpful information!

Our population of focus is children and youth ages 3-17 in out-of-home care who seek services in public mental health settings. Some children enter into out-of-home care and some return home while they are still receiving mental health services. We would like you to also consider those children when answering the questions below.

Question 1.

Over the last year, approximately what percentage of children and youth on your caseload were state dependents?

Question 2.

Working with state dependent children and youth can sometimes present challenges that are different than when working with non-dependent youth. What are some of the most difficult challenges specific to working with state dependent youth?

Question 3.

What types of information do you routinely provide to CA case workers about mental health treatment? (Check all that apply)

- Diagnosis and treatment recommendations
- Missed appointments
- Treatment progress updates
- Crisis and safety plans
- Recommendations regarding visitation
- Recommendations regarding current living situation
- Recommendations regarding permanency (e.g., reunification, termination of parental rights)
- None
- Other (please specify)

Question 4.

Which of the following sources do you regularly receive information from about state dependent children and youth for your case assessment and planning? You might not be familiar with some of these sources, because not all of them are required or relevant for every case (regularly receive/not regularly receive)

- Consultation with the CA caseworker
- Individual Service and Safety Plan (ISSP)
- Child Health and Education Tracking (CHET) Screening
- Foster parent or kinship caregiver
- Biological parents
- Other assessment (e.g. Foster Care Assessment Program/FCAP, psychological evaluation, IEPs)
- Court Appointed Special Advocate (CASA) reports or consultation
- Family Decision Making meetings (FTDM), Shared Planning meeting, or other CA sponsored case meeting
- Behavioral Rehabilitation Services (BRS) or Child Placing Agency (CPA) staff
- Diagnosis and medications from medical professional

Question 5.

Is information from those sources useful, or if you don't receive them, would it be useful for case assessment and planning (useful, not useful, don't know)?

- Consultation with the CA caseworker
- Individual Service and Safety Plan (ISSP)
- Child Health and Education Tracking (CHET) Screening
- Foster parent or kinship caregiver
- Biological parents
- Other assessment (e.g. Foster Care Assessment Program/FCAP, psychological evaluation, IEPs)
- Court Appointed Special Advocate (CASA) reports or consultation
- Family Decision Making meetings (FTDM), Shared Planning meeting, or other CA sponsored case meeting
- Behavioral Rehabilitation Services (BRS) or Child Placing Agency (CPA) staff
- Diagnosis and medications from medical professional

Question 6.

If applicable, what other type of sources of information do you use regularly to get information about state dependent children for your case assessment and planning? (Open ended)

Question 7.

How satisfied are you with the amount and quality of information and/or process by which information is shared back-and-forth between you/your agency and CA about (on a scale of 1-5):

The reasons for referral to treatment, including information from screenings or assessments done by CA

Ongoing information from the CA case worker that could help inform your treatment approach

Ongoing information from the caregiver that could help inform your treatment approach

Assessments of functioning done by you and your agency and shared with CA

The mental health treatment that you and your agency are providing

The progress made by clients in treatment

Question 8.

Any comments about the questions above?

Question 9.

What policies and practices currently facilitate communication and collaboration with CA caseworkers?

Question 10.

What could be done to improve communication and collaboration between you and the CA caseworker?

Question 11.

What additional training or support would be helpful for working with CA, foster children, foster parents and/or biological parents?

Question 12.

Any other comments or concerns?

Question 13.

How many years have you been working in children's mental health? (Restrict responses to whole numbers, if less than one, please round up)

Question 14.

Have you ever worked as an employee of the Children's Administration?

Question 15.

What county or counties do you serve clients and work in?

Appendix C: Focus Group Discussion Questions

Thank you for attending this meeting. This collaborative project between the University of Washington, Children's Administration, and the Division of Behavioral Health and Recovery, aims to enhance the safety, permanency, and wellbeing of children and youth in foster care. The information we talk about today will inform a plan to improve mental health outcomes for children and youth served by the Washington State child welfare system. The project will build on the work of Children's Administration and others to identify and connect children to effective mental health services (i.e., evidence-based practices and/or trauma informed practices), particularly those youth who have experienced a traumatic event that significantly impacts their functioning. Therefore, we want to hear from you about what works well and what could use some improvement.

Your participation in this discussion is voluntary and we appreciate the time you are taking to help! All information collected and received will be kept strictly confidential and presented without any personal identifiers (name, title, etc.). All information will be presented in aggregate. While we may use quotes in general, no other identifying information will be maintained and we will not attribute answers to any specific person. Your Management Team is aware of the efforts related to this project and that we are here to talk with you.

We are particularity interested in your experiences in the last 12 months with children and youth ages 3 - 17 in out of home care. Our discussion today will refer to this group.

Do you have any questions before we begin?

1. I'd like each person to help us get started by telling us which office you are from and what your primary role or job title is.

2. As a case worker, you must address a variety of needs and concerns for children and youth. Will you talk us through the steps that occur to determine whether a child or youth has an emotional or behavioral health concern?
   POSSIBLE PROBES, DEPENDING ON WHAT INFORMATION IS SHARED DURING THE CONVERSATION:
   - What actions do you take if you have concerns regarding the mental health, or behavioral health needs of the children and youth on your caseload?
   - Who do you consult with regarding your concerns?
   - How do you identify whether the child or youth has experienced a significant trauma that may be impacting their mental health?
   - What is the role of the child/youth's caregiver in the identification of a mental health issue?
   - How often do you think trauma contributes to the mental health concerns for children and youth on your caseloads?
   - What are the strengths of the current process for identifying mental health and trauma concerns? What, if anything, could be improved?

3. If a child or youth on your case load has an emotional or behavioral health concern identified through the CHET screen or identified by you, a caregiver, school, or community member, how do you or other social workers make referral for mental health services?
   POSSIBLE PROBES, DEPENDING ON WHAT INFORMATION IS SHARED DURING THE CONVERSATION:
   - Where are you referring – Community Mental Health Centers, , CA contracted providers, FFS, or others?
   - What type of communication is necessary between you and the mental health agency to make sure that a referral occurs?
   - What type of ongoing communication occurs between you, the caregiver, and the mental health agency?

- What type of ongoing communication happens between you and the child or youth and caregiver regarding mental health treatment?
- What are the strengths of the current process for referring children or youth to mental health services? What, if anything, could be improved?

[If necessary, remind group about the target population]

4. What are some reasons why a child or youth who has been referred to mental health services may or may not complete an initial intake?
   POSSIBLE PROBES, DEPENDING ON WHAT INFORMATION IS SHARED DURING THE CONVERSATION:
   - Is this communicated to you? If so, how? Some ways may include during a phone call, at the monthly health and safety check, in an email, or other?
   - How do you support caregivers, children, and youth to complete an intake?
   - If a child or youth does not have an intake after a referral is made, what are some ways you respond?
   - What are the follow-up activities between the caseworker, caregiver, and provider to ensure effectiveness of ongoing treatment?

5. After an intake is completed, what are some reasons why a child or youth may or may not engage in ongoing mental health care?
   POSSIBLE PROBES, DEPENDING ON WHAT INFORMATION IS SHARED DURING THE CONVERSATION:
   - Is this communicated to you, the caregiver, and the child or youth? If so, how? Some ways may include during a phone call, at the monthly health and safety check, in an email, or other?
   - How do you support caregivers, children, and youth to engage in treatment (if treatment is recommended)?
   - Have you ever been told that a child or youth does not meet access to care standards and therefore is not eligible for services? What is the follow up if this happens?

6. What type of information do you receive about the child or youth's treatment progress?
   POSSIBLE PROBES, DEPENDING ON WHAT INFORMATION IS SHARED DURING THE CONVERSATION:
   - Who do you receive the information from?
   - Do you ever receive the results of assessments showing how the child or youth's functioning is changing over time?
   - In general, is the information you receive about the child or youth's treatment progress useful and concrete?
   - What information have you found to be the most helpful?
   - Do you receive copies of the child/youth's mental health crisis plan?
   - What additional information from mental health would be the most helpful to support case planning?
   - Do you feel like the information you receive from the mental health agency meets your needs for court or case planning (FTDM and other staffings)?
   - How often do you meet or have communication with the child's treatment provider(s) regarding the child's progress?
   - Are you involved in adjustments/changes to the child/youth's treatment plan?

7. Is there an adequate range of age appropriate and effective mental health services available in the community or region you serve?
   - What are they?

- Are there trauma-related services?
- What additional mental health services would be the most helpful, if any?
- How can we achieve better outcomes?

8. Are there any additional training or supports that you or your office needs to help identify, refer, or engage children and youth in mental health services?

9. Are there additional training or supports that you or your office needs to help you to better serve youth with mental health needs?

10. If you could do anything, what are the most important improvements that could be made to the process of identification, referral, assessment, or treatment of children and youth who have mental or behavioral health care needs?

Appendix D: Focus Group Exit Survey

Thank you for completing this very short survey. It should take only five minutes to complete. This survey is designed to gather information for planning as part of this five-year project.

We want to hear from you throughout the implementation of this project! Your responses are important and will be used to develop goals and activities over the next four years. Your participation will help ensure that our plans build on the strengths of the current system and provide additional supports where needed.

Your participation in this discussion is voluntary, anonymous, and all information will be kept confidential. All information received will be presented as an aggregate and no personal identifiers (name, title, office, etc.) will be collected. While we may use quotes in general, no other identifying information will be maintained and we will not attribute answers to any person.

We are particularity interested in emotional and behavioral mental health needs and the impact those needs have on the functional outcomes of children and youth. Our population of focus is children and youth ages 3-17 in out-of-home care. By "behavioral health need", we mean children with emotional or behavior problems including posttraumatic stress, behavior problems, substance use, depression and any other mental health problem.

Were there any comments you would like to add that you did not say during our meeting?

	Not at all	Slightly	Somewhat	Moderately	Extremely	Don't know
Please circle your response:						
How well do you think the current mental health system meets the behavioral health needs of child/youth?	1	2	3	4	5	DK
How satisfied are you with the current CHET screening process for identifying youth with behavioral health needs?	1	2	3	4	5	DK
How satisfied are you with the current process for sharing results from CHET screenings with mental health staff?	1	2	3	4	5	DK
How satisfied are you with the current level of communication with mental health staff regarding the initial referral to treatment?	1	2	3	4	5	DK
How satisfied are you with the amount and quality of information you currently receive from mental health staff regarding the following three items:						
1. The mental health treatment received by children and youth on your caseload?	1	2	3	4	5	DK
2. The progress made by children and youth on your caseload?	1	2	3	4	5	DK
3. Assessments of functioning (such as how the child is doing at home, in school, and in the community)?	1	2	3	4	5	DK
How comfortable are you with describing to caregivers the treatment options available to the child or youth?	1	2	3	4	5	DK
How comfortable are you with discussing treatment options with mental health service providers?	1	2	3	4	5	DK
To what extent do you think you have an impact on caregiver follow-through with a referral?	1	2	3	4	5	DK
To what extent do you think you have an impact on caregiver participation in the child's mental health services (when indicated)?	1	2	3	4	5	DK
Please circle or write in your response						
Sex: Male Female Other						
How many years have you worked in this field? (Restrict responses to whole numbers)						
How many years have you been in your current position? (Restrict responses to whole numbers)						
Have you ever worked as a mental health provider? Yes No						

Appendix E: Passion to Action Focus Group Questions

Thank you for volunteering to be part of this focus group. The discussion will take between an hour and half hours. The purpose of this discussion is to gather your knowledge and opinions to inform a five-year federally-funded project called 'Creating Connections'. This project is collaboration among the Children's Administration, the Division of Behavioral Health and Recovery, and the University of Washington. The goals of Creating Connections are to improve the safety, permanency, and wellbeing outcomes for children and youth in out-of-home care who may have behavioral health needs and who may have experienced trauma.

Your participation in this focus group is voluntary and confidential. That means that you don't have to do this, and we won't tell anyone if you choose to do this or not. ***Your answers are CONFIDENTIAL and will only be used in the aggregate to help us understand youth's experience with the system.*** *You don't have to answer any questions that you don't want to answer, and you can stop participating at any time. Whether you decide to participate or not, it won't hurt (or help) your relationship with Children's Administration, the University of Washington, or the Division of Behavioral Health and Recovery. We are* ***not*** *going to be asking about your personal life experiences. Instead, the questions will be about what you believe can best help children in out-of-home care who have emotional or behavioral problems such as mental health problems, trouble coping with trauma, substance abuse problems, depression, or aggression. The results of the focus group will be presented as a whole and no personal identifiers (your name, your age, etc.) will be tied to the results. We may use quotes in general, however no other identifying information will be maintained and we will not attribute answers to any person. In other words, we're not going to use your name on any of the notes we write about the focus group, instead we will use a code number. This will help prevent any accidental release of your name. You should be aware that our study is intended to benefit youth who will be entering foster care and will probably not have a directly positive benefit to you.*

Our population of focus is children and youth ages 3-17 in out-of-home care who have emotional or behavioral health needs.

Before we get started, do you have any questions or concerns?

What do you think are the most important and helpful things that mental health staff do when children and youth in out of home care start mental health treatment?

What do mental health therapists need to know about children and youth in out of home care to be most effective? What can we do to support them in working with children and youth in out of home care?

What do caregivers of children and youth in out of home care need to know to support children and youth's emotional and behavioral needs, including trauma? What can we do to support these caregivers?

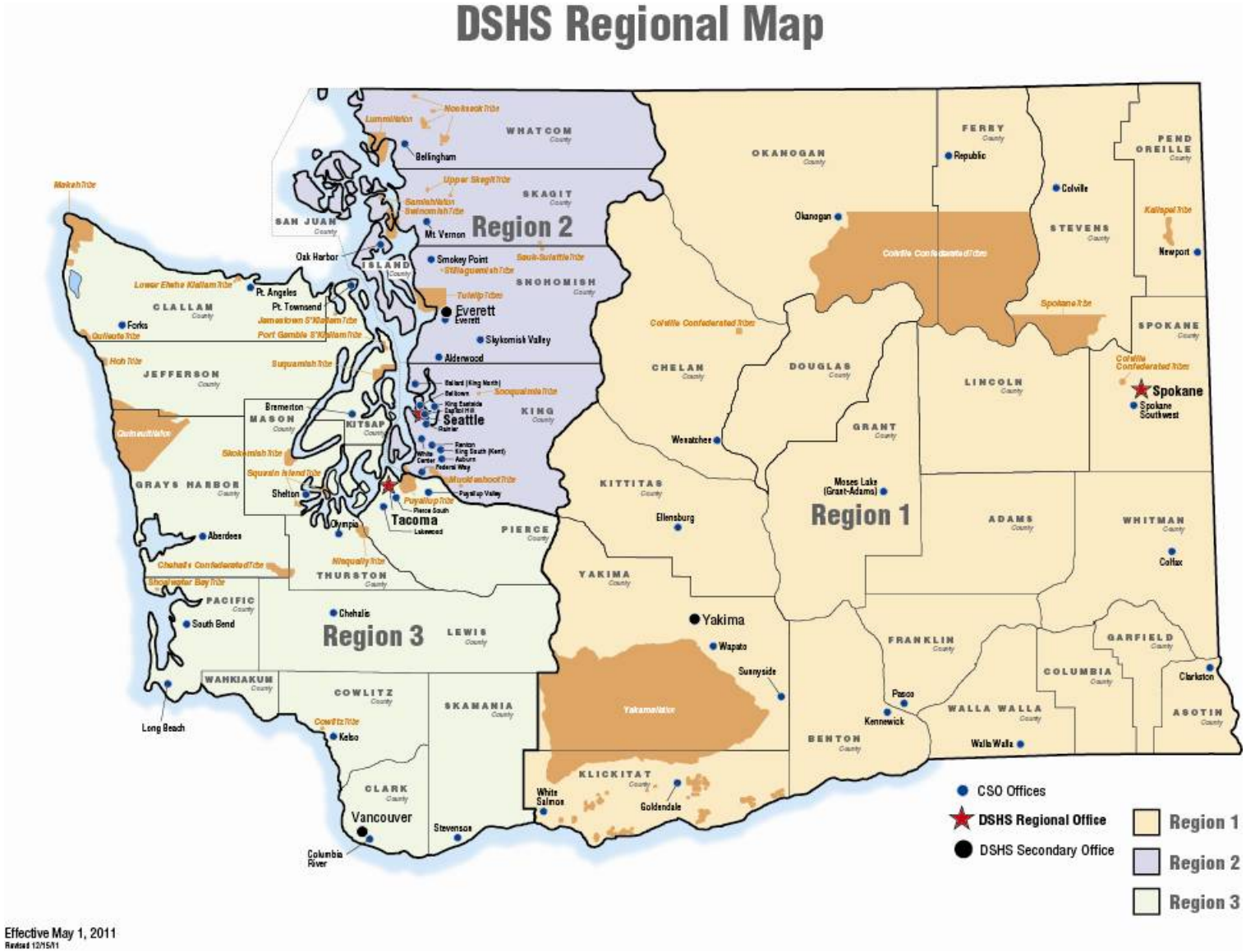
Changing placements can be especially hard for children and youth with emotional or behavioral concerns. What strengths of the system make sure placement transitions are smooth for youth? What could work better?

How do you think we could make the strongest or best connections among mental health supports/services, children and youth in out of home care, their families, and their caseworkers?

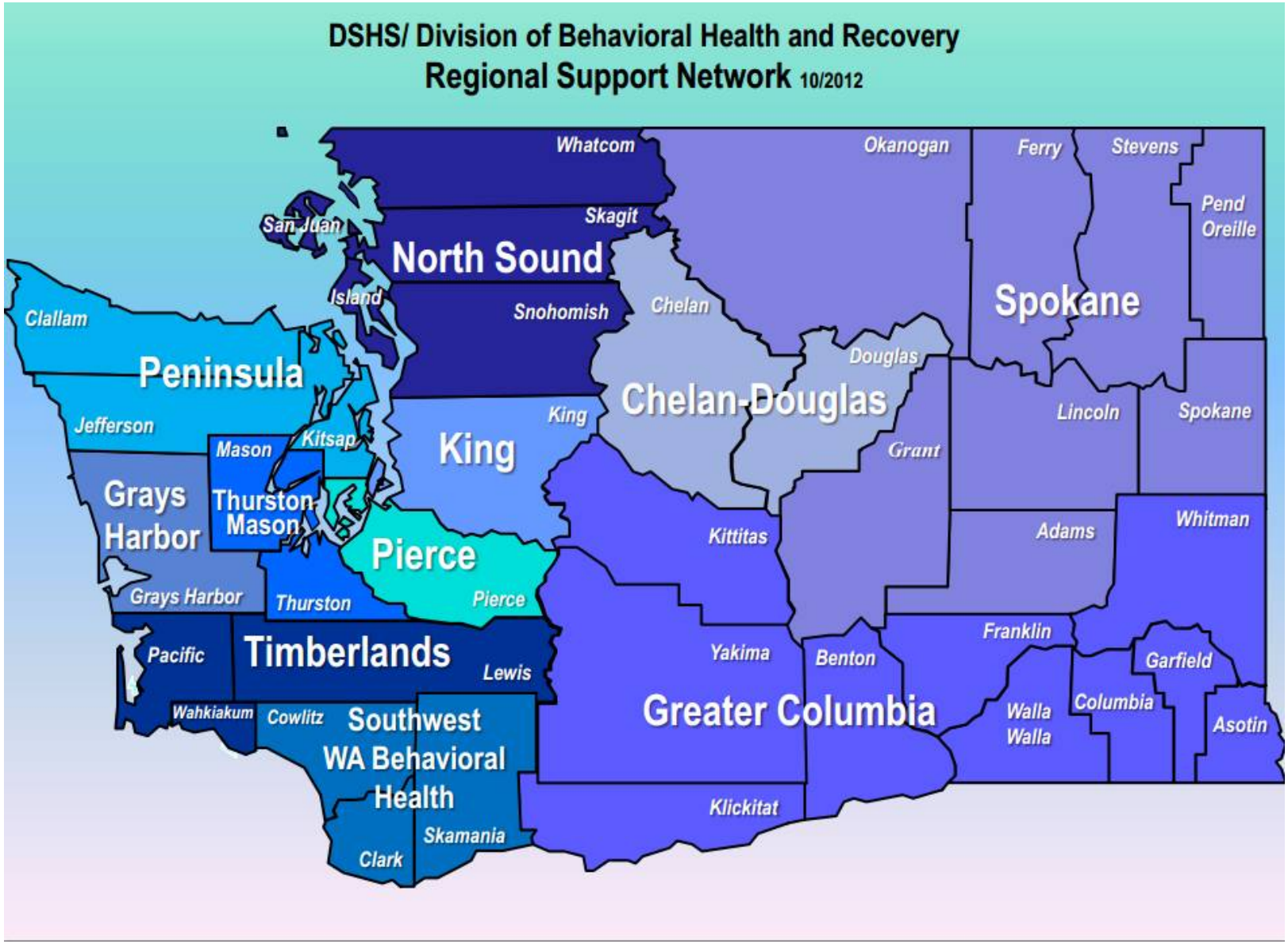
We have named our project "Creating Connections" - what does that mean to you?

What are the most important and helpful things that child welfare staff do when children and youth enter out of home care?

Appendix F: Map of Children's Administration Regions



Appendix G: Map of Regional Service Networks (RSNs)



Appendix H: Data tables with breakdowns by CA Region and RSN

Table 1

	Raw Sample		Weighted Sample	
Variable	**N=148**		**N=143**	
	n	***%***	***n***	***%***
Ever worked as employee of Children's Administration…				
Yes	*10*	6.8	12	8.4
No	*138*	93.2	131	91.6
Years working in children's mental health	Mean=13.11, SD=9.42, Median=11		Mean=13.06, SD=9.54, Median=10	
Percent of caseload who are state dependents	Mean=22.90, SD=25.76, Median=10.0		Mean=25.58, SD=28.19, Median=15	
County in which participant serves clients (check all that apply)				
Adams county	*5*	3.4	4	2.6
Asotin	*3*	2.0	2	1.3
Benton	*11*	7.4	7	4.9
Chelan	*8*	5.4	4	2.5
Clallam	*3*	2.0	3	2.0
Clark	*10*	6.8	14	10.1
Columbia	*6*	4.1	5	3.6
Cowlitz	*8*	5.4	8	5.9
Douglas	*11*	7.4	7	4.7
Ferry	*5*	3.4	2	1.7
Franklin	*11*	7.4	7	4.6
Garfield	*4*	2.7	3	2.1
Grant	*7*	4.7	4	2.9
Grays Harbor	*5*	3.4	4	2.9
Island	*5*	3.4	5	3.5
Jefferson	*5*	3.4	4	2.6
King	*16*	10.8	57	39.8
Kitsap	*8*	5.4	15	10.6
Kittias	*11*	7.4	5	3.6
Klickitat	*3*	2.0	2	1.4
Lewis	*7*	4.7	8	5.4
Lincoln	*5*	3.4	1	1.0
Mason	*7*	4.7	6	4.1
Okanogan	*3*	2.0	2	1.3
Pacific	*5*	3.4	3	2.0
Pend Oreille	*4*	2.7	2	1.7
Pierce	*11*	7.4	28	19.3
San Juan	*4*	2.7	4	2.6
Skagit	*7*	4.7	8	5.5
Skamania	*3*	2.0	2	1.4

Snohomish	*15*	10.1	34	23.6
Spokane	*45*	30.4	26	17.8
Stevens	*17*	11.5	6	4.2
Thurston	*11*	7.4	13	8.9
Wahkiakum	*1*	0.7	1	0.6
Walla Walla	*6*	4.1	5	3.4
Whatcom	*10*	6.8	11	7.6
Whitman	*2*	1.4	2	1.3
Yakima	*31*	20.9	17	11.6

Table 2: Types of information routinely provide to CA case workers about mental health treatment (Question 3)

	DSHS Region 1				DSHS Region 2			DSHS Region 3							State-wide	Statewide weighted
	Chelan-Douglas	Greater Columbia	Spokane	**Overall**	King	North Sound	**Overall**	Grays Harbor	Peninsula	Pierce	Thurston Mason	Timberlands	SW	**Overall**		
N	11	47	62	**106**	16	19	**27**	5	10	11	12	9	13	**32**	148	148
Variable	%	%	%	**%**	%	%	**%**	%	%	%	%	%	%	**%**	%	%
Diagnosis and treatment recommendations	55	77	73	76	88	84	89	60	80	64	67	78	77	78	79	82
Treatment progress updates	64	75	73	**76**	81	79	**82**	60	80	64	67	67	69	**78**	78	78
Crises and safety plans	55	57	58	**57**	81	74	**78**	60	80	73	50	56	62	**69**	62	72
Missed appointments	46	55	48	**52**	56	58	**59**	60	70	55	58	56	69	**72**	57	58
Recommendations regarding current living situation	55	40	32	**35**	56	42	**48**	40	50	73	42	33	31	**38**	35	39
Recommendations regarding permanency	36	28	19	**22**	56	32	**44**	20	30	64	42	22	23	**34**	25	39
Recommendations regarding visitation	46	26	19	**24**	44	37	**41**	20	30	64	42	22	23	**34**	26	33
Other	18	21	29	**23**	25	16	**15**	20	40	45	25	11	38	**38**	23	25
None of the above	18	9	6	**7**	6	5	**4**	20	10	9	17	11	8	**6**	5	3

Table 3: Sources of information regularly received by MHP about state dependent children and youth for case assessment and planning (Question 4)

	DSHS Region 1				DSHS Region 2			DSHS Region 3							State-wide	Statewide weighted
	Chelan-Douglas	Greater Columbia	Spokane	**Overall**	King	North Sound	**Overall**	Grays Harbor	Peninsula	Pierce	Thurston Mason	Timberlands	SW	**Overall**		
N	11	47	62	**106**	16	19	**27**	5	10	11	12	9	13	**32**	148	148
Variable	%	%	%	**%**	%	%	**%**	%	%	%	%	%	%	**%**	%	%
Foster parent/kinship caregiver	73	64	60	**65**	56	53	**59**	60	50	55	58	56	69	**69**	67	69
FTDM, shared planning, or other case meetings	46	43	34	**40**	50	37	**44**	20	40	64	50	22	54	**50**	41	45
Consultation with caseworker	36	32	32	36	38	63	56	20	40	45	33	44	23	41	41	43
Other assessment	27	38	32	**35**	50	53	**48**	40	30	45	50	33	38	**31**	35	40
Diagnosis and medications from medical professional	36	62	50	**59**	25	53	**41**	40	30	36	42	33	38	**44**	55	40
Biological parents	27	32	15	**23**	19	26	**26**	40	30	36	42	44	46	**41**	27	28
BRS or CPA staff	18	21	16	**18**	38	47	**41**	40	30	45	42	33	38	**34**	22	28
CASA reports	46	28	18	**24**	31	21	**22**	20	10	18	42	22	54	**28**	24	26
Individual service and safety plans	36	30	29	**29**	38	47	**41**	40	40	45	42	33	31	**25**	28	25
CHET screening	18	6	5	**3**	25	21	**19**	40	20	27	25	22	31	**16**	5	7

Table 4: Usefulness of information regularly received by MHP about state dependent children and youth for case assessment and planning (Question 5)

	DSHS Region 1				DSHS Region 2			DSHS Region 3							State-wide	State-wide weighted
	Chelan-Douglas	Greater Columbia	Spokane	Overall	King	North Sound	Overall	Grays Harbor	Peninsula	Pierce	Thurston Mason	Timberlands	SW	Overall		
N	11	47	62	106	16	19	27	5	10	11	12	9	13	32	148	148
Variable	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Diagnosis and medications from medical professionals																
Useful	82	89	95	93	100	100	100	100	100	100	92	100	85	94	95	96
Not useful	9	2	2	2	0	0	0	0	0	0	8	0	8	3	1	1
Don't know	9	9	3	5	0	0	0	0	0	0	0	0	8	3	4	3
Foster parent/kinship worker																
Useful	100	98	95	96	100	95	96	100	100	91	100	100	100	97	96	95
Not useful	0	0	2	1	0	0	0	0	0	0	0	0	0	0	1	0
Don't know	0	2	3	3	0	5	4	0	0	9	0	0	0	3	3	5
FTDM, Shared Planning, or other meetings																
Useful	91	89	89	91	88	84	89	80	90	82	75	78	77	88	91	93
Not useful	0	2	5	3	6	5	4	0	0	9	8	0	8	3	2	2
Don't know	9	9	6	93	6	11	7	20	10	9	17	22	15	9	7	5
Consultation with caseworker																
Useful	100	91	94	93	94	100	96	100	100	100	100	100	92	97	93	92
Not useful	0	0	2	1	0	0	0	0	0	0	0	0	0	0	1	0
Don't know	0	9	5	7	6	0	4	0	0	0	0	0	8	3	6	8
Individual service and safety plans																
Useful	100	89	84	86	94	100	96	100	100	100	92	89	85	88	87	88
Not useful	0	2	3	3	0	0	0	0	0	0	0	0	0	0	2	0
Don't know	0	9	13	11	6	0	4	0	0	0	8	11	15	13	12	12
Other assessment																
Useful	82	85	89	90	88	95	93	80	80	82	92	89	92	88	90	87
Not useful	0	0	2	1	0	0	0	0	0	9	0	0	0	3	1	3
Don't know	18	15	10	91	13	5	7	20	20	9	8	11	8	9	9	10
CASA reports or consultation																
Useful	91	77	89	84	94	74	82	80	80	91	83	78	85	84	83	86
Not useful	0	2	2	2	0	0	0	0	0	0	0	22	0	0	1	0
Don't know	9	21	10	86	6	26	19	20	20	9	17	0	15	16	16	14
BRS or CPA staff																
Useful	92	66	77	74	88	84	85	80	80	91	92	78	92	88	77	84
Not useful	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Don't know	9	34	23	26	13	16	15	20	20	9	8	22	8	13	23	16

Biological parents																
Useful	63	83	73	79	75	89	82	80	70	82	75	67	77	75	80	79
Not useful	18	4	5	3	13	5	7	20	10	18	8	11	0	6	2	2
Don't know	18	13	23	18	13	5	11	0	20	0	17	22	23	19	18	19
CHET screening																
Useful	64	55	63	58	81	63	63	100	90	91	75	78	54	69	57	58
Not useful	9	4	3	4	0	11	7	0	0	9	25	11	23	16	7	9
Don't know	27	40	34	39	19	26	30	0	10	0	0	11	23	16	35	33

Table 5: Satisfaction with the amount and quality of information and/or process by which information is shared back-and-forth between MH agency and CA (Question 7)

	DSHS Region 1				DSHS Region 2			DSHS Region 3							State-wide	Statewide weighted
	Chelan-Douglas	Greater Columbia	Spokane	**Overall**	King	North Sound	**Overall**	Grays Harbor	Peninsula	Pierce	Thurston Mason	Timberlands	SW	**Overall**		
N	11	47	62	**106**	16	19	**27**	5	10	11	12	9	13	**32**	148	148
Variable	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Mental health treatment you provide	4.5	4.5	3.9	4.2	4.2	4.3	4.2	4.3	4.4	4.5	4	4	4.2	4.3	4.2	4.1
Progress made by clients in treatment	4.4	4.3	3.7	4	4	4	4	4	4.2	4.2	3.7	4	4.2	4.3	4	4
Assessments of functioning done by MH and shared with CA	4.3	4.1	3.5	3.7	3.9	3.9	3.9	3.7	3.8	4.3	3.9	4	3.9	3.9	3.7	3.7
Ongoing information from caregiver that could help inform treatment approach	3.7	3.9	3.6	3.7	3.5	3.7	3.6	4.3	4.2	3.4	4	3.9	3.8	3.8	3.7	3.6
Reasons for referral to treatment, including information from CA screenings or assessments	3.6	3.1	3.2	3.2	3.5	3.7	3.4	4.7	3.8	3.9	3.4	3.6	3.1	3.4	3.2	3.2
Ongoing information from caseworker that could help inform treatment	3.7	2.8	2.5	2.7	2.9	3.1	3	3	3.1	3.3	3	3.2	2.6	3.1	2.8	2.9

Likert Scale: 1=Not at all; 2=Slightly; 3=Somewhat; 4=Moderately; 5=Extremely

Table 6: Characteristics of Child Welfare Focus Group Participants

Characteristic	N	%	Characteristic	N	%
Sex			**Race**		
Female	105	82.7	White/Caucasian	92	72.4%
Male	22	17.3	Multiracial	13	10.2%
			African American	11	8.7%
Role			Hispanic	6	4.7%
CFWS	46	36.2%	Asian	5	3.9%
Supervisors	23	18.1%			
CHET SW	10	7.9%	**Office**		
CPS	9	7.1%	Spokane	10	7.9%
FVS	4	3.1%	Toppenish	10	7.9%
Intern	4	3.1%	Bellingham	8	6.3%
CFWS ICW	3	2.4%	OICW	7	5.5%
AA	2	1.6%	Region 1 Regional Employee	7	5.5%
Adoptions SW	2	1.6%	Tri Cities	7	5.5%
FAR Lead	2	1.6%	Tumwater	7	5.5%
FRS / FVS	2	1.6%	Colfax	6	4.7%
FTDM Facilitator	2	1.6%	Port Angeles	6	4.7%
Practicum Student	2	1.6%	Smokey Point	6	4.7%
Program Consultant	2	1.6%	Aberdeen	5	3.9%
CFWS / CPS SW	1	0.8%	Kent	5	3.9%
CFWS / FVS	1	0.8%	Martin Luther King JR	5	3.9%
Contracts	1	0.8%	Tacoma	5	3.9%
Courtesy SW	1	0.8%	Vancouver	5	3.9%
Did not specify	1	0.8%	Wenatchee	5	3.9%
DLR	1	0.8%	Bremerton	4	3.1%
EBP and Placement Coordinator	1	0.8%	Moses Lake	4	3.1%
Family Treatment Court	1	0.8%	Region 2 Regional Employee	4	3.1%
Fiscal	1	0.8%	Clarkston	2	1.6%
FRS	1	0.8%	Ellensburg	2	1.6%
Placement Coordinator	1	0.8%	Region 3 Regional Employee	2	1.6%
RSN - MH Liasion	1	0.8%	Yakima	2	1.6%
Secretary Supervisor	1	0.8%	Goldendale and White Salmon	1	0.8%
SSI Facilitator	1	0.8%	Sunnyside	1	0.8%
			Wenatchee / Omak	1	0.8%

Table 7: Characteristics of Child Welfare Exit Survey Participants

Variable	*n=116*	%
Gender		
Male	*19*	16.4
Female	*96*	82.9
Missing	*1*	.9
Have you ever worked as a mental health provider?		
Yes	*36*	31.0
No	*80*	69.0
Office where focus group held (in order of occurrence)		
King South	*8*	6.9
MLK	*7*	6.0
Wenatchee	*6*	5.2
Tumwater	*7*	6.0
Aberdeen	*5*	4.3
Spokane	*14*	12.1
Colfax	*6*	5.2
Bremerton	*5*	4.3
OICW	*7*	6.0
Smokey Point	*6*	5.2
Tri Cities	*7*	6.0
Toppenish	*13*	11.2
Tacoma	*6*	5.2
Vancouver	*5*	4.3
Bellingham	*8*	6.9
Port Angeles	*6*	5.2
Regional Support Networks represented by focus group location (alphabetical)		
Chelan-Douglas	*6*	5.2
Grays Harbor	*5*	4.3
Greater Columbia	*26*	22.4
King	*22*	19.0
North Sound	*14*	12.1
Peninsula	*11*	9.5
Pierce	*6*	5.2
Southwest	*5*	4.3
Spokane	*14*	12.1
Thurston-Mason	*7*	6.0
Timberlands	*0*	0.0
Years working in field	**Mean**= 12.80 **SD**=8.50 **Median**= 12.00	
Years working in current position	**Mean=** 4.94 **SD=** 4.90 **Median=** 4.00	

Table 8: Quantitative Results from the Child Welfare Exit Survey

	DSHS Region 1				DSHS Region 2			DSHS Region 3							State-wide	ANOVA	
RSN	Chelan-Douglas	Greater Columbia	Spokane	**Overall**	King	North Sound	**Overall**	Grays Harbor	Peninsula	Pierce	Thurston Mason	Timberlands	SW	**Overall**			
N	6	26	14	46	22	14	36	5	11	6	7	0	5	34	116	116	
Variable	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*F*	*P*
Satisfaction with current CHET screening process	3.5	**3.5**	**4.1**	**3.7***	**4.0**	**4.7**	**4.3***	**4.0**	**3.4**	**3.8**	**4.6**	**n/a**	**4.0**	**3.9**	**3.9**	3.80	*0.03*
Comfort discussing treatment options with MHP	3.8	3.7	3.3	**3.6**	3.6	3.5	**3.6**	3.5	3.6	4.0	3.7	n/a	4.0	**3.7**	3.6	0.17	*0.84*
Extent of impact on caregiver follow-through with referral	4.0	3.3	4.0	**3.6**	3.5	3.7	**3.5**	3.2	3.7	4.0	3.2	n/a	4.2	**3.7**	3.6	0.19	*0.82*
Comfort describing child/youth treatment options to caregivers	4.2	3.4	3.5	**3.5**	3.5	3.1	**3.3**	2.9	3.6	4.0	3.1	n/a	4.4	**3.6**	3.5	0.60	*0.55*
Satisfaction with current process for sharing CHET results with MHP	3.7	3.3	2.4	**3.1***	3.8	4.0	**3.9***	3.0	3.7	3.6	3.7	n/a	3.3	**3.5**	3.4	5.03	0.01
Extent of impact on caregiver participation with services	3.9	3.4	3.2	**3.4**	3.1	3.3	**3.2**	3.0	3.4	4.2	3.1	n/a	4.0	**3.5**	3.4	0.94	0.39
Current mental health system meets needs of children/youth	3.5	2.6	2.9	**2.8**	3.2	3.0	**3.1**	2.4	2.9	3.3	3.6	n/a	3.0	**3.1**	3.0	2.21	0.11
Satisfaction with current level of	4.3	2.5	2.5	**2.7**	2.6	3.0	**2.7**	2.2	2.7	2.2	3.1	n/a	3.6	**2.8**	2.8	0.17	0.85

communication regarding referral																
Satisfaction with amount and quality of information received regarding treatment	3.8	2.5	2.7	**2.8**	2.4	2.4	**2.4**	2.0	2.3	2.5	2.9	n/a	3.8	**2.5**	2.6	1.07	0.35
Satisfaction with amount and quality of information received regarding assessments of functioning	3.5	2.5	2.5	**2.6**	2.5	2.6	**2.6**	2.2	2.6	2.3	2.8	n/a	2.8	**2.5**	2.6	0.19	0.82
Satisfaction with amount and quality of information received regarding child/youth progress	3.5	2.4	2.5	**2.6**	2.1	2.3	**2.2**	2.2	2.5	2.7	2.4	n/a	3.3	**2.5**	2.4	1.06	0.35

*indicates Region 1 and Region 2 differ significantly at $p < .05$ within each variable using between-group post-hoc Least Significant Difference tests.

Likert Scale: 1=Not at all; 2=Slightly; 3=Somewhat; 4=Moderately; 5=Extremely

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