Beyond Child Protection: Promoting Mental Health for Children and Families in the Child Welfare System

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Journal of Emotional and Behavioral Disorders 2003; 11; 49
DOI: 10.1177/106342660301100107

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Promoting Mental Health for Children and Families in the Child Welfare System

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The child welfare system is in a period of significant reform that offers both opportunities and challenges regarding more effective collaboration between the mental health and child welfare systems. In this article we examine recent federal, state, and local initiatives that have influenced child welfare policy and practice on a national scale, with particular emphasis on those policies that offer opportunities for better coordination of services between mental health and child welfare agencies. To plan for effective services, mental health policy makers and practitioners must be cognizant of available funding streams for child welfare, trends and innovations within the child welfare system, the contextual factors that shape services to the children and families who are under its supervision, and the special characteristics of the population that it serves.

THE CHILD WELFARE SYSTEM IS charged with the protection, placement, and well-being of children who are abused or neglected or whose parents are otherwise unable to care for them. In this article, we outline recent federal, state, and local initiatives that have influenced child welfare policy and practice on a national scale, particularly those that offer opportunities for organizing services that target the enhancement of child well-being in the area of mental health. We also address issues specific to the child welfare population that should be considered as policy makers and service providers design and implement services to support the mental health and well-being of children and families.

The child welfare system is in a period of significant reform, and mental health policy makers and providers should be cognizant of areas where the child welfare and mental health systems intersect as new approaches to services are developed for these vulnerable children and families. Although it may be argued that child welfare personnel must concentrate a disproportionate amount of their available time and resources on ensuring child safety and on seeking permanent placements, promoting child well-being is an expressed goal of child welfare services, and the provision of appropriate mental health services is critical to meeting that goal. Strong linkages between the child welfare and mental health systems are requisites for a child welfare agenda that places primacy on the emotional well-being of maltreated and abandoned children.

THE CHILD WELFARE SYSTEM IN CONTEXT

Despite more than a century of federal and state initiatives to prevent and reduce child maltreatment, it still remains a prominent social policy concern. The most recent national data, summarizing state reports for 1999, reported estimates that 826,000 children nationwide had substantiated reports of maltreatment, reflecting a victimization rate of 11.8 per 1,000 children (U.S. Department of Health and Human Services [U.S. DHHS], Administration on Children, Youth and Families [ACYF], 2001a). The majority of these children (58.4%) were victims of child neglect, followed by physical abuse (21.3%), and sexual abuse (11.3%). Most children who come into contact with the child welfare system remain at home, although substantial numbers are placed in foster care. For 1999, national estimates were that 171,000 child victims of maltreatment (20.7%) experienced foster care placement, while an additional 49,000 children whose cases were unsubstantiated were placed out of home (U.S. DHHS, ACYF, 2001a).

In addition to the developmental risks posed by the trauma of abuse or neglect, children in the system often face the

challenges of poverty; poor housing and neighborhood conditions; and adverse family circumstances, including substance abuse, mental illness, and domestic violence within the family. Given these circumstances, it is not surprising that studies tracking the development of children who have been maltreated often find that they experience pervasive problems in adjustment during childhood (Bolger & Patterson, 2001; Eckenrode, Laird, & Doris, 1993; Flisher et al., 1997) and that the negative consequences of maltreatment may persist into adulthood (Cohen, Brown, & Smailes, 2001; Herrenkohl, Egolf, & Herrenkohl, 1997; Widom, 1996). Studies of children placed in foster care commonly find high rates of emotional and behavioral disorders (Barth, Green, Wall, & the NSCAW Research Team, 2001; Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Glisson, 1996; Trupin, Tarico, Benson, Jemelka, & McClellan, 1993), with between half and three quarters of children typically exhibiting signs of emotional or behavioral difficulties. Children in foster care also have been found to consume disproportionate amounts of public mental health dollars (Halfon, Berkowitz, & Klee, 1992; Harman, Childs, & Kelleher, 2000). Although there is evidence to suggest that foster care exerts some protective influences for children (Horwitz, Balestracci, & Simms, 2001; Taussig, Clyman, & Landsverk, 2001), it also is the case that children who have been in foster care are likely to continue to experience adjustment problems as they age into adulthood (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001). For the large number of children who come into contact with the child welfare system but who are not removed from their homes, much less is known about service needs and access to care. Similarly, when children exit the system by adoption, the child welfare system has little knowledge about their development and well-being. It is clear, however, that the needs of these children and families are complex, and access to and utilization of mental health services must be a central component of comprehensive and effective services to the child welfare population.

Child welfare services represent a complex set of policies, regulations, and service initiatives at the federal, state, and local levels. It has been argued that child protection has dominated child welfare services over the past few decades, to the exclusion of more broadly defined efforts targeted toward the well-being of the children and families who are served in the system (American Public Human Services Association, 2001). Nonetheless, the current child welfare system offers a continuum of services, including investigation and screening of child maltreatment reports, supportive and treatment services for maltreating and at-risk families, and temporary or permanent placement of a child into an alternate home or other setting.

Federal Policy Initiatives

Child welfare services are primarily the responsibility of the states (and in some cases, the counties), which have considerable power and authority in defining who is eligible for services and how services are to be provided. State policy development is, however, an interactive process that is shaped not only by the needs and values of the local population and the political forces in the state but also by federal legislation, regulation, resources, and incentives. Judicial actions, community-level efforts, and activities by advocacy groups and charitable organizations also influence how state policy is formulated. Moreover, child welfare policy and other child services policy may evolve along different lines, in response to perceived needs of the populations to be served. The following sections outline some of the major legislative and policy initiatives that have had widespread effects on child welfare policy and practice, highlighting areas where conditions are favorable for building relationships between the child welfare and mental health systems (see also Table 1).

Federal programs provide major sources of revenue for state and local child welfare services, and much of the practice at state and community levels is shaped by the need to comply with legislation and regulations that govern the use of federal funds. In this section, we discuss the major federal initiatives that have broadly influenced child welfare policy and practice and that have stimulated new approaches to child welfare service provision, with particular emphasis on those provisions that have implications for providing mental health services to child welfare clients.

The Adoption and Safe Families Act

Passed by Congress in 1997, the Adoption and Safe Families Act (ASFA) provides an overarching framework for child welfare policy and practice on a national scale, and it clearly sets out "safety, permanence, and well-being" for children as the goals of child welfare services. Shortened timeframes for making decisions about permanent homes for children in foster care ("permanence") are a key feature of ASFA and have resulted from concerns about reports of children spending indefinite lengths of time in foster care. Although "reasonable efforts" must be made to reunify families before parental rights can be terminated, judicial "permanency hearings" no later than 12 months after foster care placement are now required to ensure that children who are unlikely to be able to return home safely can more quickly become eligible for adoption. In addition, the legislation called for states to automatically initiate termination of parental rights for certain groups of children (e.g., children with a foster care stay of 15 out of 22 months, abandoned infants, or children whose parents have committed certain felonies). An emphasis on accountability for child outcomes was a further emphasis of ASFA; the federal government was required to develop performance measures for assessing states' progress on key outcomes related to the ASFA goals.

The provisions of ASFA illustrate some of the tensions between the need to protect children and the mission to promote children's well-being, and they may have important implications for the provision of mental health and other ancillary services. Some practitioners have raised concerns that family conditions that result

TABLE 1
Federal Child Welfare Legislation and Programs

Federal law/program	Key provisions & implications
Adoption and Safe Families Act	Provides guidelines for states receiving federal child welfare funds, including (a) specific time frames to achieve permanent placements; (b) requirements for measuring outcomes; (c) child and family service reviews, which highlight service needs and child well-being; and (d) emphasis on child safety and well-being over family preservation.
Title IV-E, Social Security Act (Foster Care and Adoption Program)	Provides matching funds to states for board and maintenance for low-income children in out-of-home placements and adoption subsidies for children with special needs. States may apply for waivers for demonstration projects that redirect funds toward preventive or treatment services to reduce dependence on foster care.
Title IV-B, Subpart 1 (Child Welfare Services Program)	Federal matching grants to states to provide child welfare services; dollars can be directed toward services that prevent out-of-home placements or toward treatment of health problems or mental disorders arising from child maltreatment.
Title IV-B, Subpart 2 (Promoting Safe and Stable Families)	Grants to states for family support, family preservation, family reunification, and adoption programs. Emphasis on collaborative planning and preventive services offers opportunities for partnerships with mental health and other providers.
Child Abuse Prevention and Treatment Act	Grants to states to develop and implement child protective services; some discretionary funds available for research and demonstration projects.
Title XX (Social Services Block Grant)	Block grants to states for general social services; states often have chosen to use these funds for family preservation and other child welfare services that are not covered under other programs.
Medicaid	Funds health and mental health services for income-eligible children in foster care (and, in some states, all children in foster care). Provides early periodic screening, prevention, diagnosis, and treatment services for eligible children. Major source of funding for mental health screening and services for children in foster care.
Temporary Assistance for Needy Families	States have discretion to use some of their federal welfare funds available for services to low-income children and families.

in out-of-home placement often cannot be ameliorated within the restricted time frames required under ASFA. The "reasonable efforts" for preserving families may require services that are not readily available in a community or that typically are long-term solutions to given problems. In particular, parents with mental health and substance abuse problems may require long-term supports and treatment, and they may find it difficult to complete treatment (even if available) within the allotted time frames (U.S. DHHS, 1999). On the other hand, the need to demonstrate to the courts that reasonable efforts have been made to preserve or reunify families (under most circumstances) may propel child welfare agencies to develop partnerships with other agencies and service providers where their clients will have priority rather than having to compete for services.

States seeking to comply with the shortened ASFA time frames for permanency have increasingly turned to "concurrent planning" strategies, where alternate permanent arrangements (e.g., adoption) are sought for children at the same time agencies are pursuing efforts to reunify families. Child welfare and mental health workers must be aware of the potential effects of those kinds of strategies on parental engagement in the decision-making process and the implications for developing an effective therapeutic alliance between parents and caseworkers or ancillary personnel, including mental health workers.

Although the apparent emphasis of ASFA on safety and permanence may, in some ways, shift attention from a broader conceptualization of the well-being of children and families, ASFA also could serve to motivate states to strive for more balance in their efforts through its emphasis on accountability. As state performance and outcome measures were developed, almost all states recognized the need to create measures that would better capture outcomes related to child well being, such as educational status and social and emotional development. Although the definitions, data sources, and data elements for these types of outcomes

are not well-established, states' commitments to developing such measures were clear (U.S. DHHS, 1998), suggesting that states are beginning to embrace child well-being as a central part of their mission.

The emphasis on outcomes in ASFA also is promoted through the new Child and Family Service Review (CFSR) process, which provides federal monitoring of state performance on key outcomes. An important feature of CFSR is the review of individual case plans and the extent to which those plans are carried out. Access to appropriate mental health services is an explicit outcome that is specified in the review process, and early site visits for the reviews indicated that access to and availability of ancillary community services, such as mental health services, was a key concern for local agency personnel (Mitchell, Milner, & Hornsby, 2002). The emphasis in the CFSR on child well-being and the appropriate and timely provision of services may serve as a further impetus for agencies to develop stronger relationships with mental health and other service providers.

Title IV-E of the Social Security Act

The Title IV-E Foster Care program provides for board and maintenance costs for eligible low-income children who are placed in foster care, and it is by far the largest funding stream for children who are in the child welfare system, with more than $5 billion appropriated for 2001. Matching federal payments are provided to states for board and care, administrative costs, and training costs related to foster care. Title IV-E funds cannot, however, be used to provide *services* to the children or their families, which has led to concerns that IV-E requirements have created an incentive for states to choose foster care placement rather than develop preventative services or services designed to keep families together (American Public Human Services Association, 2001).

Many policy makers, administrators, and advocates have increasingly pressed for more state and local discretion in the use of Title IV-E funds. In response to these pressures, states in recent years have been permitted to apply for waivers from certain provisions of Title IV-E; states with waivers are developing innovative strategies for using funding more flexibly to provide services designed to prevent foster care placement or to reduce time in care by facilitating reunification or adoption. These waivers present an important avenue for developing coordinated systems of care that include mental health services in the mix. Of the 22 states that have obtained Title IV-E waivers, more than half have reallocated the funds to enhance collaborative systems of care, and in most cases, partnerships with mental health services are formally specified in the plans. Because credible program evaluation is required as a condition of the waivers, these demonstrations have the potential to break new ground in the development of evidence-based practices and approaches to multidisciplinary, collaborative, cross-agency service delivery at the community level.

Medicaid

Medicaid is the largest source of funding for services (as opposed to board and maintenance) for children in the child welfare system. Children in foster care who are eligible for Title IV-E board and maintenance funds (and in some states, all children in foster care) are automatically entitled to Medicaid, which allows access to health and mental health services as well as early periodic screening, diagnosis, and treatment. These children are disproportionately high users of Medicaid services; studies have found that they use 4 to 10 times the amount of services that would be expected, given their numbers in the Medicaid population (Halfon et al., 1992; Harman et al., 2000; U.S. DHHS, 2000a). As Medicaid increasingly employs managed-care strategies for service provision, child welfare clients are likely to experience the same difficulties in access to services that have been reported for other mental health clients (Pires, Stroul, & Armstrong, 2000). Harman and colleagues have suggested that foster children are unlikely to receive adequate mental health care under managed-care arrangements unless special rates are set that take into account the higher needs and the costs that are likely to be incurred.

Children in the child welfare system might not always receive Medicaid benefits to which they are entitled. Although children appear to be linked with Medicaid while in foster care, between one third and one half of children in a three-state U.S. DHHS study (2000a) no longer received Medicaid services upon leaving foster care. The same study found that many agencies spent their own funds instead of accessing Medicaid for mental health services; Landsverk, Rolls, and the CCCW Research Team (2001) reported a similar finding in a nationally representative survey of local child welfare agencies. There also is evidence that systematic screening and assessment for mental health problems are not available in most agencies (Landsverk et al., 2001), even though high rates of developmental and emotional disorders are a well-established fact among foster care populations. Utilization of the early periodic screening, diagnosis, and treatment program under Medicaid is lower than might be expected (U.S. DHHS, 2000a), in spite of a number of recent calls by professional and advocacy organizations for more systematic health, mental health, and developmental screenings for children in the child welfare system (American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care, 2000; Dale, Kendall, & Schultz, 2001). Efforts to improve mental health services to child welfare clients should involve attention to better linkage and improved access for children and families to the services for which they are entitled, with a particular focus on transitions in and out of foster care, when access to benefits and care may be disrupted.

Promoting the Safe and Stable Families Act

The Family Preservation and Family Support Act of 1993 was reauthorized under ASFA, and renamed the Promoting Safe

and Stable Families Act (Title IV-B, Subpart 2 of the Social Security Act). This program provides funding directly to states to develop preventative services designed to reduce the chances that a child will need to be placed in foster care, and it calls for a collaborative planning process within states to involve key stakeholders in the planning and implementation of family preservation, family support, reunification, and adoption services. Responding to requirements in the initial Family Preservation and Family Support Act legislation, most states were able to convene a broad array of policy makers, providers, and advocacy groups for this purpose, and in many states, mental health providers and advocates were active partners in these collaborations. Given the opportunity, states have chosen to use a majority of the available funding to develop community-based, preventative, and family support services rather than the more traditional child welfare services. The 2002 reauthorization of the program continued the emphasis on preventative services and flexibility to meet community needs. The Promoting Safe and Stable Families Act program represents an excellent opportunity for mental health professionals and advocates to forge meaningful partnerships with child welfare agencies at the state and local levels.

Other Federal Programs

Funding also is available for preventative and treatment services through the child welfare system via other federal programs, and mental health-related services may be a part of the way states choose to use these funds. The Child Abuse Prevention and Treatment Act allows for grants to the states to help to fund child protective services, as well as grants for community-based family support and family resource programs that are designed to prevent child maltreatment. The Child Welfare Services Program (Title IV-B, Subpart 1 of the Social Security Act) authorizes matching grants to states for services that protect children, with an emphasis on services that prevent abuse, neglect, or delinquency. States have used the Social Services Block Grant Program as a source of flexible funding for child welfare and other social services, although these funds have steadily diminished over the past few years. Welfare funds available to the states through the Temporary Assistance for Needy Families program also may be available to provide mental health and other services to child welfare clients. Still, federal funds available for preventative and treatment services lag far behind monies available for placement (Rosenbaum, 2001). For example, Bess, Leos-Urbel, and Geen (2001) found that in 1998, states expended $4.5 billion in federal funds for out-of-home placements, $686 million for adoption, and $412 million for administration, while expending $707 million for other services to child welfare clients.

Summary

In recent years, federal policy has shifted toward increased emphasis on child well-being, flexible funding, and accountability. States' efforts to comply with federal laws and regulations have spurred reforms that should provide fertile ground for the growth of new partnerships and collaborations with other child-serving entities, including mental health. Federal requirements now call for state plans that integrate planning for the use of the Child Abuse Prevention and Treatment Act program, Title IV-B, Title IV-E, and other federal child welfare funds. Integrated planning should afford new opportunities for providing a continuum of services, from prevention to out-of-home placement, that should include needed support services such as mental health and substance abuse treatment for children and their parents. Mental health providers who are knowledgeable about the potential uses of child welfare funding streams can be more involved in the planning process.

Shaping Policy at the State and Local Levels

Although federal laws and regulations provide guidance and minimum standards for key aspects of service provision, the day-to-day work of child welfare takes place at the state and local levels, and states and communities have considerable autonomy and discretion in deciding how to implement services. This local decision-making authority is manifested in substantial variations across states and localities in terms of how child welfare services are provided and to whom. Nonetheless, some common elements and practices have emerged across states, as well as some major policy and practice trends that are highly influential on a national basis. The following section highlights relatively recent reforms and innovative practices arising from the state and local levels that are of national significance and that also offer opportunities and challenges regarding integrating mental health services into a changing system.

Child Protective Services Reform

Traditionally, the mission of Child Protective Services has been to investigate and substantiate reports of child maltreatment and to take actions to protect children when safety is compromised. Newer approaches to protective service systems offer needed services to families in a non-adversarial framework, and they present important opportunities for child welfare and mental health partnerships. In recent years, some state and local Child Protective Services agencies have experimented with more flexible, "two-track" models of child protection. In general, these models emphasize assessment and service provision in those cases where the reports of maltreatment appear to be less serious and do not represent an ongoing threat to the child's safety while continuing to provide for investigations of, and appropriate action for, more serious cases of maltreatment. The evaluation of a Child Protective Services "two-track" project in Missouri showed that workers in demonstration counties referred families to community resources more often than those in the comparison counties. In particular, there were about twice as many referrals for mental health services in the demonstration counties (41% vs. 20%), and workers in those counties rated service coordina-

tion as being higher than did those in the comparison counties (Siegel & Loman, 1997).

Managed Care in Child Welfare Services

Child welfare agencies are increasingly borrowing principles of managed care from the health-care system for reforming the organization and financing of child welfare services. Generally speaking, managed care in child welfare settings has involved giving providers financial incentives for using available funds to reduce the number and duration of out-of-home placements while the public agency maintains varying degrees of control over standards, performance goals, and quality assurance. Many, but not all, such initiatives include the provision of mental health services. For example, of the 25 child welfare agencies studied as part of the Health Care Reform Tracking Project (Schulzinger, McCarthy, Irvine, Meyers, & Vincent, 1999), 22 offered mental health services as part of their managed care reforms. Of those, most provided an array of mental health services, including home- and community-based services, outpatient treatment, residential and day treatment, and therapeutic foster care.

Managed care principles may offer opportunities for flexibility of funding and the provision of preventative and supportive services, and the emphasis on outcomes and performance may be a positive force in encouraging access to mental health and other services. Kahn and Kamerman (2000), however, have pointed out that the cost efficiencies that are the driving force behind managed care are best achieved in large organizational structures. This may drive managed-care entities away from systems-of-care principles, which promote community-based services that are responsive to local needs and preferences.

Kinship Care

Mental health policy makers and practitioners who deal with child welfare clients must increasingly shape their services to address the specific needs of children who are in formal and informal out-of-home placements with relatives. In most states, placement with relatives has become the preferred alternative for children who are removed from their parents' care, and this preference is reflected in both state and federal legislation. Relative placement, or kinship care, now accounts for just over a quarter of child placements (U.S. DHHS, 2000b). Although kinship care may have a number of advantages for children (Benedict, Zuravin, & Stallings, 1996; U.S. DHHS, Children's Bureau, 1998), concerns have been raised about the type of care children receive in kinship settings. Kin caregivers are likely to be older, less educated, and have access to fewer resources than traditional foster parents (U.S. DHHS, Children's Bureau, 1998), including minimal training on caring for children (U.S. DHHS, ACYF, 2001b; U.S. DHHS, Children's Bureau, 1998). In addition, children in relative care are less likely to be reunified with their birth parents (U.S. DHHS, 2000b). There is evidence that both kinship families and the children in their care are less likely to be offered, or to request, supportive services, including mental health and substance abuse services, during the child's placement (Berrick, Borth, & Needell, 1994; U.S. DHHS, Children's Bureau, 1998; U.S. DHHS, 2000b). This potential lack of access to services for such a large group of children is troubling, and child welfare and mental health workers must become more proactive in seeking ways to serve this group.

Court Reforms

Local juvenile dependency and family courts play a critical role in decisions that are made about children and families who are in the child welfare system. Mental health providers who work with child welfare clients must endeavor to become familiar with local court issues and procedures. Indeed, mental health personnel may be extremely useful advisors to court personnel in their decision-making processes. Effective decision making in the courts has been impeded by large caseloads that limit the amount of time a judge can spend on an individual case, mistrust and lack of coordination between courts and child-serving agencies, inadequate information systems, and a lack of training for judges in child development and issues surrounding child maltreatment (U.S. General Accounting Office, 1999). In recent years, federal grants have been made to state court systems for Court Improvement Projects, which have used a wide variety of strategies to improve the capacity of local courts to make decisions that best serve the interests of the children who come before them. In addition to Court Improvement Projects, some states and localities have been experimenting with "drug courts" and "mental health courts," which are able to focus on therapeutic needs of parents while still maintaining the ability to apply sanctions and other legal remedies for protecting and placing children of those parents who are unwilling or unable to comply with the agreed-upon treatment regimens. Mental health providers and policy makers can seek to become active participants in these kinds of reforms, and they can help to shape court actions in accordance with principles that promote child and family mental health.

Litigation

Numerous state child welfare agencies have been the target of litigation aimed at improving the timeliness and appropriateness of child welfare and ancillary services to children in custody. States often will settle such suits with consent decrees in which all parties agree to conditions that bring about changes in the child welfare system. The outcomes of these efforts have been uneven, but some have brought about promising collaborative relationships among child-serving agencies. In Alabama, for example, the 1991 settlement of *RC v. Hornsby* resulted in systems-level reform that has as its basis a commitment to building and implementing individualized case plans for children. This reform has brought about collaboration among all child-serving agencies, including mental health, to meet the unique needs of children and families (Bazelon Center for Mental Health Law, 1998). Although litigation has by no means been

uniformly successful in producing the desired goals, these kinds of actions can result in sweeping changes in the way mental health and other services are provided to child welfare clients.

Family Involvement in Decision Making

Certain aspects of child welfare practice may contrast sharply with principles of child mental health service provision, which place the parent in the central role for decision making about services. Although family-centered services often are said to be the foundation of social work practice, many challenges exist concerning effecting true family participation in service planning and implementation for child welfare clients. Investigations through Child Protective Services, and decision making about placements that may result in removal from parental custody or even termination of parental rights, are inherently adversarial. Moreover, it has been estimated that between one third and two thirds of parents whose children are involved in the child welfare system have problems with substance abuse (U.S. DHHS, 1999), and those parents may have difficulty exercising judgment about appropriate services for their children.

Nonetheless, a number of practices arising from child welfare settings may promote more meaningful parental involvement, at least in cases where imminent harm to the child is of less concern. The Child Protective Services "two-track" system noted previously, in which assessment and services are offered to families who otherwise might have been subjected to investigation, is one example. A second promising strategy, which is being widely adopted, is family group conferencing. Developed in New Zealand, family group conferencing brings together family members and other key individuals in the child's life, along with community members, agency personnel, and service providers, to determine the case plan for the child. At the same time, abusers are held accountable for their actions, and a specific plan for ensuring child safety is required. The central assumption is that families who are involved in the development of the case plan will be more invested in seeing that it is implemented. Some states, such as North Carolina, have developed statewide plans for implementation of family group conferencing. Children's mental health service providers, who may have more experience with family involvement in case planning, have the potential to take a central role in helping families benefit fully from child welfare initiatives such as these.

Summary

State and local practices are at the core of child welfare service delivery, and mental health providers and policy makers who wish to enhance relationships with child welfare organizations must be cognizant of the local environment in which child welfare operates and of specific trends and emphases in child welfare services that offer avenues for promoting collaborations. Promising innovative practices arising at the state and local levels often are quickly adapted on a national scale. Nonetheless, although many commonalities exist across agencies, child welfare agencies operate in diverse ways. Child welfare administrators and practitioners often are dealing with multiple levels of regulation, oversight, and scrutiny from grassroots advocacy groups and the local press, from state and local planning bodies, and from the courts and state legislatures. Understanding the complexity of these relationships and pressures is essential for identifying those areas where the interests and practices of mental health and child welfare agencies converge.

Special Issues for Child Welfare Clients

The previous sections have focused on policies arising primarily at the federal and state levels. In thinking about how the implementation of these policies might be carried out to maximize the integration of mental health and child welfare services and to build effective systems of care, one must take into account the specific characteristics and needs of the child welfare population. In the following section, we address some of the unique population characteristics that have implications for the effective integration of child welfare and mental health services.

Race and Culture

Disproportional representation of children of color in the child welfare system is receiving increased scrutiny. In particular, African American children are overrepresented in the foster care system compared to their numbers in the population, but they may be underrepresented in preventive or treatment services (Courtney et al., 1996; U.S. DHHS, Children's Bureau, 1997). In a study exploring mental health service use of children in foster care, Garland and Besinger (1997) found that African American and Hispanic children were less likely than Caucasian children to have participated in mental health treatment before and after removal from their homes. This supports evidence from other fields, such as juvenile justice and education, about the differential patterns of mental health utilization by specific ethnic groups (McCabe et al., 1999).

The confluence of the evidence reflects a need for enhancing the use of mental health services by minority children and families in the child welfare system. Both mental health and child welfare service providers must make special efforts to identify barriers to services for minority families and to ensure that these families are linked with appropriate mental health services when necessary. Moreover, these children and families must have access to mental health services that address their unique cultural needs and incorporate culturally sensitive strategies for recruitment and intervention, as has been emphasized by many scholars and researchers in mental health (Boyd-Franklin, 1989; McGoldrick, 1998; Sue, 1998).

Adopted Children

The emphasis in child welfare on permanence of living arrangements and policies specifically promoting adoptions (including federal incentives to states for increasing adoptions) have resulted in enor-

mous increases in reported adoptions over a relatively short period of time. Many of these adoptions involve children with special needs. In 1999, more than 195,000 children received adoption assistance payments designed to support special needs adoptions (U.S. DHHS, Children's Bureau, 2001). The rapid growth in the number of adopted children has stretched the resources of an already overburdened system for providing postadoptive services, and more training and resources for both child welfare and mental health workers will be needed to meet the expanding need. Mental health providers must become more familiar with the unique needs of adoptive families and must be a key link in the expanded aftercare systems that need to be developed to support these new families. The involvement of mental health service providers is particularly germane for the adoptive placements of older children and children with diagnosed mental health difficulties.

Foster Youth Transitioning to Adulthood

Young people exiting foster care have been found to have high rates of mental health and substance abuse problems as well as difficulties obtaining employment, housing, and necessary health and social services (Dworsky & Courtney, 2000). Prior to the passage of the Foster Care Independence Act of 1999, board and maintenance services, as well as social services and entitlements such as Medicaid, ended at age 18 for most foster children. Little funding was available to agencies for creating independent living programs; youths were essentially on their own once they reached age 18. The Foster Care Independence Act greatly expanded opportunities for developing independent living programs through a funding increase of $140 million, made states accountable for outcomes of independent living program services, and allowed states to extend Medicaid eligibility for these youth through age 21. Collaborative planning with other community agencies is a requirement of state plans for expending funds under the program, and given the likelihood of a high prevalence of mental health problems in this group, those collaborations should include mental health agencies. Enhanced Medicaid coverage and the encouragement of states to plan for independent living programs more thoughtfully and strategically should offer opportunities for providing needed mental health services to this particularly vulnerable population. For professionals already engaged in children's mental health services, the challenge will be to transition these youth in a meaningful way into the adult mental health system.

Young Children

Although infants and toddlers represent the largest segment of children who are maltreated and who are placed in foster care (Wulczyn, 2002), their mental health needs are often ignored. Researchers and practitioners in the infant mental health field have pointed to the lack of knowledge about young children's mental health needs and symptomatology as a primary reason for the lack of services for this group (see Zeanah, 2000). There are many initiatives across the country that can inform child welfare policy regarding mental health service provision for young children, including (a) promising results that have been obtained through programs employing home visits, intensive assessment, and dyadic relationship building for biological parents (e.g., Heinicke et al., 1999; Zeanah et al., 2001) and (b) preservice training, support groups, crisis intervention and behavioral therapy for foster parents (e.g., Fisher, Gunnar, Chamberlain, & Reid, 2000). Given the evidence that early intervention can have long-term effects (Yoshikawa, 1995), state and local investment in programs such as these has the potential to positively affect the psychological trajectory of these children over time. There are clear needs for enhanced training for mental health providers about the specific needs of young children in high-risk situations and for increased attention to the dissemination of evidence-based approaches to assessment and treatment for very young children.

Knowledge Development

The knowledge base in child welfare services must be expanded to provide a solid foundation for social policy. Funding for child welfare research historically has been limited, and much of the outcomes research in child welfare has been restricted to service/placement outcomes. More recent efforts, however, will result in heightened awareness of the experiences of individuals who are involved in the system, their service needs, and outcomes of services. Responding to a congressional mandate, the National Institutes of Health, in collaboration with other federal agencies, has launched a number of efforts to develop a more solid research program in child maltreatment. In addition, for the first time, the National Survey of Child and Adolescent Well-Being (NSCAW Research Group, 2002) will provide a nationally representative description of the functioning, service needs, and service utilization of the children and families served by child welfare. Foundations continue to lead the way through evaluations of initiatives designed to provide comprehensive, coordinated, and individualized services to families and children. The evaluations of the Comprehensive Community Mental Health Services for Children and Their Families Program (U.S. DHHS, Center for Mental Health Services, 1998) provide new insights into outcomes of systems-of-care efforts that include both mental health and child welfare services. Finally, mental health treatment research is beginning to accumulate solid evidence concerning which types of treatments are effective for children (Burns, Hoagwood, & Mrazek, 1999), although little of this work has been done specifically with child welfare populations to date.

Conclusion

A number of reform initiatives and innovations are underway in child welfare policy that have the potential to shift the emphasis from protection and placement toward children's well-being, and these represent opportunities for child welfare and mental health providers to develop

solid collaborative relationships. Because child welfare policy is shaped by complex forces, efforts to effectively incorporate mental health services must recognize and address the multiple, sometimes conflicting forces that may be at work. Child welfare officials, whose actions are often governed by legal mandates, may be understandably reluctant to enter into agreements to participate in collaborative systems where they perceive that they may relinquish control of case management and monitoring of cases that are under their supervision. No other systems are held accountable in quite the same way for children who may be harmed or even killed while under their care and supervision, and negative publicity surrounding such incidents can quickly dismantle the most carefully crafted collaborative arrangements. Moreover, courts often have the final word about services and placements; therefore, they must be fully engaged in collaborations to make such an arrangement work.

Recognition by mental health policy makers, service planners, and practitioners of the special circumstances of child welfare clients is necessary for the development and implementation of effective service delivery systems for this population. The mental health needs of caregivers as well as children must be considered, and the principles of care that are incorporated into federal policies related to children's mental health services (U.S. DHHS, Center for Mental Health Services, 2002) may need to be adapted to meet the needs of child welfare clients. With the many recent policy shifts that allow for an integration of the child welfare and mental health service sectors, a system of care that establishes a solid infrastructure for the delivery of mental health services to the child welfare population can be realized. Such an approach has the potential to accomplish a primary goal of the current child welfare system—fostering the emotional well-being of this vulnerable population of children and families.

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Authors' Note

The views expressed here are those of the authors and do not necessarily reflect positions of the Administration on Children, Youth and Families or the U.S. Department of Health and Human Services.

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