

California Social Work Education Center

C A L S W E C

**Mental Health Service Utilization and
Outcomes for Children and Youth in the
Child Welfare System:**

An Empirically Based Curriculum

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ABSTRACT

This empirically-based curriculum focuses on a number of issues related to mental health service utilization and outcomes among children in the child welfare system. In spite of the documented need for mental health services for these children, there is a lack of information on children involved with both the child welfare and mental health systems. In order to improve our understanding of the issues and needs of this population, this curriculum focuses on five areas: (a) demographic and system-related characteristics of children involved in both the child welfare and mental health systems; (b) clinical need for services, service utilization patterns, and association between mental health service utilization and child welfare outcomes; (c) policies affecting mental health service utilization by children in the child welfare system; (d) collaboration between child welfare and mental health systems; and (e) resources for collaboration and service provision for children and youth in both the child welfare and mental health systems. The curriculum will provide research highlights, conceptual frameworks, tools, and experiential opportunities to strengthen understanding of a wide range of issues related to mental health service utilization among children in the public child welfare system.

CALSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation's largest state coalition of social work educators and practitioners. It is a consortium of the state's 16 accredited schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social Workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers who practice in the field of public child welfare. Our stated mission, in part, is "to facilitate the integration of education and practice." But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC mission. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become "educated" and then cease to observe and learn.

To foster continuing learning and evidence-based practice within the child welfare field, CalSWEC funds a series of curriculum sections that employ varied

research methods to advance the knowledge of best practices in child welfare. These sections, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, curriculum sections are made available through the CalSWEC Child Welfare Resource Library to all participating school and collaborating agencies.

The section that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.

ABOUT THE AUTHORS

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INTRODUCTION

Rationale for the Curriculum Module

This empirically-based curriculum focuses on a number of issues related to mental health service utilization and outcomes among children in the child welfare system (CWS). Estimates suggest that between 50-80% of children in out-of-home placement experience a mental health disorder (Halfon, Mendonca, & Berkowitz, 1995). However, in spite of the documented need for mental health services among children in the CWS, there is a lack of information on children involved with both the child welfare and mental health systems. In order to improve our understanding of the issues and needs among this population, this curriculum focuses on five areas: (a) demographic and system-related characteristics of children involved in both the child welfare and mental health systems; (b) clinical need for services, service utilization patterns, and association between mental health service utilization and child welfare outcomes; (c) policies affecting mental health service utilization by children in the child welfare system; (d) collaboration between child welfare and mental health systems; and (e) resources for collaboration and service provision for children and youth in both the child welfare and mental health systems.

Background and Literature Review

Research on the *demographic and system-related characteristics of children in the child welfare and mental health systems* indicates that older children and male children have an increased likelihood of using mental health services, while African American and Hispanic/Latino children are less likely than their White counterparts to

use mental health services (Breland-Noble et al., 2004; Garland, Landsverk, Hough, & Ellis-Macleod, 1996; James, Landsverk, Slymen, & Leslie, 2004; Leslie et al., 2005; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Rubin et al., 2004; Yeh et al., 2002). In addition, research has identified certain system-related characteristics that are associated with involvement in mental health services, including certain types of abuse (e.g., physical or sexual), placement in group care, multiple placements or episodic out-of-home experiences (i.e., serial out-of-home placements interrupted by a return home of at least one month), and the presence of some type of health insurance (Burns et al., 2004; Garland et al., 1996; James et al., 2004; McMillen et al., 2004; Leslie et al., 2005; Rubin et al., 2004; Shin, 2005).

Research on *clinical need for mental health services* among children in the child welfare system indicates an increased risk for a variety of mental health problems. Compared to children receiving public assistance or SSI, children in the child welfare system are more likely to have a mental health diagnosis (dosReis, Zito, Safer, & Soeken, 2001; Harman, Childs, & Kelleher, 2000), have more mental health hospitalizations, and use more mental health services overall (Reiff, 2001).

Overall, research on *mental health service utilization* suggests that children in the child welfare system are most likely to use outpatient services and that the intensity of mental health service use may vary by demographic and system-related factors, with children in kinship care receiving fewer mental health services than those in other types of out-of-home placement. While knowledge of treatment completion rates is clearly important, little is known in this area. In addition, more information is needed on ways in

which service utilization patterns vary by clinical need and by demographic and system-related characteristics, and how utilization is associated with outcomes for children and youth in the child welfare system.

To date, there is no knowledge of *how mental health service utilization affects child welfare outcomes* such as family stabilization, family reunification, or other permanent placement options (i.e., adoption or long-term foster care). This lack of information on the impact of mental health services is of particular concern because studies suggest that emotional and behavioral problems are associated with placement instability and a reduced likelihood of reunification for children in out-of-home care (Barber, Delfabbro, & Cooper, 2001; Landsverk, Davis, Ganger, Newton, & Johnson, 1996).

In addition, information on *policies affecting mental health service utilization by children in the child welfare system* can help inform child welfare practice. Current federal and state child welfare policies reflect a strong focus on child welfare outcomes, including ensuring the safety, permanency, and well-being of children in the child welfare system. Correspondingly, child welfare systems are responsible for ensuring that children receive adequate services to meet their physical and mental health needs. Such a context may provide an opportunity for improved collaborative relationships between the child welfare and mental health systems. Similarly, mental health service delivery to children in the child welfare system is also influenced by mental health service delivery structure and by mental health policies. Public mental health services for children in CWS are funded primarily by the federal Medicaid health insurance

program; however, each state may establish its own eligibility guidelines and service and payment structure. As such, there can be wide variation in the types of mental health services that children in the child welfare system can access (Geen, Sommers, & Cohen, 2005).

Mental health policies affecting children in the child welfare system who are involved with mental health services are largely focused on “system of care” interventions, those with an overarching goal to provide a comprehensive array of coordinated mental health and other social services (e.g., juvenile justice, child welfare, and Special Education). In addition, the Mental Health Services Act in California, which created a 1% tax on personal income over \$1 million, may also affect mental health service delivery to children.

The large proportion of children in CWS who are experiencing mental health problems has created a need for improved *collaboration between the child welfare and mental health systems*. A lack of such collaboration can create fragmented or inadequate service delivery, as well as service duplication, while strong interagency linkages may improve service access and quality (Darlington, Feeney, & Rixon 2004; Prince & Austin, 2005). High levels of coordination between the child welfare and mental health systems have been linked to a stronger relationship between clinical need and service use and a reduction in racial/ethnic disparities in the use of mental health services (Hurlburt et al., 2004). However, research also suggests that poorly planned or ineffective collaborative models may actually result in negative outcomes for children and families (Glisson & Hemmelgarn, 1998).

Finally, it is important to consider *resources for collaboration and service provision for children and youth in both the child welfare and mental health systems*. Promising models of cross-system collaboration between child welfare and mental health often follow a system of care model of services. In addition, this curriculum provides information on resources for cross-system collaboration and an annotated bibliography for developing collaborative models between the two systems.

CURRICULUM OVERVIEW

This curriculum provides research highlights, conceptual frameworks, tools, and experiential opportunities to strengthen understanding of a wide range of issues related to mental health service utilization among children in the public child welfare system.

Specifically, this curriculum focuses on five areas:

1. The demographic and system-related characteristics of children in the child welfare system,
2. The clinical need for services, service utilization patterns, and association between mental health service utilization and child welfare outcomes,
3. Policies affecting mental health service utilization by children in the child welfare system,
4. Collaboration between child welfare and mental health systems, and
5. Resources for collaboration and service provision for children and youth in both the child welfare and mental health systems.

This curriculum is based on the following assumptions:

- More information on characteristics of children involved in both the child welfare and mental health systems can inform service delivery and highlight possible areas of inequity in service access.
- A better understanding of the impact of mental health service utilization on system-related outcomes is important.
- A better understanding of the policy-related context affecting mental health service utilization among children in the child welfare system can help inform child welfare practice.
- A better understanding of strategies for improving collaboration between the child welfare and mental health systems may help reduce fragmented service delivery and improve the overall quality of services.

- More information is needed on resources for collaboration and service provision for children and youth involved in both the child welfare and mental health systems.

Objectives

The curriculum objectives for each section are described below.

Introduction: Overview of goals, objectives, and curriculum content. This section is intended to orient the instructor to the curriculum and provide helpful tips on classroom use.

Section I: Demographic and System-Related Characteristics of Children in the Child Welfare System. By the end of this section, participants will:

- Be able to identify demographic and system-related correlates of mental health service use by children and youth,
- Have increased knowledge of children more likely, and less likely to receive mental health services, and
- Have increased knowledge of possible inequities in service delivery, including research related to service inequities among children of color.

Section II: Clinical Need for Services, Service Utilization Patterns, and Association Between Mental Health Service Utilization and Child Welfare Outcomes. By the end of this section, participants will:

- Have increased awareness of the clinical need for mental health services for children who have experienced maltreatment,
- Have increased knowledge of the service utilization patterns by children in the child welfare system,
- Have increased awareness of the outcomes for children and youth as well as the implications for social work practice, and
- Have increased knowledge of the ways in which service utilization affects child welfare outcomes.

Section III: Policy and Legislation That Affects Mental Health Service

Utilization by Child Welfare Clients. By the end of this section participants will:

- Have increased knowledge of the mental health service delivery structure at the federal, state, and local levels,
- Have a basic understanding of Medi-Cal eligibility requirements and restrictions,
- Be able to identify three current mental health policies relating to child welfare clients, and
- Have increased awareness of impact of child welfare funding and policies on the provision of mental health services.

Section IV: Collaboration Between Child Welfare and Mental Health

Systems. By the end of this section, participants will:

- Be familiar with the highlights of the literature on systems collaboration,
- Be able to identify factors that contribute to strong inter-agency collaboration,
- Have increased knowledge of the perspectives of both child welfare and mental health systems with regard to collaboration, and
- Be able to identify strategies to enhance collaboration across systems.

Section V: Resources for Collaboration and Service Provision for Children

and Youth in Both the Child Welfare and Mental Health Systems. By the end of this section, participants will:

- Have increased knowledge of materials and resources that offer models and tips for cross-system collaboration.

Intended Audience

The primary audiences for this curriculum are Title IV-E MSW students and entry-level child welfare professionals. Although some of the materials emphasize the child welfare field, many of the sections may be used or adopted for students in a

variety of disciplines who may work in any way with issues related to mental health and child maltreatment. This content may also be appropriate for use with BSW students.

The sections in this training may be adapted for use with students or other participants with varied levels of knowledge in working with children and youth receiving mental health services related to abuse and neglect. However, instructors or trainers working with students or professionals who have little knowledge of the subject will need to cover essential information related to correlations between child maltreatment and mental health status (Sections I and II) as well as the current policies (Section III) impacting service delivery. In addition, information and activities that underscore how the collaborative process between systems (Section IV) may impact practice and consequently, positive outcomes for children in the child welfare system may also need to be addressed in more detail. These sections may also be particularly relevant to MSW practice classes.

Instructors working with advanced practitioners may elect to emphasize information and activities that underscore system-level issues and problem solving (Section IV). These segments could also be used in MSW courses related to policy, organizational development, or agency management.

Organization of Curriculum

The curriculum sections are intended to build upon one another. However, it is possible for instructors to use each of the sections independently or in combination. A brief description of each section follows:

Introduction: Overview of goals, objectives, and curriculum content. This section introduces the trainer to the curriculum goals and objectives and provides helpful information on how to best use the curriculum with varied audiences.

Section I: Demographic and System-Related Characteristics of Children in the Child Welfare System. This section provides foundation knowledge and an introduction to the topic of the demographic and system-related characteristics of children in the system including age, gender, ethnicity, and type of child maltreatment. Specifically, this section provides highlights from the literature related to demographic and system-related correlates of mental health services use including those children and youth in the child welfare system who are *most likely* and *least likely* to receive mental health services. Information in this section also highlights possible inequities in service delivery, including research related to service inequities among children of color in the child welfare system.

Section II: Clinical Need for Services, Service Utilization Patterns, and Association Between Mental Health Service Utilization and Child Welfare Outcomes. Service utilization patterns that include type of treatment, reason for referral for services, and primary clinical diagnosis are addressed in this section. Activities are included at the beginning of the module to engage participants and to raise awareness. Focus questions and a case scenario are also included to facilitate application of new knowledge. Activities include a problem-solving exercise and a case scenario.

Section III: Policy and Legislation That Affects Mental Health Service Utilization by Child Welfare Clients. This section provides an overview of child

welfare and mental health policies at the federal, state, and local levels affecting mental health services delivery for children. Information about Medi-Cal eligibility is included as well as current legislation and policies impacting mental health services for children in the child welfare system. This section concludes with group exercises emphasizing implications for practice.

Section IV: Collaboration Between Child Welfare and Mental Health Systems. This section provides highlights of the literature on systems collaboration and an overview of factors that contribute to strong inter-agency collaboration. Findings from current research are presented to clarify the collaboration perspectives of both the child welfare and mental health systems. Case scenarios that emphasize application of strategies to enhance collaboration are included.

Section V: Resources for Collaboration and Service Provision for Children and Youth in Both the Child Welfare and Mental Health Systems. This final section provides helpful resources and materials related to mental health services and children in the child welfare system.

Appendixes. The appendixes include research methods and procedures, as well as copies of the Structured Interview Guide and Structured Focus Group Guide used in the research.

Time Estimates and Tips for Training

Increasing knowledge and understanding of issues related to the utilization of mental health services by children in the system is an important component of any training intended to improve outcomes for children and youth. As such, the sections in

this curriculum may be used in conjunction with supplemental training materials that focus on other facets of direct service related to mental health for children and youth. The time estimate to complete the entire curriculum is one 6-7-hour training session. However, instructors may elect to condense the background information (based on assessment of participant knowledge, skill, and experience) or to integrate components of this training into other training or class sessions on direct or collaborative practice. Estimated time requirements for completing the sections are as follows:

| Section | Description | Estimated Time |
|-------------|--|----------------|
| Section I | <u>Content:</u> Demographic and system-related characteristics of children and youth in the child welfare and mental health systems. <u>Activity I-1:</u> Introductory Activity <u>Activity I-2:</u> Pre-Test <u>Activity I-3:</u> Focus Questions | 1 hour |
| Section II | <u>Content:</u> Literature review related to the clinical need for services, mental health utilization, and outcomes for children in the child welfare system. <u>Activity II-1:</u> Problem Solving <u>Activity II-2:</u> Discussion Questions <u>Activity II-3:</u> Case Scenario | 1 hour |
| Section III | <u>Content:</u> Policy and legislation affecting mental health utilization by child welfare clients. Focus on federal, state, and local levels. <u>Activity III-1:</u> Federal Policies <u>Activity III-2:</u> State Policies <u>Activity III-3:</u> Local Policy, Prop. 63 | 1 hour |
| Section IV | <u>Content:</u> Highlights of literature and current research on collaboration between child welfare and mental health systems <u>Activity IV-1:</u> Group Discussion <u>Activity IV-2:</u> Research Themes | 1 hour |
| Section V | <u>Content:</u> Resources for collaboration and service provision for children and youth in child welfare and mental health systems <u>Activity V-1:</u> Website Exercise | 1 hour |

Other Suggested Tools and Materials

Courses or trainings with graduate students or new workers will need to provide content on basic knowledge and skills in direct practice with children receiving mental health services in addition to the material in this curriculum. It is recommended that instructors working with graduate students or new workers also review the CalSWEC curriculum project by Black (1998) that focused on collaboration in interagency child welfare practice. This project focuses on an overview of interagency collaboration in the child welfare system, and in-depth information on strategies to develop collaborative relationships in the child welfare field and address barriers to collaboration, as well as information on common stakeholders and systems involved in cross-system collaboration within a child welfare context.

Competencies

The list of CalSWEC Curriculum Competencies for Public Child Welfare was created for use by the graduate schools of social work in California to prepare their child welfare students for competent practice. These competencies reflect the common priorities of schools and agencies, yet allow each institution suitable autonomy. This curriculum addresses the competencies listed below at both the MSW and BSW levels. Further, the introduction to each section of the curriculum provides a list of competencies specifically addressed in that particular section.

MSW Competencies

I. Ethnic Sensitive and Multicultural Practice

- 1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.

II. Core Child Welfare Practice

- 2.5 Student is aware of forms and mechanisms of oppression and discrimination pertaining to low-income and single-parent families and uses this knowledge in providing appropriate child welfare services.
- 2.10 Student understands policy issues and child welfare legal requirements and demonstrates the capacity to fulfill these requirements in practice.
- 2.11 Student understands the process of the legal system and the role of social workers and other professionals in relation to the courts.
- 2.20 Student understands and utilizes the case manager's role to create and sustain a helping system for clients, a system that includes collaborative child welfare work with members of other disciplines.

III. Human Behavior and the Social Environment

- 3.3 Student demonstrates understanding of the potential effects of poverty, racism, sexism, homophobia, violence, and other forms of oppression on human behavior.

IV. Workplace Management

- 4.3 Student understands client and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.
- 4.4 Student is able to identify an organization's strengths and limitations and is able to assess its effect on services for children and families.
- 4.7 Student understands and is able to utilize collaborative skills and techniques in organizational settings to enhance service quality.

V. Culturally Competent Child Welfare Practice

- 5.2 Student is able to critically evaluate the relevance of intervention models to be applied with diverse ethnic and cultural populations.

VI. Advanced Child Welfare Practice

- 6.3 Student understands the requirements for effectively serving and making decisions regarding children with special needs and the balancing of parental and child rights.

VII. Human Behavior and the Child Welfare Environment

- 7.2 Student demonstrates the ability to recognize potential for violence, suicide, and other potentially harmful behaviors.
- 7.4 Student is able to identify agency and legislative policies and procedures that create barriers to the growth and development of children and families.
- 7.5 Student demonstrates understanding of the dynamics of trauma resulting from family conflict, divorce, and family violence.

VIII. Child Welfare Policy, Planning, and Administration

- 8.3 Student understands how leader/managers use the collaborative process for the purpose of planning, formulating policy, and implementing services.
- 8.9 Student demonstrates the ability to negotiate and advocate for the development of resources that children and families need to meet their goals.

BSW Competencies

Ethnic Sensitive and Multicultural Practice

- 1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.

Core Child Welfare Practice

- 2.5 Student demonstrates an understanding of the dual responsibility of the child welfare caseworker to protect children and to provide appropriate services to enable families to care for their children, including preventive services.

- 2.12 Student is developing the capacity to utilize the case manager's role in creating a helping system for clients, including working collaboratively with other disciplines and involving and working collaboratively with biological families, foster families, and kin networks.

Human Behavior in the Social Environment

- 3.3 Student demonstrates understanding of the potential effects of poverty, racism, sexism, homophobia, violence, and other forms of oppression on human behavior.

Workplace Management

- 4.3 Student demonstrates awareness of community resources available for children and families and has a working knowledge of how to utilize these resources in achieving case goals.
- 4.4 Student has a working knowledge of collaboration with multidisciplinary teams and can work productively with team members in implementing case plans.

SECTION I

DEMOGRAPHIC AND SYSTEM-RELATED CHARACTERISTICS OF CHILDREN IN THE CHILD WELFARE AND MENTAL HEALTH SYSTEMS

SECTION I INSTRUCTIONAL GUIDE

Learning Objectives

This section provides foundation knowledge and an introduction to the topic of characteristics of children and youth in both the child welfare and mental health systems. Specifically, this section provides highlights from the literature related to demographic and system-related correlates of mental health service use including those children and youth in the child welfare system who are *most likely* and *least likely* to receive mental health services. Information in this section also highlights possible inequities in service delivery, including research related to service inequities among children of color in the child welfare system. Activities are included at the beginning of the module to engage participants and to raise awareness. Focus questions and a case scenario are also included to facilitate application of new knowledge.

By the end of this section, participants will:

- Be able to identify demographic and system-related correlates of mental health service use by children and youth in the child welfare system.
- Have increased knowledge of children more likely, and less likely to receive mental health services.
- Have increased knowledge of possible inequities in service delivery, including research related to service inequities among children of color in the child welfare system.

Public Child Welfare Competencies (MSW)

I Ethnic Sensitive and Multicultural Practice

- 1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.

II Core Child Welfare Practice

- 2.5 Student is aware of forms and mechanisms of oppression and discrimination pertaining to low-income and single-parent families and uses this knowledge in providing appropriate child welfare services.

III Human Behavior and the Social Environment

- 3.3 Student demonstrates understanding of the potential effects of poverty, racism, sexism, homophobia, violence, and other forms of oppression on human behavior.

V Culturally Competent Child Welfare Practice

- 5.2 Student is able to critically evaluate the relevance of intervention models to be applied with diverse ethnic and cultural populations.

VII Human Behavior and the Child Welfare Environment

- 7.2 Student demonstrates the ability to recognize potential for violence, suicide, and other potentially harmful behaviors.
- 7.5 Student demonstrates understanding of the dynamics of trauma resulting from family conflict, divorce, and family violence.

Public Child Welfare Competencies (BSW)

Human Behavior in the Social Environment

- 3.3 Student demonstrates understanding of the potential effects of poverty, racism, sexism, homophobia, violence, and other forms of oppression on human behavior.

Agenda and Suggestions for Instructors

Time allocation: Approximately 1 hour

Introduction

- Introduction of trainer(s)
- Brief introduction to section content
- Introduction of participants (if not part of ongoing course)
- Introductory Activity I-1: Icebreaker

Overview of demographic and system-related characteristics of children in the child welfare system from the literature review

- Activity I-2: Pretest
- What are the differences with regard to gender, age, and ethnicity for children most likely and least likely to be referred for mental health services?

Focus questions and problem-solving activities

- Activity I-3: Focus questions
- Activity I-4: Problem-solving

PowerPoint presentation (or use of transparencies)

- Discussion of implications for practice

Instructors are encouraged to use this section in a range of ways that meet their needs. For example, instructors may elect to provide a very brief overview of mental health issues for children in care by using only two or three of the PowerPoint slides provided for this section. Some of the activities may also be omitted or easily adapted for use with other sections of this curriculum.

Materials Needed

- Overhead projector
- PowerPoint slides 1-11 (or transparencies)
- Handouts (Activity I-1 and I-2)
- Markers and flip chart or white board (optional--for writing key points in response to questions for class discussion)

Introductory Activity I-1: Icebreaker

Purpose: To give participants an opportunity to interact and raise awareness around mental health issues for children in foster care.

Instructions: Get into dyads or triads and discuss the following:

1. Identify your role as a student or employee working with children in the child welfare system.
2. Discuss your observations about the children you have worked with:
 - Most common type of maltreatment
 - Most common presenting behavioral/emotional issues
 - Most common mental health diagnosis

Process: Small groups to share with larger group, instructor to note group findings on board for further discussion.

Introductory Activity I-2: Pretest

Purpose: To test the baseline knowledge of participants, to heighten awareness of related topic areas and to facilitate discussion.

Instructions/Process: Provide 5-10 minutes for participants to answer the following 10 questions in a T/F format. Instructors can then proceed to highlight key areas addressed in Section I by showing the PowerPoint presentation for this section.

1. Male children in the child welfare system have a higher likelihood of using mental health services than females (T/F).
2. Children over the age of 14 are more likely than younger children to use psychotropic medication (T/E).
3. African American and Hispanic/Latino youth are more likely to use residential and group home care than white youth (T/F).
4. Children who have experienced neglect or caretaker absence are more likely to receive mental health services than children who have experienced other types of maltreatment (T/E).
5. Children who have experienced multiple placements are more likely to receive mental health services than children in stable placements (T/F).

6. Children in kinship care receive more mental health services than those in non-relative foster care (T/E).
7. Children who have been sexually abused have the highest number of mental health visits (T/F).
8. Children with lengthier stays in the foster care system are more likely to use mental health services (T/F).

CHAPTER I

CHARACTERISTICS OF CHILDREN INVOLVED IN BOTH THE CHILD WELFARE AND MENTAL HEALTH SYSTEMS

Studies suggest that certain demographic and system-related characteristics of children involved in the child welfare system tend to be associated with mental health system involvement. Figure 1 provides a summary of research findings related to demographic characteristics of children in the child welfare system who are also involved in the mental health system.

Figure 1. Demographic Characteristics of Children in the Child Welfare System Who Are Also Involved in the Mental Health System

| Demographic Characteristic | Research Findings |
|----------------------------|---|
| Gender | <ul style="list-style-type: none"> • Male children are more likely than female children to use mental health services (Rubin et al., 2004). |
| Race/Ethnicity | <ul style="list-style-type: none"> • African American and Hispanic/Latino children are less likely than White children to use less restrictive mental health services such as outpatient mental health treatment and psychotropic medication (McMillen et al., 2004). • African American and Hispanic/Latino children are more likely than White children to use more restrictive mental health services, such as group home or residential care (McMillen et al., 2004). • Asian/Pacific Islander children involved in public child welfare services are more likely than White children to have been referred by the child welfare system (Yeh et al., 2002). |
| Age | <ul style="list-style-type: none"> • Older children are more likely to use mental health services than are younger children (Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004). • Younger children are more likely to use psychotropic medication than older children (Breland-Noble et al., 2004). |

Research studies using multivariate techniques (in which clinical need is statistically controlled) suggest that older children and male children in CWS have an

increased likelihood of using mental health services, while African American and Hispanic/Latino children are less likely than their White counterparts to use such services (Breland-Noble et al., 2004; Garland et al., 1996; James et al., 2004; Leslie et al., 2005; Leslie et al., 2004; Rubin et al., 2004; Yeh et al., 2002). Although older children are more likely to use mental health services, one study found that younger children (under 13 years) were more likely than older children to use psychotropic medication (Breland-Noble et al., 2004).

Other studies have found that although African American and Hispanic/Latino youth are less likely than their White counterparts to receive outpatient mental health services or psychotropic medication; they are more likely to use more restrictive mental health services, such as residential or group care (McMillen et al., 2004). One of the few studies to include Asian children found that compared to White children, Asian/Pacific Islanders involved in public outpatient mental health services were more likely to have been referred by the child welfare system (Yeh et al., 2002). Because these studies employed multivariate statistical techniques, to eliminate confounding factors such as clinical need, racial/ethnic differences in mental health service delivery may be attributable to possible inequities in service referral and access.

Research has also identified a number of system-related characteristics of children involved in both the child welfare and mental health systems. Figure 2 summarizes the system-related characteristics associated with an increased or decreased likelihood of involvement in mental health services.

Figure 2. System-Related Characteristics of Children Involved in the Child Welfare and Mental Health Systems

| System-Related Characteristic | Research Findings |
|---|--|
| Initial type of abuse | <ul style="list-style-type: none"> • Children entering the child welfare system as a result of sexual abuse, physical abuse, or abandonment are more likely to use mental health services (Garland et al., 1996). • Children entering the child welfare system as a result of neglect or caretaker absence are less likely to use mental health services (Garland et al., 1996). |
| Type of placement | <ul style="list-style-type: none"> • Children placed in group care (versus children placed in any other type of out-of-home placement) are more likely to use mental health services (Hurlburt et al., 2004). • Children placed in kinship care (versus other types of out-of-home placement) are less likely to use mental health services (McMillen et al., 2004). • Children who remain in the home (versus children placed in any type of out-of-home placement) are less likely to use mental health services (Burns et al., 2004). |
| Placement stability | <ul style="list-style-type: none"> • Children experiencing multiple out-of-home placements (versus a stable out-of-home placement) are more likely to use mental health services (James et al., 2004). • Children with episodic out-of-home placement experiences (i.e. out-of-home placement spells interrupted by a return home of at least one month) are more likely to use mental health services (Rubin et al., 2004). |
| Length of time in out-of-home placement | <ul style="list-style-type: none"> • Children who spend longer amounts of time in out-of-home placement are more likely to use mental health services (Shin, 2005). |
| Insurance status | <ul style="list-style-type: none"> • Children with public, private, or military insurance (versus children with no insurance) are more likely to use mental health services (Leslie et al., 2005). |

In addition, research has identified certain system-related characteristics that are associated with involvement in mental health services. Research using multivariate techniques in which clinical need is statistically controlled has found that certain system-related characteristics tend to be associated with involvement in mental health services, including certain types of abuse (e.g., physical or sexual), placement in group care,

multiple placements, or episodic out-of-home experiences (i.e., out-of-home placement spells interrupted by a return home of at least 1 month), and the presence of some type of health insurance (Burns et al., 2004; Garland et al., 1996; James et al., 2004; McMillen et al., 2004; Leslie et al., 2005; Rubin, et al., 2004; Shin, 2005).

Taken together, this research suggests that children involved in both the child welfare and mental health systems can be characterized by certain demographic and system-related characteristics. Less is known about how child welfare clients involved in the mental health system differ from those who do not utilize mental health services. In addition, more research is needed on ways in which specific demographic and system-related characteristics are associated with mental health service utilization and outcomes for children and youth.

Study Findings

A series of univariate and bivariate analyses were conducted to evaluate demographic and system-related characteristics of children and youth in the child welfare system (CWS) who are also involved in the mental health system (MHS), and to determine how the characteristics of these children and youth compare to those not referred to the MHS (See Appendix A for a complete description of Study Methods and Procedures).

Demographic Characteristics. The average *age* of the children referred to the MHS was 8.97 years and those not referred to the MHS was 5.08 years. In comparing age at entry into the CWS of those referred and not referred to the MHS, there was a significant difference with children referred to the MHS having entered into the CWS at

an older age. Also, among those referred to the MHS, the average age of the children at time of referral to MHS entry was 10.44 years with the youngest entering almost at birth and the oldest at just older than 19 years. In comparing the ages at entry into the two systems, there was a significant difference with children entering into the MHS an average of 1.47 years after their entry into the CWS.

In comparing the *gender* of those referred and not referred to the MHS, there was no significant difference. Of those referred to the MHS, there were 276 females (53.2%) and 243 males (46.8%) in the subsample. Of those not referred to the MHS, there were 300 females (49.4%) and 307 males (50.6%).

There was no statistical difference by *ethnicity*. Of those referred, 134 (25.8%) were White, 266 (51.3%) Latino, 61 (11.7%) African American, 48 (9.2%) Asian/Pacific Islander, and 10 (1.9%) Native American or Other ethnicity. Of those not referred to the MHS, 122 (20.1%) were White, 335 (55.2%) Latino, 78 (12.9%) African American, 58 (9.6%) Asian/Pacific Islander, and 14 (2.3%) Native American or Other ethnicity (see Table 1).

Table 1. Sample Age, Gender, and Ethnicity (N = 1,126)

| Characteristic | Total | Referred to MHS | Not Referred to MHS | Significant Differences |
|-----------------------------|--------------|-----------------|---------------------|--|
| | mean (sd) | mean (sd) | mean (sd) | |
| Age at CWS entry (in years) | 6.87 (5.03) | 8.97 (4.40) | 5.08 (4.84) | Referred to MHS > Not Referred *** |
| Age at MHS entry (in years) | N/A | 10.44 (4.68) | N/A | Age at MHS Entry > Age at CWS entry*** |
| | N (%) | n (%) | n (%) | |
| Gender | | | | No Significant Differences |
| Females | 576 (51.2%) | 276 (53.2%) | 300 (49.4%) | |
| Males | 550 (48.8%) | 243 (46.8%) | 307 (50.6%) | |
| Ethnicity | | | | No Significant Differences |
| White | 256 (22.7%) | 134 (25.8%) | 122 (20.1%) | |
| Latino | 601 (53.4%) | 266 (51.3%) | 335 (55.2%) | |
| African American | 139 (12.3%) | 61 (11.7%) | 78 (12.9%) | |
| Asian/Pacific Islander | 106 (9.4%) | 48 (9.2%) | 58 (9.6%) | |
| Native American/ Other* | 24 (2.1%) | 10 (1.9%) | 14 (2.3%) | |

* There were 15 Native Americans in the data set, about 1.3% of the total sample

*** p < .001

Child Welfare System Characteristics. There was a significant difference in the type of abuse leading to entry into the CWS between those referred to the MHS and those not referred. For example, a greater percentage of those children who were physically or sexually abused were more likely to be referred to the MHS compared to those children suffering other types of abuse, a finding that is consistent with previous research. Of those referred to the MHS, 189 (38.1%) involved caretaker absence or incapacity, 139 (28.0%) physical abuse, 60 (12.1%) general neglect, 47 (9.5%) severe neglect, 42 (8.5%) sexual abuse, 13 (2.6%) emotional abuse, 2 (0.4%) law violation, 1

(0.2%) child's disability or handicap, 3 (0.6%) relinquishment, and 3 (0.6%) other. Of those not referred to MHS, 276 (45.5%) involved caretaker absence or incapacity, 107 (17.6%) physical abuse, 97 (16.0%) general neglect, 82 (13.5%) severe neglect, 16 (2.6%) sexual abuse, 17 (2.8%) emotional abuse, 1 (0.2%) law violation, 0 (0.0%) child's disability or handicap, 6 (1.0%) relinquishment, and 6 (1.0%) other (see Table 2).

Regarding *service component at case closure*, no significant differences were found between those referred or not referred to the MHS. Of those referred, 30 (5.8%) children were assigned to emergency response (ER), 243 (46.8%) to family maintenance (FM), 54 (10.4%) to family reunification (FR), and 193 (37.0%) to permanent placement (PP). Of those not referred, 34 (5.6%) children were assigned to emergency response (ER), 290 (47.8%) to family maintenance (FM), 43 (7.1%) to family reunification (FR), and 240 (39.5%) to permanent placement (PP; see Table 2).

Regarding *time in the CWS*, there was a significant difference here with those children referred to the MHS staying in the CWS a longer time. Children referred to the MHS were in the CWS an average of 40.20 months or just over 3 years, while those not referred to the MHS were in the CWS an average of 27.49 months or just over 2 years (see Table 2).

Table 2. Abuse, Service Component at Time of Case Closure, and Time in CWS (N = 1,126)

| | Total | | Referred to MHS | | Not Referred to MHS | | Significant Differences |
|---|------------------|---------|------------------|---------|---------------------|---------|---|
| Characteristic ¹ | N | (%) | n | (%) | n | (%) | |
| Type of abuse (leading to entry into the CWS) | | | | | | | Significant Differences* ** |
| Caretaker absence/incapacity | 465 | (42.2%) | 189 | (38.1%) | 276 | (45.5%) | |
| Physical abuse | 246 | (22.3%) | 139 | (28.0%) | 107 | (17.6%) | |
| General neglect | 157 | (14.2%) | 60 | (12.1%) | 97 | (16.0%) | |
| Severe neglect | 129 | (11.7%) | 47 | (9.5%) | 82 | (13.5%) | |
| Sexual abuse | 58 | (5.3%) | 42 | (8.5%) | 16 | (2.6%) | |
| Emotional abuse | 30 | (2.7%) | 13 | (2.6%) | 17 | (2.8%) | |
| Law violation | 3 | (0.3%) | 2 | (0.4%) | 1 | (0.2%) | |
| Child's disability/handicap | 1 | (0.1%) | 1 | (0.2%) | 0 | (0.0%) | |
| Relinquishment | 5 | (0.5%) | 3 | (0.6%) | 6 | (1.0%) | |
| Other | 9 | (0.8%) | 3 | (0.6%) | 6 | (1.0%) | |
| CWS service component at time of case closure | | | | | | | No Significant Differences |
| Emergency response (ER) | 64 | (5.7%) | 30 | (5.8%) | 34 | (5.6%) | |
| Family maintenance (FM) | 533 | (47.3%) | 243 | (46.8%) | 290 | (47.8%) | |
| Family reunification (FR) | 97 | (8.6%) | 54 | (10.4%) | 43 | (7.1%) | |
| Permanent placement (PP) | 432 | (38.4%) | 192 | (37.0%) | 240 | (39.5%) | |
| Characteristic | mean (sd) | | mean (sd) | | mean (sd) | | |
| Time in CWS (in months) | 33.35 (37.71) | | 40.20 (40.88) | | 27.49 (33.70) | | Referred to MHS > Not Referred to MHS *** |

*** p < .001

¹ Type of abuse had 23 cases with missing data and were excluded from subsequent analyses for this variable.

Family Stabilization. We also compared those children referred and not referred to the MHS in terms of our basic CWS outcome: family stabilized versus family not stabilized. The variable of family stabilization was derived from 17 case closure reasons in the dataset, including: kin-care, adoption with non-relative, adoption with relative, incarcerated, child in medical facility, child runaway, closed due to interstate compact

for the placement of children/international request, court ordered termination, emancipation, exceeded time limit, family stabilized (including those originally assigned to family maintenance services, FM), guardianship established, court-ordered reunification with parent/guardian, non-court ordered reunification with parent/guardian, refused services, or services provided by another agency These were collapsed into “family stabilized” versus “family not stabilized” with only a designation of “family stabilized”, “court-ordered reunification with parent/guardian”, or “non-court ordered reunification with parent/guardian” qualifying as “family stabilized.” Family stabilized also includes those children who began in FM and remained with their families throughout the duration of the case. Of those referred to the MHS, 219 (42.2%) had families stabilized and 300 (57.8%) not stabilized. Within those not referred to the MHS, 226 (39.9%) had stabilized families and 340 (60.1%) not stabilized. There was no significant difference in this outcome by those referred and not referred to the MHS (see Table 3).

Table 3. Family Stabilization (N = 1,126)

| Characteristic | Total N (%) | Referred to MHS n (%) | Not Referred to MHS n (%) | Significant Differences |
|-----------------------|------------------------|--------------------------------------|--|------------------------------------|
| Family Stabilized | | | | |
| Yes | 445 (39.5%) | 219 (42.2%) | 226 (39.9%) | No Significant Differences |
| No | 640 (56.8%) | 300 (57.8%) | 340 (60.1%) | |
| Missing data | 41 (3.6%) | Missing data comparative | excluded from | |

Summary of Findings

- The ethnic composition and age of the study subsample of child welfare clients involved in the MHS are similar to the overall statistics for Santa Clara County’s child welfare system, during the period under study. During 2004, an average of quarterly point-in-time statistics indicate that 56.2% of children in supervised foster care were Latino (compared to 51.3% in the current sample), 24.4% were White (25.8% in current sample), 12.8% were African American (11.7% in current

sample), 6.1% were Asian (9.2% in current sample), and 0.4% were Native American (1.9% in current sample). Regarding age, the largest percentage of substantiated referrals in Santa Clara County during 2004 came from the 6-10 year age group, and within the current sample the average age at entry into the CWS was 8.97 years (Needell et al., 2005).

- The current subsample of child welfare clients involved in the MHS was comprised of a slightly higher percentage of females than is found in the caseload for Santa Clara County. Overall, during 2004, an average of quarterly point-in-time statistics in Santa Clara County's supervised foster care caseload indicate that 49.8% of children are female (compared to 53.2% in current sample) and 50.2% are male (compared to 46.8% in current sample; Needell et al., 2005).
- The majority of children in the subsample entered the CWS due to caretaker absence/incapacity (36%) or physical abuse (27%). In Santa Clara County, the primary reason for CWS involvement is neglect (general and severe) (22%) and emotional abuse (21%; Needell et al., 2005).
- Compared to those not receiving mental health services, a larger percentage of child welfare clients receiving mental health services entered the CWS due to physical or sexual abuse.
- The largest percentage (47%) of children in the subsample were assigned to family maintenance (FM), with 37% to Permanent Placement (PP), and 10% to Family Reunification (FR). In the County, during the period under study, the largest number of cases were assigned to PP (44%), with 25% to FM, and 26% to FR (Needell et al., 2005).
- Within each ethnic group, age at entry to the CWS and MHS varied, with children entering the MHS an average of 1.47 years after entry into the CWS.
- Within the subsample, Asian/Pacific Islanders had shorter stays in the CWS than either African Americans or Whites.
- Compared to those not receiving mental health services, child welfare clients receiving mental health services entered the CWS at an older age and had longer stays in the CWS.

Implications for Child Welfare Practice

- To date, studies have documented that African American or Latino children are less likely to receive mental health services (Garland & Besinger, 1997;). However, the current study indicates that the ethnic distribution of children receiving mental health services reflected the overall ethnic composition of the

CWS. The exception being that Asian/Pacific Islander children appear to receive services at a slightly higher rate than their representation in the CWS. In addition, Asian/Pacific Islander children seem to be in the CWS for a shorter period of time, implying that either their cases are less severe, or perhaps CWS and MHS services are effective in reducing the stay in that group. Understanding more about the process for referring Asian children for mental health services would be beneficial.

- Our results indicate that the most common reason for entry to the CWS for children receiving mental health services is caretaker absence/incapacity. Our findings also indicate these same children are likely to receive a smaller dosage of mental health services and are less likely to be stabilized with their families than those removed for neglect. Bivariate results (table not shown in text) show that of the children referred to the CWS because of caretaker absence/incapacity, a majority (58%) are in the non-FM (vs. FM) group. In addition, findings that were marginally significant indicate that children in non-FM (vs. FM) were likely to receive a smaller dosage of mental health treatment. More information on the referral and delivery of mental health services to children in out-of-home placements vs. those residing with their families is warranted.
- Compared to those who are not referred to the MHS, child welfare clients who utilize mental health services are more likely to enter the CWS due to physical or sexual abuse and to have longer stays in the CWS. More information on the delivery of child welfare services to this group would help explain whether their cases are more severe requiring longer stays or whether they become trapped in the system due to the difficulty of their problems.
 - There appears to be a lag between the age at which a child is referred to the CWS and referred for mental health services. Further information on the referral process is necessary to explain this finding.

Activity I-3: Focus Questions

Purpose: to give participants an opportunity to reflect on and discuss the information and issues described in Section I of the Curriculum Module.

Instructions: Participants form three or four small groups. Each group discusses an assigned question from Handout I-3.

Process: Small groups should be allowed approximately 15-20 minutes to discuss the questions and summarize highlights and responses on butcher paper for presentation to the larger group. The instructor may elect to write key points on the board.

Review Section I and address the question/s assigned to your group.

Question 1

- Describe the characteristics of children in the child welfare system *most likely* to receive mental health services. What are your theories about why this is the case?
- Describe the characteristics of children in the child welfare system *least likely* to receive mental health services? What are your theories about why this is so?
- What might be some strategies to reduce barriers in receiving mental health services?

Question Two

Estimates are that 50-80% of children in the child welfare system suffer from some type of mental health disorder, compared to 20% in the general child population.

- List the most common mental health diagnoses for children in the child welfare system. What are the differences considering age, gender, and ethnicity?

Activity I-4: Problem-Solving

Purpose: To help participants become familiar with issues affecting children of color in the foster care system and to think critically about possible strategies to address these disparities at various levels.

Instructions: Have participants form three groups and allow each group approximately 20 minutes to discuss possible strategies to one of the following areas.

Process: Small groups will present their findings to facilitate discussion with the larger group.

- Current research indicates approximately 56% of children in the child welfare system receive mental health services. However, African American and Latino children are less likely than Whites to receive court-ordered mental health services and African American children in particular have a decreased likelihood of being recommended for individual counseling. How might this disparity issue be addressed at:
 1. The micro level (individual workers and families),
 2. The mezzo level (groups and community focus), and
 3. The macro level (systems of care, agency/organization procedures/policies, and state and federal legislation)?

SECTION II

CLINICAL NEED FOR SERVICES, SERVICES UTILIZATION PATTERNS, AND ASSOCIATION BETWEEN MENTAL HEALTH SERVICE UTILIZATION AND CHILD WELFARE OUTCOMES

SECTION II INSTRUCTIONAL GUIDE

Learning Objectives

This section raises awareness about the clinical need for mental health services for children who have experienced maltreatment and increases knowledge about the service utilization patterns by children in the child welfare system. Specifically, this section helps participants better understand the outcomes for children who are involved with both the child welfare and mental health systems, a group about whom we have limited information and which requires further study.

Study findings from the current research, which address the primary diagnosis for children in the child welfare system, as well as diagnosis by age, gender, and ethnicity are included. The type of service, type of abuse, model predicting family stabilization, and length of time in the child welfare system are also included.

Activities to help integrate section material include strategizing at the micro, mezzo, and macro levels of practice, discussion questions, and a case scenario.

By the end of this section, participants will have increased:

- Awareness of the clinical need for mental health services for children who have experienced maltreatment,
- Knowledge of the service utilization patterns by children in the child welfare system,
- Awareness of the outcomes for children and youth as well as the implications for social work practice, and
- Knowledge of the ways in which service utilization affects child welfare outcomes.

Public Child Welfare Competencies (MSW)

IV. Workplace Management

- 4.4 Student is able to recognize an organization's strengths and limitations and is able to assess its effect on services for children and families.

V. Culturally Competent Child Welfare Practice

- 5.2 Student is able to critically evaluate the relevance of intervention models to be applied with diverse ethnic and cultural populations.

Public Child Welfare Competencies (BSW)

- 2.5 Student demonstrates an understanding of the dual responsibility of the child welfare caseworker to protect children and to provide appropriate services to enable families to care for their children, including pre-placement preventive services.

Agenda and Suggestions for Instructors

Time allocation: Approximately 1 hour

Introduction

- Introduction of trainer(s)
- Brief introduction to section content
- Introduction of participants (if not part of ongoing course)
- Complete Activity II-1 as an icebreaker to facilitate discussion and engagement with material

Overview of the clinical need for services and service utilization patterns.

- What is the primary diagnosis by age, gender, and ethnicity?

Overview of the association between mental health service utilization and child welfare outcomes

Significant findings from the current research include:

- Those children entering the child welfare system at a younger age are more likely to have completed treatment,
- Those diagnosed with an adjustment disorder were less likely to have completed treatment,
- Latinos were more likely to have completed treatment than Whites,
- Those receiving more out-patient services were more likely to have completed treatment,

- Those entering the child welfare system at a younger age were more likely to be stabilized, and
- Those removed for caretaker absence/incapacity or sexual abuse were less likely to be stabilized with their families than those removed for neglect.

Complete Activity II-1: Discussion Questions

PowerPoint presentation (or use of transparencies)

- Discussion of implications for practice
- Complete Activity II-2: Case Scenario (use Handout II-2)

Instructors are encouraged to use this section in a range of ways that meet their needs. For example, instructors may elect to provide a brief overview of the DSM IV disorders for children and adolescents before presenting more specific content from this section which focuses on mental health disorders for children who have experienced maltreatment. Some of the activities may also be omitted or easily adapted for use with other sections of this curriculum.

Materials Needed

- PowerPoint slides 12-20 (or transparencies)
- Overhead projector
- Handouts (Activity II-1, Activity II-2)
- Markers and flip chart or white board (optional-for writing key points in response to questions for class discussion)

SECTION II

CLINICAL NEED FOR SERVICES, SERVICES UTILIZATION PATTERNS, AND ASSOCIATION BETWEEN MENTAL HEALTH SERVICE UTILIZATION AND CHILD WELFARE OUTCOMES

Clinical Need for Services

Families whose children are involved in the child welfare system are often characterized by a variety of problems including abuse, neglect, poverty, domestic violence, parental mental illness, and substance abuse, all of which have been implicated as risk factors for developmental disruption, as well as emotional and behavioral problems (Brooks-Gunn & Duncan, 1997; Cicchetti & Lynch, 1993; Ireland & Wisdom, 1994; Sternberg et al., 1993). These risk factors, combined with the negative consequences of multiple transitions and lengthy stays in out-of-home care, put children in the child welfare system at an increased risk for a variety of psychological and behavioral problems (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Stevenson, 1999). Compared to children receiving public assistance or SSI, children in the child welfare system are more likely to have a mental health diagnosis (dosReis et al., 2001; Harman et al., 2000); have more mental health hospitalizations; and use more mental health services overall (Reiff, 2001).

Studies typically measure clinical need for mental health services by examining types of mental health problems or specific clinical diagnoses. To date, research on the clinical need (as assessed by type of problem or diagnosis) for mental health services by child welfare clients is limited. The few studies that have examined types of mental health problems experienced by children in the child welfare system suggest that

externalizing behavioral problems including conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder tend to be the most commonly reported problems (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Stein, Evans, Mazumdar, & Rae-Grant, 1996; Zima et al., 2000). Regarding diagnosis, one study using Medi-Cal data in California found that adjustment disorders (28.6%), conduct disorders (20.5%), anxiety disorders (13.8%), and emotional disorders (11.9%) tend to be the most common Diagnostic and Statistical Manual-III (DSM-III) diagnoses (Halfon, Berkowitz, & Klee, 1992).

More research is needed on the clinical need for mental health services by child welfare clients and on the relationship between clinical need and certain demographic and system-related factors such as gender, age, ethnicity, age at entry into the child welfare system, and length of time in the child welfare system. In addition, research is lacking on the relationship between clinical need, mental health service utilization, and outcomes for children and youth.

Service Utilization Patterns for Children Involved in Both the Child Welfare and Mental Health Systems

Despite the likelihood of children and youth in the child welfare system to use mental health services, service utilization patterns are not well understood. One way to assess service utilization is to examine *type of service* used. Mental health services can include a broad range of interventions, including: outpatient services (e.g., support groups, individual counseling, family counseling); residential services, or inpatient services; psychotropic medication; and day-treatment services. Studies reporting on mental health service utilization patterns define particular services in varying ways,

making comparisons between studies problematic. Data from the National Survey of Child and Adolescent Well-being (NSCAW) indicate that among children in the child welfare system who also receive mental health services, 15.1% received any type of outpatient services, 13.3% received services from a clinic or private practice, 4.3% received in-home counseling, 3.1% received psychiatric inpatient services, and 0.8% received services from a day treatment/therapeutic nursery (Burns et al., 2004). Another study using Medi-Cal administrative data from California found that children in the child welfare system accounted for 53% of all psychologist visits, 47% of psychiatry visits, 43% of Short Doyle/Medi-Cal inpatient hospitalization in public hospitals, and 27% of inpatient psychiatric hospitalizations, despite the fact that children in the child welfare system represent just 4% of Medi-Cal eligible children (Halfon et al., 1992).

A study using a sample of adolescent youth in out-of-home care ages 16 ½-17 ½ in a large Midwest state indicated that 50% received some type of mental health service. Among youth who received mental health services, 50% received a diagnostic interview, 49% received individual therapy, 33% received emergency care, 29% received family therapy, 25% received group therapy, 15% received inpatient and residential care, and 20% received medication management (Shin, 2005). Another study using a sample of older adolescent youth in the child welfare system in Missouri found that the most commonly reported types of mental health services used by youth in the previous 12 months included group home or residential treatment (60%), outpatient therapy (50%), special school help (18%), inpatient psychiatric care (15%), and juvenile detention (15%; McMillen et al., 2004).

Tracking *the intensity (frequency and duration)* of services is another way to assess service utilization. To date, few studies have examined the intensity of services used by child welfare clients involved in the mental health system. One study of children in the child welfare system in San Diego County found that number of mental health visits varied by type of maltreatment. Specifically, children in care due to sexual abuse had the highest mean number of mental health visits in the past 6 months (18.8), followed by physical abuse (15.6), and neglect/caretaker absence (13.4; Garland et al., 1996). Another study of children in the child welfare system in San Diego found that the average number of outpatient mental health visits per year varied by a number of demographic and system-related factors. Children ages 12-17 had a higher average number of outpatient mental health visits than younger children (4.36), White children (3.46) had more visits than children of other ethnicities, males (3.32) had more visits than females, and children in non-kin care (4.00) had more visits than children in relative placement (Leslie et al., 2000). Other research using Medi-Cal data from California found that children in the child welfare system who experienced an inpatient psychiatric hospitalization spent an average of 7.7 more days in the hospital than children in the general Medi-Cal population who experienced an inpatient psychiatric hospitalization (Halfon et al., 1992). In addition, treatment completion is also an important aspect of service utilization. Information on mental health treatment completion among children in the child welfare system is lacking; studies examining mental health service use among children in the child welfare system have not reported on treatment completion rates.

Overall, research on mental health service utilization suggests that children in the child welfare system are most likely to use outpatient services and that the intensity of mental health service use may vary by demographic and system-related factors, with children in kinship care receiving fewer mental health services than those in other types of out-of-home placement. While knowledge of treatment completion rates is clearly important, little is known in this area. In addition, more information is needed on how utilization is associated with outcomes for children and youth and on ways in which service utilization patterns vary by clinical need and by demographic and system-related characteristics.

Association Between Mental Health Service Utilization and Child Welfare Outcomes

One of the primary goals of the child welfare system is stabilization of children and youth with their families or reunification with families in cases in which children have been removed from the home. To date, knowledge is inadequate as to how mental health service utilization affects child welfare outcomes. Such outcomes include family stabilization and the possibility of family reunification, versus non-stabilization and related permanent placement options like adoption or long-term foster care. This lack of information is of particular concern because studies suggest that emotional and behavioral problems are associated with placement instability and a reduced likelihood of reunification for children in out-of-home care (Barber et al., 2001; Landsverk et al., 1996). More information on the relationship between mental health service utilization and child welfare outcomes, particularly family stability, is needed to ensure that

children and youth who are involved in both systems benefit from such involvement and have positive outcomes.

Study Findings

Univariate and bivariate analyses were conducted on the subset of CWS children and youth referred to the MHS to assess their clinical need (diagnosis) for mental health services, and to evaluate differences by demographic characteristics (see Appendix A for a complete description of Study Methods and Procedures).

Primary Diagnosis. Primary diagnosis was used to operationalize clinical need of the children and youth referred to the mental health system. Primary diagnosis included over 50 DSM-IV specific conditions. These were first collapsed into 17 categories: adjustment disorders, anxiety disorders, attachment disorders, attention deficit hyperactivity disorder, communication disorders, deferred diagnosis, developmental delay, disruptive behavior disorders, elimination disorders, identify disorder, impulse control disorders, learning disorder, mood disorders, no diagnosis, relational problem, or schizophrenia and other psychotic disorder. Finally, for analysis purposes, these were condensed into six categories: adult-type disorder (e.g., schizoaffective disorder); adjustment disorder (e.g., adjustment disorder with anxiety), childhood disorder (e.g., learning disorder or identity disorder), other disorder, deferred diagnosis, or no diagnosis. For the latter analyses in the study, “other disorder” was primarily those with a relational problem, with one with an organic disorder; the one case with the organic disorder was removed from most analyses and then the category renamed “relational problem.” Regarding the clinical need, as reflected by primary

diagnoses of these children, 200 (38.5%) were designated with an adult-type disorder, 142 (27.3%) with an adjustment disorder, 92 (17.7%) with a childhood disorder, 45 (8.7%) with other disorder, 32 (6.2%) with a deferred diagnosis, and 9 (1.7%) with no diagnosis (see Table 4).

Table 4. Clinical Need: Primary Diagnosis

| Characteristic | n | (%) |
|---------------------------------|----------|------------|
| Mental Health Primary Diagnosis | | |
| Adult-type disorder | 200 | (38.5%) |
| Adjustment disorder | 142 | (27.3%) |
| Childhood disorder | 92 | (17.7%) |
| Other disorder | 45 | (8.7%) |
| Deferred diagnosis | 32 | (6.2%) |
| No diagnosis | 9 | (1.7%) |

Among the 45 with an “other disorder”, 44 were diagnosed with a relational problem and 1 with an organic disorder. The one child with an organic disorder was removed from subsequent analyses, resulting in a sample of 519 and “other disorders” was specified as “relational problem.”

Diagnosis by Age, Gender, and Ethnicity. In comparing the major demographic characteristics by primary diagnosis, one comparison did vary significantly. The age of those classified with adult-type disorders was older (9.84 years) compared to those with childhood disorders (7.59 years). See Table 5.

Table 5. Primary Diagnosis by Age (in Years)

| Characteristic | Age at CWS entry Mean (sd) | Significant difference |
|-----------------------|---------------------------------------|-------------------------------|
| Adult-type disorder | 9.84 (4.18) | Adult-type > Childhood* |
| Adjustment disorder | 8.67 (4.56) | |
| Childhood disorder | 7.59 (4.17) | |
| Relational problem | 8.85 (4.83) | |
| Deferred diagnosis | 9.27 (3.72) | |
| No diagnosis | 7.77 (5.68) | |

*p < .05

Diagnosis varied significantly by gender. For example, girls were classified more often than boys with adult disorders (44.6% vs. 31.7%) and boys classified more often than girls with childhood disorders (23.0% vs. 13.0%; see Table 6).

Table 6. Primary Diagnosis by Gender

| Gender | Adjustment disorder | Adult-Type disorder | Childhood disorder | Relational problem | Deferred diagnosis | No diagnosis |
|---------------|----------------------------|----------------------------|---------------------------|---------------------------|---------------------------|---------------------|
| Female | 73 (26.4%) | 123 (44.6%) | 36 (13.0%) | 28 (10.1%) | 11 (4.0%) | 5 (1.8%) |
| Male | 69 (28.4%) | 77 (31.7%) | 56 (23.0%) | 16 (6.6%) | 21 (8.6%) | 4 (1.6%) |

Diagnosis varied by ethnicity, although not significant statistically. For example, among the four major groups, African Americans (39.3% within their ethnicity) were more likely to be diagnosed with an adjustment disorder. Also, for instance, Latinos and Asians (44.7% and 45.8% within their groups) were most likely to be diagnosed with an adult disorder (see Table 7).

Table 7. Primary Diagnosis by Ethnicity

| Ethnicity | Adjustment disorder | Adult-Type disorder | Childhood disorder | Relational problem | Deferred diagnosis | No diagnosis |
|------------------|----------------------------|----------------------------|---------------------------|---------------------------|---------------------------|---------------------|
| White | 37 (27.6%) | 39 (29.1%) | 33 (24.6%) | 13 (9.7%) | 11 (8.2%) | 1 (0.7%) |
| Latino | 67 (25.2%) | 119 (44.7%) | 40 (15.0%) | 21 (7.9%) | 11 (4.1%) | 8 (3.0%) |
| African Amer | 24 (39.3%) | 15 (24.6%) | 13 (21.3%) | 4 (6.6%) | 5 (8.2%) | 0 (0.0%) |
| Asian/PI | 13 (27.1%) | 22 (45.8%) | 3 (6.3%) | 6 (12.5%) | 4 (8.3%) | 0 (0.0%) |
| Native Am/Oth | 1 (10.0%) | 5 (50.0%) | 3 (30.0%) | 0 (0.0%) | 1 (10.0%) | 0 (0.0%) |

In testing diagnosis by gender and ethnicity, there was a significant interaction in the White group (see Table 8).

Table 8. Primary Diagnosis by Ethnicity and Gender

| Ethnicity | Adjustment disorder | Adult-Type disorder | Childhood disorder | Relational problem | Deferred diagnosis | No diagnosis |
|---------------|---------------------|---------------------|--------------------|--------------------|--------------------|--------------|
| White | 37 (27.6%) | 39 (29.1%) | 33 (24.6%) | 13 (9.7%) | 11 (8.2%) | 1 (0.7%) |
| Female | 19 (29.7%) | 25 (39.1%) | 8 (12.5%) | 8 (12.5%) | 4 (6.3%) | 0 (0.0%) |
| Male | 18 (25.7%) | 14 (20.0%) | 25 (35.7%) | 5 (7.1%) | 7 (10.0%) | 1 (1.4%) |
| Latino | 67 (25.1%) | 119 (44.6%) | 40 (15.0%) | 21 (8.2%) | 11 (4.1%) | 8 (3.0%) |
| Female | 37 (24.2%) | 73 (47.7%) | 22 (14.4%) | 13 (8.5%) | 3 (2.0%) | 5 (3.3%) |
| Male | 30 (26.5%) | 46 (40.7%) | 18 (15.9%) | 8 (7.1%) | 8 (7.1%) | 3 (2.7%) |
| African Amer. | 24 (39.3%) | 15 (24.6%) | 13 (21.3%) | 4 (6.6%) | 5 (8.2%) | 0 (0.0%) |
| Female | 8 (30.8%) | 6 (23.1%) | 6 (23.1%) | 4 (15.4%) | 2 (7.7%) | |
| Male | 16 (45.7%) | 9 (25.7%) | 7 (20.0%) | 0 (0.0%) | 3 (8.6%) | |
| Asian/PI | 13 (27.1%) | 22 (45.8%) | 3 (6.3%) | 6 (12.5%) | 4 (8.3%) | 0 (0.0%) |
| Female | 8 (29.6%) | 15 (55.6%) | 0 (0.0%) | 3 (11.1%) | 1 (3.7%) | |
| Male | 5 (23.8%) | 7 (33.3%) | 3 (14.3%) | 3 (14.3%) | 3 (14.3%) | |
| Nat Am/Oth | 1 (10.0%) | 5 (50.0%) | 3 (30.0%) | 0 (0.0%) | 1 (10.0%) | 0 (0.0%) |
| Female | 1 (16.7%) | 4 (66.7%) | 0 (0.0%) | | 1 (16.7%) | |
| Male | 0 (0.0%) | 1 (25.0%) | 3 (75.0%) | | 0 (0.0%) | |

Age at Entry into CWS by Ethnicity and Primary Diagnosis. In testing age at entry into the CWS by ethnicity and primary diagnosis, there was a significant interaction effect (see Table 9).

Table 9. Age at Entry into the CWS by Ethnicity and Primary Diagnosis

| Ethnicity | Age at entry (in years) by diagnosis | | | | | |
|--------------|--------------------------------------|---------------------|--------------------|--------------------|--------------------|--------------|
| | Adjustment disorder | Adult-Type disorder | Childhood disorder | Relational problem | Deferred diagnosis | No diagnosis |
| White | 8.11 (4.83) | 11.57 (3.58) | 8.59 (3.99) | 8.21 (5.64) | 9.79 (3.00) | 4.83 (NA) |
| Latino | 8.10 (4.64) | 8.94 (4.00) | 7.01 (4.01) | 9.41 (4.27) | 8.67 (3.89) | 8.14 (5.96) |
| African Amer | 9.81 (3.91) | 9.18 (4.82) | 7.54 (5.52) | 10.00 (6.36) | 12.81 (3.10) | NA |
| Asian/PI | 10.43 (3.41) | 11.91 (4.39) | 7.20 (1.45) | 7.52 (4.66) | 5.26 (2.22) | NA |
| Nat Am/Oth | 17.26 (NA) | 10.55 (3.59) | 4.86 (1.51) | NA | 8.61 (NA) | NA |

Diagnosis varied significantly by length of time in the CWS. Specifically, those diagnosed with childhood disorders had a significantly longer average stay (59.94 months) compared to those with adjustment disorders (35.46 months), adult disorders (38.25 months), and relational problems (28.84 months). See Table 10.

Table 10. Primary Diagnosis by Time in CWS (in Months)

| Characteristic | Time in CWS | | Significant difference |
|---------------------|-------------|---------|---|
| | Mean | (sd) | |
| Adult-type disorder | 38.25 | (39.13) | Childhood > Adjustment, Adult-Type, & Other Diagnoses * |
| Adjustment disorder | 35.46 | (35.52) | |
| Childhood disorder | 59.94 | (51.47) | |
| Relational problem | 28.84 | (38.11) | |
| Deferred diagnosis | 36.39 | (30.98) | |
| No diagnosis | 31.06 | (19.94) | |

* p < .05

Time in the CWS by Ethnicity and Primary Diagnosis. In testing time in the CWS by ethnicity and primary diagnosis, there was not a significant interaction effect. There were main effects by ethnicity and primary diagnosis. Specifically, Asian/PIs were in the CWS significantly less time than African Americans and Whites. And, those diagnosed with childhood disorders were in the CWS longer than those with adjustment, adult, or other disorders. See Table 11.

Table 11. Time in the CWS by Ethnicity and Primary Diagnosis

| Ethnicity | Time in the CWS (in months) by diagnosis | | | | | | |
|------------------------|--|---------------------|--------------------|--------------------|--------------------|------------------|------------------|
| | Adjustment disorder | Adult-Type disorder | Childhood disorder | Relational problem | Deferred diagnosis | No diagnosis | Total |
| White | 45.17 (35.50) | 35.62 (27.21) | 50.11 (43.74) | 25.73 (41.33) | 48.71 (42.43) | 78.82 (NA) | 42.26 (37.06) |
| Latino | 34.58 (37.86) | 40.10 (40.40) | 57.92 (51.97) | 25.69 (29.08) | 25.14 (23.70) | 25.09 (9.37) | 39.18 (40.69) |
| African American | 33.09 (33.27) | 63.10 (64.56) | 88.44 (60.30) | 50.39 (78.71) | 45.90 (18.25) | NA | 54.45 (53.99) |
| Asian/Pacific Islander | 18.69 (19.31) | 15.75 (13.56) | 52.60 (74.22) | 23.62 (23.94) | 21.51 (11.63) | NA | 20.31 (23.66) |
| Native Amer/ Other | 10.55 (NA) | 39.29 (13.66) | 79.07 (48.26) | NA | 36.53 (NA) | NA | 48.07 (33.69) |
| Total | 35.46 (35.52) | 38.25 (39.13) | 59.94 (51.47) | 28.84 (38.11) | 36.39 (30.98) | 31.06 (19.94) | 40.20 (40.88) |

Mental Health Service Utilization by Children in the Child Welfare System.

Univariate, bivariate, and multivariate analyses were also conducted on the subset of

CWS children and youth referred to the MHS to assess the utilization patterns for child welfare clients involved in the mental health system, including the types of services utilized, and the intensity (i.e., frequency and duration) of services. Demographic and system-related characteristics were also evaluated in terms of their association with treatment type and intensity, as well as the relationship between clinical need (diagnosis) and treatment type and intensity. Finally, we examined factors related to mental health treatment completion for child welfare clients.

Utilization of Type of Service: Outpatient, Day Treatment, and Inpatient Services. Within the 519 cases, 475 (91.5%) children received outpatient services as their primary mode, 20 (3.9%) received day treatment services, and 1 (0.2%) received inpatient services. Also, 8 (1.5%) children received both outpatient and day treatment services and 23 (4.4%) did not formally receive any of these primary modes of service. Children in these latter two circumstances (in two modes or with no services) were excluded from some comparative analyses concerning CWS characteristics.

Regarding outpatient services, the average dosage was 18.79 hours of service with a minimum of 0 hours and a maximum of 528.48 hours. For day treatment services, the average dosage was 23.30 days of service with a minimum of 1 day and maximum of 293 days. For inpatient services, the dosage was 94 days for the one client in the data set. Outpatient service was overwhelmingly the majority mode. See Table 12.

Table 12. Utilization (N = 520)

| Characteristic ² | N (%) |
|-----------------------------|------------------|
| Mode of service | |
| Outpatient | 475 (91.5%) |
| Day treatment | 21 (3.9%) |
| Inpatient | 1 (0.2%) |
| No services | 23 (4.4%) |
| | Mean (sd) |
| Dosage | |
| Outpatient (in hours) | 18.79 (38.26) |
| Day treatment (in days) | 23.30 (66.55) |
| Inpatient (in days) | 94.00 (NA) |

² The initial frequencies had “inpatient” included, which made N = 520. In many subsequent analyses, the inpatient case was dropped because n = 1 was too small for comparisons, thus making the N = 519.

Mental Health Service Utilization³ by Major Demographic and CWS

Characteristics. The overwhelming majority of cases received outpatient services as the primary mode and only a few received day treatment or inpatient services. This could have been the reason for most statistical analyses being non-significant. One statistical relationship with CWS characteristics was found, and this was with length of stay in the CWS.

Age. There was no significant relationship between age and mode of mental health service. Among the three modes of service³, the average age of children at CWS entry who also received outpatient services was 8.89 years old. The average age for day treatment was 10.36 years and the one inpatient client was 16.63 years old. See Table 13.

³ Mental health units of service may be under-reported for some of the sample during the last calendar quarter of 2004 due to a change in computer applications.

Table 13. Utilization by Age (in Years)

| Service mode | Age at CWS entry | |
|---------------|------------------|--------|
| | Mean | (sd) |
| Outpatient | 8.89 | (4.29) |
| Day treatment | 10.36 | (5.06) |
| Inpatient | 16.63 | (NA) |

Gender. There was no significant relationship between gender and mode of mental health service. Among males, 220 (98.2%) received outpatient services and 4 (1.8%) received day treatment, and among females 248 (96.5%) received outpatient services, 8 (3.1%) day treatment, and 1 (0.4%) inpatient services. See Table 14.

Table 14. Utilization by Gender and Ethnicity

| Gender | Outpatient | Day treatment | Inpatient |
|--------|-------------|---------------|-----------|
| Female | 248 (96.5%) | 8 (3.1%) | 1 (0.4%) |
| Male | 220 (98.2%) | 4 (1.8%) | 0 (0.0%) |

Ethnicity. There was no significant relationship between ethnicity and mode of mental health service. Among all ethnic groups, the majority mode was outpatient services. See Table 15.

Table 15. Utilization by Ethnicity

| Ethnicity | Outpatient | Day treatment | Inpatient |
|------------------------|-------------|---------------|-----------|
| White | 124 (99.2%) | 1 (0.8%) | 0 (0.0%) |
| Latino | 234 (96.3%) | 8 (3.3%) | 1 (0.4%) |
| African American | 54 (96.4%) | 2 (3.6%) | 0 (0.0%) |
| Asian/Pacific Islander | 47 (100.0%) | 0 (0.0%) | 0 (0.0%) |
| Native American/Other | 9 (90.0%) | 1 (10.0%) | 0 (0.0%) |

Type of Abuse. There was no significant relationship between type of abuse as reason leading to entry into the CWS and mode of mental health service. Among all types of abuse, the majority mode was outpatient services. See Table 16.

Table 16. Utilization by Type of Abuse Leading to Entry Into CWS

| Type of abuse leading to entry into CWS | Outpatient | Day treatment | Inpatient |
|---|-------------|---------------|-----------|
| Caretaker absence/incapacity | 172 (96.6%) | 6 (3.4%) | 0 (0.0%) |
| Physical abuse | 122 (96.8%) | 3 (2.4%) | 1 (0.8%) |
| General neglect | 54 (96.4%) | 2 (3.6%) | 0 (0.0%) |
| Severe neglect | 44 (97.8%) | 1 (2.2%) | 0 (0.0%) |
| Sexual abuse | 40 (100.0%) | 0 (0.0%) | 0 (0.0%) |
| Emotional abuse | 9 (100.0%) | 0 (0.0%) | 0 (0.0%) |
| Law violation | 2 (100.0%) | 0 (0.0%) | 0 (0.0%) |
| Child's disability/handicap | 1 (100.0%) | 0 (0.0%) | 0 (0.0%) |
| Other | 2 (100.0%) | 0 (0.0%) | 0 (0.0%) |

Service Component at Time of Case Closure

There was no significant relationship between service component at time of case closure and mode of mental health service. Among all types of abuse, the majority mode was outpatient services. See Table 17.

Table 17. Service Component at Time of Case Closure by Type of Abuse Leading to Entry into CWS

| Service component at time of case closure | Outpatient | Day treatment | Inpatient |
|---|-------------|---------------|-----------|
| Emergency response (ER) | 30 (100.0%) | 0 (0.0%) | 0 (0.0%) |
| Family maintenance (FM) | 225 (99.1%) | 2 (0.9%) | 0 (0.0%) |
| Family reunification (FR) | 46 (95.8%) | 2 (4.2%) | 0 (0.0%) |
| Permanent placement (PP) | 167 (94.9%) | 8 (4.5%) | 1 (0.6%) |

Time in the CWS. There was a significant relationship between time in the CWS and mode of mental health services. Those who received day treatment had a longer average stay in the CWS (67.56 months) compared to those who received outpatient services (average stay of 38.66 months). See Table 18.

Table 18 Utilization by Time in CWS (in Months)

| Mode of service | Time in CWS Mean (sd) | Significant difference |
|-----------------|--------------------------|------------------------------|
| Outpatient | 38.66 (39.08) | Day Treatment > Out-Patient* |
| Day treatment | 67.56 (56.60) | |
| Inpatient | 24.71 (NA) | |

* p < .05

Outpatient Service Utilization by Major Demographic and CWS Characteristics. Given the overwhelming majority of cases that received outpatient services, further analyses were conducted within this mode of treatment. One statistical relationship with CWS characteristics was found--age at entry into the CWS.

Age. There was a significant positive relationship between age and dosage of outpatient services. An older age was correlated with receiving more outpatient services (see Table 19).

Time in the CWS. There was no significant relationship between length of stay in the CWS and dosage of outpatient services. See Table 19.

Table 19. Outpatient Utilization (Dosage) by Age and Time in CWS

| Characteristic | R |
|-------------------------|------|
| Age (in years) | .09* |
| Time in CWS (in months) | .04 |

* p < .05

Gender. There was no significant relationship between gender and dosage of outpatient services. The average dose among males was 17.41 hours and for females 20.00 hours (See Table 20).

Ethnicity. There was no significant relationship between ethnicity and dosage of outpatient services (see Table 20).

Tweed, M., Osterling, K. L., Hines, A. M., & Lee, P. A. (2007). *Mental health service utilization and outcomes for children and youth in the child welfare system: An empirically-based curriculum*. Berkeley: University of California at Berkeley, California Social Work Education Center.

Type of Abuse. There was no significant relationship between type of abuse leading to entry into the CWS and dosage of outpatient services (see Table 20).

Service Component at Time of Case Closure. There was no significant relationship between service component at time of case closure type and dosage of outpatient services (see Table 20).

Table 20. Outpatient Utilization (Dosage in Hours) by Gender, Ethnicity, Type of Abuse Leading to Entry into CWS, and Service Component at Time of Case Closure

| Characteristic | Outpatient Dosage Mean (sd) |
|---|--|
| Gender | |
| Females | 20.00 (45.19) |
| Males | 17.41 (28.43) |
| Ethnicity | |
| White | 19.01 (41.22) |
| Latino | 18.69 (29.36) |
| African American | 19.02 (41.22) |
| Asian/Pacific Islander | 18.37 (30.14) |
| Native American/Other | 18.80 (20.49) |
| Type of abuse leading to entry in CWS | |
| Caretaker absence/incapacity | 13.50 (19.95) |
| Physical abuse | 21.49 (53.01) |
| General neglect | 28.07 (52.23) |
| Severe neglect | 25.77 (44.10) |
| Sexual abuse | 15.17 (21.16) |
| Emotional abuse | 13.00 (19.56) |
| Law violation | 7.93 (9.69) |
| Child's disability/handicap | 4.83 (NA) |
| Other | 6.17 (5.42) |
| Service component at time of case closure | |
| Emergency response (ER) | 9.04 (18.14) |
| Family maintenance (FM) | 20.88 (45.58) |
| Family reunification (FR) | 23.80 (44.23) |
| Permanent placement (PP) | 16.30 (26.30) |

Model Predicting Utilization of Outpatient Services. In predicting the utilization of outpatient services (dosage in hours), the overall model with age at CWS entry, time in the CWS, sex, ethnicity, type of abuse leading to entry into CWS, service

component at time of case closure, and mental health diagnosis was significant. Within the model, age was significant with those entering at an older age also receiving more outpatient services. Certain types of abuse were significant or marginally significant with those removed for caretaker absence or incapacity or those removed for sexual abuse receiving less outpatient services than those removed for neglect. Service component at time of case closure was marginally significant with those in FM receiving more services. Diagnosis was also significant with those diagnosed with an adjustment disorder, adult disorder, relational problem, or deferred diagnosis all receiving less outpatient services than those diagnosed with a childhood disorder (see Table 21).

Table 21. Multiple Linear Regression: Beta Weights of Outpatient Dosage (Hours of Service) by CWS and MHS Predictors

| Model | |
|---|--|
| Adjusted R ² | .072 |
| F | 3.001 |
| Df | 17, 419 |
| P | .001 |
| Predictors | Beta and Significance |
| Age entering CWS | .153** |
| Time in the CWS | .038 |
| Sex (male vs. female) | -.025 |
| Ethnicity (vs. White) | |
| African American | .019 |
| Latino | .003 |
| Asian/Pacific Islander | -.008 |
| Type of abuse (vs. neglect) | |
| Other reason | -.074 |
| Caretaker absence/incapacity | -.174** |
| Emotional abuse | -.046 |
| Sexual abuse | -.090 ⁴ |
| Physical abuse | -.066 |
| Service component at time of case closure (FM vs. non-FM) | .092 ⁴ |
| Diagnosis (vs. childhood D.O.) | |
| Adjustment disorder | -.349*** |
| Adult disorder | -.265*** |
| Relational problem | -.157** |
| Deferred diagnosis | -.170*** |
| No diagnosis | -.057 |
| Using two-tailed tests | * p < .05 ** p < .01 *** p < .001 ⁴ marginal p < .1 |

Model Predicting Mental Health Treatment Completion Outcome of Those Utilizing Outpatient Services. In predicting mental health treatment completion (vs. treatment non-completion, other, or unknown outcomes) of those receiving outpatient services, the overall model with outpatient dosage (services in hours), age at CWS entry, time in the CWS, sex, ethnicity, service component at time of case closure, type of abuse leading to entry into CWS, and mental health diagnosis was significant. Within the model, age was significant with those entering at a younger age being more likely to have completed treatment. Certain diagnoses were also significant or marginally significant with those diagnosed with an adjustment disorder or deferred diagnosis less likely to have completed treatment compared to those with a childhood disorder. Ethnicity was marginally significant with Latinos being more likely to have completed treatment compared to Whites. Outpatient dosage was also marginally significant with those receiving more services more likely to have completed treatment (see Table 22).

Table 22. Multiple Logistic Regression: Beta Weights of Mental Health Treatment Completion Outcome by CWS and MHS Predictors

| Model | | |
|----------------------------|--------|--|
| Cox & Snell R ² | .121 | |
| X ² | 47.625 | |
| Df | 18 | |
| P | .001 | |

| Predictors | B and Significance | Odds Ratio (Exp B) |
|---|--------------------|--------------------|
| Outpatient dosage | .000 ⁵ | 1.000 |
| Age entering CWS | -.077** | .926 |
| Time in CWS | .004 | 1.004 |
| Sex (male vs. female) | .044 | 1.045 |
| Ethnicity (vs. White) | | |
| African American | .155 | 1.167 |
| Latino | .507 ⁵ | 1.660 |
| Asian/Pacific Islander | .212 | 1.236 |
| Service component at time of case closure (FM vs. non-FM) | -.207 | .813 |

Table 22. Multiple Logistic Regression: Beta Weights of Mental Health Treatment Completion Outcome by CWS and MHS Predictors (cont'd)

| | | |
|--------------------------------|--------------------|-------|
| Type of abuse (vs. neglect) | | |
| Other reason | -20.885 | .000 |
| Caretaker absence/incapacity | .003 | 1.003 |
| Emotional abuse | .843 | 2.323 |
| Sexual abuse | .587 | 1.799 |
| Physical abuse | -.392 | .676 |
| Diagnosis (vs. childhood D.O.) | | |
| Adjustment disorder | -.601 ⁵ | .548 |
| Adult disorder | -.008 | .992 |
| Relational problem | -.364 | .695 |
| Deferred diagnosis | -1.451* | .234 |
| No diagnosis | .355 | 1.426 |

Using two-tailed tests * p < .05 ** p < .01 *** p < .001 ⁵marginal p < .10

In summary, the model predicting mental health treatment completion was significant with: (a) those entering the CWS at a younger age being more likely to have completed treatment, (b) those diagnosed with an adjustment disorder or deferred diagnosis less likely to have completed treatment compared to those with a childhood disorder, (c) Latinos being more likely to have completed treatment compared to Whites, and (d) those receiving more out-patient services more likely to have completed treatment.

Association of Mental Health Service Utilization and Child Welfare Outcomes. To answer our fourth research question, univariate, bivariate, and multivariate analyses were conducted on the subset of CWS children and youth referred to the MHS. These analyses focused on testing the association between mental health service utilization and the child welfare outcome of “family stabilization.” Family stabilization included cases in which children were reunified, as well as children who remained in the home with family maintenance services; cases in which family

stabilization did not occur were closed with another type of permanent placement, such as adoption, long-term foster care, or guardianship.

Mental Health Service Utilization by Family Stabilization. Within the sample of 519 children, 219 (42.2%) were stabilized with their families (defined as either family stabilized or reunified) and 300 (57.8%) were not. There was no statistical relationship between whether children were stabilized with their families and mode of mental health services. However, a trend was found in that 203 (43.4%) who had received outpatient services were stabilized with families compared to only 2 (16.7%) who received day treatment. The one inpatient client was not stabilized (see Table 23).

*Table 23. Family Stabilization by Utilization**

| Service Mode | Stabilized | | Not Stabilized | |
|---------------|------------|---------|----------------|----------|
| | n | (%) | n | (%) |
| Outpatient | 203 | (43.4%) | 265 | (56.6%) |
| Day treatment | 2 | (16.7%) | 11 | (83.3%) |
| Inpatient | 0 | (0.0%) | 1 | (100.0%) |

* Table 23 will not total to 519 due to missing data

Family Stabilization of CWS Clients Receiving Outpatient Services. In examining family stabilization by major CWS demographic characteristics (age, gender, and ethnicity) specifically among those who received outpatient services, a significant relationship was found with ethnicity (see Table 24).

Age. Among those who received outpatient services, no relationship was found between age at CWS entry and stabilization.

Gender. Among those who received outpatient services, no relationship was found between gender and stabilization.

Ethnicity. Among those who received outpatient services, a significant

relationship was found between ethnicity and stabilization. Among the four major ethnic groups, Asian/Pacific Islanders were the most likely to be stabilized (59.6%), followed by Latinos (46.2%), African Americans (37.0%), and then Whites (34.7%; see Table 24).

Table 24. Family Stabilization by CWS Demographic Characteristics

| Characteristic | Stabilized | | Not Stabilized | |
|------------------------|------------|------------|----------------|------------|
| | Mean | (sd) | Mean | (sd) |
| Age (in years) | 8.78 | (3.88) | 8.97 | (4.59) |
| Gender | n | (%) | n | (%) |
| Male | 98 | (44.5%) | 122 | (55.5%) |
| Female | 105 | (42.3%) | 143 | (57.7%) |
| Ethnicity | | | | |
| White | 43 | (34.7%) | 81 | (65.3%) |
| Latino | 108 | (46.2%) | 126 | (53.8%) |
| African American | 20 | (37.0%) | 34 | (63.0%) |
| Asian/Pacific Islander | 28 | (59.6%) | 19 | (40.4%) |
| Native American/Other | 4 | (44.4%) | 5 | (55.6%) |

Model Predicting Family Stabilization. In predicting family stabilization, the model with utilization of outpatient services (dosage in hours), age at CWS entry, time in the CWS, sex, ethnicity, type of abuse leading to entry into CWS, service component at time of case closure, successful mental health case outcome, and diagnosis was significant. Within the model, age at CWS entry was significant with those entering younger more likely to be stabilized, and similarly time in the CWS was significant with those in the system less time more likely to be stabilized. Service component at time of case closure was also significant with those in FM more likely to be stabilized. Type of abuse leading to entry into CWS was also significant with those removed for caretaker absence/incapacity or sexual abuse less likely to be stabilized with their families than those removed for neglect (see Table 25).

Table 25. Multiple Linear Regression: Betas of Family Stabilization by CWS and MHS Predictors

| Model | | |
|----------------------------|---------|--|
| Cox & Snell R ² | .374 | |
| X ² | 173.135 | |
| Df | 19 | |
| P | .001 | |

| Predictors | B and Significance | Odds Ratio (Exp B) |
|---|---------------------------|---------------------------|
| Outpatient dosage | .000 | 1.000 |
| Age entering CWS | -.070* | .932 |
| Time in the CWS | -.033*** | .968 |
| Sex (male vs. female) | .385 | 1.471 |
| Ethnicity (vs. White) | | |
| African American | .669 | 1.953 |
| Latino | .520 | 1.682 |
| Asian/Pacific Islander | -.127 | .881 |
| Type of abuse (vs. neglect) | | |
| Other reason | -.395 | .673 |
| Caretaker absence/incapacity | -.746* | .474 |
| Emotional abuse | .087 | 1.091 |
| Sexual abuse | -1.192* | .303 |
| Physical abuse | -.308 | .735 |
| Service component at time of case closure (FM vs. non-FM) | 2.396*** | 10.982 |
| MH discharge (Completion vs. non-completion) | -.266 | .766 |
| Diagnosis (vs. childhood D.O.) | | |
| Adjustment disorder | -.220 | .802 |
| Adult disorder | -.026 | .975 |
| Relational problem | .757 | 2.131 |
| Deferred diagnosis | -.416 | .660 |
| No diagnosis | -21.065 | .000 |

Using two-tailed tests * p < .05 ** p < .01 *** p < .001 ^a marginal p < .10

In summary, the model predicting family stabilization was significant, with: (a) those entering the CWS at a younger age more likely to be stabilized, (b) those in the system less time more likely to be stabilized, (c) those in FM more likely to be stabilized, and d) those removed for caretaker absence/incapacity or sexual abuse less likely to be stabilized with their families than those removed for neglect.

Activity II-1: Discussion Questions

- Studies suggest failure to address emotional and behavioral problems of children in foster care is associated with a decreased likelihood of reunification. Given the findings from Activity II-1, which groups are most likely affected by this? Should mental health services be ordered for all children who have a court-ordered plan of family reunification? Why or why not?
- What are the findings from Santa Clara County with regard to family stabilization/reunification?
- Which of the following types of maltreatment (in order of priority) does your group think most warrants mental health services? Why? (Make sure to provide a clear rationale for your response).
 - Sexual abuse
 - Physical abuse
 - Chronic neglect
 - Parental absence/incapacity

Activity II-2: Case Scenario

Purpose: To provide an opportunity to reflect on key findings from the research and apply new knowledge to a case planning scenario.

Instructions: Get into small groups and review the case scenario and key points from the quantitative research. Then address the questions following the case scenario.

Process: The instructor may elect to compile the results of the small group to determine the beliefs of the participant group as a whole.

Case Scenario

You are a social worker in the Family Reunification unit and have just received a new, recently adjudicated case with an African American family. There are two children in the family: Gloria, age 9, and Eli, age 4. Gloria has been sexually abused by her stepfather and both children have been neglected. The mother is currently incarcerated in a women's prison on an unrelated conviction. You would like to get immediate counseling services for Gloria as she is exhibiting behavioral problems in the foster home where she is placed with her sibling. However, your co-worker also has a case involving severe physical abuse that warrants mental health services and county behavioral health can only accommodate one child at this time for services.

Some key points of the quantitative research include:

- Whites are the least likely to be stabilized with their families.
- Those diagnosed with childhood disorders stayed significantly longer in the child welfare system.
- Children entered the child welfare system at 6.87 years, and yet the entry to the mental health system occurred at 8.97 years.
- A greater percentage of children are referred for mental health services who have been victims of physical and sexual abuse than other types of maltreatment (a finding that can be interpreted as meaning that sexual and physical abuse are more severe than neglect and parental absence/incapacity).
- Approximately 60% of children are not stabilized with their families. Current research indicates there is no statistically significant difference in the rate of family stabilization for those receiving or not receiving mental health services.

Questions:

- How will you advocate to your supervisor and program manager that Gloria needs services first?
- What have you learned from the current research that might support your request?
- Or, do you believe the other case is more compelling?
- If so, what have you learned from the current research that would support this opinion?
- How would you advocate for system change so that in the future there are adequate services to meet both children's mental health needs?

SECTION III

**POLICIES AFFECTING
MENTAL HEALTH SERVICE UTILIZATION
BY CHILDREN IN THE CHILD WELFARE SYSTEM**

SECTION III INSTRUCTIONAL GUIDE

Learning Objectives

This section provides an overview of federal, state, and local policies that impact service delivery for both the child welfare and mental health systems. Students may have been exposed to some of this content in their respective academic programs, but it is helpful to view these policies specifically from the perspectives of these two systems in order to better understand the issues and implications for practice. Specifically, information on the following legislation is provided:

- Adoption and Safe Families Act (1997),
- Child and Family Service Review (2000),
- Child Abuse Prevention and Treatment Act (as amended by the Keeping Families Safe Act, 2003),
- Child and Adolescent Service System Program (1984),
- Medi-Cal eligibility, and
- Mental Health Services Act (2004).

Activities in this section are intended to increase participant's knowledge and understanding of policy affecting delivery of mental health services to children by focusing on various policies at the federal, state, and local levels.

By the end of this section participants will:

- Have increased knowledge of the mental health service delivery structure at the federal, state, and local levels,
- Have basic understanding of Medi-Cal eligibility requirements and restrictions,
- Be able to identify three current mental health policies relating to child welfare clients, and

- Have increased awareness of the impact of child welfare funding and policies on the provision of mental health services.

Public Child Welfare Competencies (MSW)

I Ethnic Sensitive and Multicultural Practice

- 1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.

II Core Child Welfare Practice

- 2.5 Student is aware of forms and mechanisms of oppression and discrimination pertaining to low-income and single-parent families and use this knowledge in providing appropriate child welfare services.
- 2.10 Student understands policy issues and child welfare legal requirements and demonstrates the capacity to fulfill these requirements in practice.
- 2.11 Student understands the process of the legal system and the role of social workers and other professionals in relations to the courts.

VI Advanced Child Welfare Practice

- 6.3 Student understands the requirements for effectively serving and making decisions regarding children with special needs and the balancing of parental and child rights.

VII Human Behavior and the Child Welfare Environment

- 7.4 Student is able to identify agency and legislative policies and procedures that create barriers to the growth and development of children and families.

Agenda and Suggestions for Instructors

Time allocation: 1 hour

Introduction

- Introduction of instructor/trainer
- Brief introduction to section content on policy
- Introduction of participants (if not part of ongoing course)

Overview of federal policy

- Show PowerPoint slides (or transparencies) 21-26 related to federal policy
- Complete Activity III-1

Overview of state policy and Medi-Cal program

- Show PowerPoint slide (or transparency) 27
- Complete Activity III-2

Overview of local policy

- Show PowerPoint slide (or transparencies) 28 related to Prop. 63
- Complete Activity III-3

Overview of study findings

- Show PowerPoint slides (transparencies) 29-34
- Large group discussion focused on implications for practice

Instructors are encouraged to use this section in a range of ways that meet their goals and audience. For example, instructors may elect to provide content on policy at all levels (federal, state, and local) or may choose to focus on any one of those. Activity III-1 may be particularly relevant to a child welfare policy course.

Materials Needed

- Overhead projector
- PowerPoint slides (or transparencies) 21-34
- Handouts
- Markers and flip chart or white board (optional for writing key points in response to questions for class discussion)

SECTION III CHILD WELFARE POLICIES AFFECTING MENTAL HEALTH SERVICE UTILIZATION

Provision of mental health services to children involved in the child welfare system is affected by a number of federal, state, and local policies. The Adoption and Safe Families Act (ASFA) of 1997 created shortened timelines for the provision of family reunification services and termination of parental rights within the child welfare system. A permanency hearing must take place after 1 year of out-of-home placement and proceedings for the termination of parental rights must be initiated when a child has been in out-of-home care for 15 of the previous 22 months. Some practitioners and scholars note that it can be difficult to locate available mental health services within the shortened timelines mandated by the ASFA and that some children and families may have difficulty completing treatment within these shortened timeframes (Webb & Harden, 2003). However, it is also possible that shortened timelines may provide an impetus for child welfare agencies to establish collaborative relationships with mental health providers in order to ensure timely access to mental health services (Webb & Harden).

The ASFA also stipulated state requirements for ensuring the safety, permanency, and well-being of children in the child welfare system. In 2000, Congress passed regulations designed to monitor state performance with respect to key outcomes for children in the child welfare system. These regulations, defined as the *Child and Family Service Review (CFSR)* process, were first implemented in 2001 and focus on measuring outcomes for children and families involved in the child welfare system.

Outcomes assessed are related to child safety, permanency, and well-being. Among the priority outcomes that are assessed in the review process is an outcome related to ensuring that children receive adequate services to meet their physical and mental health needs. This outcome is assessed through case reviews. Currently, all 50 states as well as the District of Columbia and Puerto Rico have completed the first CFSR and results revealed that only one state was in substantial conformity with the outcome related to ensuring adequate services to meet children's physical and mental health needs. However, some scholars note that these data may not be reliable because they are based on a sample of just 50 cases from each state, and in many instances, information related to the outcome of interest may not be available in the case record. As a result, some outcomes are assessed based on just a handful of cases, making it difficult to truly assess state performance (Lemon, D'Andrade, & Austin, 2005). Despite these difficulties, state officials report that the CFSR process has contributed to improved collaborative relationships between the child welfare system and community stakeholders (U.S. Government Accounting Office, 2004), and scholars note that the review process may provide the momentum necessary for child welfare agencies to form stronger collaborative relationships with mental health providers (Webb & Harden, 2003).

The Child Welfare System Improvement and Accountability Act was passed in 2001 and represents California's efforts to create a system through which to evaluate child welfare outcomes and track progress toward performance goals. California Child and Family Service Reviews were first implemented in 2004 and are intended to

address many of the methodological problems associated with the federal government's measurement of child welfare outcomes and thus, they are considered to provide a more comprehensive evaluation of county performance. As in the federal review process, the overall outcomes assessed in California CFSRs are related to child safety, permanency, and well-being.

A portion of the specific outcomes assessed in the California CFSRs correspond to the federal review outcomes; however, California also included additional specific measures that are intended to be more comprehensive. For instance, California's review process includes an outcome related to the well-being of youth emancipating from the child welfare system. In addition, the California CFSRs use longitudinal data to assess county performance and thus, more accurately measure performance over time (Lemon et al., 2005). As is the case with the federal accountability legislation, this state legislation has the potential to increase collaboration between the child welfare and mental health systems.

In addition to California's statewide efforts at measuring child welfare outcomes, the federal *Child Abuse Prevention and Treatment Act, as amended by the Keeping Children and Families Safe Act of 2003*, provides grants to states to provide a variety of child welfare services. In the 2003 amendments, a new purpose related to the promotion of collaboration between the child welfare system and other child-serving systems was added. Specifically, one of the new purposes of the legislation is to encourage and support collaboration among the child welfare system, public health agencies, and community-based organizations to provide services that address the

health and mental health needs of children (U.S. Department of Health and Human Services, Children's Bureau, 2003).

Mental Health Service Delivery Structure for Children

The main funding source for mental health services for children in the child welfare system is the federal Medicaid health insurance program (Medi-Cal represents California's Medicaid program). Children are entitled to Medicaid/Medi-Cal if they are in low-income families or in families receiving welfare benefits, if they have a disability and receive Supplemental Security Income (SSI), or if they are involved in the child welfare system (Howell, 2004). Although there are federal requirements within Medicaid, each state may establish its own eligibility guidelines, and service and payment structure (Geen et al., 2005). In addition, some children in the child welfare system are covered by private insurance through their birth or foster parents. Due to differences between states in implementation of the Medicaid program, as well as differences in coverage between private insurance and Medicaid, there is wide variation in the types of mental health services that children in the child system may access (Geen et al., 2005).

In California, the Medi-Cal health insurance program has moved to a managed care model in which mental health services for children are "carved out" to create a fee-for-service (FFS) model of reimbursement (Howell, 2004). Mandated Medicaid/Medi-Cal mental health services for children include inpatient care; outpatient care; and Early Periodic Screening, Diagnosis, and Treatment (EPSDT). Optional mental health services include inpatient psychiatric care, psychiatric medications, rehabilitation, and case management. In California, children who are diagnosed as Severely Emotionally

Disturbed (SED) can receive the array of Medi-Cal mental health services with few restrictions; children who are not diagnosed with SED are limited to 20 visits or 30 days in treatment (Howell).

In addition, children in the child welfare system may also access mental health services through the Victims Compensation Program (also referred to as “Victim Witness”). This program provides funds for mental health counseling, as well as other services, for persons who are victims of violent crimes, including children who experience child maltreatment. To obtain funds for counseling, a state application must be submitted and approved by the California Victim Compensation and Government Claims Board. Applications typically take 90 days to be reviewed and approved. Children experiencing substantiated child maltreatment are eligible to receive up to \$10,000 in funding for mental health counseling (California Victim Compensation and Government Claims Board, 2006).

Mental Health Policies Affecting Mental Health Service Utilization

Among federal mental health policies, the *Child and Adolescent Service System Program (CASSP)* that was first initiated and funded by the National Institute of Mental Health in 1984 has had a major influence on interventions for children with emotional and behavioral disorders (Stroul & Friedman, 1986). The CASSP legislation provided funding for interventions that utilized a “system of care” philosophy which contains an overarching goal to provide a comprehensive array of coordinated mental health and other social services (e.g., juvenile justice, child welfare, and Special Education) in order to meet the myriad needs of children and youth with severe emotional and

behavioral problems (Stroul & Friedman). Building on the CASSP foundation, the federal Center for Mental Health Services first authorized funding for the *Comprehensive Community Mental Health Services for Children and their Families Program* in 1992. This program has provided grants to 92 communities around the U.S. in order to develop interagency systems of care that link systems serving children with mental health problems. Interagency systems of care seek to reduce service gaps and service duplication, ensure access to needed services, increase continuity of care, and ultimately result in improved outcomes for children with serious emotional and behavioral problems (Rivard, Johnson, Morrissey, & Starrett, 1999).

In November 2004, California voters approved the *Mental Health Services Act* (Proposition 63). This legislation created a 1% tax on personal income over \$1 million and has generated approximately \$600 million in new state funding for mental health services in California (California Department of Mental Health, 2005a). Approximately 20% of these funds will be devoted to children and youth with mental health problems (Fight Crime: Invest in Kids, 2005). As California counties roll out this initiative, mental health systems will need to adjust their roles within child welfare settings. One of the guiding principles of the legislation is to encourage strong collaboration between child-serving systems, including child welfare, juvenile justice, education, and mental health (California Department of Mental Health, 2005b). Counties are currently in the process of distributing grants to implement mental health services funded by the Mental Health Services Act.

In December 2005, California counties were required to submit implementation plans for funds provided by the Mental Health Services Act to the California Department of Mental Health. In Santa Clara County, where the current study was conducted, strengthening existing collaborations among child-serving systems—including the collaboration between child welfare and mental health systems—is a component of this plan. In Santa Clara County, existing interagency collaborations include the Resources and Intensive Services Committee (RISC), which is comprised of representatives from mental health, juvenile justice, and the child welfare systems, as well as other service providers. This committee meets weekly to discuss cases in which children are being considered for a higher level of care. The mental health system also meets monthly with social services and juvenile probation to address any issues related to service provision from the community treatment facility. Last, the community team wraparound interagency group meets monthly to discuss issues related to implementation of wraparound services (Santa Clara County Mental Health Department, 2005).

Study Findings

To better understand the ways in which policy issues affect collaboration between the child welfare and mental health systems, qualitative in-depth interviews were conducted with program managers and supervisors in both systems as well as focus groups with line staff. In each system, three program managers and three supervisors were interviewed and three focus groups with line staff were conducted (see Appendix A for a full description of Study Methods and Procedures).

Questions and responses from participants focused on a variety of themes (see Section IV for additional results from the qualitative portion of the study); however, responses related to policy issues focused on: (a) funding restrictions, (b) a lack of mental health services, (c) the need for infrastructures to facilitate collaboration, and (d) the potential impact of the Mental Health Services Act (Proposition 63).

Overall Theme #1: Funding Restrictions

Table 26. Funding Restrictions

| Type of Respondent | Themes |
|---|--|
| Child welfare program managers, supervisors, and line staff | <ul style="list-style-type: none"> • Difficulty accessing services for families with private insurance were described • Process of applying for Medi-Cal can delay services • Problems accessing services for children with Healthy Kids insurance • Victim Witness funds described as inadequate • Lack of services for parents due to funding • Eligibility criteria differ based on funding sources |
| Mental health program managers and line staff | <ul style="list-style-type: none"> • Not able to bill Medi-Cal for family therapy • There is a need to share resources between systems |

Funding restrictions were described as an impediment to strong collaboration between systems. Child welfare line staff discussed problems related to accessing services for families with private insurance. Among families not covered by private insurance, delays in accessing services can occur while child welfare workers are applying for Medi-Cal. Such delays were described as causing a conflict with child welfare timelines. One child welfare line worker stated:

- For families in the voluntary Family Resource Centers, they often only have services for 3 months, and we sometimes have to spend a lot of time getting them Medi-Cal, and then there is often a waiting list to see the mental health worker, so we can eat up the time that they have just trying to get them services.

Child welfare program managers also noted eligibility criteria associated with differing funding sources as a barrier. A child welfare line worker identified problems in accessing services for children covered by Healthy Kids insurance, while another worker discussed the inadequacy of Victim Witness funds. A lack of services for parents was also mentioned:

- Adults in the family have difficulty getting services; there are no resources for adults.
- The parents cannot get counseling if they do not have custody of the child, but they cannot get their children back unless they get counseling.

Similarly, mental health program managers discussed problems related to funding restrictions. One mental health program manager commented that they are not able to bill Medi-Cal for family therapy services. Another mentioned the need to share resources between systems:

- There are shared funding streams, but we need to think about how we can be more creative with funding and sharing resources.

Overall Theme #2: Lack of Mental Health Services

Table 27. Lack of Mental Health Services

| Type of Respondent | Themes |
|---|--|
| Child welfare program managers, supervisors, and line staff | <ul style="list-style-type: none"> • There is a need for more mental health services and improved mechanisms to access services, especially in the South County region • Difficulty accessing mental health services can be problematic due to child welfare timelines • Mental health system’s eligibility requirement of a mental health diagnosis can create challenges to accessing mental health services • There is a need for mental health services for parents • There is a need for mental health services targeted specifically to children in the child welfare system • There is a need for culturally competent and linguistically appropriate mental health services • There is a need for dual diagnosis services |

Table 27. Lack of Mental Health Services (cont'd)

| Type of Respondent | Themes |
|---|--|
| Mental health program managers and line staff | <ul style="list-style-type: none"> • Service access often dependent on Medi-Cal eligibility requirements that require a mental health diagnosis • There is a need to provide culturally competent and linguistically appropriate services to children of color |

Child welfare program managers, supervisors, and line workers discussed a need for more mental health services for children in the child welfare system and improved mechanisms to access services. One child welfare program manager stated:

- Access to services is difficult at times. There are limited services and waiting lists and the time frames in child welfare often make it difficult for families.

In addition, problems obtaining needed services were noted as especially difficult in the South County region. Comments included:

- The kids in South County don't always get the same assessments. We don't take kids to the Children's Shelter. There is a different process for our kids. Initial mental health assessments are done at the Children's Shelter. We can take kids to the shelter to get assessments, but it is difficult to transport kids there.
- For clients in South County, it is very difficult for them to get to the Main County. We are willing to share space [with mental health] in our office in order to get services.
- For kids not at the shelter or who are in South County, it is a barrier that we don't have someone here from mental health—that would make a huge difference.

Difficulties accessing mental health services for parents were also described. Child welfare line workers discussed the lack of mental health services as a particular problem because of child welfare timelines. One worker stated:

- Timelines are an issue too, if there are waiting lists, this can be difficult. The court orders counseling and we can't get the services.

Child welfare supervisors also described a need for mental health services that were specifically targeted to the needs of children in the child welfare system:

- They [mental health system] don't have a lot of kids programs. They don't have specializations, like sexual abuse or Post Traumatic Stress Disorder.

In addition, child welfare supervisors also expressed a need for culturally competent and linguistically appropriate mental health services, as well as more services for children and parents with a dual diagnosis of mental health and substance abuse problems.

Mental health program managers did not comment on service adequacy and access to the same degree as child welfare supervisors and program managers; however, one mental health program manager commented on the need to expand services:

- Mental health needs to look at its own system to expand capacity to provide services. For instance, we could do more to expand on the Children's Shelter—expand the link and follow-up on all children entering the system.

Another mental health program manager described the service needs of children of color in both systems:

- The majority of children in the child welfare system are children of color, especially Latinos, and we need to provide culturally competent, linguistically appropriate services to them.

Like child welfare program managers, mental health program managers described eligibility requirements as a barrier to service access, however this barrier was described as an unavoidable circumstance related to funding. One mental health program manager commented:

- DFCS feels there is a large gap that is not being served, but mental health has to deal with Medi-Cal requirements—this includes an SED diagnosis in order to be served. This is an Axis I diagnosis; there has to be clear impairment in two or three areas of functioning. Now we are seeing a movement to seeing the less serious kids. This is a positive improvement.

Overall Theme #3: Infrastructures to Facilitate Collaboration

Table 28. *Infrastructures to Facilitate Collaboration*

| Type of Respondent | Themes |
|---|---|
| Child welfare program managers, supervisors, and line staff | <ul style="list-style-type: none"> • Information sharing about available resources is important • A liaison between mental health and child welfare may improve service coordination • Co-location of services will facilitate collaboration • Memorandums of Understanding and contracts facilitate formal collaboration |
| Mental health program managers and line staff | <ul style="list-style-type: none"> • Co-location of services fosters collaboration • Formal meetings involving both systems can improve collaboration • An infrastructure for collaboration will improve communication and reduce conflicts • Increased use of multidisciplinary teams • Shared database between systems will facilitate information sharing |

The development of system infrastructures to facilitate collaboration, communication, and service coordination was consistently described as an important mechanism to foster strong collaboration between the two systems. Child welfare line workers frequently discussed the importance of communication between systems with respect to information sharing about available services. Comments included:

- Having a list of service providers would be really helpful...there is no central way of knowing the services. There are services we don't know about.
- It would be helpful to have lists on the intranet so that all social workers could access them.
- In continuing you have to be pretty motivated to build your resources, you end up preserving a lot more placements by the more [resources] you know.

- I have outdated listings of available therapists—so it [finding services] is kind of a shot in the dark a lot of the time.
- For those who do a lot of resourcing, one of the barriers is that you can't always do it in the time allotted for your job. So for those of us who are into resources, it often requires over-time and that is a big barrier. Overtime is not allowed.
- We don't know what Wraparound is required to do, what services they are to provide....it would be helpful to have Memorandums of Understanding on the intranet so that we could read them and refer to it.
- There's a lot of institutional knowledge contained by certain workers, one worker may be really knowledgeable about what is available and what should be happening, but then when that worker goes—there goes the knowledge.

A liaison between mental health and child welfare was suggested as a way to increase service coordination. Comments included:

- It would be helpful to have liaisons or gatekeepers—someone with flexibility who can work with us.
- We have an educational rights specialist to advocate for kids who aren't getting what they need in the educational system. Having something similar in mental health would help a lot.

One child welfare supervisor discussed co-location of services as a way to increase collaboration:

- The location of the mental health unit at the shelter helps with collaboration. When you have someone on site that is a big factor in collaboration.

Child welfare program managers described Memorandums of Understanding (MOUs) and contracts as tools that can strengthen communication. A need for mechanisms to share information was also noted. One child welfare program manager stated:

- Overall, there is no forum or venue for providing information—unless you are already connected—which is only a limited number and it does not trickle down to line staff.

One child welfare program manager suggested the use of newsletters to help improve communication:

- Newsletters or some updates to help inform us of system changes would be helpful.

Mental health line staff identified the co-location of services from the mental health staff at the Family Resource Centers as an effective mechanism to foster collaboration. Formal meetings involving both systems were also mentioned as promoting strong collaboration. Comments from mental health program managers included:

- We need formal meetings to take place across the systems and send messages all the way down to the line staff regarding the importance of collaboration.
- If the institution had some mechanism for collaboration such as meetings when there is an opportunity for lining up policy, programming, and practices in a way that will allow for better collaboration at the line staff level.
- It is a challenge to inform social workers what is available. With staff turnover and the golden handshake, there's been a loss of intellectual capital. We need a formal structure to tell social workers what is available.

Other comments suggested that the creation of mechanisms to foster communication could have the potential to reduce conflicts:

- We need a formal way to increase communication. This will limit finger pointing.
- There will be times when communication breaks down and this is managed on a case-by-case basis. I would like to see more structure put into that.
- We need consistent meetings from all parties involved, from the very beginning. Problems can be solved if we set up mechanisms to do that.
- We need structures and accountability, expectations and outcomes, and we need to provide concrete assistance to staff, particularly at the line staff level to embrace it.

- We need clear protocols for addressing conflicts in both systems and sticking to it.

Increased use of multidisciplinary teams as mechanisms to foster communication and collaboration between systems was also mentioned. A shared database between systems was also identified as a potentially important tool to increase the sharing of information:

- Sharing databases would be helpful, being able to access their system in order to get access to information.

Overall Theme #4: Potential Impact of the Mental Health Services Act (Proposition 63)

Table 29. Potential Impact of the Mental Health Services Act (Proposition 63)

| Type of Respondent | Themes |
|--------------------------------|---|
| Child welfare program managers | <ul style="list-style-type: none"> • Mental Health Services Act may not impact collaboration • Overall, hopefulness that it will have a positive impact |
| Child welfare supervisors | <ul style="list-style-type: none"> • Some funds from the Mental Health Services Act should be devoted to children in the child welfare system |
| Mental health program managers | <ul style="list-style-type: none"> • Involvement of Social Services Department in planning for Proposition 63 funds reflects improved collaboration |

Perspectives from child welfare program managers on the potential impact of the Mental Health Services Act ranged from the opinion that it would not impact child welfare clients to hopefulness that the new funding will improve collaboration and service provision. Comments included:

- I don't think Proposition 63 will do a whole lot for kids in child welfare. I don't think we will receive a lot from Proposition 63.
- I am hopeful that it will improve collaboration.
- Hopefully it will get us talking and thinking through these programs and how to leverage resources.

In general, child welfare supervisors felt that some funds from the Mental Health Services Act should be specifically devoted to increasing mental health services for children in the child welfare system. Comments included:

- It's a lot of money and it seems to me there ought to be some commitment to foster kids...They should prioritize programs for these kids...We scramble on our own to find services.
- I hope that it [Proposition 63] brings additional resources and ease in accessing these resources.

Mental health program managers described the involvement of the Social Services Department in Proposition 63 planning meetings as a reflection of the positive impact of the proposition on collaboration between the two systems. One mental health program manager stated:

- There were meetings between mental health providers and DFCS providers to talk about Proposition 63 and how to coordinate it with their System Improvement Plans. We were talking about our goals and objectives together and this was a first.
- We have made sure they are at the meetings to provide input and they have been doing that.

Ongoing meetings between the mental health and child welfare systems were described as a requirement of the implementation plan for the Mental Health Services Act. In addition, mental health program managers described Proposition 63 as a tool to improve collaboration and service delivery to children in the child welfare system.

Comments included:

- There's a desire to blend and integrate services more. Proposition 63 could do that.

However, one mental health program manager noted that the current request for proposals for Proposition 63 funds focuses on the most severe clients and that the capacity to serve child welfare clients will increase in the future.

Summary of Findings

The following key findings related to policy issues affecting collaboration between the child welfare and mental health systems emerged from interviews and focus groups with child welfare and mental health program managers, supervisors, and line workers.

Funding restrictions related to private insurance, applying for Medi-Cal, and Medi-Cal eligibility requirements were noted as policy-related barriers to mental health service utilization by children in the child welfare system.

- Among families not covered by private insurance, delays in accessing services can occur while child welfare workers are applying for Medi-Cal. Such delays were described as causing a conflict with child welfare timelines associated with the Adoption and Safe Families Act (ASFA).
- Difficulty accessing services for parents was noted as a problem due to Medi-Cal funding restrictions for adults or for family therapy.

An overall ***lack of mental health services*** for children in the child welfare system was also described as a policy-related barrier to mental health service utilization. A lack of mental health services was noted as a particular problem because of timelines related to the ASFA.

- Child welfare participants described limited services and waiting lists for services as conflicting with child welfare timelines.
- Child welfare participants noted problems obtaining needed services as especially difficult in the South County region.
- Mental health participants described a need for more culturally competent and linguistically appropriate mental health services.

The need for ***infrastructures to facilitate collaboration*** also emerged as a policy-related issue affecting collaboration between the two systems.

- Child welfare participants frequently discussed the importance of communication between systems with respect to information sharing about available services.
- Child welfare participants suggested a liaison between mental health and child welfare as a way to increase service coordination.
- Child welfare and mental health participants noted the co-location of services as a potentially effective system infrastructure to facilitate collaboration.
- Mental health participants suggested the increased use of multidisciplinary teams as a system infrastructure that may improve collaboration.

Respondents also provided information on ***the potential impact of the Mental Health Services Act (Proposition 63) on the collaborative relationship between systems.***

- Perspectives from child welfare participants were largely hopeful that Proposition 63 would improve collaboration between systems as well as improve services for children in the CWS.
- However, some child welfare staff expressed doubt that Proposition 63 would impact children in the CWS, and a need for the MHS to prioritize services for children in the CWS was also expressed.
- Mental health participants described the involvement of the Social Services Department in the planning of Proposition 63 implementation as a reflection of the positive impact of Proposition 63 on collaboration.

Implications for Child Welfare Practice

Qualitative results from this study suggest a number of policy-related areas that may improve collaboration between the child welfare and mental health systems.

- Streamlining application processes for Medi-Cal may increase timely access to services and reduce problems associated with access to services within the timelines mandated by the ASFA.

- There is a need to develop policies to improve access to services for families with private insurance.
- There is a need to improve communication between workers at all organizational levels. The development of system infrastructures to facilitate and encourage communication between line workers, supervisors, and program managers in both systems may improve communication and service coordination.
- For instance, the consistent use of joint treatment planning meetings (e.g., family conferences, team decision-making, etc), may help workers to overcome certain individual-level factors related to differing professional orientations and perspectives. Formalized joint treatment planning meetings may allow workers in both systems to develop a shared treatment plan that corresponds to the treatment goals within the MHS, while also meeting court mandates.
- In addition, the co-location of services also represents an important system infrastructure that facilitates collaboration. Outstationed mental health workers at the Children’s Shelter and the Family Resource Centers were identified as a positive formal collaboration between systems, and child welfare workers suggested that a liaison between mental health and child welfare could improve workers’ knowledge of existing services.
- Increased use of Memorandums of Understanding and the creation of shared databases were also identified as system infrastructures that can improve communication and collaboration.
- The Mental Health Services Act has the potential to improve mental health services for children in the child welfare system and increase collaboration between the child welfare and mental health systems.

Activity III-1: Federal Policies

Instructions/Process: Participants will review the descriptions of federal child welfare and mental health policy and legislation provided below. The instructor will then assign one of the policies to each small group to complete the activity below:

Activity:

1. In small groups, review and discuss the main elements of the selected policy.
2. Provide specific examples from experience describing how this policy has been working in your county.
3. Brainstorm with your group how mental health services utilization may be impacted by this policy.
4. Share your responses with the larger group.

Policies:

- **Adoption and Safe Families Act (1997).** The Adoption and Safe Families Act (ASFA) of 1997 created shortened timelines for the provision of family reunification services and termination of parental rights within the child welfare system. A permanency hearing must take place after 1 year of out-of-home placement and proceedings for the termination of parental rights must be initiated when a child has been in out-of-home care for 15 of the previous 22 months. Some practitioners and scholars note that it can be difficult to locate available mental health services within the shortened timelines mandated by the ASFA and that some children and families may have difficulty completing treatment within these shortened timeframes (Webb & Harden, 2003). However, it is also possible that shortened timelines may provide an impetus for child welfare agencies to establish collaborative relationships with mental health providers in order to ensure timely access to mental health services (Webb & Harden). The ASFA also stipulated state requirements for ensuring the safety, permanency, and well-being of children in the child welfare system.
- **Child and Family Service Review (2000).** In 2000, Congress passed regulations designed to monitor state performance with respect to key outcomes for children in the child welfare system. These regulations, defined as the *Child and Family Service Review (CFSR)* process, were first implemented in 2001 and focus on measuring outcomes for children and families involved in the child welfare system. Outcomes assessed are related to child safety, permanency, and well-being. Among the priority outcomes that are assessed in the review process is an outcome related to ensuring that children receive adequate services to meet their physical and mental health needs. This outcome is assessed through case reviews. Currently, all 50 states as well as the District of Columbia and Puerto Rico have completed the first CFSR and results revealed that only one state was in substantial conformity with the outcome related to ensuring adequate services to meet children's physical and mental health needs. However, some scholars note that these data may not be reliable because they are based on a sample of just 50 cases from each state, and in many instances, information related to the outcome of interest may not be available in the case record. As a result, some outcomes are assessed based on just a handful of cases, making it difficult to truly assess state performance (Lemon, D'Andrade, & Austin, 2005). Despite these difficulties, state officials report that the CFSR process has contributed to improved collaborative relationships between the child welfare system and community stakeholders (U.S. Government Accounting Office, 2004), and scholars note that the review process may provide the momentum necessary for child welfare agencies to form stronger collaborative relationships with mental health providers (Webb & Harden, 2003).

The Child Welfare System Improvement and Accountability Act was passed in 2001 and represents California's efforts to create a system through which to evaluate child welfare outcomes and track progress toward performance goals. California Child and Family Service Reviews were first implemented in 2004 and are intended to address many of the methodological problems associated with the federal government's measurement of child welfare outcomes and thus, they are considered to provide a more comprehensive evaluation of county performance. As in the federal review process, the overall outcomes assessed in California CFRs are related to child safety, permanency, and well-being.

A portion of the specific outcomes assessed in the California CFRs correspond to the federal review outcomes; however, California also included additional specific measures that are intended to be more comprehensive. For instance, California's review process includes an outcome related to the well-being of youth emancipating from the child welfare system. In addition, the California CFRs use longitudinal data to assess county performance and thus, more accurately measure performance over time (Lemon et al., 2005). As is the case with the federal accountability legislation, this state legislation has the potential to increase collaboration between the child welfare and mental health systems.

- **Child Abuse Prevention and Treatment Act (as amended by the Keeping Families Safe Act, 2003).** The federal *Child Abuse Prevention and Treatment Act, as amended by the Keeping Children and Families Safe Act of 2003*, provides grants to states to provide a variety of child welfare services. In the 2003 amendments, a new purpose related to the promotion of collaboration between the child welfare system and other child-serving systems was added. Specifically, one of the new purposes of the legislation is to encourage and support collaboration among the child welfare system, public health agencies, and community-based organizations to provide services that address the health and mental health needs of children (U.S. Department of Health and Human Services, Children's Bureau, 2003).
- **Child and Adolescent Service System Program (1984).** Among federal mental health policies, the *Child and Adolescent Service System Program (CASSP)* that was first initiated and funded by the National Institute of Mental Health in 1984 has had a major influence on interventions for children with emotional and behavioral disorders (Stroul & Friedman, 1986). The CASSP legislation provided funding for interventions that utilized a "system of care" philosophy which contains an overarching goal to provide a comprehensive array of coordinated mental health and other social services (e.g., juvenile justice, child welfare, and Special Education) in order to meet the myriad needs of children and youth with severe emotional and behavioral problems (Stroul & Friedman). Building on the CASSP foundation, the federal Center for Mental Health Services first authorized funding for the *Comprehensive Community Mental Health Services for Children*

and their Families Program in 1992. This program has provided grants to 92 communities around the U.S. in order to develop interagency systems of care that link systems serving children with mental health problems. Interagency systems of care seek to reduce service gaps and service duplication, ensure access to needed services, increase continuity of care, and ultimately result in improved outcomes for children with serious emotional and behavioral problems (Rivard, Johnson, Morrissey, & Starrett, 1999).

Activity III-2: State Policy

The Child Welfare System Improvement and Accountability Act was passed in 2001 and represents California's efforts to develop a system to track child welfare outcomes and track progress towards performance goals.

Process: Get into small groups and discuss what types of outcomes you believe would be important to track in order to better understand the status of children in the foster care system. Each group is to develop appropriate outcome indicators related to positive child welfare outcomes.

(The instructor may provide examples to illustrate outcome indicators such as: improved school performance, improved health status, fewer placement moves, or reduction in law violations.)

Groups to share their outcome indicators with the larger group.

Activity III-3: Local Policy

Instructions/Process: Review the information below about the Mental Health Services Act (Prop. 63).

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides the first opportunity in many years for the Department of Mental Health (DMH) to provide increased funding, personnel, and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition-age youth, adults, older adults, and families. The Act addresses a broad continuum of prevention, early intervention, and service needs; and the necessary infrastructure, technology, and training elements that will effectively support this system.

This Act imposes a 1% income tax on personal income in excess of \$1 million. Statewide, the Act was projected to generate approximately \$254 million in fiscal year 2004-05, \$683 million in 2005-06 and increasing amounts thereafter. Much of the funding will be provided to county mental health programs to fund programs consistent

with their local plans. *Improvement in client outcomes* is a fundamental expectation throughout the implementation process.

Then complete the following exercises in your group: (instructor may elect to have participants complete all exercises or may select only one, depending on the audience).

Exercise 1:

1. How would you describe your overall level of knowledge of Prop. 63 (minimal, adequate, thorough?)
2. Where did the information come from (supervisor, co-worker, media, academic program, other?).
3. Have you attended information sessions or received any training on Prop. 63?
4. How will mental health services be different as a result of Prop. 63?

Exercise 2:

Go online and locate a website with local information about Prop. 63 to share with the large group.

Exercise 3:

In small groups, discuss from your experience examples of how the Mental Health Services Act is being implemented in your county.

SECTION IV

COLLABORATION BETWEEN CHILD WELFARE AND MENTAL HEALTH SYSTEMS

SECTION IV INSTRUCTIONAL GUIDE

Learning Objectives

The purpose of this section is to increase the knowledge base for participants from the available literature around factors that both hinder and enhance collaborative practices between systems. Specifically, this section will address study findings from current research that highlights the perspectives of both the child welfare and mental health systems in four different areas obtained through in-depth qualitative interviews and focus groups. The four themes that emerged include: a) the ways in which the two systems currently collaborate, b) formal structures for collaboration, c) the ways in which system goals correspond or conflict, and d) factors that impede or enhance collaboration between the two systems.

Activities in this section are intended to facilitate skill development in the area of collaborative practices through the completion of various exercises.

By the end of this section, participants will:

- Be familiar with the highlights of the literature on systems collaboration
- Be able to identify factors that contribute to strong inter-agency collaboration
- Have increased knowledge of the perspectives of both child welfare and mental health systems with regard to collaboration, and
- Be able to identify strategies to enhance collaboration across systems.

Public Child Welfare Competencies (MSW)

II Core Child Welfare Practice

- 2.20 Student understands and utilizes the case manager's role to create and sustain a helping system for clients, a system that includes collaborative child welfare work with members of other disciplines.

IV Workplace Management

- 4.3 Student understands client and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.
- 4.7 Student understands and is able to utilize collaborative skills and techniques in organizational settings to enhance service quality.

VIII Child Welfare Policy, Planning, and Administration

- 8.3 Student understands how leaders/managers use the collaborative process for the purpose of planning, formulating policy, and implementing services.

Public Child Welfare Competencies (BSW)

- 1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.
- 2.12 Student is developing the capacity to utilize the case manager's role in creating a helping system for clients, including working collaboratively with other disciplines and involving and working collaboratively with biological families, foster families, and kin networks.
- 4.4 Student has a working knowledge of collaboration with multidisciplinary teams and can work productively with team members in implementing case plans.

Agenda and Suggestions for Instructors

Time allocation: 1 hour

Introduction

- Introduction of instructor/trainer
- Brief introduction to section content on collaboration

- Introduction of participants (if not part of ongoing course)
- Completion of Activity IV-1
- Show PowerPoint slides 35-42 (from literature review on collaboration)

Overview of Study Findings

- Show PowerPoint slides 43-50 (from current study by Hines, Lee, & Osterling)
- Completion of Activity IV-2

Instructors are encouraged to use this section in a range of ways that meet their goals. For example, instructors may elect to skip Activities IV-1 and IV-2 for BSW or first year MSW students who are not yet in a child welfare placement, and instead focus on the study findings and implications for practice through the PowerPoint presentation and group discussion.

Materials Needed

- Overhead projector
- PowerPoint slides 35-50 (or transparencies)
- Handouts
- Markers and flip chart or white board (optional for writing key points in response to questions for class discussion)

SECTION IV COLLABORATION BETWEEN THE CHILD WELFARE AND MENTAL HEALTH SYSTEMS

The large proportion of children in the child welfare system who are experiencing mental health problems has created a need for the child welfare and mental health systems to collaborate in order to serve children in need of services from both systems. A lack of collaboration between child welfare and mental health systems can create fragmented or inadequate service delivery, as well as service duplication (Darlington et al., 2004; Prince & Austin, 2005). In general, collaboration is defined as a process of working together to achieve goals that cannot be achieved individually; it involves sharing differing perspectives and promoting dialogue between parties in order to create effective solutions to shared problems (Darlington et al.). Collaboration is further described as a vision-driven process that involves established roles and a defined structure—rather than a problem-driven temporary partnership (Hodges, Nesman, & Hernandez, 1998).

Interagency collaborations can include various dimensions; they may occur at different *system-levels*, including administration, management, line staff, and families. Collaborations also take on differing *focuses*, including those that are case-centered, program-centered, or policy-centered. The *structure* of the collaboration may also vary including the use of committees (ad-hoc or ongoing), interagency agreements (formal or informal), and membership policies (open or closed; Hodges et al., 1998; see Figure 3).

Figure 3. Dimensions of Collaboration

| DIMENSION OF COLLABORATION | DESCRIPTION |
|----------------------------|--|
| System-levels | <ol style="list-style-type: none"> 1. The <i>administrative/management level</i> involves collaboration between agencies in order to coordinate services. 2. The <i>worker/practice level</i> involves collaboration between agencies in order to create the systems needed to deliver services. 3. The <i>family level</i> involves collaboration with children and families in order to develop individualized service plans that incorporate services from multiple systems. |
| Focus | <ol style="list-style-type: none"> 1. <i>Case-centered</i> collaboration involves case management and coordination between workers to address needs for specific cases. 2. <i>Program-centered</i> collaboration involves coordinating services into a more holistic service system. 3. <i>Policy-centered</i> collaboration involves meetings and dialogue between representatives from organizations (often at the state or national level) in order to develop policy changes. |
| Structure | <ol style="list-style-type: none"> 1. <i>Committees</i> can include ad-hoc or ongoing groups. 2. <i>Interagency agreements</i> can include formal agreements (e.g., MOUs) or informal agreements. 3. <i>Membership</i> can be open (in which new members are recruited) or closed. |

Research suggests that strong interagency linkages between the child welfare and mental health systems can have a positive impact on service provision. Using data from the NSCAW, one study found that the higher the level of coordination between the child welfare and mental health systems, the greater the relationship between clinical need and service use. Effective cross-system collaboration was also linked with a reduction in racial/ethnic disparities in the use of mental health services by children in the child welfare system, suggesting that strong collaboration between systems may be an effective strategy to promote service equity among children of varying races and ethnicities (Hurlburt et al., 2004).

However, research also suggests that the strength and quality of the collaborative relationship between service systems is a key factor affecting the adequacy of service provision. One study investigating the use of autonomous case management teams that coordinated services from multiple child-serving systems revealed that the use of service coordination teams was actually associated with *decreased* service quality. Interpretations of this finding have focused on the possibility that caseworkers incorrectly assumed that many service responsibilities would be carried out by the service coordination teams. Rather than streamlining services and reducing service duplication, the use of service coordination teams appeared to result in the diffusion of services and responsibility. In addition, service coordination teams did not work directly with children and families and this lack of a personal relationship may have resulted in reduced accountability on the part of the service coordination teams (Glisson & Hemmelgarn, 1998). These findings suggest that poorly planned or ineffective collaborative models may actually result in negative outcomes for children and families.

Given the importance of the quality of the collaborative relationship to service adequacy, understanding key aspects of collaboration between child welfare and mental health systems may be an important tool in fostering strong interagency linkages. Key aspects of the collaborative relationship between the two systems include: a) the ways in which the child welfare and mental health systems currently collaborate, b) formal structures that guide collaboration, c) the ways in which system goals correspond or conflict, and d) the factors that enhance or impede collaboration.

The Ways in Which the Child Welfare and Mental Health Systems Currently Collaborate

The ways in which the child welfare and mental health systems currently collaborate is largely focused on Systems of Care collaborative models. The Systems of Care approach to collaborative intervention with children who have mental health problems was first implemented in 1984 as a result of the federal *Child and Adolescent Service System Program (CASSP)*. The CASSP legislation provided funding from the National Institute of Mental Health for interventions that utilized a Systems of Care philosophy which aims to provide a comprehensive array of coordinated mental health and other social services, including child welfare services, to meet the myriad needs of children and youth with severe emotional and behavioral problems (Stroul & Friedman, 1986). Further funding for interagency systems of care for children with mental health problems was provided through the federal *Comprehensive Community Mental Health Services for Children and their Families Program* that began in 1992. The Systems of Care philosophy incorporates values that reflect a strength-based, family-focused, and culturally competent approach to serving children with mental health problems (Anderson, 2000). Multi-agency collaborations are the foundation for service delivery. Interagency systems of care seek to reduce service gaps and service duplication, ensure access to needed services, increase continuity of care and, ultimately result in improved outcomes for children with serious emotional and behavioral problems (Rivard et al., 1999).

A national evaluation of Systems of Care interventions found that 13% of children and youth participating in Systems of Care were referred by the child welfare system

(U.S. Department of Health and Human Services [U.S. DHHS], 2001). There is evidence to suggest that Systems of Care collaborative models in general, may be an effective intervention for children involved in both the child welfare and mental health systems. A national, quasi-experimental evaluation of Systems of Care interventions found that participation in the intervention was associated with a reduction in behavioral and emotional problems; a reduction in functional impairment; an improvement in school attendance and performance; a reduction in law enforcement contacts; a reduction in the use of cigarettes, alcohol, and marijuana; and an improvement in residential stability. Information related specifically to child welfare outcomes (e.g., reunification, adoption, etc.) were not assessed (U.S. DHHS).

Formal Structures That Guide Collaboration

Effective interagency collaboration is often enhanced through formal structures that facilitate communication and problem solving at various organizational levels. Promising collaborative models typically contain several groups and committees that facilitate collaboration at different levels within organizations and for varying purposes (Hodges et al., 1998). The use of formal committees, boards, councils, teams, coordinators, and liaisons help comprise an infrastructure within the collaboration that provides a forum for communication and for addressing any problems that arise (Hepburn & McCarthy, 2003).

Formal collaborative structures at the worker level may include the use of treatment planning teams comprised of all individuals involved in the case who come

together to create a single individualized service plan⁴. Bringing together all individuals involved with a particular case and creating one treatment plan helps to reduce service gaps or duplication, facilitate communication and information sharing among those involved with the child and family, and provides the opportunity for case planning across systems (Hepburn & McCarthy, 2003). In addition, formal collaborative mechanisms at the manager or administrative level also reflect an important aspect of collaboration. The use of planning and policy committees to guide collaborative activities are a key component of the Systems of Care collaborative models.

The Ways in Which System Goals Correspond or Conflict

Although both the child welfare and mental health systems share the overall goal of child and family well-being, differing aspects of their agency missions, mandates, and procedures can affect the collaborative process. The child welfare system is primarily concerned with child protection and safety and is influenced by court requirements and judicial processes. The mental health system is typically concerned with the emotional well-being of the child and is influenced by therapeutic processes (Prince & Austin, 2005). These differing agency goals and corresponding differences in system mandates and procedures may impact the ability of individuals within a collaboration to develop a shared vision and mission for the partnership.

⁴ Treatment planning teams and individualized service plans include collaborative approaches such as family group conferencing and team decision-making.

The Factors That Impede or Enhance Collaboration

A number of factors can impede or enhance collaboration. **Communication problems** can negatively affect interagency collaborations. Failing to share client information can lead to ineffective treatment plans and a lack of service coordination. Interagency communication and the exchange of client information may be hindered by a lack of formal systems to address confidentiality mandates concerning the release of client records. Without a system in place to allow agencies to share information about client status and progress, workers in both systems may be missing important information that can help inform case decisions (Darlington et al., 2004; Hodges et al., 1998).

Collaboration between the child welfare and mental health systems may also be impeded by *a lack of organizational support and resources*. Collaboration requires added responsibilities in addition to normal work duties. Administrative support in the form of allowing workers the time necessary to participate in collaboration activities is necessary for effective collaboration. Limited resources in the form of staff shortages and high agency caseloads may detract from collaborative activities (Hodges et al., 1998).

A commonly noted barrier to collaboration is the *desire of each system to maintain its own autonomy* and decision-making power. Within the mental health system, there may be a desire to reduce the influence of child welfare mandates or regulations on the course of therapeutic treatment, while the child welfare system may wish to limit the role of the mental health system as a result of a lack of time or

organizational support for coordination of services with mental health staff (Prince & Austin, 2005). A desire to maintain system autonomy may also stem from fear over the potential for loss of funding, the possibility of changing job duties, or a past history of conflict between systems (Hodges et al., 1998). Moreover, workers in each system are likely to have differing educational and work backgrounds that are shaped by their respective professional disciplines (e.g., psychology/mental health, social work). A commonly noted barrier to interagency collaboration is the segmentation that can result from adherence to differing professional disciplines (Hodges et al.).

In addition, certain factors may enhance the collaborative relationship. *Commitment from agency leadership* is an important factor that may contribute to strong collaboration between systems (Hodges et al., 1998). Committed agency leaders are described as those who help problem solve, as well as mediate conflicts and communicate the vision and mission of the collaboration. Strong leadership often involves several key leaders within various agencies participating in the collaboration, rather than just one leader (Hodges et al.).

Another feature of strong collaborative relationships between systems is the *widespread involvement of workers at all levels of the organization*, including administrators, managers, supervisors, and line workers, as well as family members. This widespread involvement in the collaboration reflects a strong commitment to interagency partnerships (Hepburn & McCarthy, 2003).

In addition, *cross training* can help workers understand differing agency procedures, roles, and responsibilities. A clear understanding of each system's

procedures and operations, including the influence of differing funding sources, policy mandates, and eligibility criteria may contribute to a more effective collaborative relationship. For instance, one qualitative study with mental health workers working with child welfare clients found that a lack of understanding of how the child welfare system operated interfered with workers' ability to address the anxiety felt by many children and families experiencing an out-of-home placement. This lack of knowledge was described as a hindrance to the establishment of a therapeutic relationship. Without adequate knowledge of child welfare system operation, mental health workers may not be able to respond adequately when children inquire about returning home or about court proceedings (Prince & Austin, 2005).

Study Findings

In order to better understand collaboration between the child welfare and mental health systems, qualitative in-depth interviews with program managers and supervisors in both systems, and focus groups with line staff in both systems were conducted. In each system, three program managers and three supervisors were interviewed and three focus groups with line staff were conducted (See Appendix A for a full description of Study Methods and Procedures).

Questions and responses focused on the following overall themes: (a) the ways in which the two systems currently collaborate, (b) formal structures for collaboration, (c) the ways in which system goals correspond or conflict, and d) factors that impede or enhance collaboration between the two systems.

Overall Theme #1: The Ways in Which the Child Welfare and Mental Health Systems Currently Collaborate

Table 30. The Ways in Which the Child Welfare and Mental Health Systems Currently Collaborate

| Type of respondent | Themes |
|--------------------------------|---|
| Child welfare program managers | <ul style="list-style-type: none"> • Collaboration between systems described as minimal. • Collaboration between program managers described as variable. • When collaboration between program managers occurs, it was described as involving targeted meetings focused on planning and policies. • Collaboration between systems described as important and necessary. • The need to establish a shared understanding between systems was emphasized. • Cautious optimism about the possibility of strengthening the collaboration in the future was expressed. |
| Child welfare supervisors | <ul style="list-style-type: none"> • Overall, collaboration between systems described as disjointed, variable, and limited. • Collaboration between supervisors in both systems described as almost non-existent. • A desire to have a closer collaborative relationship was described. |
| Child welfare line workers | <ul style="list-style-type: none"> • Overall, collaboration between systems described as limited. • Collaboration between line staff in both systems was described as involving consultation on particular cases. • Some felt that collaboration between line workers is working well. • The presence of mental health staff at the Family Resource Centers described as a common point of collaboration. |
| Mental health program managers | <ul style="list-style-type: none"> • Overall, collaboration between systems described as good and moderately strong. • The continuing growth and development of the collaborative relationship was emphasized. • Joint projects, such as Systems of Care and Wraparound were described as fostering collaboration between systems. • Collaboration between program managers described as positive. |
| Mental health line workers | <ul style="list-style-type: none"> • Overall, collaboration between systems described as mixed and limited. • Recent improvements in collaboration between the two systems were noted. • The importance of collaboration between systems was emphasized. • Collaboration between line staff in both systems described as minimal. • A need for more collaboration at higher levels in the agencies was emphasized. |

Overall, child welfare program managers described the collaboration between systems as minimal. Comments included:

- The systems are operating with different goals and sometimes the intersection is a tenuous one.

Collaboration occurring on the program manager level was described as variable.

Responses included:

- Within our department, we have program managers who do work with mental health, but I don't.
- We individually don't have much contact.

When collaboration at the program manager level occurred, it tended to be in the form of targeted meetings focused on policies and planning. Comments included:

- In planning committees we try to involve mental health as a stakeholder.
- Managers in child welfare and mental health have met to discuss Proposition 63.

Child welfare program managers also felt that there was a lack of collaboration at lower levels in the systems:

- The upper level determines many things...there should be more contact between line staff in both systems.

Child welfare program managers also emphasized the importance of strengthening the collaboration between systems, as well as developing a shared understanding between systems. Overall, respondents expressed cautious optimism regarding collaboration between the systems. Comments included:

- We're selling ourselves short by not seriously trying to collaborate...We could make a huge dent on our social problems by collaborating.
- We need to see each other as going down the same path.

- We need to educate each other and treat each other as partners and not get locked into silos.
- It [the collaborative relationship] is getting better, but it's not where it should be.
- The general perception is that we are at a point where it seems there is more opportunity for better collaboration, but in order to dance together we need to know the steps.

Child welfare supervisors characterized the collaborative relationship between the mental health and child welfare systems as disjointed, variable, and limited. Collaboration between supervisors in both systems was described as almost non-existent. Comments included:

- I almost never have contact with mental health unless there is a problem.

Child welfare supervisors perceived that more collaboration was taking place at higher levels in the system. Responses included:

- There is more communication at the top levels—we need more communication at lower levels.
- At the program manager level there is more collaboration, this does not go down to the supervisor level.

However, a desire to have a closer collaborative relationship between systems was also described. Comments included:

- Intentions are good on both parts.
- There's a lot of overlap between systems and it would be great if we could focus on how to best meet children's needs.

Child welfare line workers discussed a limited collaborative relationship. Collaboration between line workers in both systems was described as involving variable levels of communication regarding specific cases. Comments included:

- Sometimes a counselor will call me, but that is when a client is not showing up, so I become kind of the enforcer so that client will attend.
- We have contact with mental health indirectly through the IEP process. We work with counselors in the schools on certain cases, to share things with them—it's just a consultation.

However, some child welfare line staff felt that collaboration between line staff in both systems was working well. One worker commented:

- In terms of working directly with mental health providers, I haven't had any problems...We always invite them to meetings, they attend maybe 75% of the time.

Child welfare line workers also mentioned the presence of mental health staff at the Family Resource Centers as a common point of collaboration between the systems.

Mental health program managers described the collaborative relationship between systems as good and moderately strong. Comments included:

- I feel it is excellent—we have very good collaboration, very good communication.
- It's moderately strong and developing—there is room for improvement.

The continuing growth and improvement of the collaborative relationship was emphasized. Comments included:

- It's a good collaboration that needs to continue improving for the sake of the population we are serving.
- Overall we are making a strong move toward getting together to provide services.
- There are good intentions, but we need a lot more discussion from both mental health and social services from managers down to line staff. We need to spell out our good intentions within each layer of the system.

Mental health program managers also discussed how certain joint projects, including Systems of Care, and Wraparound services have fostered collaboration between the systems.

Mental health program managers described collaboration between program managers in both systems in a positive manner. Responses included:

- There is a fairly positive relationship in general with program managers on both sides.
- At the higher levels there is agreement that collaboration is important.
- On the program manager level there are meetings to collaborate on certain programs. These are ongoing interagency management meetings that also include department managers.

Mental health line workers reported mixed or little collaboration with the child welfare system:

- There's a lack of collaboration, I've never been to a meeting with social workers. The systems are not working together. It's just individuals wanting something from someone.
- There's a mixed dynamic. There are times when it [collaboration] is terrific and times when there are difficulties.
- We're both interested in helping, but we never talk.

Mental health line workers described collaboration at the line staff level as minimal and the need for improved collaboration at higher levels in the agencies was emphasized.

One mental health line worker commented:

- Collaboration is limited on the line staff level, the communication takes place at the higher level.
- They [upper management] need to make one policy and it will trickle down to us.

However, the importance of collaboration between the two systems was emphasized and recent improvements in collaboration between the two systems were also noted.

One mental health line worker commented,

- We need to build those relationships, it is important.
- There is a need for systems collaboration beyond just child welfare and mental health. We need to have a whole systems perspective.
- Collaboration has improved tremendously in the last few years.
- There's been an increase in meetings with child welfare.

Overall Theme #2: Formal Structures That Guide Collaboration

Table 31. Formal Structures That Guide Collaboration

| Type of respondent | Themes |
|--------------------------------|--|
| Child welfare program managers | <ul style="list-style-type: none"> • Outstationed mental health workers at the Family Resource Center. • The Resources for Intensive Services Committee (RISC), a weekly committee involving mental health, child welfare, and probation that reviews cases to decide on level of care and services. • Referral processes for children with higher needs described as more formal than those for less intensive services. |
| Child welfare supervisors | <ul style="list-style-type: none"> • Described limited contact with formal structures that guide collaboration. • There are formal referral processes for Systems of Care and Wraparound. • To refer to outpatient counseling, workers may call therapists directly. • Waiting lists and funding barriers complicate the referral process to outpatient counseling. |
| Child welfare line workers | <ul style="list-style-type: none"> • Call the Mental Health call center to refer children to outpatient counseling. • Also call agencies directly to be put on a waiting list. • Some child welfare line workers try to link children and families with mental health staff who they feel would be a good match. • A streamlined referral process to outpatient counseling specifically for children in the child welfare system was described as a way to improve the referral process. |

Table 31. Formal Structures That Guide Collaboration (cont'd)

| Type of respondent | Themes |
|--------------------------------|--|
| Mental health program managers | <ul style="list-style-type: none"> • RISC • Community Wraparound Team • RISC Leadership Group • Outstationed mental health coordinator at the Children’s Shelter • Case consultation at the line staff level, including Family Conferences, Team Decision-Making, and Wraparound Child and Family Teams. • Formal referral processes associated with Systems of Care and Wraparound services were described as working well. • Outpatient referrals described as the majority of referrals. • Referrals to outpatient services described as less straightforward than referrals to more intensive services. • The Call Center, direct referrals to agencies, and the use of Chapter 26.5 through the educational system were described as three referral processes for outpatient counseling. |
| Mental health line workers | <ul style="list-style-type: none"> • Memorandums of Understanding between the Mental Health Department and the Family Resource Centers were described as a formal point of collaboration. • The Call Center was described as the typical referral mechanism from child welfare to mental health. • A formalized process for the approval of mental health services for children who are dependents of the court was described. • Chapter 26.5 from the educational system to mental health system mentioned as a referral process. • Referrals for children placed out of the county described as problematic. |

Child welfare program managers reported the use of outstationed mental health workers at the Family Resource Centers as a reflection of formal collaboration between the two systems, as well as the Resources for Intensive Services Committee (RISC), a weekly committee involving mental health, child welfare, and probation that reviews cases to decide on level of care and services. Child welfare program managers described different referral processes for children with varying levels of need. In general, referral processes for high-need children and youth were described as more

formal and structured than referral processes for less intensive services, such as outpatient counseling. Child welfare program managers commented:

- We follow the department referral process, but children must hit a certain level of clinical need in order to get through the referral process...Mental health has a process, they don't take social workers' word that services are needed.
- It's hard to use the mental health system because they have to be in crisis to get services. But it is better for families to be seen before it turns to a crisis.

Child welfare supervisors reported limited contact with formal structures for collaboration between the two systems. Formal collaborative structures that were mentioned included: a committee that reviewed mental health protocols for children leaving inpatient facilities, and an outstationed coordinator of mental health services placed at the Children's Shelter. Child welfare supervisors mentioned that formal referral processes were associated with Systems of Care and Wraparound services.

One child welfare supervisor stated:

- For System of Care there's a form and a coordinator at the Children's Shelter and for Wraparound we have an internal review and then it goes to a committee that has representatives from DCFS, mental health, and probation.

The process for referral to outpatient counseling was described as less structured. Child welfare line workers reported that they called the Mental Health Call Center to refer a child to a county mental health agency or they may also call agencies directly to place them on the waiting list for outpatient counseling. In the referral process to outpatient counseling, child welfare workers may attempt to link children and families to therapists who might make a good match. Overall, the child welfare line workers expressed a need for an improved referral process to outpatient counseling. Comments included:

- For just counseling, we might refer to a therapist, but there are waiting lists sometimes.
- Social workers can make applications for Victim Witness funds and through this, they can identify providers who accept Victim Witness funds [for outpatient counseling].
- As a continuing worker, I think, what are the issues that need to be addressed, and I will go so far as to call an agency and ask if they have staff that speak a certain language, or other things. I will make specific requests based on what the family needs so that we can help them more quickly.
- We need some kind of streamlined approach, or a preferential approach for the child welfare clients. Some kind of way to route these clients would be helpful.

Mental health program managers discussed various formal collaborations between the two systems, including the outstationed mental health coordinator at the Children's Shelter, and the Community Wraparound Team, a group of workers from mental health, child welfare, juvenile probation, and other service providers that meets monthly to discuss system issues, address barriers, and evaluate and develop collaborative projects. The RISC Leadership Group was also mentioned. This group meets monthly and includes senior level workers who address system issues, plan system changes, and examine service gaps and ways to address these gaps. Line staff meetings to discuss specific cases were also identified by mental health program managers as formal points of collaboration. Family conferences, Team Decision-Making, and the Wraparound Family and Child Team were described as family-driven collaborative meetings in which information is shared and a treatment plan is developed. Mental health program managers described referral processes associated with specific projects, including System of Care, and Wraparound services as working well. Comments included:

- There's a good referral process for System of Care, the child welfare worker faxes referrals to coordinators who then find the services.
- The System of Care referrals work well, although there are more referrals than capacity.

The RISC committee was also described as a mechanism within the referral process for high-need children and youth. However, mental health program managers reported that most referrals to the mental health department were for outpatient counseling and the referral process for these services was described as less straightforward than for intensive services. The use of Call Center (e.g., 800 number), direct referral to service providers, and referrals through the educational system were identified as typical referral pathways to outpatient counseling. Comments included:

- Most referrals are outpatient through the 800 numbers. The social worker, foster parents, or kid calls to get services—this is for children covered by Medi-Cal or Healthy Kids.
- The social worker or the family calls the Call Center.
- The social worker can make referrals directly to the clinic.
- Another way to get service is the social worker could use Chapter 26.5 for youth in Special Education. If it is thought that they may benefit from mental health service, social workers can encourage youth to seek services through the education system.

Mental health line workers identified Memorandums of Understanding between the mental health system and the Family Resource Centers as a point of formal collaboration. A formalized process for the approval of treatment for children who are dependents of the court was also identified as a referral mechanism. In addition, some mental health line workers also discussed the problem of referrals between counties.

Comments included:

- Transitions to other counties are not smooth.
- There needs to be a better understanding between counties.

Overall Theme #3: The Ways in Which System Goals Correspond or Conflict

Table 32. Ways in Which System Goals Correspond or Conflict

| Type of respondent | Themes |
|--------------------------------|---|
| Child welfare program managers | <ul style="list-style-type: none"> • Described mental health system as primarily focused on the seriously mentally ill. • Child welfare described as “enforcers,” mental health described as “good guys.” • Mental health described as focused on treatment issues, child welfare as focused on more global issues. • Tensions around the need to address specific issues in mental health treatment within child welfare timelines were described. • Lack of understanding regarding the pressures experienced by child welfare workers. • Mental health system has goal of increasing services to Latinos and African Americans, while child welfare system would like to serve fewer Latino and African Americans. |
| Child welfare supervisors | <ul style="list-style-type: none"> • Described goals of child welfare system as centering on keeping children safe, strengthening families, and ensuring permanency. • Funding limitations for mental health services were described as creating a conflict between systems; mental health must serve a certain priority population. |
| Child welfare line workers | <ul style="list-style-type: none"> • Described conflicts around the legal-system-directed child welfare system, and the client-directed mental health system. • Areas of overlap between the two systems were described as related to the overall need for mental health services among children in the child welfare system. |
| Mental health program managers | <ul style="list-style-type: none"> • Complementary goals included wanting children to be successful community members, helping youth obtain greater self-sufficiency, and helping children and youth address issues of trauma, abuse, abandonment, and loss. • Child welfare system described as primarily concerned with child safety and monitoring. • A need for broadening the focus of mental health services in order to better meet the needs of children in the child welfare system was expressed. |
| Mental health line workers | <ul style="list-style-type: none"> • The systems share the overall goal of ensuring the welfare of the child. • Child welfare system described as focusing on parenting, whereas mental health system focused on therapeutic goals. • Child welfare system described as having goals and mandates related to the legal system. |

Child welfare program managers largely described the ways in which the goals and mandates within each system differed. The mental health system was described as primarily serving the seriously mentally ill population. Comments included:

- Mental health is focused on a certain clientele that have high level mental health needs...our clientele need services, but they are not always seriously mentally ill.

Child welfare program managers also described a number of tensions stemming from the different mandates and professional orientations within the two systems. Comments included:

- We have different mandates. We [child welfare system] are enforcers. There are different cultures because of this; they are more the 'good guys.'
- We have competing interests that don't always fit. In mental health it is treatment issues, and in child welfare the issues are more global.
- There are inherent tensions. In mental health, they usually rely on the client to identify issues. In child welfare, we have specific issues that we feel need to be addressed because of timelines.
- They [mental health system] don't always understand the demands within the child welfare system—and the consequences, like not getting the kid back. This is a system clash that has not been rectified.

In addition, one child welfare program manager noted that one of the goals of the mental health system is to increase services to Latinos and African Americans, while one of the goals of the child welfare system is to reduce the need for services for Latinos and African Americans as they are overrepresented in their system. These differing goals were described as complementary and provide an opportunity for the two systems to work together to meet the needs of Latino and African American families.

Child welfare supervisors described the goal of the child welfare system as centering around keeping children safe, strengthening families, and ensuring permanency. One child welfare supervisor commented:

- Our system is looking at families and trying to make them safe and healthy for the child or to find a permanent home.

Although this goal was considered complementary to goals within the mental health system, the funding limitations within mental health were described as a circumstance that created differing system priorities. One child welfare supervisor commented:

- Mental health services have 'priority populations' that are related to their funding limitations.

Child welfare line workers also discussed the different goals within the systems. One child welfare line worker commented on the legal-system-directed child welfare system versus the client-directed mental health system:

- The focus of our department is child welfare law. In mental health, a lot of times, the parents are dictating what they want the therapy to be.

However, other child welfare line workers discussed areas of overlap between the two systems as related to the need for mental health services among children in the child welfare system. Comments included:

- The goals of the systems can complement one another because the needs of the families are so wide.
- Our goals can be complementary. We recognize, as social workers, the important role that therapy plays in these children's lives. They go through a lot of trauma and we recognize that the therapy is crucial.

Mental health program managers described areas in which the goals of the two systems correspond and areas in which they conflict. Complementary goals included

wanting children to be successful community members, helping youth obtain greater self-sufficiency, and helping children and youth address issues of trauma, abuse, abandonment, and loss. However, tensions resulting from different system goals were also described. The child welfare system was described as primarily concerned with child safety. One mental health program manager commented:

- Child welfare deals with the safety of the child and the desire to have the child be adjusted and returned to a normalized living environment. Sometimes there is an under emphasis on mental health problems and the [child welfare] system can create problems.
- Social workers need to ensure that the child is safe. Mental health has a similar mandate, but our role is less in the role of monitoring and more in the role of working individually with youth, which may or may not include the foster family.

However, another mental health program manager described the need for the mental health system to broaden its focus in order to better serve children in the child welfare system:

- On the mental health side, we often get too clinical and focused on the diagnosis and we don't always look at the bigger picture. Mental health is one piece of a total puzzle. There is also the need to improve the environment. You can have the best treatment and then return the child to the same environment and that doesn't work.

Mental health line workers agreed that, in general, the two systems share the same goal of ensuring the welfare of the child; however, they also noted different goals of the systems. One mental health line worker stated:

- Historically there are two sets of different goals for each agency, DFCS focuses on parenting, and mental health is therapeutic, they can be at odds sometimes.
- We just have different needs and different perspectives on the system—legal vs. mental health.

Overall Theme #4: Factors That Impede or Enhance Collaboration Between Systems

Tables 33-37 provide specific information about the factors that impede or enhance collaboration between systems. Because not all types of workers (e.g., line, supervisor, or manager) discussed each area, information provided in tables reflects aggregate themes across workers in each system.

Factors that impede collaboration included: communication problems (Table 33); difficulties associated with joint treatment planning (Table 34); and individual-level factors--perceptions, professional orientations, and personalities (Table 35).

Factors that enhance collaboration included: commitment and support among organizational leaders (Table 36), and cross training (Table 37).

Table 33. Communication Problems

| Type of respondent | Themes |
|---|---|
| Child welfare line worker, supervisor, or program manager | <ul style="list-style-type: none"> • Lack of communication can lead to child welfare staff not being knowledgeable on mental health resources. • No formal opportunities for staff to communicate |
| Mental health line worker or program manager | <ul style="list-style-type: none"> • Lack of structure for line workers to communicate • Difficult to coordinate workers' busy schedules to attend joint meetings. |

Communication difficulties and the lack of mechanisms to foster communication between systems were noted as barriers to collaboration. One child welfare supervisor discussed how increased communication at the supervisor level could assist workers in locating resources:

- We need more outreach to supervisors because supervisors can suggest services to workers. We [supervisors] need to understand what is there and how to access it.

Child welfare program managers discussed the lack of opportunities for communication between workers in both systems. One child welfare program manager noted:

- There are no opportunities for line staff to communicate with one another. There is no annual or bi-annual communication forum to talk about what each system is doing.

Similarly, mental health line workers described little communication with child welfare line workers, as well as logistical problems related to scheduling cross-system meetings:

- There's a lack of structure. I've never been in a meeting with social workers.
- It's hard to get everyone in the same place at the same time; scheduling a time to meet is difficult.

Table 34. Difficulties Associated with Joint Treatment Planning

| Type of respondent | Themes |
|--|--|
| Child welfare program managers, supervisors, or line workers | <ul style="list-style-type: none"> • Disagreements regarding case goals or outcomes. • Problems sharing client information. • The value of joint treatment planning was discussed. |
| Mental health program managers, supervisors, or line workers | <ul style="list-style-type: none"> • Disagreements regarding treatment goals or outcomes. • Problems sharing client information. • The importance of joint treatment planning was described |

Difficulties associated with joint treatment planning for children and families involved in both systems were frequently described as an impediment to collaboration. Child welfare line workers discussed the ways in which conflicts can arise as a result of differences between workers with respect to treatment planning. Comments included:

- Sometimes a therapist will be very connected to a kid and invested in seeing reunification happen and they will think the kid should go home. But the social worker has more information, for instance, that the parents are still using [drugs] and so you get conflicts that way.
- Mental health might want the kid back home, but the court has to approve it.

Some child welfare line workers and program managers also mentioned problems obtaining information on client progress from mental health workers. However, although difficulties were noted, child welfare line workers also stressed the value of working with mental health workers in treatment planning. One child welfare line worker commented,

- When I really want things to work well...I invite myself to participate in a therapy session and we can all talk about whether the problems that brought them into the system are being addressed.

Child welfare supervisors also noted the importance of joint treatment planning:

- If a therapist is working with a family, they should meet regularly with the social worker and develop treatment goals and discuss how needs are being met. The way it is now is the therapist sends a written report to the court and doesn't talk to the social worker; there is no mechanism to talk together.

Mental health line workers described problems around agreement on treatment goals. One mental health line worker commented:

- Social workers may be under pressure to address certain therapeutic goals that might be set up by attorneys or judges—not by the therapist or the clinicians, and it makes it difficult, because we may not necessarily agree.

Similarly, mental health program managers discussed service coordination problems and commented on issues related to who determines the course of treatment, and the decision-making process in child welfare:

- A conflict occurs when social service workers direct what the [mental health] treatment should look like. We [mental health] make that determination. We can talk about it, but that is our decision.
- We may not understand social services enough—why reunify or not reunify? Why are some decisions made?

Problems sharing information about treatment progress were also noted. One mental health line worker stated:

- Sometimes they [child welfare workers] need last minute reports and they want the mental health specialist to drop everything to produce the report.

However, despite these problems in joint planning and sharing information, mental health line workers also discussed the value of joint treatment planning. One mental health line worker stated:

- On this one occasion, I had a case from dependency court and everyone from child welfare came to my office to get involved for this client...it was wonderful to see that it could happen—to work together.

Table 35. Individual-Level Factors: Professional Orientations, Perceptions, and Willingness to Collaborate

| Type of respondent | Themes |
|---|--|
| Child welfare program managers, supervisors, and line workers | <ul style="list-style-type: none"> • Different professional orientations—child welfare workers viewed as non-clinicians. • Individual relationships between workers in both systems can shape the quality of the collaborative relationship. • There is a need to overcome individual prejudices and perceptions. |
| Mental health program managers and line workers | <ul style="list-style-type: none"> • Different professional orientations—child welfare workers viewed as non-clinicians. • Individual personalities can greatly influence the collaborative relationship. • A willingness on the part of individuals is needed in order for collaboration to be successful. |

Individual level factors, such as professional orientations, perceptions, and willingness to collaborate were also described as common barriers to collaboration. One child welfare program manager discussed the need to address individual-level factors in order to improve collaboration:

- We need to overcome individual prejudices and our perception of each other. We need to learn about other systems so we can help each other.

In addition, child welfare line workers commented on the ways in which differing training and professional backgrounds can impact worker perceptions:

- We have different training backgrounds. We never call the parent a client, or a consumer or a patient; these are different mindsets.
- Mental health comes from a different perspective and different training, and we are coming from our perspective and sometimes it is difficult to get the two perspectives together...sometimes you can and I think a lot of the time it has to do with the personalities of the workers.

Another child welfare line worker noted that collaboration depended largely on the willingness of individual workers to collaborate:

- If you have a good relationship with the mental health person then they are going to respond—if not, then you have to get the supervisors involved.

Mental health line workers also affirmed the role of individual-level factors in determining the strength of the collaboration. Comments centered on the prominent role of workers' willingness to collaborate as a key factor in determining the strength of the collaboration. One mental health line worker stated:

- It depends on the social worker on the other side, sometimes it [collaboration] is good and sometimes it is difficult.

In addition, mental health line workers mentioned issues surrounding the influences of differing professional orientations. One mental health line worker commented:

- DFCS workers are not necessarily clinicians.

Mental health line workers also mentioned a willingness to collaborate as an important part of successful collaboration. Comments included:

- An open mind from both sides would create collaboration.
- There needs to be a willingness from both sides to create collaboration.

Table 36. Commitment and Support Among Organizational Leaders

| Type of respondent | Themes |
|---|---|
| Child welfare program managers, supervisors, and line staff | <ul style="list-style-type: none"> <li data-bbox="574 296 1406 390">• A commitment to interagency collaboration stems from organizational leadership, including the Board of Supervisors and department directors. |
| Mental health program managers, and line staff | <ul style="list-style-type: none"> <li data-bbox="574 417 1406 485">• Managers and top administrators must establish policies and plans to guide collaboration. |

Commitment to interagency collaboration among organizational leaders was described as an important factor that can facilitate collaboration between systems. A child welfare program manager stated:

- It flows from the Board of Supervisors and county executives to make collaboration a value in our county so that it is monitored.

Mental health line workers discussed the need for management to emphasize inter-agency collaboration to line workers in order for successful partnerships to occur.

One mental health line worker stated:

- We need more management interaction; they need to develop a plan that filters down to the line staff.
- We need better coordination, the top levels need to establish policies.

Similarly, one mental health program manager discussed the role of committed agency leaders in fostering collaboration:

- Having a strong, committed Board of Supervisors helps collaboration—they say they want collaboration and we do it. Having the support of executive directors is very important. They have power and can make things happen.

Table 37. Cross Training

| Type of respondent | Themes |
|---|--|
| Child welfare program managers, supervisors, and line staff | <ul style="list-style-type: none"> • It is important for workers in both systems to understand one another's roles. • Mental health system needs to understand child welfare procedures and court processes. • Child welfare system needs to understand mental health eligibility criteria and types of available services. |
| Mental health program managers and line staff | <ul style="list-style-type: none"> • Would like more information on child welfare procedures and processes. |

Cross training was repeatedly mentioned as an important strategy to improve collaboration between the two systems. Child welfare program managers discussed the need for child welfare workers to understand more about how the mental health system operates. One child welfare program manager stated:

- Child welfare staff get frustrated trying to understand how the mental health system works.

Other comments from child welfare program managers focused on the need for cross training and the types of training information that would be helpful:

- Knowing the mental health criteria that exist would be helpful.
- We need to understand the types of services they [mental health] provide.
- It would be good for line workers from both systems to meet to know resources from both systems.
- We really need cross training to understand how the systems operate. This is especially important for social work students.

Child welfare supervisors discussed the need for mental health workers to understand legal mandates and court processes associated with child welfare. One child welfare supervisor stated:

- The need for cross training is bad. A lot of mental health workers don't understand the court process and how difficult that can be.

One child welfare line worker emphasized the need for more education around child welfare procedures:

- Mental health line staff need to be knowledgeable of what the child welfare system does. Sometimes all they know is that we take kids away.

Mental health line workers expressed a desire to have more information about child welfare procedures and processes also felt that cross training would be helpful.

Responses included:

- The child welfare system is really confusing, and there is no formal training or introduction to it.
- I would like more information on DFCS, something more formal.

Similarly, one mental health program manager stated:

- Some people who work in mental health have very little idea of how DFCS works. Training from DFCS on what drives their system, their legal mandates, safety issues, and court issues. This would create a better appreciation.

Summary of Findings

The following key findings emerged from interviews and focus groups with child welfare and mental health program managers, supervisors, and line workers.

Regarding the *collaborative relationship between the child welfare and the mental health systems*, interview and focus group data suggested that:

- Workers in both systems place a high value on collaboration and recognize the important role that interagency linkages can play in service access and quality.
- However, most respondents also described a relatively limited collaborative relationship between the two systems. Child welfare program managers, supervisors, and line staff described collaboration between the systems and between workers as minimal, limited, and disjointed.

- Mental health line workers also described collaboration as mixed and limited, however, mental health program managers reported a fairly strong collaborative relationship between the systems.
- Mental health program managers also tended to emphasize the continuing growth and development of the collaborative relationship.

Interview and focus group respondents also identified *formal structures that guide collaboration*.

- Outstationed mental health workers at the Family Resource Center and the Children's Shelter were identified as a formal point of collaboration that is currently working well.
- Respondents also identified meetings connected with the Resources for Intensive Services Committee (RISC) as an existing collaborative structure between the two systems. A weekly RISC meeting in which staff from mental health, child welfare, and probation meet to review cases and decide on level of care was described, as well as a monthly RISC leadership meeting in which senior level workers meet to examine and address service gaps, address system issues, and plan system changes.
- In addition, the Community Wraparound Team, a group of workers from mental health, child welfare, and juvenile probation, meets monthly to discuss system issues, address barriers, and evaluate and develop collaborative projects.
- Other line-staff level collaborative meetings that were mentioned included family conferences, team decision-making, and the Wraparound Family and Child Team.

In addition, referral processes were described as a formal structure guiding collaboration.

- In general, the referral process for children with more serious mental health problems was described as more structured and straightforward than the referral process for children with less serious mental health problems. Referrals for System of Care and Wraparound services was described as involving a centralized coordinator and an internal review committee; these processes were generally described as working well.
- Referral processes for outpatient counseling for children were less straightforward. Workers described the Call Center as a common referral point

for children in the CWS in need of mental health services and some child welfare workers indicated that they contact service providers directly for outpatient counseling. This process was described as problematic because children are often put on a waiting list for outpatient counseling.

Qualitative data also provided information on *the ways in which system goals correspond or conflict*.

- Child welfare respondents reported a number of areas in which the goals of the two systems differ. In particular, the CWS was described as being greatly influenced by court processes and legal mandates that often carry with them serious consequences for children and families. Child welfare respondents described the MHS as being more focused on treatment issues and serving the seriously mentally ill.
- Mental health participants also described similar sentiments regarding the differing perspectives of the systems.
- However, both child welfare and mental health participants noted that the overall goals of the two systems are complementary and focus on helping children and youth address issues of trauma, abuse, abandonment, and loss, as well as assisting youth to obtain greater self-sufficiency and to be successful community members.

Responses related to the *factors that impede or enhance collaboration between the two systems* indicate a number of conditions, circumstances, and activities that can greatly influence the collaborative relationship.

- Factors that impede collaboration included: a) communication problems, b) difficulties associated with joint treatment planning, and c) individual-level factors.
- Factors that enhance collaboration included: a) commitment and support from organizational leaders, and b) cross training.

Implications for Child Welfare Practice

Qualitative results from this study have a number of important implications for child welfare practice. Qualitative findings clearly suggest areas in which the collaborative relationship between systems can be strengthened. *Commitment and*

support from organizational leaders is a key aspect in creating strong collaborative relationships.

- Workers at all organizational levels emphasized a strong commitment to collaboration among organizational leaders as a critical factor that can enhance collaboration. Collaborative relationships may be improved when senior-level staff establish plans and policies to guide collaboration between systems.
- Administrative policy and planning meetings can be used to identify and address problems that arise. For instance, interview and focus group participants identified funding restrictions and an overall lack of mental health services as factors that may impede collaboration between systems. Senior-level planning meetings to address these barriers reflect a commitment to the collaborative relationship.
- In addition, line workers noted difficulties in trying to make time to collaborate with one another in the midst of their normal work duties. Collaborative activities require additional time and responsibilities and workers need administrative support in order to engage in collaboration.

Another practice implication centers on the need for *cross training between staff in both systems*.

- Interview and focus group participants consistently discussed differing agency goals, mandates, and procedures as a point of conflict between the systems. However, workers at all organizational levels also emphasized overlapping goals of both systems, including encouraging child and youth well-being and helping children. Cross-training activities can emphasize shared system goals, while also educating staff on each system's unique policies, procedures, and mandates.
- Child welfare staff expressed a need to improve their understanding of mental health criteria and eligibility requirements, as well as to improve their knowledge of existing mental health resources.
- Mental health staff expressed a need to increase their understanding of child welfare legal and court issues, as well as safety issues.
- Moreover, the use of consistent cross-training activities between systems may also assist workers to address individual-level factors related to collaboration, including differing professional orientations, perceptions, and willingness to collaborate. Indeed, problems related to differing professional orientations, perceptions of each others' systems, and a willingness to collaborate were

identified as factors that impede the collaborative relationship. Cross-training activities may provide the opportunity for workers to get to know one another better, as well as to improve workers' understanding of the role of each other's professions in serving vulnerable children and youth. Such contact and communication has the potential to increase individual workers' willingness to collaborate with one another.

Activity IV-1: Group Discussion

Instructions: Get into small groups and address the following questions. Small groups will share their responses with the larger group.

Discuss your experiences in collaboration between public child welfare and mental health professionals at both the worker and management levels.

1. What specific factors have *helped* effective collaboration between the two systems?
2. What factors have *hindered* collaboration between the two systems?
3. What suggestions might you have to *improve* the collaborative process?

Activity IV-2: Themes from the Research

Instructions: The instructor will organize the large group into four smaller groups and will then assign one of the following exercises to each group. Each of the exercises provides an opportunity to apply new knowledge gained from the current research on collaboration between child welfare and mental health systems. Small groups will have 15-20 minutes to discuss and prepare their responses for the large group.

Exercise 1: The first theme from the research identifies ways in which systems currently collaborate and provides the perspectives of both the child welfare and mental health systems. In what ways is the perspective of the professionals in child welfare different than the perspectives of those in mental health with regard to the collaborative process? Why might this be the case?

Exercise 2: The second theme from the research identifies the formal structures that guide the collaborative process between systems. Select **one** of the formal structures discussed in the research findings (outstationed workers, committees, referrals for systems of care, wraparound, the Call Center, etc.) and describe how the model and practice has worked in your county.

Exercise 3: The third theme from the research identifies ways in which systems goals correspond or conflict. The research addresses how child welfare workers are often

seen as the “enforcers,” both by the public and by those working in the system itself. What specific ideas do you have about how this perspective might be changed to a more positive one?

Exercise 4: The fourth theme from the research identifies factors that impede or enhance collaboration. Select one finding (factor) from the research results and develop a specific plan to address this in your county.

SECTION V

RESOURCES FOR COLLABORATION AND SERVICE PROVISION FOR CHILDREN AND YOUTH IN BOTH THE CHILD WELFARE AND MENTAL HEALTH SYSTEMS

SECTION V INSTRUCTIONAL GUIDE

Learning Objectives

This section provides additional information and specific resources related to cross-system collaboration in order to facilitate improved outcomes for children through more effective collaboration between child welfare and mental health systems. Eight promising models of collaboration between child welfare and mental health systems that are currently in place are summarized in Figure 1.

The activity for this section is intended to increase participants' knowledge about the elements of promising models of cross-system collaboration so that this new knowledge may be applied in their respective professional settings.

By the end of this section participants will:

- Have increased knowledge of materials and resources that offer models and tips for cross-system collaboration

Public Child Welfare Competencies (MSW)

VIII Child Welfare Policy, Planning, and Administration

8.9 Student demonstrates the ability to negotiate and advocate for the development of resources that children and families need to meet their goals.

Public Child Welfare Competencies (BSW)

4.3 Student demonstrates awareness of community resources available for children and families and has a working knowledge of how to utilize these resources in achieving case goals.

Agenda and Suggestions for Instructors

Time allocation: 1 hour

Brief wrap-up of curriculum highlights from previous sections

- Instructor may elect to review a particular section by using the transparencies or PowerPoint slides.
- Ask participants to share new information from any of the curriculum sections that are especially meaningful for them.

Distribute Handout V-1: Cross-System Collaboration Resources and briefly describe the resources available on the Internet.

- Optional exercise: have students select (or instructor may assign) a website from Handout V-1 to visit. Students can then present their findings to the larger group.

Close the training with group discussion about “next steps” for participants. Identify any themes that seem to be prevalent.

- Optional: Ask if participants would like their written reflection on “next steps” mailed to them in 2-3 weeks time as a reminder of new knowledge and commitments to improved outcomes for children and families involved with the child welfare system. If so, obtain mailing addresses of participants and thank them for their contributions during the curriculum training.

CHAPTER V

RESOURCES FOR COLLABORATION AND SERVICE PROVISION FOR CHILDREN AND YOUTH IN BOTH THE CHILD WELFARE AND MENTAL HEALTH SYSTEMS

Promising Models of Collaboration Between the Child Welfare and Mental Health Systems

Descriptions of promising models of collaboration that follow a System of Care model are contained in Figure 4. The collaborative models contained in Figure 4 were identified from two primary sources: (a) a collection of monographs detailing promising practices within systems of care that are funded by the Comprehensive Community Mental Health Services for Children and Their Families Program, and (b) the Health Care Reform Tracking Project (HCRTP) which has investigated successful interagency initiatives between the child welfare and mental health systems that incorporate a system of care approach within the context of managed care (See annotated bibliography at the end of this section for these references).

The collaborative models described in Figure 4 are provided as examples of potentially promising collaborations; because experimental evaluations on the impact of these collaborative models on service quality and outcomes have not been conducted, it is not possible to make an evaluative statement regarding the relative effectiveness of individual collaborative models. As such, the models described in Figure 4 are intended to illustrate aspects of promising collaborative models and are not necessarily intended to reflect the most effective collaborative models. However, there is evidence to suggest that System of Care collaborative models in general, may be an effective intervention

for children involved in both the child welfare and mental health systems. A national, quasi-experimental evaluation of System of Care interventions found that participation in the intervention was associated with a reduction in behavioral and emotional problems; a reduction in functional impairment; an improvement in school attendance and performance; a reduction in law enforcement contacts; a reduction in the use of cigarettes, alcohol, and marijuana, and an improvement in residential stability. Information related specifically to child welfare outcomes (e.g., reunification, adoption, etc.) were not assessed (U.S. DHHS, 2001).

Figure 4. Promising Approaches to Collaboration Between the Child Welfare and Mental Health Systems: System of Care Models

| PROMISING COLLABORATIVE MODELS | | | |
|--|--|--|---|
| NAME | DESCRIPTION | SERVICES | CONTACT |
| East Baltimore Mental Health Partnership | <ul style="list-style-type: none"> • An administrative board comprised of city officials, representatives from Mayor’s office, families, and community members oversees the collaboration. • Agency liaisons are responsible for coordinating referrals, facilitating communication between systems, and creating cross-training opportunities. • A Multi-Agency Coordination Committee (MACC) is comprised of middle-level managers. Develops service protocols and acts as a problem-solving group to address collaborative difficulties among line staff. • An Integrated Service Planning Team (ISPT) creates case plans, sets case goals, coordinates services, and monitors case progress. | <ul style="list-style-type: none"> • Therapy • Wraparound services • Emergency support services • Case management • Linkage to community agencies • School-based services • Family advocacy • Respite • Day treatment • Outpatient services | <p>Jacqueline Duvall-Harvey, PhD Site Director East Baltimore Mental Health Partnership 1235 Monument Street Baltimore, MD 21202 Phone: 410-614-3965 Fax: 410-614-9597 crowel@gwagyatel.jhmi.jhu.edu</p> |
| KanFocus: Kansas | <ul style="list-style-type: none"> • Administered through a central office in Parsons Kansas, and five mental health centers in 13 counties in Southeast Kansas. • Contracts are used to place staff in the five mental health centers; staff create service plans, link families to services, coordinate interagency coalition meetings, and coordinate service provider trainings. • Parent TEAMS, Inc. works collaboratively with local agencies in order to provide parent input into services. • Goal is to provide wraparound services and supports to children and families. | <ul style="list-style-type: none"> • Case management • Attendant care (includes one-on-one services such as transportation, tutoring, respite care, role modeling, classroom supervision, etc.) • Psycho-social groups • Adventure-based counseling • Home-based family therapy • Early intervention & prevention for children under age 7 • Parent/family advocacy • Parent-driven participatory follow-up evaluation | <p>Jim Rast, PhD Project Director KanFocus 1730 Belmont Ave. Parsons, KS 67357 Jrast@terraworld.net</p> |

Figure 4. Promising Approaches to Collaboration Between the Child Welfare and Mental Health Systems: System of Care Models (continued)

| NAME | DESCRIPTION | SERVICES | CONTACT |
|---------------------------------|--|---|--|
| New Opportunities Oregon | <ul style="list-style-type: none"> • Located in Lane County Child and Adolescent Behavioral Health Center. • Collaborating agencies include the child welfare, juvenile justice, and educational systems, as well as Medicaid provider agencies, Commission on Children and Families, Healthy Start, and Birth to 3 prevention project, the Community Safety Net, and the Lane County Managed Care program. • Service coordination occurs across agencies and is managed by a behavior support specialist. | <ul style="list-style-type: none"> • Provides behavioral support and rehabilitation to children at-risk of out-of-home placement | <p>Bruce Abel Principal Investigator/ Site Director Lane County Mental Health 1907 Garden Avenue Eugene, OR 97403 Phone: 541-682-7577 Fax: 541-682-7598 bruce.abel@co.lane.or.us</p> |
| PEN-PAL Project: North Carolina | <ul style="list-style-type: none"> • Located in Pitt and Edgecombe-Nash counties in Eastern North Carolina. Created to establish a system of services for children with mental health problems and to provide training in system of care principles through a partnership with East Carolina University. • Oversight for the collaboration is managed by the State Oversight Committee (SOC) which includes representatives from participating agencies and advocacy groups. • Project Management Committees (PMC) include supervisors from child-serving systems and agencies. • The Social Services Training Consortium (SSTC) is coordinated through the East Carolina University and includes representatives from numerous academic programs. The SSTC is responsible for creating and implementing the system of care training curriculum. | <ul style="list-style-type: none"> • Developed a case management training manual, and pre-service and in-service training curriculum in the system of care principles • A Parents in Residence model has been implemented that includes parents as key partners within the pre-service and in-service training curriculum • A local agency assessment protocol has been developed • Evaluation and outcome tracking are integral aspects of the collaboration | <p>Mark O'Donnell Project Director PEN-PAL Project, Child and Family Services 3509 Haworth Drive Raleigh, NC Phone: 919-571-4887 Fax: 919-571-4878</p> |

Figure 4. Promising Approaches to Collaboration Between the Child Welfare and Mental Health Systems: System of Care Models (continued)

| NAME | DESCRIPTION | SERVICES | CONTACT |
|-----------------------------|--|--|---|
| Rhode Island: Project REACH | <ul style="list-style-type: none"> • Project REACH is a statewide initiative in which the state Department for Children Youth and Families contracts with Local Coordinating Councils in nine mental health center catchment areas. • Local Coordinating Councils (LCC) meet to address system and community level issues. • Family Service Coordinators (FSC) take referrals and schedule case review meetings. • Case review teams develop Individual Service Plans. | <ul style="list-style-type: none"> • Wraparound services • Respite • Therapeutic recreational services • Therapy • Day treatment • Therapeutic foster care | Susan Bowler Department of Children, Youth and Families Children's Behavioral Health and Education Division of Children's Behavioral Health 101 Friendship Street, 3 rd Floor Providence, RI 02903 Phone: 401-528-3758 Fax: 401-528-3760 |
| Stark County Family Council | <ul style="list-style-type: none"> • A board of trustees comprised of top administrators oversees the collaboration. • Working councils address problems or issues, such as communication or treatment issues. • Creative Community Options (CCO) include treatment planning meetings. • Middle level manager meetings are held to oversee decisions about service provision, including any gaps or duplications. | <ul style="list-style-type: none"> • Treatment foster care • Family resource centers • Early intervention and prevention programs • Family advocacy • Community education and support • Transitional housing • Mobile crisis response • Parenting training • Respite • Sex offender treatment • Teen pregnancy programs | Carol Lichtenwalter Site Director Stark County Family Council 800 Market Avenue North, Suite 1600 Canton, OH 44702 Phone: 330-455-1225 Fax: 330-455-2026 E-mail: lichtenwalter@juno.com |

Figure 4. Promising Approaches to Collaboration Between the Child Welfare and Mental Health Systems: System of Care Models (continued)

| NAME | DESCRIPTION | SERVICES | CONTACT |
|--|---|--|--|
| The DAWN Project, Marion County, Indiana | <ul style="list-style-type: none"> • Governed by a cross-system consortium that includes representatives from state and county agencies, as well as family members. • Monthly administrative meetings are used to share information, address any issues, and review referrals. • Multi-level interagency task forces, work groups, and committees are utilized as needed to address issues affecting the collaboration, including training and education, communication, and referrals. • A Child and Family Team comprised of family members, the child welfare worker, and other service providers meet to create a plan. | <ul style="list-style-type: none"> • Family-centered • Strength-based • Uniform screening and assessment • Service coordination plans • Use of non-traditional supports | Knute Rotto Indiana Behavioral Health Choices 4701 North Keystone Avenue, Suite 150 Indianapolis IN 46205 Phone: 317-205-8202 krotto@kidwrap.org |
| Partnership for Children, New Jersey | <ul style="list-style-type: none"> • An Executive Oversight Board comprised of state representatives oversees the collaboration. • A Partnership Management Team is responsible for implementation at the state level. • Local Implementation Teams within each region meet once a month • The Child and Family Team comprised of the child, parent/guardian, the child welfare worker, the clinician, a family advocate, and any other support persons or representatives from other involved agencies—this team creates Individualized Service Plans. | <ul style="list-style-type: none"> • Case management • Service coordination • Individualized service planning • Family-centered • Strength-based • Family support organizations provide advocacy • Uniform screening and assessment | Julie Caliwan Partnership for Children New Jersey Department of Human Services 222 South Warren St. P.O. Box 700 Trenton, NJ 08625 Phone: 609-292-4741 Email: Julie.caliwan@dhs.state.nj.us |

Resources for Cross-System Collaboration

The following list represents resources for cross-system collaboration that are available on the web:

- Georgetown University Center for Child and Human Development
<http://gucchd.georgetown.edu/index.html>
- Center for Effective Collaboration and Practice
<http://cecp.air.org/>
- Child Welfare League of America
<http://www.cwla.org/>
- U.S. Center for Mental Health Services, Council for Coordination and Collaboration
[http:// www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0016/main.asp](http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0016/main.asp)
- U.S. Center for Mental Health Services, Division of Service and Systems Improvement, Child, Adolescent and Family Branch, Systems of Care
[http:// www.mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/grantcomm.asp](http://www.mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/grantcomm.asp)
- Research and Training Center for Children's Mental Health, University of South Florida
<http://rtckids.fmhi.usf.edu/>

Annotated Bibliography of References for Developing Collaborative Models Between Mental Health and Child Welfare Systems

Anderson, J. A. (2000). The need for interagency collaboration for children with emotional and behavioral disabilities and their families. *Families in Society*, 81(5), 484-493.

This paper describes the ways in which differences in eligibility criteria serve as a barrier to cross-system collaboration among agencies serving children with mental health problems. Strategies for creating cross-system eligibility criteria are described, and a description of a System of Care model is presented.

Butler, S., Atkinson, L., Magnatta, M., & Hood, E. (1995). Child maltreatment: The collaboration of child welfare, mental health and judicial systems. *Child Abuse and Neglect, 19*(3), 355-362.

This study examined agreement between child welfare, mental health, and court systems with respect to case recommendations for children with contested child maltreatment cases. The three systems were generally in agreement concerning most placement recommendations. Disagreements tended to favor parental rights.

Darlington, Y., Feeney, J. A., & Rixon, K. (2004). Complexity, conflict and uncertainty: Issues in collaboration between child protection and mental health services. *Children and Youth Services Review, 26*, 1175-1192.

This study used survey data from child welfare workers, adult mental health workers, and child mental health workers to assess cross-system collaboration. Descriptive data provide information on the context of collaboration, the extent of collaboration, and positive and negative experiences of collaboration. A quantitative analysis indicated that uncertainty regarding mental health problems and child safety negatively impacted collaboration.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect, 22*(5), 401-421.

This study evaluated the impact of organizational climate and interorganizational coordination on service quality and outcomes among agencies serving children in state custody. Results indicated that organizational climate was significantly related to service quality and child outcomes, while interorganizational coordination was unrelated to child outcomes and had a negative impact on service quality.

Hepburn, K., & McCarthy, J. (2003). *Promising approaches for behavioral health services to children and adolescents and their families in managed care systems*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

This report describes three interagency initiatives for children and families involved in the child welfare system. Similarities, differences, and challenges among the initiatives are highlighted, as well as strategies used in these sites to meet the mental health needs of children in the child welfare system and recommendations for future initiatives.

Hodges, S., Nesman, T., & Hernandez, M. (1998). Promising practices: Building collaboration in systems of care. *Systems of care: Promising practices in children's mental health* (1998 series, Volume VI). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

This report describes promising practices for interagency collaboration among nine providers receiving funds through the federal Comprehensive Community Mental Health Services Program for Children and their Families—a System of Care program. Foundations of collaboration, strategies for implementing collaborative processes, and results of collaboration are described.

Kendziora, K., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). *Systems of care: Promising practices in children's mental health* (2001 series, Volume 1). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

This report describes the experiences of six families who have received services through the Wraparound program. Wraparound represents a collaborative approach to serving children with mental health problems; it is a mechanism through which a System of Care model of services is implemented.

Prince, J., & Austin, M. J. (2005). Inter-agency collaboration in the child welfare and mental health systems. *Social Work in Mental Health, 4*, 1-16.

This article describes the ways in which child welfare services provide an opportunity for inter-agency collaboration between the child welfare and mental health systems. Factors related to collaboration are described as well as mechanisms to improve collaboration.

Rivard, J. C., Johnson, M. C., Morrissey, J. P., & Starrett, B. E. (1999). The dynamics of interagency collaboration: How linkages develop for child welfare and juvenile justice sectors in a system of care demonstration. *Mental Health Services and Sectors of Care, 25*(3), 61-82.

This study investigated interagency collaboration between child welfare and juvenile justice systems. Measurements of the degree of interorganizational resource exchange between systems indicated increasing interorganizational relationships.

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APPENDIXES

STUDY METHODS AND PROCEDURES

The current study addresses a number of the gaps in the current literature on mental health service utilization and outcomes for children in the child welfare system.

Specifically, we pose five research questions:

1. **Demographic and System-Related Characteristics:** What are the demographic and system-related characteristics of children and youth in the child welfare system (CWS) who are also involved in the mental health system (MHS)? How do the characteristics of these children and youth compare to those not referred to the MHS?
2. **Clinical Need:** What is the clinical need for mental health services by children and youth in the child welfare system? Are there differences by demographic and system-related characteristics regarding the clinical need for mental health services?
3. **Mental Health Service Utilization:** What are utilization patterns for child welfare clients involved in the mental health system? What types of services are utilized? What is the intensity (i.e., frequency and duration) of services? What demographic and system-related characteristics are associated with treatment type and intensity? What is the relationship between clinical need and treatment type and intensity? What factors are related to mental health treatment completion for child welfare clients?
4. **Outcomes:** Controlling for demographic and system-related factors, what is the association between mental health service utilization and child welfare outcomes, specifically family stability, including family reunification versus types of permanency placement (adoption, legal guardianship, or long-term foster care)?
5. **System Collaboration:** How do the systems currently collaborate? What formal structures for collaboration are in place? Do system goals correspond or conflict? What factors impede or facilitate collaborative practice? What is the potential impact of Proposition 63 on system collaboration?

Methods for Research Questions 1-4 Design, Data Sources, Reliability, Validity, and Missing Data

In order to address Questions 1-4, secondary analysis was conducted utilizing child welfare and mental health system data files from Santa Clara County's Data

Warehouse. The study included a total sample of child welfare cases that were closed between January 1, 2004 and December 16, 2004, and a subset of those children in the child welfare system (CWS) also referred to the mental health system (MHS) during the period specified. Using a common Client ID number, data from the Child Welfare Services/Case Management System (CWS/CMS) were matched with corresponding data from the mental health system database.

Although no formal tests were conducted on the reliability and validity of original data entry by caseworkers, therapists, and staff, this particular county ranks high within the state in its training of workers and their regular and competent use of computerized data management systems. In addition, our four consultants served as professional auditors and peer reviewers. These consultants, including two senior social workers with intimate knowledge of the CWS, case records, and computer systems; an expert psychologist for the county with in-depth knowledge of the MHS, assessment, diagnosis, treatment, system characteristics, and mental health data; and a senior data manager with extensive knowledge of the county's information database and coding procedures, assisted in the collection, cleaning, and review of our data set and findings.

In our data set, we encountered missing data for some of our variables. This was due to computer system errors inherent in running queries and compiling information as part of the data collection procedure. We noted missing data whenever applicable for each of our analyses.

Measurement and Operational Definitions

Demographic and system-related characteristics. *Age* of the clients was derived from both the CWS/CMS and MHS database. Age was defined as age in years at entry into each system taking the difference from the birth date and respective case opening dates. From CWS/CMS, *gender* was denoted as either male or female. Also from CWS/CMS, *ethnicity* had originally 18 ethnic designations: American Indian, Asian Indian, Black, Cambodian, Chinese, Filipino, Hawaiian, Hispanic, Japanese, Other Asian/Pacific Islander, Samoan, Vietnamese, White, White-Central American, White-European, White-Middle Eastern, Mexican, and South American. These were collapsed for analysis purposes into five major categories: African American, White, Latino, Asian/Pacific Islander, and Native American and Other.

Type of abuse was defined as the initial reported reason leading to entry into the CWS: caretaker absence/incapacity, child's disability or handicap, emotional abuse, general neglect, law violation, physical abuse, severe neglect, sexual abuse, or other. *Service component at time of case closure* was one of four designations: emergency response (ER), family maintenance (FM), family reunification (FR), or permanent placement. *Time in the CWS* was calculated in months taken from the difference in the CWS case opening and closing dates.

Clinical need. To measure the clinical need of children and youth referred to the MHS, primary diagnosis was utilized. *Primary diagnosis* included over 50 DSM-IV specific conditions. These were first collapsed into 16 categories: adjustment disorders, anxiety disorders, attachment disorders, attention deficit hyperactivity disorder,

communication disorders, deferred diagnosis, developmental delay, disruptive behavior disorders, elimination disorders, identity disorder, impulse control disorders, learning disorder, mood disorders, no diagnosis, relational problem, or schizophrenia and other psychotic disorder. Finally, for analysis purposes, these were condensed into 6 categories: adult-type disorder (e.g., schizoaffective disorder), adjustment disorder (e.g., adjustment disorder with anxiety), childhood disorder (e.g., learning disorder or identity disorder), other disorder, deferred diagnosis, or no diagnosis. For the latter analyses in the study, "other disorder" was primarily those with a relational problem, although there was one case with an organic disorder. This one case was removed from most analyses and the category was renamed "relational problem."

Mental health service utilization. In order to measure *type* of mental health service utilization, mode of MHS was utilized. Mode of service was defined as one of three categories: inpatient (Mode 5), day treatment (Mode 10), or outpatient (Mode 15). In order to measure *intensity* of mental health service utilization, units of service were used. Units were measured in days for inpatient services, in half-days for day treatment, and hours for outpatient. From the analysis, an overwhelming majority of clients received outpatient services and thus units of outpatient services in hours became the measurement for this measure.

Treatment completion was operationalized from the case outcome variable, which originally had four categories: unsuccessful discharge, successful discharge, other discharge (including withdrawal from treatment, moved out of the area, and administrative discharge), or unknown discharge. This was collapsed into "treatment

completion" versus "treatment non-completion" since we were interested in those cases with a clear, positive outcome.

CWS Outcomes

The primary CWS outcome was stabilization of the child with his/her family. This was derived from the original 17 case closure reasons, including: kin-care, adoption with non-relative, adoption with relative, incarcerated, child in medical facility, child runaway, closed due to interstate compact for the placement of children/international request, court ordered termination, emancipation, exceeded time limit, family stabilized (including those originally assigned to family maintenance services [FM]), guardianship established, court-ordered reunification with parent/guardian, non-court-ordered reunification with parent/guardian, placement with relative, refused services, or services provided by another agency. These were collapsed into "*family stabilized*" versus "*family not stabilized*" with only a designation of "family stabilized", "court-ordered reunification with parent/guardian", or "non-court ordered reunification with parent/guardian" qualifying as "family stabilized." Family stabilized also includes those children who began in FM and remained with their families throughout the duration of the case.

Analysis

To answer the first four research questions, a series of univariate, bivariate, and multivariate analyses were conducted. Univariate and bivariate statistics were utilized to answer the questions regarding demographics and differences according to major characteristics, including the initial comparison of those children referred to the MHS

versus those who were not referred. Bivariate tests were also used to answer the questions regarding MHS utilization according to major characteristics. Finally, multivariate logistic and linear multiple regression models were utilized to answer the questions regarding significant predictors related to mental health service utilization and child welfare system outcomes.

Protection of Human Subjects

The quantitative portion of the study was exempted from Human Subjects review under Part 4, Section 46.101 (b) of federal regulation which exempts research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified directly or through identifiers linked to the subjects (U.S. DHHS, 2005).

Secondary data analyses were conducted using a merged file consisting of child welfare and mental health data, with identifiers removed. Potential risks to the clients under study were indirect and minimal, as the study used retrospective data, obtained from closed child welfare cases. Both the Principal Investigator and Co-Investigator received Health Information Portability and Accountability Act (HIPAA) training and certification in preparation for conducting this study.

Methods for Research Question 5

Design

In order to address contextual issues related to collaboration between the child welfare and mental health systems, qualitative, in-depth interviews with program managers and supervisors in both systems and focus groups with line staff in both systems were conducted. In each system, three program managers and three supervisors were interviewed and three focus groups with line staff were conducted.

Sampling

Child Welfare System. Interview and focus group participants from the child welfare system were randomly selected from a list of workers with at least 2 years of experience. The decision to limit the sample to workers with at least 2 years of experience was intended to ensure that participants had adequate knowledge and experience to answer the study's questions. Three supervisors and three program managers were randomly selected for an interview and 17 line staff were randomly selected for each focus group. In addition, in an effort to ensure a breadth of responses, one of the three child welfare focus groups was conducted with staff from the South County office. All interview participants were telephoned by a member of the research team and invited to participate in an interview. Focus group participants received an email from DFCS administration encouraging their participation in the study. They also received an email invitation and a telephone invitation from a member of the research team.

Mental Health System. Because many mental health workers do not work with children involved in the child welfare system, a random selection of participants would likely have yielded workers who would not have the relevant experience to answer study questions. Thus, interview and focus group participants from the mental health system were selected using snowball sampling techniques in which key informants identified potential participants who would be knowledgeable about the qualitative questions. This sampling method yielded only program managers (and no supervisors) as interview participants.

Data Collection

Structured interview guides were used for both the interviews and focus groups (see Appendixes B and C). Prior to beginning data collection, an informational meeting was held with administrators and staff in both systems to review and provide feedback on the interview questions and interview format. Questions focused on five overall areas: a) ways in which the two systems collaborate, including how collaboration occurs at different levels of the systems (e.g. line staff, supervisor, and program manager); b) formal structures that guide collaboration, including the ways in which inter-agency referrals are handled; c) ways in which system goals correspond or conflict; d) factors that enhance or impede collaboration; and e) the anticipated impact of Proposition 63 on the collaborative relationship between the two systems (asked only of program managers and supervisors).

Interviews lasted approximately 45 minutes and focus groups lasted approximately 1-1½ hours. A senior research assistant conducted all interviews and

focus groups and a research assistant was present during most focus groups to take notes. Interviews took place within participants' offices and focus groups took place in agency conference rooms. Interviews and focus groups were also audiotaped to ensure the accuracy of the notes. Notes taken during interviews and focus groups were subsequently transcribed.

Analysis

Following transcription of the notes, data were organized and coded using content analysis methods. A content analysis of the data was conducted to identify key themes across respondents and to provide a description of factors that have helped or hindered collaborative partnerships between the mental health and child welfare systems.

Validity of Qualitative Data

In addition to the use of an interview protocol, extensive note-taking, and detailed transcription of audiotapes, two other procedures were used to enhance the credibility of our qualitative data and interpretation. First, similar to our quantitative component, we used our research team consultants as professional auditors and peer reviewers to evaluate our findings and interpretations for accuracy and fit within the context of the study and within their experiences with the system, workers, and clients. Second, we used a form of member check, a process in which the initial recording of the qualitative data and our interpretations are reported back to the participants interviewed for their review and comment. These member checks enhance accuracy, and our final report reflects any elaboration and corrections offered by our interviewees.

Protection of Human Subjects

Since additional original data had to be collected to answer our fifth question, the procedures for this component were reviewed and approved by San José State University's Institutional Review Board. All participants received a consent form to participate in the research and were informed of the potential risks and benefits related to the study. Participants were ensured that data would be reported in aggregate and no identifying information about individuals would be included in the final report or in any subsequent reports or manuscripts developed from the research.

STRUCTURED INTERVIEW GUIDE

CaISWEC Mental Health Service Utilization and Outcomes for Children and Youth in the Child Welfare System Structured Interview Guide

1. How would you characterize the collaborative relationship between the child welfare system and the mental health system?
2. What is your understanding of the collaborative relationship between the child welfare system and the mental health system at the supervisor/program manager level?
3. What formal structures are in place for collaboration between the child welfare and mental health systems (e.g., policies, committees, etc.)?
4. How do you anticipate Proposition 63 impacting the collaborative relationship between the child welfare and mental health systems?
5. How do interagency referrals between the child welfare and mental health systems operate?
6. How do the goals of the child welfare and mental health systems complement one another or conflict with one another?
7. What factors, conditions, or circumstances facilitate strong collaboration between the child welfare and mental health systems?
8. What factors, conditions, or circumstances operate as a barrier for strong collaboration between the child welfare and mental health systems?
9. How have these barriers been addressed in Santa Clara County?
10. Is there anything else you would like to add?

STRUCTURED FOCUS GROUP GUIDE

CalSWEC Mental Health Service Utilization and Outcomes for Children and Youth in the Child Welfare System Structured Focus Group Guide

1. How would you characterize the collaborative relationship between the child welfare system and the mental health system?
2. What is your understanding of the collaborative relationship between the child welfare system and the mental health system at the line staff level?
3. What formal structures are in place for collaboration between the child welfare and mental health systems (e.g., policies, committees, etc.)?
4. How do interagency referrals between the child welfare and mental health systems operate?
5. How do the goals of the child welfare and mental health systems complement one another or conflict with one another?
6. What factors, conditions, or circumstances facilitate strong collaboration between the child welfare and mental health systems?
7. What factors, conditions, or circumstances operate as a barrier for strong collaboration between the child welfare and mental health systems?
8. How have these barriers been addressed in Santa Clara County?
9. Is there anything else you would like to add?

HANDOUTS

INTRODUCTORY ACTIVITY I-1 ICEBREAKER

Purpose: To give participants an opportunity to interact and raise awareness around mental health issues for children in foster care.

Instructions: Get into dyads or triads and discuss the following:

1. Identify your role as a student or employee working with children in the child welfare system.
2. Discuss your observations about the children you have worked with:
 - Most common type of maltreatment
 - Most common presenting behavioral/emotional issues
 - Most common mental health diagnosis

Process: Small groups to share with larger group, instructor to note group findings on board for further discussion.

INTRODUCTORY ACTIVITY I-2 PRETEST

1. Male children in the child welfare system have a higher likelihood of using mental health services than females (T/F).
2. Children over the age of 14 are more likely than younger children to use psychotropic medication (T/F).
3. African American and Hispanic/Latino youth are more likely to use residential and group home care than white youth (T/F).
4. Children who have experienced neglect or caretaker absence are more likely to receive mental health services than children who have experienced other types of maltreatment (T/F).
5. Children who have experienced multiple placements are more likely to receive mental health services than children in stable placements (T/F).
6. Children in kinship care receive more mental health services than those in non-relative foster care (T/F).
7. Children who have been sexually abused have the highest number of mental health visits (T/F).
8. Children with lengthier stays in the foster care system are more likely to use mental health services (T/F).

ACTIVITY I-3 FOCUS QUESTIONS

Question 1:

- Describe the characteristics of children in the child welfare system *most likely* to receive mental health services. What are your theories about why this is the case?
- Describe the characteristics of children in the child welfare system *least likely* to receive mental health services? What are your theories about why this is so?
- What might be some strategies to reduce barriers in receiving mental health services?

Question 2:

- Estimates are that 50-80% of children in the child welfare system suffer from some type of mental health disorder, compared to 20% in the general child population.
- List the most common mental health diagnoses for children in the child welfare system. What are the differences considering age, gender, and ethnicity?

ACTIVITY I-4 PROBLEM SOLVING

Current research indicates approximately 56% of children in the child welfare system receive mental health services. However, African American and Latino children are less likely than Whites to receive court-ordered mental health services and African American children in particular have a decreased likelihood of being recommended for individual counseling. How might this disparity issue be addressed at:

1. The micro level (individual workers and families),
2. The mezzo level (groups and community focus), and
3. The macro level (systems of care, agency/organization procedures/policies, and state and federal legislation)?

ACTIVITY II-1 DISCUSSION QUESTIONS

1. Studies suggest failure to address emotional and behavioral problems of children in foster care is associated with a decreased likelihood of reunification. Given the findings from Activity II-1, which groups are most likely affected by this? Should mental health services be ordered for all children who have a court-ordered plan of family reunification? Why or why not?
2. What are the findings from Santa Clara County with regard to family stabilization/reunification?
3. Which of the following types of maltreatment (in order of priority) does your group think most warrants mental health services? Why? (Make sure to provide a clear rationale for your response).
 - Sexual abuse
 - Physical abuse
 - Chronic neglect
 - Parental absence/incapacity

ACTIVITY II-2 CASE SCENARIO

You are a social worker in the Family Reunification unit and have just received a new, recently adjudicated case with an African American family. There are two children in the family: Gloria, age 9, and Eli, age 4. Gloria has been sexually abused by her stepfather and both children have been neglected. The mother is currently incarcerated in a women's prison on an unrelated conviction. You would like to get immediate counseling services for Gloria as she is exhibiting behavioral problems in the foster home where she is placed with her sibling. However, your co-worker also has a case involving severe physical abuse that warrants mental health services and county behavioral health can only accommodate one child at this time for services.

Some key points of the quantitative research include:

- Whites are the least likely to be stabilized with their families.
- Those diagnosed with childhood disorders stayed significantly longer in the child welfare system.
- Children entered the child welfare system at an average age of 6.87 years, and yet the entry to the mental health system occurred at 8.97 years.
- A greater percentage of children are referred for mental health services who have been victims of physical and sexual abuse than other types of maltreatment (a finding that can be interpreted as meaning that sexual and physical abuse are more severe than neglect and parental absence/incapacity).
- Approximately 60% of children are not stabilized with their families. Current research indicates there is no statistically significant difference in the rate of family stabilization for those receiving or not receiving mental health services.

Questions:

- How will you advocate to your supervisor and program manager that Gloria needs services first?
- What have you learned from the current research that might support your request?
- Or, do you believe the other case is more compelling?
- If so, what have you learned from the current research that would support this opinion?
- How would you advocate for system change so that in the future there are adequate services to meet both children's mental health needs?

ACTIVITY III-1 FEDERAL POLICIES

Instructions/Process: Participants will review the descriptions of federal child welfare and mental health policy and legislation provided below. The instructor will then assign one of the policies to each small group to complete the activity below:

Activity:

1. In small groups, review and discuss the main elements of the selected policy.
2. Provide specific examples from experience describing how this policy has been working in your county.
3. Brainstorm with your group how mental health services utilization may be impacted by this policy.
4. Share your responses with the larger group.

Policies:

- **Adoption and Safe Families Act (1997).** The Adoption and Safe Families Act (ASFA) of 1997 created shortened timelines for the provision of family reunification services and termination of parental rights within the child welfare system. A permanency hearing must take place after 1 year of out-of-home placement and proceedings for the termination of parental rights must be initiated when a child has been in out-of-home care for 15 of the previous 22 months. Some practitioners and scholars note that it can be difficult to locate available mental health services within the shortened timelines mandated by the ASFA and that some children and families may have difficulty completing treatment within these shortened timeframes (Webb & Harden, 2003). However, it is also possible that shortened timelines may provide an impetus for child welfare agencies to establish collaborative relationships with mental health providers in order to ensure timely access to mental health services (Webb & Harden). The ASFA also stipulated state requirements for ensuring the safety, permanency, and well-being of children in the child welfare system.
- **Child and Family Service Review (2000).** In 2000, Congress passed regulations designed to monitor state performance with respect to key outcomes for children in the child welfare system. These regulations, defined as the *Child and Family Service Review (CFSR)* process, were first implemented in 2001 and focus on measuring outcomes for children and families involved in the child welfare system. Outcomes assessed are related to child safety, permanency, and well-being. Among the priority outcomes that are assessed in the review process is an outcome related to ensuring that children receive adequate services to meet their physical and mental health needs. This outcome is

assessed through case reviews. Currently, all 50 states as well as the District of Columbia and Puerto Rico have completed the first CFSR and results revealed that only one state was in substantial conformity with the outcome related to ensuring adequate services to meet children's physical and mental health needs. However, some scholars note that these data may not be reliable because they are based on a sample of just 50 cases from each state, and in many instances, information related to the outcome of interest may not be available in the case record. As a result, some outcomes are assessed based on just a handful of cases, making it difficult to truly assess state performance (Lemon, D'Andrade, & Austin, 2005). Despite these difficulties, state officials report that the CFSR process has contributed to improved collaborative relationships between the child welfare system and community stakeholders (U.S. Government Accounting Office, 2004), and scholars note that the review process may provide the momentum necessary for child welfare agencies to form stronger collaborative relationships with mental health providers (Webb & Harden, 2003).

The Child Welfare System Improvement and Accountability Act was passed in 2001 and represents California's efforts to create a system through which to evaluate child welfare outcomes and track progress toward performance goals. California Child and Family Service Reviews were first implemented in 2004 and are intended to address many of the methodological problems associated with the federal government's measurement of child welfare outcomes and thus, they are considered to provide a more comprehensive evaluation of county performance. As in the federal review process, the overall outcomes assessed in California CFSRs are related to child safety, permanency, and well-being.

A portion of the specific outcomes assessed in the California CFSRs correspond to the federal review outcomes; however, California also included additional specific measures that are intended to be more comprehensive. For instance, California's review process includes an outcome related to the well-being of youth emancipating from the child welfare system. In addition, the California CFSRs use longitudinal data to assess county performance and thus, more accurately measure performance over time (Lemon et al., 2005). As is the case with the federal accountability legislation, this state legislation has the potential to increase collaboration between the child welfare and mental health systems.

- **Child Abuse Prevention and Treatment Act (as amended by the Keeping Families Safe Act, 2003).** The federal *Child Abuse Prevention and Treatment Act, as amended by the Keeping Children and Families Safe Act of 2003*, provides grants to states to provide a variety of child welfare services. In the 2003 amendments, a new purpose related to the promotion of collaboration between the child welfare system and other child-serving systems was added. Specifically, one of the new purposes of the legislation is to encourage and support collaboration among the child welfare system, public health agencies,

and community-based organizations to provide services that address the health and mental health needs of children (U.S. Department of Health and Human Services, Children's Bureau, 2003).

- **Child and Adolescent Service System Program (1984).** Among federal mental health policies, the *Child and Adolescent Service System Program (CASSP)* that was first initiated and funded by the National Institute of Mental Health in 1984 has had a major influence on interventions for children with emotional and behavioral disorders (Stroul & Friedman, 1986). The CASSP legislation provided funding for interventions that utilized a “system of care” philosophy which contains an overarching goal to provide a comprehensive array of coordinated mental health and other social services (e.g., juvenile justice, child welfare, and Special Education) in order to meet the myriad needs of children and youth with severe emotional and behavioral problems (Stroul & Friedman). Building on the CASSP foundation, the federal Center for Mental Health Services first authorized funding for the *Comprehensive Community Mental Health Services for Children and their Families Program* in 1992. This program has provided grants to 92 communities around the U.S. in order to develop interagency systems of care that link systems serving children with mental health problems. Interagency systems of care seek to reduce service gaps and service duplication, ensure access to needed services, increase continuity of care, and ultimately result in improved outcomes for children with serious emotional and behavioral problems (Rivard, Johnson, Morrissey, & Starrett, 1999).

ACTIVITY III-2 STATE POLICY

The Child Welfare System Improvement and Accountability Act was passed in 2001 and represents California's efforts to develop a system to track child welfare outcomes and track progress towards performance goals.

Process:

Get into small groups and discuss what types of outcomes you believe would be important to track in order to better understand the status of children in the foster care system. Each group is to develop appropriate outcome indicators related to positive child welfare outcomes.

Groups to share their outcome indicators with the larger group.

ACTIVITY III-3 LOCAL POLICY

Background:

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides the first opportunity in many years for the Department of Mental Health (DMH) to provide increased funding, personnel, and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition-age youth, adults, older adults, and families. The Act addresses a broad continuum of prevention, early intervention, and service needs; and the necessary infrastructure, technology, and training elements that will effectively support this system.

This Act imposes a 1% income tax on personal income in excess of \$1 million. Statewide, the Act was projected to generate approximately \$254 million in fiscal year 2004-05, \$683 million in 2005-06 and increasing amounts thereafter. Much of the funding will be provided to county mental health programs to fund programs consistent with their local plans. *Improvement in client outcomes* is a fundamental expectation throughout the implementation process.

Activity:

Complete the following exercise(s) in your group.

Exercise 1

1. How would you describe your overall level of knowledge of Prop. 63 (minimal, adequate, thorough)?
2. Where did the information come from (supervisor, co-worker, media, academic program, other)?
3. Have you attended information sessions or received any training on Prop. 63?
4. How will mental health services be different as a result of Prop. 63?

Exercise 2

Go online and locate a website with local information about Prop. 63 to share with the large group

Exercise 3

In small groups, discuss from your experience examples of how the Mental Health Services Act is being implemented in your county.

ACTIVITY IV-1 GROUP DISCUSSION

Instructions:

Get into small groups and address the following questions. Small groups will share their responses with the larger group.

Discuss your experiences in collaboration between public child welfare and mental health professionals at both the worker and management levels.

1. What specific factors have *helped* effective collaboration between the two systems?
2. What factors have *hindered* collaboration between the two systems?
3. What suggestions might you have to *improve* the collaborative process?

ACTIVITY IV-2 THEMES FROM THE RESEARCH

Instructions:

The instructor will organize the large group into four smaller groups and will then assign one of the following exercises to each group. Each of the exercises provides an opportunity to apply new knowledge gained from the current research on collaboration between child welfare and mental health systems. Small groups will have 15-20 minutes to discuss and prepare their responses for the large group.

Exercise 1

The first theme from the research identifies ways in which systems currently collaborate and provides the perspectives of both the child welfare and mental health systems. In what ways is the perspective of the professionals in child welfare different than the perspectives of those in mental health with regard to the collaborative process? Why might this be the case?

Exercise 2

The second theme from the research identifies the formal structures that guide the collaborative process between systems. Select **one** of the formal structures discussed in the research findings (outstationed workers, committees, referrals for systems of care, wraparound, the Call Center, etc.) and describe how the model and practice has worked in your county.

Exercise 3

The third theme from the research identifies ways in which systems goals correspond or conflict. The research addresses how child welfare workers are often seen as the “enforcers,” both by the public and by those working in the system itself. What specific ideas do you have about how this perspective might be changed to a more positive one?

Exercise 4

The fourth theme from the research identifies factors that impede or enhance collaboration. Select one finding (factor) from the research results and develop a specific plan to address this in your county.

HANDOUT V-1

RESOURCES FOR COLLABORATION AND SERVICE PROVISION FOR CHILDREN AND YOUTH IN BOTH THE CHILD WELFARE AND MENTAL HEALTH SYSTEMS

Promising Models of Collaboration Between the Child Welfare and Mental Health Systems

Descriptions of promising models of collaboration that follow a System of Care model are contained in Figure 4. The collaborative models contained in Figure 4 were identified from two primary sources: (a) a collection of monographs detailing promising practices within systems of care that are funded by the Comprehensive Community Mental Health Services for Children and Their Families Program, and (b) the Health Care Reform Tracking Project (HCRTP) which has investigated successful interagency initiatives between the child welfare and mental health systems that incorporate a system of care approach within the context of managed care (See annotated bibliography at the end of this section for these references).

The collaborative models described in Figure 4 are provided as examples of potentially promising collaborations; because experimental evaluations on the impact of these collaborative models on service quality and outcomes have not been conducted, it is not possible to make an evaluative statement regarding the relative effectiveness of individual collaborative models. As such, the models described in Figure 4 are intended to illustrate aspects of promising collaborative models and are not necessarily intended to reflect the most effective collaborative models. However, there is evidence to suggest that System of Care collaborative models in general, may be an effective intervention

for children involved in both the child welfare and mental health systems. A national, quasi-experimental evaluation of System of Care interventions found that participation in the intervention was associated with a reduction in behavioral and emotional problems; a reduction in functional impairment; an improvement in school attendance and performance; a reduction in law enforcement contacts; a reduction in the use of cigarettes, alcohol, and marijuana, and an improvement in residential stability. Information related specifically to child welfare outcomes (e.g., reunification, adoption, etc.) were not assessed (U.S. DHHS, 2001).

Figure 4. Promising Approaches to Collaboration Between the Child Welfare and Mental Health Systems: System of Care Models

| PROMISING COLLABORATIVE MODELS | | | |
|--|--|--|--|
| NAME | DESCRIPTION | SERVICES | CONTACT |
| East Baltimore Mental Health Partnership | <ul style="list-style-type: none"> • An administrative board comprised of city officials, representatives from Mayor's office, families, and community members oversees the collaboration. • Agency liaisons are responsible for coordinating referrals, facilitating communication between systems, and creating cross-training opportunities. • A Multi-Agency Coordination Committee (MACC) is comprised of middle-level managers. Develops service protocols and acts as a problem-solving group to address collaborative difficulties among line staff. • An Integrated Service Planning Team (ISPT) creates case plans, sets case goals, coordinates services, and monitors case progress. | <ul style="list-style-type: none"> • Therapy • Wraparound services • Emergency support services • Case management • Linkage to community agencies • School-based services • Family advocacy • Respite • Day treatment • Outpatient services | Jacqueline Duvall-Harvey, PhD Site Director East Baltimore Mental Health Partnership 1235 Monument Street Baltimore, MD 21202 Phone: 410-614-3965 Fax: 410-614-9597 crowel@gwagyatel.jhmi.jhu.edu |
| KanFocus: Kansas | <ul style="list-style-type: none"> • Administered through a central office in Parsons Kansas, and five mental health centers in 13 counties in Southeast Kansas. • Contracts are used to place staff in the five mental health centers; staff create service plans, link families to services, coordinate interagency coalition meetings, and coordinate service provider trainings. • Parent TEAMS, Inc. works collaboratively with local agencies in order to provide parent input into services. • Goal is to provide wraparound services and supports to children and families. | <ul style="list-style-type: none"> • Case management • Attendant care (includes one-on-one services such as transportation, tutoring, respite care, role modeling, classroom supervision, etc.) • Psycho-social groups • Adventure-based counseling • Home-based family therapy • Early intervention & prevention for children under age 7 • Parent/family advocacy • Parent-driven participatory follow-up evaluation | Jim Rast, PhD Project Director KanFocus 1730 Belmont Ave. Parsons, KS 67357 Jrast@terraworld.net |

Figure 4. Promising Approaches to Collaboration Between the Child Welfare and Mental Health Systems: System of Care Models (Continued)

| NAME | DESCRIPTION | SERVICES | CONTACT |
|---------------------------------|--|---|---|
| New Opportunities Oregon | <ul style="list-style-type: none"> • Located in Lane County Child and Adolescent Behavioral Health Center. • Collaborating agencies include the child welfare, juvenile justice, and educational systems, as well as Medicaid provider agencies, Commission on Children and Families, Healthy Start, and Birth to 3 prevention project, the Community Safety Net, and the Lane County Managed Care program. • Service coordination occurs across agencies and is managed by a behavior support specialist. | <ul style="list-style-type: none"> • Provides behavioral support and rehabilitation to children at-risk of out-of-home placement | Bruce Abel Principal Investigator/ Site Director Lane County Mental Health 1907 Garden Avenue Eugene, OR 97403 Phone: 541-682-7577 Fax: 541-682-7598 bruce.abel@co.lane.or.us |
| PEN-PAL Project: North Carolina | <ul style="list-style-type: none"> • Located in Pitt and Edgecombe-Nash counties in Eastern North Carolina. Created to establish a system of services for children with mental health problems and to provide training in system of care principles through a partnership with East Carolina University. • Oversight for the collaboration is managed by the State Oversight Committee (SOC) which includes representatives from participating agencies and advocacy groups. • Project Management Committees (PMC) include supervisors from child-serving systems and agencies. • The Social Services Training Consortium (SSTC) is coordinated through the East Carolina University and includes representatives from numerous academic programs. The SSTC is responsible for creating and implementing the system of care training curriculum. | <ul style="list-style-type: none"> • Developed a case management training manual, and pre-service and in-service training curriculum in the system of care principles • A Parents in Residence model has been implemented that includes parents as key partners within the pre-service and in-service training curriculum • A local agency assessment protocol has been developed • Evaluation and outcome tracking are integral aspects of the collaboration | Mark O'Donnell Project Director PEN-PAL Project, Child and Family Services 3509 Haworth Drive Raleigh, NC Phone: 919-571-4887 Fax: 919-571-4878 |

Figure 4. Promising Approaches to Collaboration Between the Child Welfare and Mental Health Systems: System of Care Models (continued)

| NAME | DESCRIPTION | SERVICES | CONTACT |
|--------------------------------|--|--|--|
| Rhode Island: Project REACH | <ul style="list-style-type: none"> • Project REACH is a statewide initiative in which the state Department for Children Youth and Families contracts with Local Coordinating Councils in nine mental health center catchment areas. • Local Coordinating Councils (LCC) meet to address system and community level issues. • Family Service Coordinators (FSC) take referrals and schedule case review meetings. • Case review teams develop Individual Service Plans. | <ul style="list-style-type: none"> • Wraparound services • Respite • Therapeutic recreational services • Therapy • Day treatment • Therapeutic foster care | Susan Bowler Department of Children, Youth and Families Children's Behavioral Health and Education Division of Children's Behavioral Health 101 Friendship Street, 3 rd Floor Providence, RI 02903 Phone: 401-528-3758 Fax: 401-528-3760 |
| Stark County Family Council | <ul style="list-style-type: none"> • A board of trustees comprised of top administrators oversees the collaboration. • Working councils address problems or issues, such as communication or treatment issues. • Creative Community Options (CCO) include treatment planning meetings. • Middle level manager meetings are held to oversee decisions about service provision, including any gaps or duplications. | <ul style="list-style-type: none"> • Treatment foster care • Family resource centers • Early intervention and prevention programs • Family advocacy • Community education and support • Transitional housing • Mobile crisis response • Parenting training • Respite • Sex offender treatment • Teen pregnancy programs | Carol Lichtenwalter Site Director Stark County Family Council 800 Market Avenue North, Suite 1600 Canton, OH 44702 Phone: 330-455-1225 Fax: 330-455-2026 E-mail: lichtenwalter@ juno.com |

Figure 4. Promising Approaches to Collaboration Between the Child Welfare and Mental Health Systems: System of Care Models (continued)

| NAME | DESCRIPTION | SERVICES | CONTACT |
|--|---|--|--|
| The DAWN Project, Marion County, Indiana | <ul style="list-style-type: none"> • Governed by a cross-system consortium that includes representatives from state and county agencies, as well as family members. • Monthly administrative meetings are used to share information, address any issues, and review referrals. • Multi-level interagency task forces, work groups, and committees are utilized as needed to address issues affecting the collaboration, including training and education, communication, and referrals. • A Child and Family Team comprised of family members, the child welfare worker, and other service providers meet to create a plan. | <ul style="list-style-type: none"> • Family-centered • Strength-based • Uniform screening and assessment • Service coordination plans • Use of non-traditional supports | Knut Rotto Indiana Behavioral Health Choices 4701 N. Keystone Ave., Suite 150 Indianapolis IN 46205 Phone: 317-205-8202 krotto@kidwrap.org |
| Partnership for Children, New Jersey | <ul style="list-style-type: none"> • An Executive Oversight Board comprised of state representatives oversees the collaboration. • A Partnership Management Team is responsible for implementation at the state level. • Local Implementation Teams within each region meet once a month • The Child and Family Team comprised of the child, parent/guardian, the child welfare worker, the clinician, a family advocate, and any other support persons or representatives from other involved agencies—this team creates Individualized Service Plans. | <ul style="list-style-type: none"> • Case management • Service coordination • Individualized service planning • Family-centered • Strength-based • Family support organizations provide advocacy • Uniform screening and assessment | Julie Caliwan Partnership for Children New Jersey Department of Human Services 222 South Warren St. P.O. Box 700 Trenton, NJ 08625 Phone: 609-292-4741 Email: Julie.caliwan@dhs.state.nj.us |

Resources for Cross-System Collaboration

The following list represents resources for cross-system collaboration that are available on the web:

- Georgetown University Center for Child and Human Development
<http://gucchd.georgetown.edu/index.html>
- Center for Effective Collaboration and Practice
<http://cecp.air.org/>
- Child Welfare League of America
<http://www.cwla.org/>
- U.S. Center for Mental Health Services, Council for Coordination and Collaboration
<http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0016/main.asp>
- U.S. Center for Mental Health Services, Division of Service and Systems Improvement, Child, Adolescent and Family Branch, Systems of Care
<http://www.mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/grantcomm.asp>
- Research and Training Center for Children's Mental Health, University of South Florida
<http://rtckids.fmhi.usf.edu/>