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Child & Family Services Reviews, Part V: **Most States Fail to Meet the Mental Health Needs of Foster Children**

This article is the fifth in a series analyzing federal Child and Family Services Reviews. Previous articles examined findings on placement stability, sibling contact,[1] *foster parent training,*[2] *and foster parent participation in hearings.*[3]

By Jennifer Huber and Bill Grimm

> As a society we have failed to meet the health needs of many of the children in out-of-home care. Most of these children have been medically neglected or abused before placement and suffer from a higher than average incidence of serious health problems. Failure to diagnose and treat these children adequately upon their entry into the out-of-home care system may mean community neglect is allowed to replace parental abuse or neglect.[4]

More than 15 years after the Child Welfare League of America, in its Standards of Excellence for Health Care Services for Children in Out-of-Home Care, cited the failure of child welfare agencies in meeting the health care needs of children in foster care, not a single state has implemented these standards.

This article explores what Federal Child and Family Service Reviews (CFSR) tell us about the manner in which states are addressing the mental health needs of child abuse and neglect victims reported to public child welfare agencies. The CFSRs, which began in 2001, were conducted by the U.S. Department of Health and Human Services (HHS). They fulfill a 1994 Congressional mandate that HHS identify strengths and weaknesses in state child welfare programs and determine the extent to which states comply with federal mandates.[5] At the time we completed our analysis, reviews of all 50 states, the District of Columbia, and Puerto Rico had been completed, but a few of the final reports had not been released.

Federal reviewers concluded that most states fail to meet the psychological and behavioral treatment needs of child abuse and neglect victims.[6] While some states are completing screenings or assessments, they are less successful in obtaining recommended services.[7] A meager four of the 48 states whose final reports we reviewed—Delaware, Iowa, Kansas, and Utah—achieved an overall rating of strength in addressing the mental health of (1) children in foster care and (2) children receiving in-home services following a substantiated report of abuse.[8] Even in those four states, reviewers noted significant deficits.[9] For the majority of states—a staggering 91 percent of child welfare agencies—mental health services were rated as an area needing improvement. Though the federal law provides for administrative and judicial review of CFSR findings,[10] not a single state has appealed the determinations.

The CFSR reports lay bare the abysmal performance of child welfare agencies in the mental health arena. The findings are all the more intolerable since standards of care were developed long ago, and the dire needs of these children have been well known for decades.

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1 Bill Grimm & Isabelle Hurtubise, *Child and Family Services Reviews: An Ongoing Series, Part II: An Examination of Placement and Visitation,* Youth Law News, January-March 2003, at 14-30.

2 Bill Grimm, *Child & Family Services Reviews: Part III in a Series, Foster Parent Training: What the CFS Reviews Do and Don't Tell Us,* Youth Law News, April-June 2003, www.youthlaw.org/downloads/BillGrimm_Reprint2.pdf.

3 Bill Grimm, *Child and Family Services Reviews: An Ongoing Series, Part IV: Foster Parents Fail to Receive Notice, Denied Opportunity to Be Heard*, Youth Law News, April-June 2004.

4 Child Welfare League of America, *CWLA Standards of Excellence for Health Care Services for Children in Out-of-Home Care,* at 1 (1988).

5 42 U.S.C. §1320a-2a; 45 C.F.R. §1355.31 *et seq.*

6 CSFR Final Reports are available at http://www.acf.hhs.gov/programs/cb/cwrp/index.htm (last visited Nov. 15, 2004).

7 Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Arkansas Child and Family Services Review,* at 41 (2002); Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Connecticut Child and Family Services Review* at 53 (2002).

8 Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Delaware Child and Family Services Review* at 45-46 (2001); Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Iowa Child and Family Services Review*, at 51-52 (2003); Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Kansas Child and Family Services Review* at 38-39 (2001); Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Utah Child and Family Services Review*, at 42-43 (2003).

9 *E.g.*, In Iowa

> "stakeholders ...reported that there are waiting lists for services for children and limits for length of treatment. They identified mental health services gaps with regard to psychiatric services, substance abuse treatment, and mental health assessments for children in foster care....Some State-level stakeholders also reported that some parents can only get mental health treatment for their children if their children enter the Juvenile Justice system."

Iowa Final Report, at 52.

10 42 U.S.C. §1320a-2a (c); 45 C.F.R. §1355.39

A Long-Documented Concern in Child Welfare Systems

For the most part, the findings and conclusions of the CFSRs are neither new nor unprecedented. Problems highlighted by the final reports echo concerns documented in research literature[11], lawsuits[12], task force reports[13], and other materials.[14]

Without exception, studies of the health status of children in care identify the pervasive presence of emotional disorders as the most serious unmet health problem.[15] Some of the earliest research was completed more than two decades before the CFSRs.[16] Several studies indicate that between 50 and 80 percent of children in foster care suffer from moderate to severe mental health problems, including socio-emotional, behavioral, and psychiatric problems warranting treatment.[17]

The more recent National Survey of Child and Adolescent Well-Being (NSCAW) found that nearly half of foster children have a clinical level of behavioral and emotional problems.[18]

11 D. Pilowsky, *Psychopathology Among Children Placed in Family Foster Care*, 46 Psychiatric Services 906 (1995)(Review of studies published between 1974 and 1994).

12 *J.K. v. Eden,* No. 91-261 TUC JMR (D.AZ); *Emily Q. v. Bonta,* 208 F.Supp.2d 1078 (C.D.CA.2001); *Katie A. v. Bonta,* No. 02-056662 AHM(SHx) (C.D CA)(First Amended Complaint filed December 20, 2002); *Rosie D. v. Swift,* 310 F.3d 230 (1st Cir. 2002); *Braam v. State of Washington*, No. 98 2 015701 (Superior Court for Whatcom County, Order Approving Class Action Settlement)(November 9, 2004)

13 E.g., State of California Little Hoover Commission, *Now In Our Hands: Caring for California's Abused and Neglected Children* (1999).

14 Ira Schwartz, *New Jersey's Indifference: A Review of Management Practices at the Division of Youth and Family Services*, 42 (2003)("DYFS does not address the emotional needs of children n DYFS custody in a manner that meets basic professional standards").

15 *See supra* note 4 at 2.

16 *Id.*

17 DosReis S, Zito JM, Safer DJ, Soeken KL, *Mental Health Services for Youths in Foster Care and Disabled Youths.* 91 Amer. Journal of Public Health 1094 (2001).

18 Sharon Vandimere, Rosemary Chalk, and Kristin Andersen Moore, *Children in Foster Homes: How Are They Faring?* Child Trends Research Brief at 4. (2003). http://www.childtrends.org/files/Foster HomesRB.pdf (last visited Nov. 10,2004). The National Survey of Child and Adolescent Well-Being (NSCAW) is a longitudinal survey that collected information about a large number of children under age 15 who have had contact with child welfare services, including 1,291 children living in foster care homes in 2000. Laurel Leslie, Michael Hurlburt, John Landsverk, Richard Barth, Donald Slymen, *Outpatient Mental Health Services For Children in Foster Care: A National Perspective*, 28 Child Abuse & Neglect 697 (2004).

Standards and Principles of Care

In 1988, the Child Welfare League of America (CWLA) issued standards for the provision of health and mental health services for children in foster care.[1] Several years later, the American Academy of Pediatrics (AAP) adopted standards recognizing the special needs of this population of children, and re-affirmed those standards in 2002.[2] The American Academy of Child and Adolescent Psychiatry (AACAP) made similar recommendations on the delivery of mental health services for children in foster care.[3] Standards adopted by the Council on Accreditation for Children and Family Services also set forth how agencies should address the mental health needs of children in foster care.[4]

Among those standards:

- A generally accepted, standardized diagnostic mental health assessment should be completed within 30 days of placement by a qualified mental health practitioner.
  - CWLA Standard 2.7
- Within 30 days of admission, each child receives a mental health screening performed by a qualified mental health professional who performs further psychological assessments and treatment, as indicated.
  - Council on Accreditation for Children and Family Services, Standard S.21.5.02
- Mental health services for children in care should focus on prevention as well as dysfunction.
  - Mel Schneiderman, et al, "Mental Health Services for Children in Out of Home Care", 77 Child Welfare 29 (1998)

Principles of care for children's mental health services have been developed in other forums. A report of the Surgeon General's Conference on Children's Mental Health supports the recommendations of professional organizations that all children entering care should receive comprehensive mental health assessments, and that public funding streams should be expanded to improve the use of evidence-based treatment.[5] The 2001 settlement agreement in *J.K. v. Eden*[6], a class action lawsuit on behalf of children in Arizona who rely on Medicaid for mental health services, incorporated a set of principles to govern the delivery of services. They embody a comprehensive approach to providing mental health services to children.[7] Other guiding principles are set forth elsewhere.[8]

1 *See supra* note 4.

2 American Academy of Pediatrics (AAP) Committee on Early Childhood, Adoption and Dependent Care, *Health Care of Children in Foster Care,* 93 *Pediatrics* 335 (1994); American Academy of Pediatrics (AAP) Committee on Early Childhood, Adoption and Dependent Care *Health Care Needs of Young Children in Foster Care*, 109 *Pediatrics* 536 (2002).

3 American Academy of Child and Adolescent Psychiatry (AACAP) Policy Statement Psychiatric Care of Children in the Foster Care System available at http://www.aacap,org/publications/policy/ps445htm (2001); AACAP/CWLA, *Foster Care Mental Health Values Subcommittee-Policy Statement* (2002); and AACAP/CWLA Policy Statement on Mental Health and Substance Abuse Screening and Assessment of Children in Foster Care (2003).

4 Council on Accreditation for Children and Family Services, *Standards for Foster and Kinship Care Services,* Standard S21.5 (7th Edition 2001). *See also* Council on Accreditation for Children and Family Services, *Standards for Mental Health Services* (7th Edition 2001).

5 *Supra*, note 27, at 25-26.

6 See, *J.K. v. Eden*, No. CIV 91-261 TUC JMR (D. Ariz.) (Settlement Agreement Mar. 20, 2001)

7 See Patrick Gardner, *Unmet Mental Health Needs Cause Failure Across Youth-Serving Institutions*, Youth Law News, Sept.-Oct. 2001, 1-10.

8 *See, e.g.,* Mel Schneiderman, Margaret Connors, et al, *Mental Health Services for Children in Out of Home Care*, 77 Child Welfare 29 (1998).

Tennessee's Commission on Children and Youth recently reported that 37 percent of children in custody had a formal mental health diagnosis, and an additional 30 percent were found to have a mild to severe impairment as measured by the Child and Adolescent Functional Assessment Scale.[19]

The prevalence of mental health problems among this population is not unexpected, considering the trauma caused by child abuse, the dysfunctional family settings from which they often are removed, and acute reactions to being placed in foster care—separated from family and familiar surroundings. Long, uncertain, and unstable periods in foster care exacerbate this situation. In turn, emotional illnesses endanger successful placements, contribute to multiple placements, and place high demands on the mental health system for services that are often not available.[20]

Children in foster care rely almost exclusively upon the public mental health system for services.[21] They also use a disproportionate amount of Medicaid-funded mental health services, as shown by data from the late 1980s in California[22], the State of Washington in the early 1990s[23], and three states (Pennsylvania, Florida, and California) in the late 1990s.[24] These studies found that children in foster care use 15 to 20 times the volume of mental health services than other children on Medicaid.[25] A more recent study in Illinois found

> a much larger percentage of children in foster care used psychiatric and mental health services compared to children in AFDC.[26]

Certain groups of child abuse victims are more likely to receive treatment than others:

> Foster children with behavioral problems are most likely to be seen … [C]hildren with a history of sexual abuse are three times more likely to receive mental health services, while children with a history of neglect are only half as likely to receive treatment. African-American and Hispanic children are least likely to receive services, and they need to display more pathology to be referred to mental health services.[27]

In many cases, the lack of appropriate community mental health care leads to high use of emergency and hospital care. Children who need mental health treatment are not getting it early enough to prevent a host of adverse outcomes. When a child's behavioral and psychological problems go untreated, the prospects of attaining a safe, stable, and permanent home progressively diminish.

CFSRs: Methodology & Mental Health Data

The CFSRs consist of a two-stage process. State and local child welfare agency staff submit a self-assessment report to federal reviewers. A joint federal-state team then conducts an on-site review of the state's child welfare system.

The onsite review takes place in three political subdivisions in the state, one of which must include the state's most populous urban area. The on-site portion of the review includes:

1. Case record reviews of approximately 50 cases, usually equally divided between foster care and in-home services, across the three sites;
2. Interviews with children, caseworkers, families, service providers, and foster families involved in the sample cases;
3. Interviews with community stakeholders including judges, child-serving agencies, community organizations, social workers, and service providers.

At each site, reviewers conduct seven to 10 stakeholder interviews. A mental health representative may be interviewed; however, his or her participation is not required.[28] Reviewers also conduct 10 statewide stakeholder interviews. Representatives from the state health program, state Medicaid program, or state mental health agency may be selected for an interview, but the participation of these representatives also is not required.[29] Most CFSR final reports do not list the persons interviewed, so it is impossible to determine how many of the reviews included information from mental health professionals and program administrators.

CFSRs examine each state's achievement on seven outcomes and the implementation of seven systematic factors. There are several indicators used to assess each of these factors and under each indicator there are one or more "items." In our analysis of the CFSR's findings related to children's mental health, we analyzed data reported under Well-Being Outcome 3 ("Do children receive adequate services to meet their physical and mental health needs"). Under that indicator there are two items—Item 22, related to physical care needs; and Item 23, which examines the extent to which the agency met the mental needs of the child. We also included two systematic factors (SF) in our analysis: SF No.

[19] Tennessee Commission on Children and Youth, *Children's Program Outcome Review Team: 2001 Evaluation Results*, 31-34 (2002).

[20] *See supra* note 4.

[21] Medicaid eligibility for this population of children is set forth at 42 U.S.C. §1396a(a)(1)(A)(i). Special needs children adopted from foster care and for whom there is an adoption assistance agreement are also eligible for health insurance coverage under the state's Medicaid program, 42 U.S.C. §671(a)(21) & 42 U.S.C.§1396a(a)(10)(A)(ii)(VIII).

[22] Halfon, N, Berkowitz G, Klee L, *Mental Health Service Utilization by Children in Foster Care in California*, 89 Pediatrics 1238 (1992).

[23] Takayama, JI, Bergman AB, Connell FA, *Children in Foster Care in the State of Washington: Health Care Utilization and Expenditures*, 271 JAMA 1850 (1994).

[24] Rosenbach M, Lewis K, Quinn B, *Health Conditions Utilization, and Expenditures of Children in Foster Care*. Mathematica Policy Research Inc. (2000).

[25] *See* Margo Rosenbach, *Children in Foster Care: Challenges in Meeting Their Health Care Needs Through Medicaid*, Mathematica Policy Research Inc. (2001) for further description of Medicaid issues such as coverage disruptions for children in foster care.

[26] P. K. Jaudes, L. Bilaver, et al, *Improving Access to Health Care for Foster Children: The Illinois Model*, 83 Child Welfare 215, 227 (2004)

[27] U.S. Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, at 25(2000).

[28] Children's Bureau, U.S. Dep't of Health & Human Servs., *Child and Family Services Review Procedures Manual* 35 (August 2000).

[29] *Id.* at 36.

5—Service Array (Items 35-37),[30] and SF No. 6—Agency Responsiveness to the Community (Items 38, 40).[31] The information reported under these two systemic factors was gathered from stakeholder interviews or drawn from the statewide self assessment.

In rating each case in the sample, reviewers determined

(1) whether mental health needs of children coming into care had been appropriately assessed, and (2) whether services to address those needs had been provided.[32]

Reviewers rated mental health as a strength when they determined that the child's mental health needs were "significantly assessed" or "partially assessed," and mental health needs for treatment were "significantly addressed." When the agency failed to assess or address the child's psychological or behavioral needs, mental health was rated as an area needing improvement. For a state to receive an overall rating of being in substantial conformity on meeting the mental health needs of children, 90 percent or more of the cases reviewed must have been rated a strength.[33]

As the terms "significantly or partially assessed" suggest, reviewers were given considerable discretion in determining whether a case was ruled a strength, or was one needing improvement. Consistency among the reviewers is unknown. We were unable to determine the background, qualifications, and training of either state or federal reviewers. Therefore, we could not assess the extent to which their determinations for each of the sample cases may have been affected, by among other things, their lack of knowledge of evidence-based practices in children's mental health.

Not all of the 50 cases in the onsite record review sample went toward the determination of a state's compliance. Cases considered not applicable were foster care cases in which the child was too young for an assessment of mental health needs,[34] and in-home cases in which children's mental health needs were not the reason for agency contact with the child. These criteria meant that federal reviewers sometimes excluded a large percentage of cases in evaluating this outcome. In Idaho, for example, 20 of the 50 cases were deemed "not applicable." [35]

Data gathered from the total sample of cases drawn from 43 states[36] suggests that one in four child abuse victims and foster children are *never* assessed for mental health needs, or *never* provided with appropriate mental health services. When this statistic is considered alongside information on state policies and practices, caseworker anecdotes, and stakeholders' concerns over service gaps that are all discussed in the final reports, a dismal picture of the provision of mental health services to children involved in the child welfare system emerges.

SUMMARY OF FINDINGS

State Policies on Mental Health Screenings and Assessments

Due in part to shortcomings in the approach of the CFSRs, it is difficult to determine the extent to which states and counties assure that all children receive comprehensive mental health assessments. Many of the final reports are silent on whether there is a state statute or policy requiring a mental health screening or assessment of children entering care.[37] Often, when it is evident that a policy exists, the reports contain no information about its implementation.[38] There also is little data on the quality or comprehensiveness of assessments.

A few final reports confirm that there is *no* statewide policy for conducting mandatory mental health screening for children entering out-of-home care.[39] For example, in Tennessee, stakeholders noted that "mental health assessments are not routine procedures and the decision to provide a mental health assessment is based on the child's behaviors."[40]

The failure of most states to adopt policies requiring a mental health assessment for all children upon entry into care is confirmed by a nationwide study, entitled Caring for Children in Child Welfare (CCCW), conducted by the Child and Adolescent Services Research Center (CASRC) at San Diego Children's Hospital.[41] In interviews

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30 Item 35 requires

"The State has in place an array of services that assess the strengths and needs of children and families and determine other service needs, address the needs of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency."

Item 36 requires

"The services in item 35 are accessible to families and children in all political jurisdictions covered in the State's Child and Family Services Plan."

Item 37 requires

"The services in item 35 can be individualized to meet the unique needs of children and families served by the agency."

31 Item 38 requires

"In implementing the provisions of the CFSP, the State engages in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals and objectives of the CFSP."

Item 40 requires

"The State's services under the CFSP are coordinated with services or benefits of other Federal or federally assisted programs serving the same population."

32 *Child and Family Services Review Procedures Manual, Appendix C.*

33 45 C.F.R. §1355.34 (b)(3)(ii).

34 No specific age was applied across the board so reviewers in one state may have excluded more children than reviewers in another state.

35 Children's Bureau, U.S. Dep't of Health & Human Servs., Final Report: *Idaho Child and Family Services Review,* at 48.

36 Five states—Arkansas, Delaware, Georgia, Kansas, and North Carolina—did not provide data on the number of cases rated as a strength or an area needing improvement.

37 *E.g.*, Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Alaska Child and Family Services Review,* at 55; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Hawaii Child and Family Services Review,* at 55-7; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Kentucky Child and Family Services Review*, at 47; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Maine Child Family Services Review,* at 43-4; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Nebraska Child and Family Services Review,* at 53; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: New Hampshire Child and Family Services Review*, at 51; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: North Dakota Child and Family Services Review,* at 53; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Oklahoma Child and Family Services Review,* at 55-6; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Oregon Child and Family Services Review,* at 44.

38 *E.g.*, Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Arizona Child and Family Services Review*, at 41; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Indiana Child and Family Services Review*, at 35; *Kansas Final Report*, at 38; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Louisiana Child and Family Services Review,* at 59; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Minnesota Child and Family Services Review,* at 28; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report:*

Ohio Child and Family Services Review, at 50.

39 *Idaho Final Review,* at 48; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Michigan Child and Family Services Review,* at 59-60; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Tennessee Child and Family Services Review,* at 50.

40 *Tennessee Final Report*, at 50.

41 The Caring for Children in Child Welfare (CCCW) study is a collaboration among CASRC and Duke University, the University of Pittsburgh, and Research Triangle Institute, under a five-year grant from the National Institute of Mental Health (NIMH). The data from CCCW will be linked to data from the National Study of Child and Adolescent Well-being (NSCAW), a longitudinal study of 6,700 youth in the child welfare system throughout the United States. For additional information go to http://www.casrc.org.

with county personnel from approximately 94 identified counties in 40 states, researchers found

> Most counties [78%] require a comprehensive physical assessment for all children entering out of home care and about 58% have a policy requiring developmental assessments for children under the age of five. However, less than 50 % require a mental health assessment for all children upon entry into out of home care. Some counties report a policy requiring assessments for subgroups of children such as children entering group care settings or those with a history of physical or sexual abuse.[42]

Standards for mental health screenings and assessments should address how soon after placement they should be completed, establish minimum qualifications for persons conducting them, and describe the elements of a thorough evaluation. Despite the existence of several sets of professional standards, the federal reviews did not apply any uniform standards to the child welfare agencies being evaluated. In the absence of federal standards reviewers simply determined whether the state satisfied its *own* policy for assessments.[43] Allowing each state to set its own standard calls into question the value of the CFSR determinations; i.e., a strength rating may not reflect conformity with recognized standards for mental health assessments if the state policy sets a low bar. It also makes comparisons among the states on this outcome difficult.

The absence of a federal standard contributes to variations in the requirements set by the states and differences in the quality of care for children from one state to another. For example, state policies that specify the minimum age of children for whom assessments must be done, may exclude children from this service. The CFSRs reveal that state policies for which groups of children are to be assessed for psychological or behavioral issues ranged from age 3 and older[44] to age 6 and older.[45]

Any policy that ignores the mental health status of young children and infants who have been the victims of child abuse or neglect is troubling, since several studies confirm that at least half of these children exhibit developmental delays four to five times the rate of developmental delays in the general population.[46] These findings are echoed by data gathered as part of the National Survey of Child and Adolescent Well-Being (NSCAW):

> One of the most troubling findings was caregivers' responses to questions designed to assess infants' and toddlers' neurological and cognitive development. According to this measure, it was determined that 59 percent of foster children age two months to two years can be described as being at high risk for a clinical impairment.[47]

Without early intervention, by the time these children reach school age, a window of opportunity to address these deficits is lost. This explains Congress' amendment of the Child Abuse Prevention and Treatment Act in 2003, to require that abuse and neglect victims under age 3 must be referred for Early Intervention Services under the Individuals with Disabilities Education Act.[48] The Congressional mandate applies to children who remain at home as well as children entering foster care.

Despite the dire need to assess and address the developmental needs of young victims of child abuse and neglect, many states' child welfare policies fail to mandate routine assessments.[49] What's worse, the federal reviews fail to examine these policies and hold agencies accountable on this important measure.

Caseworkers Act As Screeners

The majority of child welfare agencies that require or conduct screenings appear to rely on a child's caseworker to identify those children warranting a more thorough psychological or psychiatric evaluation.[50] The widespread endorsement of this approach is problematic, since many caseworkers do not have expertise in identifying children's mental health issues.

When comparing data gathered as part of the CCCW study and the CFSRs, it appears that while states have adopted training policiesin this area, many are not implementing them From telephone interviews conducted with a nationally representative sample of child welfare agency training departments, CCCW researchers found that most counties require caseworker training on mental health and developmental needs of children.[51] However, the CFSRs

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[42] Child and Adolescent Services Research Center, *Caring for Children in Child Welfare Newsletter: Health Assessments for Children Entering the CWS,*http://www.casrc.org/projects/CCCW/Newsletter2.pdf (last visited Nov.15, 2004). *See*, Laurel Leslie, Michael Hurlburt, John Landsverk, et al., *Comprehensive Assessments for Children Entering Foster Care: A National Perspective*, 112 Pediatrics 134 (2004)(detailed description of assessment study)

[43] Telephone Interview with Eileen Worrell, Child Welfare Review Project, Johnson, Bassin, & Shaw, Inc. (July 29, 2004).

[44] *E.g.*, Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: District of Columbia Child and Family Services Review,* at 55; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: New York Child and Family Services Review,* at 54.

[45] Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Georgia Child and Family Services Review,* at 32.

[46] Dicker, S. & Gordon, E., *Early Intervention and Early Childhood Programs: Essential Tools for Child Welfare Advocacy*, 34 Clearinghouse Review 727, 728 (2001).

[47] *Supra*, note 18, at 3.

[48] Pub. L 108-36 § 114(b)(1)(B)(xi), The Keeping Children & Families Safe Act of 2003 codified at 42. U.S.C. 5106a (b(A)(xxi). CFSR reviews conducted after the Act's effective date did not look for compliance with this mandate.

[49] *See* supra n. 47. Slightly more than half the counties surveyed reported policies mandating developmental assessments for young children entering care.

[50] *See, e.g.*, Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Alabama Child and Family Services Review* at 54 (2002); *Alaska Final Report,* at 55; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: California Child and Family Services Review,* at 57 (2003); Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Colorado Child and Family Services Review,* at 48 (2002); Children's Bureau, U.S. Dep't of Health & Human Servs.*, Final Report: Massachusetts Child and Family Services Review,* at 27 (2001); Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Montana Child and Family Services Review,* at 55 (2002); Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Missouri Child and Family Services Review*; Missouri Child Welfare Manual, Section 4.4.3.1: Child Assessment Guideline; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: New Mexico Child and Family Services Review,* at 47; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Nevada Child and Family Services Review*, at 61; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: New Jersey Child and Family Services Review,* at 74; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Pennsylvania Child and Family Services Review,* at 59; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Texas Child and Family Services Review,* at 49.

[51] Child and Adolescent Services Research Center, *Caring for Children in Child Welfare Newsletter: Mental Health and Developmental Training Requirements in Child Welfare Services* (March 2004), http://www.casrc.org/projects/CCCW/Newsletter2.pdf (last visited Nov.15, 2004).

suggest that while policies may require such training for caseworkers, workers are not completing the training. Stakeholders in Texas suggested, "A key problem in addressing children's mental health needs is that there is an insufficient number of caseworkers who have the training and ability to accurately assess the need for mental health services."[52] Federal reviewers found that in New York workers do not refer children for comprehensive assessments unless the child is "acting out."[53] In New Hampshire, despite a strong willingness and interest by child welfare agency staff to participate in annual mental health trainings, it is reported that caseworkers are often unable to follow through due to their high caseloads.[54]

Colorado's final report provides several examples of how reliance upon untrained caseworkers denies or delays the assessment and treatment of a child's mental health needs. Three of the cases rated as "Needing Improvement" included:

- A child who entered foster care received no mental health assessment because the caseworker indicated that there were no concerns. However, reviewers noted that the child was exposed to domestic violence and substance abuse by the mother, had separation issues with both her mother and father, and had been, at one time, kidnapped by relatives while walking home from school;
- The child did not have a mental health assessment because she did not want one, although there was evidence that an assessment was needed;
- A child has severe mental retardation but the level of mental functioning has never been assessed.[55]

In a few states, Alabama and California for example, the agency provides specialized training for workers to enhance their ability to identify a child's mental health needs.[56] In Washington, specially trained staff conducts screenings of children entering care using standardized instruments.[57] Some policies require the child's caseworker to consider a checklist or cluster of questions to assist them to identify emotional or behavioral needs. Even with specialized training or assessment tools, an agency's reliance on a caseworker to pick up on a child's behavioral and emotional issues during brief, infrequent meetings may explain, in part, why foster children's mental health needs go undetected or untreated.

Medicaid Exam Inadequate

Some states appear to rely on physicians and other health care professionals who complete the well-child or Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam to screen for mental health issues.[58] Under EPSDT, all Medicaid-eligible children under age 21 are entitled to comprehensive mental health services.[59] Despite the fact that almost all foster children are eligible for this program, EPSDT is rarely used to its full potential for identifying mental health issues. In 2000-01, the Bazelon Center for Mental Health Law conducted a survey on states' screening for mental health and substance abuse issues through EPSDT, and concluded that "very few states have policies in place that are likely to result in accurate identification of children with behavioral health disorders"[60] In fact, 23 states do not require or even *recommend* that primary care providers address behavioral health concerns at all in their EPSDT screens.[61]

Delaware's final report highlights the state's EPSDT program as the primary tool for identifying mental health issues in the child welfare population. The final report states that primary care physicians are required to incorporate children's mental health and substance abuse into EPSDT screens.[62] Delaware's EPSDT screening tool asks questions about the child's current and previous problems, such as exposure to abuse and trauma, and "problems in the child's environment" covering issues such as familial substance abuse, mental illness, and psychosocial stressors.[63] Nevertheless, the effectiveness of this tool in identifying mental health needs is dubious. A November 2000 report shows that out of the 3,890 children receiving services from the Delaware Department of Family Services, including both in-home and foster care cases, a mere 6 percent, were receiving mental health services through the Department of Children's Mental Health.[64] This statistic sharply conflicts with the estimate that at least half of all children in foster care experience moderate to severe mental health problems. Given this discrepancy, federal reviewers' conclusion that Delaware was one of few states to achieve a strength rating for meeting the mental health needs of children under its care is puzzling.

Augmentation of the EPSDT screens merely by adding tools for health care practitioners to complete may not resolve the inadequacies in the system. As some researchers noted recently

> The pediatric literature is replete with research documenting limited training of pediatricians with respect to behavioral and developmental problems and consequent limited identification of these types of problems.[65]

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52 *Texas Final Report*, at 49.

53 *New York Final Report* , at 54.

54 *New Hampshire Final Report*, at 75.

55 *Colorado Final Report*, at 48-49.

56 *Alabama Final Report*, at 54; California Statewide Assessment at 191 (2002).

57 Washington State Dep't of Social and Heath Servs., *Report to the Legislature: Foster Children-Long Term Needs/ Kidscreen* (December 2002).

58 *E.g., Delaware Final Report, at 45; Children's Bureau, U.S. Dep't of Health & Human Servs., Final Report: North Carolina Child and Family Services Review, at 30; North Dakota Final Report, at 46.*

59 42 U.S.C. Sec. 1396d(r).

60 Bazelon Center for Mental Health Law, *An Evaluation of State EPSDT Screening Tools*, http://www.bazelon.org/issues/managedcare/resources/epsdtfactsheet.htm# (last visited July 21, 2004).

61 *Id.*

62 *Delaware Final Report*, at 45.

63 *Id.*

64 *Delaware Final Report*, at 45.

65 Laurel Leslie, Michael Hurlburt, John Landsverk, et al., *Comprehensive Assessments for Children Entering Foster Care: A National Perspective*, 112 Pediatrics 134 (2004)

In-Home Children Unlikely to Get Treatment

Our analysis of the CFSRs revealed that child abuse and neglect victims who are receiving in-home services are considerably less likely than foster children to receive adequate treatment for their psychological and behavioral health needs. Taking the state reports together as a whole, the provision of necessary mental health services was rated a strength in 77.6 percent of foster care cases, compared to 62.8 percent of in-home service cases.[66]

In many states, the discrepancy between foster care and in-home cases is even more striking. In New Jersey, for example, federal reviewers determined that the agency met the mental health needs of the child in 76 percent of foster care cases, compared to 26 percent of in-home cases.[67] Similarly, California's final report included a "key finding" that the agency "did not pay sufficient attention to mental health needs of children in in-home cases."[68] Numerous final reports included comments from stakeholders voicing concern over critical deficiencies in accessing appropriate treatment for mentally ill children who were residing at home with their biological families.[69]

When abuse or neglect victims remain at home and do not receive needed mental health services, the child's risk of eventually entering the child welfare, mental health, or juvenile justice systems increases substantially. All too frequently, parents are encouraged to voluntarily give up custody of their child, to obtain state-funded services that are not available otherwise. The U.S. General Accounting Office (GAO) documented that in fiscal year 2001 alone, approximately 3,700 children were placed into child welfare systems so they could receive mental health services.[70] Moreover, this estimate is considered low, because 31 states did not respond to the GAO survey. The CFSRs substantiate the findings of the GAO survey, suggesting that increasing numbers of children are placed inappropriately in the child welfare system.

Some advocates are challenging these policies. At the end of last year, the U.S. Court of Appeals for the 7th Circuit rejected a policy requiring parents to access mental health services for their children through the state juvenile court system. In *Collins v. Hamilton,*[71] Indiana argued that the since the plaintiff child could obtain necessary mental health services if he were made a ward of the state, the state did not need to provide the service as part of its EPSDT services. The Court of Appeals held that as long as the service was "medically necessary," it had to be provided to Medicaid eligible children.[72] It remains to be seen whether this decision will have an impact on practices in other parts of the country.

Scarcity of Mental Health Services

Nearly every state described a lack of mental health services for children in their care.[73] As a result, children often are placed on waiting lists.[74] In Los Angeles County, California, waiting lists for mental health services can last up to nine months, and in Nevada and New York, up to six months.[75] In Connecticut, it often takes two to three months for mental health services, and four to six months for an evaluation.[76] As children wait for services, their placements often deteriorate, and ultimately disrupt, leading to a series of unstable placements.[77] The need for more day-treatment and home-based services was a reoccurring conclusion of stakeholders in the final reports.[78]

The CFSRs document that access to services is particularly limited for several groups. Services targeted for adolescents are often lacking,[79] as are services for youth who have been sexually abused, or who have committed sexual offenses [80] Shortages include a lack of treatment and placement options.

When an adequate array of services does not exist in the state or county, those services that are being provided often are not selected because they are appropriate, but because they are available. In a statewide assessment survey in Hawaii, only 46 percent of caseworkers said that the mental health services being provided to children were effective.[81] Agencies may attempt to "fit families and children into services," rather than tailoring services to meet unique needs.[82] Many final reports mentioned a lack of individualized services, and frequently described case plans as "cookie cutter,"

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[66] These figures are calculated from data from 33 of the 48 states for which final reports were publicly available at the time we completed our analysis. Fifteen states do not provide information by case type, preventing comparison between in-home and foster care cases.

[67] *New Jersey Final Report*, at 73. S*ee also Utah Final Report,* at 43 ("The item was rated as a strength in 97 percent of foster care cases compared to 60 percent or in-home cases"); Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Washington Child and Family Services Review,* at 46 ("The item was rated as a strength in 82 percent of the foster care cases compared to 45 percent of the in-home service cases.).

[68] *California Final Report*, at 58.

[69] *Alaska Final Report* , at 71-72; *Arkansas Final Report*, at 39-41; *District of Columbia Final Report,* at 55; *Georgia Final Report*, at 33; *Hawaii Final Report,* at 55-7; *Louisiana Final Report,* at 59; *North Carolina Final Report*, at 30; *Oklahoma Final Report,* at 73; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: South Carolina Child and Family Services Review,* at 58; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: South Dakota Child and Family Services Review*, at 3; *Washington Final Report*, at 46; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Wyoming Child and Family Services Review,* at 52.

[70] General Accounting Office Report, *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services*, GAO-03-397 (April 2003).

[71] 349 F.3d 371 (7th Cir. 2003).

[72] 349 F.3d at 376 n.7.

[73] *E.g., Alaska Final Report*, at 55; *Arkansas Final Report*, at 65; *Georgia Final Report*, at 52; *Hawaii Final Report*, at 55-7; *Idaho Final Report*, at 68; *Kansas Final Report*, at 38; *New Jersey Final Report*, at 99; *Pennsylvania Final Report*, at 59; *Texas Final Report*, at 49; *Utah Final Report*, at 59; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Vermont Child and Family Services Review*, at 49; *Washington Final Report*, at 63; *Wyoming Final Report*, at 52.

[74] *E.g., Alaska Final Report*, at 73; *Arkansas Final Report*, at 54; *California Final Report*, at 73; *Connecticut Final Report*, at 52; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Florida Child and Family Services Review*, at 59-60; *Georgia Final Report*, at 33; *Indiana Final Report*, at 47; *Iowa Final Report*, at 51; *Kentucky Final Report*, at 63-4; *Louisiana Final Report*, at 63-4; *Maine Final Report*, at 43; Tennessee *Final Report*, at 50; *Utah Final Report*, at 43; *Vermont Final Report*, at 49.

[75] *California Final Report*, at 57; *Nevada Final Report*, at 60; *New York Final Report*, at 54.

[76] Connecticut Final Report, at 71.

[77] *Kansas Final Report*, at 38.

[78] *E.g., Delaware Final Report*, at 68; *Hawaii Final Report*, at 75; *Maine Final Report*, at 43; Children's Bureau, U.S. Dep't of Health & Human Servs., at 31; *Washington Final Report*, at 64; *Wyoming Final Report*, at 52.

[79] *E.g., Delaware Final Report*, at 68; *Idaho Final Report*, at 69; *Pennsylvania Final Report*, at 79.

[80] *E.g., North Dakota Final Report*, at 34; *New York Final Report*, at 54,79; *North Carolina Final Report*, at 48; Oregon *Final Report* at 60; *Vermont Final Report*, at 33; *Washington Final Report*, at 64; Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: West Virginia Child and Family Services Review*, at 74.

[81] *Hawaii Final Report*, at 57.

[82] *Tennessee Final Report*, at 66.

"generic," and "boiler plate."[83]

Some of the specific services that reviewers frequently found insufficient among the states are described below.

Therapeutic Foster Care

Therapeutic foster care refers to a specialized type of placement and supportive service provided to children with significant emotional and behavioral needs. There are a number of therapeutic foster care models. At the Oregon Social Learning Center, Patricia Chamberlain developed the Multidimensional Therapeutic Foster Care (MTFC) program. MTFC features pre-service training of foster parents in behavior management techniques; daily communication with a treatment team, individualized treatment for the child, around-the-clock crisis management, and respite care.[84] MTFC has been subjected to rigorous studies and is being replicated in many parts of the country.[85] A report this summer by the Washington State Institute for Public Policy confirmed the success and cost benefit of MTFC.[86] Under a grant from the National Institutes of Mental Health, a modified, less-rigorous version of MTFC is being tested with several hundred foster parents and children in San Diego, California.[87]

The Council on Accreditation for Children and Family Services (COA) includes Standards for Treatment or Therapeutic Foster Care, as part of its Standards for Foster and Kinship Care Services.[88] Although the requirements for these programs are more demanding than "regular" foster care, the COA standards set the bar much lower than those of MTFC. The COA standards provide:

- Weekly foster parent communication with a treatment team, to target issues and behaviors, and update the case plan;
- In-person contact between the caseworker and foster parents at least every two weeks;
- Around-the-clock crisis intervention for foster parents;
- A limit of eight children per caseworker.[89]

Despite the evidence of MTFC's effectiveness, many final reports mention a dearth of therapeutic foster homes.[90] Ironically, stakeholders in Oregon attributed the overuse of temporary shelters to a lack of therapeutic foster homes.[91] In Hawaii, there was particular concern over the "impact of placing children with higher levels of needs in the regular foster homes that might be unprepared to deal with their needs."[92] This holds true even in Alabama, where therapeutic foster care programs have significantly increased over the past five years, so that 950 children—20 percent of Alabama's children in care—are in therapeutic foster care placements at any given time. Despite these advances, stakeholders report that therapeutic foster care is insufficiently available in most parts of the state.[93]

Respite Care

Meeting the day–to-day needs of children with emotional and behavioral issues in foster care places extraordinary demands on their caregivers. Professional standards recognize this and require

> the [child welfare agency] provides respite services as needed to treatment foster parents to prevent and reduce foster parent stress and crises.[94]

Federal law now specifically includes respite care as part of the core family support services for the prevention of child abuse and neglect authorized under the 2003 amendments to the Child Abuse Prevention and Treatment Act,[95] and adds it to the litany of services for parents adopting children with special needs from foster care.[96]

CFSRs frequently cited insufficient levels of respite care.[97] The federal reviews did find a few innovative programs developed during the last few years. In Connecticut, for example, the state created emergency mobile psychiatric services for children and the FAST program, which provides rapid support to foster families experiencing difficulties with behavioral issues among children placed in their care.[98]

Culturally Relevant or Bilingual Mental Health Services

The limited availability of services for non-English speaking children and their families is documented throughout the federal reviews.[99] Only California's final report discussed the agency's ability to meet language needs, but this was only accomplished in Los Angeles County.[100]

Substance Abuse

A number of final reports noted the need for additional substance abuse treatment for adolescents in care, and for those with a dual diagnosis of substance abuse and mental health issues.[101] Where services are provided in-home, the reviewers also considered

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[83] *E.g., Alaska Final Report*, at 47; *Arkansas Final Report*, at 67; *California Final Report*, at 78; *Georgia Final Report*, at 52; *Iowa Final Report*, at 75.

[84] *See, e.g.,* Chamberlain, P., Moreland, S., & Reid, K., *Enhanced Services and Stipends for Foster Parents: Effects on Retention Rates and Outcomes for Children,* 5 Child Welfare 387 (1992)

[85] For more information about MTFC go to http://www.mtfc.com.

[86] Steve Aos, Roxanne Lieb, Jim Mayfield, Marna Miller & Annie Pennucci, *Benefits and Costs of Prevention and Early Intervention Programs for Youth*, (2004)

[87] *See,* "Cascading Dissemination of a Foster Parent Intervention," http://www.oslc.org/projects.html#keep.

[88] Council on Accreditation for Children and Family Services, *Standards for Foster and Kinship Care Services,* Standards S21.13 through 21.16 (7th Edition 2001).

[89] *Id.*

[90] *Alabama Final Report,* at 71; *Arizona Final Report,* at 57; *Arkansas Final Report,* at 64-5; *Connecticut Final Report,* at 70; *Delaware Final Report,* at 68; *District of Columbia Final Report*, at 56; *Florida Final Report,* at 59, 61; *Georgia Final Report,* at 50; *Hawaii Final Report,* at 57, 72, 74; *Indiana Final Report,* at 69; *Iowa Final Report,* at 69; *Kansas Final Report,* at 38; *Kentucky Final Report,* at 63; *Massachusetts Final Report,* at 44-6; *New Jersey Final Report,* at 99; *Pennsylvania Final Report,* at 79; *Texas Final Report,* at 62.

[91] *Oregon Final Report*, at 60.

[92] *Hawaii Final Report*, at 57.

[93] *Alabama Final Report,* at 71.

[94] Council on Accreditation for Children and Family Services, *Standards for Foster and Kinship Care Services,* Standard S21.15.02 (2001). *See also*, Child Welfare League of America, *Standards of Excellence for Family Foster Care Services,* Standard 3.33 (1995).

[95] 42 U.S.C. §5116e (a)(3)(B).

[96] 42 U.S.C. 5113 (c)(2)(I).

[97] *E.g., Arkansas Final Report,* at 65; *California Final Report,* at 77; *Florida Final Report,* at 59-60; *Kansas Final Report,* at 61; *Kentucky Final Report,* at 61; *Pennsylvania Final Report,* at 59; *Utah Final Report,* at 58.

[98] *Connecticut Final Report*, at 70.

[99] *E.g., Alaska Final Report,* at 55, 57; *Arizona Final Report,* at 57; *Colorado Final Report,* at 62; *Connecticut Final Report,* at 52, 69; *Florida Final Report,* at 61; *Georgia Final Report,* at 54; *Indiana Final Report,* at 47; *Iowa Final Report,* at 69; *Massachusetts Final Report,* at 44-6; *New Jersey Final Report,* at 99; *Pennsylvania Final Report,* at 79.

[100] *California Final Report,* at 77.

whether the family and siblings had received appropriate services. Many states described a shortage of services for families with substance abuse issues, especially residential centers accepting mothers and children.[102] One final report pointed out that this was a major impediment to addressing family safety issues, and facilitating reunification.[103]

Lack of Services in Rural Areas

The state reports suggest that the majority of mental health services are concentrated in urban areas.[104] Children living in rural areas face reduced access to mental health services and long wait times for these services. Shortages include step-down services (less intensive services for children discharged from facilities) or in-home treatment options, a lack of qualified mental health providers, and insufficient numbers of therapeutic foster care homes.

As the Alaska final report states, "rural and remote areas receive mental health services on an itinerant basis and services are not always available during a time of crisis."[105] Similarly, the Washington final report states that "rural areas lack specialized services, have limited choices, and experience chronic shortages."[106] Lack of transportation can act as a barrier, and travel time limits the cost effectiveness of the treatment provided and increase placements away from home. Even in programs where the child receives transportation to treatment, family members' ability to participate may be limited, diminishing the effectiveness of treatment.

Federal reviewers reported that a few states have developed solutions for improving access to care for children in rural areas. In Idaho, negotiations with Medicaid to reimburse provider travel had a positive impact on service accessibility in rural areas.[107] In South Carolina, there is a volunteer driver program to assist with transportation to services,[108] and in North Dakota, the child welfare agency has begun to provide gas vouchers for transportation.[109]

Provider Qualifications

In many of the final reports, stakeholders expressed concern over the quality of mental health services.[110] There appears to be a widespread shortage of mental health providers who are skilled in the treatment of children in care—many of whom have experienced physical or sexual abuse, neglect, multiple out-of-home placements, parental substance abuse, or domestic violence.[111] In the California final report, for example, a stakeholder remarked that many mental health providers for counseling and therapy do not have sufficient skills.[112] Other reports mentioned a need for more psychologists or psychiatrists,[113] and voiced concerns about the high turnover rate among counselors, social workers and therapists.[114] Some states attribute the shortage of providers providing evaluations and therapy to Medicaid's low reimbursement rates.[115]

Insufficient Funding

Not surprisingly, budget problems have reduced the availability of mental health services in a number of states. Deficits have led to the closing of two large community mental health centers,[116] limits on the services that can be reimbursed,[117] and restrictions on eligibility for care.[118] Montana's final report presented a dismal picture of how reduced funds have affected services. Medicaid children in the state are no longer able to receive outpatient mental health services unless the child is diagnosed as seriously emotionally disturbed.[119] Similarly, in Washington, children in foster care often encounter difficulty obtaining services because their emotional or behavioral needs do not meet the medical necessity definition for Medicaid-funded services.[120] In other states, funding shortfalls were cited as the root cause of excessively long waiting lists.[121] Some states report that simply paying for evaluations is particularly difficult.[122]

These fiscal constraints, in some cases, have led mental health agencies to structure their systems to provide less expensive, short-term care, which is ineffective in treating the long-term mental health needs of children.[123] Funds for contracted services may run out before the end of the fiscal year. In Texas, for example, it is not uncommon for services to dry up during the last two months of the fiscal year.[124]

Poor Data Collection

A number of reports mentioned that states and child welfare agencies failed to keep track of the service needs of children in care.[125] In many states, there exists no statewide system for tracking mental health services that are provided to children in the child welfare system.[126] Even fewer states

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101 *E.g., Arizona Final Report,* at 54; *Colorado Final Report,* at 63; *Hawaii Final Report,* at 72; *Idaho Final Report,* at 69; *New Jersey Final Report,* at 9; *Pennsylvania Final Report,* at 79; *Final Report,* at 49.

102 *E.g., Arizona Final Report,* at 54; *Arkansas Final Report,* at 55; *California Final Report,* at 77; *Delaware Final Report,* at 68; *District of Columbia Final Report,* at 75; *Hawaii Final Report,* at 72; *Idaho Final Report,* at 48; *New Jersey Final Report,* at 97; *South Carolina Final Report,* at 72; *Utah Final Report,* at 59; *Vermont Final Report,* at 33; *Washington Final Report,* at 63.

103 *Texas Final Report,* at 62.

104 E.g., *Alabama Final Report,* at 73; *Alaska Final Report, at 55, 71, 73; Arkansas Final Report,* at 65; *California Final Report,* at 76; *Connecticut Final Report,* at 71; *Georgia Final Report,* at 33; Idaho *Final Report,* at 69; *Indiana Final Report,* at 48; *Iowa Final Report,* at 69; *Kentucky Final Report,* at 64; *Louisiana Final Report,* at 74; *South Dakota Final Report,* at 32; *Utah Final Report,* at 43.

105 *Alaska Final Report,* at 71-3.

106 *Washington Final Report,* at 64.

107 *Idaho Final Report,* at 69.

108 *South Carolina Final Report,* at 71.

109 *North Dakota Final Report,* at 45.

110 *E.g., Alabama Final Report,* at 55; *California Final Report,* at 58; *Hawaii Final Report,* at 57; *Idaho Final Report,* at 48; *Iowa Final Report,* at 69; *Kentucky Final Report,* at 63; *Louisiana Final Report,* at 59; *Pennsylvania Final Report,* at 79; *South Carolina Final Report,* at 71; *Final Report,* at 50; *Wyoming Final Report,* at 52.

111 *E.g., Ohio Final Report,* at 66; *Oregon Final Report,* at 44.

112 *California Final Report,* at 58.

113 *E.g., Alaska Final Report,* at 71; *Connecticut Final Report,* at 71; *Final Report,* at 63; *Maine Final Report,* at 58; *New Jersey Final Report,* at 74.

114 *E.g., Georgia Final Report,* at 33; *Kentucky Final Report,* at 46; *New Hampshire Final Report,* at 51-2; *New York Final Report,* at 54-5; *New Mexico Final Report,* at 47; *Utah Final Report,* at 43.

115 *E.g., Alabama Final Report,* at 71; *Iowa Final Report,* at 69; *Texas Final Report,* at 62.

116 *West Virginia Final Report,* at 75.

117 *Wyoming Child Final Report,* at 52.

118 Montana Dep't of Public Health & Human Services, Child and Family Services Division, *Child and Family Services Review: Statewide Assessment,* at 113 (April 2002).

119 *Montana Final Report,* at 55.

120 *Washington State Final Report,* at 47.

121 *Vermont Final Report,* at 34.

122 *E.g., Vermont Final Report,* at 33.

123 *E.g., Washington State Final Report,* at 47; *Wyoming Final Report,* at 52.

124 *Texas Final Report,* at 62.

125 *E.g., California Final Report,* at 58; *District of Columbia Final Report,* at 55; *Illinois Final Report,* at 35 (data on mental health needs is "conspicuously absent").

126 *E.g., Pennsylvania Final Report,* at 81.

track qualitative data on service outcomes and treatment effectiveness.[127] Agencies in just a handful of states have begun to develop tracking tools, to facilitate an analysis of service utilization and resource development.[128]

Collaboration Needed

In many final reports, stakeholders voiced concern over the lack of coordination between child welfare and mental health agencies. [129] While interagency collaboration may occur at the state level, service coordination at the local level does not necessarily follow. Indeed, several states mentioned that the autonomy of county departments hampered coordination of mental health services at the local level.[130] In describing the lack of integration, stakeholders spoke of "barriers," "gatekeeping," "conflict," "turf issues," and "logjam". Some states mentioned a need for a directory so that child welfare staff can know what mental health services are available.[131] Many of the programs that serve families have their own eligibility criteria, regulations, and case tracking and management systems. Complicated and unclear procedures for obtaining care also were identified as obstacles.[132]

When the roles of agencies are not clearly delineated, the failure to follow up on assessments or treatment is a common occurrence. [133] The District of Columbia final report, for example, describes a child who was diagnosed with post-traumatic stress disorder, but never received any follow-up or mental health services.[134] Children and families involved with multiple systems, such as child welfare, mental health, and special education, typically have many social workers, therapists, and other mental health professionals, who may not be in communication with one another or the children's caregiver about treatment.

Promising Approaches and Proposed Reforms

The CFSRs document the states' failures to meet the mental health needs of child abuse and neglect victims—both those who enter foster care and those who remain at home. They also identify some of the factors contributing to these failures, and suggest some solutions. If the poor outcomes for these children are to be reversed, states must adopt and implement uniform professional standards of care, allocate additional resources, recruit more qualified providers, and utilize their limited funds on programs with demonstrated effectiveness. Promising and evidence-based approaches should be replicated. In the next few sections, we set forth some of the changes suggested in the CFSRs. This section is not intended to be a comprehensive review of programs and models. For more information the reader should consult the additional resources listed in the footnotes in the sections that follow.

Standardized Requirements for Assessments

Despite agreement among health care professionals and child welfare experts on the need for mental health screening and assessments[135] of child abuse and neglect victims, many states fail to provide caseworkers with clear, specific expectations in this area. Uniform, national standards are needed. Either Congress or the U.S. Department of Health & Human Services (HHS) should act now to adopt those standards before another generation of children enters care.

Thorough, comprehensive and timely assessments are an essential tool for a child welfare worker, the family, foster parents, and other stakeholders in the child's life to develop an individualized service plan. Children receiving in-home services, as well as children entering foster care, should receive an assessment. Such assessments must include an evaluation of the child's emotional and behavioral health.

States should ensure that screening and assessment tools are valid and reliable, and that the professionals conducting the evaluations understand the impact of abuse and neglect, and place behavioral health findings in the broader context of the trauma and instability suffered by these children.

Since assessments for children in the child welfare system will likely require substantial amounts of time and special expertise, it is particularly important to ensure adequate reimbursement rates for mental health professionals. Florida has implemented an encouraging program to ensure that assessments are comprehensive and professionally administered, in which providers may bill Medicaid for up to 20 hours of assessment at $50 per hour.[136] Illinois has created a separate health care system for children in foster care called Healthworks.[137] Primary care physicians participating in Healthworks receive enhanced Medicaid rates (8-10 percent higher than standard fees), a monthly $5 fee for completion of paperwork, and a one-time $15 fee per child to initiate the Health Passport for a child in foster care.[138]

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127 *E.g., Alabama Final Report,* at 74; *New Jersey Final Report,* at 97.

128 *E.g., Alabama Final Report,* at 73.

129 *E.g., Alabama Final Report,* at 74; *California Final Report,* at 57; *Colorado Final Report,* at 65; *Florida Final Report,* at 60; *Iowa Final Report,* at 71; *New Jersey Final Report,* at 106.

130 *E.g., North Carolina Final Report,* at 58; *South Carolina Final Report,* at 74.

131 *E.g., District of Columbia Final Report,* at 73; *Georgia Final Report,* at 50.

132 Pennsylvania Final Report, at 81.

133 *E.g., Arizona Final Report,* at 41; *Georgia Final Report,* at 33; *Illinois Final Report,* at 35; *New Jersey Final Report,* at 74; *South Dakota Final Report,* at 31; *Texas Final Report,* at 49; *Washington Final Report,* at 47.

134 *District of Columbia Final Report,* at 55.

135 Screenings are used to identify problems that require immediate attention or further assessment. Assessments are conducted by qualified health care professionals, and are more extensive than the initial screenings. Most professional groups recommend that children entering foster care have an initial screening upon entry into care followed by a more comprehensive assessment within 30 to 60 days of placement. American Academy of Child and Adolescent Psychiatry and the Child Welfare League of America, *Policy Statement on Mental Health and Substance Use Screening and Assessment of Children in Foster Care,* (2003), http://www.aacap.org/publications/policy/collab02.htm (last visited Nov. 19, 2004); Georgetown University Child Development Center, *Meeting the Health Care Needs of Children in the Foster Care System, A Framework for a Comprehensive Approach: Critical Components, http://gucchd.georgetown.edu/object_view.html?objectID=3585 (last visited December 7, 2004)*

136 Jan McCarthy & Charlotte McCullough, *Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems: 2. A View From the Child Welfare System.* Series of the Health Care Reform Tracking Project, 31 (2003).

137 P. Jaudes, L. Bilaver, et al, Improving Access to Health Care for Foster Children: The Illinois Model, 83 Child Welfare 215 (2004)

138 *Id,* at 220

There are a handful of states with mental health assessment policies that appear to come closer to satisfying CWLA standards.[139] Arkansas, for example, requires a comprehensive health examination by University of Arkansas Medical Services (UAMS) within 60 days of a child's removal from home. Mental health is included in this exam. Reports from UAMS indicate that 67 percent of children examined need mental health services.[140] The Arkansas final report indicated that assessments occur in a timely manner as a result of the relationship that the Department of Children and Family Services (DCFS) has with UAMS.[141]

In Connecticut, the Comprehensive Multidisciplinary Exam- ination (MDE) must take place for every child entering care within 30 days of placement. The MDE includes a psychosocial assessment, which *must* be conducted by a licensed Master of Social Work (MSW) located in each foster care clinic. This assessment includes the Batelle Developmental Inventory (BDI).[142] In Georgia, a psychological examination must be completed by a licensed psychologist or psychiatrist on all children age 4 or over, within 30 days of out-of-home placement.[143] Utah's policy requires an annual mental health assessment for children as long as they are in the child welfare agency's custody.[144]

Minnesota may have the most far-reaching mandate in the nation for mental health screenings of child abuse and neglect victims. In 2003, the state legislature enacted a bill requiring mental health screenings for children in the child welfare and juvenile justice systems.[145] Child abuse victims who remain at home as well as children entering foster care are covered by the new mandate.[146] Parents whose parental rights have not been terminated must be notified about the screening, and given an opportunity to object to it.[147] Two screening tools were adopted for children receiving child protective services as well as those entering foster care—the Ages and Stages Questionnaire, and the Pediatric Symptom Checklist.[148] Specialized training is required of caseworkers who conduct the screening.[149] Funds to support children's mental health screening, diagnostic assessment, and mental health service costs were appropriated beginning in state fiscal year 2005.[150]

Cost Sharing and Coordination

Children in the child welfare system and their families require a full array of therapeutic and non-therapeutic assistance. Without access to a broad range of services, child welfare agencies are likely to continue to fail in fulfilling the well-being mandate of the CFSRs. Since essential services are not always provided by managed care organizations, child welfare agencies end up devoting some of their own limited resources to purchasing mental health services. Child welfare agencies and managed care organizations must work together to expedite children's access to services, clarify payment responsibilities, and address barriers that stand in the way of a child moving smoothly from one service to another.

In some states, child welfare agencies and managed care organizations are sharing the cost of extended psychiatric care. For example, Massachusetts has a program for children in transition from intensive psychiatric placements to lower levels of care. The Behavioral Health Organization (BHO) pays for the first 30 days of service in the lower level of care, and the Department of Social Services (DSS) picks up the cost after that. This enables children to move out of intensive psychiatric placements, thereby reducing costs, while providing DSS with 30 days to arrange payment in the lower level of care, or determine if the child is ready to move back to the community.

In Connecticut, the Department of Children and Families (DCF) and the Managed Care Organization (MCO) share costs for children in custody who are placed in inpatient psychiatric care. The MCO pays for the first 15 days of care, DCF and the MCO share the cost for the next 45 days, and DCF pays the full cost after 60 days.[151]

Evidence-Based Practices[152]

Many of the final reports indicate that dollars for children's mental health services are limited, if not diminishing. In light of these fiscal constraints, states must use limited resources to purchase effective services. Some of the Program Improvement Plans (PIP) submitted by states focus on "efforts to increase service effectiveness."[153] Some states' PIPS identify particular services.[154] Although there are increasing calls for greater use of evidence-based treatments for all children, progress is slow. As several researchers noted last year

> All too frequently, children and their families receive care that is

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139 *E.g., Arkansas Final Report*, at 39-41; *Connecticut Final Report*, at 52; *Georgia Final Report,* at 32-3.

140 *Final Report,* at 39-41.

141 *Id.*

142 Children's Bureau, U.S. Dep't of Health & Human Servs., *Final Report: Connecticut Child and Family Services Review,* at 52; Phone Interview with Dixie Dappolinio, Connecticut Department of Children and Families on June 16, 2004.

143 *Georgia Final Report,* at 32-3.

144 *Utah Final Report,* at 44.

145 MN. Stat. Ann. § 245.4874 (14).

146 *Id.* The covered children include

> a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

147 *Id.*

148 Minnesota Dep't of Human Servs., *Bulletin 04-68-05* "DHS Implements Child Welfare and Juvenile Justice Mental Health Screening," at 4-5 (April 23, 2004).

149 "Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values." MN. Stat, Ann. 245.4874 (14).

150 *Id*, at 14.

151 *Connecticut Final Report*, at

152 *See* Lynne Marsenich, *Evidence-Based Practices in Mental Health Services for Foster Youth,* California Institute for Mental Health (2002); R.Hahn, J. Lowy, et al., *Therapeutic Foster Care for the Prevention of Violence: A Report on Recommendations of the Task Force on Community Preventive Services*, 53 Morbidity and Mortality Weekly Report 1 (July 2, 2004); J. McCarthy & C. McCullough, *Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems: A View from the Child Welfare System* (2003)(for additional resources on evidence-based practices)

153 Wyoming Dep't of Family Servs, *Child and Family Services Review: Program Improvement Plan*, at 9. *See also*, Ohio Dep't of Job and Family Servs, *Child and Family Services Review Program Improvement Plan,* at 65 (including an action step to promote best clinical practices and research-based interventions).

154 *E.g.,* North Dakota Dep't of Human Servs, *Child and Family Services Review: Program Improvement Plan*, at 31 (2003)(Describing implementation of "the Wraparound Process case management model as a major initiative).

based on outdated practices and narrowly defined outcomes as opposed to care that is based on increasing evidence of effectiveness and a wider spectrum of desired functional and quality of life outcomes. The field continues to rely on practices that have little supporting evidence or, at worst, have poor outcomes. The care that is often provided is based on "that's what we've always done" rather than on an emerging evidence base for "what works."[155]

Information on successful treatment programs for children and families is available from several sources. Dr. John Landsverk identified several notable examples of promising evidence-based interventions, in a follow-up to the 1999 *Surgeon General's Report on Mental Health.* Included on this list were

- Identification of Developmental Problems
- Foster Parent Management Training
- Multi-systemic Treatment for Physically Abusive Parents
- Attachment Intervention for Foster Parents
- Treatment Foster Care
- Culture/Climate of Case Worker Teams[156]

More recently the Washington State Institute for Public Policy (WSSIP) completed its legislatively mandated study of the costs and benefits of more than 100 prevention and early intervention programs for children and families.[157] The analysis included a review of the scientific research literature, to determine if there was credible evidence that a particular program worked. WSIPP's review includes programs like Big Brothers/ Big Sisters, Family Preservation Services, Home Visiting programs, and Multi-Dimensional Treatment Foster Care.

While there is much excitement surrounding the encouraging data that has come out of these progressive programs, it is unclear the extent to which states are making concerted efforts to implement evidence-based practices on a more widespread basis. Other states may want to consider following Washington's proposal

> to adopt legislation that encourages local government in- vestment in research-proven prevention and early intervention programs by reimbursing local governments for a portion of the savings that accrue to the state as the result of local investments in such programs.[158]

Collection, Sharing and Analysis of Data

As evidenced by the final reports, most child welfare agencies fail to collect data on children's mental health needs, the type of services utilized, and treatment success.[159] In the absence of this data, planning is difficult, if not misguided. There is a dire need for accurate information on the adequacy and availability of services, if gaps are to be identified, and strategies developed.

Existing child welfare databases are largely driven by the Adoption and Foster Care Analysis and Reporting System (AFCARS) and Statewide Automated Child Welfare Information System (SACWIS) specifications, mandated by federal law, and the funds available to states under these programs. Current AFCARS data elements include little case-specific or aggregate information about children's mental health. The data that is required is often not accurate.[160]

Before redesigning child welfare databases, states should explore filling the gaps in information by tapping other agencies' databases. Texas' PIP includes the following action step

> [Child welfare agency] will share demographic information regarding children in substitute care with the Texas Education Agency in exchange for aggregate data regarding that population. Aggregate data will include such areas as standardized test scores, graduation and drop out rates, percentage of youth in special education classes, etc. The data will be a comparison of aggregate data for youth in foster care and aggregate data for youth in the general Texas population, by region and statewide.[161]

Developing interfaces or exchanges between child welfare and Medicaid data bases could help child welfare workers identify a child's health care providers, diagnoses, and services. Similar exchanges of information with education agencies would add to the health and education history for children in the system. Aggregate data from each of these systems should be available to policy makers and program administrators.

Coordination with Other Programs and Agencies

The child welfare, mental health, Medicaid, and school systems, as well as providers, families, and other

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[155] Larke Nahme Huang, Ph.D, Kathy S. Hepburn, M.S. & Rachele C. Espiritu, Ph.D, *To Be or Not to Be … Evidence-Based*, Data Matters 1 (National Technical Assistance Center for Children's Mental Health, Spring/Summer 2003). *See also,* Lynne Marsenich, *Evidence-Based Practices in Mental Health Services for Foster Youth,* California Institute for Mental Health, (2002).

[156] U.S. Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, at 25. Washington. D.C.: U.S. Dep't of Health & Human Servs (2000).

[157] Steve Aos, Roxanne Lieb, Jim Mayfield, Marna Miller & Annie Pennucci, *Benefits and Costs of Prevention and Early Intervention Programs for Youth* (July 2004)

[158] ESSB 5404 Sec. 608(2), Chapter 25, Laws of 2003.

[159] Amendments to Minnesota's Children's Mental Health Act last year took a step forward in requiring screening of children in the child welfare system but unfortunately prohibit the collection and analysis of the screening results

> Screening results shall be considered private data and the commissioner shall not collect individual screening results. MN. Stat. Ann. §245.4874 (14)

[160] Steven Rosenberg & Cordelia Robinson, *Using AFCARS to Study Relationships Between Children's Developmental and Medical Conditions and Foster Care Outcomes,* National Data Archive on Child Abuse and Neglect, Updata Newsletter Vol 13 (Fall 2002):

> An analytical issue of which researchers should be cautious concerns estimating the prevalence of developmental-medical problems based on AFCARS data. In 1999, 11 states reported to the AFCARS that less than 5 percent of their foster children under age three had developmental-medical problems. Such low levels are well below estimates provided in studies of foster children and should be regarded skeptically.

[161] Texas Dep't of Protective and Regulatory Servs, *Texas Child and Family Services Review Program Improvement Plan,* at 41 (April 2003),

caregivers, share responsibility for meeting the mental health needs of children in the child welfare system. The talk about the need for greater collaboration across these agencies needs to be converted to action. Memoranda of understanding need to be implemented, not just signed.

Title IV-E of the Social Security Act contains a specific mandate that local agencies coordinate their foster care programs with other federally funded related state and local programs.[162] However, it identifies only TANF (Title IV-A), Title IV-B (child welfare services), and Title XX (social services block grant) as the programs requiring coordination. New Congressional mandates requiring coordination of efforts with other federally funded programs; e.g., Medicaid, and Individuals with Disabilities Education Act, should be added to the list.

States are implementing a variety of inter-agency collaborations. One approach is to station mental health agency staff in child welfare agency offices. In California, public health nurses are located in all county child welfare agencies.[163] In Connecticut, substance abuse specialists provide consults with caseworkers.[164] When social workers and clinicians are housed in the same office, it improves attitudes, and encourages informal conversations and information sharing. Social workers become more sophisticated about mental health issues, and clinicians understand the realities of the child welfare system and the families in them.

The courts also may be engaged in coordination efforts. Some states have used court improvement activities as a means of enhancing behavioral health assessments and access to treatment. In Philadelphia, for example, special units created at the Department of Human Services and a Family Court work closely with Community Behavioral Health, the city-operated behavioral health organization, to integrate behavioral health and child welfare operations and services.[165]

Dependency courts also must play a greater role in overseeing the well-being of children under their jurisdiction. At every review hearing, judges should determine if the physical, emotional, mental, educational, and behavioral needs of the child are being addressed with services that are appropriate and effective. Some courts have developed checklists to guide these inquiries.[166] But simply monitoring the child's status may not be enough. Courts' authority may need to be augmented by statutes similar to California's dependency laws.[167]

Conclusion

Over the last three years, millions of dollars and countless hours of time from federal reviewers, stakeholders, families, foster parents, agency staff, and administrators went into the assessments of state child welfare programs. Those final reports are the midpoint in the process of reform Congress mandated. States must now act to resolve the problems and deficiencies noted in the final reports. States must implement PIPs that produce measurable improvements in the well-being of children's mental heath. Federal officials responsible for reviewing and approving these PIPs must ensure that they are adequate. These same officials monitor states' progress in implementing these plans, primarily through the quarterly reports that states must file.

In the next article in this series, we will provide an overview of PIPs in a small sample of states, and the progress in implementing them, as reported in the quarterly progress reports submitted to HHS. Our own investigation so far suggests that federal officials are approving PIPs that do not adequately address children's mental health. Nor does it appear that federal oversight of states' progress is sufficient.

If Congress' vision of child welfare reform is to be realized, we cannot rely solely on federal officials' oversight. Advocates in each state must participate in the development or critique of their state's PIP. But advocates' role cannot end with federal approval of the PIP—they must remain vigilant during the two-year PIP implementation phase, and be prepared to call for modifications in the PIP.

Few states make their quarterly progress reports readily available. It is unclear how closely federal officials scrutinize those reports. Advocates must routinely analyze the information being provided to HHS, and provide a check on the accuracy of the representations and claims being made. Since it will be difficult for one group to oversee all aspects of the state's reforms, foster parent associations, court-appointed special advocates, public defender associations, and others may want to consider dividing up areas to monitor.

Finally, Congress needs to turn its attention back to re-examining the incentives and penalties structures in the law. While penalties apply to most aspects of a state's program, the only fiscal incentive is attached to increasing adoptions. Additional incentives for achieving permanency, safety and well-being outcomes for children need to be considered.

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[162] 42 U.S.C. 671 (a)(4) provides

> the State shall assure that the programs at the local level assisted under this part will be coordinated with the programs at the State and local level assisted under parts A and B of this title, under title XX of this Act, and under any other appropriate provision of Federal law.

See also, 42 U.S.C.§ 629b (a) (3)

> Provide for the coordination, to the extent feasible and appropriate, of the provision of services under the plan and the provision of services or benefits under other Federal or federally assisted programs serving the same population.

[163] *California Final Report*, at 77.

[164] *Connecticut Final Report*, at 52.

[165] *See supra* note 116 at 31.

[166] *See, e.g.,* New York State Permanent Judicial Commission on Justice for Children, *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates, and Child Welfare Professionals. See also,* Sheryl Dicker & Elysa Gordon, *Ensuring Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare Professionals*, Zero to Three Policy Center (January 2004)

[167] Cal. Welf. & Inst. Code § 362 (a)

> To facilitate coordination and cooperation among government agencies or private service providers, the court may, after giving notice and an opportunity to be heard, join in the juvenile court proceedings any agency or private service provider that the court determines has failed to meet its legal obligations to provide services to the child...