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Funneling Child Welfare Consumers into and through the Mental Health System: Assessment, Referral, and Quality Issues

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Abstract

This qualitative study explores how consumers of child welfare services reach nonpsychiatric mental health providers and the perceived quality of these services. It relies on iterative interviews with individuals and groups, as well as on court observations from one metropolitan area. Results suggest that, consistent with theories of street-level bureaucracy, efficiency issues drive mental health service use, as clients are routinely subjected to psychological evaluations and funneled into mental health services as a matter of course. Referral practices are shaped by child welfare professionals' routines, discretion, and desire to meet such system objectives as providing short turnaround times for reports. The results suggest that, despite stakeholders' best intentions, maltreated children are not benefiting from thoughtful processes geared to screen for, assess, and provide targeted treatment for unmet mental health needs.

The child welfare system has been described as a gateway to mental health services for those within the system. This description reflects the high rates of mental health service use by child welfare service consumers, especially children in the foster care system (Harman, Childs, and Kelleher 2000; Zima et al. 2000; Dos Reis et al. 2001; Burns et al. 2004; McMillen et al. 2004), as well as the dramatic increases in children's service use at the point when they come in contact with the system (Leslie et al. 2005). High rates of mental health service use are of interest to practitioners and administrators charged with ensuring that children and families receive needed services. They are also relevant for policy makers who see the high costs associated with these services (Geen, Sommers, and Cohen 2005).

Empirical knowledge about mental health service use in child welfare populations comes from a variety of sources, including administrative data and case record reviews, as well as survey interviews with children and caregivers. The recognition that an individual's service use spikes after contact with the child welfare system was discovered in Laurel Leslie and colleagues' (2005) analysis of data from the National Survey of Child and Adolescent Well-Being. Their work suggests that, from the month of the first child welfare contact to the following month, the hazard rate for service use increases slightly among youth who are investigated for maltreatment and do not receive continuing services. The rate doubles among youth who remain at home but receive continued child welfare services. It more than

triples among children removed from the home. These data, however, do not reveal much about the mechanisms that influence the spike.

Leslie and colleagues (2005) speculate that the spike may be attributable to child welfare caseworkers' scrutiny of children's well-being or to mental health service referrals made simultaneously by the school and medical personnel who reported maltreatment. Those who enter out-of-home care have the largest and most sustained service spike of the studied groups. This may suggest that other mechanisms (e.g., court oversight) are related to service use by this population. For example, federal mandates require that the public child welfare authority assess the mental health needs of children in its care, meet those needs, and provide court oversight of the services (Adoption and Safe Families Act of 1997; U.S. Public Law 105–89).

Existing service guidelines recommend undertaking a thoughtful, individualized decision-making process in assessment and treatment planning for maltreated children and their families (Chaffin 2000; American Academy of Child and Adolescent Psychiatry and Child Welfare League of America 2002, 2003; Saunders, Berliner, and Hanson 2003). Mark Chaffin (2000), for example, argues that maltreated children do not always need full mental health evaluations and often are not candidates for psychotherapy. This model process is designed to answer several questions: (1) Does this client need a mental health assessment? (2) What kind of assessment is needed? (3) Who should ideally perform the assessment? (4) What treatment recommendations derive from the assessment? (5) Which mental health providers are well-suited to deliver the recommended treatments?

In daily practice, however, this assessment may not be thoughtfully individualized. Michael Lipsky (1980) observes that public service professionals, or street-level bureaucrats (hereafter, SLBs), process large amounts of work with resources inadequate to the demands. These conditions force SLBs to develop shortcuts and maximize efficiency. Further, SLBs typically address the mismatch of resources to demands by finding ways to exercise discretion, such as by rationing services. They also modify perceptions of their clients to explain away poor outcomes (Lipsky 1980). The actions of SLBs, viewed together, represent de facto policy making. Research offers compelling descriptions of situations in which public case work diverges from policy and training requirements in ways that are consistent with Lipsky's theory (e.g., Brodtkin 1997; Smith and Donovan 2003; Lindhorst and Padgett 2005).

The spike in mental health service use that consumers experience upon their contact with the child welfare system could be explained by either a rational assessment or a street-level bureaucracy model. If the child welfare system is structured to meet individuals' mental health needs by providing specific services in thoughtful and rational ways, then the need for mental health services would serve as the primary criterion for a service referral, and the quality of mental health providers would serve as a key criterion in matching providers to clients. If, however, daily practice emphasizes efficiency, then factors other than quality and client needs may drive mental health service choices.

Not much is known about the quality of mental health services received by consumers of child welfare services. One recent report (Lee et al. 2006) examines views on mental health care as they are reflected among 17-year-old youth in the foster care system. Although many youth report being helped by mental health providers who were encouraging, seemed genuine, and assisted in problem solving, others report that their providers offered little. Several youth complain about the ways in which psychotropic medications are prescribed and managed. Another study raises questions about the quality of the psychiatric care received by consumers in the child welfare system (McMillen et al. 2007); child welfare,

court, and mental health professionals report overuse of medications, overmedicated youth, and short psychiatric consultations.

The current study explores the mechanisms by which child welfare service consumers reach nonpsychiatric mental health providers in one geographic area. It also examines stakeholders' rationales for these service decisions, explores the perceived quality of these services, and considers the role of quality in referral decisions. All in all, the study examines the extent to which assessment and referral practices correspond with the individualized, rational assessment approach, as well as the extent to which practice is driven by street-level bureaucratic concerns.

Methods

This qualitative study relies on interviews with key informants in individual and group settings. It also considers data from observations of family court proceedings and member-checking groups. The groups are part of a qualitative method of sharing findings with interview participants. The key informant individual and group interviews were conducted with professionals from the child welfare, mental health, and court systems in St. Louis City and St. Louis County, Missouri. In total, 130 professionals were interviewed from December 2004 to August 2005. Of these, 88 are child welfare professionals.

The sample includes more child welfare workers than other professionals. This is done to represent child welfare professionals in the different sectors (e.g., investigation, foster care) across the system. Group interviews were conducted separately with child welfare professionals who investigate abuse and neglect allegations, provide in-home services to maltreating families, provide adoption services, and serve children (and their families) in out-of-home care. A separate group interview was conducted with supervisors from these services. In the examined geographic region, most child welfare services are provided by the Children's Division of the Missouri Department of Social Services, but some private organizations have contracts with the Children's Division to administer foster care case management services. Group interviews thus also were conducted at three private child welfare agencies. Individual interviews were conducted with a total of 69 public child welfare employees and 19 child welfare professionals in private agencies.

The child welfare professionals who were interviewed provide direct service. They hold bachelor's degrees, often not in social science or social work. Only a handful have master's degrees. Supervisors in this system typically have a master's degree and extensive child welfare practice experience. Child welfare professionals were invited to participate in the voluntary group interviews by their supervisors. There were no repercussions for declining to attend or to contribute to the group interview. These methods do not allow the authors to determine how many child welfare professionals were invited to attend the group interviews or how many chose not to attend. Group interviews were conducted during regular work hours.

Mental health professionals who provide services to consumers in the child welfare system were purposefully recruited as key informants, usually after being identified by child welfare professionals in the sample. Interviews were conducted with five psychologists who hold doctorates, five psychiatrists, and four mental health professionals who hold master's degrees. These four mental health professionals work in residential or inpatient programs. In addition, the authors interviewed 19 mental health practitioners (14 of these in three group interviews) who hold master's degrees and work in private social service agencies.

Also interviewed were six agency administrators (child welfare and mental health), three sitting or retired family court judges who hear (or heard) child welfare cases, and four

professional court-appointed special advocate (CASA) lawyers. Of the 130 participants, 97 (75 percent) are female, 72 are white (55 percent), 53 are African American (41 percent), and five (4 percent) are of other races.

Data Collection Methods

Individual and group interviews were typically conducted at the participant's place of employment; however, two group interviews and three individual interviews took place nearby. Four individual interviews were conducted by phone. Group interviews were the most efficient way to talk with child welfare professionals and agency-affiliated mental health professionals. This format also allowed researchers to inquire about agreements and disagreements among participants. Initial interview guides were created in consultation with experts in qualitative methods, mental health, and child welfare. The guides were used for both individual and group interviews. The interview guides evolved over the course of the study, helping to confirm findings from earlier interviews and to explore new questions raised by those interviews. In total, 10 iterations of the guide were used in interviews. Questions focus on how mental health matters come to the attention of child welfare professionals, how referrals for mental health services are made, why certain providers are preferred over others, and how different types of mental health services are viewed by participants.

Participants' responses also led the researchers to conduct subsequent interviews with other professionals. For example, participants indicated that the process of connecting clients with services is influenced by court officials and psychologists who evaluate consumers. As a result, the researchers subsequently interviewed both types of actors. Interviews were conducted by three of the authors: a medical anthropologist, a public health researcher, and a social work researcher with practical experience in the child welfare and mental health systems. Study participants who were not state employees were paid \$30 for their time. State rules do not allow the researchers to pay public employees.

On the basis of the interview results, the authors decided to observe how mental health issues are handled in family court cases involving child welfare. Two researchers observed a total of 63 cases over 5 weeks in a 2-month period. The cases stemmed from two different courts. The researchers also conducted unstructured interviews with several additional court professionals, including deputy juvenile officers, court clerks, and attorneys. These contacts were identified during observation of cases, and interviews were conducted during breaks between court cases. A convenience sample of court cases was developed, and a full docket was observed on several days. The observers took field notes during these observations and wrote summaries for each case after the observation periods. The institutional review board of Washington University in St. Louis approved all procedures in advance.

Data Management and Analysis

Interviews were audiotaped and professionally transcribed. Transcripts were cleaned by purging all identifying information, verifying the accuracy of the text with audiotape recordings, and fixing typographical errors. Final transcripts were imported into NVivo2, a qualitative data management software package. The analysis followed a systematic iterative process of interpretation and categorization "involving repeated delving into and experiencing of the data" to establish patterns and connections (Borkan 1999, 182). The starting theoretical position was the rational assessment model of assessment and referral. Subsequently, the results were reanalyzed through the lens of Lipsky's (1980) views on street-level bureaucracy. This reanalysis allows the research team to gauge the extent to which the data confirm or disconfirm two examined models.

Data analysis and coding began early in data collection and continued iteratively throughout the project. The first seven transcripts were read by the three research team members to identify the major issues being discussed; coding for these issues was developed by consensus. These early analyses provided the foci for subsequent interviews. To continue developing the codebook, researchers read subsequent transcripts, and additional codes were added as interviews raised new topics of interest. In order to compare codes, improve agreement, and thus refine the codebook, two researchers applied the codebook to early transcripts. One researcher coded the rest of the transcripts. The NVivo2 software was primarily used to generate reports on specific topics. These reports were then read numerous times by multiple readers who were asked to identify regularities and connections in the data (themes). These elements are described in the study's findings.

Several steps were taken to increase confidence in the validity of the data. These steps include the use of multiple interviewers (to determine whether a participant related the same account to different interviewers), multiple readers (to determine whether readers discovered the same story), and member-checking groups (Lincoln and Yuba 1985). The use of member-checking groups is a qualitative method of sharing findings with interview participants. The member-checking interactions become part of the analytic process helping researchers to determine whether the findings represent the story as participants perceived it. A total of 125 child welfare professionals, court professionals, and agency administrators, not all of whom were interview participants, attended one of four member-checking events. Preliminary findings were presented, and group attendees were asked to elaborate on any feature of the analysis that they deemed not adequately represented. If group members raised questions about any findings, the authors constructed additional related questions. These group discussions were also audio-taped, and professional transcripts were prepared. The group meetings were held prior to a reanalysis of the data from a street-level bureaucracy perspective.

Results

In interviews and reanalysis, Lipsky's (1980) street-level bureaucracy theory emerged as a relevant framework by which to explain the context for the sharp increase in mental health service use when children enter the foster care system. In the first interviews, child welfare case managers report that forces beyond the identification of mental health needs and quality of services drive the use of mental health services for these children. Several actors, including case managers, judges, and psychologists, appear to be acting in ways characteristic of SLB, optimizing their use of discretion while emphasizing efficiency in dealing with clients face to face. Foremost among the forces driving service use is the court process, during which mental health assessments and treatments are often discussed and ordered by family court judges.

The Role of Courts

Although the courtroom is a main stage for mental health decision making, results suggest that family court judges, case managers, and others have great influence and discretion in the ordering and directing of mental health care for consumers in the child welfare system. Child welfare professionals report, and observational data confirm, that family court judges presiding over child welfare cases routinely order both mental health evaluations and treatment for consumers. Their reasons for making such recommendations are not always clear. Numerous interview participants report that this practice results in the use of mental health care as a rubber stamp. A child welfare professional's comments exemplified this perception: "You get the cookie-cutter court order. Everyone has individual counseling and then, when they are ready, family counseling. I think therapy is important, but you get the

pressure from the court. You need to give them referrals to therapy and you need to get them into therapy.”

Another child welfare professional characterized the role of the court in service recommendations, stating, “From the court’s perspective they just throw people into therapy. They throw them into services probably because there is some comfort in that. They feel that as long as they have a qualified professional looking at whatever issues, they are going to hit whatever issues that are out there, and if concerns come up, great, and they will bring those to our attention.”

Respondents report that the use of mental health jargon by judges, lawyers, child welfare professionals and other actors is common during even the briefest court proceedings and in cases when mental health issues are not part of the child welfare investigation. The authors’ courtroom observations confirm that the courts regularly discuss mental health issues through issuance of orders for psychological evaluations and progress reports, as well as through review of treatment options and such reports. In one observed case, a judge ordered a host of mental health treatment services for a parent and child. The parent disagreed with a judge’s order, asking, “Why family therapy?” “So you and your child can get along,” the judge replied. “But my child and I get along. That is not why we are here,” the parent countered. The judge ordered the parent and child to participate in family therapy despite the objection. The result of the typical procedure appears to be an overuse of services, especially psychotherapy and evaluation services. Many interviewed stakeholders noted such overuse.

Consistent with Lipsky’s (1980) theory, court decision makers have mainly good intentions when suggesting and ordering mental health assessments and treatments. These SLBs indicate that they find mental health services to be a useful tool in building their cases, in demonstrating to others that they are doing their jobs, and in providing a useful service to consumers in the child welfare system. Unfortunately, very few decision makers report that court personnel possess the knowledge necessary to direct effective mental health care. Judges, court-appointed special lawyers, and child welfare case managers admit that they lack the knowledge and resources needed to provide the most appropriate services. This lack of knowledge and understanding of mental health issues often results in service orders that some respondents consider to be ill conceived, inappropriate, or unnecessary. A case manager explained the dilemma, stating, “I just referred a 3 and a half year old to therapy. When asked [by the therapist] why he needs therapy, I said, ‘because it is court ordered.’ I said truthfully, ‘He is not really having that many problems. It has been court ordered to refer him to therapy and if he does not at least get the referral and initial evaluation, I will be in contempt of court.’” Echoing the sentiment, a mental health professional said, “There are times when therapy is needed. I don’t deny that. But just to send every kid to therapy is, I think, a waste of time and money.”

Court-ordered psychological evaluations are a frequent and important courtroom catalyst for the provision of mental health services. Evaluations are requested by a variety of actors in the court process. They are a staple tool that judges use to order therapy and to explore topics identified in the psychologist’s report. One child welfare professional pinpointed the process: “Well, the first step is always to get the psychological evaluation and follow those recommendations while you set them up with the therapists.” Another child welfare professional summed up the use of evaluations: “It’s like a cookie-cutter requirement that we have to give all families, parents, and children when they come into care, period.” A different child welfare professional captured the child welfare case routine: “A lot of our kids just automatically get psych evals [psychological evaluations]. The parents automatically get psych evals. It’s ordered by the court usually.”

Evaluations provide the expert opinions by which guardians *ad litem* support their requests and on which judges base their decisions. Thus, ordering services for the system's consumers serves utilitarian purposes beyond addressing individuals' mental health needs. A court official explained the role of ordered services in his decision making, stating, "I can tell you, from my perspective, as the person who made the decisions, I felt more comfortable when I did have some mental health professional look at the situation and make some assessment even though it might have been just outside of what I wanted. At least I had somebody that was looking at that person very closely." A CASA expressed the value of evaluations: "We just find that it's more helpful if we have kids who we know have been in difficult situations to have a complete psychological because then the good people that do them evaluate what perhaps the therapeutic goals might be."

Such comments reflect the common perception among participants that psychological evaluations serve as the cornerstone of legal decision making. This perception is consistent with Lipsky's (1980) theory of street-level bureaucracy. The SLBs in this study, especially the judges and guardians *ad litem*, understand the legal ramifications of psychological evaluations. A child welfare professional depicted this awareness, stating, "We had a former judge say that they are ordering many of these psychologicals because the appeals court wants to have a sealed case. They don't want someone to come back and say, 'Now we're going to overturn this because you didn't do the psychological.' So they are trying to have a tight case." Participants reported that although psychological evaluations are central to court cases, they also provide the opportunity to demonstrate that all parties, including judges, work to help the families in the system.

The majority of child welfare and court professionals indicate that there are numerous problems with the psychological evaluations. They point to the limited utility of evaluations in treatment planning and child welfare decision making. Participants of all types use the term "cookie-cutter" to describe the type of psychological evaluations received by consumers in the child welfare system. One child welfare professional remarked, "With some psychologists, you can tell that they just go through it and change just the person's name. You can tell it by the report being the same."

Another child welfare professional observed, "With psych evals, I mean you pretty much know beforehand what's going to be on it. But you have to do it anyway and it takes time and energy to get all this set up for something you know when it comes back what it is going to say. All of it is pretty much irrelevant for the most part." A court official provided a similar characterization: "I find them pretty much boilerplate, the psychological assessments. I read them and I see real holding back of the psychologists. They just hold back. It's all dressed up in their language, but I reach the end of it and I don't know what they hell they said." These comments reflect a common perception among participants: because of their evaluations, psychologists, even those in private practice, are considered to operate in ways similar to the methods of SLBs.

Child welfare professionals express frustration with the amount of weight given to the evaluations conducted by psychologists compared to the weight given to recommendations from child welfare case managers. Treatment recommendations made by doctorate-level professionals are understood to carry more weight than those of child welfare case managers. The frustration stems in part from the perception that the assessment process has several deficiencies. A child welfare professional expressed discontent over this: "Because in these psych evals they are making recommendations for treatment or what other evals might be needed, it's very difficult to go into court and say I have this psych eval but I really don't think you need to follow their recommendations. Sometimes I just think the wrong interventions are put into place."

The authors raised complaints about cookie-cutter psychological evaluations with some of the psychologists who provide evaluations. These psychologists agreed that many of their reports appear similar but denied that efficiency is their main goal. They attribute similarities to a variety of causes, including shared characteristics of the evaluatees, resource constraints, lack of information provided by child welfare professionals, and unfocused referrals. One of the psychologists remarked, "So I think that you can write a very, very good report and some of your reports may sound the same. But it is because the issues are the same, the variables are the same, the options are the same in terms of your reckoning, your conclusions, and recommendations. We only have so many options of what we can recommend." Another psychologist stated, "They will ask me to do a battery of tests but ... why are they requesting these tests be done? And again, I view the test primarily as a way to answer specific questions, and there usually is not a question framed. It's, 'give a full battery of tests.'" When asked about the purpose of psychological evaluations, an interviewed psychologist replied, "I've never asked anybody that question. If you would ask [child welfare professionals], I guess they would say, 'The purpose is the judge says I gotta have it. It is to meet a requirement.'"

Other comments by psychologists suggest that they are concerned with issues of efficiency as a means of maximizing profit when providing what they see as an underreimbursed service. One psychologist bristled at the suggestion that anyone could criticize the products of such a process, pointing to Medicaid reimbursement rates (roughly \$460 per evaluation). Another psychologist summed up this discrepancy: "Some of them are looking for champagne products for less than the cost of a beer." To maximize the reimbursement and minimize overhead, some of the most heavily used psychologists report that they run mobile psychological evaluation businesses and move from child welfare agency to child welfare agency, conducting one evaluation in the morning and one in the afternoon.

The routine use of psychological evaluations seems to be driven by efficiency concerns and desires to demonstrate that the bureaucrats are doing their jobs, but some child welfare professionals indicate that this overuse of evaluations is detrimental to the well-being of some child welfare clients. Two interrelated concerns emerge: efficiently conducted psychological evaluations miss the complex historical and environmental influences affecting children's behavior; also, the evaluations are overreliant on potentially dangerous labels, often psychiatric in nature. A child welfare professional observed, "There are professionals who will see a child for 30 minutes and make five axes worth of diagnoses, do a full battery of psychological testing, and rate [a child in] the mild retardation range, but not do any adaptation skills testing. They are just really quick to give these kids really severe labels that impact them. They are not looking at the whole picture, at the environment, what the current circumstances are." Another child welfare professional illuminated the long-term implications of psychological evaluations:

Many times they are used to terminate parental rights and keep kids in foster care. I mean, that is not their intent, but that is what happens. You know, if a kid starts a fire when he is 4, when he is 15 he is still a fire-setter. We label parents the same way, too. If a mom admits during her psychological that she had used drugs when she was younger, she is a drug addict and the court is going to make her get drug tests and things, which are demeaning and labeling and prevent the child from going back home.

Charting the Referral Process

Although the court and psychological evaluations appear to drive the initiation of mental health services, the child welfare case manager is largely responsible for securing these

services. The following sections detail how quality, efficiency concerns, and desires to affect case outcomes reportedly contribute to mental health service referral practices.

Quality as a criterion in mental health service referrals—Child welfare professionals frequently mention quality as a key criterion in making mental health service referrals, but they also claim that they have little capacity to determine who provides quality services, especially services like psychotherapy. Two reported proxies for quality are word-of-mouth recommendations from peers and how busy a practitioner is. As a child welfare professional explained, “The way a referral gets made is perhaps the person that sits across the aisle says, ‘So and so was a good provider of therapeutic services,’ or, ‘A certain provider did a good psychological on this child, why don’t you try them?’ Therefore, the way that a child or family gets referred to an agency or referred to an individual provider is oftentimes by word of mouth instead of by what kind of credentials they may have.” Another admitted that referrals are made by “talking to other people. We do that all the time. ‘Hey, I need a black female therapist to go to the home. Who do you like?’” A third professional noted, “The providers who proceed with doing really good work with families tend to get overburdened because they get so many referrals. It is word of mouth that the direct line workers use as quality assurance, which is not good quality assurance.”

Although case managers report that they seek high-quality therapists for their clients, the case managers and other stakeholders also report much dissatisfaction with the therapy services that their clients receive. Participants note three interrelated concerns: unfocused therapy, a lack of specialists, and unqualified therapists. Some participants report that they see therapy as ineffective because it is provided in a generic, unfocused way. One child welfare professional observed, “Some therapists I’ve been involved with ... they kind of lose focus on why we are there, what we’re supposed to be doing.” Participants assert that the needs of consumers in the child welfare system require specific and targeted mental health interventions. For example, a psychologist noted, “Sometimes the therapy—it’s so nonspecific. I see kids and they come in for a psychological evaluation, and they’ve been in care for, say, sexual abuse, and they’ve been in therapy but no one’s really addressed the sexual abuse in the therapy.”

Case managers report that they have trouble finding treatment specialists trained to deal with the issues often seen in child welfare. The child welfare professionals provide a long list of specialist treatment needs for which they have no or few providers. For example, one acknowledged, “I have big problems finding counselors that do counseling for the nonoffending parent [in a child sexual abuse case]. There are people that won’t even touch that. There is only one person that will touch sexual abuse for the nonoffending parent.”

Interviewed psychiatrists, psychologists, and therapists reported that many of their colleagues choose not to supply services for the child welfare system because reimbursement rates are below industry standards and bureaucracy is extensive. Participants report that these conditions limit the child welfare case managers’ abilities to connect consumers with appropriate services and providers. The conditions also impede their ability to use quality as a main criterion in choosing providers. One psychologist noted, “We have to remember they have a limited pool to choose from. They only have therapists who either have a contract with the state or who will take Medicaid clients. Sometimes they have to take whoever is available.” A child welfare professional described the situation: “She specializes in sexual abuse psychological evaluations, so when you are trying to get that service you call in February and she will say, ‘I cannot see you until April.’ It is very difficult. You just do not have enough [providers] out there. So you end up with [some doctor] who you really did not want in the first place.”

Many caseworkers say they prefer therapists who understand the kinds of families with which the child welfare system works, indicating that they are suspicious of newcomers and providers who too eagerly seek referrals. One child welfare professional depicted the scenario, stating, “[Therapists] drop off business cards and letters because they want to have a Medicaid contract and they want to take clients, but they don’t have any idea what it means to work with these children.”

Efficiency as a referral criterion—Child welfare professionals report that they use discretion in choosing mental health providers, including therapists and psychologists, in ways that maximize efficiency. Courts put significant pressure and responsibility on child welfare case managers to supply documentation showing that consumers in the child welfare system receive requested or ordered mental health services. Child welfare case managers report that they seek mental health providers who would meet court-initiated report deadlines. One child welfare professional noted, “You have to learn who to use. Some of them call and say ‘I’ll get it [a report] to you Friday,’ and it’ll happen 10 Fridays from today. But some of them, it’s like, ‘I need a report,’ and you get it tomorrow.” Another child welfare professional reported, “[Other workers] say, ‘Hey look, they’re wonderful, they turn their notes in on time, they attend our Family Support Team meetings, they will communicate with us, we call and they talk to us.’”

Mental health providers admit learning that, in the competition for service referrals, they have an advantage if they work well with child welfare and court deadlines. Child welfare workers’ drive for efficiency in the completion of evaluations appears to contribute to the cookie-cutter reports about which they complain so bitterly. They need these reports quickly and use psychologists who turn them around quickly. One psychologist described what happens: “If I don’t have the report in a certain amount of time then they will call me and say, ‘I need my report because I am going to court next week.’ So we get it so they can go to court. So they want to be able to check off the five things that they have done, one of which is the psychological. So they are happy.”

Influencing case outcomes—Many child welfare case managers report using their discretion to seek mental health service providers who would support their case recommendations. In other words, child welfare case managers explicitly choose providers who are likely to agree with their assessments of the general direction that child welfare cases should take. One child welfare professional described this approach: “If I need a psychological to say something, I know who to get. Then when they ask me specifically, ‘So, what’s going on?’ I know what to tell them and I know what I’ve said to them will be verbatim in this report. I know that with this information I’ll be able to get what I need.”

Another child welfare professional shared this strategy:

What I do when I refer a child for a psychological is I let that doctor know that I need this recommendation to be based around this child who is in a foster home and [that] he is going to stay there. I am looking for recommendations that are going to maintain that child in the foster home. I put the community idea in that doctor’s head before he ever sits down with my kid. I will tell the doctor that this cannot say that you recommend residential treatment because that is not the right direction. Then if the doctor tells me, “Well I can’t promise it,” then that is not the doctor I want to work with. There are plenty of psychologists around. I will shop around for one who will give me a community-based recommendation.

Although child welfare case managers have the greatest opportunity to use discretion to choose mental health providers who will influence case outcomes, other actors in the case, such as judges, guardians *ad litem*, CASAs, and deputy juvenile officers, also reportedly

influence referrals to support their own case agendas and beliefs. Participants related stories about occasional requests by these parties that certain providers not be used and about requests to change health provider assignments to ensure that provider placement recommendations match their own. During the authors' court observations, one court official reported that other court stakeholders strategically use psychological evaluations not to help determine what help families need but to build the legal case to terminate parents' rights.

Discussion

This qualitative study explores the mechanisms behind the spike in mental health service use among children upon their entry into the child welfare system. The findings suggest an organizational system, mainly ensconced in Lipsky's (1980) street-level bureaucracy, which promotes de facto policy making that is arguably responsible for the spike. The SLBs (in this case, judges, CASAs, and child welfare case managers) act in such a way that current practice deviates markedly from the tenets of the rational assessment model of service provision. Maltreated and neglected children are not benefiting from thoughtful, individualized, and well-documented decision-making processes that are geared to screen for, assess, and provide appropriately targeted treatment for unmet mental health needs. Instead, the experience is better characterized as a spinning cycle, with efficiency and discretion driving consumers in the child welfare system to experience a wide array of mental health services. They are analyzed, labeled, and perhaps stigmatized as they are steered through and eventually out of the system.

Surprisingly, the court emerges as the central location for the discussion of mental health services, and it is where orders for services originate. Courts are held to national standards that emphasize efficiency in permanency planning, and mental health care is an important component of this process (Adoption and Safe Families Act of 1997; U.S. Public Law 105–89). Lipsky (1980) identifies low-level judges as classic SLBs. They process large numbers of cases while seeking help in making tough decisions. Ordering mental health evaluations and services for all consumers in the child welfare system helps meet both needs. Judges may find that sending consumers for evaluations and services is easier than taking the time to thoughtfully determine when and what services are really needed. In addition, the evaluations and therapy reports provide information that can be used in making difficult decisions.

In keeping with Lipsky's theory, SLBs in this study seem to be motivated by good intentions in using mental health services as a tool for children who enter the child welfare system. In ordering evaluations and services, judges intend to help children and families and to improve decisions; child welfare case managers choose mental health providers whom they think will agree with their assessment of what is best for a child and family; psychologists produce evaluations (on short notice) that they hope will provide needed guidance; mental health treatment providers intervene as much as they are able. These practice patterns have troubling implications, however. Mental health services are overused, low in quality, and paid for with taxpayer dollars. There also is great potential that children and parents will endure unnecessary labeling as a result of psychiatric diagnoses from unneeded evaluations. The recommendations of mental health providers may have a veneer of impartiality, but the provider may have been chosen explicitly because of his or her known biases in child welfare decision making.

The great majority of interviewed child welfare professionals express great concern regarding the quality of the services that system consumers receive from mental health providers. They indicate that they favor a process that involves thoughtful assessment and referral decisions, but such a process is difficult to follow without information on quality.

No participant voluntarily mentioned evidence-based mental health treatments for consumers in the child welfare system. Child welfare case managers apparently do not seek evidence-based treatments. Psychologists do not recommend them, and therapists do not mention them among the services they provide. This scenario stands in tension with the recommendations of a number of organizations and experts who call for bringing evidence-based mental health care to system consumers (Marsenich 2002; Saunders et al. 2003; Chadwick Center on Children and Families 2004; Wulczyn et al. 2005; Craven and Lee 2006).

Although child welfare professionals express frustration and dissatisfaction with such mental health services as psychological evaluations and psychotherapy provided for consumers in the child welfare system, it is unclear how to improve these services. Court and child welfare professionals could be trained to identify cases for which psychological and psychiatric evaluations are indicated. They may also learn how best to focus referrals for such cases. Court officials may, however, prefer the efficiency of ordering evaluations for all system consumers, thwarting improvement efforts. It is also unclear how to provide child welfare case managers with more than word-of-mouth information about the quality of mental health providers. The quality of services may improve if the contracted mental health providers are trained in evidence-based treatments for child welfare populations. Credentialing exists for many (but not for all) of those treatments and would provide managers with a way to assess the quality of available therapists.

This study examines the mechanisms that underlie referrals to mental health services and perceptions of the quality of these services in two jurisdictions of one state. Although child welfare and mental health systems have similarities across jurisdictions, unknown variations in referrals, psychological evaluations, and psychotherapeutic practices can hamper efforts to determine the extent to which the findings are related to a specific geographic location. In addition, different researchers may have pursued different paths of inquiry as the project unfolded.

The study relies on data from two different interview types: group and individual. This decision may affect results in unknown ways. Child welfare professionals' comments about psychological evaluations and psychotherapy may not have been as pointedly negative without the group context. Although the authors attempted to identify any variation in viewpoints, child welfare professionals may have been more motivated to participate in the study if they held negative views of the child welfare system, the child mental health sector, or both. As is common in most interview-based qualitative research, participants' claims could not be empirically verified. For example, the authors were not able to verify the participant assertion that the overuse of evaluations can hinder efforts to return children to their homes.

This study reveals the need for more research on the factors that drive mental health care for consumers in the child welfare system. Specifically, research is needed to determine whether the findings reported here generalize to other child welfare and court systems. The dramatic increase of service utilization warrants variation in research methodology and locale. National quantitative studies, such as the work of Leslie and colleagues (Leslie et al. 2005), are essential because they describe the landscape of service use for the child welfare population. If they are to understand the mechanisms driving these trends, however, researchers and policy makers must investigate beyond the numbers. Future examination will allow for aptly targeted system interventions and more appropriately applied policies. Still, the results of this study illuminate the importance of understanding the mental health service climate from the perspective of the players who shape the experiences of the system's consumers.

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