Inter-Agency Collaboration in Child Welfare and Child Mental Health Systems

Jonathan Prince PhD & Michael J. Austin PhD

Inter-Agency Collaboration in Child Welfare and Child Mental Health Systems

Jonathan Prince, PhD
Michael J. Austin, PhD

ABSTRACT. While most children living in foster care experience emotional disturbance as a result of their maltreatment or out-of-home placement, most do not receive needed mental health assistance that can prevent a variety of negative outcomes. Child welfare services related to placement prevention, treatment foster care, and group care provide unique opportunities for promoting inter-agency collaboration with mental health services. In order to address more effectively the needs of families utilizing both service systems, this analysis focuses on the factors that enhance or impede child welfare and child mental health collaboration and strategies for enriching the relationship. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]*

Jonathan Prince, PhD, is affiliated with the School of Social Work, Rutgers-The State University of New Jersey, 536 George Street, New Brunswick, NJ 08901-1167 (Email: jdprince@rci.rutgers.edu). Michael J. Austin, PhD, is affiliated with the School of Social Welfare, University of California at Berkeley, 120 Haviland Hall #7400, Berkeley, CA 94720-7400 (Email: mjaustin@uclink14.berkeley.edu).

> Despite ample opportunities to provide appropriate care, little children some who enter foster care as babies can be repeatedly traumatized by their families, by other children, and by a system that fails to meet their needs. California has a delivery system that was built but never planned. New programs are layered on top of old services. Children who enter the system through the wrong doorway find staircases leading nowhere or end up behind locked doors. (The Little Hoover Commission, 2001)

Many low-income families receive child welfare services that are designed to protect children from parental maltreatment, as well as child mental health services that are designed to facilitate youth functioning. A 1992 study by Halfon and colleagues found that California children living in foster care account for 41% of all public (Medi-Cal reimbursable) mental health services even though they comprise less than 4% of Medi-Cal eligible children.

The need for mental health services can be illustrated by examining the life of a child who is placed in foster care. The multiple adjustments include: (a) responding to new people and situations, (b) recovering from the abuse or neglect that necessitated out-of-home placement, (c) coping with separation from his or her biological parents, and (d) often dealing with a very difficult family situation that led to abuse or neglect. Children living in foster care frequently face the complexity of dealing with two different families and neighborhoods as well as a variety of social service and public school staff. This complexity can increase when a child "drifts" through multiple foster care placements. Finally, many children prior to entering foster care have lived in poverty with limited access to health, mental health and educational resources. Many of these factors have contributed to the increased prevalence of emotional problems among children living in foster care (Garland, Landsverk, Hough, & Ellis-MacLeod, 1996; Halfon, Berkowitz, & Klee, 1992). The Little Hoover Commission (2001) estimates that almost 70% of the more than 100,000 children in California's foster care system experience emotional disturbance as a result of maltreatment or out-of-home placement, and that more than 50,000 children living in foster care do not get the mental health treatment that they need.

There are a variety of reasons why mental health services are often inaccessible to families in the child welfare system. The Little Hoover Commission (2001) suggests that the access barriers occur because child welfare and child mental health assistance is most often delivered separately. The service inaccessibility can then lead to school failure due to emotional distress, home instability, hospitalization, residential care placement, and/or juvenile and criminal justice system involve-

ment. From the perspective of children living in foster care and experiencing emotional disturbance, the Commission notes that:

> The quality of care is severely limited by . . . the bewildering and expensive patchwork of social, health, educational, and other services that fail to meet the sophisticated needs of young and developing human beings in the context of their families . . . No services are holistic. No one is accountable for how decisions affect the overall quality of life of children or their families. Disparate programs translate into little or no continuity of care as children age or their needs evolve . . . Families are confused and frustrated because services are organized in ways that are confusing and frustrating. (p. iv, v, xxi)

When asked separately to describe some of the more pressing challenges resulting from the lack of inter-agency collaboration, several Northern California county child welfare staff (direct service and management) and their child mental health counterparts echo many of the issues raised in the professional literature (Prince & Austin, 1998). A county child welfare director noted:

> There is an insufficient supply of mental health services for children in out-of-home care, and it is hard to find mental health professionals who will work beyond the traditional '50-minute-hour' of office-based service provision. It is also hard to access in-home counseling and care during nontraditional work hours (i.e., before 9 a.m. and after 5 p.m.), especially if multiple sessions are required in a single week. As a result, many of the children in the child welfare system have mental health needs that are never addressed, or are not addressed effectively during short, office-based, weekly sessions. Increased collaboration with mental health staff would provide the children with much-needed assistance, as child welfare caseloads are larger and there is a limited amount of time that our staff can share with each family. (Fabella, 1998)

Taking a different perspective, a county child mental health clinician noted after speaking with several colleagues that:

> We don't have enough understanding of the child welfare system, especially of the foster care process, to alleviate the high levels of anxiety experienced by children in out-of-home care. The children in this turbulent situation are often distrustful of adults as most have been victimized by their own parents. In my work with foster children I do not know the child's current status in the child wel-

fare system. If a child asks about going home and living with her parents again, or about what will happen in court, I am frequently unable to respond effectively, with the resulting anxiety and distrust hindering progress in forming or maintaining a therapeutic relationship. (Spars, 2001)

While there are multiple factors that can impede inter-agency collaboration, two major issues related to funding and mission need to be taken into account. First, the two agencies receive separate federal funding; child welfare services receive mostly Social Security Act Title IV funding while child mental health agencies receive mostly Medicaid Title XIX funding. Second, they have the differing missions of youth protection and home stability in child welfare in contrast with youth development and emotional stability in child mental health. Despite these differences, these two youth service systems share several significant collaboration opportunities.

Both child welfare and mental health professionals seek to maintain families by preventing out-of-home placement as they assist emotionally traumatized children and their families (family preservation services). While the initial decision to utilize family preservation services is often based on an assessment by a child welfare worker, mental health and child welfare agencies frequently collaborate in providing the service. Families can receive preservation services if child safety issues have been assessed and found to be adequate and if there is at least one caretaker who will accept assistance (Westat, 1995).

In addition, both child welfare and mental health professionals can facilitate child reentry into the biological family after the occurrence of an out-of-home placement (family reunification services), as there is a high prevalence of mental health disturbance in households that receive them (Rzepnicki, Schuerman, & Johnson, 1997; Quinn, Epstein, Dennis, Potter, Sharma, McKelvey, & Cumblad, 1996). As with family preservation, reunification services can vary in intensity and duration (generally less than six months), and offer both concrete and supportive services. Concrete services include money, food, clothing and transportation, while supportive services include individual counseling, parent training and education, drug and alcohol treatment, family counseling, advocacy services, and crisis intervention (Rzepnicki et al., 1997). A Westat (1995) study revealed that some reunification programs reach out to parents shortly after a child is placed in order to prevent long stays in out-of-home-care, while other programs focus on families that have experienced several unsuccessful reunifications in the past and are in need

of intensive support. Reunification programs may also reach out to children whose out-of-home-care costs are high, such as children who may need placement in a group home or hospital.

Family preservation and reunification services are often referred to collectively as home-based services, the *first collaboration opportunity*. When they are not sufficient or feasible, then it is necessary to place children experiencing emotional disturbance in either treatment foster care or group care, reserving traditional foster care placements for psychologically healthier youth. Treatment foster care (TFC), the *second collaboration opportunity*, often involves foster parents, biological parents, and siblings as members of a treatment team that delivers planned services to children and adolescents with emotional, behavioral and/or medical problems (Meadowcroft, Thomlison, & Chamberlain, 1994; Reddy & Pfeiffer, 1997). Most of them would otherwise require a more restrictive and costly level of care in a group care or residential facility (Fine, 1993). In terms of placement stability, most children complete their TFC program and generally display behavioral improvement (Chamberlain, 1996; Meadowcroft et al., 1994; Reddy & Pfeiffer, 1997). A major challenge for child welfare and child mental health professionals is to evaluate the characteristics of children who use TFC programs to determine if they are reaching those children most in need of TFC services. Children who would benefit from traditional foster care services are not appropriate for TFC because they do not need the assistance to prevent a more restrictive and costly placement in group or residential care, the *third collaboration opportunity*.

In contrast to the family-like environment of TFC, group homes or residential treatment centers provide 24-hour staff assistance to children with emotional or behavioral problems. The children are often older and more disturbed, relative to other foster children, most likely as a consequence of child welfare policy that prevents placement in the more highly restrictive settings. Only the more seriously disturbed and/or older children are placed in group care because the remaining children are cared for at home, with relatives, or in foster care. Children in group care are therefore most in need of mental health intervention, and another major challenge for child welfare and child mental health professionals is to increase the amount of mental health support that is available for them. Consequently, on-site service provision may be most warranted for this population, and youth service professionals can jointly assess service needs, respond to crises, deliver short-term interventions in times of intensive need, and provide avenues for ongoing support that promotes functioning and prevents negative outcomes.

THE IMPACT OF INTER-ORGANIZATIONAL FACTORS ON COLLABORATION

Given these three opportunities for collaboration between child welfare and mental health systems (home-based services, TFC, and group or residential care), what organizational or inter-organizational factors can be identified for understanding and strengthening the collaborative process? On-site partnership between the two service systems can increase the amount or quality of assistance, while a more informal inter-agency affiliation can introduce needed expertise at a lower cost. In general, service systems that actively negotiate with each other over time to ensure efficiency and goal attainment typically include three collaborative elements: (1) inter-agency structures, or mechanisms that address shared needs (e.g., pooled funding), (2) ongoing relationship processes designed to address environmental constraints such as insufficient resources or fragmentation of services (e.g., multi-agency task forces), and (3) use of a central authority (e.g., legislation) to manage networks of systems that actively negotiate with each other (Blau & Rabrenovic, 1991; Bolland & Wilson, 1994; Fleisher, 1991; Hasenfeld & Gidron, 1993; Mattessich & Monsey, 1992; Miller, Scott, Stage & Birkholt, 1995; Provan & Milward, 1995; Oliver, 1988; Reitan, 1998).

These three inter-organizational factors can be applied to the three opportunities for collaboration between child welfare and child mental health agencies. *Inter-agency structures* are critical in home-based services. Inter-disciplinary teams, for example, can prevent out-of-home care when child welfare staff rely on mental health expertise in improving family functioning and mental health staff rely on child welfare expertise in providing a stable home environment. The structures can foster relationship building, providing participating agencies with an *ongoing relationship process* for reducing service fragmentation and increasing coordinated assistance for families with multiple needs (Blau & Rabrenovic,1991; Bolland & Wilson, 1994; Fleisher, 1991; Hasenfeld & Gidron, 1993; Provan & Milward, 1995; Reitan, 1998). For example, child welfare and child mental health staff in several Northern California counties meet weekly to review potential "high end" placements (e.g., costly group care, residential care, treatment foster care). Typically, the members must first determine the appropriateness of a placement and then prevent the referral of any child to group care when treatment foster care or traditional foster care is a better option. An inter-agency case is also prepared in order to address the child's home stability and emotional

health. In some counties, the team also includes probation and school staff who attend to the child's legal and educational needs.

The last inter-organizational factor, a *centralized authority*, can be seen when legislation encourages child welfare and mental health collaboration in home-based preventive interventions. For example, children who are at risk of placement in a residential facility can use state foster care funding to access comprehensive, in-home services to families in California's wraparound program (2002). Establishing centrally-linked networks help staff to view the child more holistically and provide services that are more carefully planned to address individual needs as part of a single system of care.

The three inter-agency factors of inter-agency structures, relationship process, and use of a central authority can be employed to facilitate collaboration, as noted in Figure 1. In addition to placement prevention teams, child welfare and child mental health collaboration related to the home-based services provides an ongoing partnership where inter-disciplinary staff can increase advocacy for the funding of in-home family assistance. The inter-agency relationship process can also be developed, for instance, through the partnership between child welfare staff, community mental health providers, and family therapists as they help each other to preserve and reunify families. With respect to structures that promote alliance, blended funding provides an example whereby child welfare and child mental health agencies can access federal funds that exceed the amount available to each agency independently (Edelman, 1998). Much as legislation can reward inter-agency collaboration, the use of a central authority can be seen in cross-system oversight (e.g., overlapping boards of directors) where child welfare interests and child mental health interests are both represented.

Beyond home-based services, collaboration in the area of treatment foster care can be enhanced by placement review teams. The ongoing process of ensuring service access in the least restrictive setting can facilitate relationship-building as treatment foster care staff and child mental health assessment specialists together monitor the appropriateness of each treatment foster care placement. The treatment foster care homes are themselves examples of structures that promote child welfare and child mental health collaboration. In addition, inter-agency child welfare and child mental health oversight committees that maintain service standards (e.g., access, quality) exemplify the centralizing of authority needed to facilitate collaboration.

Relationship-building processes are also central to collaboration in group care services as reflected in placement review and case planning

FIGURE 1. Inter-Agency Factors That Facilitate Collaboration Between Child Welfare (CW) and Child Mental Health (CMH) Services

Inter-agency Factors ⟶	*Processes that foster collaboration*	*Structures that promote alliance*	*Central authority to facilitate integration*
Collaboration Opportunities:			
Home-Based Services (Family Preservation and Family Reunification)	CW and CMH placement prevention teams Shared CW and CMH advocacy for in-home assistance CW partnership with family and youth therapists and CMH service providers	Blended CW and CMH funding Increased funding dedicated to in-home inter-agency prevention	CW and CMW cross-agency board of director representation Legislation encouraging collaboration
Treatment Foster Care (TFC)	CW and CMH inter-agency placement review teams CW partnership with child mental health assessment specialists to ensure placement appropriateness	An increased capacity of TFC homes that by definition provide CW and CMH inter-agency assistance	Enhance TFC oversight with a committee that reviews service access and quality
Group Care	CW and CMH shared placement review and case planning Group care staff partnership with community mental health providers for additional assistance	Pooled CW and CMH funding dedicated to addressing the MH needs of the group care population	Full-time mental health clinician employment in child welfare services dedicated to the group care population

teams, or in enhanced access of group care staff to mental health staff networks. The structures that promote collaboration include the pooling of child welfare and mental health funding for this population of children. An example of the use of a central authority would be the employment of full-time mental health staff who are supervised by the child welfare agency.

PROVIDING A COLLABORATIVE PROCESS

There are multiple factors that motivate inter-agency collaboration. In the human services, Hasenfeld and Gidron (1993) suggest that collaboration between two organizations is motivated, in part, by the compatibility of their philosophies and goals. Clinically, child welfare and child mental health organizations share such similar values and philosophies as: (a) preventing out-of-home placement, hospitalization, or the escalation of psychological difficulties, (b) providing a continuum of care for different levels of client functioning, and (c) relying on case plans and periodic progress reviews. These shared philosophies can provide the foundation for inter-agency coordination as well as major themes for the cross-training of staff.

In addition to client-focused collaboration, child welfare and child mental health professionals share several administrative concerns. These include: (a) reducing recidivism related to reentries to out-of-home care in child welfare and repeated psychiatric hospitalizations in mental health, (b) addressing the increasing cost of out-of-home care in child welfare and costly inpatient services in mental health, (c) agreeing on the meaning of key terms such as competent parenting in child welfare or classifying behavior problems as children's disorder or temporary growing pains in mental health, (d) addressing service fragmentation, as occurs in foster care drift in child welfare or the disconnection between intake and treatment services in mental health, and (e) stabilizing funding and services to manage uncertainty or to obtain external resources (Fleisher, 1991; Perrucci & Lewis, 1989).

While these administrative concerns and services impact the collaboration between child welfare and child mental health professionals, successful partnerships may also require organizational change. For example, Mattessich and Monsey (1992) found that effective inter-agency relationships need to be facilitated through strategic changes processes. First, in order to build trust and understanding between the collaborators, it is necessary to set aside time at the beginning of the initiative for the members to become better acquainted by devoting adequate time and resources to developing ownership among all partners. Second, it is important to build incentives for partners to become and remain involved in the collaboration, such as the cost-savings and increased purchasing power resulting from pooled resources, and by fostering compromise and flexibility. Third, it is important to establish clear, attainable goals at the beginning of the collaborative alliance to ensure both short-term positive outcomes (to promote realistic expec-

tations and enthusiasm) and opportunities to report periodically on progress made.

Successful inter-agency relationships often require the resolution of conflicts between the demands of the collaborative alliance and the demands of each agency. For example, the child welfare team members need to address the conflicts between team participation and the multiple obligations to other families, the courts, coworkers, and supervisors. Similarly, mental health staff may need to introduce flexibility into their traditional working hours and environments in order to meet the immediate in-home needs of youth receiving family preservation or reunification services.

Effective collaboration between child welfare and child mental health professionals, therefore, requires trust, incentives, goals, and compromise. Once launched successfully, the collaboration process can consist of four developmental stages that include formation, conceptualization, development, and implementation (Flynn and Harbin, 1987). For example, an interagency team reviewing high-cost placements for maltreated youth (e.g., group homes, hospitals) might be composed, in the formation stage, of staff with different types of child welfare and mental health expertise. Their charge could be to search collectively for ways to prevent unnecessarily restrictive out-of-home placements for children experiencing emotional disturbance. In the second stage of collaboration, where goals and objectives are linked to desired outcomes, the interagency review team could set a goal of reducing the number of children who are placed in high-end foster care facilities by 50 percent. The goals are further defined in the third stage (development). In the fourth stage (implementation), the shared plans are enacted and outcomes are measured. The success of the effort can be gauged by assessing service accessibility (e.g., low to high) in a collaborative system, the magnitude of resource investment, the degree of organizational commitment (e.g., intensity of meetings, referrals), and the number of written agreements that reflect collaborative teamwork (Bolland and Wilson, 1994; Miller et al., 1995; Oliver, 1991).

In the light of the overlapping philosophies and shared concerns, it is also important to identify some of the barriers to collaboration.

POTENTIAL OBSTACLES TO COLLABORATION

Research on inter-agency collaboration has identified some of the factors that impede effective organizational relationships (Blau &

Rabinovic, 1991; Miller et al., 1995; Oliver, 1991). The most common barrier to collaboration is the desire for organizational autonomy and freedom to make decisions. For example, mental health staff may seek to function autonomously in order to limit the impact of child welfare regulations and case overload on the therapeutic relationship. Similarly, they may remain autonomous because they prefer the privacy of office-based service provision over the field-based service delivery of child welfare services (e.g., private homes, court).

In contrast, child welfare staff may also seek to retain their autonomy, given the lack of time, funding, and administrative support for collaboration with mental health staff. From a funding perspective, there could be a clash of organizational cultures whereby child welfare staff are funded on the basis of caseload, and mental health staff are funded on a fee-for-service basis. Given this environment of financial resource constraints, it is useful to explore the impact of financial decision-making on collaboration.

Contractual relationships represent one approach to managing scarce resources, and several authors have examined them (Bolland & Wilson, 1994; Fleisher, 1991; Hasenfeld & Gidron, 1993; Oliver, 1988; Reitan, 1998). For example, according to the principal-agent contracting approach (Bolland & Wilson, 1994; Reitan, 1998), a county child welfare agency (the principal) contracts with a mental health managed care organization, or MCO (agent), to assess the mental status of maltreated children upon entry into out-of-home care on the assumption that the agent is the most skilled resource to complete the task. However, in order to ensure that the agent is maximizing the principal's investment, the principal needs to clearly delineate the number of children to be assessed, the scope of the assessment, and the process for monitoring compliance in the contract.

The process of contracting involves transaction expenses that are evaluated in terms of their cost-effectiveness. Is it less expensive to contract with an MCO or develop internal capacity by hiring full-time mental health professionals to work in the child welfare agency? Incurring the costs for contracting may prove to be more effective if three conditions are met (Oliver, 1991). First, the investment should yield the highest quality of service. Second, it is helpful if there are other MCOs that can be utilized if contract expectations are not met. Finally, contracting seems to be more effective when there is a high degree of trust based on prior performance.

Irrespective of transaction costs, there may be other obstacles to collaboration. For example, child welfare staff may choose to remain autonomous because they feel that mental health assistance is not immediately necessary to provide services that promote safety, placement stability,

and resource access. Furthermore, the two agencies may not collaborate because of "turf" issues between different professional groups and/or the lack of knowledge across disciplines and service sectors (Reitan, 1993). Other potential obstacles to fostering inter-agency collaboration include new legislative mandates in one or both sectors, and difficulties in sharing information and protecting client confidentiality. Despite these obstacles, service providers and managers still face the challenge of providing holistic services to the children who need assistance with both child welfare and mental health issues.

IMPLICATIONS

Given the hardship that accompanies maltreatment and out-of-home placement, it is clear that many children living in foster care could benefit from supportive mental health services. When the emotional distress is inadequately addressed, the result can lead to school failure, group care placement, psychiatric hospitalization, or juvenile justice system involvement (The Little Hoover Commission, 2001). Even when mental health services are available, child welfare staff report that it is often only offered in the office, during traditional working hours, and in brief weekly sessions. Child mental health staff also report that they could benefit from an increased collaboration with child welfare professionals, especially when they have difficulty alleviating a child's anxiety about returning home to their families or dealing with the complexities of the child welfare placement process.

The most promising opportunities for child welfare and child mental health collaboration are in: (1) home-based services that preserve families or reunify them after a foster care placement, (2) services that address the emotional and behavioral needs of children in treatment foster care, and (3) group or residential care, for the children receiving this more custodial assistance experience typically a great deal of emotional distress. When the three collaboration opportunities are examined in relationship to the three domains of inter-organizational relations (alliance-promoting processes, structures, and authority), there are several ways to enhance the collaborative partnership without incurring the high cost of integrated service systems:

- Placement prevention teams, placement review teams, and inter-agency case planning committees can foster collaboration, as can increasing child welfare staff access to centrally linked networks of community

mental health staff or family and youth therapists (as well as probation and school staff to address legal and educational child needs).

- Alliance-promoting structures such as blended or pooled funding mechanisms can help to reduce service fragmentation and increase coordinated assistance for families with multiple needs.
- Collaboration can be enhanced by centralizing authority in legislation (e.g., the California "Wraparound" Program), in cross-agency board of director representation, or in an inter-agency project oversight committee.
- Partnership can be promoted when cross-training includes some of the shared administrative challenges, especially the need to control recidivism in foster care and hospitalization, and the shared values such as care continuity and placement in the least restrictive environment.
- Collaboration can be enhanced by providing ample room in the partnership for compromise and flexibility, by preserving the ability of each participating agency to make autonomous decisions, by establishing attainable goals at the beginning of the collaborative alliance, and by ensuring that there are short-term positive outcomes in order to promote realistic expectations and enthusiasm.
- Partnership can be facilitated by joint advocacy, especially for increased funds that comprehensively assist families experiencing multiple and severe problems (Fein & Staff, 1993).
- An inter-agency oversight committee can monitor the accessibility and quality of treatment foster care, and prevent the placement of children in group care or treatment foster care whose emotional needs could be addressed equally well in traditional foster care.
- The children who are distressed enough to require group or residential care can perhaps benefit the most from collaboration, and mental health clinicians need to be dedicated to serving these typically older children who are less likely to be adopted or reunified with their families.

CONCLUSION

As children living in foster homes must cope with a difficult family situation and out-of-home care, many of them could benefit from mental health services. However, this assistance is frequently not available due to separate funding for categorical services. The lack of help can

then lead to school failure, hospitalization, residential care placement, and/or juvenile and criminal justice system involvement. Increased collaboration between the two systems could help to prevent these negative outcomes by: (1) increasing the availability of mental health care, especially for more intensive assistance in nontraditional working hours and environments, and (2) actively sharing information about child welfare system processes with mental health clinicians who can help alleviate child anxiety about biological or foster family issues. While there are some tensions between the two systems, they share several common philosophies and concerns that can provide a natural incentive for collaboration in family-based services, treatment foster care, and group care. Partnership can be promoted by expanding child welfare and child mental health collaborative process (e.g., inter-agency case planning), structure (e.g., pooled funding), and central authority (e.g., legislation encouraging comprehensive care).

REFERENCES

Bickman, L. (1996). Implications of a children's mental health managed care demonstration evaluation. *Journal of Mental Health Administration*, *23*(1), 107-117.

Blau, J.R. & Rabrenovic, G. (1991). Interorganizational relations of nonprofit organizations: An exploratory study. *Sociological Forum*, *6*(2), 327-347.

Bolland, J.M. & Wilson, J.V. (1994). Three faces of integrative coordination: A model of interorganizational relations in community-based health and human services. *Health Services Research*, *29*(3), 341-366.

California's "Wraparound" Program (2001). Internet: http://www.emq.org/PressRoom/wrap_stats-simple.pdf

Chamberlain, P. (1996). Highlights of findings from the Oregon Social Learning Center TFC study. *Treatment Foster Care On Line*. Internet: http://www.oslc.org/~marke/tfcstudy.html

Edelman, S. (1998). Developing Blended Funding Programs for Children's Mental Health Care Systems: California Institute for Mental Health. Internet: http://smhp.psych.ucla.edu/smph.exe?ACTION=POPUT&ITEM=1404DOC51

Fabella, D. (Personal communication, Spring, 1998).

Fein, E. & Staff, I. (1993). Last best chance: findings from a reunification services program. *Child Welfare*, *72*(1), 25-40.

Fine, P. (1993). *A developmental network approach to therapeutic foster care*. Washington, D.C.: Child Welfare League of America.

Fleisher, C.S. (1991). Using an agency-based approach to analyze collaborative federated interorganizational relationships. *Journal of Applied Behavioral Science*, *27*(1), 116-130.

Flynn, C.C. & Harbin, G.L. (1987). Evaluating interagency coordination efforts using a multidimensional, interactional, developmental paradigm. *RASE*, *8*(3), 35-44.

Garland, A.F., Landsverk, J.L., Hough, R.L. & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect*, *20*(8), 675-688.

Halfon, N., Berkowitz, G. & Klee, L. (1992). Mental health service utilization by children in foster care in California. *Pediatrics*, *89*(6), 1238-1244.

Hasenfeld, Y. & Gidron, B. (1993). Self-help groups and human service organizations: An interorganizational perspective. *Social Service Review*, *67*(2), 217-236.

The Little Hoover Commission (2001). *Young Hearts & Minds: Making a Commitment to Children's Mental Health*. Internet: http://www.bsa.ca.gov/lhcdir/161/report161.pdf

Mattessich, P.W. & Monsey, B.R. (1992). *Collaboration: What Makes It Work*. St. Paul, Minnesota: Amherst H. Wilder Foundation.

Meadowcroft, P., Thomlison, B. & Chamberlain, P. (1994). Treatment foster care services: A research agenda for child welfare. *Child Welfare*, *73*(5), 565-581.

Miller, K., Scott, C.R., Stage, C. & Birkholt, M. (1995). Communication and coordination in an interorganizational system: Service provision for the urban homeless. *Communication Research*, *22*(6), 679-699.

Oliver, C. (1991). Network relations and loss of organizational autonomy. *Human Relations*, *44*(9), 943-961.

Oliver, C. (1988). The collective strategy framework: An application to competing preconditions of isomorphism. *Administrative Science Quarterly*, *33*, 543-561.

Perrucci, R. & Lewis, B.L. (1989). Interorganizational relations and community influence structure: A replication and extension. *The Sociological Quarterly*, *30*(2), 205-223.

Prince, J.D. & Austin, M.J. (1998). *Linking child welfare and child mental health services: Challenges and opportunities*. The Bay Area Social Services Consortium, University of California, Berkeley.

Provan, K.G. & Milward, H.B. (1995). A preliminary theory of interorganizational network effectiveness: A comparative study of four community mental health systems. *Administrative Science Quarterly*, *40*, 1-33.

Quinn, K.P., Epstein, M.H., Dennis, M.S., Potter, K., Sharma, J., McKelvey & Cumblad, C. (1996). Personal, family, and service utilization characteristics of children served in an urban family preservation environment. *Journal of Child and Family Studies*, *5*(4), 469-486.

Reddy, L.A. & Pfeiffer, S.I. (1997). Effectiveness of treatment foster care with children and adolescents: A review of outcome studies. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*(5), 581-588.

Reitan, T.C. (1998). Theories of interorganizational relations in the human services. *Social Service Review*, September, 285-309.

Rzepnicki, T., Schuerman, J.R. & Johnson, P.R. (1997). Facing uncertainty: Reuniting high-risk families. In Berrick, J.D., Barth, R.P., & Gilbert, N. (Eds.) *Child Welfare*

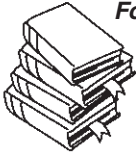*Research Review, Volume Two* (pp. 229-251). New York: Columbia University Press.

Scannapieco, M. (1994). Home-based services program: Effectiveness with at risk families. *Children and Youth Services Review, 16*(5/6), 363-377.

Spars, J. (Personal communication, Spring, 2001).

Westat, Inc. (1995). *A review of family preservation and family reunification programs*. Internet: http://aspe.os.dhhs.gov/hsp/cyp/fpprogs.htm