

Integrating Child Welfare and Behavioral Health Services: A Multidisciplinary Approach to Improving Outcomes for Children in Foster Care

Abstract

Children in foster care represent one of the most vulnerable groups within child welfare and social care systems. Many children enter foster care following experiences of abuse, neglect, family instability, domestic violence, parental substance misuse, poverty, loss, or other forms of adversity. These experiences can affect emotional wellbeing, psychological development, physical health, educational participation, behavior, attachment and relationships. Despite the complexity of these needs, child welfare and behavioral health services are frequently delivered through separate systems, creating fragmented assessment, referral, treatment and follow-up processes. This article examines the importance of integrating child welfare and behavioral health services through a multidisciplinary approach to improve outcomes for children in foster care. It explores the behavioral health needs of children in foster care, the importance of trauma-informed care, the roles of multidisciplinary professionals, the contribution of integrated assessment and case planning, technological opportunities, implementation barriers and international best practices. Evidence indicates that children in foster care experience disproportionately high levels of mental-health difficulties and that coordinated models can improve access to services, strengthen communication and support better health and behavioral outcomes. Recent research identifies practical strategies including co-location of professionals, joint supervision, referral protocols, expedited access arrangements, shared decision-making and data sharing. The article proposes a seven-pillar framework centred on child participation, trauma-informed care, integrated assessment, multidisciplinary collaboration, caregiver engagement, digital coordination and continuous evaluation. The article argues that effective integration should not merely bring professionals together administratively; it should create a genuinely child-centred system in which the child's safety, emotional wellbeing, physical health, education, relationships, identity and future are addressed as interconnected dimensions of wellbeing. Strengthening collaboration between child welfare and behavioral health systems is therefore essential for creating more responsive, humane and effective services for children living in foster care.

Keywords: *Child Welfare, Foster Care, Behavioral Health, Mental Health, Multidisciplinary Approach, Trauma-Informed Care, Child Wellbeing, Care Coordination, Social Work*

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I. INTRODUCTION

1.1 Background to Child Welfare and Foster Care

Foster care constitutes a significant component of contemporary child welfare systems and is primarily intended to provide children with safety, stability and appropriate caregiving when remaining in their biological or primary homes is no longer considered safe or feasible. Children may enter foster care following experiences of abuse, neglect, abandonment, domestic violence, parental substance misuse, severe parental mental-health difficulties, incarceration, homelessness, chronic family instability or other circumstances that threaten their safety and healthy development. In principle, foster care is designed to provide a protective environment while longer-term decisions concerning reunification, kinship care, guardianship, adoption or another form of permanency are considered. However, the experience of entering care is often much more complicated from the child's perspective. Removal from home can involve separation from parents, siblings, relatives, friends, teachers, neighbourhoods, schools and familiar routines. Thus, although foster care can protect a child from an unsafe environment, the transition into care can simultaneously introduce another form of loss, uncertainty and emotional disruption.

The importance of child welfare must be understood within the broader problem of child maltreatment. The World Health Organization (WHO, 2024) identifies child maltreatment as a major public health and social welfare concern involving physical or emotional ill-treatment, sexual abuse, neglect, negligent treatment and exploitation that results in actual or potential harm to a child's health, development, dignity or survival. Importantly, maltreatment is not simply an isolated childhood experience with temporary consequences. Evidence

indicates that exposure to violence, abuse and neglect can have enduring effects on physical health, mental health, learning, social relationships and later functioning. The WHO reports that child maltreatment is associated with impaired lifelong physical and mental health and can contribute to adverse social and occupational outcomes later in life.

The scale of the problem further demonstrates why child welfare should be approached as both a social protection and public health responsibility. The WHO (2024) reports that approximately six in ten children under five years of age around 400 million children globally—regularly experience physical punishment and/or psychological violence from parents and caregivers. The organization also notes that child maltreatment is frequently hidden, meaning that only a proportion of affected children ever come into contact with professionals who can identify their experiences and provide appropriate support. This hidden nature of maltreatment creates an important challenge for child welfare systems because children may enter formal care only after experiencing prolonged exposure to adverse conditions. By the time a child is removed from an unsafe environment, the consequences may already be reflected in emotional distress, developmental difficulties, behavioral changes, educational disruption and difficulties forming trusting relationships.

For a child, therefore, entering foster care should not be understood merely as a change of residence. It can represent a profound transition in the child's social and emotional world. A child may simultaneously experience relief from an unsafe home, grief over separation from loved ones, fear about the future and uncertainty about whether the new placement will be permanent. These apparently contradictory emotions can coexist. A child may feel safer physically while still feeling emotionally insecure. Similarly, a child may display difficult or withdrawn behavior not because the child is inherently problematic, but because the behavior represents an attempt to communicate fear, confusion, grief or a learned response to previous experiences.

The American Academy of Pediatrics (AAP) emphasizes that children and adolescents entering foster care frequently present with complex medical, mental-health, developmental, oral-health and psychosocial needs associated with childhood trauma and adversity. The AAP has consequently recognized children in foster care as a population with special healthcare needs requiring more intensive monitoring, coordination and advocacy. Earlier AAP evidence indicates that a substantial proportion of children entering foster care have significant mental-health needs, while many also experience physical health conditions, developmental difficulties and educational challenges.

These needs rarely exist independently. A child experiencing untreated trauma may have difficulty concentrating at school; poor concentration may affect academic performance; academic difficulties may reduce self-esteem; low self-esteem may influence peer relationships; and repeated placement changes may further intensify emotional insecurity. Similarly, a child with a chronic physical health condition may experience additional distress when moved between caregivers if medical information, medication routines or treatment plans are not transferred effectively. This interconnectedness demonstrates why a single-discipline response is often insufficient for children in foster care.

The experience of placement itself is another important consideration. Foster care is intended to create stability, yet children may experience multiple changes of placement, caregivers, schools and social environments. Each transition may require the child to adapt to unfamiliar adults, rules, routines and expectations. A systematic review by Maguire et al. (2024) found evidence that placement instability is associated with adverse emotional and behavioral outcomes, particularly externalizing behavior, while also identifying associations with internalizing difficulties and post-traumatic stress symptoms. Although the authors caution that the strength of the relationship varies across studies and that methodological differences limit direct comparisons, the review nevertheless highlights the psychological significance of stability and relational permanence for children in care.

This issue is particularly important because relationships are central to children's development. Children need dependable adults who respond consistently to their emotional and physical needs. When a child has experienced repeated disruptions in caregiving, developing trust may become difficult. Some children may become withdrawn and avoid emotional closeness, whereas others may seek excessive reassurance or display behaviors that adults find difficult to understand. Such behaviors can be interpreted negatively if professionals focus only on observable conduct without considering the child's developmental and relational history. A trauma-informed approach instead asks what the child may have experienced and what the behavior might be communicating.

The AAP similarly notes that children in foster care may have histories of complex or ongoing trauma, including abuse and neglect, parental absence, family violence, parental substance misuse, parental mental-health difficulties and repeated changes in caregivers. Importantly, the organization observes that removal from familiar surroundings, ongoing separation and uncertainty associated with foster care can compound previous trauma and loss. (AAP) This suggests that foster care should not merely prevent further harm; it should actively create conditions in which children can experience healing, stability and healthy development.

Consequently, the purpose of foster care extends beyond providing food, clothing and physical shelter. A high-quality foster-care environment should provide predictable routines, responsive caregiving, emotional security, appropriate healthcare, educational support and opportunities for children to develop healthy

relationships. Children should also be supported in maintaining safe and meaningful relationships with siblings, biological parents and extended family members where appropriate and consistent with their safety and welfare. Such relationships can contribute to continuity of identity and belonging, particularly for children whose lives have already been disrupted by removal from home.

Healthcare is particularly important during the transition into foster care. The AAP recommends that children entering foster care receive timely health assessment and ongoing monitoring because many health needs may be previously unidentified or inadequately treated. Its guidance emphasizes the importance of coordinated care involving pediatricians, child welfare professionals, caregivers and mental-health practitioners. This is significant because a child's medical, psychological and social circumstances often overlap. For example, sleep difficulties may be associated with anxiety or trauma; behavioral changes may be related to medication or an underlying health condition; and poor school attendance may reflect both emotional distress and physical illness.

Mental and behavioral health deserves particular attention. The AAP describes mental and behavioral health as one of the largest unmet health needs among children and adolescents in foster care. It emphasizes the importance of stable, nurturing caregivers and continuity of mental-health services. Yet access to such services can be disrupted by placement changes, difficulties obtaining consent, insurance or funding barriers, workforce shortages and weak communication between agencies. Consequently, simply identifying that a child requires psychological support does not guarantee that the child will receive timely or continuous treatment.

This is where the integration of child welfare and behavioral health becomes particularly important. Child welfare professionals may possess detailed information about a child's family history, placement experiences, safety concerns and permanency objectives, while psychologists and behavioral health professionals may have specialized knowledge concerning trauma, emotional regulation, attachment and therapeutic intervention. Pediatricians can identify physical and developmental needs, teachers can provide information about educational and social functioning, and foster caregivers can describe the child's everyday behavior and adjustment. Each professional therefore sees a different part of the child's life. Without communication, these perspectives remain fragmented; with effective collaboration, they can form a more complete understanding of the child.

Integration is consequently not simply a matter of having several professionals involved in the same case. It involves establishing mechanisms through which professionals communicate, share appropriate information, coordinate assessments, develop common goals and monitor progress collectively. The AAP emphasizes care coordination and advocacy as essential components of healthcare for children in foster care, particularly because their lives may involve multiple caregivers and professionals and frequent transitions.

A humanistic approach is equally important. Children in foster care should not be reduced to diagnoses, case files, placement numbers or behavioral descriptions. Behind every case is an individual child with a personal history, relationships, fears, abilities, hopes and aspirations. A child who repeatedly asks whether they will be moved again may be communicating a need for security. A child who refuses to speak with a therapist may be protecting themselves from another unfamiliar adult. A teenager who appears indifferent to school may be responding to years of instability rather than lacking ambition. Understanding these behaviors requires professionals to see the child as a whole person rather than as a collection of problems.

The ultimate purpose of foster care should therefore be broader than protection from immediate danger. It should provide an environment in which children can recover from adversity, experience stable and supportive relationships, participate meaningfully in decisions affecting their lives, maintain important connections where safe, succeed educationally and develop confidence in their future. Protection is the foundation, but wellbeing, belonging and development are the broader goals.

In this context, integrating child welfare and behavioral health services becomes a necessary component of effective foster-care practice. When social workers, psychologists, psychiatrists, pediatricians, educators, caregivers and community professionals work collaboratively, they are better positioned to identify interconnected needs and respond to them in a coordinated manner. The goal is not simply to treat symptoms after they appear, but to create a supportive environment in which children have opportunities to heal and thrive.

Thus, foster care should be understood not as the endpoint of a child-protection intervention but as a critical period during which coordinated support can influence the child's developmental trajectory. The quality of relationships, continuity of care, stability of placement and accessibility of behavioral health services can all shape how children experience life after removal from an unsafe environment. An effective child welfare system must therefore ask not only "Is the child safe?" but also "Is the child emotionally secure, physically healthy, heard, supported, connected and hopeful about the future?" These broader questions provide the foundation for integrating child welfare and behavioral health services around the needs of the whole child.

1.2 Behavioral Health and Children in Foster Care

Behavioral health encompasses mental health, emotional wellbeing, psychological functioning and behaviors that influence health and social relationships. For children in foster care, behavioral health is particularly important because many have experienced adverse circumstances that can affect emotional regulation, attachment, trust, self-esteem and interpersonal relationships.

A systematic review by Engler et al. (2022) examined the mental-health disorders experienced by children in foster care and demonstrated the substantial burden of psychological difficulties within this population. The review considered disorders such as depression, anxiety, post-traumatic stress, conduct-related problems and attachment-related difficulties, while also examining the influence of maltreatment and placement-related factors.

Behavioral difficulties should nevertheless not automatically be interpreted as evidence of a psychiatric disorder. A child's aggression, withdrawal, poor concentration or emotional outbursts may represent an understandable response to fear, grief, instability or previous trauma. Professionals therefore need to understand what may have happened to the child rather than focusing exclusively on what appears to be wrong with the child. This perspective supports the development of trauma-informed behavioral health services that recognize the child's history while also identifying strengths, protective factors and opportunities for recovery.

1.3 Child Welfare and Behavioral Health Systems

Child welfare and behavioral health systems have different institutional responsibilities. Child welfare agencies primarily focus on child protection, safety, placement, family relationships and permanency. Behavioral health services focus on psychological assessment, diagnosis, treatment, emotional wellbeing and behavioral functioning.

Although these responsibilities are distinct, they are deeply interconnected in the lives of children in foster care. A child's mental health can influence placement stability, while placement instability can affect mental health. Family contact can influence emotional wellbeing, while emotional difficulties can affect relationships with caregivers and siblings.

Unfortunately, separate administrative structures can create fragmented services. Children may undergo repeated assessments, caregivers may have to communicate with several agencies, and professionals may develop treatment plans without access to important information held by other services.

Bunger et al. (2024) found that cross-system interventions involving child welfare and behavioral health can be strengthened through practical strategies including contracting for expertise, joint supervision, co-location, referral protocols, expedited access agreements, shared decision-making meetings and data sharing.

1.4 Multidisciplinary Approach to Child Welfare

A multidisciplinary approach to child welfare involves the coordinated participation of professionals from different fields in identifying, assessing and responding to the complex needs of children and families. Child welfare concerns rarely occur in isolation; rather, they may involve interconnected social, psychological, medical, educational, legal, economic and family-related factors. Consequently, no single professional is likely to possess all the knowledge and skills required to address the full range of challenges experienced by a child in foster care. A multidisciplinary approach therefore brings together professionals with different areas of expertise to develop a more comprehensive understanding of the child's circumstances and to provide coordinated interventions.

Depending on the child's needs and the nature of the case, a multidisciplinary team may include social workers, psychologists, psychiatrists, paediatricians, nurses, occupational and speech therapists, teachers and other educational professionals, foster carers, biological parents or relatives, lawyers, case managers, child protection officers, law enforcement personnel and representatives of community-based organisations. Each professional contributes a particular perspective to the assessment and care process. For example, a social worker may assess the child's family circumstances, safety and placement needs; a paediatrician may identify physical health problems; a psychologist or mental-health professional may assess emotional and behavioural difficulties; while an educator may provide information about learning, school attendance and educational progress. Legal professionals may provide guidance on custody, protection orders and other legal matters, while foster carers contribute valuable day-to-day observations concerning the child's behaviour, relationships and adjustment.

The purpose of multidisciplinary practice is not simply to increase the number of professionals involved in a child's case. Its central objective is to integrate different forms of knowledge and professional expertise around a shared understanding of the child's needs. Effective collaboration allows professionals to exchange relevant information, identify risks and protective factors, avoid unnecessary duplication of services and develop intervention plans that address the child holistically. Where professionals operate independently without adequate communication, important information may be overlooked, resulting in fragmented services or inconsistent decisions. In contrast, coordinated multidisciplinary practice can improve continuity of care and ensure that interventions provided by different agencies complement rather than contradict one another.

Multidisciplinary collaboration is particularly important in foster care because children entering care may have experienced multiple forms of adversity before placement. These experiences can include abuse, neglect, abandonment, domestic violence, parental substance misuse, family instability, separation from caregivers and repeated changes in living arrangements. Such experiences may affect physical health, emotional wellbeing, behaviour, educational achievement and the child's ability to form secure relationships. A comprehensive assessment therefore requires professionals to consider not only the immediate reason for placement but also the

child's developmental history, family relationships, health status, educational needs and long-term permanency options.

Healthcare professionals play an important role within this multidisciplinary framework. Children in foster care may have unmet physical and mental-health needs that require early identification and continuing monitoring. Paediatricians and nurses can contribute to health assessments, immunisation reviews, developmental monitoring, treatment and referrals to specialist services. Mental-health professionals can assess trauma, anxiety, depression, behavioural difficulties and other psychosocial concerns, while therapists may provide interventions aimed at improving emotional regulation, communication, attachment and functioning. Integrating healthcare information with social-work and educational assessments allows the team to develop a more complete picture of the child's wellbeing.

The American Academy of Pediatrics (AAP) recognises team-based care as an important feature of effective healthcare services for children and adolescents in foster care. Its approach highlights the value of coordination between child welfare personnel, healthcare providers, mental-health professionals and community resources. Such collaboration can support the identification of health needs, facilitate appropriate referrals and promote continuity of care when children move between placements or services. This is particularly significant because changes in foster placement can result in changes of healthcare providers, schools and other support systems, making communication between professionals essential for maintaining consistent care.

Education is another important component of multidisciplinary child welfare practice. Children in foster care may experience interrupted schooling, poor attendance, learning difficulties or changes in educational placement. Teachers and school counsellors can provide information about academic performance, classroom behaviour, peer relationships and social adjustment. Collaboration between schools and child welfare professionals can help ensure that educational difficulties are recognised alongside other welfare concerns. Educational professionals may also contribute to individualised support plans and help maintain educational continuity when a child changes foster placement.

Foster carers and biological family members should also be regarded as important participants in multidisciplinary practice. Foster carers have direct knowledge of the child's everyday experiences and can provide information about routines, behaviour, emotional responses, relationships and adjustment to placement. Where it is safe and appropriate, biological parents and relatives can contribute information about the child's developmental history, cultural background, family relationships and previous care experiences. Their involvement can support family-centred decision-making and, where reunification is the agreed permanency goal, help strengthen relationships and facilitate the child's transition back to family care.

Effective multidisciplinary practice also requires clear communication, defined responsibilities and respect for professional boundaries. Team members need to understand who is responsible for particular aspects of the child's care, how information should be shared and how disagreements will be managed. Regular case conferences, joint assessments, shared care plans and appropriate information-sharing procedures can strengthen coordination. At the same time, professionals must protect confidentiality and ensure that information is shared ethically and only where necessary for safeguarding and promoting the child's welfare.

A further strength of multidisciplinary practice is that it supports early identification of problems. When professionals from different sectors communicate regularly, changes in a child's physical health, emotional state, behaviour, school performance or relationships may be identified more quickly. Early intervention can prevent relatively manageable difficulties from developing into more serious problems. For example, a teacher who notices a sudden decline in classroom participation may alert the social worker, who can coordinate with a mental-health professional to determine whether the change is related to trauma, placement instability, bullying or another underlying issue.

Despite its advantages, multidisciplinary practice can face challenges. Differences in professional priorities, organisational procedures, terminology and approaches to risk assessment may create disagreements. High workloads, inadequate staffing, limited funding, poor communication systems and unclear responsibilities can also undermine collaboration. In some cases, professionals may work within separate institutional structures, making information sharing and coordinated decision-making difficult. These challenges demonstrate that simply bringing professionals together does not automatically produce effective multidisciplinary practice. Successful collaboration requires organisational support, professional trust, clear communication mechanisms, appropriate training and strong leadership.

Ultimately, a multidisciplinary approach places the child's welfare at the centre of decision-making. It recognises that children in foster care have interconnected physical, emotional, developmental, educational, social and legal needs that cannot always be addressed through a single service. By bringing together complementary forms of expertise, multidisciplinary teams can improve assessment, strengthen case planning, promote continuity of care and support better developmental and permanency outcomes. The approach is therefore an important foundation for a child-centred welfare system in which decisions are informed by a broad understanding of the child's circumstances and guided by the principles of safety, stability, participation, wellbeing and long-term development.

1.5 Problem Statement

Children in foster care frequently experience multiple and interconnected health, psychological, developmental and social challenges. However, child welfare and behavioral health services may operate through fragmented structures in which professionals assess and treat children separately.

Fragmentation can lead to delayed referrals, inconsistent information, repeated assessments, poor communication, difficulties accessing treatment and weak continuity of care. These problems may be particularly damaging for children who already have histories of disrupted relationships and instability.

The problem is therefore not simply a lack of behavioral health services. In many circumstances, the deeper challenge is the failure to connect available services around the individual child.

Recent evidence indicates that integrated healthcare can reduce barriers, improve coordination and potentially improve health outcomes for young people in foster care, although researchers continue to identify the need for stronger evidence regarding the most effective and sustainable models (Quick et al., 2026).

1.6 Objectives of the Article

The broad objective of this article is to examine the integration of child welfare and behavioral health services as a multidisciplinary approach to improving outcomes for children in foster care.

The specific objectives are to:

1. Examine the behavioral health needs of children in foster care.
2. Explain the importance of integrating child welfare and behavioral health services.
3. Examine the roles of multidisciplinary professionals in foster-care service delivery.
4. Assess the contribution of trauma-informed and child-centred approaches.
5. Identify barriers affecting integrated child welfare and behavioral health services.
6. Examine technological opportunities for improving service coordination.
7. Propose a multidisciplinary framework for improving outcomes for children in foster care.

1.7 Significance of the Article

This article is significant because it shifts attention from fragmented service delivery toward coordinated, child-centred care. For social workers and child welfare practitioners, it emphasizes the importance of recognizing behavioral health as part of child protection and permanency planning.

For healthcare and behavioral health professionals, it highlights the importance of understanding the child's placement, family and social circumstances when providing treatment.

For foster and kinship caregivers, integrated care can reduce the burden of navigating multiple systems and provide clearer access to support.

For policymakers, the article demonstrates the importance of developing funding, workforce, data-sharing and accountability structures that support collaboration between child welfare and behavioral health organizations.

Ultimately, the greatest significance is for children themselves. A child who has already experienced instability should not be expected to navigate another fragmented system in order to receive help.

II. CONCEPTUAL AND THEORETICAL FRAMEWORK

2.1 Concept of Foster Care

Foster care refers to an arrangement in which children who cannot safely remain in their original homes receive care from approved alternative caregivers. Depending on the circumstances, foster placements may involve unrelated foster parents, relatives, kinship caregivers or other approved arrangements.

Foster care is generally intended to provide safety and stability while decisions are made concerning reunification, guardianship, adoption or another permanency arrangement. However, the quality of foster care depends not only on physical safety but also on the child's emotional security, relationships and developmental needs.

Children require more than shelter and food. They need adults who can provide predictable care, emotional responsiveness, encouragement and a sense of belonging.

2.2 Concept of Child Welfare

Child welfare encompasses policies, institutions, professionals and services concerned with protecting children from abuse and neglect while promoting their safety, development and wellbeing.

Effective child welfare requires a balance between protection and family support. Removing a child from an unsafe environment may be necessary, but intervention should also consider the child's relationships, identity and long-term developmental needs.

The WHO (2026) emphasizes that child maltreatment has consequences extending beyond immediate physical injury, affecting mental health, cognitive development, educational performance and later behavioral outcomes.

2.3 Concept of Behavioral Health

Behavioral health refers broadly to emotional, psychological and behavioral wellbeing. In foster care, it includes the identification and treatment of mental-health difficulties as well as promotion of resilience, emotional regulation, healthy relationships and adaptive coping.

Behavioral health services may involve psychological assessment, counseling, psychotherapy, psychiatric care, family interventions, behavioral interventions and psychosocial support.

An effective approach should avoid viewing children exclusively through diagnostic categories. Behavioral health should also consider the child's developmental stage, relationships, culture, experiences and strengths.

2.4 Trauma-Informed Care

Trauma-informed care recognizes that previous experiences of abuse, neglect, violence, loss and instability can affect the way children perceive relationships, authority, safety and their own emotions.

The WHO (2026) identifies child maltreatment as a major source of long-term physical and mental-health consequences and emphasizes prevention and appropriate support for affected children and families.

Trauma-informed care therefore seeks to promote safety, trust, collaboration, empowerment and choice. Professionals should avoid unnecessarily forcing children to repeatedly recount painful experiences and should explain procedures in ways that children can understand.

2.5 Multidisciplinary Care

Multidisciplinary care involves professionals from different areas contributing to the assessment and support of a child. The central principle is shared responsibility.

The 2024 study by Bunker et al. demonstrated that multidisciplinary collaboration can be operationalized through specific organizational mechanisms rather than informal communication alone. These mechanisms include joint supervision, co-location, referral pathways, expedited access, shared decision-making and data sharing.

2.6 Child-Centred Practice

Child-centred practice places the child's wellbeing, voice, dignity and developmental needs at the centre of decision-making.

Children should not be reduced to case numbers or diagnoses. Their interests, fears, friendships, cultural identities, aspirations and relationships are important components of care.

Recent research on narrative interventions in foster care similarly emphasizes identity, belonging and resilience as important dimensions of children's experiences and therapeutic support (2026).

III. BEHAVIORAL HEALTH NEEDS OF CHILDREN IN FOSTER CARE

3.1 Mental Health Problems

Children in foster care have elevated behavioral and mental-health needs compared with many children in the general population. Engler et al. (2022) synthesized research on mental-health disorders among children in foster care and identified a substantial burden of psychological difficulties.

These difficulties may include anxiety, depression, trauma-related symptoms, behavioral disorders, attachment difficulties and problems with emotional regulation. The presentation varies according to age, developmental stage, previous experiences and placement circumstances.

Mental-health screening should therefore form part of comprehensive foster-care assessment. However, screening must be followed by appropriate access to services. Identifying a problem without providing treatment may create another form of system failure.

3.2 Trauma and Adverse Childhood Experiences

Trauma is a central consideration in foster care. Children may have experienced multiple forms of adversity before entering care.

Child maltreatment can affect brain development, emotional functioning, learning and later behavioral health. The WHO (2026) notes associations between maltreatment and depression, anxiety, post-traumatic stress, substance misuse, poor educational outcomes and other long-term difficulties.

For this reason, professionals should avoid interpreting children's behavior without considering the circumstances surrounding it.

3.3 Attachment and Relationship Difficulties

Children who experience disrupted caregiving may find it difficult to trust adults. Some may become excessively dependent on caregivers, while others may avoid closeness.

Placement changes can intensify these difficulties because every move can require the child to establish new relationships.

Behavioral health interventions should therefore pay attention to relationships rather than focusing exclusively on individual symptoms.

3.4 Educational and Developmental Challenges

Maltreatment and instability can affect children's concentration, learning, school attendance and academic performance. The WHO identifies violence against children as an important contributor to educational inequality. Consequently, education professionals should form part of multidisciplinary care where educational difficulties are present.

3.5 Substance Use and Risk Behaviors

Older children and adolescents in care may face increased vulnerability to substance use and other risk behaviors, particularly where they have experienced trauma, social disadvantage or weak support networks.

Behavioral health services should therefore combine treatment with prevention, life-skills development, positive peer relationships and opportunities for meaningful participation in education and community life.

IV. INTEGRATING CHILD WELFARE AND BEHAVIORAL HEALTH SERVICES

4.1 Integrated Assessment

Integrated assessment means that professionals collectively examine the child's physical, psychological, developmental, educational, family and social needs.

Rather than requiring a child to complete several unrelated assessments, information should be shared appropriately so that professionals can develop a coherent understanding of the child.

The AAP emphasizes coordinated healthcare and communication among caregivers and professionals involved in the child's life.

4.2 Integrated Case Planning

Integrated case planning is an important component of effective child welfare practice because it provides a structured framework for coordinating the different services required to meet a child's needs. Rather than treating each area of the child's welfare separately, an integrated case plan brings together safety, health, education, family relationships, placement stability and behavioural or mental-health support within a single coordinated framework. This enables professionals to develop a comprehensive understanding of the child's circumstances and establish clear priorities for intervention.

A shared case plan should begin by identifying the child's immediate safety needs. This involves assessing whether the child is exposed to any continuing risks of abuse, neglect, exploitation, violence or instability and determining the measures required to maintain safety. The plan should also identify the child's mental-health concerns, including emotional distress, trauma-related symptoms, anxiety, depression, behavioural difficulties and other psychological needs that may require assessment or intervention.

Physical-health needs should form another important component of the case plan. This may include routine medical assessments, immunisations, developmental monitoring, treatment of existing health conditions and referrals to specialist healthcare services where necessary. Educational needs should also be clearly documented, particularly where the child has experienced disrupted schooling, learning difficulties, poor attendance or changes in educational placement. Specific educational objectives can help professionals monitor academic progress and ensure that changes in foster placement do not unnecessarily interrupt the child's education.

The case plan should further establish clear placement objectives. These may involve maintaining the child's current foster placement, identifying a more suitable placement, supporting reunification with biological family members, considering kinship care or pursuing another appropriate permanency arrangement. Family relationships should also be addressed, including contact with parents, siblings and other significant relatives where such contact is safe and consistent with the child's best interests. Maintaining meaningful relationships can contribute to children's emotional security, identity and sense of belonging.

Behavioural-health interventions should be incorporated into the overall plan rather than being treated as a separate service. Depending on the child's circumstances, interventions may include psychological assessment, trauma-informed counselling, behavioural support, therapeutic services, family interventions or other appropriate forms of psychosocial care. The case plan should also recognise the support needs of foster caregivers. Caregivers may require training, respite services, counselling, financial assistance or guidance on managing challenging behaviours and responding appropriately to children who have experienced trauma.

An effective integrated case plan should clearly identify the professionals responsible for each aspect of intervention. Assigning responsibilities helps prevent duplication of services and ensures accountability. Social workers, healthcare professionals, mental-health practitioners, educators, foster carers and other relevant stakeholders should understand their respective roles and communicate regularly about the child's progress. The plan should also include measurable indicators of progress so that interventions can be reviewed over time. These indicators may relate to improvements in emotional wellbeing, school attendance, physical health, behavioural adjustment, placement stability, family relationships and achievement of permanency goals.

Overall, integrated case planning prevents behavioural health from becoming an isolated component of the child's welfare plan. Instead, behavioural and mental-health needs are considered alongside safety, physical health, education, placement, family relationships and caregiver wellbeing. This coordinated approach promotes continuity of care, improves communication among professionals and increases the likelihood that interventions will respond to the child as a whole rather than addressing individual problems in isolation.

4.3 Social Workers

Social workers often serve as the central coordinating professionals within child welfare systems. They may understand the child's placement history, family circumstances, legal situation and permanency objectives. Their role should include facilitating communication between agencies, advocating for the child, monitoring placement stability and ensuring that behavioral health recommendations are incorporated into broader care planning.

4.4 Psychologists and Mental-Health Professionals

Psychologists, therapists, psychiatrists and behavioral health practitioners provide specialist assessment and intervention.

However, their work is more effective when they understand the child's broader environment. A therapist should know, where appropriate, whether the child has experienced placement changes, family separation or school disruption.

4.5 Pediatricians and Healthcare Professionals

Healthcare professionals can identify developmental, neurological, physical and behavioral concerns that may otherwise be interpreted solely as social or psychological problems.

The AAP's foster-care guidance emphasizes comprehensive, continuous, coordinated and compassionate care and identifies multidisciplinary relationships as important features of effective service delivery.

4.6 Foster and Kinship Caregivers

Caregivers should be treated as partners rather than passive recipients of professional instructions.

They observe children in everyday situations and can provide important information about sleep, appetite, emotional regulation, behavior, medication adherence, school participation and relationships.

Caregiver training should include trauma-informed parenting, emotional regulation, positive behavior support and knowledge of available services.

4.7 Schools and Educators

Schools are important settings for identifying changes in behavior and learning.

Teachers may observe withdrawal, aggression, poor concentration, attendance difficulties or social isolation. Collaboration between schools, child welfare and behavioral health professionals can help ensure that educational problems are understood within the child's broader circumstances.

V. IMPACT OF MULTIDISCIPLINARY INTEGRATION ON CHILD OUTCOMES

5.1 Improved Mental Health

Integrated models can improve access to behavioral health assessment and evidence-based interventions.

The Partnering for Success model provides an important example. The model combined cross-training and collaboration between child welfare and mental-health professionals with evidence-based interventions. Across four sites, 2,285 clients were served and improvements were observed across treatment targets.

5.2 Improved Service Access

Children in foster care may experience difficulties accessing behavioral health because of transportation, waiting lists, caregiver changes, insurance or administrative barriers.

Integrated models can reduce these barriers by creating direct referral pathways and improving communication between agencies.

Quick et al. (2026) found that integrated healthcare models can reduce healthcare barriers and improve coordination for youth in foster care, while noting that further research is needed to determine the most sustainable approaches.

5.3 Improved Placement Stability

Mental-health difficulties can contribute to caregiver stress and placement disruption. Better behavioral health support may therefore contribute indirectly to placement stability.

Integration can also help caregivers understand challenging behavior and respond more appropriately rather than interpreting trauma-related behavior simply as disobedience.

5.4 Improved Educational Outcomes

When behavioral health difficulties are identified and addressed, children may be better able to concentrate, participate in school and develop positive relationships with teachers and peers.

Integrated teams should therefore consider educational participation as an important outcome.

5.5 Improved Physical Health

Behavioral and physical health are interconnected. Children experiencing psychological distress may have sleep problems, appetite changes, somatic complaints or difficulties adhering to medical care. Integrated healthcare can ensure that physical and behavioral health are addressed together.

5.6 Improved Relationships

A successful intervention should help children develop stronger and safer relationships with caregivers, siblings, peers and professionals.

Relationship quality is particularly important for children who have experienced disrupted attachment.

VI. TECHNOLOGICAL INNOVATIONS AND INTEGRATED CHILD WELFARE SERVICES

6.1 Electronic Case Management Systems

Electronic case-management systems can help authorized professionals access relevant information about assessments, referrals, appointments and care plans.

However, systems should be designed around children's needs rather than administrative convenience.

6.2 Electronic Health Records

Electronic health records can improve continuity by ensuring that important health information follows the child across placement changes.

The AAP has previously highlighted electronic information-sharing as a mechanism for improving coordination of health information for children in foster care.

6.3 Telehealth

Telehealth can improve access to psychologists, psychiatrists and other specialists, particularly for children living in areas where specialist services are scarce.

However, telehealth should complement rather than replace relationships and in-person services where these are necessary.

6.4 Digital Referral Systems

Digital referral systems can reduce the loss of referrals between agencies. A referral should ideally generate confirmation, appointment information and follow-up responsibilities.

Bunger et al. (2024) identified formal referral protocols and expedited access agreements as practical strategies for improving cross-system implementation.

6.5 Artificial Intelligence and Data Analytics

Artificial intelligence and data analytics may eventually support the identification of patterns across large child welfare and healthcare datasets.

However, the use of AI involving children must be approached cautiously. Algorithms can reproduce bias, and highly sensitive child welfare information requires strong privacy safeguards.

Technology should support professional judgment rather than replace human decision-making.

VII. CHALLENGES AFFECTING INTEGRATED SERVICES

7.1 Fragmented Organizational Structures

Child welfare and behavioral health organizations may have different funding systems, professional requirements and accountability structures.

Bunger et al. (2024) found that differences in priorities, regulations, funding, staffing and organizational capacity can undermine cross-system collaboration.

7.2 Workforce Shortages

There is a need for professionals with specialist knowledge of childhood trauma, foster care, developmental psychology and evidence-based behavioral interventions.

Shortages can produce long waiting periods and interruptions in treatment.

7.3 Inadequate Funding

Integrated care requires funding for staff, training, information systems, supervision, transportation and coordination.

If coordination activities are not recognized within funding arrangements, organizations may struggle to sustain them.

7.4 Poor Communication

Poor communication remains one of the most significant barriers to integrated care.

Professionals may not know whether referrals were completed, whether treatment was effective or whether the child's circumstances have changed.

7.5 Confidentiality and Data Sharing

Information about children in foster care is highly sensitive. Professionals must balance appropriate information sharing with privacy and confidentiality.

Clear protocols should specify what information is shared, why it is shared and who can access it.

7.6 Caregiver Exclusion

Another challenge occurs when caregivers are treated as outsiders.

Foster parents and kinship caregivers require sufficient information and support to understand and respond to children's needs.

7.7 Child Participation

Children can also be excluded from decision-making.

Professionals may make plans about children without adequately asking what the child wants or fears.

A truly integrated model must therefore include child participation appropriate to age and developmental capacity.

VIII. COMPARATIVE PERSPECTIVES AND GLOBAL BEST PRACTICES

8.1 United States

The United States has developed several cross-system models linking child welfare and behavioral health. The Partnering for Success model provides an example of coordinated training, implementation support and evidence-based behavioral interventions.

Ohio START provides another important example. Bunker et al. (2024) identified seven practical collaboration strategies involving staffing, service access and case planning.

8.2 United Kingdom

The United Kingdom provides important lessons concerning multi-agency safeguarding and coordinated support for children. The central principle is that children's welfare cannot be effectively addressed by one agency working alone.

8.3 Canada

Canadian approaches emphasize collaboration between healthcare, social services, education and community organizations, particularly for children and families facing multiple social disadvantages.

8.4 Australia

Australia's child and family service approaches increasingly emphasize trauma-informed practice, family participation, cultural identity and prevention.

8.5 Lessons for Developing Child Welfare Systems

Across international examples, several common principles emerge:

- early identification of needs;
- multidisciplinary assessment;
- coordinated case planning;
- trauma-informed services;
- caregiver involvement;
- child participation;
- information sharing;
- professional training;
- evidence-based interventions; and
- continuous evaluation.

These principles can be adapted to different national and cultural contexts rather than simply copied from one country to another.

IX. PROPOSED MULTIDISCIPLINARY INTEGRATION FRAMEWORK

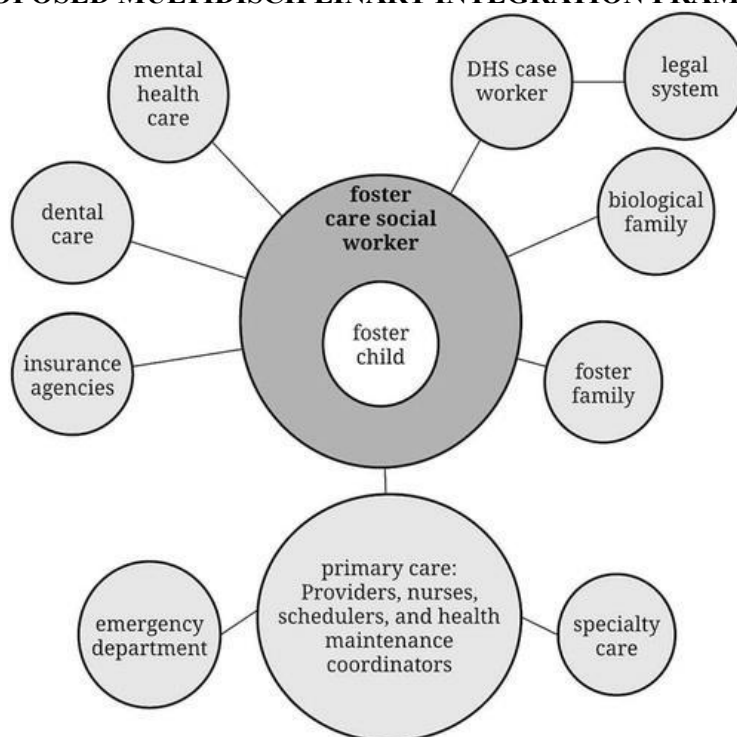


Figure 1: Proposed integrated child welfare and behavioral health framework. The model places the child at the centre and connects welfare, health, behavioral health, education, caregivers and community support through coordinated assessment and case planning (Hoffmann et al., 2021).

To improve outcomes for children in foster care, this article proposes a **seven-pillar multidisciplinary integration framework**.

Pillar 1: Child-Centred Care

The child should be the central focus of every assessment, intervention and policy decision.

Children should be listened to and supported to express their views about placement, treatment, family relationships and future goals.

Pillar 2: Trauma-Informed Behavioral Health

All professionals working with children in foster care should understand the effects of trauma and adversity.

Behavior should be interpreted within context, and interventions should emphasize safety, trust, emotional regulation and resilience.

Pillar 3: Integrated Assessment and Case Planning

Professionals should develop a shared assessment covering physical health, mental health, development, education, family relationships and placement stability.

The resulting care plan should have clearly identified responsibilities and timelines.

Pillar 4: Interprofessional Communication

Regular multidisciplinary meetings should be established for children with complex needs.

Communication should include social workers, therapists, healthcare professionals, educators and caregivers where appropriate.

Bunger et al. (2024) provide evidence for practical strategies such as joint supervision, co-location, shared decision-making and data sharing.

Pillar 5: Caregiver Partnership

Foster and kinship caregivers should receive training, emotional support and accessible communication with professionals.

Where safe and appropriate, biological parents should also be included in planning because family relationships remain important to many children's identities and emotional wellbeing.

Pillar 6: Digital Integration

Digital systems should support secure information sharing, referral tracking, appointment monitoring and continuity of care.

Technology should be designed around privacy, accessibility and child safety.

Pillar 7: Continuous Monitoring and Evaluation

Integrated services should be evaluated using meaningful child outcomes rather than simply counting referrals or meetings.

Indicators should include:

- mental-health improvement;
- placement stability;
- school attendance;
- educational engagement;
- physical health;
- caregiver wellbeing;
- treatment completion;
- child satisfaction;
- family relationships; and
- progress toward permanency.

X. EXPECTED OUTCOMES FOR CHILDREN IN FOSTER CARE

Improved Mental and Emotional Wellbeing

Integrated services can improve the early identification and treatment of children's psychological and emotional difficulties. When mental-health professionals work closely with social workers, healthcare providers, educators and caregivers, children can receive more coordinated and timely support. This can help address anxiety, depression, trauma, behavioural difficulties and other emotional challenges associated with adverse childhood experiences. Early intervention may also prevent these difficulties from becoming more severe and affecting other areas of the child's development.

Greater Placement Stability

Better behavioural-health support can contribute to greater stability in foster and alternative care placements. Caregivers who receive appropriate guidance and professional support may be better equipped to understand and respond to challenging behaviours associated with trauma, neglect or previous instability. Rather than interpreting difficult behaviour simply as disobedience, caregivers can develop more appropriate and trauma-informed responses. This may reduce caregiver stress and the likelihood of placement disruption, thereby providing children with greater continuity and security.

Improved Access to Healthcare

Integration can also improve children's access to physical and mental healthcare by reducing administrative and organisational barriers. When information and responsibilities are better coordinated among healthcare providers, social workers and caregivers, children are less likely to experience delays, duplicated assessments or gaps in treatment. Improved communication can support continuity of care, particularly for children who move between placements or require multiple forms of health and social support.

Improved Educational Participation

Addressing children's emotional, psychological and behavioural difficulties can have positive implications for their educational participation. Children experiencing untreated trauma, anxiety or behavioural challenges may struggle with concentration, regular school attendance and classroom engagement. Coordinated interventions can help address these underlying difficulties and provide appropriate support within educational settings. As a result, children may become more capable of attending school consistently, concentrating on learning and participating positively in academic and social activities.

Stronger Caregiver-Child Relationships

Integrated services can strengthen relationships between children and their caregivers by providing caregivers with practical knowledge and professional support. Family-based interventions can help caregivers understand the effects of trauma, separation and adverse childhood experiences on children's behaviour and emotional development. With improved understanding, caregivers may respond with greater patience, consistency and sensitivity. These interactions can promote trust, emotional security and stronger attachment between the child and caregiver.

Increased Sense of Belonging

Child-centred and identity-sensitive interventions can help children develop stronger connections with their families, culture, school and wider community. This is particularly important for children in foster care who may experience disruption to their family relationships, cultural identity and sense of belonging. Services that recognise the child's cultural background, personal identity, family history and individual preferences can help maintain meaningful connections. A stronger sense of belonging can contribute to emotional security, self-esteem and positive social development.

Improved Long-Term Development

Early and coordinated support may also improve children's long-term developmental outcomes. Childhood adversity can have lasting effects on emotional wellbeing, physical health, educational attainment, relationships and social functioning. By identifying difficulties early and providing coordinated interventions, integrated services may reduce some of the negative consequences associated with abuse, neglect, family instability and

placement disruption. Continued support throughout childhood and adolescence can therefore contribute to healthier transitions into adulthood.

Overall, the evidence provides cautious optimism regarding the value of integrated healthcare and child welfare services. Integration appears capable of improving coordination, reducing barriers to care and strengthening support around vulnerable children. However, the benefits should not be overstated, as researchers continue to call for stronger longitudinal and comparative evidence to determine whether integrated approaches consistently produce better long-term outcomes. Effective integration also depends on adequate funding, information sharing, professional collaboration, caregiver involvement and sustained attention to the individual needs and best interests of each child.

XI. POLICY AND PRACTICE RECOMMENDATIONS

Based on the evidence reviewed, the following recommendations are proposed.

11.1 Establish Formal Child Welfare-Behavioral Health Partnerships

Child welfare agencies should develop formal partnerships with behavioral health organizations to establish clear referral, communication and case-management procedures.

11.2 Develop Multidisciplinary Foster-Care Teams

Teams should include social workers, behavioral health professionals, healthcare providers, educators and caregiver representatives.

11.3 Introduce Joint Professional Training

Professionals should receive joint training on trauma, child development, behavioral health, safeguarding, communication and interprofessional collaboration.

11.4 Establish Shared Care Plans

Every child with complex needs should have a coordinated plan that identifies goals, interventions, responsible professionals and review dates.

11.5 Strengthen Caregiver Support

Governments and agencies should provide foster and kinship caregivers with accessible behavioral health consultation, training and respite support.

11.6 Create Child-Friendly Participation Mechanisms

Children should be given developmentally appropriate opportunities to express their views about care and treatment.

11.7 Improve Digital Information Systems

Secure digital platforms should be developed to support appropriate information sharing and continuity of care.

11.8 Strengthen Referral Systems

Referral pathways should include mechanisms for confirmation, appointment scheduling, follow-up and feedback.

11.9 Increase Investment in Behavioral Health Workforce Development

More professionals should receive specialist training in childhood trauma, foster care and evidence-based interventions.

11.10 Evaluate Outcomes Continuously

Integrated programmes should be evaluated using child-centred outcomes, including wellbeing, placement stability, educational participation and quality of relationships.

11.11 Protect Confidentiality

Clear data-sharing protocols should protect children's privacy while allowing professionals to access information necessary for safe and effective care.

11.12 Promote Research on Integrated Care

Future research should examine which models work best, for whom, under what conditions and over what period. Quick et al. (2026) specifically identify the need for standardized approaches and stronger evidence regarding sustainability.

XII. CONCLUSION

Integrating child welfare and behavioral health services is an important strategy for improving the lives of children in foster care. Children who enter foster care frequently have needs that extend across psychological, physical, developmental, educational, relational and social domains. Treating these needs separately can create fragmented services and place unnecessary burdens on children and caregivers.

The evidence reviewed demonstrates that multidisciplinary collaboration can improve coordination and access to behavioral health services. Cross-system research has identified concrete mechanisms including co-location, joint supervision, referral protocols, expedited access, shared decision-making and data sharing.

At the same time, integration should not be understood merely as an administrative arrangement. Genuine integration requires professionals to develop a shared understanding of the child and to accept shared responsibility for outcomes.

Most importantly, children should not be defined by the circumstances that brought them into care. They are not simply victims of maltreatment, patients with behavioral problems or cases within a child welfare database. They are children with personalities, hopes, talents, fears, relationships and futures.

A humane foster-care system should therefore ask not only whether a child is safe, but whether the child feels safe; not only whether a treatment referral was completed, but whether the child felt heard; and not only whether a placement remains intact, but whether the child experiences belonging within it.

Integrated child welfare and behavioral health services provide a pathway toward this more holistic approach. When social workers, behavioral health professionals, healthcare providers, educators, caregivers, communities and children themselves work together, the system becomes better positioned to address the complexity of children's lives.

Ultimately, the goal of integration is simple but profound: to ensure that a child who has already experienced disruption does not have to experience further fragmentation from the very systems designed to help them. Effective multidisciplinary care can create stronger relationships, more stable placements, improved mental and physical health, better educational opportunities and greater hope for the future.

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