Introduction

In recent years, numerous national reports and professional journal articles have documented the rising number of children, youth, and families in need of behavioral health* (mental health or substance abuse) services and supports across the nation. This trend cuts across all races, ages, geographic areas, and socioeconomic levels, but most significantly affects children, youth, and families involved with the child welfare, juvenile justice, or behavioral health service systems. These individuals' needs are complex and require a comprehensive response; however, no one service system has the mandate, resources, or reach to address both the client presenting issues and the interrelated and larger social problems that so often contribute to these untreated behavioral health needs.

Children, youth, and their families known to these systems are often victims of abuse and neglect or suffer from significant emotional or behavioral disorders. Often parental substance abuse or co-occurring substance abuse and mental health disorders** are prevalent, as well as a host of other social issues, such as poverty, racism, unemployment, or racial disparities, that exacerbate these individuals' behavioral health problems and further contribute to the deterioration of the communities in which they reside.

The consequences of this unmet need are significant. For example, the General Accounting Office (GAO, 2003) identified more than 12,700 cases in which parents were forced to choose between obtaining needed mental health services for their children and relinquishing custody of their children with mental or emotional disorders to the child welfare or juvenile justice systems. In another example, parents who successfully graduated from family drug treatment courts often relapsed because they did not receive adequate mental health services to address underlying issues related to trauma and violence (C. Lu, personal communication, September 6, 2002). These relapses jeopardize the successful reunification efforts of children, youth, and their families.

In the case of children and youth involved with the juvenile justice system, a growing evidence base suggests that many children and youth are transferred to the juvenile justice system as a solution to a lack of available, accessible, and effective community-based substance abuse and mental health services. This trend

* *Behavioral health* refers to a broad spectrum of services, from prevention to aftercare, that address the emotional, psychological, developmental, physical, and social well-being of children, youth, and families affected by substance abuse or mental health disorders.

** This monograph defines *co-occurring substance abuse and mental health disorders* consistently with the definition developed by the Substance Abuse and Mental Health Services Administration as follows: "People with co-occurring substance abuse disorders and mental disorders are individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of the other" (*Report to Congress on Co-Occurring*, 2002, p. 2).

is particularly disturbing because many professionals working in this system have suggested that the capacity of the current system to address these issues is grossly inadequate (Bilchik, 1998).

These examples demonstrate why a consensus of dissatisfaction and outrage is growing among consumers, families, and stakeholders from child- and family-serving systems (both formal and nontraditional) who feel that the current quality, accessibility, and outcomes of these behavioral health services, particularly among low-income children, youth, and families—and in communities of color—are inappropriate and inadequate at best.

In light of these complex circumstances, a comprehensive, integrated systems of care approach is emerging as a beneficial and cost-effective method of delivering services and supports to this vulnerable population of children, youth, and families. Programs such as Wraparound Milwaukee and Reclaiming Futures are using this approach to provide comprehensive, individualized care to children and youth through a coordinated system of care that draws on resources from the juvenile justice, child welfare, and behavioral health systems.

For example, the Wraparound Milwaukee program has seen a reduction in juvenile delinquency and school truancy (President's New Freedom Commission, 2002). In addition, clinical outcomes have improved and policymakers have seen a cost savings of almost $3,000 per child per year (President's New Freedom Commission, 2002).

In the juvenile justice system, program developers have learned that incarceration alone will not solve the problem of children and youth with substance abuse issues (Reclaiming Futures, 2002). Information from studies and pilots shows that children and youth who receive enhanced care through comprehensive networks of community services fare much better than those who do not receive such services (Reclaiming Futures, 2002). Findings show that after 12 months, less than half as many children and youth who had access to these networks were back in confinement and more than twice as many were abstaining from subsequent alcohol and drug use (Reclaiming Futures, 2002).

Other grantees of the Comprehensive Community Mental Health Services for Children and Their Families Program are seeing positive behavioral changes associated with children who received continuous, uninterrupted care (Reclaiming Futures, 2002). In addition, children who received intensive, home-based services showed greater reductions in functional impairment compared with children who were required to seek services outside their home environment (Reclaiming Futures, 2002).

In the case of mental health and emotional well-being in adolescents, one literature review of nearly 300 research studies found that the use of comprehensive, integrated approaches is effective in preventing a range of behavioral health problems, such as conduct disorder, attention deficit/hyperactivity disorder, and alcohol and drug abuse (Zaff, Calkins, Bridges, & Margie, 2002). As the literature suggests, comprehensive, integrated systems of care are effective, however, developing such systems is challenging, and planners must address the following barriers:

- establishment and maintenance of effective leadership,
- dissemination and adaptation of evidence-based practices,
- differing system mandates,
- other policy issues,
- legislation and financing issues,
- underlying values and principles,
- practice issues,
- involvement of youth and families,
- accessible service array,
- information issue,
- workforce issues, and
- evidence of the effect of service integration.

Project Background

In 2002, staff from the Child Welfare League of America and the Robert Wood Johnson Foundation engaged in a series of discussions on children, youth, and families receiving, or in need of, behavioral health services from one or more of the child welfare, juvenile justice, or behavioral health service systems.

Drawing on their collective knowledge of what works in each of these systems, and in other discussions with consumers, families, professionals from a range of child- and family-serving agencies, and other community stakeholders, staff realized that a coordinated, multiprong effort for systems-culture change was needed to create an integrated system of care for this population of children, youth, and families.

Based on this mutual understanding and shared vision to improve the long-term health and well-being of the nation's most vulnerable children and families, the staff conceptualized this project to ensure that all children and youth—but especially the most vulnerable—would have the opportunity to develop to their fullest potential.

Therefore, beginning in June 2003 and ending in March of 2004, CWLA and RWJF convened a series of three summits. This is the first of two monographs they are releasing to support the development of a consensus agenda for systems-culture change. The monographs will outline a detailed plan across these systems and identify the steps needed to implement this approach at a national, state, or local level.

The summits discussed the experience and expertise of a diverse range of stakeholders: federal, state, and local officials; public and private service agencies; researchers and academics; and a range of other community stakeholders, including consumers and their families. The summits' advocacy agenda highlighted policy recommendations that can be used on the federal, state, and local levels and outlined a social marketing plan to influence public opinion and encourage policymakers to accept and support these systems' change efforts. The summits' research agenda outlined the information gaps that exist in the work of cross-systems and interagency integration efforts. Attendees addressed issues of cross-system evaluation, slow knowledge transfer, application, and dissemination, and the minimal use of evidence-based programs and practices. CWLA will compile and release information gathered from the summits in the second monograph, which will outline the consensus agenda.

To facilitate these dialogues and foster both the depth and breadth of exchange of what is known in the child welfare, juvenile justice, and behavioral health service systems, CWLA commissioned three authors to write chapters highlighting issues facing these systems, describing the barriers and opportunities for collaboration, and illustrating how to involve family members and engage community stakeholders. CWLA identified these authors because of their familiarity with and expertise in at least one service system and their experience in cross-system collaboration efforts.

Each chapter also raises questions the authors believed should inform the summits. Both the contents and questions raised, along with the participants' issues, are the basis of the first summit and define the starting areas for the initial deliberations.

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Literature Review

CWLA staff undertook this literature review to identify gaps and opportunities to improve the quality of care and, thereby, the well-being of those children, youth, and families involved with or in need services and supports from the child welfare, juvenile justice, and behavioral health systems.

Vulnerable families and communities are often the most in need of multiple services and community supports to address their behavioral health needs. These needs are often exacerbated by larger social conditions such as poverty, racism, violence, and untreated trauma. Currently, children of color are overrepresented in the child welfare, mental health, and juvenile justice systems. Such disproportionality further complicates the health disparities of this vulnerable population as the service delivery systems struggle to provide appropriate services. The solution lies in an integrated response because no one child- or family-serving system has the resources to address person-specific issues and the larger social conditions that affect them.

As vulnerable children and families navigate the various systems—often simultaneously and at times unsuccessfully—emerging research suggests comprehensive human services are what these people desperately need (Anonymous, 1999; ORC Macro, 2003; Report to Congress, 2002; Voydanoff, 1995). An integrated system-of-care approach is emerging as an effective and more compassionate response to families and children who require services and supports from multiple service systems. Key assumptions guiding this approach should include the idea that children, families, agencies, and entire communities benefit by having increased access to a wide range of community-based services and supports to address such family and community issues as homelessness, domestic and community violence, drug dependence, mental illness, neglect, and abuse. This approach also includes the premise that clients receive the services and supports they need regardless of which child- or family-serving door they enter. Qualified, well-trained, culturally competent staff provide these services. This integrated approach can improve the quality, success, and cost-effectiveness of how human services are delivered as well as the outcomes for children and families.

Comprehensive, integrated human services approaches are about more than improving the ability of multiple systems to effectively deliver services and supports to children, youth, and families. These approaches are collaborations across the child welfare, juvenile justice, mental health, and substance abuse service systems. They build bridges between formal and informal systems of services; create partnerships between children, youth, and families that use the services of professionals and paraprofessionals; and limit harm families may experience when they are forced to rely on public human services systems to meet their most basic needs.

This literature review focuses on highlighting the implementation and sustainability of integrated systems of care in

child- and family-serving systems. The ultimate goal is to identify the barriers that impede these systems from implementing an integrated service delivery system, as well as some of the positive advancements in system integration.

The authors conducted a review of the literature in 2003, and sources included periodicals, books, and numerous technical and research reports from federal, state, and local agencies, and communities.

The System-of-Care Model

The phrase *system of care* has been used in many different ways. It is most commonly used in the Substance Abuse and Mental Health Services Administration (SAMHSA) Comprehensive Community Mental Health Services Program for Children and their Families, or the System of Care grant program.

According to SAMHSA, a *system of care* is a wide range of mental health and related services and supports organized to work together to provide care. It is designed to help a child or adolescent with serious emotional disturbances, with the involvement of his or her family, get the services the youth needs in or near his or her home and community. In systems of care, local public and private organizations work in teams to implement a tailored set of services for each child's physical, emotional, social, educational, and family needs. Teams include family advocates and may consist of representatives from mental health, medical, education, child welfare, juvenile justice, vocational counseling, recreation, substance abuse, and other organizations (see SAMHSA, http://www.mentalhealth.org). This system-of-care approach has set values and principles with key focuses on providing community-based, culturally competent, child- and family-driven services, and strength-based individualized care (Bazron, Dennis, & Isaacs, 1989; Osher & Osher, 2002).

Other definitions of the term *system of care* are:

- A method of delivering mental health services that helps children and adolescents with mental health problems and their families receive the full range of services in or near their homes and communities. These services must be tailored to each individual child's physical, emotional, social, and educational needs. In systems of care, local organizations work in teams to provide these services (see Parents Involved Network of Pennsylvania, http://www.pinofpa.org).

- A comprehensive spectrum of mental health and other necessary services organized into a coordinated network to meet the multiple, changing needs of children and their families (Stroul & Friedman, 1986).

The concept of service integration has been present in varying degrees throughout the various child- and family-serving systems and may be called by different names, such as system of care, continuum of care, caring communities, circles of care, and networks of community care. The phrase *system of care* emerged in the mental health sector of the human service system in the late 1980s (Stroul & Friedman, 1986). Workers used the term to describe a comprehensive network of services and supports organized to address the needs of children with serious emotional and behavioral problems.

System Integration

Overall, many believe an integrated service delivery system is the most effective method of delivering services to vulnerable children, youth, and families. The concept of comprehensive and integrated human service systems is not a new approach to serving children and families in communities. This approach was used from the 1920s to 1940s with the establishment of "united charity" buildings, area projects, and neighborhood councils. These efforts provided the first models of co-location and "one-stops." The 1960s and 1970s saw the development of a number of federal flexibility, coordination, and integration efforts, such as community mental health centers to address specific problem areas. In subsequent years, block grants and federal monitoring and oversight requirements created categorical funding programs and efforts to address the lack of coordination and differing mandates among these programs began to surface. The government created human service "super agencies" and, in the 1990s, enacted federal legislation, such as the Workforce Investment Act, Personal Responsibility and Work Opportunity Reconciliation Act, and Temporary Aid to Needy Families. These legislative efforts provided opportunities and incentives to collaborate with agencies and across human service systems (Nagle, 2003). The child- and family-serving systems have been more restricted in their ability to create super agencies due to their separate funding streams and differing eligibility requirements. Despite these limitations, communities, counties, and states have made efforts through creative financing, waiver programs, grants, and legislation to design, develop, and deliver their own version of integrated services. (Examples include such efforts as those in El Paso County, Colorado; the Dawn Project in Indiana; and integrated programs in New Jersey and Connecticut.)

As the system-of-care approach began showing effectiveness in meeting the complex, specialized needs of children and families, other human service systems and communities began using

the term and variations on the approach. These system-of-care approaches are provided for children and youth who require services across various systems and who may or may not have a serious emotional disturbance; the agencies work without funding from the SAMHSA system-of-care grants.

Today, we use *system of care* more broadly. Human service systems use it to refer to comprehensive system reforms. They may also refer to these efforts as a continuum of services that are community based or to wrapping services around a child, called the wraparound model,* so that the agency can provide children and their families with services in their community. Example of this are the Durham Family Initiative; integrated programs in Vermont, Connecticut, and New Jersey; and states and communities that have been able to obtain Title IV-E waivers, which they have used to develop more integrated service delivery systems initiatives. Although many of the system-of-care initiatives incorporate the wraparound model, this type of service coordination is analytically distinct from the more individual approach, which involves coordinated services and supports (Kendziora, Bruns, Osher, Pacchiano, & Mejia, 2001). These system-of-care efforts do not necessarily embrace all of the values and principles from the SAMHSA system-of-care approach. The broader use of the term describes a network of resources and community supports to provide coordinated, comprehensive approaches to the delivery of human services to children, youth, and families.

The growth and success of system-of-care models in the United States is the result of demonstration grants from SAMHSA's Center for Mental Health Services and the evolution of the wraparound model (see http://www.samhsa.gov). These and other integrated human service efforts under way in places such as El Paso County, Colorado, are helping generate more interest in and awareness of the effectiveness of comprehensive service approaches (Hutson, 2003).

Professionals often use the terms *system integration*, *service integration*, *coordination*, and *collaboration* interchangeably, however, there are distinctions in how these words are applied. Martinson (1999) said it best:

> Over the years, the terms "coordination" and "integration," as well as "collaboration" and "linkages," have often been used interchangeably and with varying connotations and meanings. More recent studies have reached some consensus and define coordination as situations where two or more organizations work together, through a formal or informal arrangement, to meet one or more goals such as improving the effectiveness and/or cost-effectiveness of programs, avoiding the unnecessary duplication of services, and improving performance. While many of the terms are interchangeable, there is generally a distinction between service integration—which implies logistic and physical proximity—and coordination, linkages, or collaboration, which refers to agencies' efforts to work together to achieve specified goals. Clearly, coordination can occur without operational integration, and physical integration does not necessarily improve system or program coordination. Based on this distinction, most of the studies in this area have focused on coordination rather than service integration.

Furthermore, Nagle (2003) made a distinction that could be characterized as two types of service integration, systemic or direct practice:

> Service integration can be system oriented or administrative—service integration can be used to identify system-oriented changes including the creation of umbrella agencies, information linkages among state agencies, and blended funding streams. This aspect of service integration addresses the alignment of official structures that govern and shape services.
>
> The second type of service integration is service oriented and operational—this type of services integration can also be used to describe service-level integration including co-location of services, benefits, linking information systems at the client level, integrated intake procedures, and coordinated case management. This aspect occurs when clients walk in a human service agency's door and the kind of information that is available about a client to caseworkers.

Therefore, one can view service integration as a continuum that "progresses from communication to cooperation to coordination to collaboration to integration to consolidation" (Nagel, 2003).

Such service integration highlights both the systemic, or macro-level, issues as well as the actual service, or micro-level issues. Although systemic integration may be necessary to access enough resources to address a family's multitude of problems, systemic integration in itself is not enough. Direct practice must also change, and some evidence shows that the use of comprehensive, community-based interventions at the micro level can effect successful outcomes for individual clients (ORC Macro, 2003).

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* The wraparound model is both a process and a philosophy in a system of care that individualizes services for children and youth with complicated multidimensional problems. The term *wraparound* originated from the idea that these youth could best be served in their home communities by "wrapping" individualized services around them in the home, in the mainstream regular education classroom, and in their community (Burns & Goldman, 1999).

Community-Based Interventions

Community-based interventions have many characteristics in common with systems of care. Specifically, these interventions:

- adhere to system-of-care values, such as providing treatment in community settings, using parents as partners, and being sensitive to culture;
- are provided in neighborhoods, homes, and school—not in an office;
- are provided often by parents and paraprofessionals (except Multi-Systemic Therapy);
- can be operated by any human service sector;
- should be developed and studied in the real world—not in university settings; and
- are less expensive than institutional care. (Marsenich, 2002)

Creating any kind of integrated service is difficult. It takes time and commitment from front-line staff, program managers and supervisors, administrators, and the community. Although some communities have had success, many communities that attempt this level of innovation struggle to implement and sustain the effort. Common barriers and ways to work through them highlighted in this literature review are listed in the Introduction.

Establishing and Maintaining Effective Leadership

Effective leadership is crucial for any major business, community, or personal change. In 2000, the United Way of America and AECF produced a competency study on leaders of successful community-building initiatives. Their research indicated that effective leaders:

- promote strong social networks through individual encouragement,
- facilitate linkages between those with different resources and influence, and
- continually accomplish tasks and engage others. (United Way of America, 2000)

In April 2003, the National Academy of Public Administration (NAPA) produced a report on high-performance partnerships. The authors cited capability, communication, change agent, commitment, and credibility as the "5 Cs" for effective leadership:

> Failure to achieve and sustain effective leadership that is capable of producing results is associated with breakdowns among relationships and the intangible features in partnerships, such as community buy-in (NAPA, 2003). Strong leadership is key in implementing and sustaining any type of systems reform effort. After site visits of interagency collaborative initiatives of child-serving systems addressing the behavioral health needs of children in El Paso County, Colorado; Franklin County, Ohio; Massachusetts; and Missouri, a key finding was that the successes of the interagency collaborations depends largely on key leadership having the authority, and taking responsibility, for developing and implementing programs that stress coordinated approaches to holistic care. (Mauery, Collins, McCarthy, McCullough, & Pires, 2003, p. 36)

Recruitment and Development of New Leaders

Agencies should not leave the recruitment, development, and nurturance of leaders to chance. They should give careful consideration to this process early in the formulation of a partnership and strategic plan. This issue is particularly urgent in the child welfare system, in which research has identified that as many as 50% to 75% of chief administrators plan to retire in the next decade (Drais-Parrillo, 2002). As these data suggest, the recruitment and development of the next wave of leaders is critical for the successful development, implementation, and sustainability of major human service system reform efforts currently under way.

Despite an awareness of this knowledge, many initiatives are slow to address long-term plans for leadership succession. Bruner (2000), a national expert in public policy and comprehensive and community-based responses to children, families, and neighborhoods, said that often, partnerships view the task of identifying new leaders and nurturing current leaders as a separate category of activity; however, agencies should integrate this task and reflect it in their strategic plans and all associated tasks. Bruner inferred that one of the major contributing factors to the failure of effective leadership is that leaders experience burnout because they do not have a support system in place to help them deal with the difficulties that arise from taking big risks and making difficult decisions. With no support system in place for leaders and a leadership structure that equates leadership to a single person or a few people, child- and family-serving systems cannot build the capacity needed to implement and sustain large-scale systems reform efforts.

No one individual is likely to exhibit every leadership characteristic needed to create and sustain partnerships involved in

major systems reform efforts (NAPA, 2003). In a NAPA (2003) report, an expert panel described a new model of cross-sector collaboration that resulted in high-performance, cross-sector partnerships. The report highlighted findings from two years of in-depth research and nationwide consultation and described the importance of a two-phase approach to leadership.

The first phase involved the recruitment of a traditional leader who is dynamic, inspirational, direct, and able to motivate partners and harness the resources needed to get the work of the partnership under way. In the second phase, leadership functions were diffused throughout the partnership. Without this expansion, a partnership becomes dependent on personality-driven leadership, which can contribute to nonproductive partnerships and the demise of the partnership altogether (NAPA, 2003).

The second important finding from the research involved the recruitment and retention of leaders involved in the partnership. NAPA (2003) suggested that in the formative stage, partnerships should map the assets of individuals in the partnership. This is necessary so those people can be nurtured and trained to develop their leadership skills. In addition, the partnership should invest time in team building. This would facilitate a greater understanding of the needs and perspectives of each partner to help overcome competition and facilitate healthy power sharing distribution. Also, agencies should spend time recruiting leaders from other successful partnerships (NAPA, 2003).

Another finding, particularly important for partnerships involving human services, was the need for a formal plan to survive transitions in leadership by listing leadership succession from the inception of the partnership and using incentives to recognize achievements of partners (NAPA, 2003). Extensive research has identified that the most effective incentives include increased decisionmaking authority, monetary rewards, and recognition for a job well done (Bazelon Center, 2003; NAPA, 2003).

Leadership Outside the Box

Lasker, Weiss, and Miller (2001) stated that one of the key challenges in achieving true collaboration is that a limited pool of leaders are capable of achieving the synergy required to fully realize the vision of collaboration. Today, many leaders across sectors have a narrow range of expertise, speak a language that can only be understood by their peers, are used to being in control, and can only relate to the people with whom they work as followers or subordinates rather than partners. Lasker et al. described a need for a different type of leader, who can span boundaries with a keen ability to understand and appreciate partners' different perspectives; can bridge their diverse cultures; and is comfortable sharing ideas, resources, and most important, power. In addition, today's changing environment requires that a leader be able to adapt to changing conditions and keep abreast of current research in the field and data on the economic, demographic, and social conditions of the community (Bryant, 2002).

Need to Diversify Leadership Base and Draw on Strengths of Partnerships

Frequent staff turnover and changes in political administrations or in key positions in agencies often stall reform or, in some cases, can derail large-scale system reform entirely. Efforts to expand the pool of leaders are critical and should include the participation of front-line staff and members of the community. Although not trained in policy and administration issues, front-line staff play a critical role in implementing the change efforts, and their support and buy-in can make or break system reform efforts (Reclaiming Futures, 2003). Furthermore, middle managers are key stakeholders in any system reform or collaboration effort because they supervise and monitor staff performance (Young, Gardner, & Dennis, 1998).

The Dissemination and Adaptation of Evidence-Based Practices

Human service workers need to stay abreast of current research in various professional fields, such as social work, psychiatry, and psychology, and to have information on the economic, demographic, and social conditions of their community. Central to this idea is the ability of the researcher to translate research into meaningful information that can be used to help shape policy and practice at the local, state, and national levels (Bryant, 2002). This can be difficult, however, due to fiscal, individual, and organizational challenges to new technologies being implemented (National Institute on Drug Abuse [NIDA], 1995). In addition, the Institute of Medicine (IOM, 2001) indicated that it takes 15 to 20 years for a new, successful practice to migrate and become standard daily practice. It is crucial that human service systems shorten this time lag so that the most effective services are delivered to improve quality of care and outcomes for children and families.

One way of shortening this lag is by increasing the effectiveness of disseminating research and thereby accelerating the science-to-service cycle. According to the Addiction Technology Transfer Centers (ATTC, 2000), *technology* is defined as "the science of the application of knowledge to practical purposes; the application of scientific knowledge to practical purposes in a particular field." Therefore, technology transfer is the act of moving

research into standard professional practice. ATTC (2000) developed a checklist of principles needed for successful technology transfer:

- relevancy of technology and research,
- timeliness to fit recipients' needs,
- clarity of language,
- credibility of the source,
- multifaceted and active strategies,
- continuous reinforcement, and
- bidirectionality among implementers.

A Center for Substance Abuse Prevention (CSAP, 2001) publication cited that perhaps the most difficult challenge to effective substance abuse prevention programming was determining the perfect balance between research fidelity and real community needs. Backer (2001) noted that attention to both research fidelity and adaptation are crucial to successful, sustained implementations of evidence-based programs in the field. As of yet, the various professional disciplines and policymakers in child- and family-serving systems have not reached consensus on the level of rigor required for determining what is evidence-based practice (EBP) or the methods or technology necessary to transfer such EBP into practice (IOM, 2001). As stated in an implementation guide for EBPs for community-based substance abuse treatment agencies:

> Although "evidence-based practice" has become a buzz word in the last few years, there is still no consensus on what exactly constitutes an evidence-based practice. What kind of evidence is needed, how much evidence? A practice can have excellent research qualities—it can be extensively tested with randomized clinical trials, have a detailed treatment manual, and perform well with a variety of clients in controlled research studies—but still not meet practical considerations that determine its applicability to the field. (Iowa Consortium for Substance Abuse Research and Evaluation, 2003)

Differing System Mandates

The implementation of laws, policies, and goals is a well-documented problem that could potentially hinder true partnership and collaboration among human service systems. For example, in the child welfare system, the passage and implementation of the Adoption and Safe Families Act of 1997 (ASFA) decreased the time available for a parent or caregiver to achieve permanence from 18 months to 12 months. This legislation also expedited the termination of parental rights when a child had been in foster care for 15 of the last 22 months. These timelines conflict with the needs of parents and caregivers who require substance abuse or mental health treatment (Young, Gardner, & Dennis, 1998).

Research from various sources shows that recovery from alcohol and drug addiction is a long-term process and may require multiple episodes of treatment (NIDA, 2000). Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness. Rather, research shows that the effective treatment for alcohol and drug addiction should last significantly longer (NIDA, 1999).

Other major conflicts across systems include differences in definitions of who is the client, for example, the child, parent, or caregiver; the family; or even the general public. In the case of the juvenile justice system, the shift away from prevention of crime and rehabilitation of youth demonstrates this conflict. Although the juvenile justice system is mandated to serve the child, the current concerted efforts to introduce retribution and punishment for children and youth suggest that the general public, and the public's safety, are the client. The idea that community safety takes precedence over children in need of mental health or substance abuse treatment is a philosophy not favored by the mental health and substance abuse treatment systems (Shelton, 2002). These systems know that treatment for alcohol and drug addiction, or for mental illness, is highly effective when careful consideration is given to the level of care, length of treatment, and access to support services during and following treatment.

In another example, Nicholson, Biebel, Hinden, Henry, and Stier (2001) suggested that a parent or caregiver with mental illness is more vulnerable to losing custody of his or her children. Custody loss rates can be as high as 70% to 80% (Nicholson et al., 2001). This outcome demonstrates major differences in how the child welfare and mental health system understand and engage the client and treat mental illness.

For children with mental health problems, custody and relinquishment issues occur despite the fact that many federal laws require that state and local agencies provide mental health services to children in least restrictive settings (Pietrowiak & White, 2003). In other words, children have the right to receive services in their communities, not in residential settings, unless that is the only way their needs can be met. Although the law does not

call for the relinquishment of parental rights if their child is placed with child welfare agencies due to mental illness, timeframes in which a child must be placed in a permanent setting exist, and in some cases, this has led to termination of parental rights.

In several states, poorer parents are faced with the difficult decision of obtaining desperately needed mental health services for their children by relinquishing custody to the state (GAO, 2003; Giliberti & Schulizinger, 2000; Koyanagi, Boudreaux, & Lind, 2003). A federal Title IV-E requirement, as implemented by state officials, made it impossible for parents to obtain needed services unless the child was surrendered to the state. Federal initiatives are trying to clarify these policies and mandates to ensure that, whenever appropriate, children can remain with their families and receive treatment (GAO, 2003).

Another issue identified as a barrier to collaboration across human service systems is differences in language and eligibility criteria**.** Each system uses its own definitions (e.g., what risk is assessed, role of the case manager) and criteria, which further hinders communication and team building and the ability to provide the full range of services needed by children. Eligibility criteria are often focused specifically on the areas that are mandated in the mission of the agency (i.e., child safety in child welfare, level of dysfunction in substance abuse, risk of reoccurrence in juvenile justice). These variations and discrepancies in criteria often result in an underidentification of emotional and behavioral disorders (Anderson, 2000).

Other Policy Issues

Each system (child welfare, juvenile justice, mental health, and substance abuse) is at odds with the others over timelines, time limits, treatments, benefits, and perspectives. Federal, state, and local policymakers have given little guidance for successful collaboration. Agencies are starting to look to each other to meet the needs of families with co-occurring needs and issues. Agencies need to learn how to value the power of networking, develop information-sharing tactics, foster workforce development, and establish new pathways for funding (SAMHSA, 2003; Tuell, 2003; Walter & Petr, 2000).

Communities are beginning to recognize the need to create positive change at the local level. Researchers have developed models of community readiness and community programs (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000; Leon, 1999), although they have not rigorously documented their successes (McElrath, McBride, Vander Wall, & Ruel, 2002). One barrier to community readiness is stakeholder attitudes toward implementing or modifying certain behaviors, that is, one community's problem may be another community's status quo.

Historically, social welfare and government policies rarely reflected the true needs of the families they served. This still holds true today. Federal and state policies are created that directly affect families in contact with any of the human services. Many of these mandates create chaos and competing demands for the family that needs several interventions at once. Briar-Lawson (1998) called for more indigenous experts as primary providers; the promotion of innovation in social welfare and the better use of human capital; more focus on economic, employment, and income issues; more collaboration; and advocacy.

On the other hand, the federal government has begun to fund cross-collaborative efforts among the different systems (Bruner, 2000). The federal government also offers technical assistance to states and communities that desire new strategies to improve the lives of families. Although the federal funding streams and grants encourage, if not mandate collaboration, far too often, federal agencies and officials are not collaborating across respective child- and family-serving departments and systems. Such fragmented policymaking breeds fragmented understanding of the problem and therefore fragmented service delivery solutions and evaluation (Bazelon Center, 2003).

Mental Health

Prevention programs in general need more federal and state policy attention. Estimates place cost savings of preventative services at several billion dollars per year. Adolescents in particular need access to preventative services because many of the most common, costly, and serious problems are potentially preventable (Brindis, Park, Ozer, & Irwin, 2002; Ford, Gregory, McKay, & Williams, 2003; Horwitz et al., 2002). Adolescent social and behavioral risks account for 70% of adolescent deaths (Brindis et al., 2002). Research has also shown that providing targeted, early substance abuse treatment to mothers reduces medical and law enforcement costs in the long run (Clark, 2001). Barriers to preventative and treatment services, for both substance abuse and mental health issues, include lack of insurance coverage, eligibility requirements, inability to meet copayment obligations, confidentiality concerns, inconvenient appointment times, and lack of professionalism of clinicians (Brindis et al., 2002; Physician Leadership on National Drug Policy, 2002; Report to Congress, 2002). Recommendations for government policy improvements include adequate funding of health care and the development of innovative approaches to health care service delivery for youth (Brindis et al., 2002; Malekoff, 2000).

Many people who need mental health services face tremendous barriers to treatment, including a lack of income support, affordable housing, employment, and access to health care. Those who are able to receive needed services often find those services to be fragmented, expensive, and short staffed. Many children in the foster care system in need of mental health services find that service delivery itself is a barrier to treatment because of the inability of staff to communicate effectively across systems (Marsenich, 2002). Mental health agencies have called on the government to create community-based mental health services by continuing to support research, revise federal programs, enhance interagency initiatives, reduce stigma, and create culturally appropriate programs (Bianco & Wells, 2001).

Substance Abuse

In the area of substance abuse, the federal government has recognized the need for stronger leadership in building bridges between substance abuse and child protection. In 1999, Congress commissioned a study on the scope of parental substance abuse in the child welfare population, the types of services provided, the effectiveness of those services, and recommendations for legislative changes (Blending Perspectives, 1999). Findings from this study included the uncovering of a communication barrier between the legal and policy environments of child welfare and substance abuse systems. Positive efforts to increase collaboration between the two systems included training and identification skills, client retention, enhanced risk assessment, improved timelines, support of ongoing recovery (Blending Perspectives, 1999), staff buy-in, and an action agenda (Young et al., 1998).

Juvenile Justice

The relationship between juvenile justice and child welfare may be the most difficult to conceptualize and influence. The juvenile court is most often known for its dealings with juvenile delinquents and status offenders. But the court is also responsible for the placement of children removed from their homes due to abuse or neglect. Schwartz, Weiner, and Enosh (1999) called for an overhaul both of the court and the child welfare system based on the belief that the systems had failed at their core missions to protect and rehabilitate children. The court and child welfare system must examine their relationship and look to other countries for examples of successful blending of the two (Schwartz et al., 1999).

The relationship between juvenile justice and mental health has become strained as juvenile detention centers are transformed into mental hospitals for youth (Shelton, 2002). More and more youth who have mental health problems are ending up in the juvenile justice system. As Pietrowiak and White (2003) reported, youth with mental health problems are ending up in the child welfare and juvenile justice systems as they are not able to obtain services through the mental health system. Mental health treatment is cost prohibitive, especially for youth who come into contact with the juvenile justice system (Shelton, 2002), and, often, the juvenile justice system is ill equipped to work with children with mental health problems (Teplin, Abram, McClellan, Dulcan, & Mericle, 2002). A shift has occurred from treatment and rehabilitation to punishment. For children in the juvenile justice system with mental health problems, the two systems have parted company. The mental health system wishes to heal and modify behavior, whereas the juvenile justice system wields punishment and damage repair. In 2002, representatives introduced several bills in Congress to address these disparities (Shelton, 2002).

Legislation and Financing Issues

Research from programs such as Wraparound Milwaukee have demonstrated that integrated systems of care are possible and sustainable when states are given flexibility for simplifying administration and blending funding pools through a combination of capitated fees, Medicaid, Temporary Aid to Needy Families, Title IV-E dollars, and block grants from child welfare, juvenile justice, and behavioral health treatment systems (Kamradt, 2002). This approach allows resources to follow people instead of programs and categories.

Much literature, however, documents the current federal financing system for public human services as a major obstacle to implementing comprehensive and integrated systems of care (Bazelon Center, 2003). The current structure is outdated and not compatible with mandates that have been imposed through federal legislation implemented in the past decade, such as the welfare reform/Personal Responsibility and Work Opportunity Reconciliation Act, Temporary Aid to Needy Families, and ASFA (Bazelon Center, 2003). Furthermore, the mandates ASFA imposed are not consistent with the current behavioral health needs of today's families, nor are they complementary to what researchers and communities identify as best or innovative practices (Center for the Study of Social Policy [CSSP], 2003).

For example, in the case of ASFA, the federal government increased the link between federal funds and the successful implementation of the program as an incentive to state and local child welfare services and systems to comply with its goals (CSSP, 2003). "While the 1997 law created new incentives, in the form of bo-

nuses to states for permanency, it only provides funding for permanency through adoption" (CSSP, 2003). Funding is geared toward maintaining children in out-of-home care and precludes financing for preventative and in-home services that might reduce the need to remove children from their families and communities (CSSP, 2003). In addition, the new incentives do not provide funding to address the goal of well-being, which includes primary and preventive medical and behavioral health care, as well as learning, for children at risk of maltreatment or in placement (CSSP, 2003). Finally, this financing structure does not address the actual needs of families, but rather encourages providers to steer children toward out-of-home placements to secure additional funding for their agency (CSSP, 2003).

Present eligibility requirements for funding of child welfare services are tied to outdated programs, such as Aid to Families with Dependent Children, and are based on current data related to states' pools of children and families at risk of maltreatment and neglect (CSSP, 2003). In addition, eligibility standards are tied to data that may not be truly reflective of each family's unique situation and do not take into account other risk factors, such as poverty, race, or education.

For example, the financing structure of the current human service system favors institution-based services provided in groups, away from family, home, and community. Furthermore, the financing structure significantly relies on categorical funding, restricts the type of services that providers can offer, and imposes strict regulations on what funds from a particular source (federal, state, local, private) agencies can use for what services (Bianco & Wells, 2001). This type of stringent eligibility makes it difficult for a provider to tailor services to individual needs, and, as a result, a provider may find it is cheaper to place a child in a residential setting. This limits the choices that are available and moves away from what has been determined as best practice—matching needs to services and providing care in the context of one's family and community (Bazelon Center, 2003).

Although research has emerged on the best ways to finance an integrated system of care, other policies, such as stringent eligibility, narrowly drawn benefits from insurance providers, and competition among systems, create resistance to developing and implementing a pooled funding approach to financing the system of care (Kamradt, 2002). Changes to the reauthorized Juvenile Justice and Delinquency Prevention Act (JJDPA) allowing states to use funds to help child-serving systems coordinate treatment for delinquent children or those at risk of delinquency hopefully will facilitate more system integration and better coordination of services (Tuell, 2003).

Another barrier frequently cited in the literature is a lack of understanding on the part of decisionmakers (Giliberti & Schulzinger, 2000; Koyanagi et al., 2003). Decisionmakers need to make a greater effort to learn how to work with policies that are in place and how to use waivers and other entitlements to secure funding.

Cost-Benefit

Research has shown that the successful prevention and treatment of mental health and substance abuse issues are cost-saving measures. Estimates place the cost savings of the availability and use of adolescent preventative services in the billions of dollars per year (Brindis et al., 2002). Unfortunately, the availability of and financing for prevention, assessment, and treatment of adolescent substance abuse have not kept pace with young people's needs (Cavanaugh, 2002), despite the fact that research indicates a number of ways that agencies may finance treatment through both the public and private sectors (Cavanaugh, 2002) and that treatment can be cost effective (Center for Substance Abuse Treatment, 1999; Kraft, Vicary, & Henry, 2001).

Research has indicated that for-profit centers for youth rehabilitation have failed to improve the lives of the children they work with and have failed to become profitable (Press & Washburn, 2002). These corporations are unable to obtain partnerships and needed resources compared to their nonprofit counterparts (CASAWorks for Families, 2001; Shoveling Up, 2001).

Underlying Values and Principles

The discussion of values and principles is fundamental to collaboration and coordination among human service agencies. Professionals frequently note that differences in values and principles among partners is a major obstacle to achieving true collaboration. This may not be an accurate statement, however, because it is not the differences among the partners that hinder cooperation and partnership, but rather the inability of partners to come to an understanding about and acceptance of these differences. The obstacle may be the inability of partners to overcome differences by accepting the perspectives of others and finding common ground. Professionals frequently note that differences in values and principles—the attitudes of an individual, agency, and system—are embedded in the culture of each agency (Gardner, 1998). The presence of values and beliefs permeate every activity. In child- and family-serving sectors, the stakes are significant, and mistrust and reluctance to collaborate and partner with others are major obstacles to developing and implementing an integrated system of care (Young & Gardner, 2002).

Sandfort (1999) closely examined the attitudes and beliefs of front-line staff. Sandfort determined that too much attention was focused on policy and administration activities, rather than on the social processes in the front lines of child- and family-serving systems. These front-line actions play a role in why system and service integration efforts fail. Sandfort revealed how the beliefs and actions of front-line staff create and sustain barriers between agencies and other systems. In one instance, a front-line worker felt stigma and shame because she worked at a state agency that the general public saw as lazy, ineffective, and incompetent. These feelings are perpetuated in front-line staff at other agencies, who hear stories from their clients and buy into these stereotypes rather than inquiring as to why a policy is in place at a partnering agency. The result often becomes avoidance among the front-line staff at agencies that are mandated to work together (Bazelon Center, 2003; Sandfort, 1999).

Another example of values and beliefs affecting service delivery is the inclusion of children and families as partners with professional staff. The value of partnering with clients in their treatment is new for many human service systems, and not all staff embrace it. Without an explicit understanding of why this type of partnering is important, staff will make a continued effort to exclude children and families in critical planning, service delivery, and evaluation processes that affect their lives (Gardner, 1998).

According to lessons learned from the Starting Early Starting Smart (SESS) programs, many families involved in SESS felt mistrust about family-serving systems because of past negative experiences (Casey Family Programs and the U.S. Department of Health and Human Services, 2001). As a result, clients appeared hostile and difficult to work with, and the SESS site staff were resistant to working with children and families. SESS staff felt confident that the frustration caused by fragmented, uncoordinated human service systems contributed to the distrust between clients and staff. SESS leadership, however, recognized that staff were also resistant. Staff did not understand the importance of working with parents as equal partners, and SESS needed training to educate staff on the value and benefits of consumer and family involvement (Casey Family Programs, 2001).

Involvement of Families and Youth

Child welfare, juvenile justice, mental health issues, and substance abuse affect whole families, never just one individual. Therefore, recovery and reintegration into a community should include the whole family. Successful community initiatives for people with mental illnesses include family supports (Bianco & Wells, 2001). The Center for Substance Abuse Treatment has recommended family involvement in creating systems of care for substance-abusing juvenile offenders and a holistic approach to working with youth (Ford et al., 2003). A study of substance abusers in treatment showed that having the support of a significant other was the key to successful treatment (Gregoire & Schultz, 2001). On the other hand, when examining child welfare practice, despite what policymakers and agency directors claim, families are rarely engaged in the creation of policies or programs that directly affect them (Briar-Lawson, 1998; Bruner, 2000; Lewandowski & GlenMaye, 2002). Furthermore, Marsenich (2002) found that foster parents want to be seen as part of the treatment team for children in their care.

Agencies have created innovative programming around recovery work and family preservation for substance-abusing parents and their children. The Bridges Program, an in-home recovery program provided in seven different states, helps families avoid relapse by addressing individual actions and cognitions, individual recovery action steps, family actions and cognitions, and family recovery action steps (Gruber, Fleetwood, & Herring, 2001). An in-home social work clinician meets with the family four to six hours each week for 8 to 12 weeks.

Researchers have found other innovative family involvement work in the field of children's mental health. To improve outcomes for children with emotional disturbances, planners developed, implemented, and evaluated a school-based intervention called the School, Family, and Community Partnership (the Partnership Program) (Kutash, Duchnowski, Sumi, Rudo, & Harris, 2002). The Partnership Program aimed to increase family involvement in the children's education and increase access to supportive services in the community. A major component of the Partnership Program was the development of a team around the student and family that included school personnel. The team developed a plan for the student that addressed the student's strengths, limitations, and needs; identified barriers to meeting those needs; and included action plans.

Agencies have made some inroads in family involvement in child welfare work through the system-of-care model programs that began in 1993. One of the key elements of the system-of-care model is the family's involvement in its own case planning. Vinson, Brannan, Baughman, Wilce, and Gawron (2001) reviewed the implementation of the system-of-care model across 27 sites over a five-year period. According to their results, some sites have been successful at family involvement. The data suggest a need to improve how family involvement is implemented. Walter and Petr (2000) cited family-centered principles as being the core of interagency collaboration. They stated that the first step in inte-

grating family-centered services and interagency collaboration is to recognize the major elements of family-centered practice, that is, choosing the family as the smallest unit to work with, encouraging the family by using proactive decisionmaking, grounding work in a strengths-based model, and ensuring cultural sensitivity. An interagency collaborative would then need to create an advisory panel of experts in the field to guide the adaptation of family-centered services. The panel would empower front-line staff to help families beyond strident mandates. The advisory panel would also work to ensure that the agency did evolve into an organization that empowers both workers and families.

The Administration for Children and Families' (ACF's) evaluation process of the public child welfare systems in each state, the Child and Family Services Reviews, has found that states are continuing to struggle with involving families. Of the first set of states that participated in the federal evaluation process, all but one failed this federal standard (ACF, 2002). In those states in which family involvement was rated higher in individual cases, however, the state was rated higher for the federal requirement that families be involved in the case plan development (ACF, 2002).

Practice Issues

Practice across the fields of mental health, child welfare, substance abuse, and juvenile justice is evolving. As more research becomes available, systems are trying to collaborate on and adapt more effective and efficient programs for maintaining the treatment gains of children and families. Numerous studies have issued recommendations for policy and practice changes.

Mental Health

Researchers have long recognized schools as the first place to "catch" a child's emotional or behavioral problems. Due to this unique opportunity, planners formed a partnership between schools, families, and the community (Kutash et al., 2002)—the Partnership Program. Researchers evaluated the program for buy-in from all participants. Findings indicated that school staff members who participated in trainings increased their knowledge. This increase was sustained through a six-month follow-up. Measures of student behavior and academic functioning showed a significant decrease in discipline referrals and improved behavior.

In addition, specific integrated, community-based treatments have demonstrated positive outcomes (Hoagwood, 2001) for children with co-occurring disorders or involvement in multiple systems. These include intensive case management and treatment foster and home-based services, in particular, multisystemic therapy.

Child Welfare

Many in child welfare see the need for greater cross-system collaboration to address the needs of families facing multiple problems. Effective collaborative efforts across services require that team members have an awareness of their partners' duties and respect differences as well as celebrate achievements. One study found that styles of teamwork, educational background, and role specificity were all associated with level of commitment (Lewandowski & GlenMaye, 2002). Specifically, social workers tended to collaborate more effectively than non-social workers.

At times, cross-collaboration and implementation of new programs prove to be extremely challenging. Liddle et al. (2002) highlighted the transfer of multidimensional family therapy (MDFT) as a researched treatment into actual practice in an agency. Clinical models can successfully move into the practice arena if there is staff buy-in and a demonstrated readiness to change. Liddle et al. (2002) detailed the transfer from the university setting to a day-treatment clinic. MDFT staff found that technology transfer to an agency was not a simple task and spent months working with and training the agency staff on the new program. Change was not immediate, and the agency had a long transitional period between the "old way" and the "new way." MDFT and agency staff did see an improvement in staff buy-in and patients' response to the new treatment.

Substance Abuse

Black, Tobler, and Sciacca (1998) explored ways of influencing the behaviors of adolescents related to substance use. Through the analysis of 120 researched programs, they found that peer interventions were statistically superior to lecture programs delivered by teachers for middle-school children.

Partnerships between child welfare and substance abuse services are starting to emerge as agencies begin to recognize that they are often working with the same families. Agencies in Montgomery County, Maryland, developed a blended model to combine their mandates to better serve children and families (McAlpine, Courts-Marshall, & Harper-Doran, 2001). A goal of the partnership was to address the requirements of ASFA. Child welfare and substance abuse treatment programs are trying to work together to both address parents' treatment needs and provide a safe, stable environment for children. The partners placed a substance abuse liaison in the child welfare services department who was available for consultation on all casework. Preliminary analysis showed a positive relationship between child welfare workers and the alcohol and other drugs (AOD) liaison. Child welfare workers showed a greater willingness to learn about AOD and volunteered for trainings.

Young people are subject to the same influences as adults. Children are not immune from pressure to experiment or a desire to escape everyday troubles or rebel against others. Youth substance use continues to be a growing issue (Kraft et al., 2001; Physician Leadership on National Drug Policy, 2002; Stevens & Morral, 2003; Treating Teens, 2003). Youth substance use can be linked to mental health issues (Cocozza & Skowyra, 2000; Deas & Thomas, 2002; Shelton, 2002; Stevens & Morral, 2003) or a history of abuse or neglect (Prescott, 1997), or can be a practice "inherited" from parents (Deas & Thomas, 2002; Physician Leadership on National Drug Policy, 2002).

Girls with substance abuse problems in the juvenile justice system have become a growing problem (Prescott, 1997). The risks for females who come into contact with the juvenile justice system include abuse, substance use, difficulty in school, and gang-related activities (Prescott, 1997). In addition, 20% of girls in the juvenile system have been sexually or physically abused, and most of them have co-occurring mental health and substance abuse problems (Prescott, 1997). Girls need gender-specific programming to address their needs, including strengths-based assessments and single-sex residential placements (Prescott, 1998).

Until recently, youth substance abuse treatment programs were modeled after adult treatment programs, which did not take into account youths' developmental stages and tendency to binge (Muck et al., 2001; Physician Leadership on National Drug Policy, 2002; Shenk & Zehr, 2001; Stevens & Morral, 2003; Treating Teens, 2003). Some researchers have found success in using restorative justice models with substance-abusing youth (Braithwaite, 2001; Center for Substance Abuse Treatment, 1999; Kraft et al., 2001). The theory is that the youth admit their use, the family shares their problems, and a team creates a solution to address both the juvenile's actions and addictions and the family's pain. The Center for Substance Abuse Treatment (1999) found that youth in detention who receive drug treatment while in custody are less likely to reoffend. The center also found that effective programs for juveniles with substance abuse issues are based on research, screen juveniles as soon as possible, develop individualized treatments, create overarching case management, involve the family, and create systems of care for the youth.

Prevention programs have also gained popularity, especially among schools. By supporting youth and supplying needed resources early, youth are less likely to use drugs or alcohol, engage in unprotected sex, and become involved in other dangerous activities. Successful programs were of substantial duration and intensity and included multiple-component interventions (Eisen, Pallitto, Chapman, & Phillips, 2000). Research has also shown the prevention programs can be universal in nature (Williams, Ayers, Abbott, Hawkins, & Catalano, 1999).

Community readiness and buy-in are also significant factors to consider when looking at practice change. Without community buy-in, prevention and treatment programs cannot work. Edwards et al. (2000) found that communities experience several stages of readiness:

- no awareness—problem is not recognized;
- denial—nothing needs to be done locally;
- vague awareness—general feeling that a problem exists, but no motivation to fix it;
- preplanning—identifiable leaders picked but no action yet;
- preparation—planning is focused;
- initiation—action is under way as a new effort;
- stabilization—programs are running but need evaluation;
- confirmation/expansion—original efforts are modified or expanded; and
- professionalization—highly trained staff and effective evaluation.

Additional Practice Issues

Mental health and substance abuse issues affect other aspects of families' lives and can be a major reason for child protective services or the criminal justice system to intervene. The growing number of children in foster care may be related to parental drug and alcohol addictions, poverty, homelessness, AIDS, and domestic violence (Marsenich, 2002). A researcher stated that the issues of drug dependency and treatment cross child welfare, juvenile justice, mental health, and welfare reform systems and are related to child abuse and child poverty (Anonymous, 1999). Also, public and private health insurance company policies directly affect what types of services a family can obtain and when, by whom, and with which clinician they can obtain them (Bazelon Center, 2000). Historically, poorer families face more difficult problems and are less likely to obtain needed services (CASAWorks for Families, 2001). Children of impoverished families are also less likely to receive needed mental health services (Farmer, Burns, Chapman, & Phillips, 2001).

Simms, Freundlich, Battistelli, and Kaufman (1999) predicted that more children would enter the child welfare system with significant physical, mental, and developmental problems due to reductions in welfare, food stamps, and disability benefits for fami-

lies with children. Rising costs of health care coupled with the failure of Medicaid payments to keep pace has resulted in fewer doctors who are willing to accept Medicaid families. States are placing more poor families into managed care organizations (MCOs). MCOs focus heavily on preventative care and accept patients for a fixed sum of money per enrollee. MCOs also make it more difficult to receive specialized treatments, but MCOs are better equipped to spot potential disorders in young children. Child welfare service staff are not always able to obtain medical backgrounds for children in agency care. Therefore, foster parents are often left with the task of figuring out if the child needs any sort of physical or mental health attention.

Jayakody and Stauffer (2000) examined substance abuse and mental health problems among single mothers and how this related to receipt of welfare services. Results suggested that mental and behavioral health problems were barriers to self-sufficiency. The development of the Personal Responsibility and Work Opportunity Reconciliation Act required welfare recipients to be employed within two years of receiving aid. A five-year lifetime limit on federally funded aid also exists, with an exemption for up to 20% of a state's caseload. The difficult question becomes, who should be exempt? Many statutes punish those with substance abuse problems. Jayakody and Stauffer suggested that approximately 40% of welfare mothers report high levels of depressive symptoms. Compared with single mothers, single welfare mothers experienced more problems with substance abuse involving marijuana and cocaine. Welfare recipients were also more likely to experience depression and agoraphobia. Jayakody and Stauffer did not find evidence of widespread substance use among welfare recipients. Rather, the data suggested that more welfare recipients suffer from mental health problems. States are contemplating mandatory drug testing for welfare recipients, but this would not address the bigger problems of finding and administering effective integrated services to assist welfare recipients who have drug-related problems.

A great difficulty for child welfare workers is being able to predict when and if it is safe for a child to return home to a substance abuse-recovering families. According to Semidei, Feig-Radel, and Nolan (2001), parents in early recovery have a greater chance of relapse than parents who have been in recovery for a longer time.

This literature review has highlighted parental substance abuse as a significant factor that affects an adult's mental health as well as his or her child's likelihood of being placed in out-of-home care, suffering from mental health issues, and ultimately suffering from substance abuse issues as well (Blending Perspectives, 1999; Gruber et al., 2001; McNichol & Tash, 2001; Semidei et al., 2001; Shulman, Shapira, & Hirshfeld, 2000; Wilens, Biederman, Kiely, Bredin, & Spencer, 1995). Many substance-abusing parents are single mothers who suffer worse health problems due to drug and alcohol abuse; have lower incomes, poor education, and few job skills; and typically have abusive partners (H. W. Clark, 2001) who are also substance users (Gregoire & Schultz, 2001).

Mental health disorders and substance abuse have been shown to be barriers to self-sufficiency (Jayakody et al., 2000). Also, many programs have been designed for substance-abusing men and cannot meet the special needs of substance-abusing women, especially those with young children (Uziel-Miller & Lyons, 2000; Whiteside-Mansell, Crone, & Conners, 1999). Research, however, has demonstrated positive outcomes for these women if they receive targeted and early services (H. W. Clark, 2001). More treatment options exist today for single mothers with drug addictions. Residential services are showing positive results through research (Killeen & Brady, 2000; Metsch et al., 2001; Whiteside-Mansell et al., 1999).

Drug dependency and its treatment affects child welfare, juvenile justice, mental health, and welfare reform (Anonymous, 1999). It is also related to child abuse and child poverty. For caseworkers, dealing with substance-abusing families is extremely difficult on several levels: first, trying to identify the problem; second, attempting to find proper treatments; and finally (and most difficult), assessing when a substance-using parent has received sufficient treatment to be able to care for his or her children again (Blending Perspectives, 1999; National Center on Addiction and Substance Abuse, 1999; Semidei et al., 2001; Sun, 2000; Young & Gardner, 2002). One solution has been to place substance abuse treatment workers with child protective services workers. Research has shown a positive relationship between the two and a willingness on the part of child welfare staff to learn more about identifying substance abuse and finding proper treatments (McAlpine et al., 2001). Another solution has been to increase the knowledge and training of health care professionals to help them better identify substance-abusing families and offer them treatment options (Werner, Joffe, & Graham, 1999).

Accessible Service Array

Over the past several years, agencies, foundations, universities, and federal and state government have sponsored research studies on a variety of hypotheses in the cross-connections between child welfare, juvenile justice, mental health, and substance abuse, with the hope of finding answers to make collaborations between systems more responsive to the families they serve.

Mental Health

Mental health research has examined local systems of care for children and adolescents with serious mental health issues, systems of care for parents of children in the child welfare system, treatment of youth in the juvenile justice system, and the effects of the other systems on mental health issues. A study of federal grantees found that children who received continuous care showed more positive behavioral changes compared with children who had a gap in service (Annual Report to Congress, 1998). Children who received in-home services showed greater reductions in functional impairment compared with children who did not receive in-home services. Overall, children who received services had reduced mental health problems and improved school attendance.

Eisen et al. (2000) found that out of 51 prevention programs for adolescents reviewed by researchers, 21 had rigorous research results. Of those 21, the authors were able to identify common elements for success, including theory-based, targeted behavior goals; skill-based, written curricula and trainer feedback; substantial duration and intensity; and multiple-component interventions. Greenburg et al. (1999) examined mental health disorders in children and reviewed programs used to treat those symptoms. The authors found that short-term programs had limited success, ongoing interventions were necessary, targeting multiple negative outcomes was feasible, interventions should address multiple environments, no single program component worked by itself, and community buy-in was key.

Substance Abuse

In the field of substance abuse, evaluated programs tended to focus on either parental (mostly young mothers) or juvenile (usually in detention) substance abuse. In the past, substance abuse programs for women did not address women's special needs, such as higher rates of psychological distress, trauma, socioeconomic problems, and complications from pregnancy and parenting (Uziel-Miller & Lyons, 2000; Whiteside-Mansell et al., 1999). A study of women on Temporary Assistance to Needy Families (TANF) in California found that those with substance abuse problems were significantly less likely to have worked their required 26 hours per week (Chandler & Meisal, 2002). Having more than one impairment (substance use, mental health issue, domestic violence) severely curtailed a woman's ability to work a full week. In Year 2 of the study, those women with more than one impairment were more likely to not have a job and were in need of cash assistance.

Sun et al. (2001) studied drug-abusing families with single mothers and found that they were 96% more likely to have substantiated child welfare cases than families without substance abuse. Interestingly, however, alcoholic families were not significantly more likely to be substantiated than non-substance-using families. Finally, Sun et al. found that the number of children a woman had was significantly related to child protective services involvement. This was a directly proportional relationship.

Research has found a link between poverty, abuse, violence, mental health issues, and substance abuse (CASAWorks for Families, 2001). The CASAWorks program offered substance-abusing mothers a chance to receive treatment, parenting and social skills, family violence prevention, and health care. Researchers tracked women in the program for 12 months and found a rise in abstinence rates from alcohol and drugs. Employment rates rose as well. A program for pregnant and postpartum women with substance abuse problems found that residential services not only enabled many of the women to receive treatment but, more important, allowed them to have their children with them (Clark, 2001). For those who completed the program and had their children living with them, 68% were not using drugs or alcohol at the six-month follow-up. The program offered the women counseling, relapse prevention, parental training, employment training, and legal assistance. Children received medical services, therapy, and help with developmental delays.

Research on another residential treatment center for substance-abusing mothers found that those who stayed with the program did significantly better than those who left early (Killeen & Brady, 2000). At the 12-month follow-up, graduates had lower levels of stress. Children of graduates were also functioning in a normal behavioral range, down from a clinical range at intake. A third residential programs for mothers and their children showed that mothers who had their children with them throughout the program were less likely to use drugs or alcohol afterward (Metsch et al., 2001). At the six-month follow-up, 82% of these mothers remained drug and alcohol free. A study in Arkansas found that pregnant substance-abusing women who participated in residential programs had less premature labor and infection (Whiteside-Mansell et al., 1999). Their children had higher birthweights and were less likely to be born prematurely.

Children of substance abusers are often the least likely to receive needed services. This is often due to the parents' continued substance use or the parents being overwhelmed with their own recovery. Shulman et al. (2000) examined these children and found that 83% had nutritional or medical disorders, 68% had a variety of speech or language impairments, 50% were in the borderline range of intellectual functioning, 19% showed mental retardation, and 16% had emotional or behavioral disorders. A follow-up survey indicated that out of 100 children,

59 were receiving services, 18 were not eligible, and 17 were of unknown status. Wilens et al. (1995) showed that children of opioid-dependent parents had significantly higher levels of dysfunction than a comparison group. They had significant internalizing and externalizing behavior scores and higher rates of delinquent behavior.

A study in New York City of substance-abusing families found that families offered help in case management and other services to supplement probation, parole, or pretrial supervision had significantly better access to medical and social services, and substance users in the program had a decline in drug use from 80% to 42% (Sullivan, Mino, Nelson, & Pope, 2002). Over a six-month period, program participants had fewer arrests and convictions than a comparison group. Research has also shown that having a supportive significant other helps substance-abusing parents seek and complete treatment (Gregoire & Schultz, 2001).

Muck et al. (2001) examined several types of substance abuse treatments for adolescents and found that the 12-step model (based on Alcoholics Anonymous) had positive effects for youth who completed the entire program. Results after one year were mixed, however.

A behavioral treatment approach also showed positive results for youth. This method focused on the underlying cognitive processes, beliefs, and environmental cues associated with drug and alcohol use. The treatment taught youth coping skills. Research indicated a 73% decrease in drug use for youth who completed this program.

Family-based treatment was found to sustain results for at least one year after services ended. This treatment focused on adolescent functioning as it is related to parents, siblings, and extended family.

Finally, the researchers evaluated an MDFT model. Studies indicated positive outcomes for youth in this type of program, and the results were more likely to hold at the follow-up.

Another study of substance use prevention for adolescents found that churches are often the best social institution from which to launch prevention efforts, and integrative parent-youth training models strengthen family resilience (Johnson et al., 1998). Also, in 2002, Connecticut developed better tools and services for youth in the juvenile justice system (Ford et al., 2003). Staff first identified service gaps, including the absence of a behavioral screening tool at intake and the absence of effective service collaboration. Some of the findings indicated that positive outcomes for the youth were connected to the identified services being provided at the same time.

Williams et al. (1999) examined substance use among white and African American adolescents and found that patterns of usage were different enough to warrant separate types of treatment options. Low academic and social skills, as well as peer and sibling influence, were significant predictors of substance use for both groups, even when controlling for socioeconomic status and family type. These findings indicated that universal prevention planning and interventions can work but caution against disregarding proper culture and race issues when deemed appropriate.

Information Issues

Staff frequently cite sharing information across systems and even within agencies as a barrier to implementing and, more important, evaluating cross-systems initiatives (Martinson, 1999). Without a data collection process in place and the use of some type of management information system, it is impossible to improve the quality of care for children, youth, and families, due to an inability to provide services or identify the gaps or weaknesses in current systems or programs (Martinson, 1999; Young et al., 1998).

For example, in the case of alcohol and drug addiction, child welfare information systems can mask the extent of substance abuse problems in families involved in the child welfare system (Young & Gardner, 2002). Although professionals in the child welfare system know that parental substance abuse contributes to child abuse and neglect, many states do not require screening of a parent or caregiver for substance abuse. Nor do case records capture the current usage or history of substance abuse. As a result, professionals suspect that many cases of parental substance abuse go unnoticed and untreated, which may explain the large range in the number of families reported with a substance abuse problem from one state to another.

The juvenile justice system experiences a similar problem, in that many youth entering the system are not screened for substance abuse or mental health disorders (Cocozza & Skowyra, 2000). Similar to the child welfare system, many facilities do not require screening and assessment for substance abuse or mental health issues.

The most common barrier cited about information exchange involves privacy concerns and limitations of current management information systems to share data across programs (Ragen, 2003). Recent studies have shown, however, that reluctance to share information may be related to a negative mindset and mistrust between programs and agencies (Martinson, 1999; Young & Gardner, 2002). A closer look at policies to protect consumers has shown that agencies have ways to uphold confidentiality policies and help consumers achieve their service plan goals, while still protecting the clients' privacy.

Workforce Issues

Several reports document the human service workforce and its direct relationship to child and family outcomes (Clark, 2003; Glisson & Hemmelgarn, 1998). As a result of this growing evidence base and a closer scrutiny of policies and practices used by human service agencies in recent years, a growing consensus exists among stakeholders that the human service workforce plays a central role in whether vulnerable children achieve positive outcomes (Annie E. Casey Foundation [AECF], 2003; Glisson & Hemmelgarn, 1998; Sandfort, 1999).

A study in implementing social policies that focused on supporting vulnerable families found new hypotheses that lend support to the critical role of front-line staff in implementing human service system reform (Sandfort, 1999). The research suggested that agencies placed too much emphasis on how organizational, interagency, or societal forces influence human service collaboration, paying little attention to the social processes that play out at the front line where most social policies are actually implemented (Sandfort, 1999).

Additional findings by other researchers and policy analysts have supported Sandfort's (1999) hypothesis (AECF, 2003). Key legislation, such as TANF and ASFA, included new policies to increase the level of accountability to which human service agencies are held. A review of the literature in this area identified barriers hindering the human service workforce from successfully implementing comprehensive care networks. These barriers include high worker turnover, insufficient resources (including training), and inadequate supervision and support networks for workers (Clark, 2003; U.S. General Accounting Office [GAO], 2003).

The Child and Family Services Review process has provided data to indicate that when the frequency and the number of the social worker visits to children in open cases is greater and responsive to the specific needs of the case, the outcomes for the child are improved in areas related to safety, permanence, and well-being (ACF, 2002).

The GAO (2003) cited the lack of human service agencies' ability to recruit and retain staff as a major barrier deterring agencies from ensuring positive outcomes for children and their families. The report found that turnover rates were directly related to low salaries, high caseloads, and heavy workloads that required many workers to spend as much as 80% of their time on administrative tasks, such as completing paperwork.

Another significant report evaluating the health of the human service workforce stated that these workers were unique and unparalleled in any other work sector (Light, 2003). This research found strong evidence of a vast gulf between what human service workers are asked to do and how they are equipped for the task. Light's (2003) survey identified three different kinds of resource shortages that put front-line staff at risk: access to information, equipment, and supplies; a safe environment in which front-line staff can work; and basic organizational support, in the form of a lack of ongoing training and inadequate staffing that results in unreasonable caseloads and long hours.

An emerging leader in human service workforce reform is the Annie E. Casey Foundation (AECF). It published a 2003 report that examined college students' perceptions of careers in public human service settings, as well as those of current and previous front-line staff, to learn why they left their jobs and what their perspectives were on several components of their jobs.

AECF (2003) suggested that people had a clear lack of understanding in and outside the human service field of who exactly comprises the human service workforce and what role they play. It suggested that without further clarification and a national effort to track and compile this information, implementing and sustaining human service reform efforts will be difficult—if not impossible. Findings revealed that the human service workforce is not considered a "sector" by the American public—despite many front-line workers who adhere to similar policies and regulations and who are subject to similar responsibilities to staff in other sectors. This misunderstanding by the public contributes to many problems inherent in the human service workforce, including lack of professionalization, standardization of policies directed at practice, credentials, and support of tangible rewards, such as increases in pay or opportunities for career advancement (AECF, 2003; National Association of Social Workers, 2003).

Front-line staff are often inadequately trained to address the complex needs of families needing specialized services (AECF, 2003). Even in well-run child welfare systems, if the training needs of front-line staff remain unaddressed, clients may not achieve positive outcome (AECF, 2003).

Many social work programs focus on clinical approaches that are not sufficient or are generic in nature, in which the child welfare program only trains for child welfare, and the mental health program only trains for mental health, and the social work students are not prepared to work collaboratively with children and families who are involved in multiple systems (Zlotnik & Cornelius, 2000). These students learn victim-blaming approaches and do not focus on collaboration or integration approaches. In addition, given that social work training has focused on identifying and correcting problems—a deficit model, not a strengths-based approach to assessment and service delivery—families feel that they are blamed for problems (Ryan, 1976).

Evidence of the Effect of Service Integration

The heart of any integrated system of care or any type of service integration is the role of partnerships and collaboration:

> Estimates from various health promotion studies suggest that up to half of new partnerships do not survive past their first year; of those that do, many falter in the development of plans or the implementation of interventions. Additionally, a review of the literature on this topic shows that many partnerships serve to exist only on paper and to satisfy the requirements of funders. Despite the enormous body of literature that exists on how to engage in partnerships and collaborative efforts, there is limited evidence that partnerships and collaboration actually improve the health and well-being of children, families, and communities. (Lasker et al., 2001)

One theory that is gaining acceptance is focused on direct evidence of the effects of service integration. Mark Ragan (2003), a Senior Fellow at the Nelson A. Rockefeller Institute of Government in Albany, New York, and a national expert on human service integration, stated that despite a hunger for empirical evidence, the most obvious and telling evidence may be in the attitudes of staff and managers.

Research by several scholars suggests that integration by itself may have little effect on services and outcomes (Glisson & Hemmelgarn, 1998; Provan, Milward, & Isett, 2002).

Glisson and Hemmelgarn's (1998) findings suggest that improvements in the psychosocial functioning of children served by human services are related more to the organization's climate and the service providers' attitudes than to service system configurations. Positive climates reflect work environments that complement and encourage the type of service provision that leads to success. Not only were children who were served by agencies with more positive climates more likely to experience improved psychosocial functioning, but they also received more comprehensive services, there was more continuity in the services they received, and their caseworkers were more responsive and available. Agencies that scored higher on levels of job satisfaction, fairness, role clarity, cooperation, and personalization of the workers, and lower on levels of role overload, conflict, and emotional exhaustion of the caseworkers, were more likely to support caseworkers' efforts to provide nonroutinized, individualized casework, which leads to improved outcomes for the children. Correspondingly, the more pronounced and visible the role of the service coordination team in an area, the less responsibility caseworkers assumed for the activities related to the indicators for service quality. This was for all children on their caseloads, and it happened when the caseworkers had less discretion to make key service decisions for the child, as these decisions were the responsibility of the service coordination team.

Other research has found a positive link between integration and outcomes when certain conditions are in place, such as program stability and access to funds (Provan et al., 2002). Overall, a review of the literature on this topic found that available information is limited to partnerships involving one or two service systems or agencies, and the data gathered are often descriptive or based on short-term evaluations (Diaz et al., 2002). Barriers most frequently cited were:

- The cost of cross-systems evaluation (or any evaluation, for that matter) can be expensive. Data collection does not come without a cost.
- Multisystem efforts cause multiple interactions and involve numerous variables. As a result, it can be difficult to determine what interaction caused what result.
- Research design and implementation often happens in a vacuum, without input from a range of stakeholders.
- Researchers find it difficult to measure the effectiveness of collaboration and partnership.

Projects that involve the delivery of services across multiple service systems present a complex set of activities and outcomes to be measured. The costs and effort that are needed to measure a broad array of systems-specific activities are enormous (Fishman, Farrell, Allen, & Eiseman, 2000). Because of the high costs associated with maintaining a cross-system evaluation, it is difficult to conduct this level of evaluation in the long term. In a fiscal environment in which many programs are struggling to maintain the funds and resources to support basic program operation, sustaining funds and resources to maintain program evaluation can be challenging.

Multisystem projects are intended to create change at multiple levels, for instance, clinical outcomes for children, youth, and families; agency and system processes; and improvement in overall community functioning. Outcomes at each of these levels are a result of many interactions, and it can be difficult to pinpoint the specific nature of such interactions (Diaz et al., 2002). To ensure positive outcomes for children, Glisson and Hemmelgarn (1998) suggested that organizational culture (including low conflict, cooperation, role clarity, and personalization) was the primary predictor of positive service outcomes for

children, and not interorganizational service coordination. Further research is required to better understand the effect of an organization's culture when multisystem integration efforts are undertaken.

Integrated service approaches must integrate paperwork as well as resources. Creating cross-system information-sharing processes requires innovative thinking and intense collaboration and follow-up. It is not uncommon for a system reform effort to struggle to document case information consistently and share information across systems. Without a coordinated effort to formulate policies, and strategies and work plans to implement this kind of information sharing, a true cross-system evaluation will be difficult to implement.

Finally, what has been proven effective in a controlled research setting may not be effective in a less-controlled community setting (Diaz et al., 2002). Issues of transferability and fidelity are significant (CSAP, 2001), as is accelerating the science-to-service cycle for implementation. It is hard to measure the effect of change with an insufficient baseline of data for comparison.

Given the scope of work required to develop a system of care, multisystem projects should be given ample time for planning, implementation, and evaluation. In the present environment, which stresses immediate accountability, however, agencies seldom have time for the long-term evaluations and rigorous research that will positively determine if an integrated system approach improves the long-term well-being of children and families (Diaz et al., 2002). Furthermore, researchers have stated that it is difficult to conceptualize and measure what outcome of partnership makes collaboration effective (Lasker et al., 2001) without a theory-of-change logic model (Lasker & Weiss, 2003):

> There needs to be closer attention paid to how a goal will be measured at the outset of the project...a collaboration should not determine goals without considering its overall ability to measure them. (NAPA, 2003)

Even innovations that have been implemented are somewhat limited in their ability to be replicated because so few have been evaluated. For example, a review of the literature shows that university partnerships are helping prepare the current human service workforce and future social workers for the demands of the child welfare profession (GAO, 2003). As a result, in an environment of increasing accountability from a fiscal and outcome perspective, with an increase in the demand for services and a decrease in the resources available, it is not surprising that many administrators are steering clear of implementing programs that have not been tested (GAO, 2003).

Finally, the inability to effectively evaluate collaboration and partnership hinders the long-term sustainability of many projects because designers are unable to convey to funders why their project will benefit from additional time or investment. In an environment of limited resources and stiff competition for funding, the ability to assess the synergy of partnerships is critical, and few initiatives are able to do this (Lasker et al., 2001).

Conclusion

Government, organizations, foundations, agencies, and communities are beginning to see the value in having and using solid research to address the needs of both the community and the families that live in it; large gaps exist, however, in the research on the linkages between child welfare, juvenile justice, mental health, and substance abuse. For example, little research is available on the effect of child welfare on juvenile justice, mental health, and substance abuse issues, despite some evidence showing a link between being in contact with child protective services at any time in a child's life and eventual contact with any of the other three systems. The field needs more research on juvenile justice programs that addresses the co-occurring mental health and substance abuse needs of children in detention.

More research needs to be conducted on the effect of prevention and early intervention services on the promotion of health and well-being. Literature is starting to show that prevention programs for youth positively affect their lives. Youth are less likely to become involved with the juvenile justice system and less likely to use alcohol or other drugs if they take part in a prevention program. Finally, the field needs more research on partnerships and interorganizational collaboration across the four systems, and on how budget cuts and funding variations affect the quality of services and supports provided and the outcomes of the children and families served.

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Where Child Welfare and Substance Abuse Intersect

Changing Organizational Cultures

Sid L. Gardner and Nancy K. Young

The most important intersection of child welfare and substance abuse is the more than 1.4 million substantiated child abuse and neglect reports, of which an estimated 40% to 60% involve some kind of substance abuse on the part of parents or caregivers. For the thousands of caregivers with substance use disorders and related problems, the child welfare system may respond along a broad spectrum of practice, from essentially ignoring the problem to the best practice response of effectively screening, assessing, and engaging the caregiver in treatment as part of a comprehensive plan for services for the whole family.

The ability of the child welfare and substance abuse systems to respond to these needs is affected by their resources, their history, and their different organizational cultures. Organizational culture can be defined with a useful metaphor:

> Culture is to an organization what personality is to an individual. As with personality, change takes time and may be hard to discern, especially for persons inside the organization. (Hickok, 1998)

But planners must work with more than a single culture; they work across cultures. Organizational cultures can be as difficult to understand and change as racial and ethnic cultures. Boundaries between cultures create barriers to communication and effective working relationships. Professionals and policy leaders in the child welfare, substance abuse, juvenile justice, and mental health systems may all work with families or family members, but their starting points and their basic assumptions can be very different:

- Child welfare professionals start from an assessment of child safety and then move on—in some cases—to a full assessment of the strengths and needs of the family as they relate to child safety.
- Substance abuse professionals seek engagement of their clients in a commitment to get treatment and begin a lifetime of recovery with the supports needed to ensure recovery.
- Juvenile justice professionals take a legal infraction as given and try to determine how serious it is and what diversion from the juvenile justice system may be possible.
- Mental health professionals use a variety of diagnostic techniques to determine how to classify mental illness and its severity and then move to treatment of the illness or disorder.

Each of these disciplines has its own organizational culture, reinforced by the particular organization in which they operate: a child protective services unit or foster care or adoption unit, a recovery home or outpatient treatment agency, a probation officer assigned to a school or in the main department, or a mental health clinic or private provider. To bridge the gulfs between agencies, agencies use a variety of boundary-spanning efforts, such as outstationed staff, joint training, interagency protocols, and memoranda of agreements on how agencies will work together.

Appendix 3-A describes several of these practices in an overall framework of practice among multiple systems. Young and Gardner (2002) also described them in more detail. A network of national agencies has also been addressing these issues in depth, and Appendix 3-B describes a selected set of their activities.

The Special Challenge of Family-Centered Practice

Family-centered practice, by definition, is interorganizational in nature. No one agency, discipline, or profession possesses the skills or resources to address the full range of the needs of at-risk families. That fact is the fundamental rationale for family-centered, rather than discipline-centered, practice. Yet the prescription for family-centered practice is often offered up as though it were a simple matter of linking these agencies in some form of case management or other type of interagency connection. When each agency has different screening and assessment tools, eligibility standards, definitions of who the client is, training programs, and measures of outcomes, however, it becomes difficult to assume that agencies can achieve family-centered practice without addressing these issues. These barriers are more than minor administrative inconveniences; they go deep into the personality of the agencies. As noted, changing personalities is hard, uphill, time-consuming work. Taken together, these barriers comprise the culture in which each of these agencies operates. Changing culture demands more than changing training curricula or information systems.

Family-centered practice at its most thorough may also take the form of a family systems-of-care approach, which demands even more organizational culture change. Planners can develop a system of care in a single field with relative ease, compared with the much larger challenge of doing so across programmatic areas. A system of care funded by a single program area is really a contradiction in terms, however, because it is likely to only fund those parts of the system that are under control of the funder. In contrast, tapping resources from more than one categorical funding stream to respond to families' needs requires careful negotiations about what is inevitably seen as "our money" and "their money." If only "our money" is used, it is clear that not much organizational culture is being changed.

Seeing the whole family and listening to their range of strengths and needs as the starting point for services and supports is itself a culture change. Without that perspective, however, fragmented diagnoses and fragmented services and supports inevitably win out. Family-centered practice is both an area that can test an organization's current culture and a new set of demands that the culture be widened and broadened.

Worst Practices in Changing Organizational Culture

A large body of experience makes clear that the worst way to seek organizational culture change is to mandate it. Shallow innovation usually runs into the "B team"—those who will "be around before this change and who will be around after it." Such well-established members of agency midlevel leadership may resist change because it is unfamiliar, may seem to require new methods, and may increase accountability for results. Mandates are often met with shallow compliance and watchful waiting for the innovators to tire and move on, which innovators tend to do. This chapter, however, discusses a possible exception to this general rule in the role of court mandates.

The second worst approach is to "do training" that is divorced from daily practice, in which trained workers return to their old routines immediately because nothing else in their policy, incentive structures, or resources has changed—they have only received "a training."

Other worst practices make up an unfortunately large portion of the history of efforts to change organizational culture. A hollow vision or mission statement full of glittering generalities that lack any relevance to resources or daily practice does not change culture; it merely erects a set of new slogans over old practices. A discussion of vision and mission is essential, but it must include a serious debate about alternative visions and missions, tradeoffs, and hard choices. Otherwise, the vision statement merely becomes another opportunity to postpone the hard decisions about policy directions.

Seeking organizational change through an organization's foreign policy, that is, its negotiations with other agencies, may overlook the prior need for internal coherence before an agency can negotiate seriously with anyone else outside the agency. In that connection, the most important challenge to organizational culture in interagency relations may be what has been called the "myth of self-sufficiency." This myth leads an agency to believe that its own resources are adequate to solving the problems it is mandated to address, without paying enough attention to the needs of its clients for services that are under the control of other agencies (Gardner, 1998).

The myth can acquire great power because most of the daily practices of agencies take place in their borders, using their screening and assessment tools, drawing on their training, licensure, and accreditation processes. This insular daily practice reinforces the myth of self-sufficiency, as do the complicated eligibility, funding streams, and assessment processes of "foreign" agencies and disciplines.

Organizational culture change has to begin at home, not at the boundaries or in foreign territory, with an understanding of the home agency's practices and governing policies. To start prematurely on boundary-spanning efforts before one's own agency develops a well-understood consensus may risk superficial solutions, in which a single joint training or outstationed staff member is assumed to be powerful enough to change deeply ingrained internal practices.

A final worst practice is assuming that organizational culture change is entirely about the agency's own staff and operations, without reference to either its clients or its community. One of the most important aspects of an agency's culture is how it sees its clients and the larger community in which it operates. Some agencies see their clients as law breakers, others as customers, vessels to be filled with education, or patients who need the skilled treatment that only the agency can provide. Too few agencies see their clients as the agents of their own change, able to participate in the design, operation, and evaluation of their own growth and improvement. When an organization's culture ignores its clients, its insularity becomes another large barrier to changing that culture by relying more on the strengths of the families it seeks to help.

Some agencies see their community narrowly, or simply as the geographic area in which they work. They do not work to understand the many ways a community's assets can help create a constituency for innovation. Community leaders and members of community-based groups may have a keen sense of the culture of the community and how it affects services and supports. These leaders may be sources of outreach to ethnically diverse populations, and they may help recruit community-minded staff and paraprofessionals who can work to engage clients more effectively than the public or private agencies may be able to achieve on their own.

Lessons from Other Systems and Recent Areas of Culture Change

The literature on educational innovation is a fertile field for human services innovators, because schools tend to be more rigidly organized systems than most social services agencies. In a widely praised book on educational change, Fullan (2001) concluded that innovation has two essential ingredients: accountability standards and networks of practice-based professionals. Fullan noted that it is not enough to demand better outcomes from schools; they must also have a committed body of professionals, joined by community members, who agree on the directions and tools of change and who are willing to stay the course, rather than seeking a quick fix.

The same is certainly true of both child welfare and treatment agencies. Demanding greater accountability of both systems is an undeniable trend, with the use of Child and Family Services Reviews in child welfare agencies and the proposed performance partnership grant's emphasis on outcomes in the substance abuse treatment field. Agencies will need investments in capacity building, however, to realize the benefits promised by a new emphasis on outcomes; merely mandating them is unlikely to do more than ensure that agencies will compile and submit different data. These mandates do not ensure that different ways of practice will emerge. That will require a longer time span and deeper investments in creating the kind of professional networks that Fullan (2001) stressed.

These issues of organization culture change are illustrated in family drug treatment courts (FDTCs), an innovation of cross-system practice based in the court system and in recent legislative changes regarding income support. FDTCs view the cultures of the child welfare system, the treatment system, and the courts all as important targets for change. A recent assessment of FDTCs highlights these issues:

> The implementation of a FDTC requires culture change across each agency, organization, and public entity involved with these families. Yet, each system faces its own challenges. In the child welfare system, the timeline compliance issue...is of great importance. Being out of compliance with the underlying federal legislation governing child welfare is a fundamental challenge to the goals of the projects. In the treatment agency context, FDTCs have brought new case management staffing to some of the sites, but issues of client engagement, retention, and treatment effectiveness remain critical. For treatment agencies to participate as full partners in FDTCs may require their own internal reforms in client engagement and treatment monitoring at the same time they are working more intensively with other agencies. It is clear that the complexity of families served in these programs require multiple components of services, especially children's mental health services, as key partners in the development and implementation of these programs.
>
> In the courts, the sites referenced the initial problems of securing cooperation from the defense bar, as well as their significant impact on the project, once cooperation was secured and the non-adversarial nature of the FDTC was fully understood and implemented. There has been extraordinary change among the attorneys who have implemented these models and learned to work coopera-

tively in a team approach. (Young, Wong, Adkins, & Simpson, in press)

Furthermore, Hercik (1998) described the arena of welfare reform as a series of organizational culture hurdles over different conceptions of the goals. An agency may experience internal disagreement about fundamental aspects of TANF, such as:

- whether TANF is about the well-being of children or getting jobs for recipients,
- whether a strong emphasis on work participation means that eligibility determination promptness and error rates are now less important, and
- whether the government should limit TANF services to current and former welfare recipients or make it more broadly available to the working poor.

Issues that Raise the Question

Some issues, such as the appropriate response to substance-exposed infants, create challenges to organizational culture that can become quite intense. In these issues, the problem on which two or more agency cultures disagree is immediate, visible, and client based, not an abstract discussion among agencies that stretches over time. Hospitals see the problem as affecting client privacy, child protective services and family support agencies see an opportunity to intervene with a family, maternal and child health agencies see the problem as requiring child health services, and drug treatment agencies see the problem as requiring immediate engagement to enroll a client in treatment.

A second, closely related set of issues are those conflicts that often arise in a discussion about confidentiality—who can be given what information about which clients. These issues have arisen repeatedly with issues of trust and communication, rather than legal prohibitions on sharing information. In the children's services and substance abuse arena, several forms of this conflict occur:

- parents' attorneys' views that information about their clients' drug use should not be provided to anyone, which may lead them to recommend that their clients not participate in early screening programs or enrollment in treatment prior to court jurisdiction;
- child welfare agencies' views that information about the family (e.g., prior abuse and neglect reports and other factors in the case records) should not be conveyed to the treatment agency under state laws protecting child welfare records;
- treatment agencies' views that information about treatment progress or lack thereof should not be conveyed to child welfare agencies, lest they take action the treatment agency views as inappropriate; and
- judges' views that any information they want conveyed should be completely and immediately conveyed.

Another area in which beliefs and values often form the basis of the organizational culture is in regard to a parent with addiction to opiates. Some jurisdictions exclude individuals on methadone from participation in their innovative models. Some child welfare agencies counsel heroin addicts not to take methadone as a component of treatment based on locally driven views of its utility rather than medically driven decisions about treatment.

In addressing these issues, some of the underlying value differences come out clearly. These disagreements can have major benefits if the conflicts are discussed in depth, in terms of daily practice and "what do we do next" specifics, not global generalities. Agencies addressing their cultural and policy differences might want to use hypothetical case studies of these kinds of issues to explore their differences and areas of agreement.

A Framework for Addressing Organizational Culture Change: The Special Case of Child Welfare and Substance Abuse

Children and Family Futures staff have developed a 10-element framework that staff can use to guide discussions among child welfare agencies, treatment agencies, the courts, and other agencies that serve these families and their children (Young & Gardner, 2002). Table 1 shows more recent revisions to the framework incorporating linkages across child welfare, substance abuse, and family courts.

Why are the elements in Table 1 so important to a partnership between AOD agencies and child welfare agencies?

- Partnerships can address underlying values, because the partners are very likely to come to the table with different perspectives and assumptions about their agency's mission. Unless these differences are out in the open, the partners will be unable to agree on surface issues commonly cited as barriers between systems, if they diverge widely on underlying ones.
- Partnerships can address daily practice in AOD screening and assessment, as it is in these first contacts with the client that agencies must begin the process of determining

TABLE 3-1 Issues and Models Across Child Welfare, Substance Abuse, and Family Courts

The Issue	*Bridge-Building Model*
Conflicting values and principles	Review of shared values and consensus development of cross-system principles
Conflicting screening and assessment practices and protocols	Co-located assessment staff with clear communication protocols and comprehensive family assessments that go beyond risk to address family functioning and child development
Conflicting methods and reactions to treatment engagement and retention in services	Specific models of client engagement, including peer mentors, motivation enhancement strategies, recognition of drop-off points, and joint case plans
Services to children affected by alcohol and other drugs	Development of program strategies based on developmental stages and incorporating substance abuse prevention, intervention, and treatment
Staff training and development	Engaging staff supervisors to develop clear protocols for new practices implemented through cross-systems joint training
Joint accountability and shared outcomes	Consensus on outcome measures in each system with methods to collect information and understanding of interdependence in the outcomes achieved
Information sharing and systems	Clear communications protocols determining who needs to know what information and when, supported by data systems that provide timely information
Funding and program sustainability	Inventories of multiple sources of treatment and support services funding
Building community supports	Engagement of community members in prevention and post–formal services supports, including clear linkages among community partnerships for child protective services and environmental efforts aimed at alcohol and other drug abuse
Working with related agencies and support systems to ensure comprehensive services	Development of partnerships with service agencies based on family assessments indicating which types of services families most frequently need

what kind of AOD problem—if any—caregivers have, and what form of treatment can best respond to the problem. Having consensus on these processes and what information needs to be communicated among workers requires having the parents' legal advocate as part of the system to ensure that messages delivered about substance use disorders are consistent.

- Partnerships can address daily practice in engaging and retaining parents, as new time limits demand the best possible efforts to keep clients on track in meeting their goals while balancing the many obstacles confronting chemically dependent caregivers and their children. The judicial officer and defense bar are critical players due to their potential for reinforcement and motivation toward case plan participation.
- Partnerships can address daily practice in services to children, as treating caregivers alone ignores the effects of AOD on children. In a family in which caregivers are substance abusing or addicted, the risk is that without intervention, a new generation may repeat the same patterns in which they were raised. Advocates for children's interests must be part of this effort to ensure that agencies address the long-term interests and service needs of children.
- Partnerships can address training and staff development, because without cross-training efforts, conventional practice will deepen the division between agency staff who are oriented to think separately or take adversarial tactics, rather than working collaboratively in serving shared clients.

Joint accountability and shared outcomes are the best test of whether a collaborative relationship has achieved interagency agreement on desired results. Without such an agreement, each of the partners is likely to continue measuring its own progress as it always has, using only the outcomes to which the agency is accustomed. Agencies can only achieve accountability across systems when they have clarified each group's role, responsibility, and contribution to its partners' outcomes.

Shared information systems and communication are the prerequisites for joint accountability and effective communication across systems. Without such information systems, which can determine whether joint outcomes are achieved, the partnership will have no guideposts to gauge its program' effectiveness.

Partnerships should address funding and program sustainability because tapping the full range of funding resources

available to a state or community is the only way to develop multiyear stability for innovative approaches and set locally determined priorities for these families.

Community roles in child welfare reform and substance abuse have been shown to be great resources, able to mobilize community members and community-based organizations (CBOs). These CBOs and support systems have served as a front-line of child protective services that functions as child and substance abuse prevention as well as provides ongoing supports after formal services have ended.

Partnerships should consider working with other agencies because many families with AOD problems also require assistance from services other than AOD and child welfare to address the complex issues impeding their functioning. Partnerships with mental health, domestic violence, primary health, and employment services are critical.

Many CBOs have addressed the environmental dimension of substance abuse—the ways in which a community's norms accept or reject widespread use of AOD. A number of evaluations have pointed out that it is not easy to mobilize these resources, however, and that effective community efforts require sustained efforts in which small, initial victories are followed up by longer range campaigns to widen both resident participation and the targets of community efforts (Budde, Daro, Baker, Harden, & Puckett, 2001; Solomon, Brooks, Ortiz, & Iglehart, 2000). These issues seem vital for enhancing the formal system's culture change through community-driven action to change community norms on these issues.

Urgency: The Four Clocks

It is critical to recognize the great importance of timetables in the lives of children and families and in the deadlines faced by agency staff. Organizational reform can sometimes operate at a deliberate pace, which does not always take into account either child development or agency mandates. For example, postponing a developmental assessment for a young child affected by substance abuse can mean that a sizable portion of that child's life goes by without an in-depth appreciation of the developmental effects of substance abuse on that child. The developmental timetable, the TANF two- and five-year timetables, the child welfare timetables as altered by the Adoption and Safe Families Act, and the timetable of recovery ("one day at a time, for the rest of your life") all matter. But agencies do not have the luxury of debating these in periodic meetings that may stretch out over several months, because the clocks keep running and the effects on children keep happening. Thus, a greater sense of urgency is important in organizational reforms that are affected by these timetables.

Changing from Within Versus Externally Mandated Change

Mandates cannot change culture, but sometimes mandates are aimed at changing priorities. Over time, working on those priorities may have the effect of changing the underlying culture. An example of this comes at the intersection of child welfare, substance abuse, and the courts: the expansion of family and youth drug courts. In the Reclaiming Futures program, juvenile court judges are critical leaders in securing new treatment resources for youth. These mandates may not be cultural change by themselves, but they can be a powerful claim on resources that would not be available if the agencies simply tried to negotiate those resources without such support.

But if the agencies had the resources to start with, is it essential to get court intervention to achieve lasting change? And if only courts can achieve that kind of change, then don't the courts have to move into an even more active role, because most drug courts have so far only been able to handle a limited number of cases?

The jury is still out (no pun intended) on whether judge-driven change can be as effective throughout an entire agency as a culture change that is given the time and resources to achieve changes in practices. But an important question about court-driven change is whether these changes can operate at scale. A second question is whether the kind of intensive case management that has accompanied the strongest drug court innovations would be as effective if it were based in agencies that had the resources to give priority to parents in the child welfare system, youth in the juvenile justice system, and other clients who do not receive priority access to comprehensive services and sufficient treatment resources.

Some Rules for Organizational Culture Change

Know yourself—and your agency. Recognizing that an agency's practices may vary widely from staff member to staff member, and not assuming that best practices are always the norm, can be important in understanding how your agency operates and how others perceive its operations.

Know your prospective partners and what resources and skills they can bring to bear to work with families you are serving. Look actively for the skills and life and community experience of your partners, and spend time understanding how their mandates and the outcomes they use to measure success can bring strengths to an interagency team.

Keep talking. Staff never achieve the vital stage of information exchange, as the first level of collaboration, in a single workshop. Information exchange requires active listening, which may be

enhanced by actually working a case, in which a collaborative group drawn from different agencies sees how different staff approach a case with multiple needs and strengths.

Tackle some specific barriers with your partners, but pick the barriers carefully and do not try to overcome them all at once. Drawing on practical experience (perhaps based on a pilot project that keeps running into the same organizational barriers, like personnel rules or eligibility regulations), frame a challenge to policy leaders: You told us to work together, and this barrier keeps us from it. So help us get rid of the barrier. The message to organizational cultures is clear—front-line staff are encouraged to identify recurring barriers, whereas policy leaders are held accountable not for preaching change, but for busting barriers and changing the rules. In the debate about why the rules need to be changed, the organization's basic culture will be revealed.

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APPENDIX 3-A Matrix of Progress in Building Linkages Among Alcohol and Drug Agencies, Child Welfare Services, and the Dependency Court, as of May 17th, 2003

Issue	*Fundamentals for Improved Practice*	*Good Practice*	*Best Practice*[a]
Underlying Values and Principles of Collaborative Relationships	Values clarification efforts have begun among the three systems. Groups understand and articulate the value of family strengths and how family systems and issues of culture and gender relate to addiction, recovery, relapse, and their effects on families. Discussions have begun concerning the political will to address the overlapping alcohol and other drug (AOD)/child welfare services (CWS) population. Different time limits and developmental needs of children have been identified as critical issues.	The systems have negotiated a formal joint statement of principles covering responses to CWS-involved children and parents with substance abuse problems. The groups institute cross-system discussions and problem solving among policymakers, administrators, and practitioners.	Formal values clarification efforts include all staff of the three systems. The systems agree on individual and joint goals to serve the whole family as their primary client.
Daily Practice: Client Screening and Assessment	The three systems have a joint policy on decisionmaking regarding screening and assessment and effects of results on removal and placement decisions. A jointly developed risk assessment protocol includes a formal review of parents' and children's AOD needs and is recorded for all clients. The assessment process addresses culture and gender.	The groups have clarified roles for screening and assessment; AOD workers have been outstationed at CWS offices and dependency courts for screening and assessment, or contracted staff have been assigned screening and assessment roles for CWS parents. Culture- and gender- appropriate joint case assessments and plans have been developed with CWS-involved parents with substance abuse problems.	The systems have negotiated screening and assessment roles about which system will perform each role, using tools that have been revised and refined based on interagency discussions of how best to detect and follow up on substance abuse problems. Jointly developed quality assurance mechanisms have been implemented for interpretation of assessment information.
Daily Practice: Client Engagement and Retention in Care	Systems have begun "drop-off mapping" of the points at which parents are not responding to referrals and not complying with treatment requirements. Systems have agreed on procedures for culture- and gender-specific approaches to outreach for parents who miss appointments. The issue of relapse has been identified as a major area needing clarification between the two agencies and the courts, and discussions are under way to negotiate a consensus on shared outcomes that reflects both child safety and recovery goals. Dependency courts understand that they have a role in monitoring compliance with court orders for treatment and case plans.	Staff learn motivational interviewing or other methods of engaging and retaining parents in treatment. The agencies have programmatic responses to improve family participation and completion rates. Systems understand and respond to how AOD issues and treatment requirements of families interact with CWS and court requirements.	Client relapse typically leads to a collaborative intervention to re-engage the parent in treatment and to reassess child safety. Systems monitor and respond to how compliance with case plans and requirements is resulting in changed behavior. The three systems agree on how they will monitor aftercare and what the desired long-term outcomes of treatment are. Efficient case management and outcomes monitoring tools enable tracking of the progress of individual clients as well as the effectiveness of the whole system.

APPENDIX 3-A Matrix of Progress in Building Linkages Among Alcohol and Drug Agencies, Child Welfare Services, and the Dependency Court, as of May 17th, 2003 (continued)

Issues	*Fundamentals for Improved Practice*	*Good Practice*	*Best Practice*[a]
Daily Practice: Services to Children of Substance Abusers	Systems are taking a developmental perspective to addressing needs of children of substance abusers in their own system. Each system has a focus on child safety as well as family recovery. Each system is ensuring that children and youth are assessed for the effects of parental substance use on children as well as the youth's own AOD use. Service delivery and programs for all children incorporate issues of culture and gender.	Each system ensures that children and families are linked to specific programming for family treatment and children of substance abusers prevention and intervention services. Each system understands and implements its role in ensuring child safety. Independent living programs include AOD prevention and intervention programs for youth.	All CWS-involved children receive developmentally appropriate interventions to address their status as a child of a substance abuser.
Joint Accountability and Shared Outcomes	Each system has its own outcome measures with beginning recognition of the overlapping issues in cross-system outcomes. Some shared outcomes have been agreed on but each system feels primarily accountable for its own measures of success.	Systems use outcomes criteria in their contracts with community-based providers (who serve CWS- and AOD-involved parents) to measure their effectiveness in achieving shared outcomes.	The child welfare agency accepts shared accountability for recovery outcomes for its clients. The treatment agency accepts shared accountability for child safety for the children of its clients. The court accepts responsibility for monitoring the outcomes of children and families in the court system. All three systems are accountable for safety, permanence, and well-being outcomes for children and families. Systems use summaries of outcomes data from across the three systems to inform policy leaders and community about progress toward consensus benchmarks.
Information Sharing and Data Systems	The three systems have documented the gaps in their current client information systems and are addressing them. AOD assessment at intake captures data about child needs among child welfare families. CWS assessment at intake captures data about AOD issues. Data on the overlap between child welfare families and the caseloads of other systems has begun to be available to AOD, CWS, and court systems. An interagency process has identified the confidentiality provisions that affect AOD, CWS, and court connections and has devised means of sharing information while observing these regulations.	The three systems agree on information systems that track parents' referral, prior episodes in each system, progress in treatment, and family outcomes for those parents whom the agencies can regularly identify as shared clients. Data on the overlap between child welfare families and the caseloads of other systems is consistently available to AOD, CWS, and court systems. Interagency communication protocols have been developed, and staff use them for information sharing between the three systems.	The systems use information systems that can be linked to track parents through all three systems and monitor family and treatment outcomes, using data to reallocate resources toward client and community needs and the most effective programs. Overlap data is used to redirect resources. The systems monitor the outcomes of information sharing.

APPENDIX 3-A Matrix of Progress in Building Linkages Among Alcohol and Drug Agencies, Child Welfare Services, and the Dependency Court, as of May 17th, 2003 (continued)

Issue	*Fundamentals for Improved Practice*	*Good Practice*	*Best Practice*[a]
Training and Staff Development	The agencies have committed to staff development in each system to address AOD and CWS issues. Training for all stakeholders has begun, with regular updates and a set curriculum that devotes adequate time to substance abuse and child welfare issues. Training for parents, guardians, and foster parents has begun to address substance abuse issues.	Training in each system is institutionalized, with regular updates and a set curriculum that devotes adequate time to substance abuse and child welfare issues. Multidisciplinary training has been implemented. Training for parents and foster parents addresses substance abuse issues by drawing on parents' experience and the lessons of services and prevention efforts with children of substance abusers.	The three systems engage local colleges, universities, and law schools to develop preservice education that addresses the cross-system issues. Systems monitor the outcomes of the training. Training for parents and foster parents is treated as an equal priority as professional training.
Budgeting and Program Sustainability	Systems have begun to inventory all funds available for treatment and children's services in the state and community. Systems have begun to identify the outcomes of innovative practices that merit sustained funding.	Temporary Assistance to Needy Families, Medicaid, and other major funding sources for treatment are used regularly for funding treatment for child welfare parents.	A multiyear funding plan has been developed with input from all three systems, which includes negotiated commitments from multiple funding sources, including those beyond the direct control of substance abuse and child welfare agencies.
Working with Related Agencies	A partnership with law enforcement is in place to appropriately address the needs of children during any needed police action. All three systems recognize that each member of a family may have a variety of co-occurring needs. • Core clinical issues—mental health, family violence, and trauma. • Concrete support services—income support, employment training, transportation, housing, and child care. • Other needed supports—primary health care, HIV/AIDS, education, and dental services. Staff are aware of how to link families with the other services that are frequently needed by AOD- and CWS-involved parents and make referrals to those agencies. Parent education courses for AOD- and CWS-involved parents include significant content on alcohol and drug issues.	Staff assess and address children's and parents' needs as barriers to family recovery. The three systems monitor receipt of services. Parent education courses are formally evaluated for their effect on parenting practices. The three systems have a case management role of mentoring and facilitating engagement in and delivery of services. The three systems coordinate with law enforcement and corrections agencies, and criminal courts, to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation and treatment while parents are incarcerated).	All three systems evaluate outcomes of services provided to families and routinely monitor the effectiveness of services. A fully collaborative process exists across systems with the resources needed by parents with substance abuse problems, including screening, assessment, follow-up, and joint advocacy for the added resources needed in each system to adequately serve families who have co-occurring problems affecting their parenting, family stability, and risks to children.

APPENDIX 3-A Matrix of Progress in Building Linkages Among Alcohol and Drug Agencies, Child Welfare Services, and the Dependency Court, as of May 17th, 2003 (continued)

Issue	*Fundamentals for Improved Practice*	*Good Practice*	*Best Practice*[a]
Working with the Community and Supporting Families	Community members are included in the planning and development process. The agencies are in the beginning stages of implementing proactive responses to prevention of substance abuse and child abuse/ neglect and providing support for families through partnerships with community members and family support systems. A system for community education about substance abuse, child abuse/neglect protection, and reporting exists that includes civic groups in the collaborative efforts. Efforts have begun to engage faith-based communities in supporting families. A variety of supports provide mutual aid and recovery networks to families.	Environmental data collection supports community education (e.g., mapping liquor stores and driving under the influence arrests). Agencies have implemented geo-mapping of family resource centers and other community assets. Agencies use consumers/families/ graduates as active members of service implementation. A formal mechanism exists to solicit the support of a community advisory group including consumers in its membership. Community supports for sustaining sober living communities and environments exist.	Sober living and transitional housing programs are linked to institutionalized funding sources. Communitywide accountability (report cards) systems are in place, and information is used to redirect resources toward highest priority areas and most effective programs. Community partnerships in child welfare recognize the central role of substance abuse and have shown their willingness to accept direct family support roles for substance-abusing parents.

a *Best practice* refers to the most fully developed system envisioned by a collaborative of the substance abuse, child welfare, and dependency courts working together. It does not imply “evidence-based practice,” and it includes a desire to continue to assess best practices.

APPENDIX 3-B National Publications Regarding Substance Abuse

Organization	*Year*	*Product*	*Activity*	*Target Audience*
National Governor's Association		Position paper on child welfare that calls for flexibility in funding to address substance abuse and mental health issues		State governors
National Council of State Legislatures	2001	Book: *Linking Child Welfare and Substance Abuse Treatment: A Guide for Legislators*	Workshop at annual meeting: "Linking Child Welfare and Substance Abuse Treatment" (Children and Family Futures [CFF])	State legislators
American Public Human Services Association		Policy resolution on substance abuse and child welfare		State child welfare administrators
National Association of Public Child Welfare Administrators/ National Association of State Alcohol and Drug Abuse Directors	2000	Resource guide to integrating services that contains information on best practices, training and curricula, and federal-level and foundation funding sources	Joint forum on collaboration between agencies	State child welfare and alcohol and other drug (AOD) administrators and front-line supervisors
Child Welfare League of America	1998	Book: *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy* (Child and Family Futures) (CCF)		Federal, state, and local child welfare and AOD administrators
	1998	Issue Forum on Capitol Hill: "Breaking the Link Between Substance Abuse and Child Maltreatment"		Federal legislators and federal child welfare and AOD administrators
	1998	AOD survey of state child welfare agencies		State child welfare administrators
	2001	Website about proposed Child Protection/Alcohol and Drug Partnership Act (CPADPA) encouraging collaboration between state child welfare and AOD agencies		Federal and state policymakers and child advocates
	2001	Book: *Alcohol, Other Drugs, and Child Welfare*		Federal and state policymakers and child advocates
	2001	*Children's Voice* article: "Substance Abuse and Child Abuse"		Federal and state policymakers and child advocates

APPENDIX 3-B National Publications Regarding Substance Abuse (continued)

Organization	*Year*	*Product*	*Activity*	*Target Audience*
Children's Defense Fund	1998	Book: *Healing the Whole Family: A Look at Family Care Program*		Federal and state policymakers and child advocates
	2001	Website about the proposed CPADPA		Federal and state policymakers and child advocates
	2001	Fact sheet: *Substance Abuse and Child Protection*		Federal and state policymakers and child advocates
Annie E. Casey Foundation	1998	Curriculum: "Working with Drug-Affected Families"		Child welfare workers
	1996		Funded pilot project: START (Sobriety Treatment and Recovery Team), a child welfare model for drug-affected families, part of the Family-to-Family Initiative	State and local child welfare administrators
U.S. Conference of Mayors	1998, 2001	Conference resolution calling for a national substance abuse strategy, including more money for treatment		Congress and federal AOD policymakers
	1999		Winter meeting: U.S. Department of Health and Human Services Committee identified drug treatment as a top priority of the committee	Mayors, Congress, and federal AOD policymakers
Columbia CASA	1999	Book: *No Safe Haven: Children of Substance-Abusing Parents*		Federal and state AOD and child welfare policymakers
	1999	Op-ed for various national newspapers		General public
	2001	Handbook: *Safe Haven Manual*		State and local AOD and child welfare administrators
U.S. General Accounting Office	1998	Report: *Foster Care: Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers*		Federal legislators
Center for Substance Abuse Treatment and U.S. Children's Bureau with Office of the Assistant Secretary for Planning and Evaluation	1999	Report: *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*		Federal legislators

APPENDIX 3-B National Publications Regarding Substance Abuse (continued)

Organization	*Year*	*Product*	*Activity*	*Target Audience*
Center for Substance Abuse Treatment and U.S. Children's Bureau with Office of the Assistant Secretary for Planning and Evaluation (cont.)	1999	Stakeholders meeting on substance abuse and child protection (CFF)		Federal, state, and local child welfare and AOD administrators
	2001	Confidentiality forum		Federal and state child welfare and AOD administrators
	2001		Regional team-building workshops: *Protecting Children: Substance Abuse Treatment and Child Welfare Working Together*	Federal, regional, and state child welfare and AOD administrators
	2001	Book: *Navigating the Pathways: Connecting Alcohol and Other Drug Treatment, Child Welfare, and Family Support Services* (CFF)		Federal, regional, and state child welfare and AOD administrators
Addiction Transfer Technology Centers	1998	Conference report: *Child Welfare and Addiction Services: Working Together for California's Children and Families*	Conference: *Child Welfare and Addiction Services: Working Together for California's Children and Families*	Local AOD and child welfare administrators and front-line workers
		Curriculum: *Notes from the Field: Outreach Workers' Perspectives on Engaging and Motivating Clients to Enter Substance Abuse Treatment*		Local child welfare administrators and front-line workers
National Resource Centers	Ongoing		Technical assistance to various states on request	State and local child welfare administrators
	1997	Publication: *Delivering Culturally Competent and Sensitive Services to Women with Drug Abuse Problems and their Children*		State and local child welfare administrators
	1997	Publication: *Integrated Services and Permanent Housing for Families Affected by Alcohol and Other Drugs*		State and local child welfare administrators
	1998	Monograph: *Between Two Worlds: Child Maltreatment and Substance Abuse*	Symposium: *Between Two Worlds: Child Maltreatment and Substance Abuse*	State and local child welfare administrators
Recipients of FY 97 Child Welfare Training Grants	1997	Curricula developed for child welfare workers on substance abuse and other issues		Local child welfare administrators and front-line workers

Responsive Communities to Heal and Support Vulnerable Children and Families

Nancy P. Gannon

The Juvenile Court: An Agent in a Responsive Community

The juvenile court system engages both children and their families. It also acts as an agent in a responsive community. The mission of the juvenile court has been the same since its inception more than 100 years ago: to provide a locally governed process, by which children charged with offenses may be given an impartial hearing and assessment, acquitted or sanctioned for wrongdoing as warranted, and, if found guilty of an offense, provided with rehabilitative services in the context of their family and community life.

Treatment and rehabilitation for troubled, vulnerable, court-involved children and youth have been shown to be most effective when children stay at home or close to home in a healthy family and community environment—or the nearest possible and least restrictive equivalent. Although the field may hold this as an ideal, today's juvenile court population has brought challenges and complexities to often failing and under-resourced systems and programs, resulting in many policies, programs, and practices that take children far away from family-, home-, and community-based supports.

The most critical changes in the juvenile court population bring with them the greatest challenges—the majority of adjudicated children and teens today have serious emotional and behavioral problems, compounded by years of neglect and nonexistent or grossly inadequate therapeutic treatment, on top of many family, community, and system failures. Tragically, parents may not find any assistance or support for serious mental and behavioral health issues until their children enter a system or institution.

Although a general lack of research into the prevalence and type of mental health issues affecting adjudicated youth exists, what is known is alarming. An estimated 50% to 75% of incarcerated juvenile offenders throughout the United States have diagnosable but largely untreated mental illnesses (Coalition for Juvenile Justice, 2000). More than two-thirds of delinquent youth have co-occurring substance abuse and mental health problems (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). In a national survey of parents with adjudicated children, 36% of parents stated that they were forced to relinquish custody or guardianship to the court to access mental health services for their emotionally disturbed children (National Alliance for the Mentally Ill, 1999).

One of the strongest and most effective innovations in juvenile justice in recent years, to better respond to the needs of this growing population, has been to engage families and develop family-linked supports and services across child-serving institutions and agencies. Some large-scale reform efforts hold the potential to have even greater positive cross-system effects, such as JJDPA (P.L. 107-273, Title II-B §42 U.S.C. 5601), legal action, and the international movement for balanced and restorative justice. Important also are smaller seeds of innova-

tion emerging in the juvenile justice community, including the use of multisystemic, family-based therapies; wraparound approaches; and critical reforms in practice with promise to stem the flow of children and youth into secure detention.

Nevertheless, funding mechanisms that favor institution-based care and lock-step reactions to youth offenders that place cost savings ahead of prevention and rehabilitation reinforce three negative trajectories for court-involved youth: (1) confinement, control, and punishment; (2) dispensing them back to their homes or communities with no services, supervision, or support; and (3) inaction, which allows children and youth to develop ever more problematic behavior. As a result, optimal services based on family-driven and community-based supports are delivered too late and are too limited.

A Case in Point

Daphne, age 13, lived with her grandmother in a high-rise subsidized housing complex in San Francisco. Their two-bedroom apartment was neat, tidy, and sunny. The girl's grandmother clearly loved her, but knew that she could no longer set enforceable limits on Daphne's behavior. She had no idea where her granddaughter went from early morning when she left the apartment until after dark when she returned home. She hoped that Daphne was attending school and packed lunch for her some days. But deep down the grandmother had doubts; she hadn't seen school records or a report card in years.

In a little crib in the corner of the living room, an infant once slept. But Daphne, left alone with her newborn for a few minutes while her grandmother was out on an errand, killed the baby. She picked up her baby girl and dropped her from the 15th-story window of her grandmother's apartment.

Now charged with the equivalent of first-degree murder, Daphne began her connection with the juvenile court system. As a result, she received her first comprehensive evaluation of her emotional, social, and intellectual functioning. The results revealed that she was emotionally and cognitively functioning at about age 6, could not even write her name, had an amphetamine habit, displayed affective and conduct disorders, and was able to show little remorse about taking the life of her baby. She confessed that she had sex with men to get drugs and money, but was not sure how she had become pregnant.

Other than social security and welfare income, her grandmother had never received supportive resources. She expressed despair that strangers had to come into her home to tell her how to raise her granddaughter, but she opened the door and listened. Her own daughter, Daphne's mother, was in prison serving a 10-year sentence for armed assault. The court, feeling that Daphne was little risk to her own safety or that of others, returned her to her grandmother's custody after a 30-day stay in secure detention. They required her to check in with a probation officer daily and also enrolled her in a nonsecure day treatment and school program.

Daphne's first system contact came at her arrest. She was referred to a day treatment/youth service agency. Her probation officer and caseworker were to piece together her life, draw in all of the supports—principally among them family, as well as professionals in multiple systems—and provide her with guidance, structure, education, and therapy to heal her young life. Their task was to help Daphne become a young woman who, at the very least, would learn to care for herself and others by having her re-engage in school and attend counseling, drug rehabilitation, and peer support programs. Even so, it seemed like too little, too late, and of little relevance to what Daphne faced each day in the crime-ridden corridors of her grandmother's apartment building.

Daphne's case can illuminate many of the issues that converge when the neglect and suffering of children remain largely invisible until something terrible happens. Although the homicide of a newborn is, fortunately, not a common outcome, children and youth with life trajectories similar to Daphne's are not uncommon. She is one of an estimated 1.5 million minor children with a parent in prison, for whom rates of delinquency are higher than average and who elicit an expanding response from the child welfare community (Mumola, 2000).

She is also one of a rapidly increasing number of girls coming into the juvenile justice system. Although overall rates of delinquency fell from 1988 through 1997, delinquency cases involving girls increased 83% during that time span, and they climbed most significantly in the category of violent assault. Researchers frequently identify histories of substance abuse, as well as trauma related to physical and sexual abuse, among girls who are arrested (American Bar Association and National Bar Association, 2001).

What Is the Change We Seek?

The change that professionals in the field seek in building responsive communities to heal and support vulnerable children and families is a change that would mean that all of the responsible and caring adults in the life of a child like Daphne would take responsibility. No one who could see her pain, struggles, and disabilities would assume that she is somebody else's responsibility.

A responsive community would have many checkpoints and supports to provide critical help at earlier and more frequent times along the lifepath of such a child. For instance, when Daphne was first absent from school at age 9, a child and family support team could have been alerted and visited her home. When her mother was arrested—even before her trial—an agency could have identified family support needs and put a plan in place to give the grandmother the needed and desired support to raise Daphne. The law enforcement officers who saw Daphne roaming her neighborhood in the questionable company of adult men could have looked into her well-being. Clearly, many other possible opportunities existed for early and ongoing interventions and support.

System links and community collaborations to support healthy, safe, and mainstream outcomes for such a child and her family would be in place. For instance, preschools and schools, as a daily point of contact with children and families, can link them to medical, social, and therapeutic prevention and intervention resources. Faith institutions are often the place of family-community contact where trust and positive regard are strongest and the most influential in the lives of families—particularly families experiencing stress and families with cultural and linguistic differences from mainstream America. Innovations in public health have led community health clinics to see part of their charge as staying alert and intervening when they see early warning signs of child and family stress. Citizen volunteers and advocates for children work with the courts to represent the needs and interests of children like Daphne.

Implementation of comprehensive juvenile justice and delinquency prevention practices that provide for the healthy development of children, adolescents, and families necessitates the collaboration of many local service systems, including nontraditional community providers: schools, courts, child protection agencies, public health services, private nonprofit organizations, public recreation agencies, faith institutions, and caring adults in the community serving as mentors and tutors. With comprehensive practices, evidence-based interventions would be the norm. Daphne slipped through cracks in the system. She was not a child who acted out early in school, and many children lived in her neighborhood whose behavior or peer interactions presented far more danger to others.

The common denominators among best practice programs in child development and juvenile justice are early invention, family engagement, and cognitive/behavioral treatment delivered across multiple settings—primarily in the home, pediatric office, school, and community.

Even later, a prenatal or infancy nurse visitation program might have provided Daphne with instrumental support during her pregnancy as tertiary prevention. Juvenile justice professionals and advocates are familiar with several prevention and intervention programs that meet scientific standards of proven program effectiveness, including nurse visitation (Muller & Mihalic, 1999).

Care at home or close to home, ensuring a healthy and safe environment, would be prized. The court returned Daphne home and required her to report to a day treatment program. This is a better outcome than remaining in detention, however, supports in her home or closer to her daily life would have been optimal. Providing supportive services in Daphne's neighborhood and in her grandmother's public housing apartment would require rethinking and retooling the standard "you come to us" relationship of child and family service providers.

To the greatest possible extent, supportive services would identify and overcome barriers. Although the rates of juvenile arrest, juvenile violations of the law, and juvenile reoffending have all steadily fallen in the past decade, an unfavorable view of youth in general, coupled with the "superpredator" theories of the early 1990s, have caused many policymakers and juvenile justice practitioners to increase the use of highly restrictive and punitive interventions. Since the early 1990s, through legislative mandates, ballot initiatives, and redirection of funding streams toward interdiction and incarceration, juvenile justice has become excessively punitive, at the expense of prevention and rehabilitation. Dire ramifications have come about for multiproblem and multisystem children and their families, particularly families of color.

It is in this climate of widespread, punishment-oriented policies and practices that juvenile justice professionals, those from other child-serving systems, family members, and advocates must work to produce positive change.

Moving the Mountain– Large-Scale Supports and Reforms

Several major national and federal initiatives in both the public and nonprofit private sectors have helped generate large-scale supports and reforms for noninstitutional, multidisciplinary policies and practices for troubled, fragile, adjudicated youth and families. They have moved mountains. Yet much of what professionals could do to take full advantage of such movement—such an innovative and collaborative opportunity—remains before us.

Involving State Juvenile Justice Advisory Groups Via JJDPA

Since 1974, JJDPA has maintained a structure for local citizen involvement in the development and implementation of policies and programs for delinquency prevention and the overall care and custody of adjudicated children and youth. The act, reauthorized with bipartisan support in 2002, requires the involvement of state advisory groups (SAGs), which are appointed by governors or chief executives in all U.S. states, territories, and the District of Columbia. SAGs are composed of voluntary representatives from multiple child-serving professions and agencies, blending the public and private sectors. They are required to have youth members, preferably youth who have had system contact. Family members are not required, but several SAGs have had the foresight to include family members or representatives of family organizations.

In addition, JJDPA provides basic protections for children and youth and calls for a coordinated, cross-agency response to the care and custody of court-involved children and youth. In 2000, the 56 SAGs empowered by the act, represented by a national association known as the Coalition for Juvenile Justice (CJJ, 2000), published an advisory report for the president, Congress, the Office of Juvenile Justice and Delinquency Prevention, and the states that addressed the mental health needs of young offenders. The report called for the following, among other recommendations:

- Congress should acknowledge the underlying role that mental illness can play in crimes committed by youth and authorize and appropriate $100 million to assist states in supporting cost-effective family- and community-based mental health treatment.
- Policymakers should mandate that no parent be forced to surrender legal custody of their child solely for the purpose of acquiring mental health treatment.

Moreover, new mental health language in the reauthorized act provides federal funding to the states and directs its use toward providing:

- pretrial services, such as mental health screening and assessment;
- plans detailing needed mental health services to juveniles in the juvenile justice system, including information on how such plans would be implemented and how such services would be targeted to those juveniles in the system who are in greatest need of such services;
- mental health services for incarcerated juveniles suspected to be in need of such services, including assessment, development of individualized treatment plans, and discharge plans; and
- mental health treatment for juvenile offenders and at-risk youth to reduce the likelihood that they will commit future crimes.

Such language presents a double-edged sword. The new language and the attendant funding that flows with it could fuel continued use of institution-based services, which often involve little assessment and heavy use of medication and control-oriented treatment, rather than more effective family-driven, community-based assessment and treatment.

Yet JJDPA also opens the door for innovation and change in mental health and substance abuse services that are stimulated and delivered by the juvenile court and juvenile justice system. Professionals and advocates for behavioral health, mental health, child welfare, and substance abuse treatment, as well as families, must join with juvenile justice advocates to inform the process of how the states can best expend these funds strategically to produce cross-system changes as well as effective home- and community-based services.

Child welfare language has also been added to the reauthorized act in ways that, if managed wisely, could also produce constructive and proactive change and spur greater family and community collaboration and responsiveness. Specifically, the act urges SAGs and the states to provide for the following:

- Treatment, including treatment for mental health problems, to juvenile offenders and juveniles who are at risk of becoming juvenile offenders, who are victims of child abuse or neglect, or who have experienced violence in their homes, at school, or in the community. SAGs and states also need to treat the youths' families, to reduce the likelihood that such juveniles will commit violations of the law.
- Comprehensive juvenile justice and delinquency prevention projects that meet the needs of juveniles through collaboration of the many local service systems juveniles encounter, including schools, courts, law enforcement agencies, child protection agencies, mental health agencies, welfare services, health care agencies, private nonprofit agencies, and public recreation agencies.
- Policies and systems to incorporate relevant child protective services records into juvenile justice records, for the purposes of establishing treatment plans for juvenile offenders.

Legal Action as an Engine of Reform

Although the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice may seem distant from the heart of a responsive community, major federal reforms, including the Civil Rights of Institutionalized Persons Act (CRIPA, §42 U.S.C. 1997), the Individuals with Disabilities Education Act, and the Americans with Disabilities Act, have produced much-needed changes. Lawyers dispatched into local juvenile justice facilities by the U.S. Attorney General's office set the stage for system reform. In recent years, they have investigated conditions of confinement and unlawful activities in more than 100 juvenile facilities in 16 states, Puerto Rico, and the northern Mariana Islands (U.S. Department of Justice, n.d.). As a result, thousands of juvenile offenders who were confined in life-threatening and inhumane conditions have received relief and, in many cases, have received far more safe and appropriate care and services.

Investigations, monitoring, court orders, consent decrees, negotiations, and conciliations, as well as settlement agreements, have shut down juvenile facilities and produced changes that have significantly increased the value and quality of care for adjudicated youth and families. CRIPA actions in juvenile facilities have exposed widespread conditions that exacerbate and create mental distress and disorders among youth in confinement, including a general lack of appropriate recreation, education, counseling, and family contact, as well as extremely dangerous conditions such as gang warfare; physical abuse and coercion by staff; lack of ameliorative medications, or excessive use of medications to dope youth into lethargy; and excessive use of physical restraints, pepper spray, and isolation.

The most frequently cited allegations leading to CRIPA actions against juvenile facilities are systemic deficiencies connected with staff abuse and inadequate mental health, drug treatment, and medical services. Family members and juvenile advocates often inform authorities about concerns. Suicide risk, too, sounds the alarm. Youth in confinement have a substantially increased risk of suicide, yet 75% of the nation's juvenile confinement facilities fail to conform to even the most basic suicide prevention guidelines (CJJ, 2000). In fact, youth suicide rates in juvenile detention and correctional facilities are more than four times greater than youth suicide rates in the general population (Memory, 1989).

Although CRIPA actions occur in response to crisis conditions, each crisis exposes a powerful opportunity for change. CRIPA actions not only offer an important means of keeping watch on the mental health and drug treatment services given to youth who are considered the least socially desirable, but also offer an opening for change in the services provided to these most vulnerable and easily forgotten youth. Given that CRIPA actions against juvenile facilities are widespread and ongoing, it is critical to consider how such actions can bring youth out of the institutions and back into family- and community-care settings while also providing comprehensive, family-friendly, and truly rehabilitative services for youth who must remain in confinement.

In cooperation with the Special Litigation Unit of the U.S. Department of Justice, advocates and professionals have redesigned and reorganized juvenile corrections and detention facilities. They have shut down harmful facilities, moved youth out of facilities into community placements, enhanced assessment and treatment services in facilities and transitional settings, and created new policies and procedures for managing the behavior and treatment of youth, among other system reforms (Rosenbaum, 1999).

Citizen Involvement in Balanced and Restorative Justice

Drawing on international models from New Zealand, Australia, and Canada, a new way of thinking about and addressing juvenile offending emerged in the mid- to late-1990s and moved rapidly throughout the nation. It is known variously as balanced and restorative justice, victim-offender mediation, family group or community conferencing, and circle sentencing. The essential idea of balanced and restorative justice is that if crime is about harm, then justice should emphasize repairing the harm. The people involved pursue repairing the harm, as it relates to youth offenders, in a three-point balance of the needs of victims, offenders, and communities.

Because crime is considered as harm and justice as repair, young offenders and their families are not simply the objects of punishment, but the primary people responsible for repairing harm. Active participation of victims, victims' families, offenders, offenders' families, and community members make the process work. Agents of the court and other child- and family-serving agencies facilitate, support, and enforce reparative agreements.

Restorative justice is not, however, only an extension of the "neighborhood justice centers" or "community justice models" that began in the 1970s and resulted in positive changes to bring the courts into local neighborhoods, along with informal practices such as dispute resolution, mediation, and negotiation. Restorative justice goes further: It defines distinct, instrumental roles for community members in determining the terms of a young

offender's accountability or that of his or her family and how they are to make repairs as part of the dispositional or diversionary sanction (Bazemore & Umbreit, 1998).

Local community responses and collaborations affect both the sanctioning and the rehabilitative potential in restorative justice practice. Studies from the United States and other countries cite significant benefits both to offenders, in terms of reducing recidivism, and to victims and survivors, in terms of enhancing their sense of well-being and healing (CJJ, 2002). With more than 300 restorative justice programs nationwide, many of which handle juvenile cases, cross-system pioneers have a platform for breaking down boundaries. "The framework for restorative justice involves the offender, the victim, and the entire community in efforts to create a balanced approach that is offender-directed and, at the same time, victim-centered" (Prison Fellowship Ministries, 2001).

From This Tiny Seed—Small but Mighty Change Initiatives

Across the United States, small-scale supports and reforms are powerful levers for change in and across multiple systems. It becomes crucial, therefore, to consider ways to invest in local collaborative efforts built on values and system reform practices, rather than just the charisma of individuals. At the same time, it is crucial to invest in expansion and replication initiatives that can scale up local activities of high promise and effectiveness, appropriately blending local needs and local tailoring with the fidelity and integrity of strong program models.

The Detention Reform Movement

Today, the juvenile justice system and, more specifically, its detention centers and corrections institutions, are gateways to mental health and substance abuse screening, assessment, and treatment services. A gateway, however, should not be construed as a door closed and bolted behind the child who enters.

Despite continual decreases in juvenile offending, the population of youth confined in pretrial detention is steadily growing and includes an alarmingly high census of youth of color and fragile youth with serious emotional, behavioral, and substance abuse issues. The number of youth who reside in detention centers on an average day is estimated to be more than 27,000, and it has grown 72% over the past decade. It is also estimated that as many as 600,000 children and teens cycle through secure detention each year. These numbers are especially poignant when one realizes that most of these youth do not need to be there at all (CJJ, 2003).

In a recent CJJ interview (available from the author), Bart Lubow, director of the Program for High-Risk Youth at AECF and a national leader in detention reform, stated:

> When you talk to judges, prosecutors, or other juvenile justice professionals, many of them say things like, "We locked him up for his own good." Or, "We locked him up because his parents weren't available." And, "We locked him up to get a mental health assessment." But none of these reasons are reflected in statute or professional standards.

Not surprisingly, 60% of youth in secure detention have behavioral or mental health disorders, and up to 70% have substance abuse problems (National Mental Health Association, 1999).

Detention reform efforts push many levers of system change and collaboration. In communities as diverse as Tarrant County, Texas; Multnomah County, Oregon; North Dakota; and New York City, reformers have found that keeping youth out of secure detention accrues many benefits for youth and families, including better mental health assessment and treatment, greater and stronger connections with family and community supports, and a reduction of harsher, more punitive treatment of youth of color compared with their white counterparts (CJJ, 2003).

In North Dakota, for example, agencies use short-term "holdovers" in lieu of detention in community sites throughout the state. While awaiting their hearings, youth get one-on-one attention from trained adult advocates, including social workers, teachers, clergy, and retired volunteers. The goal is to return juveniles home or to a more appropriate setting within 8 to 12 hours. For youth, families, and communities, the effect has been positive. Holdovers preserve the safety of youth and communities, hold youth in the least restrictive setting and for the least amount of time possible, hold youth as close to home as possible, put law enforcement back to work sooner, and free up valuable resources (North Dakota Association of Counties, 2003).

Treatment at Home or Close to Home

A principal benefit of treatment models that engage the social ecology of a child's life, linking formal and informal supports, is that juvenile justice programs have also moved from a framework of trying to "fix" children by removing them from family and community connections, and away from seeing family as a source of dysfunction, to seeing family and community as sources or potential sources of strength. Indeed, several states and localities have made a critical shift from institutional placement to community-

based approaches that aim to maintain and build the stability and integrity of families while addressing the serious emotional and behavioral needs of children, including adjudicated children.

The 1980s and early 1990s found deeply troubled children expensively treated for lengthy stretches in hospitals, learning routines and habits that interfered with or reversed healthy development and that did not prepare them to return home, safe and sound. Partly born out of such treatment failures, coupled with fiscal exigencies, family- and community-rooted approaches, such as wraparound and multisystemic therapy programs, are having significant positive effects. Wraparound Milwaukee, for example, has reported reductions in recurrence of serious criminal behavior associated with mental illness among youth, including sex offenses, weapons offenses, drug offenses, assaults, and property offenses. At the same time, inpatient psychiatric hospitalization for youth decreased by 80% and residential treatment by 60%. Because care is provided in the community, in family settings, or at home, Wraparound Milwaukee reduced costs from an average of $5,000 per child per month to an average of $3,300 per child per month (CJJ, 2000).

Wraparound and other similarly effective treatment models are changing the manner of business in juvenile justice—not only do they offer strengths-based approaches, but they involve families as active, sometimes driving participants in service planning and delivery. Other key components that make such approaches effective include child and family teams, composed of all of a youth's primary supports, and care coordination by professionals, which assists families in managing their particular treatment plans. Mobile crisis units can support the entire wraparound process with 24-hour contact availability, and community provider networks can respond to the multiple needs identified by each family.

Yet the future of wraparound and similar initiatives often centers on addressing barriers to service and system collaboration, along with issues of community cohesion and safety. Some of the tasks identified by providers include reconciling the different "languages" spoken by participants (e.g., mental health and court jargon), handling role definition and role sharing, engaging culturally and linguistically sensitive community partners, building bridges with faith communities, sharing case records and information, and dealing with the ongoing, essential need to keep families centrally involved.

Responsive Individuals in a Responsive Community

Contemporary philosopher Amatai Etzioni (1995) stated, "Justice comes from responsive individuals in a responsive community." In a responsive community, individuals work cooperatively for the benefit of the whole. One cannot mandate the teamwork that develops; it must be motivated by common purpose and vision.

The vision for building responsive community care for seriously emotionally disturbed, court-involved children, youth, and families requires complete recognition of the negative status quo that exists for many juvenile justice services today, a status that too often results in damaging and dangerous outcomes for both youth and communities (see Table 4-1). The vast majority of children and youth who come to the attention and into the care of the juvenile justice system would fare far better if the responses to them created bridges to healthy outcomes. Right now, the juvenile justice system too often creates bridges to further delinquency and criminality. A moral imperative, as well as strong public safety rationale, urges us to do much better and to achieve optimal practices based on healthy and safe outcomes for youth, families, and communities.

Seeking the answers to key questions can guide intentional development of a common vision for optimal practice and responsive community. Some beginning questions to consider include:

- What is the value to be found in building links across systems if individual systems are themselves broken? How can professionals avoid having efforts be corrupted and sabotaged? Can the process of building links itself catalyze constructive and sustainable change?
- What can agencies do to engage families first and throughout the development and implementation of cross-system communication, integration, and collaboration?
- Who should be in charge of treatment and services—the courts, the juvenile, the family, victims, communities, or providers?
- How can systems stay true to collaboration when money resources may work against them?
- How can agencies ensure that the positive outcomes of large-scale or demonstration initiatives have positive effects on local practice?
- How can the field broadly replicate and expand effective, small-scale policy and program initiatives with fidelity, so as to make them widespread norms?
- How can the values and principles of cross-systems work be infused into your practice and into widespread practice?
- Ultimately, how will we define and measure our success?

TABLE 4-1 Building Responsive Community Care

Negative Status Quo	*Better*	*Optimal*
Neglect	Consistent attention	Individualized adult involvement
Inhumane conditions	Secure, safe environment	Safe, supportive home
No support	Support in one or two formal systems	Family-driven support
Punitive control	Caring institution or agency	Caring, community-based team
Overburdened	Lower caseload ratios	System follows child's needs

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APPENDIX 4-A JJDPA of 2002

JJDPA of 2002 became P.L. No. 107-273 on November 2, 2002. It took effect October 1, 2003. Before then, JJDPA of 1974, as amended, remained in effect.

The purpose of the act is:

- to support state and local programs that prevent juvenile involvement in delinquent behavior,
- to assist state and local governments in promoting public safety by encouraging accountability for acts of juvenile delinquency, and
- to assist state and local governments in addressing juvenile crime through the provision of technical assistance, research, training, evaluation, and the dissemination of information on effective programs for combating juvenile delinquency.

The act also serves as the authorizing legislation for the Office of Juvenile Justice and Delinquency Prevention at the Office of Justice Programs, U.S. Department of Justice.

Under JJDPA, states are charged with appointing and staffing SAGs, which will monitor the care and custody of children and youth in the delinquency system, in keeping with core requirements. SAGs will disperse federal grant monies to support effective delinquency prevention programs.

JJDPA's core requirements contain basic protections for children and youth, including:

- Agencies must serve youth who commit status offenses, such as breaking curfews, running away, or using tobacco and alcohol—offenses that if done by an adult, would not be considered crimes—outside of secure confinement, close to home, and in their communities whenever possible.
- Courts and agencies must keep children out of adult jails. If it becomes absolutely necessary to place children in adult lock-ups, they must be kept completely separate from adult inmates and may not be held for more than six hours.
- Research has shown that the system confines youth of color more often, and these youth have system contact more often, than white youth charged with similar offenses under similar circumstances. Therefore, states must undertake efforts to ensure that all children are treated equitably.

Collaboration for Family-Driven Systems and Services

Trina W. Osher

On February 5, 2003, the Subcommittee on Children and Family of the President's New Freedom Commission on Mental Health advanced a new vision for children's mental health, in which:

> our communities, states, and nation provide access to comprehensive, home and community-based family-centered services and supports for children with mental health disorders...while creating conditions that promote positive mental health...and prevent the onset of emotional problems in all children. (Huang & Mayberg, 2003, p. 1)

In describing the status of children's mental health in this country as a crisis and in presenting its vision, the subcommittee declared most emphatically that "our nation [must] adopt a comprehensive, systematic, public health approach to improving the mental health status of children" (Huang & Mayberg, 2003, p. 1). Collaboration, partnerships, and coordination are called for again and again in the policy options and implementation strategies delineated in the subcommittee's summary report (see Appendix 5-A). To achieve this vision requires a radical change in the organizational cultures of the systems and agencies that currently provide services to children with mental health needs and their families.

A central feature of the organizational culture of any child-serving system is how the system perceives children and families and how the children and families are expected to engage in decisionmaking. Everything agencies do for children who have behavioral health needs and their families requires a decision. Every system, agency, and provider faces the daily challenge of fully, effectively engaging families in making decisions about the care, supports, and services they receive. Agencies also must make decisions about the policies and practices that shape the way these systems and services operate and meet individual child and family needs. Engaging families in making decisions in a multisystem context is especially hard because of the effort it takes to reach consensus among many different systems, each with its own perspective. One of the hallmarks of systems-of-care approaches is the way people reach this consensus. The values and principles of systems of care require collaboration, cooperation, and shared decisionmaking across all the child-serving systems and agencies in a community, including family-run organizations and family members who receive services themselves.

The Paradigm Shift

The paradigm shift shown in Table 5-1 provides a framework for understanding the evolving role of families and family-run organizations, as systems and services make the shift from being exclusively driven by providers to being driven by families. By collectively adopting this framework, child welfare, juvenile justice, and child mental health systems will be taking a significant step toward cultural change and cross-system collaboration. Acting together with families and youth to adjust agency and system policy

TABLE 5-1 Paradigm Shift

Row	*Source of Solutions*	*Provider Driven*	*Family Driven*
1	Relationship	Professionals and agencies	Child, family, and their support team
2	Orientation	Child and family are a dependent client expected to carry out instructions	Partner/collaborator in decisionmaking, service provision, and accountability
3	Assessment	Isolating and fixing a problem viewed as residing in the child or family	Ecological approach enabling the child and family to do better in the community
4	Expectations	Deficit oriented	Strengths based
5	Planning	Low to modest	High
6	Access to services	Agency resource based	Individualized for each child and family
7	Outcomes	Limited by agencies' menus, funding streams, and staffing schedules	Comprehensive and provided when and where the child and family require

Source: Adapted from Osher and Osher (2002).

and practice to facilitate a family-driven approach to their work gives child-serving systems a common goal around which to build strong and productive relationships and the infrastructures to sustain them.

In communities in which agencies have begun to make this paradigm shift from a provider- to a family-driven system, some encouraging changes in system behavior and outcomes are occurring:

- Treatment settings have shifted from hospitals and long-term residential treatment to care in the community. The percentage of children served as emotionally disturbed under the Individuals with Disabilities Act (IDEA) receiving services in residential schools or hospitals has dropped, despite a 20% increase in the total number of children served in this category.
- The array of treatments, services, and supports has greatly expanded, including such novel services as therapeutic horseback riding, mentors, anger management, and respite care.
- The background of the individuals who provide mental health services has also changed. Many children now receive their primary mental health care from group home staff or specialized foster parents, classroom teachers and paraprofessionals in public schools, probation offices, social workers, family-run organizations, and even volunteers from the community.

Table 5-1 depicts different ways many professionals, agency staff, and families and youth view their relationship and interact with each other. Both individuals and organizations are complex—they are pushed and pulled by many factors, and they can change over time. Hence, these two paradigms can be conceptualized as the ends of a continuum on which the orientation and behavior of single individuals, agencies, and service systems can be located, both at individual moments and over time. Shifting the paradigm requires fundamental change in an organization's or system's culture.

The first two rows specify factors that affect the interaction of professionals and agencies on one hand and families and their children on the other. They identify who is the key force in improving outcomes, the nature of the relationship between the system and the family, and the orientation of service delivery.

Provider-driven systems view professionals and agencies as the key force in solving problems. They possess the expertise and tools to diagnose problems, the unique knowledge to prescribe the solution, and the precise skills to implement, monitor, and evaluate the prescribed interventions. Furthermore, the system presumes that they have the professional or bureaucratic values to do all of this in an appropriate manner, consistent with professional ethics and agency procedures. Through the implementation of best practices, they use their professional expertise to fix their clients' problems, and perhaps in some cases, the clients

themselves. Goffman (1961) defined this orientation as that of the "tinkering trades," in which the professional and agency approach fixing their client in the same way that a watchmaker fixes a watch. Professionals who believe in this role typically expect strict compliance from relatively passive children and their families. They also expect deference to their particular expertise from professionals in other disciplines.

This orientation may be shared by family members. They may be socialized by their culture or taught by the professionals and agencies themselves that the preferred role is deferential compliance (Katz & Danet, 1973). Although this orientation has been general to the human services, it has been particularly powerful in children's mental health, child welfare, and juvenile justice, in which workers have blamed families—not other agents—for children's problems and viewed youth as too young, too troubled, or too disobedient to define solutions.

Systems that operate from a family-driven paradigm assume that a child's family has expert knowledge gained from experience or training. Families are entitled and expected to contribute to defining the nature of the presenting problems, the various internal and external factors contributing to them, the range of strategies that could resolve these problems, and the criteria by which the team will determine successful outcomes. The child's service planning team, which includes the family and its support network as well as providers and agencies, takes collective responsibility for making decisions. They subscribe to a common goal of providing whatever it takes for the child and family to experience a better quality of life consistent with the family's goals, values, culture, and spiritual beliefs.

The third and fourth rows of Table 5-1 address problem assessment and the expectations that individuals and agencies bring to service design, anticipated outcomes, and service evaluation. Under the provider-driven paradigm, assessment tends to be deficit oriented and narrowly focused. The provider-driven paradigm addresses specific problems, conceptualized as being located in the child or family individually. Given the resource limitations, focus on deficits, and need to manage the professional or the agency's expert image, expectations in provider-driven systems typically are limited and modest.

Family-driven systems undertake assessment in a holistic and strengths-based manner. They start by building on the things the child and family can do well and incorporating the natural supports in the child's and family's everyday environment and community. Problems are, to be sure, identified. But they do not ascribe blame to individuals in the family or their provider network. The task is to get a clear, universally understood, reasonably objective description of the problems and how to remedy them. The expected outcomes are high and include every child living safely at home, getting good grades at school, adhering to rules, and participating in community life alongside their siblings, friends, and neighbors. The Federation of Families for Children's Mental Health offers "The World of Evaluation," a three-course curriculum to train families in understanding and using evaluation and research to advocate for their children and for system change.

The fifth and sixth rows address the approach to service planning and accessing services. In a provider-driven system, planning starts with agency resources and the skill set of the professionals it employs. The questions asked usually are about how the existing resources (staff and programs) of the agency can be employed in a cost-efficient manner to address the presenting problems or identified needs. Not surprisingly, access to services in provider-driven systems is limited by the existing menu of agency services, agency procedures, funding mandates, and service delivery patterns. Families may feel compelled to accept what is offered, even it if does not meet their needs, simply because other options are not available, they are desperate for help, or they will be punished if they do not agree (Cloward & Piven, 1972). In contrast, a family-driven system asks, "What are the needs, and how can they best be met?" Services are selected, structured, or developed to address these needs and ensure they are provided at times, in ways, and at places where family can access them without causing further disruption to their already highly complex and stressful life.

Finally, the seventh row contrasts the overall outcomes of the two paradigms. The provider-driven outcomes are delimited by system function as well as by the need to protect the image of an agency or provider. Outcomes measured in provider-driven systems tend to focus on the relief of specific symptoms. Lack of progress (treatment failure, recidivism) is attributed to noncompliance of the child and family with the treatment plan as directed by the provider alone.

Systems that are family driven see evaluation as a tool yielding data for continuously improving services and their delivery. Such systems set, and typically attain, high performance standards. When families are actively and respectfully engaged in making decisions at every stage, they are invested in making things work and actively participate in services to achieve their own desired outcomes. The providing systems, individual providers, and service recipients all experience greater satisfaction with the process and its results.

Service programs are paying increased attention to family participation in research and evaluation activities. Results of a

survey conducted in 37 sites constituting 31 programs funded by the Center for Mental Health Services indicated participants perceived family involvement as improving the quality of data collected, and ultimately, the services provided to children and their families (Osher, Van Kammen, & Zaro, 2001). Sites with family members as full partners in their evaluation activities reported an increase in the amount of data collected and in the degree to which families provided complete and honest responses to questionnaires and interviews.*

Collaborative Practice

Systems that understand this paradigm shift adapt their philosophy, values, policies, and practices to actively operate in a true collaboration with families. In systems of care, this collaboration extends across systems and agencies, facilitating access to resources, sharing responsibility, and building consensus between family members and professionals. Families have identified several practices that support cross-system and interagency collaboration (*Collaborations*, 1995):

- Collaboration can reduce the number of separate interventions to the family and the number of individuals working with the family. Families involved with several child-serving systems need relief from the stress and burden of integrating the goals and requirements of several different systems, especially when these are in conflict with each other.
- Collaboration, even when the actual number of individuals intervening with a family is reduced, can provide more support and more time for those who actually do the work with the family. It can also make it possible for the individuals providing services to work better with each other.
- Collaboration can put the family at the center of the planning process. Developing one unified plan, regardless of the number of systems and agencies involved with the family, unifies goals and allows planners to resolve conflicts between the different systems' requirements. Family needs become the focus of the planning process and services. Families have a greater array of services and providers from which to choose how their service plan will be implemented.
- Collaboration can improve training for all stakeholders in systems of care. Including family members as designers, facilitators, and participants in training along with system providers ensures the content focuses on what families truly need, resulting in improved outcomes and consumer satisfaction with services.
- Collaboration can facilitate follow up, support systems, and communication.

Keys for Networking, a statewide, family-run organization in Kansas, affiliated with the Federation of Families for Children's Mental Health, has developed a checklist that community planners (see Table 5-2) can use to self-assess their progress in collaborating.

What Families Need from Professionals

Children and families are typically resilient, bouncing back to normal after a special event, whether tragic or happy, that disrupts their everyday routines. Families raising a child with an emotional, behavioral, or mental health problems, however, are sometimes overwhelmed by the energy required over a sustained period that is necessary to attend to the needs of their child. Other children and family responsibilities can be neglected during the most stressful stages of this experience. It can be humiliating and embarrassing for parents to admit this to others. This is especially true when parents fear being blamed by professionals for causing their child's problems or being accused of neglecting their child-rearing responsibilities. Families want to regain their ability to manage their lives and their children while accessing services.

A study of factors that promote resilience in children with serious emotional disturbances "suggests that family functioning and access to resources is an important protective factor" (Gyamfi, Price, & Sukumar, 2003). To accomplish this, families need professional partnerships that focus on the whole family system. Families need relationships with providers that include sufficient trust and safety to feel comfortable asking for the help they really need. They need choices and a voice in the decisions made about their children. Families need information about their child's mental health condition and about local resources so they can work with professionals to resolve their problems. They need jargon-free explanations of diagnostic and other technical information, opportunities to get their questions answered in straightforward

* The Federation of Families for Children's Mental Health offers "The World of Evaluation" a three course curriculum to train families in understanding and using evaluation and research to advocate for their children and for system change.

TABLE 5-2 Checklist for Collaborative Practices

Yes	No	Check Your Collaborative Practices
❑	❑	Do parents participating in collaborative committees represent the community's racial, cultural, economic, educational, and geographic situation?
❑	❑	Do parents participating in collaborative committees include those representing parent organizations and coalitions?
❑	❑	Is there a community appeal process? Do procedures allow families an appeal process in the community when they are dissatisfied with services from any agency?
❑	❑	Do service planning groups and advisory boards hold meetings at times when families can attend?
❑	❑	Are meetings of community planning groups and advisory boards composed of equal numbers of parents and providers?
❑	❑	Are procedures in place to reimburse family members for time, services, transportation, and child care when they attend planning meetings and advisory boards?
❑	❑	Do community mechanisms disseminate to and receive information from individual parents and parent groups? Do procedures assess the effectiveness of these mechanisms?
❑	❑	Are parents involved at the planning and policymaking level for all programs and services targeted at children with emotional disabilities?
❑	❑	Are community resources available for parents to share information and support each other?
❑	❑	Does the community have a coalition of parents or parent support groups?
❑	❑	Do families in this community have access to a statewide referral or parent support system?
❑	❑	Do community mechanisms, such as community respite and attendant care programs, support families to care for children in their homes?
❑	❑	Do community agencies include training in the following areas: skills and methods for working with families and other professionals, and financing home care options?

Source: Adapted from Collaborations (1995).

terms, and time to digest and think about what it all means for them, their child, and their family. Families need to connect and network with other families who are traveling (or have recently traveled) a similar path.

Families need support to recognize their own strengths and training to acquire new skills to meet their child's special needs. Families need service environments that are warm, upbeat, supportive, engaging, accepting, nonjudgmental, and culturally, linguistically, geographically, and emotionally accessible. Families need in-home supports. Families need peer support—including sibling support groups. They need respect for what they know about their children, their compassion, and their intelligence, culture, time schedules, and commitments. Families need respite from the stress of their responsibilities. Table 5-3 lists responses from professionals that parents view as helpful.

Advice from Youth

Fully developed and effective systems of care include youth in their collaborations in addition to families. Anyone who has worked with children and youth knows firsthand that even the best plan implementing evidence-based practices with fidelity will fail when youth do not actively collaborate in the services. In 2000, youth with co-occurring mental health and substance abuse disorders and their families described how they wanted to be included in collaborative service planning and delivery (Federation of Families for Children's Mental Health, 2000).

Chief among these was to be treated with dignity, respect, honesty, and fairness and for providers and policymakers to truly hear their desires, perspectives, and concerns. These youth recommended that providers:

TABLE 5-3 Helpful Responses from Professionals

"It's not your fault! You are not powerful enough to have caused the kinds of problems your child has."

"I think your son could be a success story for our agency."

"I value your input."

"Under the circumstances, you are doing the best you can do. Frankly, I don't know what I would do or how I would be able to carry on."

"I agree with you."

"Your son has made progress and I know he can do more, so we will continue to work with him."

"I don't know. I can't tell you what's wrong with your child or what caused the problem."

"Your child knows right from wrong. She knows most of society's values and that's because you taught them to her."

"You know, it is OK to take care of yourself too."

- rely on youth to guide them in understanding who they are, what problems they face, and how to help them;
- actively engage youth in designing and evaluating programs, providing access to information, and having a voice in making treatment decisions;
- create opportunities for youth to turn their experiences into positive growth experiences and reclaim their self-esteem, such as by helping others in treatment and aftercare;
- individualize services and supports while treating each individual as a whole and complex person, and including the whole family in the healing process;
- give youth and their families usable and helpful information in illness, treatment, aftercare, and funding so they can make well-informed decisions;
- have youth- and family-friendly staff available at convenient times to answer questions from youth and their parents; and
- educate the public about mental health issues and encourage positive models of treatment for families, in schools, and through youth groups. (Federation of Families for Children's mental health, 2000)

Summary

Successfully bridging the cultures of the different child-serving systems depends on having a common goal of high importance to all stakeholders. Family and youth involvement is just such a goal. In making the paradigm shift to a family-driven system, the participating systems and agencies adopt policies and change their practice to facilitate, encourage, and reward collaboration, promote understanding, and overcome their differences.

Questions to Generate Dialogue

- What will it take to ensure a full, representatively diverse, and sufficient youth and family voice in all aspects and levels of the systems and programs serving children with mental health needs and their families?
- What specific policy, practice, or behavior are you prepared to change to bring about full involvement of families in the agency or program where you work?
- Why is it that funding to support infrastructure for family organizations is so hard to come by? What will it take to change this?
- Why is it that when money gets tight, funds for family organizations, family support, family training, family participation in policy work, and other family-driven activities are the first to be cut? What will it take to change this?

Suggestions for Further Reading

The following are available from the Federation of Families for Children's Mental Health, 1101 King Street, Suite 420, Alexandria, VA 22314; 703/684-7710; ffcmh@ffcmh.org.

- *Blamed and Ashamed: The Treatment Experiences of Youth with Co-occurring Substance Abuse and Mental Health Disorders and Their Families.* This monograph documents the treatment experiences of youth with co-occurring mental health and substance abuse disorders from the perspective of youth and their families.
- *Family Guide to Systems of Care for Children with Mental Health Needs.* A collaboration between the federation and Vanguard Communications, Inc., this bilingual (Spanish and English) booklet is published by the Caring for Every Child's Mental Health: Communities Together Campaign sponsored by the Center for Mental Health Services.
- *Learning from Colleagues: Family/Professional Partnerships Moving Forward Together.* A product of the peer technical assistance network, this monograph presents research and commen-

tary on the issues involved in using a family/professional partnership systems approach in situations involving children who have developed or are at risk of developing serious emotional, behavioral, or mental health disturbances and their families.

- *New Roles for Families in Systems of Care* (Volume 1) of the 1998 series of monographs, "Systems of Care: Promising Practices in Children's Mental Health." This book provides background on how families raising children with mental health needs have found and developed their voice to become strong partners and assertive leaders in developing a better system of care. The executive summary of this and the six other volumes in the series also are available in Spanish.

- *Offering Technical Assistance to Native Families: Clues from a Focus Group.* This 24-page report provides information about the culturally specific technical assistance needs of Native American families.

- *Opportunities for Parental Involvement in Special Education Afforded by the Individuals with Disabilities Education Act Amendments of 1997.* This tool for families is based on excerpts relating to parent involvement that are taken from P.L. 105-17, known as IDEA. Using a table format, it presents suggestions for how parents can responsibly take advantage of the opportunities afforded by the referenced sections of the law. (Also available in Spanish.)

- *Principles of Family Support.* This handout defines family supports and describes how to provide them to help families maintain close involvement with their children even when they are in out-of-home placement and how to help families when their children are ready to return home.

- *Staying Together: Preventing Custody Relinquishment for Children's Access to Mental Health Services*. This advocate's guide offers several suggestions for state policies to reduce the practice of requiring families who have exhausted all their insurance and private resources to relinquish custody of their children to get mental health treatment paid for with public funds.

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APPENDIX 5-A Policy Options: President's New Freedom Commission on Mental Health Subcommittee on Children and Family

Promoting Preserving and Restoring Children's Mental Health, February 5, 2003

Mental health problems among children and adolescents constitute a public health crisis for our nation. They affect an increasing number of children and youth, impact children and their families in all spheres of life, and result in costly and often tragic consequences. Yet our nation has failed to adopt a comprehensive, systematic approach in response. At the first ever Surgeon General's Conference on Children's Mental Health in 2000, the Surgeon General reported "growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them." The National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health, after reviewing data on how mental illnesses affect morbidity, mortality, and disability among children, concluded, "no other illnesses damage so many children so seriously." The extent, severity, and far-reaching consequences of mental health problems in children and adolescents make it imperative that our nation adopt a comprehensive, systematic, public health approach to improving the mental health status of children.

A Public Health Crisis

The scope of this public health crisis can be characterized by the following:

- The problem of emotional disorders in children is large—20% of all children are affected—and seems to be growing.
- Emotional problems in children often are both serious and long lasting, and can lead to tragic consequences: poor academic achievement, failure to complete high school, substance abuse, involvement with the correctional system, lack of vocational success, inability to live independently, health problems, and suicide.
- Youngsters with emotional problems not only have diagnosable disorders but also show significant impairments in important life domains, such as family, education, peers, work, and community.
- The human and financial costs of emotional problems in children are both broad and deep; they affect the children and their families, schools, communities, employers and the nation as a whole. Expenditures for mental health services in the specialty mental health and general health sectors alone were $11.75 billion in 1998.
- A disproportionate number of low-income children experience emotional problems and a disproportionate number of low-income and racial and ethnic minority children do not access services for their emotional problems.
- Youth with emotional problems are invariably involved with more than one specialized service system, including mental health, special education, child welfare, juvenile justice, substance abuse, and health; but no agency or system is clearly responsible or accountable for them.

The Vision

In response to this identified need, the Subcommittee seeks to advance a new vision for children's mental health that will make a real difference in the lives of children and their families. The vision calls for a commitment to promote the emotional well-being of children and ensure that children with emotional disorders live, learn, work, and thrive in their communities. The vision for children's mental health is one in which our communities, states, and nation provide access to comprehensive, home and community-based, family-centered services and supports for children with mental health disorders and their families, while at the same time creating conditions that promote positive mental health and emotional well-being and prevent the onset of emotional problems in all children.

Our vision embraces:

- A comprehensive array of home and community-based services and supports to provide treatment and to support the functioning of children with emotional disorders and their families at home, school, work, and in the community;
- The full participation and partnership of families and other caregivers at all levels;
- The recognition that this is a nation of diverse races, ethnicities, and cultures and that services must be culturally competent and equitable for all children and families; and
- Efforts to promote mental health and prevent emotional disorders among children, as well as to identify disorders and intervene early in order to maximize positive outcomes and minimize disability.

The values underpinning our vision reflect certain "standards of care" for children's mental health:

- Home and Community-Based Care—Children belong in their homes and in their communities and every effort should be made to keep them there and to return them from institutional to home and community settings.

APPENDIX 5-A Policy Options, Subcommittee on Children and Family (continued)

- Family Partnerships—The family is the most important and lifelong resource in a child's life, as well as being legally and morally responsible for a child.
- Comprehensive Services and Supports—A broad array of services and supports should be available to children and their families, responding to issues that are biological, neurological, psychological, and social.
- Cultural Competence—Services and systems should be responsive to the cultural perspectives and racial, ethnic, cultural, and linguistic characteristics of the diverse populations served.
- Individualized Care—Services should be individualized to each child and family, guided by a comprehensive, single plan of care for each child and family that addresses strengths as well as problems and needs.
- Evidence-Based Practices—When state-of-the-art, evidence-based interventions are available, families should be informed of them, and these interventions should be made available to children and families.
- Coordination—Services and systems should be coordinated at the service delivery level, and the agencies and programs that serve children should be linked with those serving adults.
- Early Identification and Intervention—Services and supports should emphasize early identification and intervention, as well as prevention of mental health problems, to maximize the likelihood of positive outcomes.
- Accountability—There should be a clear point of responsibility and accountability for children's mental health care at all levels.

Expanding on the Commission's Interim Report, the Subcommittee delineates nine problem areas that hinder the vision for children's mental health and its underlying values from becoming reality:

- Fragmentation in responsibility and funding
- Lack of family partnerships and family support
- Unmet need and disparities in access
- Gaps in services
- Gap between what we know and what we do
- Lack of prepared workforce
- Lack of focus on prevention and early intervention
- Lack of accountability and quality improvement
- Lack of understanding of mental health problems in children and stigma

Policy Options to Achieve the Vision

The Subcommittee highlights ten policy options as essential strategies to begin building a better system to address the mental health needs of the nation's children. These ten, followed by implementation options, are the first steps toward achieving the Subcommittee's vision. In its final report, the Subcommittee offers a more extensive blueprint for building the system.

1. Implement a Comprehensive Approach to Children's Mental Health at Federal and State Levels

The federal government and each state government should plan and implement a comprehensive, cross-agency, public health approach for promoting, preserving, and restoring children's mental health. The approach should focus on both strengthening services and supports for children with serious emotional disorders and their families, and on prevention and early intervention strategies for all children.

Implementation Options

- Plan and implement a cross-agency, comprehensive, public health approach for children's mental health at federal and state levels;
- Strengthen children's mental health focus in state governments;
- Establish a federal interagency entity for children's mental health;
- Reinstitute white house conferences on children.

2. Finance a Broad Array of Services and Support

Federal and state agencies and commercial insurers should realign funding policies related to children's mental health to support a comprehensive array of services and supports, including home and community based services and supports that are individualized, family focused, coordinated, and culturally competent.

Implementation Options

- Develop a plan for Medicaid to support home and community-based services and supports and individualized care;
- Allow families to buy into Medicaid in order to access intensive rehabilitative community services and supports only available through publicly funded systems;

APPENDIX 5-A Policy Options, Subcommittee on Children and Family (continued)

- Develop strategies to better align children's mental health funding streams across systems;
- Maximize strategies to provide coverage and mental health care to uninsured children;
- Develop strategies to increase coverage of home and community-based services, preventive interventions, and screening in private insurance and managed care systems;
- Demonstrate home and community-based alternatives to Medicaid-funded psychiatric residential treatment; and
- Provide technical assistance related to more efficient and effective implementation of early and periodic screening, diagnosis, and treatment.

3. Strengthen Family and Youth Partnerships and Family Support

Federal, state, and local governments should ensure that families, substitute families, and other caregivers, as well as youth, are full partners and have substantial involvement in all aspects of service planning and decision making for their children at federal, state, and local levels.

Implementation Options

- Implement strategies to prevent the unnecessary transfer of custody in order to provide care;
- Review and strengthen federal and state requirements for family participation;
- Expand support for family organizations to provide information and training; and
- Provide coverage for family support services in public and private insurance.

4. Individualize Care: A Single Plan of Care for a Child and Family

States should ensure that each child with a serious emotional disorder has an individualized, single plan of care (Individualized Service and Support Plan—ISSP) that addresses the child's and family's needs across life domains and incorporates services and supports from all needed agencies and systems.

Implementation Options

- Develop and implement an individualized service and support plan for each child with a serious emotional disorder; and
- Provide technical assistance on individualized service planning (developing a single plan of care) and providing individualized care.

5. Broaden the Range of Services and Supports and Build Capacity

Federal and state governments should promote a broader concept of "mental health" services for children and adolescents with emotional disorders and their families. This concept should include the comprehensive array of treatment services and supports needed to enable these youngsters to reach and maintain their optimal level of functioning within their homes, schools, and communities.

Implementation Options

- Develop a model benefit design for children's mental health services for public and private insurers;
- States and foundations initiate demonstration programs of services and supports considered to be high priority service caps;
- Implement a demonstration of respite services for caregivers of children with serious emotional disorders;
- Provide support for research in the area of psychopharmacology for children;
- Provide incentives to state governments to invest in building service capacity;
- Increase development of services for youth with co-occurring substance abuse and mental health disorders; and
- Develop state plans to improve access to high quality, culturally appropriate mental health services for racial and ethnic minority youth with emotional disorders.

6. Strengthen Mental Health Services to Children Within Schools

Recognizing that children receive more services through schools than any other public system, federal, state, and local agencies should more fully recognize and address the mental health needs of youth in the education system. Likewise, these agencies should work collaboratively with families and develop, evaluate, and disseminate effective approaches for providing mental health services and supports to youth in schools.

Implementation Options

- Strengthen mental health services in schools and schools' role in promoting social and emotional well-being;

APPENDIX 5-A Policy Options, Subcommittee on Children and Family (continued)

- Expand prevention/early intervention approaches and positive behavioral supports in schools;
- Train teachers and school personnel to recognize signs of emotional problems in children and to make appropriate referrals for assessment and services;
- Create a state-level infrastructure for school-based mental health services; and
- Ensure state special education and related services for children with emotional disorders under IDEA.

7. Screen High-Risk Populations (Juvenile Justice and Child Welfare Populations) and Link Them with Services

Systematic screening procedures to identify mental health and substance abuse problems and treatment needs should be implemented in specific settings in which youngsters are at high risk for emotional disorders or where there is known to be a high prevalence of these or co-occurring mental health and substance abuse disorders. Screening should be implemented upon entry into, and periodically thereafter in, the juvenile justice and child welfare systems, as well as in other settings and populations with known high risk, such as the Medicaid population. When mental health problems are identified, youth should be linked with appropriate services and supports.

Implementation Options

- Analyze existing tools for screening and identifying mental health problems and support research to develop new tools where needed;
- Incorporate developmentally and culturally appropriate behavioral health screening into EPSDT screens;
- Improve training for professionals in schools, child care, and primary health systems to recognize signs of mental health problems and take appropriate action;
- Screen high risk children in settings with high prevalence (juvenile justice and child welfare systems) and link to services.

8. Strengthen Early Childhood Mental Health Interventions

A national effort focusing on the mental health needs of young children and their families should be implemented. Grounded in emerging neuroscience research highlighting the ability of environmental factors to shape brain development and subsequent behavior, this effort should include educating parents, the public, and professionals about the importance of the first years of a child's life for developing a foundation for healthy social and emotional development.

Implementation Options

- Develop a collaborative state plan for early childhood mental health;
- Provide technical assistance to states to implement a comprehensive approach to early childhood mental health services;
- Explore feasibility of coverage for early childhood mental health services in public and private insurance and eliminate barriers to coverage; and
- Train mental health practitioners to diagnose and treat mental health problems in young children and families.

9. Prevent Mental Health Disorders

The federal government should develop and implement a comprehensive approach for enhancing the well-being of children and adolescents, based on a bio-psychosocial model, through preventive interventions prior to the onset of mental and behavioral disorders.

Implementation Options

- Screen all children ages 0 to 5 for social and emotional development as part of primary health care visits;
- Provide mental health screening in community health centers; and
- Address barriers to coverage of preventive intervention services in health insurance.

10. Build an Adequate Workforce

The federal government should work in partnership with state governments, national accrediting organizations, professional disciplines and organizations, licensure entities, family organizations, and universities to ensure an adequate workforce for the delivery of children's mental health services.

Implementation Options

- Develop and implement a strategic plan to develop the children's mental health workforce; and
- Develop and implement a strategic plan to address the workforce crisis in mental health services and research for racial and ethnic minority youth and their families.

Conclusion

This first of two monographs describes the complexity, urgency, and severity of the needs for the children, youth, and families receiving or in need of services and supports from the child welfare, juvenile justice, and behavioral health systems. Furthermore, it highlights the emerging evidence base supporting the use of an integrated systems-of-care approach to improve the quality of care for this most vulnerable population. This monograph offers different systemic perspectives on changing the circumstances, conditions, and outcomes of this most vulnerable population. The three summits that will follow, the deliberations of the seven work groups, and the diversity of participant stakeholders will all inform the consensus agenda in the second monograph.

Building on the latest program, practice, and policy innovations in each system, this initiative seeks to overcome the obstacles that currently hinder multisystem efforts. It will draw on the expertise of diverse cultural and ethnic groups; federal, state, and local agencies and elected officials; public and private service agencies, including faith-based agencies; researchers; foundations; business stakeholders; and other community stakeholders, including service consumers and family members, to determine how to foster system culture change among child- and family-serving systems to improve the quality of care. This broad consensus is essential to creating a meaningful and realistic agenda that agencies can collaboratively implement and sustain over time.

> "Broader participation is required to
>
> 1. Empower people who have not previously been involved in community level problem solving;
> 2. Create relationships between people from various backgrounds, disciplines, sectors, and levels; and
> 3. Bring together people and organizations with sufficient range of knowledge, skills and resources so the group, as a whole, can achieve the breakthroughs in thinking and action that are needed to understand and solve complex problems." (Lasker & Weiss, 2003, p. 27)

The consensus agenda will articulate the services and supports needed across and in these systems and the actions required to design, implement, and sustain a comprehensive, integrated system of care. Such an integrated system of care would be responsive, effective, and successful in improving the quality of care and thereby improve the well-being of this vulnerable population. Given the engagement of community stakeholders as well as public system stakeholders, it is not unreasonable to also anticipate that such efforts will increase the social capital in these impoverished communities and foster increased community-building capacities as well.

Only when we, who work in or influence these systems, fundamentally change how we understand our roles with one an-

other; change our relationships with the children, youth, and families we serve; and actively engage community stakeholders, will this most vulnerable population have the supports and opportunities necessary for a successful life in the community.

Ultimately, the mutual task and responsibility is to agree on the agendas and actions that will fundamentally change this population's circumstances and conditions. Such a multipronged and integrated approach is necessary to improve the quality of care for these vulnerable children, youth, and families and, therefore, improve their service outcomes. Certainly, the American public, legislators, policymakers, consumers, and professionals and other stakeholders reasonably expect us to improve the quality of care, life circumstances, and well-being of the children, youth, and families served by these public systems.

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