When Worlds Collide: *Improving the Interface between our Children's Mental Health and Juvenile Court Systems*

By John Franz

Introduction

Sometimes when we try to integrate the world of the juvenile court with the world of our public mental health systems it feels like we are caught in a 1950's science fiction film. I almost expect Michael Rennie and his enigmatic robot, Gort, from *The Day the Earth Stood Still* to step into the room and mutter, "Klaatu, Berrada, Niktu," before warning us that we must cooperate or perish. And those who continue to exhort us to collaborate, despite all the difficulties, sound like Larry Keating in the role of Cosmos Observatory astronomer Dr. Herndon in *When World's Collide*, ominously warning us that soon, "Even a layman will be able to see the danger."

Our communities are facing a complex, two-part crisis in children's mental health services. Children in our child welfare and juvenile justice systems have immediate and compelling emotional and behavioral needs that are not being met. In addition, children in our communities who as yet are in no formal system are also presenting increasing needs for which there are few resources. The two challenges are related: it is generally assumed that the rising prevalence of mental health and substance abuse disorders in children and youth under juvenile court jurisdiction is due in part to the lack of early prevention, treatment and support in our communities.

This environment of escalating needs and diminishing resources is generating renewed calls for more behavioral health services in our juvenile court system. But there is a risk in doing this without at the same time improving our community services. As long as the only way to get help is through the juvenile court, even more parents will be forced to use that pathway. So to be effective we need a combined effort that simultaneously improves both our community-based and court-accessed services in the context of a single collaborative infrastructure.

While it is essential that this occur, it is also important for us to use what we have learned through our attempts at system integration during the last 10 years to insure that our efforts don't also produce the unexpected negative consequences that are the primary plot devices for most sci-fi flicks.

In this article I will summarize some of the reports from our human service astronomers regarding the various dangers that are closing in on our communities, outline their proposals for reform and offer some suggestions for next step efforts in our continuing struggle to facilitate inter-galactic cooperation.

New reports from the folks with bottle-bottom glasses

During the last two years several significant reports regarding the needs of youth in the juvenile justice and child welfare systems were released.

The CASA Report. In October, 2004 the National Center on Addiction and Substance Abuse at Columbia University issued a major assessment of the substance abuse treatment needs of youth in the juvenile justice system: *Criminal Neglect: Substance Abuse, Juvenile Justice and The Children Left Behind.* (Available on the web at www.casacolumbia.org). The 177-page report is described as the most comprehensive analysis ever undertaken of substance abuse and state juvenile justice systems. The report found that while 1.9 million of 2.4 million juveniles arrested in the year 2000 had substance abuse and addiction involvement, only 68,600 of those youth received substance abuse treatment. Other findings included:

- 50 - 75% of incarcerated youth suffer from one or more diagnosable mental health disorder
- 80% of incarcerated youth have a significant learning disability
- Overall arrest rates fell 12.9% from 1990 - 2000
- Property crime arrests fell 38.4%
- Violent crime arrests fell 33.2%
- Drug related arrests *rose* 105%

The report contains an extensive analysis of the costs and benefits of improving our adolescent substance abuse and mental health services and concludes that, "were society to invest just $5,000 in substance abuse treatment and getting comprehensive services and programs like drug courts for each of the 123,000 substance-involved juveniles who would otherwise be incarcerated, we would break even on our investment in the first year if only 12 percent of these youth stayed in school and remained drug and crime free."

CASA's recommendations include creation of a new model juvenile justice code, extensive training of all staff in the various components of the juvenile justice system, a variety of diversion options, such as comprehensive in-home services, juvenile drug courts and other drug treatment alternatives to incarceration, improved treatment services for incarcerated juveniles, establishment of a national data system for baselining current outcomes and measuring progress, and increasing federal grants to states through the Office of Juvenile Justice and Delinquency Prevention.

The NASCAW study. A report published in August of 2004 concerned the needs of children in our child welfare system. Using data obtained through the extensive National Study of Child and Adolescent Well-Being, which looked at system involved youth who were in foster care as well as those who remained in their homes, the researchers concluded that:

- Children in the child welfare system have 2.5 times greater incidence of mental health needs than the general population
- 47.9% of youths age 2-14 with completed CW investigations had clinically significant MH needs

- Yet only 1/4 of those received MH care
- Children with multiple foster care placements have the highest mental and physical health needs and utilization, yet nearly half still received no services at all. [Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y., Landsverk, J. (2004) Mental health need and access to mental health services by youth involved in child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*. v. 43, i. 8, p. 960.]

The authors recommend that existing policies for treatment of children who have been maltreated and neglected actually be followed, such as those adopted by the American Academy of Child and Adolescent Psychiatry, the Child Welfare League of America, the American Academy of Pediatrics, the National Academy of Sciences and the U.S. Department of Justice. At the organizational level, the authors note that while strong linkages between the mental health and child welfare systems have long been advocated, many barriers to collaborative relationships remain and require "policy and organizational solutions and understanding about how to bring these two types of organizations and cultures together. Active involvement and leadership by child clinicians in the public sector are a special interest, especially because 20% of youths seeking care from public mental health settings present with abuse or neglect."

Other suggestions for structural changes include joint quality review processes, application of evidence-based clinical care, retraining of mental health specialists and the use of integrated models of care.

Foster care and mental health needs. A May, 2004 report provided an in-depth look at the mental health needs of children in foster care from one urban setting. 41% of the 1,635 children in the study had more than 3 foster care placements, and 5% went home and returned to foster care one or more times during the one-year period included in the study. The top 10% of mental health users in the group accounted for 83% of the $2.4 million spent on mental health services for these children. Both multiple placements and bouncing from foster care to home and back predicted higher mental health service use, with the later having the most dramatic probability of high usage. The study also noted that higher physical health needs also increased the probability of higher mental health service usage. [Rubin, D.M., Allesandrini, E.A., Feudtner, C., Mandell, A.R.L., Hadley, T. (2004) Placement stability and mental health costs for children in foster care. *Pediatrics* v. 113, i. 5 pp 1336-1342.]

The authors conclude that: "the provision of health services, long viewed as beyond the auspices of the child welfare system, is closely linked to the stability of foster care placements. Consequently, when considering interventions and targeting resources to children in foster care, we should account for the heterogeneity of their experience and consider the importance of global health, and not merely the domain of mental health, in initiatives to improve the health of this vulnerable population."

Race and mental health services. A July, 2004 report examined the impact of race and ethnicity on the level of mental health needs and the response to those needs in the juvenile justice system. The authors completed standardized psychiatric chart reviews of 473

petitioned, adjudicated and incarcerated youth in Illinois to identify current needs, prior utilization, family history and other factors. The study corroborated previous findings of the overall high rate of mental health and substance abuse disorders among all members of this population. But they also found statistically significant differences among the subgroups of African American, Caucasian and Hispanic youth in the study. Some of the findings included:

- The juvenile justice system is a primary gateway for mental health services for minority youth
- African American youth had the highest mental health needs and the lowest access to services
- Caucasian youth were more likely to be served in the mental health system than the juvenile justice system, but it was the other way around for minority youth
- Although Hispanic youth were found to have relatively stronger family systems, they nonetheless had significant behavioral health needs, and received the least amount of treatment and services.

The authors recommended that in addition to improving services within the juvenile justice system it was also critical that front-end options for culturally competent service access in the community be established. [Rawal, P, Romansky, J., Jenuwine, M., Lyons, J. (2004) Racial differences in mental health needs and service utilization of youth in the juvenile justice system. *The Journal of Behavioral Health Services and Research*. v. 31, n. 4, p. 242.]

Getting the court involved. Two recent articles address different aspects of improving our ability to meet the needs of court-involved children and their families. In April of 2004 James Howell and his colleagues published a proposal calling on the juvenile court to facilitate the process of bringing the system partners together. [Howell, J.C., Kelly, M.R., Palmer, J., Mangum, R.L. (2004) Integrating child welfare, juvenile justice and other agencies in a continuum of services. *Child Welfare,* v. 83, n. 2., pp. 143-156.] In 1993, Howell and his colleagues had promulgated a nationally recognized program for serious, violent and chronic juvenile offenders called the Comprehensive Strategy that integrated the various service and intervention components within the juvenile justice system. Based on a decade's experience of attempting to implement the Comprehensive Strategy, they now propose that reform must extend beyond the juvenile justice system if it is to be effective. A multi-system approach would allow communities to take into account the developmental models of delinquent behavior that have been promoted in the last few years. The goal is to "address problem behaviors early with less costly and more effective family- and child-centered treatment interventions."

In describing the kind of infrastructure they would use to support interagency collaboration, the authors cite as models the structures and processes used in two mental health system of care sites, Wraparound Milwaukee and the Dawn Project in Indianapolis, such as information exchange and management systems, cross-agency client referrals, networking protocols, interagency councils, and integrated service delivery. The primary difference between their proposal and the format in the mental health system of care projects is one of emphasis. Even though their model focuses on prevention and early treatment, Howell suggests that the juvenile court should play a pivotal role in facilitating the development of the cross-system

infrastructure because of the court's authority to make decisions about placement, participation in involuntary mental health services and service coordination among agencies – although Howell does state that the court should not coerce agencies into collaborative relationships. Looking at Howell's proposal from an organizational design perspective, he is saying that the court should be the pivot point for system integration because it is the primary boundary spanning entity in the universe of child and family serving efforts.

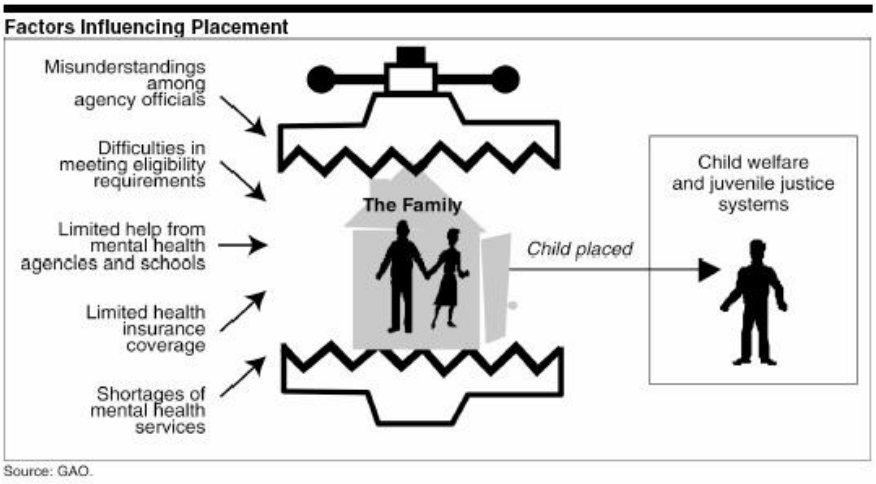
However, if we are to think seriously about making the court the fulcrum for change, we should also pay attention to the assessment and suggestions from another article, published in October of 2003, that focuses on the information gap that would have to be closed if our juvenile courts were to become more proactively involved in fostering collaborative service systems. David Mitchell, the executive director of the National Council of Juvenile and Family Court Judges, who served for many years as a juvenile court judge in Baltimore, points out that if courts and court personnel are going to be at the focus of decisions about collaborative interventions for children and families with complex needs, they must be better trained in fields other than those directly related to the practice of law. [Mitchell, D.B. (2003) Building a multidisciplinary, collaborative child protection system: The challenge to law schools. *Family Court Review*, v. 41, n. 4, pp. 432-438.]

After briefly describing how challenging the interagency process was for a court that was part of a court improvement process designed to increase positive outcomes for families with complex needs, Mitchell points out that "legal advocates who participate in the juvenile justice system must understand the research and findings of those engaged in other disciplines if they are to effectively represent litigants in the courts and before administrative agencies that affect the lives of children" and proposes that the foundation for collaborative action through the courts should start with collaborative instruction in law schools.

A dangerous gateway. Another reason for addressing the juvenile court's pivotal role in cross-system integration with mental health is the court's de facto function as a gateway to mental health services when other access options are blocked. In April of 2003 the GAO (Government Accounting Office) reported on the results of a survey of 19 state child welfare directors and 30 county juvenile justice officials, who together estimated that in their systems 12,700 children had been placed under juvenile court jurisdiction in order to obtain mental health services. Factors cited as reasons why the families had no other recourse than to give up custody to get treatment for their children included: misunderstandings among service agencies, difficulty in meeting eligibility requirements, limited help from mental health agencies and schools, limited health insurance coverage and a lack of available mental health services. [A copy of the report in pdf format can be downloaded from the GAO website, http://www.gao.gov. It is report # GAO 03-397. The testimony of the GAO to congress is GAO 03-865T.]

An illustration from the report captures its main points effectively:

Figure 1. Factors Pressuring Parents to Use the Juvenile Court Gateway



Avoiding the Tragedy of the Commons

Every sci-fi thriller has to have a scene where the populace is confronted by whatever monster the directors have dreamed up. In response, crowds of people invariably start to run around screaming and looking back over their shoulders in wide-eyed terror. Usually a valiant hero or heroine tries to stand in their way, telling them not to panic. For some reason the extras running madly down the streets inches ahead of the giant robots never listen to this advice. Frustrated, the movie's star will rescue one child who is about to be crushed and then safely run off in a direction that no one in the mob thought to take. (Usually the child is trying to save a little dog named Muffy from the robot, but the hero can't save both of them, and the closing shot in the scene is the sobbing child looking back over the hero's shoulder as the robot gets the dog.)

An example of the dangers of unstructured collective behavior in less melodramatic situations was offered in a groundbreaking article by Garett Hardin published in the journal *Science* in 1968, entitled "The Tragedy of the Commons." The commons referred to in the title was the common grazing land in the center of medieval villages. It was open land that could be shared by all. As populations in the villages grew, everyone took advantage of the resource but no one worked to maintain or restore it, or to set up boundaries for its use, and soon the resource was lost to everyone through over-grazing. While Hardin's analysis, which led to Malthusian recommendations for population control, has been superceded by more sophisticated models of self-limiting systems and the function of semi-permeable boundaries between open systems, the central metaphor has retained its power and been used in a variety of settings. [Hardin, G. (1968). The tragedy of the commons. *Science*, v. 162, pp. 1243-1248. It is available on the web at several sites, including http://dieoff.org/page95.htm.]

Narrowly focusing our development of resources on youth under court jurisdiction can lead to a variation of this phenomenon. Families and communities will use the juvenile court as a gateway for behavioral health services for children when no other option exits, even though using the court carries a high decision cost and often leads to resources that are poorly

matched with the needs that were driving them to seek assistance in the first place. Because of this, service improvement strategies that only add to the resources available for children and youth under court jurisdiction run the risk of increasing the misuse of the juvenile court pathway and continuing the depletion of whatever community-accessed resources might be left.

In the context of the relationship between the juvenile court and a community's mental health system, the commons would be the resource pool of all publicly funded behavioral health services used by children and families (the various types of mental health and substance abuse treatments as well as pro-social instruction and supports such as mentors, parenting instruction, in-home therapies and alternatives to aggression training). Rather than a wide-open field, such as the medieval village commons, the behavioral health resource pool is fenced and can only be accessed through a limited number of gates. Also the range of options available upon entry depends on which gate is used.

The juvenile court gateway. Of the various ways an individual or family can access publicly funded mental health services, entering through the juvenile court is the most complex. Since the court mediates events when the community has to exert social control over its members (such as when a child is abused or neglected or has committed a delinquent act) its gateway procedures must include additional controls to insure due process and fundamental fairness. These controls add to the cost of operating the gateway (paying for judges, lawyers, court staff, temporary custody, evaluations, etc.). They also affect the services provided after the child or family passes through the gateway. Child welfare and juvenile justice interventions must be able to compel people to change their behaviors even when they don't want to make those changes. When people turn to the juvenile court gateway because no other option exists they may be frustrated by the procedural barriers and offended by the intrusive nature of the services they do receive.

Some components of the resource pool are under the immediate control of the court (for example, services offered in a juvenile detention center and case management and counseling from a child welfare social worker or a probation officer). The court gateway can also be used to enter a set of captured resources that have been purchased by the court or the court related agencies from private providers (such as intensive in-home services, foster care and placement in residential treatment centers). Finally, staff within the juvenile court may also instruct clients to approach other gateways, such as community mental health centers. (For example, when parents are told to sign up for family counseling as a condition of a dispositional order in juvenile court.)

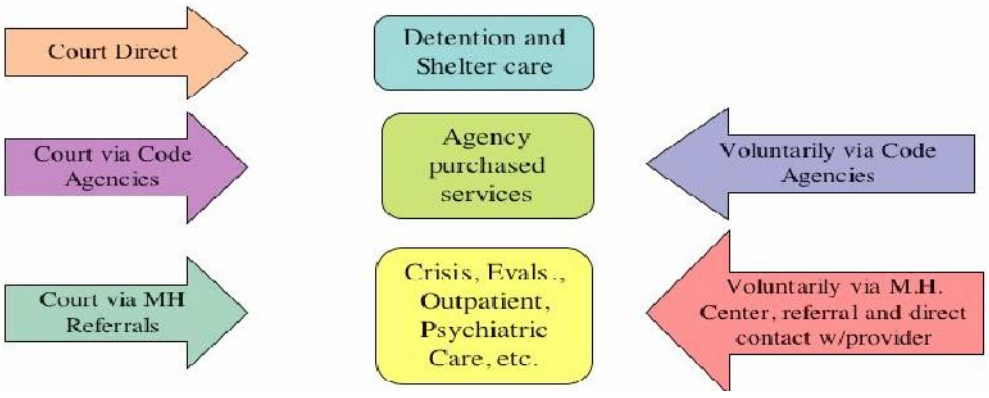
The mental health gateway. Entering the behavioral health service pool directly through a community mental health center without court intervention has a much lower decision cost and logically should be the preferred point of access to reduce depletion of scarce resources. Many, if not most localities in North America have some type of mental health center that offers a variety of services such as outpatient therapy, group therapy, substance abuse treatment, evaluations and instructional programs. People can approach the center and sign up for the services, possibly having to pay a certain amount for them based on a sliding fee scale if they are not covered by private insurance or medical assistance. Yet despite its

simpler and less expensive operation, this gateway is often not available to children and families. As funding for public services of all types is reduced relative to the number of people seeking these services, applicants for publicly funded mental health services often find themselves on waiting lists or excluded altogether because of restricted diagnostic eligibility.

The services that are available through this gateway are often limited in scope. Frequently the only options will be individual or group counseling. More specialized or intensive assistance, such as help for youth with developmental disabilities and aggressive sexual behaviors, or youth with co-occurring mental health and substance abuse issues, or in-home support for families with multiple complex concerns won't be present.

Other gateways. Courts and community mental health centers are not the only gateways to a community's behavioral health resource pool. Private, non-profit agencies may offer help for children and families with specific types of challenges or in certain neighborhoods. Public schools offer varying degrees of help, some through relatively open gateways (such as after school student assistance programs), others can be reached only by going through the more restrictive gateway of the special education program (such as the use of a behavioral aide).

Figure 2. Pools and Pathways



Some components of the community's behavioral service resource pool can only be accessed through certain gateways. Other components can be accessed via multiple gateways.

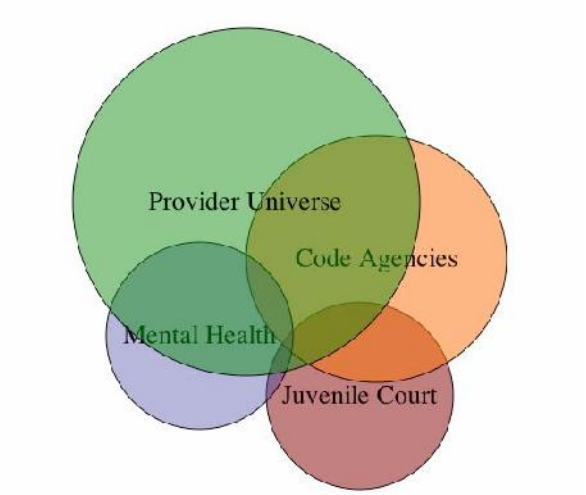
At first it would seem that the pool of publicly funded behavioral health services is not really a commons, but a collection of fenced-off reserves. But the fences are not solid boundaries. Clients move across them all the time, with varying degrees of difficulty, and often either try to or are forced to occupy more than one enclave at a time. In addition, there is a complex relationship among the gateways. School officials may suggest to parents that they file a petition in juvenile court to obtain an order for residential treatment for their child. Court staff may press mental health agencies to bounce clients over the waiting list. A private provider may tell its clients to seek services through a public agency when insurance coverage is exhausted.

Over time these dynamics can lead to a series of strategic adjustments in the shape and management of the overall resource pool that renders it less and less effective, regardless of the point of entry. One reason for this is that no matter how they are sliced, fenced, labeled and modified, a community's resources form a limited set, controlled by the amount of local, state and federal funds available to purchase these services. So as courts become frustrated when community mental health centers put children and families that have been referred for services onto waiting lists, they respond in two ways. First they advocate with local and state funding bodies (county boards and state legislatures) to allocate more of the available behavioral health dollars to the child welfare and juvenile justice systems to purchase captive services. In the meantime, they also put additional informal and political pressure on the community mental health center to serve their clients.

Community mental health centers respond to these two actions with their own survival strategies. First, they compete against the courts and court-related agencies for public funding ("Give it to us, not to them, because our needs are greater, our services more effective, etc.") They also react to pressure to open up their existing resources by creating additional barriers so they can retain control of the services they still have.

The actual dynamic is more complex. One non-public agency may provide court-ordered interventions, voluntary reduced-fee services and private pay services at the same time. The court-driven code agencies (child welfare and juvenile justice) may offer voluntary services. Medical providers like pediatricians and public health nurses may offer behaviorally related services. The needs are great and people are trying to help but although their efforts often overlap, there is little coordination. Figure 3 illustrates the basic distribution with a universe of private providers offering their own services, plus those purchased by the child welfare and juvenile justice systems, the mental health system and the juvenile court. In addition, the code agencies and the mental health system and the juvenile court also have some of their own services. Some children and families may be involved in some or all of these circles.

Figure 3: Service worlds in collision.



The code agencies (child welfare and juvenile justice), community mental health, and the juvenile court itself all have attempted to capture a portion of the universe of behavioral health services in our communities, but the boundaries between systems and the gateways for access are not well defined – nor do they operate efficiently.

Draining the pool. The impact of these interactions on the overall pool of behavioral health resources in a community is largely negative – a more complex enactment of the tragedy of the commons. As competition increases the decision cost at all gateways goes up – which means that more is spent on guarding resources and less on delivering them. In addition, the continuing competition results in repeated calls for better collaboration and coordination of services, which also means less will be spent on helping people and more on operations. However, because the underlying dynamics leading to competition are not resolved, the collaborative efforts, while time consuming, often remain superficial. These exercises of overt cooperation while maintaining covert independence drain the enthusiasm of the participants, rendering them even less available to provide direct help to their clients. In addition, the covert competition among the gateways for funding tends to undermine public confidence in the system as a whole. When each contestant implies that everyone else needs the money less than they do, the functional sum of all the arguments is that no one needs the money.

Avoiding the tragedy: Heeding Klaatu's warning

The way to avoid continuing deterioration of a community's behavioral health resource pool is to use a whole system model that addresses the collective needs and purposes of the various gateways to the pool as well as the arrangement of resources within the pool's subsets. If we approach the issue in this way, a three-part strategy emerges:

1. Create an ongoing infrastructure for system improvement to insure that as a community we purchase the most effective resources available and use the most efficient pathways possible for connecting people with the help they need.
2. Restore the broader community resource pool.
3. Address the immediate press of unmet need in the overloaded juvenile court pathway.

The trick is that these strategies must be implemented simultaneously rather than sequentially to keep from exacerbating the already difficult dynamics among the service systems. For example, if we start by expanding services for children and youth under juvenile court jurisdiction without creating a broader community pool, it will compel more people to find some way to get their children or clients into court because that will be the only place to find help. If we attempt to build community resources without addressing the shortages in the court-related systems, the burden on the community of additional arrests and increasing recidivism will soon overwhelm the budget. And even if we work on both the court and community resource pools at the same time, the implicit competition between the two systems will cause the effort to falter unless there is a meaningful infrastructure to oversee the development process.

For community teams that are trying to accomplish these objectives it will be like a dozen jugglers trying to keep a cloud of colored balls in the air at the same time. While this is a challenging exercise, we can do it if everyone involved understands how things operate

across the various segments of the universe, is clear about one another's roles and goals and has a reliable mandate from within their own organization. In addition, it is important that there be a clear message from the external funding sources that this is a problem that everyone has to solve together. Finally, the whole team must agree on a common goal that can help them stay aligned with one another throughout the process.

While it may be almost as hard for us to accomplish something with all these "ifs" as it was for Sam Jaffee to get the leaders of all the nations to believe that Klaatu was serious about blowing up our planet, the risk if we fail to learn how to work together is nearly as great. In the remainder of this article, I will suggest a framework for putting this juggling act into action, and discuss ways in which a community's juvenile court can help keep the team in sync.

Should we make the effort?

Another mandatory scene in disaster flicks is at the end of the third act when the main character stops, often leaning against a pile of rubble, wipes the sweat and grime from his or her exhausted face, and tells the others, "It's no use. They just won't listen. The world is doomed. Find a way to save yourselves." For some reason the alien robots or whoever is tearing up the place then pause in their destructive efforts long enough for the rest of the crew to stop complaining and backstabbing and convince the despairing leader to carry on. Occasionally it's the sooty-faced urchin that was snatched from sure death who tugs at the sleeve of the exhausted heroine and mutters, "We have to do it for Muffy." (Muffy being the child's little dog that the robot crushed.) At any rate, the story then moves on to the fourth act and suddenly they have resolved their differences and are working together with renewed zeal.

Maybe the problem is that we don't have enough berserk robots, doe-eyed waifs and puppies named Muffy in this business, but for whatever reason, many communities give up their efforts to create an interagency collaborative. In the article by Howell and his associates mentioned above, the section on building a collaborative infrastructure begins with the statement "The youth service field is littered with failed collaborative initiatives." They then say that people should start such initiatives anyway – without explaining why their plan for integration is any more likely to be successful, except to say that "the model we envision requires the transformation of agency ownership of clients into integrated, shared agency-client relationships."

After more than 12 years of work with communities who hoped to create collaborative infrastructures, one thing I can assert is that while shared agency-client relationships describes a wonderful ideal, achieving it on a sustained basis solely through the good will of the participants is virtually impossible. The code agencies and the schools have duties and obligations imposed on them by statute that service development and management agencies lack. A child welfare agency can't put abused children on a waiting list – they have to intervene when a substantiated report is received, whether they have the resources they need or not. Community mental health centers or in-home treatment programs only have to provide services up to the limit of the funding they have received. Good will agreements are sufficient for short-term fixes, but tend to dissolve as participants and circumstances change.

True integration of services requires the establishment of a meaningful, enforceable and functional foundation on which enduring partnerships can be formed. Building such a foundation demands important sacrifices of autonomy from each partner.

The decision about whether to use this difficult but powerful approach should be based on a careful assessment to see whether the effort is worth the potential gain. Inter-agency collaboration is a tool for reaching a goal, not an end in itself. The first question a community should consider is whether the challenges they are facing are ones that are best resolved with this type of mechanism.

Indicators that an integrated system should be established might include:

- Significant numbers of youth are being held in secure or non-secure temporary custody because there are no community-based resources capable of addressing their treatment needs.
- Residential treatment center and group home placements are being used as destinations because no one knows what else to do with the children involved, instead of as interventions with specific goals for measurable change.
- Parents are being advised by school officials or their health care providers to file petitions in juvenile court in order to get mental health services or placements.
- Significant numbers of children are bouncing from one foster home to another or are experiencing multiple episodes of foster care placement, driven by the behavioral health needs of the children and their families.
- Youth in the juvenile justice system are demonstrating repeated recidivism and escalation of challenging behaviors because they are unable to reconnect with their families, schools and neighborhoods due in part to their unmet emotional and behavioral needs.
- School officials are complaining that child welfare staff refuse to follow up on reports of suspected abuse and neglect when those reports are based on the children's challenging or aberrant behavior.
- Youth with psychiatric disorders are having repeated hospitalizations, often combined with short stays in detention prior to a return to the hospital.
- Juvenile justice staff are complaining that mental health staff are refusing to address the behavioral, emotional and psychiatric needs of youth in detention or on probation.
- Mental health staff are complaining that juvenile justice staff are refusing to provide appropriate consequences when youth under psychiatric care commit law violations.
- Juvenile court judges are threatening to hold human service and mental health agencies in contempt for failure to provide court-ordered services to adjudicated children and families.
- A civil rights lawsuit is pending or in place because large-scale system issues have threatened the well-being of children in the county or state.

Where patterns or situations like these are developing in a community, it is unlikely that single system fixes will do enough. At a certain point it becomes necessary to break through the fragmentation. The primary reason is that children and families are stubborn in their refusal to align their problems with our service structures. If we could just keep the group of families with children who have juvenile justice concerns and those with children who have

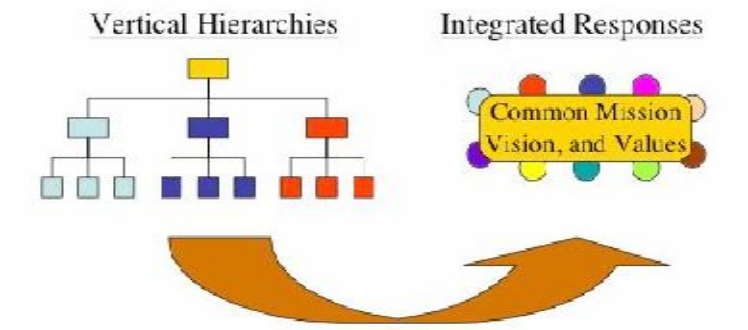
mental health concerns in separate cohorts, it would be easier to meet their needs using a system with divided services pathways.

None of our systems are complete in themselves. While each can provide many of the children and families it serves with all of the help they need, none has the flexibility or range to meet all of the needs of all of their clients on their own.

Since our total community resources are limited, the competition among systems can cause duplication of services, or worse, service strategies that work at cross-purposes. Without a collaborative infrastructure our communities lose the opportunity for synergy in the human services they purchase.

The move from competition to collaboration begins when people see how inter-related their efforts already are. What have been experienced as discrete hierarchies are recognized as components of a larger entity. The more we are able discover and build upon a common sense of mission, vision and values, the better we will be able to align our efforts. Figure 4 illustrates this transition.

Figure 4. Envisioning a transition from competition to collaboration



Finding shared mission, vision and values is a first step towards forming a collaborative infrastructure that unites our various service subsystems

Challenges at the interface

You can tell when you are in the fourth act of a thriller when the lead actors get together and lay out the seemingly unrelated tools and weapons they have for dealing with the marauding robots and someone says, "There's no way you can stop a giant robot with chewing gum, dish detergent and three stale croissants." Then one of the actors comes out of his or her stupor of despair and realizes that, when properly combined, the dinner rolls, soap and gum can be fashioned into a miniature nuclear bomb. (Jeff Goldblum has made a career out of such cinematic discoveries.)

Assuming that a community does decide to establish a formal structure for aligning their juvenile court and mental health systems, challenges in seven areas must be faced and

resolved in the design of their infrastructure, each of which requires its own creative solution. The seven areas are:

- Language
- Culture
- Mandates
- Protocols
- Schedules
- Competition
- Funding

Language. The first task in building a collaborative infrastructure is learning how to communicate among the participating systems. Each system has its own specialized vocabulary. It's as if two worlds long separated were coming back together. While the inhabitants of these worlds still use the same basic language, each has developed new words that aren't used on the other planet as well as different meanings for old words they have in common.

For example, the word "risk" is used on both the juvenile justice and the mental health planets but carries different connotations. In juvenile justice it refers to the likelihood that a youth will re-offend. In mental health it means the likelihood that a youth's clinical symptoms will get worse. So, a young person may be at low risk for reoffending but at high risk for becoming more ill, or vice versa. In the world of mental health, terms like decompensation, transference and countertransference refer to concepts that have no direct referents in the juvenile justice world. And juvenile court terms like subject matter jurisdiction, hearsay evidence and *res judicata* aren't in the mental health lexicon.

To surmount this barrier, we need to take the time to check with one another to be sure that the other person is hearing what we are trying to say and to avoid making assumptions about the intent or attitudes of people from the other world.

Culture. Language is just one aspect of a much broader and subtler set of differences between systems that is generally referred to as organizational culture. Habits, attitudes, modes of dress, unspoken beliefs, the ways things get done, even what is considered funny and what isn't all are part of what gives each organization its own personality.

When staff from different organizational cultures work together, they face the challenge of maintaining competence within the culture of their home system while simultaneously generating a hybrid culture that defines the space where collaborative efforts take place. When the contrast between cultures is too great, staff may feel isolated or rejected by their home culture, or become too uncomfortable to continue to function in the culture of the interface.

Learning to navigate in multiple cultures and obtaining official guidance and support for multi-cultural behavior is another important step in creating a collaborative infrastructure.

Mandates. As organizational culture defines the intangibles that set one system apart from another, statutory mandates establish the formal distinctions. Some roles and goals are chosen by organizations, but others are imposed on them. Child welfare and juvenile justice have a statutory mandate to intervene in, stop and remediate harm resulting from incidents of delinquent behavior and maltreatment of children. Mental health centers are responsible for developing and maintaining a competent and comprehensive array of low cost public behavioral health services. Except for the case of involuntary commitment, their job is to provide outreach and access to those in need, rather than to compel participation in services.

Table 1. Comparing System Mandates

Child Welfare and Juvenile Justice	Mental Health
Identify, intervene in, stop and remediate incidents of child maltreatment and delinquent behavior	Develop and maintain a competent and comprehensive array of low cost public behavioral health services

The fit between the mandates of the two systems is not perfect. For example when a juvenile court orders a child or parent who is not under a commitment to see a therapist, whether they want to or not, staff in the mental health system may see this as sentencing a person to therapy. On the other hand, staff in the juvenile court system may perceive a therapist's expressed desire to work only with clients who want to work with her as a way of ducking the hard issues.

An important aspect of system alignment will be creating forums through which participants from each system can not only learn more about each other's legal mandates, but also resolve the grey area conflicts in roles and goals that the statutes and administrative rules don't address.

Protocols. Each system has its own procedures. Aligning systems doesn't mean adopting a single set of procedures for both systems, but it does require a careful analysis of the steps each one follows from first contact to closure, looking in particular at points where the procedural pathways in the two systems intersect with one another. Sometimes inter-system conflict occurs because of a lack of congruence in procedure that can be resolved by adjustments in both systems or by creating a bridging protocol that both can use.

For example, one of the most important intersections between the juvenile court and mental health system occurs when a child welfare investigation reveals that a child has suffered severe abuse or neglect and is in immediate need of care. The procedural steps in juvenile court are investigation, apprehension, intake, temporary custody, adjudication, evaluation, disposition and dispositional review. The procedural steps in the mental health system are intake, engagement, assessment, treatment planning, treatment implementation, monitoring progress, treatment adjustment and closure. The usual cross over between the juvenile court system and the mental health system is at disposition. At that point the court has assumed the power to compel children and families to take part in a treatment process. Temporary custody is usually a holding period where a child is kept safe while the court decides whether the facts support jurisdiction. While a child who has been traumatized by abuse or neglect

should get help right away, delivering intervention and treatment out of sequence upsets the court's procedural requirements. Also, the process of treatment has the potential of undermining the investigation of the circumstances of the abuse and could result in the court losing the power to intervene and protect the child.

Many communities have resolved this conflict in protocols by creating a bridging resource for meeting the immediate needs of children who have been abused while also addressing the investigatory and procedural requirements of the court system. Often referred to as child advocacy centers, they provide a safe place for a child to be appropriately interviewed by a single, well-trained person, while others can watch through closed circuit television. The results are video-taped using techniques designed to comply with statutory provisions for evidence. The child only has to go through an interview a single time and then arrangements can be made for support and treatment as needed without undermining the ongoing court process. An effective child advocacy center requires careful and thoughtful coordination among people from a variety of agencies, sufficient shared resources to do the job well, and the administrative and statutory authority to act in this cross-system mode. [To learn more about these centers, visit the website of the National Children's Alliance at http://www.nca-online.org/.]

The same flexibility and creativity that helped launch the child advocacy center movement can help us design better cross-system interfaces when communities are responding to the needs and challenges presented by children who have serious emotional disorders. In the case of child abuse, the court protocols stood in the way of getting help to traumatized children in a timely fashion. Sometimes when youth and families have complex needs, the difficulty is reversed. The court is ready to go to disposition and folks from the mental health system aren't ready to provide a final answer on what should be done.

To address this issue, some courts have reached an agreement with their local mental health system to use a sequenced or interim dispositional process rather than trying to put all of the services into the initial order. For example in Milwaukee, Wisconsin, when children are at risk of placement, the juvenile court's initial dispositional order delegates responsibility for planning and implementing services to an interagency system of care called Wraparound Milwaukee. Wraparound Milwaukee then assigns a facilitator to create a child and family team, the team develops a comprehensive plan of care and the proposed plan is presented to the court for approval. The plan may include a brief period of stabilization and assessment in a residential facility followed by a return to community based services, or may be community-based from the start. [Kamradt, B. (2000) Wraparound Milwaukee: Aiding youth with mental health needs. *Juvenile Justice*, v.7, n.1. Available on the web at http://www.ncjrs.org/html/ojjdp/jjjnl_2000_4/wrap.html]

Table 2, below, lays out the procedural cascades in the mental health and juvenile court systems. In order to work the discrepancies in the two systems, a planning group may wish to map out the current points of cross-over between the two systems, the places where needed connections are being made, and opportunity for better linkages.

Table 2: Comparing Process Steps between the Systems	
Juvenile Court	**Community Mental Health**
Investigation	Referral/Outreach
Apprehension/Intervention	Intake
Intake	Engagement
Temporary Custody	Assessment and Diagnosis
Diversion/Deferral Options	Treatment Planning
Adjudication (Trial/Plea Hearing)	Treatment Implementation
Evaluation	Monitor Progress
Disposition	Modify Plan
Post-Disposition Review	Discharge Planning
Collateral Actions (Sanctions, Waiver, Termination of Parental Rights, Adoption, Emancipation, Guardianship, etc.)	Resolution and Closure

As each community compares the protocols for their two systems, they can look for creative bridges between the two that will support more efficient and effective responses to child and family needs.

Schedules. An important subset of the differences in protocols between the two systems is the varying time requirements under which they operate. Most state juvenile codes impose strict limits on the time that juvenile courts can take to complete each of the steps from intake to disposition, especially when children are being held in detention or temporary custody while the process continues. Once a dispositional order has been entered, other timelines may apply. For example, if a child is placed in foster care, federal law [The Adoption and Safe Families Act of 1997 (Public Law 105-89), Titles IV-B and IV-E, Section 403(b), Section 453, and Section 1130(a) of the Social Security Act] now requires that the child welfare agency implementing the disposition move quickly to reach a permanent placement for the child, either with family or in an adoptive home. The pressure for quick resolution on the child welfare agency may conflict with a treatment provider's need to help a family slowly and carefully work through a variety of long-term issues.

Competition. An infrastructure for alignment between the juvenile court and mental health systems should also contain an explicit mechanism for dealing with the natural tensions between the systems. Conflict can occur at many levels. For example, at the child and family level a representative from the mental health system may favor a community-based dispositional option for a youth with a severe emotional disorder who has committed a delinquent act, while the assistant district attorney prosecuting the case wants the youth to serve time in a residential treatment center because of the severity of the offense. Ultimately the presiding judge will have to decide if the parties can't agree. But in many cases the issue can be resolved without judicial fiat if the two systems develop criteria for making decisions when the need for consequences and treatment appear to be in conflict.

An example at the program level: a probation office may have concerns with certain practices of the staff from the children's mental health unit. If the mental health staff are using a strength-based, family-centered planning approach, probation may feel like insufficient attention is being paid to the need to hold youth accountable for their misbehavior or to

insuring the safety of the community. To counteract this problem, the inter-system team should make sure that besides addressing unmet needs and building natural circles of support, plans of care also discuss the risk of additional harm occurring, propose ways of avoiding it and insure that youth take responsibility for their misbehavior.

At the system level competition can develop in a variety of areas. One of the most frequently mentioned challenges is conflict over who's in charge – what are generally referred to as turf wars. As demonstrated repeatedly in philosophical masterpieces such as the aforementioned *The Day the Earth Stood Still* as well as analogous treatises such as *The Blob* and the definitive *Godzilla* series, human beings are incredibly cantankerous and usually the only way they will get along with one another is if there is a really big monster or a fleet of raygun-toting alien space ships bearing down on them.

Managing system level competition without the help of an alien space fleet usually requires the formation of something like a local Federation of Planets – what is more often called an interagency council. An important difference between interagency councils that work and those that keep work from happening is the willingness of the participants to trust one another enough to create an enforceable structure for joint management of services when clients' lives require support from multiple systems. This can be accomplished through contracts, county board resolutions or state statutes and administrative rules but must include a design for shared governance of the commonly held pool of resources and for structured resolution of the inevitable disputes that will occur over the nature of, access to and use of those resources.

Funding. A specific subset of conflict at the system level is funding. Creating inter-system alignment around funding may be the most challenging aspect of establishing a collaborative infrastructure. Even when the participants can agree to share with one another, the task of how to accomplish this sharing still remains. The funding streams that are used for the court, for the operation of juvenile justice and child welfare agencies and for community mental health services are all different. Not only does the money come from different places, but it also comes in different ways with different requirements for its access and use.

When interagency councils are formed to develop a collaborative infrastructure they tend to focus on practice issues: How should children and families be identified as needing integrated services? Who should provide those services? Where should they be housed? What procedures should they use for developing plans of care? And so forth. But frequently, instead of developing a sustainable mechanism for cooperative funding to support the integrated practice system, the community planning team will rely on short-term funding options like grants, or special county or state allocations. Or they may decide to maintain the existing separate funding streams and expect the collaborative process to accommodate them.

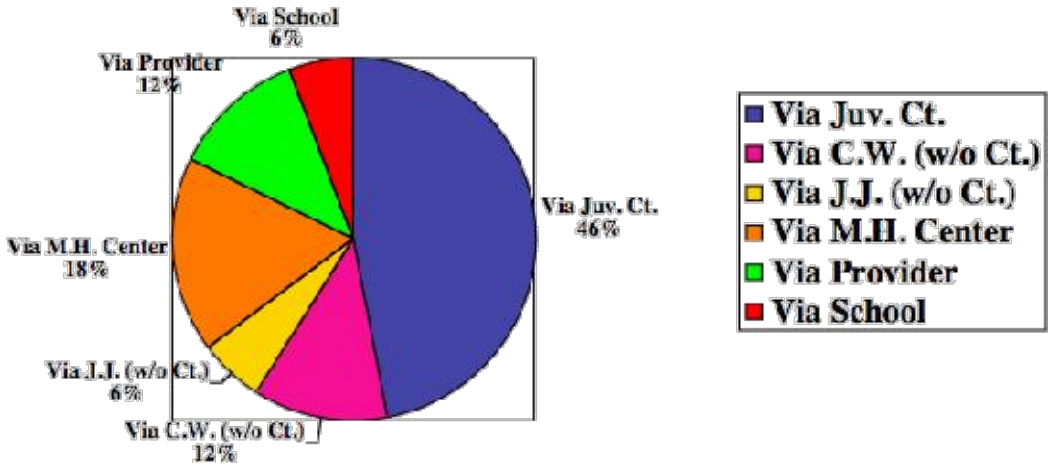
Both of those options (using specialized, short-term funding or trying to collaborate without blending funding) have a short shelf life. When grants go away, projects tend to evaporate. Partnerships by handshakes rather than shared budgets last only as long as the folks shaking hands stay friends, or stay in the positions they were in when they shook hands. When new people take over, they often decide to use the money allocated to the collaborative project in other ways.

Besides making it more likely that the collaborative infrastructure will endure after the first phase of enthusiasm fades, resolving funding-related competition can have other benefits as well. When the mental health and juvenile court related agencies reach a level of cooperation where they can show how their mutual budgets support collaborative action, reduce duplication and improve outcomes, they will have a more persuasive argument to present to their funding sources.

Specific mechanisms for blending and braiding funding to support more enduring system integration are beyond the scope of this article, but a description of some of the strategies used by mental health systems of care for sustaining their efforts are described in a monograph prepared for the federal Center for Mental Health Services. [Koyangi, C. & Feres-Merchant, D. (2000) *For the long haul: Maintaining systems of care beyond the federal investment.* (Vol. III in the series, *Promising Practices in Children's Mental Health*). Center for Mental Health Services, U.S. Dept. of Health and Human Services. Available on the web at http://www.mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/practices.asp.]

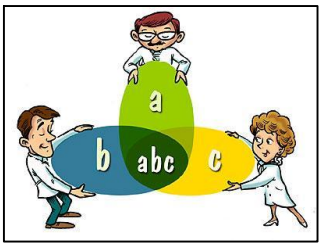
A first step towards better collaboration in funding is reaching a better understanding of how resources are currently being accessed. Figure 5, below, represents an analysis of the pathways being used by a community to access the total pool of its publicly funded behavioral health services. In this illustration 46% of the services the community is purchasing are being used pursuant to a juvenile court order in a delinquency or child welfare matter. The way the services are funded may vary. A child in a treatment foster home might be receiving therapeutic case management paid for using state dollars, outpatient therapy paid for by medical assistance, and crisis and mentor services paid for using county dollars, but everything is happening in the context of the child's dispositional order. 12% of the services occur when people go directly to private providers who are reimbursed in one way or another by the public (as opposed to private pay or privately insured clients.) 6% of the total are provided or paid for by the schools, and so forth. The point is not to say who should or should not be paying for them, but for a community to decide together what mix and method makes the most sense.

Figure 5. How is Your Resource Pie Divided?



As part of their effort to resolve competition among systems, a community might analyze the ways in which the total pool of publicly funded behavioral resources is accessed by children and families. Once they have a baseline for this distribution, they can work together to develop strategies for more balanced usage. The above chart is a hypothetical illustration of a community in which the juvenile court is the major gateway for services. In the illustration, 46% of the services purchased with public funding would be used for court-ordered dispositions.

Learning to live at the boundaries



In monster movies the 5th act is the shortest. The exploding croissants work, the giant robots are vanquished amid a flurry of special effects, there's a party, and then folks go back to being themselves as soon as they say a hearty thanks (with an implied hit the road) to the person who brought them together (unless the hero or heroine died tragically in saving them). Oh, and Muffy usually crawls miraculously out from under the wreckage of one of the robots and jumps into little Timmy's arms just before the credits roll. What makes inter-agency collaboration so tough is that the 5th act is supposed to go on indefinitely.

Continued successful co-existence in cross-system collaboratives requires us to learn to live well at our boundaries. In some of the earliest efforts at system collaboration, all of the agencies were simply lumped into one mega-agency often named something like the department of human everything. Not surprisingly the underlying barriers between the functions once filled by different agencies often endured even though all of the players were getting paychecks signed by the same director.

In the Star Trek: The Next Generation series one of the nastiest opponents faced by the valiant crew of the starship Enterprise is the Borg. They are literally single-minded in their drive to assimilate everyone they encounter (including Captain Picard, for a while) into their hive-mind. Sometimes being invited to join an interagency collaborative can feel like an encounter with the Borg's ominous, cube-shaped battle station. You can almost hear the mechanical voices of the Borg whispering, "Freedom is irrelevant. Self-determination is irrelevant. You must comply."

Effective collaboration involves the integration, not the obliteration, of a community's service components. To accomplish this feat three steps are necessary:

- Seeing the big picture
- Uniting around a common mission
- Clarifying roles and goals

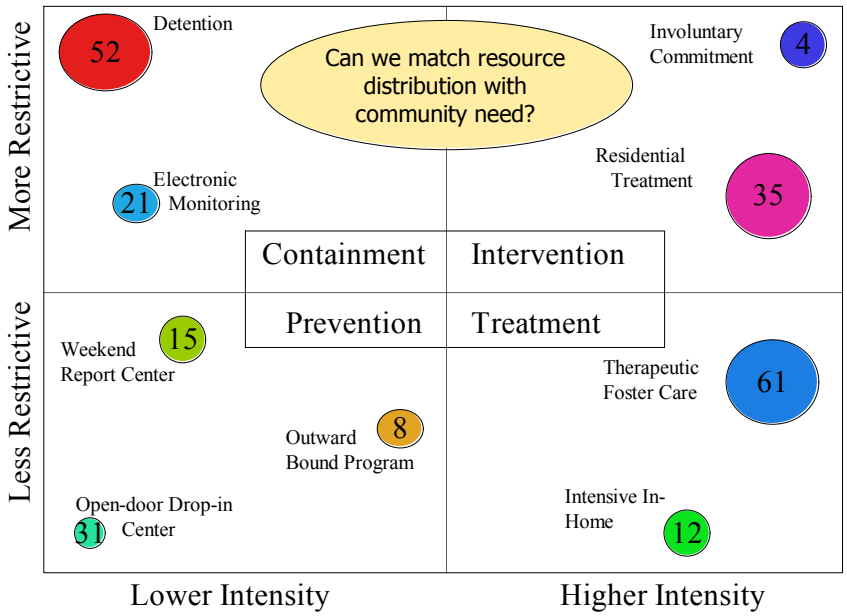
Seeing the big picture. The analysis of the distribution of community mental health services by gateways that was presented in Figure 2, above, is one example of how everyone involved in a collaborative effort can begin to acquire a big picture perspective. Other methods for getting everyone on the same page might include diagramming the process flows in each system and comparing and contrasting the statutes and rules that each participant operates

under. More directly experiential exercises are also helpful, such as having staff from one system job shadow staff in other systems, then returning the favor, or having administrators from each system tag along with clients from first contact through resolution.

Children, youth and families who have experienced life in the service universe are an essential resource for gaining a better understanding of the big picture. An interagency planning group that does not include youth and parents is going to be flying blind from the start.

Another way of gaining the big picture is by sorting out the various kinds of behavioral service options in a community based not on who operates or pays for them, but on the comparative restrictiveness and intensity of each service and the amount that is being spent on each type. Figure 6 is an example of a grid on which these resources can be mapped. Options are laid out with increasing restrictiveness on the vertical axis and increasing intensity on the horizontal axis. Thus a voluntary after school drop in center would exhibit both low restrictiveness and intensity. The size of the dot indicates that it consumes a relatively small amount of funding. At the opposite corner is involuntary commitment in psychiatric facility: high intensity and restrictiveness. The number in each dot indicates the number of youth currently being served with that resource. By looking at the distribution, a planning group can see the gaps and overlaps in the total service picture. They can also decide if they have a balance of prevention, containment, intervention and treatment that matches the needs of their community.

Figure 6. Mapping Existing Community Resources



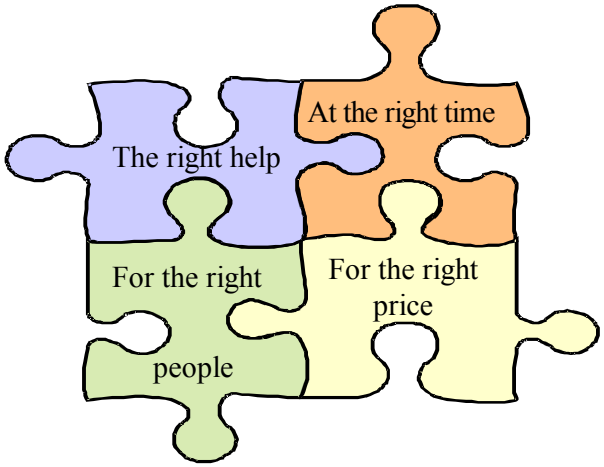
A resource distribution map for a hypothetical community. Dots are placed based on the relative intensity and restrictiveness of each option. The size of the dot indicates the cost for the option and the number tells how many clients are being served using that option. One youth or family could be counted in multiple dots.

Uniting around a common mission. Katzenbach and Smith define a team as a small number of people with complementary skills who are equally committed to a common purpose, goals and working approach for which they hold themselves mutually accountable. [Katzenbach, J.R., Smith, D.K. (2003). *The wisdom of teams.* New York: Harper Business Essentials, p. 92.] For an interagency body to move from being a group of folks gathering to admire their community's problems to an action team uniting to address those problems through collective action they must find a core mission to which everyone can make a firm commitment.

In the movies, people of diverse backgrounds come together for a brief time to defeat an enemy who is so threatening and different from them that their own differences evaporate. The problem is that once the incendiary croissants have reduced the robots to rubble, the original differences reappear. This is a time-limited team. Interagency teams, on the other hand, have to endure. Thus, they must be motivated by the achievement of positive goals, rather than the elimination of a negative problem. This is the point where the development of a collaborative infrastructure must depart from the lessons and procedures of sci-fi monster movies.

A proactive mission that can unite the juvenile court and mental health systems is the core enterprise that both share: achieving goodness of fit. Both are designed to connect people with the help they need, albeit through different mechanisms. At their heart, both operate at their best when they get the right help to the right people at the right time for the right price. Obviously, the determination of what is "right" in each of these elements will be a community-specific judgment, but deciding to make that assessment together is what will transform an interagency work group into a true team.

Figure 7. Goodness of Fit

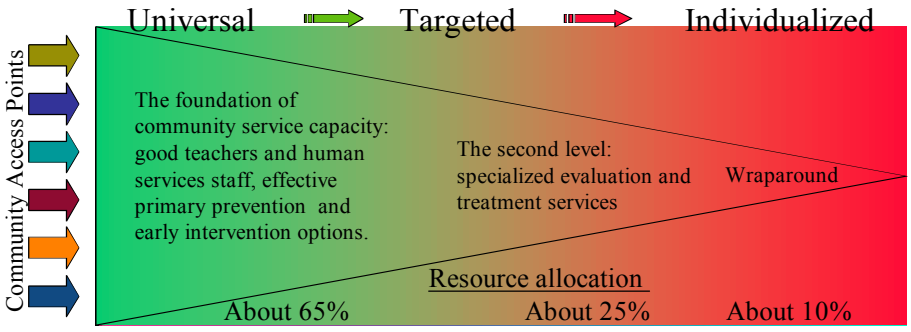


Clarifying roles and goals. If integration is not obliteration, then those who are helping to transform the interagency planning group into a working team will have to help all of the participants see the ways in which who they are and what they do contribute to the collective action of the community. People who are working the front end services where children and families first contact the formal system have to not only know what they do, but also how what they do affects and links to what everyone else at the other levels of intervention does

as well. Otherwise they can't make proper engagement decisions. People who are involved in mid-level specialized or targeted services, while being experts at what they do, must also understand how their efforts link with larger community objectives. Finally, a resource must be available for situations in which neither our primary nor our targeted options are likely to be effective. This is when we use child and family teams that have the resources and flexibility to create unique, family specific responses across life domains and service categories; what is often referred to as wraparound planning.

It is the task of the team developing the community's collaborative infrastructure to decide how much help they should allocate to each of these levels, and how children and families will access and move through the levels. Figure 8 is an illustration of service distribution in a community that chose to put the majority of its assistance at the front end, with proportionately smaller amounts at mid and upper levels.

Figure 8. Building an integrated array of system responses



In this illustration a community has chosen to commit about 65% of its publicly funded behavioral health resource pool to front-end responses accessed through a variety of gateways. When staff at this enhanced front-end recognizes the need for more specialized services they can make appropriate referrals to targeted options or to the community's wraparound response, using collaboratively developed procedures and criteria.

Evil robot or romantic lead? Defining the role of the court.

In the article cited earlier, James Howell recommended expanding the role of the juvenile court in establishing a collaborative infrastructure for a community's behavioral health services. The question is, what should that role be, and how can the court be written into the script? Characters with stature equivalent to that of the court's generally take one of two possible roles in a thriller: evil robot or the romantic lead – either compelling the parties to cooperate, or facilitating the cooperation.

In recent years, courts in many states have been the primary antagonists in the effort to improve mental health services for children and youth. Civil rights class actions and lawsuits for damages have spurred a variety of change efforts. There's nothing like being named as co-defendants to improve collaboration among former competitors. But courts and court staff, including judges, prosecutors, public defenders, guardians ad litem, court

administrators, intake and detention staff, and court-attached evaluators, have also become important protagonists in a number of communities.

Therapeutic jurisprudence. Under the general heading of therapeutic jurisprudence, courts have begun to recognize and emphasize the impact that the court process itself can have on client outcomes. Examples of the therapeutic jurisprudence movement are drug courts, mental health courts, unified family courts and family treatment courts. As distinguished from procedural jurisprudence, which is concerned with matters such as personal and subject matter jurisdiction, fact-finding, interpretation of statutes, and allocation of punishment or liability, therapeutic jurisprudence focuses on the role of the court as a forum and on the activities of court staff in crafting, implementing and managing effective services for children, families and adults with complex needs.

The point is not to have the court take over all of these tasks, or to have all the planning and implementation done in the context of a court hearing, but instead to recognize that the court has been influencing outcomes all along and to clarify and improve the consistency and impact of that influence. [Brooks, S.L. "Therapeutic jurisprudence and preventive law in child welfare proceedings: A family systems approach" *Psychology, Public Policy and Law*, vol. 5, Dec. 1999, p. 951ff.]

An example of the implementation of the principles of therapeutic jurisprudence is the family treatment court. Originally developed in Suffolk County, New York, the court was designed to respond to the needs of families in which parental substance abuse was a driving force behind ongoing neglect of the children in those families. It has since been replicated in many counties in New York State through the assistance of the state's Center for Court Innovation, which now helps local communities develop a variety of what they call "problem solving courts."

The Center lists the following principles for problem solving courts:

> **Case Outcomes**
> Problem-solving courts seek to achieve tangible outcomes for victims, for offenders and for society. These include reductions in recidivism, reduced stays in foster care for children, increased sobriety for addicts and healthier communities.
>
> **Judicial Monitoring**
> Problem-solving courts rely upon the active use of judicial authority to solve problems and to change the behavior of litigants. Instead of passing off cases – to other judges, to probation departments, to community-based treatment programs – judges at problem-solving courts stay involved with each case throughout the post-adjudication process
>
> **Informed Decision-Making**
> Problem-solving courts seek to improve the quality and quantity of information available in the courtroom through, among other things, innovative computer technology, frequent court appearances and on-site professional staff. With better information, judges can respond more swiftly and effectively to problems and hold defendants, as well as partner agencies, to a higher level of accountability.

Collaboration
Problem-solving courts employ a collaborative approach, relying on both government and non-profit partners (criminal justice agencies, social service providers, community groups and others) to help achieve their goals.

Non-Traditional Roles
Some problem-solving courts have altered the dynamics of the courtroom, including, at times, certain features of the adversarial process. For example at many drug courts, judges and attorneys (on both sides of the aisle) work together to craft systems of sanctions and rewards for offenders in drug treatment. And by using the institution's authority and prestige to coordinate the work of other agencies, problem-solving courts may engage judges in unfamiliar roles as conveners and brokers.

System Change
Problem-solving courts promote reform outside of the courthouse as well as within. For example, family treatment courts that handle cases of child neglect have encouraged local child welfare agencies to adopt new staffing patterns and to improve case management practices.

[For more information visit http://www.problem-solvingcourts.org/ on the web. A similar set of principles has been used to develop a dependency drug court in Miami, FL. See: Dice, J.L., Claussen, A.H., Katz, L.F., & Cohen, J.B. (2004). Parenting in dependency drug court. *Juvenile and Family Court Journal*, Reno: v. 55, i. 3, p. 1ff.]

The court's role in resource access decisions. Implicit in Howell's recommendation is recognition that the juvenile court functions as a de facto managed care organization. Because of budgetary restraints, many child welfare and juvenile justice agencies are only able to intervene (and offer assistance) in what are called "petitionable" situations. This means that the court is used to triage limited resources in much the same way as a care manager who provides treatment authorizations at an HMO. But instead of basing the decision about whether someone is eligible for services on diagnostic labels, only cases that meet the requirements for court jurisdiction are able to access system resources.

Once families are under court jurisdiction, judges decide who gets what as part of their dispositional orders, and as more and more children in court present with emotional and behavioral needs, more and more therapeutic components are included in those orders. But as Judge Mitchell cautions, for these orders to be effective not only judges but also other court personnel should know a lot more about how to match the right service with the right need. Otherwise the court will be just as impersonal and draconian as the anonymous voice at the other end of the HMO line.

Besides good information, courts should also have a clear heuristic to guide their decision-making. In an article promoting more effective advocacy in child welfare matters, Jean Koh Peters proposed a set of guidelines for family-focused decision-making that may be helpful in developing a rubric for an informed and inclusive court. For the purposes of this article I have restated them as questions that those present at a dispositional hearing might consider when choosing among possible interventions and alternatives:

- Has there been a thorough investigation that helps us understand this child and family's network of relationships, history and daily life?
- Have we realistically analyzed the service options that are actually available in light of the family's strengths and needs?
- Are we making fundamental changes in a child and family's life only when the child's safety and development are clearly at risk?
- In ambiguous situations, do we err on the side of minimizing state intervention?
- Do we use expert recommendations cautiously, taking into account their limited contact and availability, their personal limitations and biases, and any ongoing role they may have with the child and family?
- Do we honor the perspectives of the child and family both in terms of the situation that brings them to court, as well as the options that are being considered?

Adapted from Peters, J. K. (1996) "The roles and content of best interests in client-directed lawyering for children in child protective proceedings." 64 *Fordham Law Review 1507*.

Conclusion

Considered from one perspective, the juvenile court and the mental health system may seem like two different universes. But if we pull back and examine them from a more objective point of view we can see that they are simply two of the many ways a community goes about caring for children and families whose lives are coming apart. The secret to creating a functional interface between these worlds in collision is to hold fast to that central purpose and to remember that from the Creature in the Black Lagoon to Sigourney Weaver's nasty Alien, we create most of the monsters we encounter out of our own imaginations, fears and misconceptions.

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