MIDD Briefing Paper

BP 116 Youth Mental Health Alternatives to Secure Detention

Existing MIDD Program/Strategy Review □ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept □ (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This concept proposes creation of 10-15 community placement specialized alternative to secure detention (SASD) beds for children and youth who are detained in juvenile detention and who have mental health, substance use disorder (SUD) related or other behavioral health needs. The youth utilizing the beds would be supported with a full continuum of therapeutic behavioral health services. A full continuum means that behavioral health supports are available that include one on one therapy, family counseling, group counseling, case aide support, vocational training, behavioral support, social skills training, medication management. It also includes all services included in the Medicaid continuum of care for youth (whatever is medically necessary to treat or ameliorate the condition). Treatment modalities that are recommended include evidence-based treatment protocols such as: DBT (Dialectic Behavioral Therapy), MST-FIT (Multi-Systemic Therapy - Family Integrated Transitions), and Motivational Interviewing.

Collaborators:

Name	Department
Dr. Eric Trupin	University of Washington
Judge Susan Craighead	King County Superior Court
Margaret Soukup	DCHS

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
Dr. Eric Trupin	Psychologist	University of Washington
Sandy Tomlin	Wraparound PMIII	MHCADSD/DCHS

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This concept proposes creation of 10-15 community placement specialized alternative to secure detention (SASD) beds for children and youth who are detained in juvenile detention and who have

mental health, substance use disorder (SUD) related or other behavioral health needs. The youth utilizing the beds would be supported with a full continuum of therapeutic behavioral health services. A full continuum means that behavioral health supports are available that include one on one therapy, family counseling, group counseling, case aide support, vocational training, behavioral support, social skills training, medication management. It also includes all services included in the Medicaid continuum of care for youth (whatever is medically necessary to treat or ameliorate the condition). Treatment modalities that are recommended include evidence-based treatment protocols such as: DBT (Dialectic Behavioral Therapy), MST-FIT (Multi-Systemic Therapy - Family Integrated Transitions), and Motivational Interviewing.

The staffing for this program would include mental health professionals at an appropriate ratio to the number of children in their care. A consulting psychiatrist with prescriptive authority, psychologist for conducting assessments, along with case aides and family therapists will be necessary to address the need for rigorous assessment, to initiate treatment and to support the transition back to the community. Please note that implementation of a specific staffing model for this concept is dependent upon be provided by a stand-alone agency with one placement/point of contact, or whether the service could be dispersed through a Behavior Rehabilitation Services (BRS) model of treatment homes or other multi-location provision of service. BRS is a temporary intensive comprehensive support and treatment program for youth with high-level service needs, funded through Children's Administration, the public child welfare agency for the State of Washington. BRS are used to stabilize youth (in-home or out-of-home) and assist in achieving their permanent plan. BRS are intended to safely keep youth in their own homes with comprehensive supports to the family, safely meet the needs of youth in family- based care to prevent the need for placement into a more restrictive setting, and safely reduce length of service by transitioning youth to a permanent home or less intensive service.

In addition, this proposal creates a complementary less restrictive program where the family would be able to provide the housing for the child/youth as long as the counseling, assessment, case aide support and other interventions would be available to support the home, similar to how services are available to support a youth in a BRS placement. These services should be easily accessed to assist families and other caregivers who, without access to these services, would be forced to leave their children in juvenile detention.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☒ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

Depending on the unique needs of each youth, these mental health treatment beds could serve as any of the four functions above. The treatment beds could be a way to perform **early intervention** for a youth with a serious emerging mental health disorder that is identified through juvenile court, by making sure the youth is thoroughly evaluated and that interventions are put into place at the earliest possible moment. The treatment bed can be a crisis diversion, for a youth with mental health needs who is having a **crisis situation** that manifests with juvenile court involvement, that quickly puts comprehensive intervention into place, rather than having the youth wait in detention until the juvenile court matter is resolved before intervening. The treatment bed can be a vehicle for assisting with **recovery and re-entry** back into the community for a youth with chronic mental health needs or who may be facing a competency situation, after competency has been assessed. And lastly, **system**

improvement, as these treatment beds address a serious gap in the county's current mental health system that is not able to provide the needed treatment for youth with serious mental health needs when those needs manifest in ways that divert the youth to the juvenile court system.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

These additional and expanded services would address a critical need for youth whose mental health and wellness are worsened by their exposure to the juvenile justice system and specifically, incarceration in the county's juvenile detention facility. Research has shown that 70 percent of youth involved in the justice system have mental health needs.[1] Youth may be arrested because of behaviors stemming out of a mental health crisis. Incarceration exacerbates these acute conditions. Even if a youth is not in crisis, youth in detention experience additional trauma, depression, anxiety, and other conditions that undermine their health and well-being. The County's 2006 study of the prevalence of mental illness, chemical abuse and homeless, found that 49 percent of the 2,301 youth admitted to secure detention were referred to the mental health clinic (27 percent for depression/anxiety, 28 percent suicidal, 17 percent thought disorder).[2] If detained youth become suicidal or if they pose a risk of acting out towards others, they are often held in isolation in detention. While this approach helps detention staff to monitor the youth, the use of isolation (and restraints) in the detention context can further damage the health and well-being of the youth.[3]

While the goal of the King County Juvenile Court has been to reduce the use of detention, when a youth's mental health needs exceed their family's ability to care for them, detention is often viewed as the only option available. A number of youth who are held in detention have mental health conditions and behaviors that may be severe enough to qualify for intensive residential treatment through Washington's Children's Long-term Inpatient Program (CLIP), but there is no short process for accessing CLIP on a voluntary basis, and most youth in detention are over 13 and would not volunteer for CLIP, and are not likely to meet criteria for an ITA to CLIP.

In 2015, 25 of 35 children/youth from King County were formally referred to CLIP and were admitted in less than 30 days and an additional seven were admitted in less than 60 days. In 2014, 22 of the 42

[1] Attachment A of the Community Crisis Alternatives Action Plan: Phase III Report, Prevalence of Mental Illness, Chemical Abuse and Homelessness, p. 6, Skowyra, K.R., and Cocozza, J.J. (2007) Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System. National Center for Mental Health and Juvenile Justice Policy Research Associates, Inc. Delmar, NY.

[2] Attachment A of the Community Crisis Alternatives Action Plan: Phase III Report, Prevalence of Mental Illness, Chemical Abuse and Homelessness, p.5

[3] Juvenile Detention Alternatives Initiative (JDAI), A Guide to Juvenile Detention Reform: Juvenile Detention Facility Assessment 2014 Update 177-80 (2014).

children/youth referred were admitted in less the 30 days, and an additional 15 were admitted in less than 60 days.

Youth with mental health needs wait in detention for a therapeutic response that does not currently exist in King County. This proposal provides a response that resides therapeutically somewhere between detention and CLIP. Youth who have family with the resources to pay for and arrange the intensive level of support and care a youth with emerging or escalating mental health needs can get released from detention. The youth who are held often do not have family available to care for them and their intensive needs, or their families lack the resources to put into place the intensive level or support the youth requires. Youth in detention with mental health needs are often not able to actively connect with community based treatment providers. While youth who are currently receiving community based mental health services may be able to have visits from their counselor when they are in detention, those youth cannot access more intensive community based support until they are released. And youth who have not yet accessed a benefit in the mental health system must wait until they are released to the community to initiate community based treatment.

The following three examples describe three youth served with mental illness who would have been better served if community based mental health beds and family supports described were in place.

1. The first youth's family became concerned when he started exhibiting concerning behavior. He talked to himself and to the voices in his head, he ate non-food items, and he started to lash out physically at people around him. During one of these physical outbursts, the police were called and he was arrested. Detention staff recommended that he be sent to the inpatient psychiatric unit at Children's Hospital. After his behavior started to improve, Children's Hospital sent him back to detention. The juvenile court case will not resolve quickly because A's competency needs to be evaluated. The juvenile court judge could release A at this stage of the proceeding, but he is being held in detention because he has no community based mental health services in place and his family feels ill equipped to keep him safe at home. Although his behavior had stabilized, he is being held mostly in solitary confinement while in detention because of concerns his behaviors create a risk to himself or other youth in detention. Solitary confinement is an extreme behavioral control, not therapeutic and arguably damaging to A's well-being.

2. The second youth had experienced a lot of conflict at home, and when his behavior "got out of hand" his parents kicked him out of the house. They refused to let him back. He came into detention on several charges. Although he had no history of receiving mental health treatment, a mental health assessment in detention diagnosed him with severe PTSD and other disorders. He has no connection to any community based mental health system and no parent willing to take the steps to help him get connected to services while he sits in detention. He has been detained for more than a month. He is held without treatment or other intervention to address his mental health needs.

3. The third example involves a youth who had been in a residential mental health treatment facility and was charged with a crime at the facility. He was arrested and incarcerated in the detention facility. He was not allowed to return to the mental health facility. His advocates were able to get him on wait lists for other residential treatment facilities. A bed finally opened up for him after waiting over 60 days in detention. During his time waiting, he tried to kill himself. He had to be held in isolation while in detention to keep him safe.

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

In each of the cases described above, detention became the default placement for youth with significant mental health needs. This proposal calls for the creation of specialized detention alternative beds to include 24 hour therapeutic staff support so that the youth can receive necessary and appropriate therapeutic assessment and interventions. While alternatives to secure detention beds for youth exist, these beds are not currently staffed with the expertise to manage emerging or acute mental health needs. The child welfare system has staffed BRS homes, which is a model that could be mirrored or adapted for this purpose. Dedicated community based treatment beds can also facilitate quicker connections to the community based mental health system. These providers can intake the youth and begin to establish a treatment team and treatment plan for the youth and his or her family. If a family is willing to take a youth back, the concept also calls for easily accessed in-home supports so that youth can be at home while the juvenile offender case is pending.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

Strong, positive, empirical evidence supports programs that reduce recidivism and are designed to incorporate the lessons learned through research on adolescent brain development[4]. In addition, those programs that utilize cognitive-behavioral interventions in a culturally responsive manner and recognize and address the consequences of trauma have demonstrated strong positive outcomes in reducing juvenile justice involvement for youth with both behavioral health disorders and delinquent behavior.[5]

The intervention that will be provided to youth and families/caregivers through the proposed treatment beds will be focused on helping youth on improving social development skills in areas of interpersonal relations, self-regulation, addressing trauma, and supporting a transition back to the community with services that will align with the intervention initiated in the residential setting. The intervention will incorporate components of the highly effective approaches developed for youth in both juvenile justice and mental health settings referred to as the Integrated Treatment Model (ITM). The ITM is composed of many of the skills utilized in the Dialectic Behavioral Therapy[6] and have been adapted for adolescents in Washington and numerous other states throughout the country.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

The proposed intervention is composed of a combination of practices which are identified on the Inventory of Evidence Based, Research and Promising Practices developed by the Washington Institute for Public Policy (WSIPP) in collaboration with the University of Washington's Evidence Based Practice

[4] Lipsey, 2001, Steinberg, 2014, Trupin 2005, Aos, 2001, Greenwood, 2007

[5] Lipsey, 2001, Grisso, 2004: *Double jeopardy: Adolescent offenders with mental disorders*. University of Chicago Press, 2004. This book identifies the screening and assessments and interventions necessary to improve outcomes for youth with behavioral health disorders who are involved with the juvenile justice system

[6] Schmidt, H., III. & Salsbury, R.E., III. (2009). Fitting treatment to context: Washington state's integrated treatment model for youth involved in juvenile justice.

Institute as meeting criteria for Research Based or Promising practices (WSIPP, 2015)[7]. Skills based approaches such as CBT and DBT have strong research support in effecting positive clinical outcomes for youth with behavioral health and delinquent behaviors.[8] Engagement of families and other community stakeholders who are involved with youth prior to their transition from the proposed facility around strategies that will improve a youth's capacity to sustain a positive developmental trajectory will be an essential component of the proposed model (Trupin, 2011).

The transition component of this program will adapt the evidence based and research based strategies derived from Functional Family Therapy (FFT), Family Integrated Transitions (FIT) and Multisystemic Therapy (MST)—each of these interventions meet criteria as either Evidence Based or Research Based interventions. The proposed program, being an adaption of existing evidence based and research based practices, will meet the criteria established by WSIPP as a promising practice (see criteria established by WSIPP in the developing of its Inventory of Evidenced Based Practices, 2012).[9]

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Outcomes: Improved health and well-being for youth (via the CANS, MAYSI, GAIN or other measure of health and well-being), reduced days incarcerated, increased connection to community services, improved connections to family and natural supports, reduced contact with juvenile justice.

Most of this data is being collected by the court and community mental health providers. The court measurement tools include: Juvenile Information Management Systems (JIMS), the Positive Achievement Change Tool (PACT), King County Case Management System (KCMS) and the providers could report through contract related reports required through the MIDD.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

- ☐ **All children/youth 18 or under**
- ☐ **Children 0-5**
- ☐ **Children 6-12**
- ☒ **Teens 13-18**
- ☐ **Transition age youth 18-25**
- ☐ **Adults**
- ☒ **Racial-Ethnic minority (any)**
- ☐ **Black/African-American**
- ☐ **Hispanic/Latino**
- ☐ **Asian/Pacific Islander**
- ☐ **First Nations/American Indian/Native American**
- ☐ **Immigrant/Refugee**

[7] Updated Inventory of Evidence-Based, Research-Based, and Promising Practices for Prevention and Intervention Services for Children and Juveniles in the Child Welfare, Juvenile Justice, and Mental Health Systems (July 2015). Evidence-based Practice Institute & Washington State Institute for Public Policy. Document No. E2SHB2536-6. Updated Inventory of Evidence, Research and Promising Practices in Child Welfare, Juvenile Justice and Mental Health.

[8] Steinberg 2004; Scott and Steinberg 2009; Grisso 2008; Trupin, 2007

[9] Inventory of Evidence-Based, Research-Based, and Promising Practices for Prevention and Intervention Services for Children and Juveniles in the Child Welfare, Juvenile Justice, and Mental Health Systems (September 2012). Evidence-based Practice Institute & Washington State Institute for Public Policy. Document No. E2SHB2536.

- ☐ **Older Adults**
- ☐ **Families**
- ☐ **Anyone**
- ☒ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☐ **Veteran/US Military**
- ☒ **Homeless**
- ☐ **GLBT**
- ☐ **Women**

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

The population served by these beds would be youth ages 12 to 18 who are at risk of involvement with juvenile court. The population would include youth most at risk of being detained in the detention facility due to untreated mental health disorders. The lack of treatment can lead to homelessness as families are often challenged to provide the necessary help or services for severely mentally ill youth. The youth most impacted by risk of detention are youth of color.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

This concept is mostly likely to impact families in South King County the most, even though it will be available to youth county-wide. The reason why it will impact South King County the most is because youth from South King County are at the highest risk of being detained in the juvenile court system[10]. Youth from other parts of the county are not arrested at rates as high as youth from South King County and youth from other parts of the county are able to find services and resources that allow them to avoid being held in detention.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

King County Behavioral Health providers – specifically the current treatment team that works with youth who are involved with Juvenile Court, high fidelity Wraparound facilitators, Juvenile Justice Assessment Team (JJAT), University of Washington, Seattle Children's Hospital as well as licensed homes for youth, detention facility and the juvenile court system (courts, prosecutors and defense attorneys), child welfare and probation staff.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

[10] An Analysis of the Rise in Referrals of African American Youth 2014 compared to 2013 January through August; King County Juvenile Special Report (2015).

Changes could include rethinking the determination of whether a youth meets the criteria to be committed to a mental health facility under RCW 71.34 because currently most mental health providers find that youth who are in a detention facility do not meet the criteria to be committed to a mental health facility. CLIP is a very limited resource; it has 85 beds to serve the entire state and only 73 beds for youth 13-17 years old. Since CLIP is not a crisis intervention, there needs to be something in the community to respond in a crisis when needs warrant that level of intervention. Review the intake and assessment process for CLIP, as it seems onerous, perhaps due to the limited capacity. Lastly, the process for having youth evaluated for competency in the community and restored if found not competent should be addressed so that the interventions can occur within the statutory framework already delineated by law.

The initial implementation of the Behavioral Health Organization that will take place on April 1, 2016 could impact the number and quality of SUD and mental health treatment services these youth receive for both inpatient and outpatient services, due to the agency transition into the new system. These changes are likely to improve the impact on the ability for these youth to have timely access to these services, although it may take time.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

The juvenile court system, including judges, prosecutors, defense attorneys, probation counselors, and detention staff, would need to be trained on how to access and implement a process for assessing the mental health needs of youth facing detention time. This would include both at pre-adjudication and post adjudication considerations in order to establish a protocol for access to this vital service. Mental health advocates working closely with these system partners would be necessary to identify youth eligible for this treatment.

This barrier could be overcome with establishing and maintaining collaborative partnerships that establishing common goals for the project, along with expectations for communication and information sharing.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Intensive and thorough assessments of youth and their mental health needs could reveal deficits in the youth's family that would need to be addressed and could have consequences for siblings and parents and relatives. For example, a youth with emerging mental health conditions who receives a timely and thorough assessment could reveal other problems in the home that have led to his or her manifestations of trauma, anxiety or depression. Those problems could lead to further system involvement for the family.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

One of the most significant unintended consequences of the current gaps on the continuum of care for youth with emerging or serious mental health conditions are that people in the community experience victimization when a youth with untreated mental health is acting out in the community. Youth with serious mental health conditions can create trauma and anxiety for siblings, their school community, their neighborhood and extended family. The lack of an intensive and comprehensive system to respond in a timely manner to the needs of youth leads to traumatic experiences that ultimately alert law enforcement and the juvenile justice system.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

The Children's Crisis Outreach Response (CCORS) appears to be an effective response for certain youth. This program has a limited scope of diversion/crisis beds: three beds county-wide in licensed therapeutic foster homes. CCORS can decline to serve kids based on severe mental health issues and/or violence to others. CCORS is known to do well with kids under 13, and could potentially take older kids. At this time this service is not suitable for most homeless and juvenile justice youth because youth need to be in school during week days.

Currently there are no other approaches that address this specific need because it requires a response somewhere between detention and CLIP (Children's Long Term Inpatient Program). This proposal can include CLIP into the overall behavioral health response continuum and remove detention as an alternative (if youth do not meet CLIP criteria). The current capacity for CLIP is limited to a medical necessity criterion and is **not** a crisis service. Another available resource to include in the behavioral health response continuum is the King County high fidelity Wraparound facilitation **process**. This process can be effective in the community to support a youth after a crisis has subsided. Wraparound is also **not** a crisis service. Wraparound is an effective process and due to the great community need, current capacity is not always sufficient (as recently demonstrated in south King county).

This proposal could be merged with another proposal submitted for ES 7a Respite Cottages for youth **without a criminal matter** in a crisis. A youth in crisis is defined as an 18 year old individual or younger, who is struggling with mental health/substance use disorder (SUD) issues, including trauma; is the status of a dependency youth, has been involved in a domestic violence incident in their home, is truant, is of Commercially Sexually Exploited Children (CSEC) status, is homeless and/or is a runaway subject to an At Risk Youth (ARY) petition or from foster care placement. It is anticipated that the Respite Cottages would serve youth 13-18 years of age. This would provide an immediate short-term placement alternative to detention for these youth, as well as, perhaps, homeless youth whose mental health problems are too complex for shelters. Like the Crisis Solutions Center for adults, this concept would avoid unnecessary incarceration or emergency room care while stabilizing youth in crisis while supports are put in place or appropriate placements are identified (within a specified time period).

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and**

Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

This concept fits well into the Youth Action Plan as many youth with emerging and intensive mental health disorders are barred from their family home when the family is unable to get the help needed to keep the youth safely at home. These youth often end up on the streets and in the shelter circuit and can also develop addiction related problems as a way to avoid the mental health problems they are facing.

In addition, this program also supports and/or aligns with the goals of Behavioral Health Integration, Best Starts for Kids, All Home, the King County Behavioral Health and Recovery Ordinance, the King County Strategic Plan, and the King County Equity and Social Justice Ordinance.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

The proposed intervention is derived from the most well established concepts and interventions that have been researched which are rooted in the importance of supporting youth and family in positive skills-based approaches based on adolescent brain development and psychosocial interventions. The intervention will provide tools for youth and family to move from a pathway that often leads to increased enmeshment in the juvenile justice and correction systems toward more positive fulfillment of a trajectory that emphasizes achievement and success in the social, emotional, academic and vocational activities. The intervention will move a youth off the "cradle to prison" pathway towards outcomes derived from their own, their parents' and care givers' and their community's positive aspirations and goals.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

This concept would reduce inappropriate and inhumane use of detention for King County's most vulnerable youth. Managing behavior through incarceration is not an intervention that has long term or sustainable benefits for individual youth, families or the community. Placing youth with mental health needs in specialized alternatives to secure detention (SASD) beds that are staffed with appropriate mental health professionals significantly increases the likelihood that the youth will be appropriately connected to the right treatment and support to maintain healthy and full functioning in the community.

SASD beds for youth with mental health needs will reduce the likelihood of re-traumatizing often already traumatized youth. Often, youth who do not have family resources to assist in providing the appropriate resources are also in foster care.

Youth of color are disproportionately represented in both the juvenile justice and foster care systems. SASD beds and more in home support for families and caregivers would help to reduce the disparities in detention and in child welfare by creating a path and means for youth to get their mental health needs without being criminalized or removed from their families.

Reducing the detention population and ensuring that youth with high needs get meaningful treatment and support will produce immediate and long term cost savings. Youth will experience better health

and well-being and they will stay connected to families and schools.

Estimates below are based on the costs for child welfare's BRS placements, which are highly specialized, therapeutic foster homes. The highest BRS level placement cost $7,225 a month, which is $240 a day. Not all youth in detention would need this most intensive BRS level placement. Some would meet the criteria for "severe" (at $5,389 a month) or "serious" (at $3,710 a month), which cost significantly less than detention. There may be other models for delivering SASD beds that leverage existing placements by adding more specialized staff and expertise. These other models could be a less costly approach than the highest BRS level placement.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

This concept could use existing residential bed space in programs currently operated by agencies such as Youth Care, Friends of Youth or other BRS licensed placements, as long as additional mental health treatment providers were connected with the physical location of the youth to provide the necessary intervention, assessment and support. The CCORS model is tested and will be an informative structure for lessons learned in startup of this type of programming.

Trained mental health professionals would be needed to fully implement this program. BRS type placements would be necessary, either in stand-alone foster homes, or as part of a larger facility providing housing to youth.

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

Based on the current funding model for BRS level services, $200,000 per year for up to 24 people (2 beds for 12 months), $500,000 per year serving up to 60 people (5 beds for 12 months) or $1,000,000 for serving up to 120 people (10 beds for 12 months).

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

King County Juvenile Court could supplement some of this program with money saved by the reduction of the use of the detention facility. Resources from the state TR settlement, as well as Title IVE and Medicaid would support this treatment and intervention.

4. **TIME to implementation: 6 months to a year from award**
   a. **What are the factors in the time to implementation assessment?**
   Factors may include raising capital funds, siting, construction or remodeling process.

   b. **What are the steps needed for implementation?**
   Design the screening/assessment and entry criteria for youth involved in the program;
   Create a program model and train staff in the proposed strategies;
   Develop the transition component of the model;
   Develop "buy in" from various stakeholders in the community –schools, community organizations, law enforcement etc. and;
   Identify a site where community interest in its location will be high.

c. Does this need an RFP?
Yes**.** There will need to be an RFP.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

#116

Working Title of Concept: MIDD Youth Mental Health Alternatives to Secure Detention Beds

Name of Person Submitting Concept: Karen Pillar, Caedmon Cahill and Anne Lee
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

The creation of 10 -15 community placement (specialized alternative to secure detention (SASD) beds) supported with a full continuum of therapeutic behavioral health supports that are targeted for children and youth who are detained in juvenile detention and who have mental health, substance abuse related or other behavioral health needs. Additionally, creating an ample and easily accessed individualized home-based behavioral health support and therapeutic service to assist families and other caregivers who, without access to these services, are forced to leave their children in juvenile detention.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

These additional and expanded services would address a critical need for youth whose mental health and wellness are worsened by their exposure to the juvenile justice system and specifically incarceration in the county's juvenile detention facility. Research has shown that 30-60% youth involved in the justice system have mental health needs. Youth may be arrested because of behaviors resulting from a mental health crisis. Incarceration exacerbates these acute conditions. Even if a youth is not in crisis, youth in detention experience additional trauma, depression, anxiety, and other conditions that undermine their health and well-being. In the County's 2006 study of the prevalence of mental illness, chemical abuse and homelessness, found that 49% of the 2,301 youth admitted to secure detention were referred to the mental health clinic (27% for depression/anxiety, 28% suicidal, 17% thought disorder). If detained youth become suicidal or if they pose a risk of acting out towards others, they are often held in isolation in detention. While this approach helps detention staff monitor the youth, the use of isolation (and restraints) in the detention context can further damage the health and well being of the youth.

While the goal of the King County Juvenile Court has been to reduce the use of detention, when a youth's mental health needs exceed their family's ability to care for them, detention is often viewed as the only option available. A number of youth who are held in detention have mental health conditions and behaviors that are severe enough to qualify for intensive residential treatment through Washington's Children's Long-term Inpatient Program (CLIP), but the waiting list to get into CLIP is long. Some youth wait in detention for CLIP beds and that can take weeks or months. Youth who have family with the resources to pay for and arrange the intensive level of support and care a youth with emerging or escalating mental health needs can get released from detention. The youth who are held often do not have family available to care for them and their intensive needs, or their families lack the resources to put into place the intensive level or support the youth requires. While in detention, youth with mental health needs are often not able to actively connect with community based treatment providers. Though some youth may get visits from their counselor when they are in detention, those youth cannot access more intensive community based support until they are released. And youth who have not yet been tiered into the mental health system must wait until they are released to the community to initiate community based treatment.

The following three examples illustrate the need for community based mental health beds and family supports in lieu of reliance on the use detention for children with serious mental health needs:

1. A's behavior was increasingly alarming to his family. A talked to himself and to voices in his head and he started to lash out physically at people around him. During one of these physical outbursts, the police were called and he was arrested. Detention staff recommended that he be sent to the inpatient psychiatric unit at Children's Hospital. Once his behavior started improving, Children's Hospital sent him back to detention. The juvenile court case will not resolve quickly because A is in the process of getting a competency evaluation. The juvenile court judge could release A at this stage of the proceeding, but he is being held in detention because he has no community based mental health services in place and his family does not feel capable of meeting his health needs at home. A is mostly kept alone, in isolation, in the health clinic, in conditions similar to solitary confinement due to concerns that his behaviors create a risk to himself or others. Solitary confinement is an extreme behavioral control, not therapeutic and only exacerbates his deteriorating health.

2. B was in the middle of terrible conflicts at home and when tensions escalated, his parents kicked him out of the house. He came into detention on several charges. Although he had no history of receiving mental health treatment, a mental health assessment in detention diagnosed him with severe PTSD and other disorders. Prior to his arrival in detention, he had not enrolled in any community based mental health system and his parents refuse to assist in connecting him with services while he sits in detention. He has been detained for more than a month. He is held without treatment or other intervention to address his mental health needs.

3. C had been hospitalized at a residential mental health treatment facility when he was charged for an incident that occurred during his hospitalization. He was arrested and brought to detention. He was not allowed to return to the mental health facility and was on a waitlist for another inpatient facility. After waiting over 60 days in detention, a bed finally opened up. During this wait, he tried to kill himself. Following this attempt, detention staff kept C in isolation to keep him safe.

3. How would your concept address the need?
Please be specific.

In each of the cases described above, detention became the default placement for youth with significant mental health needs. Our concept calls for the creation of specialized detention alternative beds to include 24 hour therapeutic staff support so that the youth can receive necessary and appropriate therapeutic assessment and interventions. While alternatives to secure detention beds for youth exist, these beds are not currently staffed with the expertise to manage emerging or acute mental health needs. The child welfare system has staffed BRS homes which is a model which could be mirrored or adapted for this purpose. Having dedicated community based treatment beds can also facilitate effective connections to the community based mental health system. These providers can intake the youth and begin to establish a treatment team and treatment plan for the youth and his or her family. Where family is willing to take a youth back, our concept also calls for easily accessed in-home supports so that youth can be at home while the juvenile offender case is pending.

4. Who would benefit? Please describe potential program participants.

The benefits would be tremendous for youth in the juvenile justice system who have mental health needs and who are incarcerated in the juvenile detention facility. The average daily population in detention is around 50 youth. Most of these youth are detained for minor offenses, probation violations and warrants. As the county develops alternative pathways for these lower level offenses, the remaining youth in detention will have higher needs and more complicated lives. Families would benefit from this concept. They would be able to stay more engaged in the youth's care and overall well being. Courts and the public would benefit because resources would be shifted away from punishment and incarceration to a humane, more therapeutic approach that has potential for long term sustained improvement in the health and well being of youth, families and community..

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Outcomes: Improved health and well being for youth (via the MAISY or other measure of health and well being), reduced days incarcerated, increased connection to community services, improved connections to family and natural supports, reduced contact with juvenile justice
Most of this data is being collected by the court and community mental health providers.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

X Prevention and Early Intervention: Keep people healthy by stopping problems before they start and preventing problems from escalating.
X Crisis Diversion: Assist people who are in crisis or at risk of crisis to get the help they need.
X Recovery and Reentry: Empower people to become healthy and safely reintegrate into community after crisis.
X System Improvements: Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

This concept would reduce inappropriate and inhumane use of detention for our most vulnerable youth. Managing behavior through incarceration is not an intervention that has long term or sustainable benefits for individual youth, families or the community. Placing youth with mental health needs in specialized alternatives to secure detention (SASD) beds that are staffed with appropriate mental health professionals significantly increases the likelihood that the youth will be appropriately connected to the right treatment

and support to maintain healthy and full functioning in the community.

Specialized ASD beds for youth with mental health needs will reduce the likelihood of retraumatizing often already traumatized youth. Frequently, youth who do not have family resources to assist in providing the appropriate resources are also in foster care.

Youth of color are disproportionately represented in both the juvenile justice and foster care systems. SASD beds and more in-home support for families and caregivers would help to reduce the disparities in detention and in child welfare by creating a path and means for youth to get their mental health needs without being criminalized or removed from their families.

Reducing detention population and ensuring that youth with high needs get meaningful treatment and support will produce immediate and long term cost savings. Youth will experience better health and well being and they will stay connected to families and schools.

We provided estimates below based on the costs for child welfare's BRS placements, which are highly specialized, therapeutic foster homes. The highest BRS level placement cost $7,225 a month, which is $240 a day. Not all youth in detention would need this most intensive BRS level placement. Some would meet the criteria for "severe" (at $5,389 a month) or "serious" (at $3,710 a month), which cost significantly less than detention. There may be other models for delivering SASD beds that leverage existing placements by adding more specialized staff and expertise. These other models could be a less costly approach than the highest BRS level placement.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Mental Health providers, licensed homes for youth, detention facility and the juvenile court system (courts, prosecutors and defense attorneys), probation

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: $ 200,000 per year, serving up to 24 (2 beds for 12 months) people per year
Partial Implementation: $ 500,000 per year, serving up to 60 (5 beds for 12 months) people per year
Full Implementation: $ 1,000,000 per year, serving up to 120 (10 beds for 12 months) people per year

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.