MIDD Briefing Paper

Existing MIDD Program/Strategy or New Concept Name: 5a Juvenile Justice Youth Assessments (JJAT)/Enhanced Engagement and Connection to Ongoing Mental Health and Substance Use Disorder Services

Existing MIDD Program/Strategy Review [x] **MIDD I Strategy Number __5a_____ (Attach MIDD I pages)**
New Concept ☐ **(Attach New Concept Form)**
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: The original concept for this existing strategy was to increase mental health and substance use disorder assessments for youth who enter the juvenile justice system in order to increase the appropriate response to youth whose involvement with the juvenile justice system is due to substance use disorder and/or mental health issues.[1] This strategy was implemented in 2009 when the first Mental Illness Drug Dependency Drug Action Plan (MIDD I) [2] was approved by the King County Council and named the 'Juvenile Justice Assessment Team' (JJAT).[3]

JJAT serves any King County youth age 12 years or older who have become involved with the juvenile justice system by providing mental health and substance use disorder screening/assessment services and psychological evaluations.

This briefing paper also includes an expansion of the existing JJAT concept. The expansion would pilot a focus on youth identified to have high need co-occurring disorders through current JJAT services of screening, triage, assessment, and evaluation.[4] JJAT has found that youth often need ongoing support and engagement to take action on treatment referrals received from and recommended by JJAT team members.

Collaborators:

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

[1] http://www.kingcounty.gov/healthservices/MHSA/MIDDPlan.aspx
[2] http://www.kingcounty.gov/healthservices/MHSA/MIDDPlan.aspx
[3] JJAT is located in the Juvenile Court Services. The Juvenile Court Services is a Division of King County's Superior Court. http://www.kingcounty.gov/courts/SuperiorCourt.aspx
[4] 'Co-occurring disorders' is the term used to describe people who have both substance use disorders and mental health disorders. This is sometimes also referred to as having a 'dual diagnosis'.

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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?**

The original concept for this existing strategy was to increase mental health and substance use disorder assessments for youth who enter the juvenile justice system in order to increase the appropriate response to youth whose involvement with the juvenile justice system is due to substance use disorder and/or mental health issues.[5] This strategy was implemented in 2009 when the first Mental Illness Drug Dependency Drug Action Plan (MIDD I) [6] was approved by the King County Council and named the 'Juvenile Justice Assessment Team' (JJAT).[7]

JJAT serves any King County youth age 12 years or older who have become involved with the juvenile justice system by providing mental health and substance use disorder screening/assessment services and psychological evaluations.

JJAT: a) Makes recommendations to the court regarding possible outcomes and youth needs, including sentencing options and diversion from criminal justice sentencing due to underlying mental health or substance use disorder issues, perhaps recognized by JJAT services for the first time; b) Refers youth to treatment services when a treatment need has been identified; and, c) Works to help youth follow-up on the treatment referrals and transition from screening/assessment/evaluation to ongoing treatment services when indicated. This briefing paper includes an expansion pilot to improve and increase the work described in c).

[5] http://www.kingcounty.gov/healthservices/MHSA/MIDDPlan.aspx
[6] http://www.kingcounty.gov/healthservices/MHSA/MIDDPlan.aspx
[7] JJAT is located in the Juvenile Court Services. The Juvenile Court Services is a Division of King County's Superior Court. http://www.kingcounty.gov/courts/SuperiorCourt.aspx

Screening, assessment services, and psychological evaluations are collaboratively supported by: 1) King County's Behavioral Health and Recovery Division (BHRD), formerly the Mental Health and Chemical Abuse and Dependency Services Division (MHCADSD)[8]; 2)King County's Superior Court through its Juvenile Court Services staff[9]; and, 3) Contracted community mental health and substance use disorder agencies[10].

JJAT has two staff[11], a Program Coordinator/Staff Supervisor and a Clinical Psychologist. The JJAT team also includes staff hired via mental health contracts with Navos and Therapeutic Health Services and substance use disorder contracts with Washington Asian Pacific Islander (WAPI) Community Services and Ryther for JJAT related work and assessments. To best serve King County's youth, JJAT's Clinical Psychologist may also refer youth in need of more intensive services to psychiatric or neuro-psychological evaluations within the community.

JJAT services aim to divert youth with mental illness and substance use disorder needs and diagnoses from initial or further justice system involvement and reduce the incidence and severity of chemical dependency and mental and emotional disorders in youth. Data from the Substance Abuse and Mental Health Services Administration (SAMHSA)[12] indicates that 50 to 70 percent of youth involved in the Juvenile Justice System met criteria for a mental health disorder, and 60 percent of youth met criteria for a substance use disorder. Models for Change[13] and the Justice Policy Institute[14] report that while up to 34 percent of children in the U.S. have experienced at least one traumatic event, 75 to 95 percent of youth entering the Juvenile Justice system have experienced some degree of trauma.[15]

The Adverse Childhood Experiences Study (ACE) is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being.[16] To date, more than fifty scientific articles have been published and more than one hundred conference and workshop presentations have been made.[17] The ACE study findings suggest that certain experiences are major risk factors for leading causes of illness and death as well as poor quality of life in the U.S., including childhood experiences of abuse, neglect, and family dysfunction (which include mental illness and/or substance abuse of a parent/caregiver, divorce and/or incarceration of a parent, domestic violence).

Traumatic experiences affect brain development in children.[18] Youth who have experienced trauma may be more likely to be involved in illegal behavior for a variety of reasons, including the neurological,

[8] Given the multiple funding sources of BHRD resources devoted to JJAT, there are two different contract monitors ensuring contract compliance and adequate available resources. DBHR's Children's Mental Health Planner also provides clinical and systems coordination consultation, support and technical assistance.
[9] The two staff are a Program Coordinator/Staff Supervisor and a Clinical Psychologist.
[10] Four agencies have contracts to provide mental health or substance use disorder assessments/screenings.
[11] The JJAT staff is employed by King County Juvenile Court Services and is the conduit for providing, compiling and/or coordinating all JJAT activities.
[12] SAMHSA is the federal administration responsible for improving the quality and availability of prevention, treatment and rehabilitative mental health and substance use disorder services. http://www.samhsa.gov/
[13] Models for Change: Systems Reform in Juvenile Justice. http://www.modelsforchange.net/index.html
[14] Justice Policy Institute, Juvenile Justice http://www.justicepolicy.org/research/category/38
[15] *Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense, Justice Policy Institute, 2010.* *http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf*
[16] The Adverse Childhood Experiences Study is a collaboration between the Centers for Disease Control and Prevention, and Kaiser Permanente's Health Appraisal Clinic in San Diego
[17] http://www.cdc.gov/violenceprevention/acestudy/
[18] Coalition for Juvenile Justice,2006 Emerging Concepts Brief: What are the Implications of Adolescent Brain Development for Juvenile Justice?(Washington, D.C.: Coalition for Juvenile

psychological and social effects of trauma. According to the Centers for Disease Control, children and adolescents are at greater risk for Traumatic Brain Injury (TBI) than adults, with the highest rates being for ages 0-4 years and 15-19 years.[19]

A TBI during the period of brain development, which lasts well into a person's 20's,[20] could disrupt the full development of decision-making skills and emotional controls that guide behavior. A TBI combined with the impulsiveness of a youthful, developing brain can increase the likelihood that a young person is involved in delinquent behavior. A large scale longitudinal research study in Finland found increased incidents of delinquency among youth who had experienced a TBI prior to age 14.[21] Recent research (2008) examining youth currently incarcerated in juvenile detention facilities in Missouri found high prevalence rates of TBI.[22] Children are rarely screened for trauma, especially in the juvenile justice system.

One of the best ways to bend the cost curve of health care and criminal justice costs is to directly address core causes of much delinquent behavior by assessing and providing behavioral health[23] services to youth who have experienced significant and/or multiple traumatic events as soon as indicated. JJAT services implement these best approaches for youth involved in the juvenile justice system.

This briefing paper also includes an expansion of the existing JJAT concept. The expansion would pilot a focus on youth identified to have high need co-occurring disorders through current JJAT services of screening, triage, assessment, and evaluation.[24] JJAT has found that youth often need ongoing support and engagement to take action on treatment referrals received from and recommended by JJAT team members.

The JJAT expansion pilot will be known as the Behavioral Health Juvenile Justice (BHJJ) Pilot Project. These youth would receive up to six additional months of enhanced engagement and follow up support services to:

- Increase treatment engagement of the youth and family;
- Increase the youth and family following JJAT treatment and service recommendations; and
- Provide support and advocacy to ensure the youth's needs are being met by the treatment provider selected by the youth and family.

Justice,2006).www.juvjustice.org/media/resources/public/resource_134.pdf
www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf

[19] Mark Faul and others, Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths 2002-2006 (Washington, DC: Center for Disease Control and Prevention, 2010). www.cdc.gov/traumaticbraininjury/pdf/blue_book.pdf

[20] Coalition for Juvenile Justice, 2006 Emerging Concepts Brief: What are the Implications of Adolescent Brain Development for Juvenile Justice? (Washington, D.C.: Coalition for Juvenile Justice, 2006). www.juvjustice.org/media/resources/public/resource 134.pdf

[21] Paula Rantakallio and others, "Association of Perinatal Events, Epilepsy, and Central Nervous System Trauma with Juvenile Delinquency," Archives of Disease in Childhood 67 (1992): 1459-61.

[22] Brian E. Perron and Matthew O. Howard, "Prevalence and Correlates of Traumatic Brain Injury among Delinquent Youths," Criminal Behaviour and Mental Health 218 (2008): 243-55.

[23] 'Behavioral Health' is the term used to describe the combination of mental health and/or substance use disorder needs.

[24] 'Co-occurring disorders' is the term used to describe people who have both substance use disorders and mental health disorders. This is sometimes also referred to as having a 'dual diagnosis'.

JJAT staff meets with a youth, collects background information, and uses a variety of assessment tools to complete the assessment. In the course of the assessment, staff often learns a youth has already spoken with a number of detention, court and probation staff, and are sometimes reluctant to provide the same private information to a number of different people who are collecting information but may never help them with their issues. Building trust and establishing rapport with youth and families often takes time and repeated contact with staff to verify to the youth staff will actually follow through with needed help.

Currently, JJAT staff sees a youth once, or perhaps twice. While engagement is a main focus for all JJAT assessment staff, it is difficult to accomplish without really getting to know the family members. Trust and rapport are essential to eliciting honest information and sufficient background knowledge to effectively create a workable behavioral health plan. The BHJJ pilot project expansion proposes to increase the JJAT staff time available to develop necessary trust and rapport to best support the youth and their family to successfully engage in needed and available treatment for their behavioral health needs.

The proposed eligibility criteria for the BHJJ pilot project expansion are:

1. Youth with more severe and complex co-occurring disorders and who need the additional assistance of mental health and substance use disorder professional staff to assist them in accessing and engaging in appropriate services to address their needs;
2. Any youth between the ages of 13-17 involved in the Juvenile Justice System within King County Offender, Probation, At Risk Youth (ARY)/Child In Need of Services (CHINS), truancy, youth with concurrent (child welfare) Dependency and Juvenile Offender matters;
3. Youth who score a 2 or 3 on the Child Severity of Psychiatric Illness (CSPI) scale and qualify for Level 2, 3, or 4 services as determined by the Child and Adolescent Level of Care Utilization System (CALOCUS);
4. Youth with a mental health diagnoses that include anxiety, depression, attention deficit hyperactivity disorder, psychotic symptoms or post-traumatic stress. Youth with diagnoses of disruptive disorders, i.e., Conduct Disorder, are not eligible, unless there is a concurrent diagnosis that includes anxiety, depression, psychotic symptoms or post-traumatic stress; and,
5. Parents or Caregivers and Juvenile Probation Counselor must consent to program participation.

The BHJJ pilot expansion will identify youth with co-occurring mental health and substance use diagnoses and work with the youth's family and Juvenile Court Services staff for a period of up to six months in order to:

1. Provide an assessment to identify a youth's integrated behavioral health needs, and develop an individualized treatment plan, which involves the family, the court and treatment staff, and the community.
2. Engage the youth and family in developing a workable action plan to address and identify needs.
3. Identify and provide direct linkage to appropriate services within the community, as well as ongoing support to keep youth engaged in treatment.
4. Provide support to the youth and family through home and school visits as well as court related requirements.
5. Link the youth with pro-social activities in the community – mentorship, athletics, arts, jobs programs, etc.

The JJAT pilot expansion also seeks to strengthen and enhance relationships among the court, probation, schools and other community-based service providers.

The State of Illinois has successfully utilized a service model that allows juvenile justice related assessment staff to provide ongoing support and advocacy through direct linkage to treatment and continuing work with the youth and family to ensure successful outcomes.[25] The proposed BHJJ expansion pilot is based upon this model, and seeks to provide the supports necessary to increase the likelihood of improved behavioral health outcomes and decreased criminal justice involvement for the youth served by JJAT. This is sometimes referred to as a 'warm hand off'.[26]

Just as King County has the goal to make homelessness a brief and one-time experience, implementing the proposed pilot expansion of JJAT engagement and linkage supports increases the likelihood of the earliest and most cost-effective interventions for often marginalized youth of color and their families, with the goal of limiting juvenile justice involvement. It strengthens and increases the positive impact and long term outcomes JJAT would be able to have on the youth they serve who are suffering with significant mental health and/or substance use disorders.

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).

System Improvement: reduced disproportionate representation in the criminal justice system, improved care coordination, improved quality of care, improved client experience.

Prevention and Early Intervention: increased access to person centered, culturally appropriate treatment, reduced use of drugs and alcohol, reduced risk factors for substance use and mental health disorders, increased access to primary behavioral health care services, reduced barriers to services.

Crisis Diversion: increased access to community alternative options such as diversion, increased access to treatment courts, reduced barriers to services, reduction in use of detention and jail for crisis services, availability and use of community alternatives to detention, decreased re-use of criminal justice services and resources.

Recovery and Re-entry: Increased person centered, culturally appropriate recovery and/or treatment services, reduced barriers to services, increased implementation of recovery and resiliency principles in services provided.

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.**

[25] Cook County Mental Health Juvenile Justice Program. http://psychiatry.northwestern.edu/research/mental-health/index.html

[26] http://www.ibhp.org/?section=pages&cid=122

A majority of youth entering the juvenile justice system have underlying mental health and/or substance use disorder issues that may have caused the behavior which resulted in the initial need for juvenile justice involvement. JJAT services aim to divert youth with mental illness and substance use disorder needs and diagnoses from initial or further justice system involvement; and reduce the incidence and severity of mental health and substance use disorders in youth.

While people of color are more likely to be victims of crime and violence, America's criminal justice system reveals an unfair impact on marginalized communities.[27] People of color are disproportionally arrested, sentenced and incarcerated when compared to white people accused of similar offenses.[28] Juvenile Court service information reveals this racial disproportionality exists in the juvenile justice portion of the criminal justice system in King County and needs focused, concerted, and ongoing efforts such as JJAT to increase diversion from formal charging, sentencing, and incarceration of youth, and to assist youth with serious behavioral health needs to get those needs met. Since 2009, 65 percent of youth served through JJAT have been youth of color. JJAT services reduce the racial disproportionality in the juvenile justice system by meeting the mental health/substance use disorder needs of youth without unnecessary criminal justice involvement.

JJAT provides a unique blend of cross-disciplinary screenings, assessments, evaluations, and consultations not found elsewhere in the community. The MIDD Strategy 5a[29] was designed to be a true collaboration between county staff and community providers, to address the need to screen and assess youth early in their Juvenile Court involvement, to provide underserved populations with high quality inter-disciplinary assessments, and to make referrals to clinically appropriate and culturally targeted services.

If this strategy does not continue to receive MIDD funding, these services would be much more difficult to access in the community and King County Juvenile Justice involved youth would be sorely underserved. It is reasonable to predict a lack of continued funding of JJAT would result in an increase of youth with mental health and substance use disorders not receiving the health care services they need, in addition to experiencing an increase in formal charges and sentencing, detention, and/or criminal justice incarceration. These traumatic experiences will build upon and multiply the effects of the significant trauma with which 75 to 90 percent of youth enter the Juvenile Justice system. Additionally, being charged and convicted of a crime, coupled with incarceration, guarantees the youth will be less able to become gainfully employed upon release. This leads to poverty, homelessness, increased and ongoing despair, possible return to criminal behavior to earn money, and/or ongoing untreated mental illness and substance use disorders. These types of suffering increase the need for additional community resources and decrease the likelihood the youth/young adult will be able to successfully integrate into the community as a contributing, self-sustaining member whose strengths and abilities are both supported and benefited from.

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

JJAT services aim to divert youth with mental illness and substance use disorder needs and diagnoses from initial or further justice system involvement; and reduce the incidence and severity of mental health and substance use disorders in youth. JJAT services reduce the racial disproportionality in the juvenile justice

[27] *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*, Michelle Alexander, 2010. http://newjimcrow.com/media

[28] http://www.justicepolicy.org/research/category/36

[29] The MIDD I Strategy 5a is the Juvenile Justice Assessment Team [JJAT].

system by meeting the mental health/substance use disorder needs of youth without unnecessary criminal justice involvement.

Since its inception in 2009, JJAT has served over 2400 youth, 71 percent of which were male, and 29 percent of which were female. Sixty five percent of these youth identified primarily as youth of color. It is important to note 20 percent of this population also identified as bi-racial or multi-racial, thus historically underrepresented ethnic groups are present in greater number than usually counted. Twenty percent of these 2400 youth identified as being of Hispanic or Latino descent. Of the total number of youth served, five percent primarily identify as Native American or Alaskan Native, but that number rises to 8.5 percent when viewed through a bi-racial or multi-racial lens.

JJAT often diagnoses for the first time youth who have mental health and or substance use disorder treatment needs, refers those youth to treatment, and advises the court to enable decisions that increase diversion options. These concrete system changes help King County's juvenile justice system reduce the effects of institutionalized racism in the criminal justice system and support youth to get healthier and be integrated as valuable community members without a criminal record.

During the calendar year 2014, 2111 youth were admitted to secure detention in King County, with an average daily population of 57.4. The average monthly number of youth receiving probation services for that same time period was 721. During MIDD year 6 (10/1/2014-9/30/2015), JJAT served a total of 380 unduplicated youth, with a total of 831 service coordinations. While JJAT met target goals for each assessment classification, the total number of service coordinations was lower than in past years, due in part to a 5.3 percent reduction in the number of filings from January – September 2015. This is an important reminder of the interconnected nature of juvenile justice reform efforts to respond to racial disproportionality, root causes, and to increase person centered, strengths based, and recovery oriented diversion options for delinquent behavior.

JJAT accepts referrals for youth from all areas of Juvenile Court – Truancy, ARY/CHINS matters, Offender matters (pre-adjudication), Probation matters, Juvenile Drug Court referrals and those currently involved in Juvenile Drug Court, and crossover Dependency/Offender/Probation youth. While JJAT typically serves youth from ages 12 through 18, Drug Court youth still enrolled in the program after their 18th birthday or youth on probation after their 18th birthday may also be referred for assessment. In line with national statistics, the youth JJAT sees have comparable rates of mental health and substance use disorders, many of who have co-occurring disorders, as well as histories of exposure to violence and trauma. JJAT serves youth enrolled in the King County Juvenile Drug Court.

JJAT focuses screenings, assessments, and evaluations on the impact of trauma upon youth involved in commercial sexual exploitation, substance use, gang affiliation, or who live in homes or communities in which violence has had a substantial impact on their lives, and refers youth to services that are targeted to address these issues. For youth with identified co-occurring disorders, pilot enhanced services will provide an additional safety net in guiding youth to services that will actually address their individual issues and provide the ongoing clinical support to ensure progress in their treatment.

When interviewing youth for an assessment, JJAT staff often find a youth has already spoken with a number of detention, court and probation staff and is reluctant to provide the same private information to multiple people all collecting information who may never really help them with their issues. Building trust and establishing rapport with youth and families often takes time and a demonstration that staff who are there to help will actually follow through with that help. JJAT staff currently only see a youth once or

perhaps twice, and while engagement is a main focus for all of JJAT assessment staff, it is difficult to accomplish without really getting to know the youth and family. Trust and rapport seem essential to eliciting honest information and sufficient background knowledge to effectively create a workable behavioral health plan.

This current JJAT customer need and program design deficiency is corrected by the proposed pilot enhancement, the Behavioral Health Juvenile Justice Pilot Project (BHJJ), in which assessment staff can provide up to six months of ongoing support and advocacy through direct linkage to treatment and continued work with the youth and family to ensure successful outcomes. Staff will work in teams to engage the youth and family in developing a workable action plan, identify and directly link youth to appropriate services in the community, and follow up to troubleshoot clinical and treatment issues that may arise. Clinical oversight and ongoing support are necessary if the youth is to continue to be engaged and progress in treatment. This program enhancement responds to a system gap experienced by the youth served by JJAT that became clear to JJAT staff as they implemented the original program design.

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.**

Answers to previous briefing paper questions above have provided research evidence that JJAT services directly address the need to divert youth with mental illness and substance use disorder needs and diagnoses from initial or further justice system involvement and reduce the incidence and severity of mental health and substance use disorders in youth. Research identified above included the underlying relationship of mental health and substance use issues to behavior that brings youth into the juvenile justice system. It is also important to remember children are rarely screened for trauma, especially in the juvenile justice system. JJAT changes this truth for juvenile justice involved youth in King County. Information was provided about Adverse Childhood Experiences (ACEs) research, and effects of childhood traumatic brain injury (TBI) and its high correlation with delinquent behavior.

Further evidence JJAT is an essential part of King County's youth system services:

- JJAT as an existing MIDD I strategy has provided mental health and chemical dependency assessment and psychological evaluation services, as well as community based psychiatric and neuro-psychological evaluations to over 2400 youth since its inception in October 2009.
- JJAT has consistently met or surpassed MIDD target numbers for 140 Mental Health Assessments, 200 Psychological Services and 165 Chemical Dependency Assessments each year since its inception.
- JJAT accepts referrals for youth from all areas of Juvenile Court-Truancy, At Risk Youth (ARY)/Children in Need of Services (CHINS) matters, Offender matters (pre-adjudication), Probation matters, Juvenile Drug Court referrals and those currently involved in Juvenile Drug Court, crossover Dependency/Offender/Probation youth. While JJAT typically serves youth from ages 12 through 18, Drug Court youth still enrolled in the program after their 18th birthday or youth on Probation after their 18th birthday may also be referred for assessment. In line with national statistics, the youth seen by JJAT have comparable rates of mental health and substance use disorders, many of whom have co-occurring disorders, as well as histories of exposure to violence and trauma.

This comprehensive access and partnering effort is evidence the JJAT concept is being thoughtfully and comprehensively implemented in an efficient and cost effective manner by being a centralized nexus for these multiple systems' needs.

- Through existing MIDD demographic data, JJAT has recognized underserved populations within the Juvenile Justice system and has strengthened relationships with culturally appropriate community based agencies to serve these populations.
- Since 2009, 65 percent of youth served through JJAT have identified primarily as youth of color. It is important to note 20 percent of this population also identified as bi-racial or multi-racial, and that historically underrepresented ethnic groups are present in greater number than usually counted. This specific and complex data identification issue is a notable achievement of the JJAT program. They are providing leadership in this area with system and partner collaborations. Twenty percent of these 2400 youth identified as being of Hispanic or Latino descent.
- As of March 2015, 46 percent of youth receiving JJAT services have had one or more mental health diagnoses, and 72 percent of youth had one or substance use diagnoses. Not all youth referred to JJAT have been assessed for both mental health and substance use issues. While the Global Appraisal of Individual Needs-Initial (GAIN-I) identifies mental health diagnoses in substance abuse assessments, Chemical Dependency Professional staff must have a concurrent mental health credential in order to include the mental health information in the written report.
- JJAT has recently responded to this issue and King County behavioral health integration in April 2016 by developing a new assessment format that will focus on the behavioral health needs of every youth referred for assessment. This new behavioral health assessment format will incorporate a variety of tools designed to assess the current functioning, substance abuse severity and needs and strengths of the child including: a clinical interview, the Child and Adolescent Level of Care Utilization System (CALOCUS), the Child Severity of Psychiatric Illness (CSPI) scale and the Global Appraisal of Individual Needs (GAIN). JJAT staff will team together on each referral and create one document that more fully addresses the needs of the whole child.
- JJAT has developed and is proposing a program enhancement, the Behavioral Health Juvenile Justice Pilot Project (BHJJ), which will respond to a system gap and to unmet clients' needs made obvious during implementation of the initial JJAT program design. It will improve JJAT's ability to link youth with services and provide ongoing clinical support to keep youth engaged in treatment. JJAT has based its Behavioral Health Juvenile Justice (BHJJ) Pilot Project on the work being done in the state of Illinois,[30] in which assessment staff follows a youth who meets certain diagnostic criteria for a period of up to six months. Support is provided to both the youth and family through home, school and treatment visits, as well as court related matters. Staff will also link youth with pro-social activities in the community.

[30] The Illinois Department of Human Services' Division of Mental Health directs the Mental Health Juvenile Justice (MHJJ) Initiative, a program that funds local mental health providers in every county that has a juvenile detention center to provide liaisons to the court in order to: (1) identify those youth in the juvenile justice system who have a major mental illness, (2) develop a community-based treatment plan for those youth and (3) establish the necessary community support for that youth and family. MHSPP has evaluated the program since its inception in 2000 and has been able to demonstrate that youth with mental illness can be identified in the juvenile justice system and that, when treated in the community, their clinical condition improves, their school attendance increases and their re-arrest rate declines. The State of Illinois *Annual Evaluation Findings for the Illinois Department of Human Services' Mental Health and Juvenile Justice (MHJJ) Program for Fiscal Years 2013-2014,* which outlines the basis for adopting this model with some adjustments for eligibility criteria, reports that "six or more months of participation are associated with greater psychosocial improvement than five or less months of participation" in the program.

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

The existing JJAT strategy is a best practice in the juvenile justice field. It address core causal factors of behavior that bring many youth into the juvenile justice system; a) mental health and/or b) substance use disorders, c) Adverse Childhood Experiences; d) childhood traumatic brain injuries; and e) the effects of trauma on young and adolescent brain development.

The program expansion proposed to start in January 2017 is an emerging practice area. Findings from the Illinois Department of Human Services Mental Health and Juvenile Justice Program, for fiscal years 2013-2014, indicate that participation in the program for a period of six months or more was associated with greater number and degree of psychosocial improvements. The Illinois *Mental Health Juvenile Justice Program* served a total of 868 youth during FY 2013 and FY 2014, through one of twenty-two MHJJ agencies. A total of six agencies were responsible for opening services for over 50 youth each during those past two years.

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?**

MIDD evaluation data will continue to track JJAT's provision of assessments for any youth referred through Juvenile Court Services. JJAT's current program design results in one or two appointments with no clinical follow up sessions and a lack of ability to clinically advocate for youth once the assessments have been completed. Implementing the proposed program pilot enhancement will yield additional data to track and compare with the Illinois model being proposed for replication, as well as an ability to review and identify improved health outcomes for the youth participants. JJAT will work with Juvenile Court Services staff to develop a comprehensive, individualized, behavioral health treatment plan, and provide support to assist the youth in following through with their treatment plan activities. This approach will yield additional data that can be gathered and evaluated to determine the benefits of the base program model and the pilot's enhanced services.

JJAT will continue to meet basic target numbers for different types of services, i.e., behavioral health assessments, substance abuse assessments using the GAIN-I, psychological evaluations and consults, as well as referrals for higher levels of assessment within the community. In addition, the Juvenile Court Behavioral Health Juvenile Justice Pilot Project will work with up to six youth per six month period to provide these enhanced services for a total of 12 youth during the first year of the Pilot Project. Pre and post testing measures will be implemented to track improvements across domains.

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**
- ☒ **Racial-Ethnic minority (any)**
- ☒ **Black/African-American**
- ☒ **Hispanic/Latino**
- ☒ **Asian/Pacific Islander**

- ☒ **Transition age youth 18-25**
- ☐ **Adults**
- ☐ **Older Adults**
- ☒ **Families**
- ☐ **Anyone**
- ☒ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☒ **First Nations/American Indian/Native American**
- ☒ **Immigrant/Refugee**
- ☐ **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.

Please see details provided about this population in B. 2.

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 .**

JJAT serves any youth in King County involved in the Juvenile Justice system.

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.**

JJAT is in the unique position of having continuously developed collaborative working agreements with community based agencies and private service providers within the community to provide screenings, assessments and evaluations since its 2009 start. JJAT works closely with Probation, Drug Court, ARY/CHINS and Truancy staff in order to provide the types of screenings and assessments needed for each group. In addition, JJAT utilizes Behavioral Health and Recovery Division (BHRD) staff (formerly known as MHCADSD) for consultation on policy and procedural issues affecting the program as a whole.

JJAT currently contracts with two community mental health agencies and two substance use disorder agencies to provide screening, assessment and consultation services to Juvenile Court. Additional beneficial partnerships for the Behavioral Health Pilot Project would be: 1) educational partnerships to assist with helping youth reconnect with and stay in school, gain a high school diploma or GED and connect with vocational preparation and/or employment supports; 2) public health partnerships to ensure youth are enrolled for health benefits and access needed health care; and 3) family support advocates to assist with the individual needs of all project participants.

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?**

Anticipating legislatively mandated Washington State Behavioral Health Integration as of April 1 2016, JJAT plans to implement a new assessment format in February 2016 to comprehensively address a youth's behavioral health issues. The format will include a team approach, which results in the creation of one report that incorporates information from both the mental health assessment and the GAIN-I. In addition, the report will include a chart crosswalking the transition from the Diagnostic and Statistical Manual IV (DSM-IV) to DSM 5 diagnoses, and better utilize the mental health findings from the GAIN-I in the completed report. While the proposed BHJJ pilot project is not slated to begin until 2017, and plans to initially serve a limited number of youth during its first year, JJAT plans to comprehensively assess the behavioral needs of every youth beginning February 2016.

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?**

JJAT has undergone many transitions in staff over the past MIDD year resulting in the team being understaffed for half of MIDD Year 6. The current .50 FTE mental health position through Navos has been vacant since May 2015, which could be a potential barrier for moving forward with the new assessment format and the Behavioral Health Pilot Project. Ideally, this .50 FTE position would be increased to a 1.0 FTE, with the person filling the position holding dual credentials in both mental health and substance use disorders. Funding for this additional .50 FTE could possibly come from re-allocating under-utilized Juvenile Court Services positions or through attrition. This barrier could also potentially be overcome by utilizing the 1.0 FTE Group Care Enhancement Chemical Dependency Specialist position in elements of JJAT program and pilot project development that do not include case management functions. Specifically, these functions could include partnership development, communication enhancement, and troubleshooting treatment related issues.

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?**

If JJAT is left understaffed, the responsibilities of the current staff will increase with the implementation of the new assessment format and the additional responsibilities for youth admitted into the BHJJ Pilot Project expansion. Staff may have more difficulty meeting target numbers for assessments if they are working more intensely with up to six youth over a six month period of time.

JJAT has been operational since 2009 and has regularly updated procedures and assessment tools to keep current with trends and priorities, i.e., updating assessment tools, creating a trauma informed assessment team and approach, focusing referrals on underserved populations, and targeting recommendations for youth who are disproportionately overrepresented in the juvenile justice system. Potential unintended consequences have been addressed. The program is sustainable and well managed.

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?**

Without the services provided by the Juvenile Justice Assessment Team, youth would not have access to the range of assessments and evaluations provided by staff. Similarly, Judicial Officers and Juvenile Court Services staff would not have access to the behavioral health information they need to develop and implement successful treatment planning and outcome recommendations.

Youth served by JJAT have unique and often complex needs, including co-occurring disorders, one or more mental health and chemical dependency issues, criminogenic behavior or status offender matters (At Risk Youth, Child in Need of Services, Truancy, and Dependency contempt cases) pending in Juvenile Court. Without JJAT's early screening and assessment approach, this unique population will go unserved, and as a result, King County may see an increase in the number of youth with unmet behavioral health issues, and the related increased health, housing, human and criminal justice system costs.

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?**

No other services exist at this time that can provide mental health and substance use disorder assessments, psychological evaluations, cross-disciplinary consultation, private psychiatric or neuropsychological evaluations for youth in the King County Juvenile Justice system. Education advocacy and screening for Medicaid eligibility would increase the effectiveness of services for both core program assessments and the enhanced services project.

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?**

JJAT and the proposed expansion pilot project (BHJJ) both overlap and coordinate with many current county initiatives. It directly increases a trauma informed services approach in line with Best Starts for Kids, the Children and Family Justice Center Planning/Disproportionality and Justice, and All Home, formerly Committee to End Homelessness. JJAT core services and proposed enhancement pilot also meets the county's Health and Human Services Transformation Plan vision to "shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities." Pilot Project enhancement data may be useful in demonstrating how to shape some services offered in the planned Child and Family Justice Center.

JJAT's new behavioral health assessment format will create one report with two components (assessment plus GAIN Recommendation and Referral Summary (GRRS) to coincide with the county becoming the King County Behavioral Health Organization as of April 1, 2016. The assessment will combine developmental, psychosocial, and behavioral health history, and incorporate mental status and substance use data to create a holistic snapshot of each youth.

JJAT services support the King County Equity and Social Justice Plan by creating pathways to access health and human services, as well as creating enhanced community engagement, partnerships and communications with Juvenile Court Services for marginalized, disenfranchised community youth involved in the juvenile justice system. JJAT implements the King County Youth Action Plan, in supporting "at-risk teens and families to assisting youth who have become involved in the criminal justice system to take a

fresh path."[31] JJAT regularly serves at-risk youth from high need, low income, and underserved areas of the county, African American, Latino, Native American/Alaskan Native, gay, lesbian and transgender youth.

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

All of JJAT's services are rooted in the principles of recovery. Assessments help to identify the youth and family's strengths and resiliency to meet the challenges they face. Staff have received training in recognizing and screening for the impact of trauma and violence on youth, and focus on appropriate trauma focused solutions and resources. Through the enhanced clinical services provided by the BHJJ Pilot Project, professional staff will be able to better monitor the type and quality of treatment services to ensure they are actually addressing the youth's complex needs and issues, and supporting the youth's resilience.

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

JJAT provides mental health and substance abuse assessments, on-site psychological evaluations, cross-disciplinary consultations, and linkage to private psychiatric and neuropsychological evaluations at no cost to the youth or family. Sixty five percent of youth served by JJAT identify primarily as youth of color. Twenty percent of this population also identifies as bi-racial or multi-racial, lending to the JJAT team awareness that historically underrepresented ethnic groups are present in greater number than usually counted. Twenty percent of the 2400 youth served by JJAT since 2009 identify as being of Hispanic or Latino descent.

While private referrals for higher levels of assessment often have lengthy waiting lists, JJAT has been able to develop community partnerships that usually result in appointments within two weeks of referral. Families with few resources would not be able to access these kinds of services anywhere else in the community.

JJAT staff is comprised of one African American-specific Mental Health Liaison and one Latino-specific Chemical Dependency Liaison who provide assessments and develop resources specifically for youth of color. JJAT seeks to increase access for all youth to resources and treatment, and thereby reduce the barriers these youth may have faced in the past.

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.)**?**

The following table represents the resources necessary to maintain JJAT in its current form.

Staff	Community Staff	Office Space
.8 - Staff psychologist	**2.5 - Mental Health Professionals**	**1 - Copier Lease**

[31] http://www.kingcounty.gov/council/issues/YouthActionPlan.aspx

1.0 - Staff Supervisor	**1.0 – Chemical Dependency Professional + 1.0 –Chemical Dependency Professional**[32]	

The following table represents the recommended **additional** resources needed to pilot enhanced JJAT services.

Staff	Community Staff	Office Space
.2 FTE - Staff Psychologist	**.5 0FTE - Mental Health Professionals**	**1- Leased Office Space**
	1.0 FTE– Chemical Dependency Professionals	

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

The following table represents the resources necessary to maintain JJAT under its current form.

RESOURCE	COST	Funding Source
(Staff)		
.8 FTE – Staff Psychologist	$121,500.00	MIDD
1 FTE - Staff Supervisor	$113,100.00	MIDD
(Community Contracted Staff)		
2.5 FTE - Mental Health Professional	$180,000.00	MIDD
1 FTE Chemical Dependency Professional	$70,000.00	MIDD
(Office Space)	$51,840	King County Court
1 - Copier Lease	$4,380.00	King County Court
(Other Expenses)		
Psychiatric Services	$20,000.00	MIDD
Evaluation Tools/Licenses	$1000.00	MIDD
Training	$1500.00	MIDD
Mileage	$500.00	MIDD
TOTAL	**$563,820.00**	

[32] This second Chemical Dependency Profession [CDP] position has to date been paid via a fee for service methodology. As of April 1, 2016, this funding approach will no longer exist. So to maintain the program as well as provide sufficient staffing for the program expansion, two, rather than one CDP will need to be directly funded. This change is a result of behavioral health integration, which includes a shift in funding substance use disorder services from a fee for service to a managed care methodology.

The following table represents the total request, including additional resources for the engagement pilot.

RESOURCE	TOTAL COST	FUNDING SOURCE	ADDED COST [subset of TOTAL COST Column to left]
(Staff)			
1.0 FTE – Staff Psychologist	$146,900.00	**MIDD**	**$25,400.00**
1 FTE - Staff Supervisor	$113,100.00	MIDD	
(Community Contracted Staff)			
3.0 FTE - Mental Health Professional	$220,000.00	**MIDD**	**$40,000.00**
2.0 FTE – Drug and Alcohol Professional	$140,000.00	**MIDD**	**$70,000.00**
(Office Space)			
1 - Copier Lease	$4,380.00	King County Court	
1- Office Space Lease	$51,840.00	**MIDD**	**$51,840.00**
(Other Expenses)			
Psychiatric Services	$20,000.00	**MIDD**	
Evaluation Tools/Licenses	$1,000.00	**MIDD**	
Training	$1,500.00	**MIDD**	
Mileage	$ 500.00	**MIDD**	
TOTAL	**$699,220.00**		**$187,240.00**

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

There are no other revenue sources available to fund this work. King County is anticipating a $58 Million budget shortfall in the next biennial budget. King County Superior Court anticipates it will be asked to absorb a percentage of the total shortfall, as will all county departments.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

a. JJAT services are currently being provided and could continue with the necessary contract extensions or new contract executions. Proposed service enhancement pilot can be easily added as additional contract terms.
b. Depending on King County contract requirement regulations and guidelines, the current contract would need a time extension exhibit with additional contract terms for the expansion pilot, if that is possible. If King County contract regulations and guidelines require commencement of a new contract, term construction should be fairly straight forward, given that the current contract terms may be used as a starting point.

c. No, an RFP is not needed. This strategy is intended to foster inter-department and community service integration and serve the needs of youth in the juvenile justice system. It is most reasonably placed among the Juvenile Court Services staff.

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?

Strategy Title: Expand Assessments for Youth in the Juvenile Justice System

Strategy No: 5a – Increase Capacity for Social and Psychological Assessments for Juvenile Justice Youth

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

The juvenile court processes 4,850 youth per year. National estimates suggest that 65-70% of youth in the juvenile justice system have problems with mental illness. Of those, approximately 60% had a co-occurring substance abuse problem. Of the 2300 youth admitted to King County juvenile detention in 2006, approximately half were referred to the mental health clinic due to their response on the Massachusetts Youth Screening Instrument (MAYSI), a standardized screening tool used in justice systems to determine the need for further mental health evaluation. An estimated 80% of the 1300 King County youth annually placed on probation, who are moderate or high risk to re-offend are chemically dependent or substance abusers.

◊ *B. Reason for Inclusion of the Strategy*

To successfully reduce future involvement in the justice system, the behavioral health issues of youth entering the juvenile justice system need to be effectively and assertively assessed and treated.

◊ *C. Service Components/Design*

Under this strategy, the system will add staff capacity to increase the availability at the juvenile court of screening and assessment to determine if juvenile justice and child welfare system involved youth have substance abuse and/or mental health issues. Following screening and assessment, this strategy will help assure treatment service linkage for youth identified with

substance abuse and/or mental health treatment needs. The following staffing capacity will be added to the system: one chemical dependency professional, one mental health treatment liaison, one assessment coordinator, one psychologist, and contracted professionals to perform specialty assessments (psychiatric, medication evaluation, forensic psychiatric, neurological, etc.).

◊ *D. Target Population*

Youth age 12 years or older who have become involved with the juvenile justice and/or child welfare system.

◊ *E. Program Goal*

Increase the appropriate response to youth who have become involved with juvenile justice system due to substance abuse or mental health issues.

◊ *F. Outputs/Outcomes*

- Screening and assessment of up to 1,080 youth per year.
- Linkage to treatment services for those youth identified with a treatment need.
- Reduction in future involvement in the juvenile justice system.

2. Funding Resources Needed and Spending Plan

The project needs $361,000 to increase assessment staff capacity to address the needs of youth involved in the juvenile justice system.

The spending plan is as follows:

Dates	Activity	Funding
Sept – Dec 2008	Start-up (staff hiring and training and award of the RFP for specialty professional assessment services)	$60,000
	Total Funds 2008	**$60,000**
Jan – Mar 2009	Continued start-up (training for court staff on how to utilize the specialty assessment services and implementation of CD and MH assessment and linkage services)	$60,000
Jan – Dec 2009	Phasing in ongoing services	$250,000
	Total Funds 2009	**$310,000**
2010 and onward	Ongoing assessment and linkage services	
Ongoing Annual	**Total Funds**	**$361,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of Providers (and where possible FTE capacity added via this strategy)*

- One FTE Chemical Dependency Professional (CDP) (contracted)
- One FTE Mental Health Liaison—Children's Mental Health Professional (contracted)
- One FTE King County Superior Court Assessment Coordinator

- One FTE King County Superior Court Psychologist
- Consultant contracts for professionals who provide specialty assessments

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

The CDP will need to be qualified to administer the Global Assessment of Need (GAIN) assessment instrument. Certification to administer this assessment tool can take up to three months if the individual is not qualified at the time of hire.

All other staff and consultants should be hired with appropriate qualifications to perform required assessments.

◊ *C. Partnership/Linkages*

Partnerships with substance abuse and mental health treatment providers for the purpose of assuring quality linkages to needed treatment and/or evidence based programs specifically designed to reduce juvenile justice recidivism.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Continued planning related to the implementation of this strategy proceeds from May – August 2008.

◊ *B. Procurement of Providers*

The RFP(s) for the specialty assessment professionals will be released no later than August 30, 2008.

◊ *C. Contracting of Services*

Amendments to existing contracts for the CDP and the mental health liaison will be in place by September 1, 2008.

◊ *D. Services Start Date(s)*

CDP Assessments, Assessment Coordinator and MH Liaison services will begin September 15, 2008.

The Psychiatric staffing and specialty assessment services will begin no later than January 1, 2009.