PLAYING 52 PICK UP WITH A HOUSE OF CARDS

Behavioral Healthcare for Juvenile Justice Involved Youth in King County

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By: Tamara S. Wehmeyer

University of Washington, Bothell

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Advisor: Camille Walsh, Ph.D.; J.D.

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Table of Contents

Contents

ABSTRACT

The behavioral health care needs of juvenile justice involved youth in King County are not being met. This project aimed to show that the Mental Illness and Drug Dependency Tax Act (MIDD) collected within King County was predominantly to blame for this lack of care through misguided management of funds directed at supporting this vulnerable population. Through a deep policy review of the previous and current itinerations of the Mental Illness and Drug Dependency Tax Act, and through the conducting of stakeholder interviews, it has become clear that MIDD alone is not to blame for a lack of behavioral healthcare services for juvenile justice involved youth, but, rather, it is a combination of lacking incentives for clinicians to work within the adolescent-based behavioral healthcare system as well as a lack of collaborative efforts between both MIDD and community behavioral health providers to ensure access to such care for the juvenile justice involved population who may be required to seek and complete such care services as part of their criminal adjudication processes.

CHAPTER ONE: INTRODUCTION

The heading of a recent article in *The Everett Herald* reads, "As local kids get hooked on fentanyl, there's 'no place for them to go' (Yam, *The Everett Herald*. May 2022). The implication of this headline is that youth who have developed a dependence on the deadly and illicit substance fentanyl have few if any options for professional medical services to care for this ailment. This is the case both in Snohomish County and across the State of Washington where there are no publicly-funded or Medicaid accepting detoxification facilities to aid youth in safely and humanely weaning off of illicit substances such as fentanyl or methamphetamine. By contrast, it is hard to imagine that a child living in the state of Washington would struggle to find care for other medical issues such as a broken leg or other serious disease such as diabetes. Barriers to treating broken legs or caring for youth with diabetes are much lower as there are existing medical standards and norms in place to care for such ailments. While it is distressing to have a young person struggling with any medical conditions, most have adequate access to state or privately-funded professional interventions for physical health matters by accessing local emergency rooms and walk-in clinics. Youth who experience substance abuse to a degree that qualifies them for professional care find significant barriers, including social stigma and fear. For youth who have no medical insurance or who are insured through Medicaid, it is difficult to identify agencies and facilities that are both equipped to offer the age-appropriate medical and psychosocial care necessary to treat adolescent substance use disorders. It can be said that the nature of these two types of medical needs differ so greatly because their origins are so divergent. A broken leg or diagnosis of childhood diabetes carry minimal, if any commonly known social stigma or individual blame. Facilities (hospitals) and providers (doctors and nurses) are readily available to provide care for youth who may suffer from these

medical issues. However, the stigma associated with both substance use disorders and mental health crises likely influence the degree to which these care systems and infrastructures are failing youth in King County and contribute to the limited access that youth in King County have to such care. This is particularly true when the added stigma and complication of involvement in the juvenile court system is added to the equation.

According to Aalsma et al., 60% to 80% of detained youth have at least one mental disorder, compared with only 15% to 20% of the general youth population (2015). This is especially true of youth with substance use disorders or a combination (co-occurring) of both mental health and substance use disorder issues. As such, addressing issues of substance use disorder and mental health crises for juvenile justice involved youth is an urgent matter and providing adequate and appropriate services presents a plethora of challenges for county agencies and community providers alike. Like municipalities across the country hoping to both decrease youth contact with the juvenile court system and address the behavioral health issues that often contribute to such contact, King County has followed a national trend of transitioning their criminal court model from a strictly punitive approach to a more therapeutic umbrella of services, including services (such as behavioral health screenings and assessments) that acknowledge the significant behavioral health needs of the juvenile justice involved youth (National Association of Counties, Community Services Division, 2011).

BACKGROUND

A 2006 publication from the Washington State Institute for Public Policy entitled *Evidence-Based Treatment of CD and MH and co-occurring disorders: benefits, costs, fiscal impacts – INTERIM REPORT,* reviews the 2005 *Omnibus Treatment of Mental Health and Substance Abuse Act* (OTMHSAA), an act whose stated goal "is to reform how publicly-funded mental health and chemical dependency programs are provided in Washington." This is the legislation that created the Mental Illness and Drug Dependency Tax (MIDD) aimed at reducing costs associated with the lack of appropriate, professional mental health and substance use disorder treatment programs within Washington state. The legislation recognized that Washington state lacked efficient and effective care facilities and programs to meet the needs and demands for both mental health and substance use disorder care across the state. The Legislature is quoted as saying, "Persons with mental disorders, chemical dependency disorders, or co-occurring mental and substance abuse disorders are disproportionately more likely to be confined in a correctional institution . . ." (https://doi.org/10.2105/AJPH.2014.302529). Correctional institutions are one of three facility types, also including emergency rooms and hospitals, that MIDD was created to help avoid using as placements for those struggling with behavioral health disorders. The OTMHSAA is one piece of legislation aimed at addressing the massive need for creating actual care settings with a more fiscally responsible approach to care

that would also provide credentialed and ethical care for people suffering with these types of disorders.

According to one Briefing Paper associated with the Mental Health and Drug Dependency Tax Act (MIDD) "King County currently has five adult SUD (substance use disorder) residential facilities with a total bed capacity of 130 and one 16-bed withdrawal management (detoxification) program. Youth residential programs are limited to two facilities that can house 22 young people at any one time . . ." (Soukup & Finegood, BP 113 *Increase Adult/Youth SUD/COD Residential Treatment, Detox and Recovery House Facilities* 2014). These limited resources are not meeting a growing demand for juvenile-justice involved youth who may be required to obtain such care as their criminal cases move through the juvenile judicial system.

The Mental Illness and Drug Dependency (MIDD) Tax Act collection was initiated in 2007 after King County opted to begin collecting a new tax that would begin in 2008. These steps followed the passage of the 2005 "Sales and use tax for chemical dependency or mental health treatment services or therapeutic courts." (Revised Code of Washington 82.14.460). This sales tax system provides for an optional sales tax collection of 0.1 percent for all counties in the State of Washington as a means to close existing gaps in state and county budgets and to provide for the growing need for behavioral health services, including those for individuals involved in the court system. Ultimately the motivation for the creation of the MIDD tax revenue stream was influenced by the 2005 *Omnibus Treatment of Mental Health and Substance Abuse Act* (OTMHSAA) to develop

programs and policies that discouraged the use of expensive resources in the county, such as jails, emergency rooms and hospitals to treat acute behavioral health issues that could be more reasonably cared for in appropriate clinical settings by community providers.

FROM MIDD to MIDD 2

In 2018, MIDD (referred to as MIDD 2) was extended by the King County Council to run through 2025 with an estimated biennium income of $134 million dollars. King County is one of 23 other counties and one city in the State that has authorized the use of taxes collected in this manner to be slated for behavioral health care needs within their municipalities (2020 MIDD Annual Report *Investing in Communities, Strengthening Resilience).* This flow of funding would keep diversionary programs such as the Behavioral Health Response Unit (previously Juvenile Drug Court) up and running within the juvenile court.

In 2021 King County Juvenile Court participated in "a comprehensive probation system review" by the Robert F Kennedy Children's Action Corps and the Robert F. Kennedy National Resource Center for Juvenile Justice that was conducted between April, 2020 and June, 2021, entitled the *King County, Washington Probation System Review Final Report*. In part, this report represents an ongoing reimagining of juvenile court ideology, moving from a strictly punitive model to a more therapeutic model. The report refers to RCW 13.40.500-509 which "addresses juvenile court and community partnerships . . ." and further quotes from Section 500 specifically, "'The legislature finds that meaningful community involvement is vital to the juvenile justice system's ability to respond to the serious problem of juvenile crime'" (2021). The report

highlights the legislative agenda of controlling and reducing juvenile crime but acknowledges that bridges between the juvenile court and community services, presumably for things such as mentorship, assistance with school success, family problem solving and supports as well as care for behavioral health needs, are as essential to the reduction of juvenile crime as the more traditional punitive approaches such as youth being placed in various forms of juvenile detention or other custody. MIDD 2 attempts to function as one such bridge, providing funding for programs that connect juvenile justice-involved youth with the community resources that best serve their needs.

MIDD 2 encompasses 53 Initiatives that cover both youth and adult behavioral health programs. Of these 53 Initiatives, approximately ten are directed at programs for youth and their families. Of those ten youth-focused initiatives, four are specifically directed at juvenile justice-involved youth. Under the section entitled "Prevention and Early Intervention", Initiative PR1-02 funds the Juvenile Justice Youth Behavioral Health Assessment Team, also known as JJAT. JJAT performs clinical substance use disorder and mental health assessments as they may be deemed necessary through a series of four behavioral health screens that are given to each youth in contact with the court. The team is made up of both contracted clinicians enlisted from community providers and clinicians who are employed directly by King County Juvenile Court. (MIDD Annual Report Attachment A. *Investing in communities, strengthening resilience* (2020). The "Therapeutic Court" Initiative (noted as TX-JDC) funds the Behavioral Health Response Unit (BHR) which has replaced the old Juvenile Drug Court model and allows more flexibility for youth with a variety of behavioral health needs beyond substance use disorders. The final

two Initiatives aimed at youth within the Juvenile Court include those under the "Crisis Diversions." Initiative CD-13 known as Family Interventions Restorative Services allows youth involved in domestic violence situations to avoid being placed in detention and instead spend a cooling period in a respite center near the detention facility. Initiative CD-16 known as the Youth Behavioral Health Alternatives to Secure Detention seeks to provide appropriate and safe places for homeless youth to stay outside of the secure youth detention facility.

Juvenile court systems, including the King County Juvenile Court system, have historically acted as a hub for identifying youth with behavioral health and other urgent and sometimes chronic social needs such as homelessness, trauma, trafficking and abuse. King County Juvenile Court Services has created in-house, evidence-based programs to address such needs with youth as their cases are adjudicated. As a result, programs such as Juvenile Drug Court (now known as the Behavioral Health Response Unit) may be the first place where a young person can be screened and assessed for behavioral health concerns. Unfortunately, such youth must first be adjudicated for a qualifying criminal offense in order to receive the intensive case management and assistance in addressing their mental health and substance abuse issues that is available through the BHR program (interview with court stakeholder 6/1/2022).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) it is estimated that 50 to 70 percent of all youth who come in contact with juvenile courts meet criteria for a mental health diagnosis and 60 percent meet criteria for a substance use disorder (MIDD Briefing Paper. BP *113 Increase Adult and Youth SUD/COD Residential*

Treatment, Detox and Recovery House Facilities. Soukup, M. and Finegood, B. 2016). These numbers also correspond with a shockingly high rise in recent years of fentanyl use and other opiate-related substances and illicit benzodiazepines which are also laced with the powerful opioid fentanyl (de Luna, 2022). During the week of July 4th, 2022, the "King County Council approved a resolution (that) it hopes will eventually be the groundwork for declaring fentanyl abuse a public health crisis" (Markovich, Matt, 2022). Such crises extend to young substance users.

MIDD 2 TODAY

MIDD 2 functions within a patchwork of behavioral health services spread throughout King County and often uses an existing, community-based, behavioral health system as the foundation for the creation of new programming, meaning that MIDD is soliciting funding for and building new programming on top of an unsound foundational framework. For example, one particularly vulnerable initiative focus is the Prevention and Early Intervention Initiative aimed at children and youth within King County. This MIDD initiative includes youth-based programs for crisis level interventions such as the Children's Crisis Outreach System (CCORS) that includes Crisis Outreach Services and Non-Emergent Outreach, Intensive Stabilization Services (ISS) and Crisis Stabilization Beds (CSDs) (*Mental Illness and Drug Dependency Service Improvement Plan* 2016). Unfortunately, there are long waitlists and high degrees of crisis criteria that must be met in order for a youth to qualify for such intensive services. On August 11, 2022, the County Executive, Dow Constantine, held a joint press briefing directly

acknowledging the loss of behavioral health services in King County. *The Seattle Times* reported, "A wide-ranging proposal to address holes in the crisis response system, lack of beds at residential treatment centers and workforce shortages is expected to head the Metropolitan King County Council next month . . ." (Furfaro, 2022).

An additional example that demonstrates the need to have community infrastructure that supports the initiatives presented by MIDD 2 is the creation of the Juvenile Justice Assessment Team (JJAT). JJAT was created through the first version of MIDD initiatives in 2009 and its aim is to provide clinical assessments within the Juvenile Court domain for court-involved youth suspected of having mental health and/or substance-related use issues (MIDD Briefing Paper 2016 www.kingcounty.gov/healthservices/MHSA/MIDDPlan.aspx). The completed assessments are meant to diagnose clinical issues as well as recommend appropriate care and may be used as part of an adjudication process for a youth's individual court case, possibly to divert them from a strictly punitive resolution to a more therapeutic case diversion conclusion.

These clinical mental health and substance use disorder assessments are one step in the process of addressing a youth's behavioral health needs and include treatment and care recommendations as the next logical step to address any identified needs. Much like an x-ray may be used to assess a broken leg, these assessments allow practitioners and clinicians to narrow the scope of the care that is needed and articulate next steps; hopefully care and treatment within a youth's specific community. Despite MIDD's substantial program funding with a current budget noted as $25,446,536.00 Biennial-to-Date in 2021-2022 (*MIDD Financial Plan*

2021) King County is struggling to collaborate or incentivize the creation or support of existing requisite community providers necessary to offer the care identified in the assessments that it pays to have completed. The infrastructure, and in particular, the workforce necessary to support JJAT assessments is insufficient, leaving youth with few options to follow through with the care recommendations and potentially complicating the conditions of their criminal diversion arrangements and leaving their behavioral health needs untreated, and time matters for each step in the process.

According to the Office of Juvenile Justice and Delinquency Prevention, "intervention start date" and "referral to services date" are two fundamental measures in determining the effectiveness of caring for court-involved youth with various needs. "The amount of time it takes for a youth to begin participation in a program he or she was referred to based on their individualized risk factors and needs" (*NCJJ Releases a New Website-Fundamental Measures for Juvenile Justice*, 2019). In the case of King County Juvenile Court, in particular with the JJAT group and their relationship with MIDD, these fundamental measures are negatively correlated in this instance because of the length of time it takes for a youth to complete an assessment and thereafter access behavioral health services.

JJAT also has few options to track such outcomes and timelines. Once an assessment is completed the youth's case management moves to his or her Juvenile Probation Counselor (JPC) whose job it is to connect youth to the services recommended in the assessment. JPCs find that more often than not initiating care for youth can be daunting due to a lack of community

providers within a youth's community, and an inability to provide step-by-step outreach services which could provide door-to-door service for youth from court to a community provider.

MIDD 2 allocates funds for just one position within JJAT for an outreach employee to help youth, their families and the JPCs navigate care coordination.

PURPOSE OF STUDY

The purpose of this study is to examine how King County, though it's Mental Illness and Drug Dependency Tax program known as MIDD and MIDD 2, is addressing the care needs of juvenile justice involved youth struggling with behavioral health issues, whether they be mental illness, substance use disorder or a co-occurring combination of disorders. Highlighted in this study is the tethering of King County's juvenile justice system to the treatment of youth behavioral health which makes a lack of available care particularly troubling and problematic for youth who are required to seek and complete such care as part of the adjudication of their criminal cases. Potentially limited resources fail to meet a growing demand for juvenile-justice involved youth who may be required to obtain such care as their criminal cases move through the juvenile judicial system. When considering the population of court-involved youth who qualify for behavioral health treatments, King County is not currently able to keep up with growing demand. The purpose of this study is to find out why. As such, this study will also examine a lack of community-based infrastructure to serve this specific population; court-involved youth with behavioral health needs.

CHAPTER TWO: LITERATURE REVIEW

Much of the existing literature pertaining to the behavioral health needs of juveniles who are in contact with the criminal justice system focuses on causation and not necessarily the lack of access that youth have to such care. This segment of the literature seeks to determine whether or not the existence of a youth's mental health issues or substance use disorder indicate that they are more prone to have contact with juvenile criminal courts or, are there other risk factors, such as being incarcerated, that exacerbate existing mild disorders and increase a youth's proclivity to have additional contact with the juvenile justice system, and eventually, the adult, criminal court system? In the article entitled *Influence of Mental Health and Substance Use Problems and Criminogenic Risk on Outcomes in Serious Juvenile Offenders* the authors completed a longitudinal study of 949 serious juvenile offenders to study the association between the exitance of mental health or substance use disorders with criminality in youth involved in the juvenile justice system (Schubert et al., 2011). Like much of the existing literature on the topic, the authors have found that "There are few data on whether and how mental health problems relate to later offending or to the positive adjustment of offenders" (Schubert, 2011) finding that the existence of a mental health disorder alone is not a significant indicator of youth involvement with juvenile justice. The authors did find that the existence of a substance use disorder, however, is more closely related to the prevalence of a youth having contact with juvenile justice systems based on the finding that the majority of youth in their study met criteria for a substance use disorder. This makes sense as it is more common for people struggling with serious substance use disorders to be involved in activities (crimes) that help them gain access to the

funds necessary to feed their substance use habit. It is important to note that in this article the authors often lump substance use disorders under an umbrella of having a "mental health problem" rather than separating the two disorders as separate variables in their study. They write, "More than half of the participants (57.5%) met criteria for at least one of the assessed mental health problems. Of participants with at least one mental health problem, the most common was a substance use disorder (76%). The authors conclude that "Current juvenile justice policies that focus treatment efforts on both criminogenic and mental health factors (with particular emphasis on treating substance use disorders) appear well founded (Schubert, 2011). This article mirrors the current efforts being put forth by King County Juvenile Court through their behavioral health screening and assessment services but also highlights the need for requisite care of juvenile justice involved youth nationally.

In a 2015 article published by the American Orthopsychiatry Association entitled *Responding to the mental health and substance abuse needs of youth in the juvenile justice system: Ohio's Behavioral Health/Juvenile Justice Initiative*, the authors claim that "The three largest providers of mental health services in the United States are jails: Cook County in Illinois, Los Angeles County in California and Rikers Island in New York" (Kretschmar et al., 2015) and add that "The majority of juvenile justice involved (JJI) youth has a history of behavioral health (mental health or substance use) problems." Kretschmar et al., go on to recognize the current national trend in youth detention, which is to be more rehabilitative than punitive. It makes sense to surmise that "rehabilitative" efforts in juvenile courts would include addressing the

mental health and substance use disorder needs of youth in custody based on the article's estimate that "between 65% to 75% of JJI youth have at least one behavioral health disorder . . ." similar to trends discussed in the Schubert article. With such high estimated numbers of youth coming into detention with existing behavioral health needs, screening and assessment are but the tip of the iceberg of the care needed to treat such disorders. The article goes on to suggest a need for collaboration-building and funding that allows "local projects to collaborate with implementation and fidelity experts" within the juvenile justice domain and therefore increase the chances of positive outcomes with youth receiving the care they need while moving through the process of adjudicating their court case(s) (Kretschmar et al., 2015). This concept is in line with King County's MIDD policy ideology that youth and others within the court system be treated by behavioral health professionals and not housed or placed in costly jails, hospitals or emergency rooms that are not equipped or prepared to handle such disorders.

In a 2015 multisite, survival curve analysis presented in an article entitled *Behavioral Health Care Needs, Detention-Based Care, and Criminal Recidivism at Community Reentry from Juvenile Detention" A Multisite Survival Curve Analysis* the study results showed an overall significant relationship between behavioral health issues in youth, including mental health, psychological problems and substance use disorders or abuse, and recidivism rates. This article claims similar statistics as the previous two articles when it comes to juvenile justice involved youth, stating that " . . . about 60% to 80% of detained youths have at least 1 mental disorder, compared with only 15% to 20% of the general adolescent population" (Aalsma et al

2015). Here too the authors are using mental disorder to refer to both mental health issues and substance use disorders. In their study, youth (n=8363) from one of 16 facilities in Indiana were screened between 2008 and 2012 using a behavioral health screening tool called the MAYSI-2. Such a screening is used to detect the need for further intervention, such as a more thorough assessment**.** The overarching result of this study, which considered demographic factors such as age and race, found that " . . . behavioral health problems are related to recidivism . . ." and added that " . . . Black males are disproportionately rearrested after detention" (P. 1372). No demographic information will be discussed in this project as it is beyond the scope of the research conducted herein. This article does not discuss the need for community behavioral health providers or agencies who could presumably take over the behavioral health care needs of youth who were screened through the juvenile court system.

Screening practices like those discussed in this article can also be found in the King County Juvenile Court system, following recommendations from an outside consultant report completed in 2021 and conducted by the Robert F Kennedy Children's Action Corps and the Robert F. Kennedy National Resource Center for Juvenile Justice to explore ways to make the King County Juvenile Court system more therapeutic for the juveniles coming into contact with the court and moving away from a strictly punitive model. Based on recommendations from that report, juvenile probation counselors in King County are now required to complete a set of four behavioral health screens with every youth who comes into contact with the court for any reason and at any level. These four screening tools are considered a best-practice, evidence-based

approach, like the MAYSI-2 referred to in this study, to detect if a youth may have a more significant behavioral health issues such as depression or substance abuse, generalized anxiety or evidence of PTSD/trauma, in which case they are to be referred for further assessment within a set period of time (5 days). Such an assessment may be done in-house within the JCS domain with the Juvenile Justice Assessment Team (JJAT) or a youth may be referred to a community provider if available. In the report's conclusions, the results did indicate that "detained youths have significant behavioral health difficulties ... and that there is a clear public policy mandate for detention centers to identify youths with behavioral health needs." Despite these findings, Aalsam et al., are unable to draw a significant conclusion of the role that juvenile detention centers or courts may play in the behavioral health care of such youth. This study seems to mirror events within King County Juvenile Court, meaning that there is often a need for more than screening and assessment to be done with youth and that the path from in-house screening and assessment to actual behavioral health care is complicated by a lack of collaboration between the court and community behavioral health providers and a massive shortage of qualified clinicians.

Collaboration and cooperation are the essential elements of treating substance use disorders for juvenile justice involved youth according to a 2000 article entitled *Provision of Drug Treatment Services in the Juvenile Justice System: A System Reform.* Terry et al., espouse "Systems collaboration between service providers must exist for juveniles to receive appropriate and comprehensive services" (Terry et al., 2000). The authors claim that more effective care

delivery for the treatment of substance use disorders with youth will "reduce the presence and effect of drug use on the juvenile justice system." Like much of the literature related to behavioral health and juvenile justice involved youth, the motivation behind improving the efficiency of such a system is to reduce the interactions, contacts and recidivism rates of youth and the juvenile justice system.

This article goes further by introducing the judicial practice known as graduated sanctions. This practice maintains a tether between youth compliance with behavioral health care and a youth's criminal case benefits or diversion. The practice of graduated sanctions requires youth (and those in adult systems) to comply with certain therapies in order to have their cases resolved without full adjudication and is "used as part of a 'carrot and stick' approach to treatment progress" (Terry et al., 2000). This sort of practice, tying behavioral health care to successful completion of a criminal court case, is not necessarily evidence-based or trauma informed, two ideals that behavioral health care providers strive for. As is the case in King County, this may be a complex undertaking when community-based service providers are lacking and those agencies who offer behavioral healthcare services often have weeks to months long waitlists for initial appointments which can further delay the resolution or disposition of a youth's case within the court.

The authors of this article further point out that when there is a lack of collaboration, the danger becomes that an "adolescent is left to fall through the cracks of unlinked systems" with provider agencies and court systems actually working against one another instead jointly to meet

the needs of such youth. For example, the authors point out "Each point of contact (with a service provider) generally conducts its own assessment, develops its own treatment plan, and acts as if the juvenile has no other system contacts" (Terry et al., 2000). The authors make the point that even among community-based providers, on an agency-to-agency level, the lack collaboration is detrimental to the service structure and the care of youth clients. There are similar collaboration issues between King County community providers and the juvenile court system. In order to initiate treatment and Medicaid billing, a youth will typically be required to complete an intake appointment with a community agency which includes a full clinical assessment. This is the case even if the youth has recently completed a clinical assessment though the court (with the JJAT group). The community provider must start the flow of funds through this intake appointment and cannot substitute the court's assessment for their own. This may lead to over assessing which can be traumatizing and is contraindicated in the behavioral health field. Ultimately this article proposes a single contact or case manager to be assigned to any youth in contact with the court who would serve to guide a youth through both the legal system and the community care system in an effort to create "community-based collaborative efforts" which will "ensure that services are accessible to the target population and are relevant to the community's unique needs and structures . . ." (Terry et al., 2000). Funding for such collaborations would be found in the form of block grants though groups such as the Annie E. Casey Foundation and organizations like the Office of Juvenile Justice and Delinquency Prevention, a dramatically different funding stream than those provided through the MIDD Tax system in King County.

Each of the previous articles and studies examines important questions about how to curtail juvenile justice involved youth from having initial and recurrent contact with criminal courts by addressing their behavioral health issues, be they mental health or substance abuse/misuse. What they all tend to agree on is that youth who are in contact with juvenile courts have higher rates of behavioral health issues despite their limited access to behavioral health care.

Clair White writes in her 2019 article *Treatment Services in the Juvenile Justice System: Examining the Use and Funding of Services by Youth on Probation* that the "primary factors associated with unmet service needs are elements related to economic disadvantages such as living on public assistance, lack of health insurance, and transportation problems" and continues to say that "only 23% of youth (in a study concentrated on Arizona) diagnosed with mental health disorders received treatment and that having a mental health disorder was not a significant indicator if receiving service" (White, 2019). What White does not address is the current, national shortage of clinical personnel, leaving community providers without the staff to meet behavioral health care demands. Additionally, White overlooks the national trend of low wages for such clinicians and a lack of incentives for qualified employees to seek and maintain clinical positions. All of these factors are at play nationally and within King County, contributing to the difficulties of getting juvenile justice involved youth engaged in behavioral health services.

In an article written in The Seattle Times by Hannah Furfaro, the behavioral health provider shortage is identified as a "workforce crisis" that leaves community agencies unable to

fulfill the growing demand for youth-based behavioral health services. Of the four intensive inpatient facilities that specialize in crisis-level adolescent mental health services, it may take up to 144 days for admission to a long-term care facility. One provider, Pearl Youth Residence in Tacoma has had to cut its 27-bed inpatient capacity to just 17 patients due to a 50% staff turnover in 2021 (Furfaro 2022) a trend that is mirrored across the county and across the state of Washington.

CHAPTER THREE: METHODOLOGY

This research project uses a two-pronged, qualitative methodological approach to explore and gain understanding of the nuanced relationships between the systems being researched; the Mental Health and Drug Dependency Tax Act (MIDD), King County Juvenile Court Services (JCS) and the community behavioral health providers within King County, in particular the providers who take Medicaid funding through the state and county insurance structure. First, this study employees an initial deep policy and financial review of the origins and iterations of the MIDD Tax system as it has evolved since its inception in 2008. Since MIDD intersects with multiple other systems within King County, a needs assessment has been designed to review the responsivity of the behavioral health system in King County meant to address the needs of juvenile justice involved youth. This needs assessment focuses on whether or not MIDD is adequately funding the behavioral health needs of this population.

In support of the evaluative nature of this needs assessment, the second qualitative methodology consists of one-on-one interviews with eight stakeholders from both Juvenile Court Services and from the MIDD Advisory Committee. These interviews were conducted via the Zoom platform and were later transcribed using Otter.ai software. Interviewees were provided approximately seven interview questions (see Appendix IV) prior to the interview and were advised of the parameters of the project and its intended analysis. Interviewees were also advised that by recording the interviews, portions of their interview may be used for direct quotes within the body of the project. The names and professional roles of each interviewee have

been withheld for each participant. Instead, each will be identified as either a JCS (Juvenile Court Services) stakeholder or a MIDD (Mental Illness and Drug Dependency) stakeholder. Additionally, it was important to be transparent with each interviewee about the nature of my own role within King County Juvenile Court Services and the fact that my annual salary is paid for, in part, with MIDD funding.

Needs assessments are often done directly within and among the community, entity or population being studied. In this project, the needs assessment is being completed using analysis of existing policy and online interviews. This approach reflects the vulnerability of the population at the heart of the study, juvenile justice involved youth, as well as the time constraints associated with the project which have prohibited an extensive dive into the local behavioral health community provider structure. The interviews provide the main source of original data. In the 1998 article *Using interviews as a Needs Assessment Tool*, author Sonia Crandall notes that use of interviews has both advantages and disadvantages as a needs assessment technique. She writes that, "Interviews have one distinguished advantage over other needs assessment techniques. They are personal. In an interview, one has the ability to solicit in-depth information that leads to deeper understanding . . ." (Crandall 1998). She continues by saying that interviews have a distinct drawback in that they are time consuming and can be difficult to arrange. In this case, with the ability to do the interviews on a remote platform (Zoom) there was little inconvenience in scheduling or conducting the interviews and virtually all of the original data collected for this project was done through these interviews.

It was through data collected in the interviews that the final methodological research in this project was conducted. This included an online search of available behavioral health providers within King County as listed by the Behavioral Health and Recovery Division (BHRD), the King County entity that oversees MIDD. The search was focused on providers that could serve the target population; juvenile justice involved youth. These findings are reviewed in the Discussion Chapter.

Limitations & Bias

Limitations to the methodological design of this project include the writer's personal contact with the subjects of the interviews and potential bias toward the Juvenile Court Services (JCS) program in general. This writer is employed by the JJAT group that works within King County Juvenile Court that is funded, in part, by MIDD. Additional limitations to this design strategy include the writer's personal relationships with some of the interviewees who are colleagues and coworkers in the Juvenile Court system. The potential for writer bias must be acknowledged. A thorough exploration of the existing intersections of MIDD, JCS and King County's community behavioral health providers was not examined due to time constraints, leaving a large section of research to be addressed in the future. Additionally, the very nature of the subjects of this study, youth in contact with juvenile court who also struggle with behavioral health issues, represent an extremely vulnerable population and were not directly contacted or individually studied. This leaves an additional gap in the research process of this project. Finally, it is important to note that the names and positions of all interviewees have been

withheld allowing for a more candid inclusion of quotes and themes brought forth in the interviews.

CHAPTER FOUR: RESULTS & DISCUSSION

Through each of the interviews conducted for this project, themes emerged. The predominant issue brought forth was a workforce shortage across the behavioral health spectrum, in particular for clinicians willing to undertake the work of adolescent behavioral health care. Additionally, the disparity of spending for adult behavioral health services over that spent to serve youth with behavioral health issues was also brought forth in the interviews. Finally, the reality that MIDD and its current initiatives are not the only sources of funding or source of blame for shortages was also discussed.

MIDD Funding System

At the inception of this project, the hypothesis was that the MIDD Tax system and related MIDD 2 initiatives were not sufficiently providing the much-needed resources to care for the behavioral health needs of youth who were involved in the juvenile court system in King County. The resulting research proved that MIDD is, in fact, heavily focused on adult behavioral health needs, concentrating approximately 50% of its programming to people ages 25-54, 37% on people ages 55 and up, 7% to young people aged 18-25 and just 6% of programming focused on youth ages 0-17 (*2021 MIDD Annual Report Supporting Recovery and Wellness for All in King County*, n.d. p. 17). This disparity is also reflected in MIDD's 2021-2022 biennial budget breakdown, spending approximately 91.5% ($140,814,215) on adult behavioral health care and 8.5% ($12,041,786) on youth behavioral health programs. Even the makeup of the MIDD

Advisory Committee reflects this disparity of a heavy adult focus, with just four of its thirty-two-member body representing youth or adolescent behavioral health care needs.

Through the one-to-one interviews with Juvenile Court Services (JCS) stakeholders, as well as with community and MIDD stakeholders, it became clear that MIDD alone is not the only reason JJIY are not getting the levels of care that have been identified as necessary for them through therapeutic court services such as the behavioral health screenings and clinical assessments completed by the MIDD-funded Juvenile Justice Assessment Team. In 2021, MIDD allocated approximately $5,626,355 to juvenile justice related initiatives (*2021 MIDD Annual Report Supporting Recovery and Wellness for All in King County*, n.d. p. 67). These funds, among other services and diversion programs, allow the court (though the JJAT group and each youth's juvenile probation counselor) to screen each youth who comes into contact with the court for depression, anxiety, trauma and substance abuse issues and thereafter refer them for appropriate mental health or substance abuse assessments. The assessments, where appropriate, will then recommend behavioral health treatment services for youth to seek within their community.

Make It Attractive/Workforce Shortage

In the majority of the interviews conducted, the interviewees independently mentioned their concern that youth seeking behavioral health services face a provider shortage that is significantly contributing to youth not receiving their behavioral health care services in their own

communities. This is particularly true for youth who are either uninsured or who have Medicaid as their primary source of healthcare coverage. In one interview with a community stakeholder the theme was focused on the struggle to maintain the necessary levels of staff in community provider agencies, associating that with a lack of funding, minimal incentives for qualified clinicians to accept positions and a disparity between funding adult behavioral health programs over youth behavioral health programs. In our conversation, the interviewee reported that,

> one of the biggest challenges, and it's probably across the board for any field right now, is just the hiring, right? You know, getting people to accept the job. And I think coming with that also is the funding, right, the level of funding . . . that's available to pay people. You know, the key word 'livable wage', right? But I think they're (MIDD) in a tough position of where do we find the money? And how do we change our funding model? How do we fund these programs at a level where they can attract and retain staff? Right? I think I've had, I have probably about five or six positions that have sat open for a year that haven't got a single hit on them after I posted them. Right? And it's just, they just sat there, and they're just, Indeed's making a killing right now off the employer. So yeah, overall, when we're talking about youth services and adult services, I would definitely say that (the adult) service sector is way more robust. I think that kind of points out to what you just identified that there's thirty-two positions (on the MIDD Advisory Committee), and only four are designated for youth services or youth resources. So yeah, that's, that's a really big, disparity for you. And we've always found that when a new policy or something comes out, and they're tied to both adult and youth services, the adult services, it's almost three to one.

Assessment Wars/The Medicaid Tiering System

The next interviewee's statements went beyond the provider shortage issue and added concerns over the disjointed Medicaid tiering system that it not systemically associated with the juvenile court behavioral health system. This lack of systemic collaboration presents another hurdle for JJIY:

> I think the issue you have now is that you just don't have the workforce. And so, you end up stretching out even further the moments from 'I know I got something going on. I'm willing to sit for an assessment. Oh, and then I have to go sit for another intake somewhere' . . . I think that's something you might want to take a deeper look at, too, is the process for King County to get a kid tiered. And I know you're seeing a lot of it in JJAT, because I was seeing when I was the supervisor there. . . and you can't just send that assessment to the community provider, they need to do a service called intake, which then kicks off the tier with the county, and the county is not going to give you those dollars unless you do the kickoff service, which is a tier, you know, like tier the kid. And so, you've now done an assessment to identify these things, then they have to sit for another assessment. But that's only just for them to check the box to start the dollars to flow."

This interviewee is describing two barriers that exist within the current behavioral health system in King County that can impact a youth's ability to access behavioral health care. First, he describes the system-wide barrier of managed care that exists within King County wherein a service provider must get a youth, or any Medicaid client, initially tiered with the Health Care Authority, by initiating service though and intake appointment. This first appointment establishes a medical necessity for care as evidenced by an assessment showing need for additional services. This appointment is required to begin the flow of payment for services from the Managed Care Organization to the agency. Typically, this intake appointment includes a full clinical assessment to determine any diagnosis and the appropriate level of care for a client, which therefore determines the rate of reimbursement based on intensity of care deemed necessary through the assessment. The tiering system is but one hurdle to establishing care for juvenile justice involved youth when you consider that many of the youth in need of behavioral health services that are also in touch with the juvenile court system have been screened and assessed prior to their initial intake appointment with a community provider. This means the

youth will need to patriciate in two separate yet repetitive processes to get to the same result; behavioral health care services. This interview echoed points made in the Kretschmar et al., article *Responding to the mental health and substance abuse needs of youth in the juvenile justice system: Ohio's Behavioral Health/Juvenile Justice Initiative* regarding the lack of collaboration between entities such as the juvenile court and community-based behavioral health providers.

In the next interview with a JCS stakeholder, the interviewee echoed the complication of having an in-house JJAT assessment and not being able to utilize that assessment to facilitate treatment services within a community setting due to the Medicaid tiering system of the community provider and Medicaid. She stated, "So, JJAT was created because it was hard to get into community agencies because of waitlists or because of like, insurance issues, or whatever. And basically, like families just had a challenge navigating that process and had delays. So, JJAT (the in-house juvenile court assessment group) was created in 2009 to try to remedy some of those problems by offering the sort of in-house, on-demand assessments and linkages to services without going through Medicaid or an agency or whatever. Which is great. But that's only one part of process, right? Like an assessment is just an assessment unless you actually are able to like follow up with what's in the assessment."

Worth noting here is that JJAT was part of the initial MIDD initiatives, trying to remedy the long waitlists and troubles with accessing assessments back in 2009. And thirteen year later we are seeing the same struggles and barriers for youth who are unable to receive these services

in their own communities. The interviewee continues by adding, "I mean, I think one piece that was really overlooked when JJAT was created (by MIDD) was this requirement by Medicaid that these agencies conduct their own assessments, and we've just never really been able to get around that . . ." Here we can see in real time the conflicts that exist between systems as described in the Terry et al., article, *Provision of Drug Treatment Services in the Juvenile Justice System: A System Reform* which states that systems working against one another as we see with King County Juvenile Court and the Medicaid tiering system, act as exacerbating factors and keep youth locked in the juvenile court system without being able to access the care they need. The interviewee also discusses the complicating factor of maintaining community agency staff, explaining that " . . .it also affects service delivery as far as like youth getting what they need, because we have way higher turnover with agency staff because the pay is shitty . . .like, that's a barrier for us when we're understaffed. And so, I think even just correctly funding the agencies is problematic." The interviewee highlights a lack of collaboration between MIDD initiatives and the community providers, as well as each entities' relationship with the Medicaid tiering system and juvenile court. They essentially work against each other, building yet another barrier to youth accessing services in a timely fashion.

Another community stakeholder also discussed the barrier of a diminished workforce as well as the disparity between youth-focused funding from MIDD Initiatives and the disparity of MIDD's adult versus youth behavioral health program spending. This interviewee explained, "Because what we're trying to do is, can we, like the state's offering some dollars to incentivize, I

have retention bonuses for the providers and so we're, like, look at that, um, because it's just really around workforce. We just don't have enough people." This community stakeholder expresses their frustration at not being able to fill vacancies within community behavioral health agencies which creates long waitlists, high turnover rates and decreases the chances of youth being connected to behavioral health services. The interviewee continued by adding her experience with MIDD's workforce development program, which appears to have been disbanded. She commented, "that was really focused on workforce, like paying for tuition books, for people, like you know, at Ryther (a community-based youth outpatient provider in King County) that may, maybe they have their masters, but they don't have their SUDP." In regards to benefits for employees and ongoing education and professional development in their field, this interviewee also commented, " . . .we were able to take some of the burden of student loans off and things like that. And that was taken away. We're like, why? Why did that go?" This conversation brought forth yet another potential solution for building the behavioral health workforce in King County through incentivizing people to undertake this work.

In my discussion with a MIDD stakeholder, it was noted that MIDD is just one source of funding for Juvenile Court Services behavioral health and diversion programs. The interviewee stated that,

> I can say that, you know, MIDD, MIDD isn't the full funder of these programs, you know they are some of (it), they're half, they cover half the cost of the juvenile court services. The other funds sometimes come from, like the King County general fund, or City of Seattle. So, it's a braided funding system that covers these programs, MIDD definitely helps out with their part too, you know, to keep these programs viable, and making any adjustments that are needed to continue to help with the funding. As you know, right

> now, one of the biggest barriers right now is finding qualified clinicians to fill a lot of these FTE (full time employee) positions. And I can tell you that from not just only the JJAT Program, but other programs that I'm overseeing that, that's one of the biggest barriers is, is finding FTEs, which leads to some underspend and leads to a lot of barriers in providing treatment to youth.

This interviewee makes an important point about the "braided system" of funding for both Juvenile Court Services and other MIDD sponsored programs throughout the county. MIDD is not the sole source of revenue for many of the programs addressing behavioral health throughout the county. Funding is also funneled through the executive and legislative branches of Washington state government and even so, these revenue streams are not enough to build the infrastructure and workforce necessary to meet the demands of King County youth.

It's Already Built/In-House Care at the Children and Family Justice Center

The idea of having in-house behavioral health care for youth at the juvenile detention facility (known as the Children and Family Justice Center or CFJC) is not new. The benefit of having a centrally located resource or resources near to where youth are being housed could offer a shortcut across the red tape of current treatment bureaucracies such as the Medicaid tiering system. The problem with this potential solution becomes one of politics within King County where the optics of maintaining the custody of youth within a detention facility regardless of the reason do not align with the current hashtag of #zeroyouthdetention. Several stakeholders recognized this complicating factor. One stated that, "Many people would have issues with that in and of itself, us having another program under the court umbrella." Yet another JCS

stakeholder, when discussing the idea of bringing treatment services physically into the courthouse and detention facility, framed their idea as follows;

> we play this game where we're bringing kids in constantly that are on some sort of court supervision. And we know they need inpatient treatment, but there's no beds or they won't go. We can't, we can't physically make them go. So, we do detention over and over. And sometimes finally, it works and you can get a kid to agree to go and you get them right from detention to a facility, actually transporting them, you know, and there's really only there's a couple (of inpatient facilities) in Seattle, and there's a handful in other cities, but it's a challenge to get kids physically there and get them to stay there and complete (the) program. So, I wish we had an inpatient option near or right in our building that that we could pop kids over to immediately after they come in to limit detention time. Although I think it would need to be secure, at least semi secure. But kids could be getting really great assessments and treatment. And you would save time, I think it would save lives, we lose some kids because of how hard it can be to get them into things treatment wise. A kid could go to an in-house co-occurring treatment program for 30 days, 60 days, 90 days, whatever. He's got well-paid, well-trained folks, right there (in the courthouse).

Additional frustration can be found in the words of another interviewed JCS stakeholder who describes the limitations put on existing funding sources that are directly related to the politics of the day. The interviewee stated, "there's still limitations on what you can and can't spend the money on and what qualifies. And it's, it's not often that it's just based on need, which I think everybody would agree we should be able to spend the money to treat people or serve people who have the specific need." Echoing the sentiment of a prior stakeholder this interviewee highlights the underlying reluctance to fund additional court programs. "I do think that there's a general hesitancy to fund courts, and anything associated with law and justice right now, those are just very, very tricky political issues for the powers that be to navigate right now." And in consideration of the political aspect of funding various juvenile court programs, the interviewee added that the King County Council and King County Executive are ultimately the

entities that decide what MIDD funding goes where, stating “I think, you know, while the MIDD operates as a separate, you know, with its own oversight and all that, the decisions for funding are ultimately made by the council and strongly influenced by the executive.” Additionally, this interviewee highlighted the role the court has traditionally played in identifying youth with behavioral health needs and how that role has diminished over time as fewer and fewer youth are being directed to the court, even if they have had contact with a police agency. “Fewer and fewer kids are coming to juvenile court. We've been traditionally relied upon as the point of (need) identification for these kids.” He continues by highlighting the complex role the court has played in the absence of other infrastructure, “I think it's this really interesting catch 22 where you don't want the court to be put in this role, but the (lack of) infrastructure has relied upon the court to play that role and you have to consider that. And then you also have to be willing to partner with the court and partner with other folks and not let the politics of the day stand in the way of what's best for kids.” This interviewee also acknowledges the lack of well-funded community resources for youth with behavioral health needs, “obviously community mental health is always in need of additional resources.”

The next juvenile court stakeholder brough forth the topic of how MIDD funding is steered from program to program in response to the many stakeholder voices aimed at the MIDD Advisory Committee as well as the County Council and County Executive. When reviewing the status of the Behavioral Health Response Unit (BHR) (formerly juvenile drug court) he commented;

> I think that's just one area where we've been able to kind of algin. And another thing, you know, I think you're aware like BHR, there had been a hold on prosecutors referring to be BHR, right? And for us, we're like, whoa, we got to work that out, because if they decide to say, you know, we're not even going to like, refer to this program, like, we're just gonna go to the normal court process, it could have an impact on us receiving that MIDD funding, right?

All of the interviews echo sentiments brought forth in the literature review section. The lack of autonomy of the court and how it spends MIDD funds, a severe clinical provider shortage and a lack of collaboration between the court and community providers as well as the Medicaid tiering system all work in tandem to create unintentional, but very real, barriers to behavioral health care juvenile justice involved youth.

CHAPTER FIVE: CONCLUSIONS & RECOMMENDATIONS

The dramatic disparities between treating physical medical conditions and treatment of behavioral health issue were highlighted in the opening paragraphs of this project and noted that the standards of care and care protocols for treating a young person's broken leg are drastically different from treatment of a young person's behavioral health condition. Someone with a broken leg understands how to seek help, typically in their local emergency room or urgent care clinical. Doctors, nurses and medical assistants understand the standards of care to assess, diagnose and recommend a course of treatment (surgery, casting and possibly physical therapy) to care for broken bones and although there may be some delay from the point of initial care to seeing a specialist, the patient can anticipate continuing to receive emergent care in the interim. This study has shown that seeking similar services for behavioral health issues is not comparable. This disparity in treating behavioral health care needs was highlighted by using the King County juvenile justice involved youth population as the main group to be studied in a needs assessment that aimed to reveal the shortcomings and assets of the existing behavioral health care service structure within King County.

This project initially sought to show that the Mental Illness and Drug Dependency Tax Act MIDD was a significant contributing factor to the lack of available behavioral health services for juvenile justice involved youth. But what has become evident through the course of the research and the interviews conducted for this project, is that MIDD is only part of the equation. Since MIDD intersects with the court and community behavioral health agencies,

there are a multitude of factors that limit the availability of behavioral health services for JJIY. In King County, as represented in MIDD 2 and its Juvenile Court Initiatives, there exists more policy language about how to determine the behavioral health conditions of youth than there are on-the-ground infrastructure supports to actually address and treat such issues that would meet the implied intent of the policy language. It would appear that both MIDD and King County Juvenile Court have entered into a policy-driven relationship that falls short on its recognition of the limited availability of community-based services and providers as well as overlooking the barriers that exist for youth to access these limited resources through the Medicaid tiering system. The disfunction between these three structures (juvenile court, community providers and Medicaid) were found to have a significantly more dramatic impact on the inaccessibility of behavioral healthcare for juvenile justice involved youth because they fail to collaborate their efforts and make transitions from one system to the next impossible to navigate successfully. This dysfunction was highlighted in the series of interviews conducted with both juvenile court and MIDD/community provider stakeholders.

One of the more obvious disparities found in the MIDD funding system is the large proportion of funds directed at adult behavioral health programming versus youth programming for behavioral health. To some degree this makes sense as the adult population likely has a higher need based of size of population, but when considering the urgency of the adolescent population and the potential to curb future behavioral health needs, MIDD may be better off investing heavily in the youth behavioral health population's programming which could offer a better rate on return of investment in the long run. The most dominate theme of all of the interviews was the impact of a provider shortage within King County where qualified clinicians

have been leaving the youth behavioral health field due to poor pay rates and difficult working conditions.

The shortage of qualified employees had left some agencies to close their doors completely, eliminate their adolescent programming options or minimize the numbers of youth who may be served in a given time, creating waitlists and crowded service schedules. Although not mentioned by any of the interviewees, it is feasible that those clinicians who stay to do the work are less qualified, newer to the field, and may not grasp the serious nature of the work they will be doing to serve the juvenile justice population. One interviewee did mention that MIDD has previously instituted a community providers incentive program that was disbanded but that could be reinstituted to incentivize new and experienced clinician by offering hiring bonuses, offer retention bonuses, pay livable wages based of years of experience and levels of education as well as paying for training and licensure costs and providing relief from the burden of student loans.

The tiering system in King County was another source of discussion within the interviews with concern being expressed that the current system for tiering youth for service with a community provider is to invalidate previously completed behavioral health care services performed within the juvenile court structure (the screenings and assessments) by requiring the same steps be taken in order to begin their payment for treatment. One stakeholder was quoted as saying, "I mean, I think one piece that was really overlooked when JJAT was created was this requirement by Medicaid that these agencies conduct their own assessments." Highlighted in this passage of the interview, is what appears to be a common-sense fix wherein Medicaid allows

community agencies to honor existing assessments completed by licensed and credentialed clinicians that may have completed an initial assessment outside their agency but would still meet the requirement of having an assessment that could begin the tier and the flow of funding to the agency instead of creating an additional barrier to services for juvenile justice involved youth.

Finally, there was discussion with one stakeholder about the possibility of providing on-site, on-demand baronial healthcare services for youth both within the juvenile justice system and those living in and around the community; something akin to a behavioral health drop in center that acts as a free, openly accessible and centrally located facility within the Children and Family Justice Center that would especially eliminate Medicaid red tape with a proper source of funding, possibly through a reallocation of MIDD funds. Juvenile Court was once the initial hub of contact a youth and acted as an initial source of identifying social service needs. However, the political climate within King County, led by the rallying hashtag *#zeroyouthdetention*, may be negatively impacting the validity of the idea of housing social service works under the Juvenile Court umbrella. This may be leaving community providers further away from collaborating with Juvenile Court Service bodies despite the court's attempt to shift its focus to a more therapeutic domain and a less punitive model.

APPENDICES

Appendix 1: MIDD 2 Annual Report – Youth-related Initiatives Legend

PR=Prevention & Early Intervention

PR1-02 JJAT

PR1-05 School-Based Screening, Brief Intervention & Referral to Treatment (SBIRT)

CD=Crisis Diversion

CD-02 Youth Detention Prevention BH Engagement

CD-11 Children's Crisis Outreach Response System (CCORS)

CD-13 Family Intervention and Restorative Services (FIRS)

CD-15 Wraparound Services for Youth

CD-16 Youth Respite Alternatives

TX=Therapeutic Courts

TX-JDC Juvenile Therapeutic Response and Accountability Court – Behavioral Health Response (BHR)

Appendix 2: MIDD 2019-2020 vs MIDD 2021-2022 Budget

Youth related budget:	***2019-20***	***2021-22***
PR1-02 JJAT	***$1,254,726***	***1,254,726***
PR1-05 School-based SBIRT	***$3,364,863***	***2,811,616***
CD-02 Youth Detention Prevention BH	***$1,844,486***	***1,669,489***
CD-13 FIRS	***$2,335,897***	***2,335, 897***
CD-15 Wraparound for Youth	***$6,603,815***	***3,603.815***
CD-16 Youth Respite Alternatives	***$1,046580***	***0***
TX-JDC Behavior Health Response (court)	***$2,361,802***	***2,035,732***
	$16,450,367.00 ***vs***	***$13,711,275.00***

Appendix 3 Behavioral Health Providers available in King County

Asian Counseling & Referral – Medicaid and MH OP

Atlantic Street – Medicaid, OP MH for youth

Catholic Community Services, Medicaid and OP MH youth

Center for Human Services – Medicaid and SUD OP

Consejo Counseling & Referral – Medicaid, SUD and MH OP

Friends of Youth – Medicaid SUD for Youth

Kent Youth & Family – Medicaid, SUD and MH OP

Navos - Medicaid and OP services for SUD and MH for youth

Nexus – Medicaid OP MH and SUD for Youth

Ryther Child and Family - Medicaid and OP services for SUD and MH for youth

SeaMar Community Health Centers Medicaid and OP/IP services for SUD (males only) and OP MH for all youth

Senaca Family Agencies- Medicaid OP MH for Youth

Sound - Medicaid and OP services for SUD and OP MH for youth

SW Youth and Family - Medicaid and OP services for SUD and MH for youth

SE Youth and Family - Medicaid and OP services for SUD and MH for youth

Therapeutic Health Services - Medicaid and OP services for SUD and MH for youth

WAPI - Medicaid and OP services for SUD and MH for youth

Youth Eastside Services – Medicaid and OP for MH and SUD for youth

You Grow Girl – Medicaid OP MH youth (female identifying only)

Valley Cities Counseling and Consultation – Medicaid OP for MH and SUD for Youth

Appendix 4 Interview Questions & Talking Points for Interviews

Please give me your name, job title and a brief description of your employment duties.

Can you please describe your understanding of the MIDD Program and how it functions in King County?

Please expand on your understanding of how MIDD Initiatives function and/or interact with King County Juvenile Court Services?

Do you know of any challenges that court-involved youth may have had in accessing the programming that is offered though Juvenile Court Services that is funded by MIDD?

How, if at all, do you think MIDD could be a more effective and efficient source of support/funding for behavioral health services for youth who are associated with Juvenile Court Services?

Is there anyone else you feel it would be beneficial for me to speak to about the issues we just discussed?

Do you have any questions for me related to this project or my research thus far?

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Possibly revisit/add to body of the paper:

When asked their thoughts on ways that MIDD could be more efficient in their funding of youth-related behavioral health services, the same interviewee noted that,

> I would say, you know, continue to offer programs that encourage and support youth to get involved in behavioral health. You know, it's really important. I know that a lot of youth are struggling with behavioral health, and I will say one good thing about it is that behavioral health has been destigmatized, we've done we've done a really good job of destigmatizing the need for behavioral health where as you know, traditionally, in communities of color that has been like, don't say that, right? Don't say that. We'll go to church and pray about it, we'll go see grandma, we'll do whatever we got to do. But don't

say that, you know? I have a(n) East African counselor and for the longest (time) his way of getting clients to engage in services or to get the parents to sign off on services, was he build it as after school homework? Help? Okay. Right? So, he would help them with their homework, but at the same time, we're talking about what's going on in your life, right. And he's really digging and pulling apart a lot of that stuff. So as long as the parents thought they were the kids getting help with their homework, they were fine. But the minute you say, hey, behavioral health service, they were like, we're out. Right? We don't need that. We don't do that. Yeah. So, I think just think offering more programs that are tailored toward youth (Interview with Anthony Austin 7.8.2022).

Maybe additions for Lit Review

Urgency of the Issue

5% of overdose deaths in King Co in 2020 were people under the age of 20. 68% were white, 89% were housed and 94% of all overdose deaths were found to be accidental.

https://kingcounty.gov/depts/health/examiner/services/reports-data/overdose.aspx

Youth seeking substance use treatment find there are few options for treatment and no options for medical detoxification. https://www.heraldnet.com/news/as-local-kids-get-hooked-on-fentanyl-theres-no-place-for-them-to-go/

King County pushes to declare fentanyl use a public health crisis

https://www.q13fox.com/news/push-to-declare-fentanyl-abuse-a-public-health-crisis-moves-forward-with-few-details-on-how?fbclid=IwAR1CuDPiVxfqSNAOp5MaUJfw70vzcwRcl-6CvfqAe-7uk7JWiF8QbSxYMWI&fs=e&s=cl

Topics to explore in recommendations section.

What does the existing literature mean for future programming and initiatives for projects like MIDD? Do they continue to invest solely in screening and assessment and hope for the best when it comes to the availability of appropriate providers in the community? Does MIDD begin to invest or create initiatives that bridge the gaps between diagnosis and care, considering an outreach-based, door-to-door type service from detention to assessment to treatment provider admissions? Or could MIDD bring these care services to the youth in detention and invest in an in-house behavioral health drop-in center that offers screening, assessment and treatment, essentially repairing the holes in their fishing net and assuring that no child falls through the cracks again? Is the political environment in King County and the rhetoric of the King County Council and King County Executive (Zero Youth Detention) eliminating the possibility of creating in-house behavioral healthcare options for youth who are involved with juvenile court to receive their care, in addition to their screening and assessments, at the juvenile courthouse? How can MIDD, or can MIDD, provide relief of any kind that could aid in the solicitation of qualified clinicians to fill vacancies in the behavioral health community provider agencies?

To highlight the urgency of this deficit, there are fewer than 10 inpatient facilities in the State of Washington for youth who need inpatient care for substance use disorders that are funded by Medicaid. Only two of these facilities are within the boundaries of King County. There are slightly more inpatient facilities for mental health disorder care, but their

doors continue to close as well. One major facility, Fair Fax, closed its adolescent programming altogether in the Spring of 2022. In a statement to The Seattle Times hospital CEO Christopher West said, "Based upon current patient demand and demographics, we suspended the inpatient adolescent program, effective May 16, 2022. This will allow us to dedicate more beds to serve our adult population, an area of continued need in our community" (BHRhttps://www.seattletimes.com/seattle-news/mental-health/fairfax-behavioral-health-in-kirkland-closes-youth-unit-shortly-after-state-cites-safety-violation/#:~:text=Mental%20Health-,Fairfax%20Behavioral%20Health%20in%20Kirkland%20closes%20youth%20unit,after%20state%20cites%20safety%20violation&text=The%20Mental%20Health%20Project%20is,mental%20and%20behavioral%20health%20issues).

For youth with mental health and substance use disorder needs who are insured by state or county programs, there are approximately 20 providers within King County that could, potentially, provide the outpatient or inpatient behavioral health services needed by juvenile justice involved youth (Department of Behavioral Health and Recovery (https://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/services/providers.aspx).

Despite having twenty potential providers, the workforce shortage is evident on some of the websites of these providers. A large provider of youth behavioral health services, under the umbrella name Navos, notes on its website that, "Our greatest priority is the safety of our patients and employees. For the last several years, the Sunstone staff have focused relentlessly

on improving quality of care, safety and regulatory compliance in order to deliver the best possible services to our patients and their families. Unfortunately, recent staffing shortages across out Behavioral Health Network have hampered out ability to continue our progress and we have made the difficult decision to stop providing this program while we redesign our services" https://www.navos.org/get-help/children-youth-families/youth-young-adults/residential/ (accessed 7/18/2022).

Another provider, Youth Eastside Services, had this message on their website for potential clients: **"**CURRENTLY NOT ACCEPTING NEW CLIENTS OVER AGE 7. Due to an unprecedented high demand for services, Youth Eastside Services (YES) has made the difficult decision to temporarily stop taking new clients to ensure that we are able to provide services to those individuals who have already completed their intakes or have scheduled intakes in the weeks ahead." : https://www.youtheastsideservices.org/about/contact/ (accessed 7/18/2022)

You Grow Girl, an outpatient program that provides mental health counseling services for female -identifying youth also had a message of limited availability on their website as well as a link to their waitlist, "We are not accepting counseling or WISe services referrals at this time. Please check back in May 2022 or join our waitlist. We review bi-weekly for availability." (website citation)

So, while there are community-based resources, the shortage of qualified providers is having its impact on these agencies' ability to meet demand for care. The variety of services available at the time of this capstone submission in July/August 2022 is limited to just one

inpatient SUD provider for youth with Medicaid. Several other agencies do provide this service in the State of Washington, but only one in King County. Nineteen of these providers offer outpatient care, predominantly for mental health services over substance use disorder services, which is troubling as it is the youth with substance use disorder issues that have the highest rates of contact and recidivism with the juvenile court system (source).