JUVENILE REHABILITATION INTEGRATED TREATMENT MODEL

Legislative Report

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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In accordance with Engrossed Substitute Senate Bill 6168 Section 225(3), this report is in response to the Legislature's request for an evaluation of the Department of Children, Youth and Families Integrated Treatment Model.

> (m) $200,000 of the general fund—state appropriation for fiscal year 2020 is provided for the department to measure the fidelity of the evidence-based interventions incorporated into the integrated treatment model. By July 1, 2020, the department must report to the Governor and the appropriate fiscal and policy committees of the Legislature on the results of the assessment of the integrated treatment model.

About Juvenile Rehabilitation

Juvenile Rehabilitation (JR) became part of Washington State's Department of Children, Youth, and Families (DCYF) on July 1, 2019. JR serves the state's highest-risk youth who have been charged with a qualifying offense and either adjudicated in a county's juvenile court or convicted in an adult criminal court. As the state moves away from institutionalizing youth and the youth crime rate declines, JR has gone from an average daily population in 1998 of 1,272, to 402 in 2019, an almost 68% decline in 20 years. Many of the youth who have historically been served at JR are now receiving local sanctions. This change has resulted in a changing profile of youth (i.e. higher proportion of high-risk youth) committed to JR. As of 2019, JR runs three institutions and eight community facilities. Youth start at an institution, then, depending on risk level, sentence, suitability and bed availability, can be moved to a community facility before being released. About half of JR youth receive community supervision (parole) when they are released from residential care.

The Integrated Treatment Model

In 1999[1], JR implemented a competency-based treatment and case management model. The model focused on increasing youth accountability, skill development and measuring youth changes in skill areas throughout their stay in the JR continuum of care.

In 2000, JR needed to further define and specify the appropriate interventions with both the individual youth in residential care and subsequently in families as the youth returned to their home communities. JR formed the Integrated Treatment Model (ITM) Workgroup, charged with the task of developing a research-based treatment model that utilized cognitive-behavioral principles. The model was to be tailored for use in both residential and community settings in the juvenile justice continuum of care. Goals for the model included:

- Research-based effectiveness
- Motivation and engagement of both youth and families
- A commonly understood language to be utilized throughout the juvenile justice continuum
- A uniform set of cognitive-behavioral skills
- The ability to generalize and maintain positive changes
- Ongoing clinical consultation system to ensure the continuity of the interventions and adherence to the model

The workgroup's report was finalized in 2002 and the process of implementing the ITM began. This model views all behavior, including a youth's criminal behavior as occurring in a larger social and historical context,

[1] This section is adapted from the Executive Summary of the original ITM Report from 2002.

serving a specific function. As such, criminal behavior is a product of one's learning history, encompassing family dynamics, specific circumstances and thoughts and feelings.

For example, in residential care (state institutions and community facilities) the model focuses on improving the skills of the youth who are separated from their family and removed from the community context in which their behavior occurred. Assessment of the criminal and other undesirable behavior uses a behavioral analysis to identify the contextual variables and the function of the behavior. Using basic behavioral change techniques of shaping, reinforcement, extinction and contingency management, the therapist implementing the model engages the youth in the change process, targets behavior using a hierarchy system and then teaches the youth specific behavioral skills to change their actions, thoughts or feelings. Much of the theoretical basis of the residential treatment component of the ITM is based on the researched-based treatments of Cognitive Behavioral Therapy (Linehan, 1993), Aggression Replacement Training (Glick, Goldstein, and Gibbs, 1998), and Moral Reconation Therapy (Little and Robinson, 1988), although the latter has never been fully implemented.

Once a youth leaves residential care and moves back into the community, the context of their behavior changes. The ITM reflects this difference. In community settings, where youth are monitored while on parole, the primary focus shifts to creating a more functional environment within the family where the youth resides. Again, research on maintaining and supporting behavior change for at-risk adolescents indicates intervention is most effective if supported within a family context. Parole staff work with families to shift the "problem behavior" to a relational issue between family members. The primary theoretical underpinnings for this section of the model come from Functional Family Therapy (Alexander and Parsons, 1982; Sexton and Turner, 2010), a research-based family intervention. At the onset of the ITM (early 2000s), all youth received some level of parole supervision; at the time of this report (2020), only about 50% of youth leaving a JR residential facility receive some form of community supervision.

Since its original inception in 2002, the ITM has evolved to include a risk and needs assessment called the Integrated Treatment Assessment (ITA) as well as other assessments that help determine placement, treatment needs, and facility and parole eligibility. The main residential treatment model is Dialectical Behavior Therapy (DBT) and the main parole treatment model is Functional Family Parole (FFP) with Functional Family Therapy (FFT) for those with high needs. Aggression Replacement Training (ART) is another treatment offered to eligible youth in the institutions. Additionally, there are Specialized Sex Offender Treatment (SOT), Substance Use Disorder (SUD) treatment and Mental Health (MH) treatment available in the institutions. Rounding out the ITM, there are protocols in place for suicide and self-harm prevention. The goal is this array of assessments and treatments are integrated and aligned using a Risk-Need-Responsivity (RNR) framework. The RNR freamework is comprised of three principles. First the "risk principle," which suggests that those with the highest risk for reoffending should be prioritized for treatments and other interventions. Second, the "need principle" recommends that the individual needs of each youth are determined, specifically those needs that are most likely to be associated with criminal behavior. Third, the "responsivity principle" requires that the correct type of programming be offered based on an individual's risk and need profile (Crites and Taxman, 2013; Brogan, Haney-Caron, NeMoyer, and DeMatteo, 2015).

In 2009, a study was conducted by The Washington State Department of Social and Health Services, Research and Data Analysis Division (Lucenko and Mancuso, 2009), that compared outcomes for JR youth from before and after the ITM was implemented. Allowing a two-year period to fully implement the ITM, the study compared state fiscal year 2002 outcomes to 2006, for youth who were released from JR. The study found

that employment rates for JR youth increased by 34% and re-arrest rates declined by 10%, coinciding with the implementation of the ITM. While parts of the ITM have been evaluated for their effectiveness over the years, there has yet to be an assessment of the implementation of the ITM as a comprehensive treatment model.

Starting in early 2016, an internal JR committee (called the ITM Reboot Committee) convened to start integrating a Positive Youth Development (PYD) framework into the ITM and to examine ITM implementation issues. The three main priorities identified by the committee were to improve and streamline training, clarify supervision standards, and update quality assurance tools. The committee finalized its findings in early 2018 and JR leadership has been working since then to address the issues raised by the committee.

Current Study

In 2019, the Washington State Legislature allocated funds for a fidelity assessment of the ITM in DCYF's Juvenile Rehabilitation. To accomplish this task, the DCYF Office of Innovation, Alignment and Accountability (OIAA) collaborated with external experts to assess the current implementation fidelity of the treatment areas in the ITM. The following treatment areas of the ITM were identified as part of the current assessment:

1. Assessment System
2. Dialectical Behavior Therapy (DBT)
3. Functional Family Parole (FFP)/Functional Family Therapy (FFT)
4. Aggression Replacement Training (ART)
5. Specialized Sex offender Treatment (SOT)
6. Substance Use Disorder Treatment (SUD)
7. Specialized Mental Health Treatment (MH)
8. Suicide and Self-Harm Prevention (SSP)

For the assessment system, the consultants were asked to address questions related to the appropriateness, quality and monitoring of the assessments used to inform the ITM. The specific questions can be found in Appendix A. For all the treatment areas, the consultants were asked to address questions related to treatment quality, integration and monitoring. The specific questions can be found in Appendix B. The consultants reviewed available policies and documentation, studied the available published literature and conducted site visits at JR facilities and parole offices before providing their expert responses to the questions. All the original consultant reports can be found in the Appendix C through J. Below, we summarize the findings across all the treatment areas and provide recommendations for JR's ITM moving forward.

Main Findings on Current ITM Implemetation

Here we present first the findings that apply to the ITM as a whole, and then we summarize the area-specific findings. Overall, there are four main findings from this study. First, consultants consistently reported that JR has passionate and motivated staff, however, in many cases they are being asked to work outside of their job description or are not adequately trained for the job they are being asked to complete. Second, the JR organizational structure often impedes effective treatment integration and delivery. Third, the assessment system lacks oversight and has not been effectively integrated into treatment eligibility and dosage decisions. Fourth, there are inconsistent quality assurance and implementation monitoring practices across JR's integrated treatment model.

Finding One: Staff Are Passionate, but Not Adequately Trained

Across treatment areas, consultants noted the dedication and compassion of JR staff. The interaction between youth and front-line staff is the key to effective implementation of the ITM. Having dedicated staff is essential to provide a quality treatment model. Dedicated staff, however, are not sufficient. Nearly all the consultants mentioned staffing issues, including high turnover, low pay, staffing levels and lack of training. Staff must be supported and adequately trained for the treatment to produce the desired outcomes. Importantly, JR recently completed a staffing study for both the residential facilities and parole services. The findings from those two studies are relevant here and confirm the findings from the consultants in this study.

Some of the relevant findings from the residential staffing model study include: (1) "The current number of staff and composition of the workforce cannot support full implementation of all the components of the Rehabilitation Model," (2) "Staff do not receive the necessary training time to gain requisite knowledge and skills for working with youth. In addition, training is not always provided in a timely manner." (3) "Actual turnover and turnover intent of staff are significant issues." (4) Line-level staff "all appear to be 'under classified' and underpaid relative to other positions with similar qualifications and responsibilities" (Hyzer Group, 2019a). Additionally, the parole services staffing model studies concluded that the current model "does not account for the time to conduct the range of necessary reentry services youth require in order to successfully reenter their homes and communities. The current model also does not account for the time parole counselors spend with youth who are still in residence" (Hyzer Group, 2019b).

Taken together, from the current report and the extensive staffing model studies that were completed last year, it is clear that the supports (number of staff, staff pay and training) do not match the expectations required of the treatment model. This imbalance is likely driving the high staff turnover rates, which exacerbates the staffing challenges.

Finding Two: JR Organizational Structure Impedes Effective Treatment

Juvenile Rehabilitation offers an array of treatment options, and currently most of the important treatment areas for effective rehabilitation are present, at some level. However, there are a number of occasions where it is evident that the organizational structure is inhibiting effective integration of treatment. Currently, there is no clear oversight structure for the Integrated Treatment Model. Treatment administrators are spread throughout the organization and do not have direct authority over how treatment is administered. In short, the ITM has never been fully integrated, and the agency is not attending to the on-going process of integration.

The agency is teaching youth many skills through different treatments. For example, DBT, ART and FFP all have a full set of skills and many youth will be exposed to all three sets of skills. While there are commonalities across these treatments, each contains distinct elements and there is little to no attempt to help youth understand how all these sets of skills are related. This is largely due to the fact that staff have not been trained on all the sets of skills being presented throughout the ITM. Youth will not be able to generalize the skills they have learned – the therapeutic step where the youth implements these skills in their own life – if staff are not trained to reinforce the skills while they are in JR.

Finding Three: Assessment System Lacks Oversight and Is Not Integrated Into Decisions

The JR assessment system is currently using assessment instruments that have not been validated.[2] Additionally, there is no oversight of the assessments being used to make important treatment and residential housing decisions. This lack of oversight could result in differential assessment results and differential access to services depending on who conducted the assessment. Finally, the assessments are generally not integrated into treatment decision-making (i.e. the assessment does not directly inform the type of treatment needed or dosage of treatment). Too often treatment is being determined by which facility a youth is placed at, and the interventions available at that location, instead of the RNR principles.

Finding Four: Inconsistent Monitoring of Treatment Quality

There is a patchwork of quality assurance practices across JR's ITM. In some treatment areas, there are full-time staff who conduct observations and provide a highly reliable assessment of the residential environment (for example DBT environmental adherence assessments), while in other areas, very little quality assurance has been implemented (substance abuse treatment, see Appendix H and other DBT treatment modes, see Appendix D). Additionally, for most of the treatment areas, the treatment administrator is also responsible for providing the quality assurance monitoring. This creates a situation where the treatment administrators are being asked to provide objective monitoring of their own program, which is contrary to best practice in quality assurance. The result is inconsistent, and in many areas, inadequate, quality assurance protocols across the ITM.

Treatment Specific Findings

Summary of Assessment Findings

The ITM relies on one risk and needs assessment, called the Integrated Treatment Assessment (ITA) and three actuarial risk assessments, the Risk Assessment-Recidivism (RAR), Risk Assessment-Institution (RAI) and Risk Assessment-Community Facility (RACF). These four assessments are not subjected to oversight and do not have a governance structure. None of them have been validated locally using a JR sample.

"Of the four instruments the ITA holds the greatest potential to drive case planning, youth classification (on risk and need), treatment models and the assessment of change over time. While the ITA does provide a great deal of important information, it does not appear that it is currently integrated into the treatment model as much as it could be. For example, treatment activities are driven largely by [living unit] placement, which appears to be driven by procedures that do not involve the ITA to a substantial degree. Overall, the potential for the ITA is not currently being realized" (Holsinger and Holsinger, 2020 – see Appendix C for the full assessment system report).

Summary of Dialectical Behavior Therapy (DBT) Findings

"The intention [of JR] to provide DBT to fidelity is deeply rooted – from the behaviorally specific DBT standards for each DBT mode to the sophisticated and rich intranet of DBT resources to aid in its delivery. Staff shortages and staff turn-over have significantly compromised JR's ability to train up its workforce in DBT and to maintain

[2] The only evidence that the items in the assessments are associated with the outcomes come from the construction sample, from when the assessments were created. In order for the instruments to be considered validated, the instruments need to be tested using a sample that is different from the one used to create the assessments.

whatever training gains it makes. Non-competitive wages make it particularly challenging to recruit personnel at all levels (AA, BA, MA, PhD). The situation is even more dire in rural areas.

Training, consultation and supervision resources are insufficient to meet the actual demand that counselors have in order to fulfill the DBT standards and deliver DBT to fidelity. In contrast to the early years of DBT implementation at JR where staff attended intensive trainings with ample consultation from other JR DBT experts, the trainings are now limited to two and three-day trainings and very limited consultation. Staff shortages have made it difficult for new staff to attend the trainings that are offered."

"The DBT standards accurately capture what a gold-standard JR system should seek to do… With respect to the individual delivery of DBT… the majority of today's counselors have not had enough training to know how to deliver DBT individual counseling to fidelity" (Dimeff, 2020a – see Appendix D for the full DBT report).

Summary of Functional Family Parole (FFP) Findings

Currently only about half of youth released from JR residential facilities receive some level of aftercare/parole services. About half who receive parole do so because they committed a qualifying offense, the other half are eligible because they score in the highest 25% on a JR risk assessment. The risk assessment used to determine parole eligibility has not been validated. "Without validation, the accuracy of placements is unknown and significant numbers of youth may be underserved due to scores that result in no JR parole placement upon reentry into their communities, while many other youths at lower risk may be placed" on parole. "It is likely that a significant number of non-placed youth are in need of monitoring and have significant reentry needs for services that would be best provided by JR parole [aftercare]."

"The treatment quality of FFP appears more variable, relative to FFT quality, ranging from low for FFP counselors with seemingly limited commitment and fidelity to the FFP approach and moderate for counselors who seem to have embraced the FFP model and appear motivated to implement FFP with integrity. Hampering treatment quality for FFP is the inadequacy of training, beyond the initial FFP training, the supervision structure, and fidelity monitoring procedures" (Waldron, 2020 – see Appendix E for the full FFP report).

Summary of Functional Family Therapy (FFT) Findings

"As a whole, the FFT therapists appear to be performing at a uniformly exemplary level, given the restricted resources available to them. Without exception, all of the FFT therapists participating in the site visits associated with this report demonstrated the high levels of knowledge and skills required for effective FFT implementation. Treatment dosages for youth and families who receive FFT appear quite good, with number of therapy sessions and rates of treatment retention and completion for FFT providing solid indicators of FFT quality."

"The structure of placing FFT therapists in the role of [clinically] supervising FFP counselors is detrimental to both FFT and FFP implementation quality because FFT therapists are responsible for overseeing FFP fidelity for counselors who do not directly report to them and who are formally supervised by others who conduct their performance evaluations. This situation gives FFP counselors the option to follow or reject the guidance of FFT therapists, limiting the impact of therapists' time and skills. …FFT quality is also diminished somewhat by the lack of systematic training for all therapists in all elements of the ITM" (i.e. DBT and ART), (Waldron, 2020 – see Appendix E for the full FFT report).

Summary of Aggression Replacement Training (ART) Findings

JR uses the Integrated Treatment Assessment (ITA) to determine eligibility for ART. "None of the research reviewed indicates that the current eligibility criteria is predictive of future violent behavior, which would require ART as an appropriate treatment. The current program is using an assessment for eligibility, and the assessment is being used appropriately, however, JR has not determined that the eligibility criteria that have been selected are appropriate."

"JR appears to be implementing the treatment according to the design. There are strong training and quality assurance protocols in place. In terms of dosage, all those who start the program receive the same dosage, which is three sessions per week for 10 weeks. It is not clear whether youth are receiving the right dosage. It is likely that some youth require more treatment and some less, however, the current design of ART does not allow for this type of dosage variation…There was some reporting that ART is only allowed 45 minutes for sessions in some places due to school schedules. This would result in a lower dosage than intended. There is variation by location in terms of when ART is administered, but the standards and quality assurance for the program is consistent across location" (Fox, 2020 – see Appendix F for the full ART report).

Summary of Specialized Sex Offender Treatment (SOT) Findings

"The DCYF program, particularly as delivered in its inpatient facilities, emphasizes a strong skills-based approach using empirically supported treatments such as Dialectical Behavior Therapy and Aggression Replacement Training… Case notes reflected treatment plans, which in turn reflected the medical and/or psychiatric evaluations from which they were drawn as well as the legal documents for each youth. Case notes were generally well written and the treatment plans themselves reflected and enabled an individualized treatment approach for each youth in treatment… On balance, there is much to be proud of within this branch of DCYF services.

The number one concern expressed by all interviewed is that the treatment provided within the inpatient components [DBT and ART] of the program is not provided by licensed clinicians. Although the programs are assisted by psychologists, the treatment itself is delivered by people who do not have specialized training in psychotherapy… The second most cited concern is staff turnover"[3] (Prescott, 2020 – see Appendix G for the full SOT report).

Summary of Substance Use Disorder (SUD) Treatment Findings

"It does not appear that youth are being appropriately matched with treatment based on need. While there is a range of levels of care provided across the institutions, each institution only provides one or two levels of care that may be dependent on what substance is being used.

Assignment of youth to particular institutions is made based on multiple considerations, including age, gender, sentence length and other considerations, of which SUD prevalence/severity is not one. Youth in need of SUD treatment get the level of treatment offered at the institution to which they were remanded, regardless of

[3] Specialized sex offender treatment for youth in state community facilities and for youth on parole supervision are provided through contracted services from community providers.

their level of need/severity. In many cases, this means youth get less treatment than they need, in some cases, more treatment than they need and in other cases, no treatment at all."[4]

"JR appears to be implementing the chosen treatments as well as possible given the constraints of the settings. Treatments are generally manualized and delivered in the context of an individualized treatment plan. Staff are passionate about providing high quality SUD care. However, systemic issues interfere with the ability of JR to provide optimal treatment. For example, it was noted that staffing was often a problem. As noted, at the time of the site visit, Echo Glen Children's Center (EGCC) was not providing intensive outpatient due to staffing challenges. As long as this is the case, no girls in a JR institution receive SUD treatment… There was no formal quality assurance plan identified at any of the sites visited" (Stoner, 2020 – see Appendix H for the full SUD treatment report).

Summary of Special Mental Health (MH) Treatment Findings

"While all of the mental health treatment providers were clearly motivated, compassionate and conscientious, they also all reflected on the inadequacy of the system (lack of sufficient staff, high complexity of needs) for delivering high quality mental health treatment. Neither approach (short term or through the entire term) appeared to be guided by symptom reduction (with the exception of TF-CBT which could be extended if youth symptoms were not resolving)."

"A strength of mental health treatment across all institutions is the effort to coordinate the medical and psychosocial treatment of mental health needs through team-based planning and ongoing coordination. Treatment plans are reviewed with mental health therapists, coordinators, psychiatrists and medical directors in the three institutions."[5]

"Mental health therapists serving youth in the JR institutions are not being routinely trained in best practice clinical treatment standards. The fellowship rotation at Echo Glen ensures a number of youth have access to treatment by residents who are being exposed to evidence-based treatment strategies through other rotations but training for JR therapists is otherwise limited to what the clinician was trained to do prior to hire and whatever clinical strategies they are motivated to learn more about as part of their ongoing clinical education. The treatment approach is generally eclectic and therapists are being called upon to address a very wide range of needs without adequate training and consultation support… There did not appear to be a quality assurance plan for monitoring the treatment of specific mental health disorders" (Walker, 2020 – see Appendix I for the full Specialized MH Treatment report).

Summary of Suicide and Self-Harm Prevention (SSP) Findings

"The policy that governs the procedural practice of assessing, managing and treating suicidal and self-harming youth is comprehensive, sophisticated, and contains numerous safeguards to ensure each at-risk youth's situation is carefully assessed. All staff working with youth are required to complete multiple trainings on suicide and self-harm prevention… This training is very thorough, comprehensive, and is likely more than most licensed clinicians receive in graduate school. Brilliantly, employees are expected to study and memorize risk

[4] Substance use disorder treatment for youth in state community facilities and for youth on parole supervision are provided through contracted services from community providers.

[5] Specialized mental health services for youth in state community facilities and for youth on parole supervision are provided through contracted services from community providers.

and protective factors *before* arriving at their training… These training approaches are sophisticated and rigorous."

"The treatment plan to address suicidal and non-suicidal self-injurious behavior requires sophisticated behavioral procedures that are contained within Dialectical Behavior Therapy (DBT)… Staff shortages and staff turn-over have significantly compromised JR's ability to train up its workforce in these and other procedures and to maintain whatever training gains it makes. Non-competitive wages make it particularly challenging to recruit personnel at all levels (AA, BA, MA, PhD). The situation is even more dire in rural areas. Without staff retention and comprehensive training, consultation and supervision [related to DBT], it is difficult how counselors can be expected to actually *implement* an effective treatment plan that reduces suicide and self-harm risks. Blocking procedures and the [Suicide Precaution Level] SPL procedures will ensure that those at risk in the moment do not have access to lethal means and methods to cause self-injury or death by suicide. This is different, however, than having a carefully developed treatment plan…that will serve them well after they leave JR" (Dimeff, 2020b – see Appendix J for the full SSP report).

Finding a Path Forward: Recommendations

The goal is to create an ITM that can work effectively today, and that can also expand as additional resources are added. The basic JR ITM approach is sound, however, significant improvements to integration and implementation are needed. Many of the recommended changes to the ITM can be made without additional funding. The agency must focus on treatment implementation, which includes having the correct eligibility criteria, high quality treatment and providing the correct dosage based on the client's level of need. As implementation improves, we expect that this will have a direct impact on improved outcomes. There are numerous treatment area-specific recommendations in the assessments located in the full consultant reports, which are provided in the Appendix, and a list of some of the top area-specific recommendations can be found in the table at the end of this section. For those interested in a specific treatment area, we encourage you to read the assessment report on that treatment. Experts wrote these comprehensive and insightful reports. The following recommendations are seen as the top priorities to improve JR's ITM implementation.

Recommendation 1: Realign Organizational Structure to Create Clear ITM Oversight

This recommendation is the top priority. The remaining recommendations are not likely to be successful without a clear oversight and management structure for the ITM. DCYF should re-align the organizational structure to create a clear decision making process and monitoring of the ITM. This includes a more clear plan for how DCYF will align QA practices, treatment options and assessment in support of the ITM. The current structure, where treatment administrators are spread throughout the agency and there is no clear oversight or accountability of assessments (recommendation 2) or treatment quality (recommendation 5), is hindering the agency's ITM implementation. Further, under the current structure there is no clear process in place to correct the issues that have been identified in this report. A defined organizational structure that prioritizes treatment will provide the structure for an accountable and transparent process to be implemented. DCYF should take this opportunity to define what integrated treatment means, and better align the resources necessary for an efficient, effective and culturally responsive treatment model. By aligning the treatment resources, the agency will be in a better position to create an ITM with feedback loops for continuous improvement and monitoring.

JR has selected the ITM as its strategy to rehabilitate youth. The organizational design should support that strategy. The first step in operationalizing this recommendation should be a more formal assessment of how

the strategy, structure, processes, rewards and people are all aligned, or misaligned. This can be done through a STAR model assessment to determine if the agency is designed to accomplish its goal of effective treatment and rehabilitation (Galbraith, 2014).

The more appropriate organizational structure would view treatment through the lens of the ITM and RNR principles. Where youth are being assessed, highest risk youth are prioritized and youth are being matched with treatments based on their needs. Treatment access should not depend on the facility the youth is placed in. Instead, the youth should be placed in the facility that can best meet the youth's treatment and other needs. By realigning the JR organizational structure, which should include the integration of assessment, QA and treatment oversight into the broader DCYF plan, the treatment model can move forward with the tasks of integration, monitoring and refinement that are outlined in the consultant reports. An integrated and realigned organizational structure would include one person (or a clearly defined and empowered committee) who is ultimately accountable for the ITM implementation. They would oversee all the treatment administrators, and the implementation and oversight of the risk and needs assessments (recommendation 2). Further, the ITM oversight structure would also provide the clinical oversight for those providing case management (recommendation 4).

Recommendation 2: Create an Accountability Structure for Risk and Needs Assessment

There has never been a full integration of the assessments and the treatment programs in the JR ITM. First, there needs to be a process of identifying and prioritizing the top needs of a youth when they enter custody. Every youth's top treatment needs should be identified during the initial intake process, and then referrals made for both the treatment type and the dosage needed for each youth. As part of this process, eligibility criteria for all the treatment options and dosage levels needs to be clearly established and routinely tested. The assessment process, and clearly matching youth to the appropriate treatment, is essential for their future success.

The fact that JR continues to use risk assessment tools that have not been validated is a major concern. All risk assessments that make decisions about youth care must be routinely validated and tested for reliability. DCYF should identify or develop an administrative position or function to oversee assessments. "The new administrative position would oversee new and ongoing training for existing (and newly adopted) assessments. The position would also be responsible for conducting quality assurance reviews of case plans derived from assessment activities insuring that they are driven by the RNR (Risk Need and Responsivity) principles. Likewise, the position would oversee regularly scheduled tests of validity for all assessments in use, as well as efforts to ensure acceptable levels of interrater agreement and interrater reliability, and would also oversee the adoption and implementation of a standardized responsivity assessment process. Under the assumption that assessment activities should drive, and be integrated with the treatment models, the Director [or Administrator] of Assessment would be ultimately responsible for making sure that true integration occurs. Assessment procedures are the cornerstone of any effective intervention model, and as such the integrity of the information that is gathered, the way the information is used and the extent to which the information undergirds every part of the system is paramount" (Holsinger and Holsinger, 2020 – see Appendix C).

No matter how the agency decides to oversee the assessments, all assessments, particularly those used to make decisions related to facility placement and length of incarceration, should be routinely validated.[6] "[The RAR, RAI, RACF] continued use should be based in large part on both the results of tests of predictive validity as well as the overall agency objectives" (Holsinger and Holsinger, 2020 – see Appendix C).

Recommendation 3: Provide Transition Support to All Youth Leaving Residential Facilities

In the recently released DCYF draft strategic plan, one of the agency priorities is to "create successful transitions into adulthood for youth and young adults in our care." This successful transition for JR youth is largely dependent on the successful process of reentry from a residential facility back into the community. The reentry planning process begins right when youth are admitted to a JR facility. It is paramount that JR support the successful transfer and maintenance of gains made by youth while under residential supervision (e.g. treatment progress, education improvement and housing stability) into the community setting (including the Child Welfare system).

Parole is an important component of successful community reentry. About half of youth released do not have any support from JR when they are released from a residential facility and transition back into the community. Even without additional resources, JR should consider how all youth might receive community supports. "Although this would require a systemic change at the legislative level, such a change could be initiated at a minimal level without an increase in funding… Monitoring and providing services to [all JR] youth would also likely result in substantial savings to the state through decreased recidivism and reincarceration. Although attempting such a change without an increase in funding would not produce optimal results, the empowering of JR parole to allocate resources across the single continuum of need would help guide the application of current resources more efficiently" (Waldron, 2020 – see Appendix E).

"Supervising all youth transitioning to the community would double the overall number of youth served, but would not require a doubling of the workload for JR parole staff. A substantial number of lower risk youth would need less monitoring and could be supervised with monthly FFP check-ins and brief phone contacts. Similarly, youth with moderate risk, including those who would have been placed in JR parole and those who would have been released without JR parole placement, could be supervised with bi-weekly FFP check-ins, with phone contacts as needed, while higher risk youth could receive services as they are now provided by JR parole. Allowing adjustments in length and intensity of service to be made internally by JR parole, based on validated assessments, would significantly enhance the efficiency and effectiveness of services across all youth. Because all youth not placed in JR parole are released from incarceration with some arrangement for housing, funding for housing services would not necessarily need to increase" (Waldron, 2020 – see Appendix E).

JR, with the support of the Legislature, must find innovative ways to ensure all youth can transition smoothly into the community. For example, all youth have a residential sentencing range and are required to spend a minimum amount of time in a residential facility. The time between the minimum and maximum sentencing range could be seen as the transition period. After the minimum date, JR could begin to transition the youth back to their home community, with parole services and electronic home monitoring, returning the youth back to a facility if they violate certain rules. The important factor here is that all youth need support as they

[6] Through this ITM assessment process, DCYF has engaged the external consultants to begin risk assessment validation work of the RAR, RAI, and RACF.

return to their community and JR should not release youth from an institution directly back to the community, without some level of support for a successful transition. This process must be guided by data and the research on what is most effective.

Recommendation 4: Transition to "DBT for Some," and Develop Specialized Therapists in Residential Facilities

It is clear that adjustments are needed so that youth receive the services outlined by agency standards, particularly related to the main residential treatment model, DBT. Although there are staffing issues such as turnover and staffing levels that need to be addressed, there are changes the agency can make now to implement DBT in a manner that enables JR professionals to provide higher quality treatment to youth. Specifically, JR should transition to providing full DBT only to those who need it the most. Second, JR should begin transitioning toward specializing responsibility for providing individual counseling sessions and skills groups. Staff are not adequately trained to administer the treatment and turnover is high. It takes a significant amount of resources to sufficiently train staff to effectively perform their job duties and many leave before they are proficient.

As outlined by Dimeff (2020a, Appendix D), "JR should reconsider comprehensive DBT for some (vs. comprehensive DBT for all). It is a noble effort to seek to provide comprehensive DBT for all youth, particularly in light of the real challenges to hiring and retention of staff. While DBT for all may be the ideal, it may also not be affordable (and therefore realistic). It is better to provide comprehensive DBT to those who need it the most rather than "DBT Lite" for all. Clear criteria could easily be established to determine those who most need DBT counseling to fidelity. A small cohort of clinicians/counselors could then be trained and supervised to ensure they have the capability of providing DBT to fidelity in the individual counseling mode. All other residents could receive DBT Lite (EA, DBT skills). Those selected to provide 1:1 DBT to fidelity may also have additional incentives to tackle work with the most difficult of youth (e.g. more training opportunities, opportunity for more competitive wages, protected time for consultation team)."

DBT can be a valuable treatment, however, not all youth need it and certainly not all youth need the same dosage. This decision to attempt to give everyone adherent DBT has resulted in very few youth actually receiving the treatment with high quality (Fox, Miksicek and Veele, 2019).

Next, JR should have specialized therapists provide DBT and case management. JR is asking too many staff to take on too many tasks. Currently, JR expects staff to be proficient in three of the four DBT treatment modes: coaching on the floor, individual sessions and skills groups. The training requirements are significant in order to bring a staff up to speed in all three areas. It might take years for a professional to develop proficiency in all modes. Consequently, staff are providing DBT modes without sufficient training and quality improvement support. They are leading skills groups with insufficient training in DBT skills and group management; coaching youth on the floor without enough training in behaviorism and goal-directed coaching; and conducting individual sessions without sufficient training in engagement, motivation and behavior change strategies. The current implementation strategy is not producing the quantity or quality of treatment necessary for effective DBT treatment dosage. This recommendation will help improve treatment for youth in JR and will, hopefully, align workers' expectations with their compensation (Hyzer Group, 2019a).

Leadership should focus and specialize the scope of responsibilities for the current job classifications within JR, and consider adding a classification for specialized staff who provide individual counseling, case management and reentry planning. As an example, the staff with specialist classification would be responsible for a larger individual counseling caseload, and would have limited or no duties managing the floor. This group of

specialists will receive intensive training in DBT case management and reentry support. Having DBT provided by a specialist would allow others in the living units to focus solely on coaching youth and managing the living unit environment. The specialists would be accountable to the ITM oversight structure (see recommendation 1).

The agency could realize cost savings by targeting specific training and quality assurance activities with smaller groups of specialists based on their scope of responsibility. Training everyone on everything remains a significant logistical and financial challenge. Tailoring and prioritizing trainings for targeted specialists (therapists, group facilitators, and coaches) will accelerate competency and mastery, resulting in a multitude of benefits to the agency, facilities, employees and clients. This new approach could contribute to increased staff morale and retention by empowering and supporting staff to focus their development, with considerably more targeted and direct support. Staff specialization will allow staff to feel more capable once they are able to master their responsibilities.

Recommendation Five: Adopt a Uniform and Clear Quality Assurance Program Across the ITM

Currently, there is a lack of consistent monitoring of treatment implementation. In the absence of data, it becomes difficult to create a system of accountability and transparency. To that end, JR needs to create a uniform quality assurance and continuous quality improvement model for the ITM. Currently, the ITM Quality Assurance team is only dedicated to conducting QA for a portion of DBT. In order to monitor the ITM, so that agency leadership can see both the quality and quantity of treatment being delivered, the new QA structure should include a number of key features. First, a treatment dashboard needs to be developed. Data on both treatment need and treatment access could be monitored in near real time. Second, the role of quality assurance should be seen as separate from program oversight. Often the administrator for the program or program area is also the same person who provides quality assurance monitoring. This creates a situation where treatment administrators are being asked to report on the quality of their own work. Third, JR needs a more routine and standardized quality assurance process. Currently, each program in the ITM has a different QA structure and reporting process. QA needs to be consistent so that changes over time can be identified, but it also has to be feasible given the limited resources. JR should explore the Standardized Program Evaluation Protocol (SPEP) or a similar standardized tool that will allow for the routine monitoring of programs with the same set of protocols.

There is significant institutional knowledge among JR staff about what works, and what does not work, for treatment and rehabilitation of juveniles. The youth in JR have many treatment needs and are at high risk for future offending. Because of this, an efficient system of assessment that informs treatment prioritization is essential. Leadership (both within the agency and the Legislature) must ensure that our most valuable asset, the staff, are supported by a system that is designed for success. This will result in lower recidivism, fewer victims and youth leading lives that are more successful in the long term. The adoption of the recommendations listed in this report will move JR into a new phase of treatment implementation that is more effective, efficient and data-driven.

Top Area-Specific Recommendations From Consultant Reports

Recommendation Number*	Focus Area	Recommendation
C.1	Assessment system	Develop a point person (e.g. a Director [Administrator] of Assessment) or function and a small administrative structure that would be dedicated solely to implementing, monitoring and driving everything related to the system's assessment procedures.
C.2	Assessment system	The continued use of the RAR, RAI and RACF should be based in large part on the results of their tests of predictive validity.
C.3	Assessment system	If the RAR, RAI and RACF do possess current predictive validity, consider utilizing them as instruments that dictate intensity of supervision and/or the intensity of the residential placement.
C.4	Assessment system	Give priority to the ITA in order to drive more aspects of the treatment model currently in place. Ensure that the ITA and the information that it renders is fully understood and utilized by any and all staff that work with the youth in any capacity.
D.1	Dialectical Behavior Therapy (DBT)	Reduce staff shortage and improve retention. Staff shortages make it difficult for staff to attend trainings and have the necessary time to do what is required well.
D.2	Dialectical Behavior Therapy (DBT)	Reconsider comprehensive DBT for some (instead of attempting DBT for all)
D.3	Dialectical Behavior Therapy (DBT)	Offer comprehensive, intensive training in DBT over the course of a year.
E.1	Functional Family Parole (FFP)	Parole could have a far greater impact if each region maintained oversight and supervision of *all* youth re-entering their communities.
E.2	Functional Family Parole (FFP)	A more rigorous fidelity monitoring measure is needed to improve the quality of FFP.
E.3	Functional Family Parole (FFP)	Additional FFP counselors are needed at all sites to improve the frequency and duration of FFP sessions with youth and families.
E.4	Functional Family Therapy (FFT)	Funding is needed to increase FFT and FFP staff salaries.
E.5	Functional Family Therapy (FFT)	Provide additional resources to FFT therapists for travel.
E.6	Functional Family Parole (FFP)/Functional Family Therapy (FFT)	Develop checklists, procedures and/or benchmarks to monitor cross-site consistency of FFP and FFT implementation.

E.7	Functional Family Parole (FFP)/Functional Family Therapy (FFT)	Allow all FFT therapists and FFP counselors to attend or "audit" ongoing trainings for DBT and ART.
E.8	Functional Family Parole (FFP)/Functional Family Therapy (FFT)	Add capacity to conduct data analyses to monitor program performance (treatment quality, quality assurance, FFT and FFP outcomes) internally.
F.1	Aggression Replacement Training (ART)	Refine the ART eligibility criteria so that it is based on evidence accumulated over the past 10 years of implementation, and then focus ART on those with the greatest need and the highest risk.
F.2	Aggression Replacement Training (ART)	Reconsider how ART is being implemented to ensure a full hour for programming for ART sessions, to ensure implementation fidelity.
F.3	Aggression Replacement Training (ART)	Implement a process that allows for closely monitored variations of ART programming. For example, JR could test a shortened version of ART for youth who have the assessed need and are high risk, but do not have a very long sentence.
F.4	Aggression Replacement Training (ART)	Set up a curriculum review committee for ART, to make sure lessons can continually improve.
G.1	Specialized Sex Offender Treatment (SOT)	Advancements in the areas of trauma-informed care, motivational enhancement and the further development of approach goals would be welcome.
G.2	Specialized Sex Offender Treatment (SOT)	On-site clinicians for treatment provision in the residential programs would be ideal.
H.1	Substance Use Disorder Treatment (SUD)	Provide SUD treatment staff with a new title (and higher pay) that reflects their different role within the institutions.
H.2	Substance Use Disorder Treatment (SUD)	Continuity of care could be enhanced by providing SUD treatment records to community facilities when youth arrive there from institutions and to community treatment providers with whom paroled youth continue their treatment.
H.3	Substance Use Disorder Treatment (SUD)	Make regular use of a SUD treatment oversight committee to guide the implementation of SUD assessment and treatment in juvenile justice settings in the state.
H.4	Substance Use Disorder Treatment (SUD)	Each institution should provide multiple levels of care to better match youth to SUD treatment according to need.
H.5	Substance Use Disorder Treatment (SUD)	Funding for alternative curricula could also improve treatment quality if other treatments can be identified that better fit the constraints of correctional settings.
H.6	Substance Use Disorder Treatment (SUD)	Refresher training for providers in their treatment models could enhance fidelity. Curriculum review by credentialed treatment trainers could also be beneficial.

I.1	Specialized Mental Health Treatment (MH)	Restructure the delivery of mental health treatment to provide more stepped care approaches beginning with group-based treatment facilitated by mental health staff and then moving to one on one treatment for youth who continue to display consistent and concerning behaviors.
I.2	Specialized Mental Health Treatment (MH)	Improve clinical continuity by either a) involving regional mental health coordinators from the youth's home community; or b) improve telemedicine facilities.
I.3	Specialized Mental Health Treatment (MH)	Ensure mental health treatment plans and targets of therapy are integrated in milieu behavioral goals and planning by adapting current family system models to work with line staff in cottages and units.
J.1	Suicide and Self-harm Prevention (SSP)	Reduce Suicide & Self Screen (SSS) interview process. It is recommended that JR consider convening a task force comprised of all relevant stakeholders (including youth) and outside suicide experts to streamline the method.
J.2	Suicide and Self-harm Prevention (SSP)	Ensure adequacy of training for DBT core competencies. The only way a counselor will be able to actually treat that which they assessed using the SSS is by receiving comprehensive training in the treatment procedures, including ongoing consultation and supervision.
J.3	Suicide and Self-harm Prevention (SSP)	Carefully consider providing Designated Suicide Prevention Specialist (DSPS) option to deviate from standard procedure.
J.4	Suicide and Self-harm Prevention (SSP)	Consider having a designated suicide expert available for more complex cases and to conduct quality assurance review of SSS.

** The letter before the recommendation number indicates the appendix where the full report can be found. Please see the full consultant reports for more details on each of these recommendations.*

References

Alexander, J., & Parsons, B. V. (1982). *Functional family therapy*. Brooks/Cole Publishing Company.

Brogan, L., Haney-Caron, E., NeMoyer, A., & DeMatteo, D. (2015). Applying the Risk-Needs-Responsivity (RNR) Model to Juvenile Justice. *Criminal Justice Review, 40*(3), 277-302.

Crites, E. L., & Taxman, F. S. (2013). The responsivity principle: Determining the appropriate program and dosage to match risk and needs. In F. S. Taxman and A. Pattavina (Eds.), *Simulation strategies to reduce recidivism: Risk need responsivity (RNR) modeling for the criminal justice system* (pp. 143–166). New York, NY: Springer Science and Business Media.

Fox, A. M., Miksicek, D., & Veele, S. (2019). *An evaluation of Dialectical Behavior Therapy in Washington State's Juvenile Rehabilitation.* Olympia, WA: Department of Children, Youth, and Families, Office of Innovation, Alignment, and Accountability.

Galbraith, J. R. (2014). *Designing Organizations: Strategy, Structure, and Process at the Business Unit and Enterprise Levels*. John Wiley & Sons, Incorporated.

Goldstein, A. P., Glick, B., & Gibbs, J. C. (1998). *Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth* (rev. ed.). Champaign, IL: Research Press.

Hyzer Group. (2019a). *Current State Staffing Analysis Volume 1. Juvenile Rehabilitation*. Department of Social and Health Services, Rehabilitation Administration.

Hyzer Group. (2019b). *Current State Staffing Analysis Juvenile Parole*. Department of Social and Health Services, Rehabilitation Administration

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. Guilford Press.

Little, G. L., & Robinson, K. D. (1988). Moral Reconation Therapy: A systematic step-by-step treatment system for treatment resistant clients. *Psychological Reports, 62*(1), 135–151. **https://doi.org/10.2466/pr0.1988.62.1.135**

Lucenko, B. & Mancuso, D. (2009). *Integrated Treatment Model outcomes: A first look at ITM outcomes*. Washington State Department of Social and Health Services, Research and Data Analysis Division. Report number 2.22.

Sexton, T., & Turner, C. W. (2010). The effectiveness of functional family therapy for youth with behavioral problems in a community practice setting. *Journal of Family Psychology, 24*(3), 339–348. **https://doi.org/10.1037/a0019406**

Appendices

Appendix A: List of questions related to ITM assessment system

Appendix B: List of questions related to ITM treatment areas

Appendix C: Fidelity Assessment of ITM Assessment System
by Dr. Alex Holsinger and Dr. Kristi Holsinger

Appendix D: Implementation Assessment of Dialectical Behavior Therapy
by Dr. Linda A. Dimeff

Appendix E: Implementation Assessment of Functional Family Therapy and Functional Family Parole
by Dr. Holly Barrett Waldron

Appendix F: Implementation Assessment of Aggression Replacement Training
by Dr. Andrew M. Fox

Appendix G: Implementation Assessment of Treatment for Youth Who Sexually Offend
by David Prescott

Appendix H: Implementation Assessment of Specialized Treatment for Substance Abuse
by Dr. Susan A. Stoner

Appendix I: Implementation Assessment of Specialized Mental Health Treatment
by Dr. Sarah C. Walker

Appendix J: Implementation Assessment of Suicide and Self-Harm Prevention
by Dr. Linda A. Dimeff