

# Systems Change & Shrinking Budgets

## Improving a Juvenile Justice System Despite Declining Resources

By Cheryl Stephani

Creating something from virtually nothing, spinning straw into gold, making stone soup and feeding the village, taking a few loaves of bread and a few fish and providing for a multitude of people — these and other traditional stories may have modern day implications for juvenile justice professionals. As is depicted in the Bible, tackling the seemingly impossible (feeding a large crowd of people) with extremely limited resources (a few loaves of bread and some fish) is amazing both in the end result (no one went away hungry) and the sheer audacity of the initial undertaking. Who would have thought that it could be done? Surely, one would need much more than was apparently available to fill those hungry stomachs.

In this era of shrinking resources, declining populations and growing complexity of youth treatment issues, how does an agency meet the demand for new and better services to address the rehabilitation needs of juveniles? Can an organization deal with a fiscal crisis and still move in a direction that provides better outcomes for juveniles and their families?

Amid shrinking resources, program closures, underfunded treatment interventions and difficult legislative sessions, the Washington State Department of Social and Health Services Juvenile Rehabilitation Administration (JRA) decided to examine options for improving services to youths committed to state care. Facing an already insufficient base budget, the leadership team forged ahead to significantly change interventions for youths, developing and implementing an inte-

grated treatment model that holistically addresses treatment interventions for youths and their families from admission through aftercare.

### The Challenge: Retrench or Retool?

Along with 47 other states, Washington has been faced with monumental budget deficits during the past few years. Balancing the state budget meant making deep cuts in existing programs and services. In Washington, JRA lost \$14.8 million during the four-year period from fiscal years 2001 through 2004. Some of the reductions were due to a downturn in the population of youths committed to state long-term residential care. With JRA's base budget driven by population forecasts, a decrease in the population means a reduction in beds, and beds were reduced across the entire continuum of residential care. Two medium-security youth forestry camp programs were closed within three years, minimum-security group care beds were lost and entire housing units were mothballed on the remaining secure campuses. Although staff philosophically acknowledge that a reduced need for long-term residential juvenile services is a positive situation, the loss of friends and colleagues due to facility and unit closures took its toll on staff morale and optimum programming opportunities for youths.

In addition to bed reductions, service reductions occurred. Although cutbacks were successive and the impact to programs was felt over time, the comprehensive list of programs and services that were reduced or eliminated is staggering, particularly

in parole aftercare programs. Employment programs, day reporting programs, counselor assistant services, key elements of the intensive aftercare program, staff specialists for substance abuse and sex offending treatment issues, and administrative and support services are all gone or have been significantly reduced. State employees received no cost-of-living increases for two years and saw their health care premiums increase.

At the same time, legislative appropriations did not provide the resources necessary to meet the mental health needs of youths in the system. Both the acuity of the treatment needs for these youths and the proportion of the population with significant mental health issues were growing. Today, more than 60 percent of the youths committed to JRA care either have a significant mental health issue identified on the standard mental health diagnostic tool, the DSM-IV (excluding oppositional defiant disorder, conduct disorder, pedophilia or substance abuse as a single issue), are taking psychotropic medications or have been suicidal within the past six months. Additionally, almost 60 percent of all JRA youths have two or more significant treatment needs (i.e., mental health treatment needs, sex offender issues, cognitive impairments, medical fragility, or substance abuse or chemical dependency issues). Treatment costs for this multi-service-need population greatly exceed generic unit costs. The budget cuts driven by decreasing population forecasts have not recognized nor funded the costs associated with serving high-cost, complex populations.

Budget reductions occurred over a number of years. Each successive budget session brought with it the agonizing discussion of whether to retrench or retool. Should the administration retrench — pull in the JRA belt another notch and maintain the existing approach to working with youths? How could one move ahead with such uncertainties? Or should the administration continue to retool and proceed with developing and implementing an integrated holistic treatment approach to be used across the entire system?

## Developing and Following A Strategic Vision

In the midst of the continuing fiscal uncertainty, potentially shaky morale, reductions in programs and lack of resources, Washington decided to divide up its existing insufficient loaves and fish and create something better. In October 2001, undaunted by the monumental task in front of it, hampered by inadequate existing resources, yet inspired by a vision of competent, confident, responsible youths, the management team chartered a work group of clinicians, residential and community staff, managers and university professionals to develop an integrated cognitive-behavioral therapy (CBT) treatment model for

use in residential programs. The management team set parameters. The model must be family focused and use evidence-based programs that had been proved to reduce recidivism for youths. It also should identify and prioritize youth treatment needs, provide a consistent framework for planning and skill building across the entire continuum of care, increase youth competence in targeted areas and reduce recidivism. The model's development and implementation became the core of the agency's six-year strategic plan.

Beginning from a program using dialectical behavioral therapy (DBT), which was developed and piloted for aggressive youths with significant mental health issues, the team spent a year constructing a skill-based residential CBT/DBT treatment model that met the criteria initially established by the management team. Throughout the planning period, the fiscal challenges continued. Aftercare parole services were significantly reduced. As a result, the management team and the model development team needed to make another key decision: Was it time to retrench or should the model be retooled to reflect the new budget realities? The managers decided that this was no time to retrench, so the retooling began.

## The Initial Implementation — Redirecting Resources

Retooled and ready to implement, a number of resource questions remained unresolved. Staff training, clinical consultation, information systems requirements and the continued impacts of real and feared budget cuts needed attention.

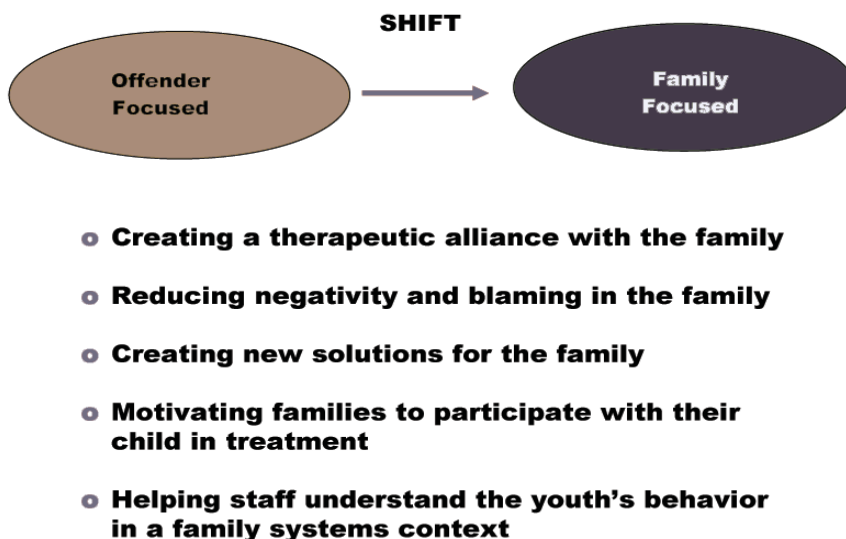
One by one, management staff examined and addressed a number of critical issues. Using existing resources, clinical consultation to assure adherence to the model was secured. Consultation services were limited but clinical expertise had always been in short supply.

A family-focused aftercare parole program based on the successful outcomes of functional family therapy was added to the integrated model and adopted as the reintegration approach for parole counselors. Functional family parole services seeks to motivate and engage youths and their families in working together with parole counselors and local service providers as youths return home. Counselors would use the new case management framework to work with youths and their families as youths learned to apply the skills acquired in JRA residential settings to their experiences at home and in the community (see Figure 1). The ultimate goal of family functional parole services is to enable the family to function better in support of the successful reintegration of youths.

Parole staff were trained in the new functional family parole services process. Six staff members, each of different parts of the state, were selected to receive intensive training as functional family therapy therapists. They now carry family caseloads and consult with staff about the new model's implementation.

Existing residential psychologist resources provided internal consultation for the new CBT/DBT skill-building treatment approach. Residential programs staff looked to their base budgets and asked themselves tough questions about how their expenditure of resources supported the strategic direction. Contracts with companies adept in the model elements enhanced residential and parole staff training and early implementation.

**Figure 1:** Parole counselors work with youths and their families to improve the way the family functions in support of youths' successful reintegration into their homes/community settings.



Existing training dollars and every spare (and rare) bit of discretionary money were used to begin training staff in six residential pilot sites. The information technology system steering committee switched development priorities to begin building case management modules to support the new treatment intervention. Continual updates were provided to staff who feared the loss of more programs or facilities.

Training for the first six residential pilot sites began in October 2002. Interim outcomes were charted and, as the sites began to have increased success in teaching youths to manage their own behavior, the interest and momentum in what was happening grew. At the same time, data collected from the original DBT pilot sites for aggressive mentally ill youths showed a decrease in maladaptive behaviors and an increase in pro-social behaviors for the system's youths with the most challenging behaviors (see Figure 2). A follow-up recidivism study at 12 months confirmed the efficacy and the cost-effectiveness of the intervention (see Figure 3).

Legislative leaders deeply concerned about providing effective programs to enhance long-term community safety and achieve better outcomes for juveniles had solid information to share with colleagues about the positive interim outcomes achieved in the initial pilot programs.

Still, the budget reductions kept coming. Anxiety around more residential bed closures threatened to derail implementation, and additional cuts in the aftercare parole budget again reduced staff and services to youths.

But the success demonstrated by the residential pilot sites, the family motivation and engagement success staff were having in the community, and the professional desire of staff to do the best they could possibly do for youths and families allowed them to focus on reinventing their programs in support of the model.

### Staying the Course — Lessons Learned

The successful implementation of the integrated treatment model throughout all parts of JRA continues to be the center of the administration's strategic plan. Implementation of the model dominates the annual work plan. By the end of June, all of the aftercare parole staff and 75 percent of the residential staff will be trained in the new model. Additionally, new information technology tools will be available to assist in treatment planning and model adherence. Baselines for performance will be established for staff, consultants and administrators, and goals for improvement will be set as well.

However, there is still much work to be done. Base budget deficits continue to exist. Doing a better job with existing resources does not resolve all the critical fiscal issues related to increasing needed clinical consultation, inadequate staffing levels, salary inequities or loss of programs. The period of aftercare parole services for many youths is far too short to enable full generalization of CBT/DBT skills and provide optimal support for improved family functioning. Although initial staff training is one thing, full adherence to the model is another.

The success of the model itself is its own reinforcement, and the establishment of a strong clinical consultation team will assist staff in their professional growth and development in using the model.

Beginning any systems change is challenging. Communication mishaps, missed cues or the potential complications of implementation can impede progress. Certainly, unrest and budget reductions can be huge organizational energy drains. And as always, there are many lessons to be learned along the way.

**Lesson 1: There is never a "right" time to begin a system change.** The stars will not fall into alignment; a bright light will not appear in the sky overhead. The right time to begin a systems change is when the hearts and minds of a committed, dedicated leadership team is captured by a vision to improve the system.

**Lesson 2: Capitalize on work that has been previously done.** Some pieces to support Washington's new direction were already in place. The administration's mission, vision and values were well articulated; the leadership team was committed to meeting the treatment needs of youths; key legislative leaders long interested in outcome-based programs provided support in advancing the effort; and successful residential pilot programs supplied a starting point uniquely connected to the larger system. With these key elements aligned, the administration could move quickly to affirm the existing mission and values and tune up the vision. With the bulk of the groundwork in place, the organizational effort could focus on identifying

Figure 2: Incidents Requiring Physical Control of Youths at Maple Lane School in Snoqualmie, Wash.

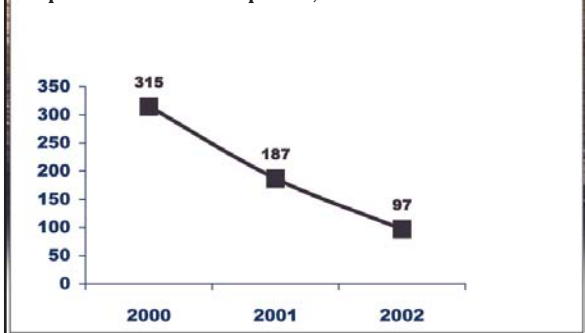
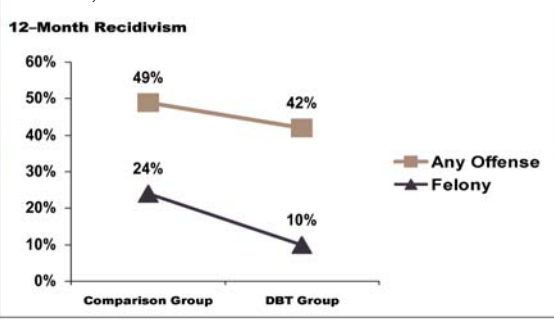


Figure 3: Evidence-Based Intervention Dialectical Behavior Therapy at Copalis Cottage — Echo Glen Children's Center in Centralia, Wash.



a process for developing a model and implementation.

**Lesson 3: Collect the data.** The ability to use both data and anecdotes to support the new systemwide approach became important in sharing information about the new direction with both internal and external stakeholders. It was important to be able to give supporters sound, data-driven arguments as they continued advocating for treatment-based interventions. This became particularly crucial in the legislative arena to stave off even deeper erosions of base resources during extremely tight fiscal times.

**Lesson 4: Communicate and then follow through.** Based on past experience, the administration clearly understood that ongoing communication and support for the model were essential for success. Too often, past systemwide initiatives had been launched with some fanfare, only to watch the momentum fade and the initiative disappear into the woodwork while a small group of dedicated individuals worked on the details. Many months later, as the small work group emerged ready to implement a new direction, the momentum was gone and needed to be rebuilt. Similarly, fanfare surrounding the initial implementation of a new initiative would fade without adequate support and follow-through.

**Lesson 5: Listen carefully to feedback and actively support the new direction.** Management leaders listened to the feedback from staff, clinical consultants and each other, and actively sought ways to support the new direction. Recognizing both the positives and negatives surrounding the implementation process, leaders consistently sought to claim the possibilities and strategize around the barriers. Leaders were also visible in the field, on the floor and in training sessions, talking to youths and staff about their experience in learning and applying the family motivation and engagement skills and CBT/DBT skills. Local sites hosted legislators and other key stakeholders to provide a hands-on view of the work being done.

**Lesson 6: Continue to prioritize budgets in support of the systemwide change.** Initial implementation is only a beginning. As experience with the model grows, adjustments will need to be made. In today's monetary environment, crafting new solutions will require continued scrutiny of the use of base resources to support necessary modifications.

## Conclusion

There are intangible "blessings" in taking what limited resources exist and turning them toward a dynamic shared vision. Leaders learn how to stretch yet

not break an organization in pursuit of a vision. There is a limit to organizational capacity and flexibility, but in pursuit of the right vision, the capacity and flexibility may be greater than one thinks. Beginning a new, pro-active direction while in the middle of difficult economic times provided not only a positive focus for staff, but also a new skill set to enhance their professional capabilities.

Although Washington's economy is starting to improve, budget constraints and possible reductions may still lie ahead. Washington's JRA will only be stronger in its ability to work with youths and their families effectively. A solid foundation is being laid for the future, whatever the future may hold. It will take time to fully develop the model and the infrastructure in support of it, but at the end of the journey, because of the efforts of staff and stakeholders in pursuit of a vision of more competent, confident and responsible youths leaving JRA care, Washington can look forward to better functioning families and safer communities.

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