San Diego County Juvenile Justice Commission
Supplemental Questions for Behavioral Health Services

Data from Calendar Year 2017

☒ Camp Barrett

☒ East Mesa Juvenile Detention Facility

☒ Girls' Rehabilitation Facility; and

☒ Kearny Mesa Juvenile Detention Facility

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I. Behavioral Health Care Services

A. Behavioral Health Staffing

The STAT (Stabilization, Treatment, Assessment, and Transition) Team is managed by two Mental Health Professionals: a Licensed Clinical Social Worker (LCSW) and a Licensed Psychologist (PhD) employed as Behavioral Health Program Managers. Clinical team members may be assigned to multiple locations based on need. As of March 28th, 2018, primary direct service staffing is as follows:

KMJDF

Staff Type ***(At time of inspection)***	**# Filled**	**# Open**	**# Contractors**	**# Staff**	**Avg. staff hours per week at facility**
Psychiatrist	5	0	0	5	100*
Psychologist	4	0	0	4	150
LCSW	2	1	0	2	60
LMFT	3	1	0	3	90
Psychiatric Nurse	1	0	0	1	40
Unlicensed Mental Health Staff	1*	0	0	1*	40*

*We currently have a KMJDF psychiatrist on maternity leave. Her hours are not reflected in the statistics above. **Consists of one full-time Post-Doctoral Psychology Intern supervised by a Licensed Clinical Psychologist.

EMJDF

Staff Type ***(At time of inspection)***	**# Filled**	**# Open**	**# Contractors**	**# Staff**	**Avg. staff hours per week at facility**
Psychiatrist	3*	0	0	3	40
Psychologist	0	1	0	0	0
LCSW	0	0	0	0	0
LMFT	5**	0	0	4	160
Psychiatric Nurse	1	0	0	1	40
Unlicensed Mental Health Staff	1***	0	0	1	40

*We currently have an EMJDF psychiatrist on maternity leave. Her hours are not reflected in the statistics above. **Included in the statistic above, a full time LMFT has been hired and scheduled to start April of 2018. ***Consists of one full-time Post-Doctoral Psychology Intern supervised by a Licensed Clinical Psychologist.

GRF

Staff Type *(At time of inspection)*	# Filled	# Open	# Contractors	# Staff	Avg. staff hours per week at facility
Psychiatrist	1*	0	0	1	10
Psychologist	1	0	0	1	40
LCSW	0	0	0	0	0
LMFT	0	0	0	0	0
Psychiatric Nurse	0	0	0	0	0
Unlicensed Mental Health Staff	0	0	0	0	0

*One psychiatrist is the primary provider of psychiatric services at GRF; however, other STAT Team psychiatrists also see GRF youth. Their combined hours per week total approximately 10 hours.

KMJDF STAT-Team resources and services are provided to GRF as needed. For example, the Psychiatric Nurse at KMJDF coordinates medication orders and records for the psychiatrists working with GRF youth.

Camp Barrett

Staff Type *(At time of inspection)*	# Filled	# Open	# Contractors	# Staff	Avg. staff hours per week at facility
Psychiatrist	3*	0	0	3	32
Psychologist	1**	0	0	0	40
LCSW	0	0	0	0	0
LMFT	1	0	0	1	20
Psychiatric Nurse	0	0	0	0	0
Unlicensed Mental Health Staff	1***	0	0	1	40

*Tele-psychiatry is utilized to provide ongoing medication management to youth at Camp Barrett; initial medication evaluations, for Camp Barrett youth, are done face-to-face at Kearny Mesa Juvenile Hall. **Included in the statistics above, a full time Psychologist has been hired and is scheduled to start March 30, 2018. * **Consists of one full-time Post-Doctoral Psychology Intern supervised by a Licensed Clinical Psychologist.

The STAT-Team Psychiatrists, working both full and part time, provide consultation, medication assessments and ongoing medication management services for KMJDF, EMJDF, Camp Barrett and GRF.

B. Behavioral Health Statistics

- In FY 2016-17, the STAT Team served a total of 1,179 unduplicated clients in the 4 detention facilities. Some of the youth transfer between facilities and obtain STAT services in multiple locations.
- In FY 2016-17, 1,078 (91.4%) of STAT team clients had one or more identified psychiatric diagnoses; the remaining (usually those who were seen very briefly) had not been formally diagnosed.
- On February 28, 2018 there were 113 youth prescribed psychotropic meds in all detention facilities; this was 30% of the total population of 374 youth. Data by Detention facility:

Location	Youth Prescribed Medication	Total Population	Percentage
KMJDF	40	139	29%
EMJDF	41	139	29%
Camp Barrett	24	73	33%
GRF	8	23	35%
Total	**113**	**374**	**30%**

- In FY 16-17, an average of 136 youth per month were prescribed psychotropic medications; this was, on average, 37% of the total population in the detention facilities per month.
- In FY 2016-17, a total of 648 unduplicated clients received a Medication Support service from the STAT Team, which constitutes 55.0% of the total youth served in that time frame. A psychiatric encounter may or may not lead to psychotropic medication being administered during the youth's stay in the detention facility.

Regarding requests for data for specific diagnoses and for specific types of psychotropic medication:

Youth diagnosed with Attention Deficit Hyperactivity Disorders may or may not be prescribed psychotropic medication, depending on the clinical needs of each individual youth. While stimulant medications are commonly used for youth with this diagnosis, a variety of other psychotropic medications may also be used (i.e., alpha-agonists, buproprion, atomoxetine, and others) depending on co-morbid diagnoses, prior experiences with stimulants, etc. While the number of youth prescribed stimulants is not tracked, a point-in-time count completed on 3/27/18 of the number of youth prescribed stimulants was 11 (8% of youth prescribed psychotropic medications, 4% of the youth in the detention facilities).

Regarding youth prescribed "anti-anxiety medications," first line treatments for anxiety disorders are anti-depressant medications (SSRI medications), and often mood and anxiety symptoms are co-morbid. There exists multiple psychotropic medications that are used to manage symptoms of anxiety (mood stabilizers, second generation antipsychotics, anticholinergic medications, and others) and selection of a medication again depends on co-morbid diagnoses, prior experiences with typically prescribed first-line agents, etc.

Sleep disturbance is typically managed in the context of sleep representing a symptom of a larger clinical disorder. Thus, agents used to manage sleep (certain anti-depressant medications, mood stabilizers, alpha-agonists, anticholinergic medications, second generation antipsychotic medications) are used with the intent to relieve suffering from the primary diagnosis, not to solely sedate a youth.

Benzodiazepine medications, controlled substances which are clinically utilized for management of anxiety, insomnia, mania, catatonia, seizure disorders and other conditions, are rarely used in the detention facilities. The number of youth prescribed benzodiazepines is not regularly tracked, but a point-in-time count (3/27/18) there are zero youth prescribed benzodiazepines.

For youth prescribed psychotropic medication who enter the detention facility, those medications are continued by the STAT Team psychiatrist. The average length of stay for youth at KMJDF is 18 days. Because of the short length of stay, STAT Team psychiatrists will evaluate the appropriateness of making substantive changes in their regimen. For youth that have been adjudicated and a longer stay is anticipated, STAT Team psychiatrist will be more involved with modifying existing medication regimen.

STAT Team psychiatrists work to carefully evaluate the youth in the detention facilities, identify their complex needs, clarify their multiple diagnoses and recommend treatments appropriate to manage symptoms that disrupt their ability to function with their family and peers, in school and in society. Efforts are made to minimize the total number of psychotropic medications prescribed to any one youth. Treatment is informed by the California Guidelines for Psychotropic Medication for Foster Youth and the focus is on providing safe, effective care.

C. Behavioral Health Screening

1. Which MAYSI screening test is used?

   Youth complete the MAYSI-2 upon entry into Kearny Mesa Juvenile Detention Facility (KMJDF). KMJDF is the only point of entry for youth coming into the detention facilities. The MAYSI-2 is a self-administered screening tool written at the 5th grade level, completed on computer. If the youth's answers regarding suicidal ideation exceed an established threshold, a probation officer will complete a face-to-face screening with questions that specifically address suicidal ideation. If there are continued concerns, the youth is immediately placed on Suicide Watch and is closely monitored by probation.

2. When MAYSI is administered, who does initial and follow-up interpretation?

   A Probation Officer reviews the screening reports from all completed MAYSI-2 screenings. If a youth scores in the "Warning" level on any of the 7 scales (Alcohol/Drug Use, Angry-Irritable, Depressed-Anxious, Somatic Complaints, Suicide Ideation, Traumatic Experience, and, for boys only, Thought Disturbance), the Probation Officer forwards the report to the Mental Health Resources Center clinician.

   Title: Licensed Marriage and Family Therapist (MFT) employed by the Mental Health Resources Center through a County contract (part of the San Diego Unified School District). The clinician enters the data into a scoring program operated by San Diego Unified School District Mental Health Resources Center; the scoring algorithm was

developed by a Licensed Clinical Psychologist. If the score is within an established range indicating a need for further evaluation, the clinician goes to juvenile hall and conducts a face-to-face assessment using a structured interview.

a. What happens to this interpretation?

The clinician makes appropriate referrals for follow up and appropriate interventions for services both in the detention facilities and out of the detention facilities. Possible referrals include the Stabilization, Transition, Assessment, and Treatment Team (STAT-Team), psychiatric medication management, outpatient mental health services upon release from detention.

3. Has the Probation Department used the Columbia Suicide Severity Rating Scale (C-SSRS) instead of or in addition to the MAYSI? ☒ Yes ☐ No

YES, the C-SSRS is now used in addition to the MAYSI.

a. If yes, when did the facility begin using the C-SSRS? March 1, 2016

4. What are the clinical credentials of person who does initial and follow-up interpretation?

The clinician is a Licensed Marriage and Family Therapist.

5. What other mental health screening tools are used?

The California Forensic Medical Group (CFMG) conducts a face-to face medical intake that has questions pertaining to mental health and substance use. The Initial Booking and Screening Questionnaire, the Juvenile Health Appraisal, and the Juvenile Readmission Health Appraisal include questions about suicide risk factors, substance use, trauma etc. If there are concerns regarding immediate safety, CFMG will place the youth on Suicide Watch, the youth will be closely monitored by Probation, and CFMG will initiate a more in depth mental health assessment. If there are concerns regarding mental health that are not imminent, a referral to the STAT-Team is generated. Referrals for a STAT-Team evaluation can be generated by any individual with concerns about a youth, both in the institutions (Probation, CFMG, Education staff, etc.) and outside the institution (family, outpatient mental health providers, etc.)

6. How are LGBTQ youth identified upon admission to the facility?

The Department of Probation manages the intake process at the facilities.

a. Are there anti-bullying programs in the facility? ☐ Yes ☐ No

The department of Probation manages the programs in the facilities.

D. Therapeutic Services: Regarding "How Often" youth are seen for therapy, the frequency of individual therapy is determined by clinical assessment. Youth are seen weekly, bi-weekly, monthly, or as needed or requested depending on his/her mental health issues and degree of stability or instability in the institution. Therapeutic services include individual and group therapy, transition work, and also significant collateral work with Probation staff and medical clinic staff, such as multidisciplinary team meetings and consultations with unit staff. After care transition services are provided to youth who, while in custody, were engaged in therapy and demonstrated an ability and interest in change, and formed a therapeutic alliance with a

STAT clinician as a positive vehicle for change. In FY 16/17 70 youth received aftercare services from the STAT team, while other youth who could benefit from therapeutic services were connected to community based services

In FY 16/17, individual and group therapeutic services/sessions were:

Type of Therapy	KMJDF Average per month	EMJDF Average per month	GRF Average per month	Camp Barrett Average per month
Individual	334	167	80	102
Group	5	0	4	15

1. What is the procedure for youth to request mental health services?

   A youth in detention may request mental health services in several ways. They may self-refer by asking a probation officer to fill out a referral slip. They may also put in a sick call slip to California Forensic Medical Group (CFMG) asking to be seen by a mental health staff. Probation may identify a youth who appears to be in some form of distress and refer the youth for mental health services. This would also apply to CFMG staff. Any other provider at the facility (educational, clergy, contracted providers, current outpatient providers) may also refer a youth to the STAT Team. Family members can also call the STAT Team and ask for mental health services to be initiated.

2. Are probation staff members permitted to refer youth for mental health services?

   ☒ Yes ☐ No Please see above.

E. Behavioral Health Emergency Referral Process:

The emergency referral process is managed by the department of Probation.

1. Please attach a copy of the written suicide prevention plan.

   The suicide prevention process is managed by the department of Probation.

   a. Please list all agencies who participated in developing this plan.

      _____ _____

2. How often do Probation staff attend suicide prevention training?

   The department of Probation manages their suicide prevention training.

   a. What topics are covered during this training?

      _____ _____

3. In the last calendar year have there been any instances where the written plan was not followed in response to a youth at risk of suicide? ☐ Yes ☐ No

   The department of Probation manages their own data.

   a. If yes, what happened?_____

4. Number of referrals of youth with suicidal ideation during the last calendar year?

   When there is any suspicion (a verbalization or other indication) that a youth has suicidal ideation, the youth is placed on Suicide Watch (SW).

Data on Suicide Watch referrals at KMJDF for calendar year 2017 indicates there were 155 referrals for new instances of Suicide Watch. There are sometimes several Suicide Watch referrals for one youth.

Data on Suicide Watch referrals at EMJDF for calendar year 2017 indicates there were 34 referrals for youth placed on Suicide Watch. Similar to KMJDF, there are sometimes several Suicide Watch referrals for one youth.

Youth at the Girls Rehabilitation Facility (GRF) placed on Suicide Watch are immediately transferred to KMJDF for close monitoring; thus, there are no Suicide Watch referrals to the STAT psychologist at GRF. GRF data is represented in statistics listed for KMJDF.

Youth at Camp Barrett who are suicidal are placed on Suicide Watch and transferred to EMJDF; thus, there are no Suicide Watch referrals to the STAT psychologist at Camp Barrett with data reflected in EMJDF data listed above.

5. On average, how long does it take a JFS/STAT team member to call the institution to respond to suicidal ideation?

   When probation staff, STAT Team staff or any other staff member in the institution identifies a youth who has or may have suicidal ideation, the youth is immediately placed on Suicide Watch and is under the close supervision of probation to maintain safety. A face to face evaluation is immediately facilitated through a STAT Team member during programming hours. After hours, an on-call STAT-Team psychiatrist is contacted to review the circumstances and determine if an immediate face-to-face evaluation is indicated. This can occur via a transfer to the Emergency Screening Unit or through the on-call psychiatrist. Only licensed mental health staff members evaluate youth on Suicide Watch.

6. What percentage of those calls result in JFS/STAT team member physically seeing the youth?

   All youth placed on Suicide Watch are physically seen by a licensed STAT-Team clinician unless the youth has imminent needs and is transferred to the Emergency Screening Unit. STAT-Team and Probation policies are that only a licensed STAT-Team clinician can discontinue Suicide Watch.

7. What are the specific criteria used to determine if a youth is seen in person?

   See #8, below, for triage process and criteria.

8. How long before a JFS/STAT team member sees the youth in person?

   Referrals are triaged with intent to provide services as soon as possible but not to exceed the established protocol. Timelines include days with routine STAT Team staff coverage only (some weekend days and some holidays are not included in the timelines). If a critical issue arises and there is no staff on site, the on-call psychiatrist is contacted.

   Urgent Behavioral Health Care:
   Child will continue to be under the close watch of probation staff for safety and seen as soon as possible and within 24 hours by a STAT-Team Clinician. Examples of Urgent referrals include, but are not limited to, the following:

- Imminent dangerousness with symptoms of mental illness.
- Homicidal or suicidal ideation/behavior.

Urgent Medical Care:
Child will be seen by a STAT psychiatrist or psychiatric nurse as soon as possible but no later than twenty-four (24) hours. Examples of medically urgent referrals include, but are not limited to, the following:

- Admission to Juvenile Hall on medications that should not be discontinued suddenly.

Priority Care:
Child will be seen as soon as possible but within one (1) week. Examples of Priority cases include, but are not limited to, the following:

- Youth with a history of having been prescribed psychotropic medication who has recently been non-compliant with medication will be seen within one (1) week if there is a history of rapid decompensation when without medication.

Routine Care:
Child will be seen as soon as possible and as time permits. Examples of Routine *cases include, but are not limited to, the following:*

- Mild psychiatric symptoms.

9. Are all youth with suicidal ideation put in a "suicide watch" room? ☐ Yes ☐ No
   a. If no, why not? The department of Probation manages room assignments.
10. Have tear-away bed sheets been installed in "suicide watch" rooms? ☐ Yes ☐ No

    This is managed by the department of Probation.

11. What happens if a youth does not meet the criteria to be seen in person?

    In regards to suicide watch, all youth are seen in person.

12. What percentage of those calls result in a medication being prescribed?

    All youth placed on Suicide Watch status are evaluated by licensed mental health clinicians and the youth receive continued behavioral health services as clinically indicated. Some of these youth have existing STAT Team services, which may or may not include psychotropic medications. For youth not receiving psychotropic medication placed on Suicide Watch, the licensed mental health clinician will refer to a STAT Team psychiatrist for a medication evaluation when it is clinically indicated. Medication services are determined by clinical need only. Placement on Suicide Watch status is considered in creating a youth's comprehensive treatment plan, but is only one of many factors that lead to a recommendation for psychotropic medication prescription. Thus, Suicide Watch status in and of itself never solely results in psychotropic medications being prescribed.

13. On average, how long before a psychiatrist reviews the medication impact?

    STAT Team child and adolescent psychiatrists evaluate youth as frequently as is clinically indicated to address benefits and potential side effects of the psychotropic medications.

The frequency of visits can range from multiple visits per week for youth with complex needs, to every 4 weeks for a youth stable on a psychotropic medication

14. What percentage of those calls result in Emergency Screening Unit (ESU) contact?

    This is not a data point that our system tracks, however from experience we are able to make the observation that the vast majority of youth placed on Suicide Watch remain in the detention facility and are not transported to the Emergency Screening Unit (ESU) that is available to children/youth experiencing a psychiatric crisis. The STAT Team is available to provide crisis intervention services and Probation is available to ensure a youth's safety. STAT Team and Probation, along with CFMG and representatives from the schools work together, when it is clinically indicated, to develop special protocols to provide multi-disciplinary support for youth whose needs exceed traditionally offered levels of service. Only when a youth's needs exceed services and support provided on-site and there is concern that a youth's safety is in jeopardy, is the youth transported to the ESU. In situations where there are grave concerns for safety, Suicide Watch status may be bypassed and the youth is transported directly to the ESU.

15. What percentage of those ESU contacts result in hospitalization or other transfer?

    Because of the availability of STAT Team services, support from Probation to ensure safety, and the ability to develop a multidisciplinary treatment plan, youth in the detention facilities are rarely hospitalized in a psychiatric facility. Data tracking hospitalization rates for youth at ESU who had been referred from a detention facility are not specifically tracked. Overall, ESU diverts approximately 75% of all youth seen from psychiatric hospitalization by providing crisis stabilization services and ensuring access to appropriate follow-up.

    a. What is the "other" transfer? See above.

16. What percentage of those ESU contacts result in "stabilization"?

    All youth transported to ESU receive crisis stabilization services. Crisis stabilization includes a therapeutic assessment completed by a team of child and adolescent psychiatrists and licensed mental health professionals. The goals of crisis stabilization are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system, family members, and others for ongoing maintenance, and rehabilitation.

    - In FY 2016-17, 40 (3.4%) of JFS STAT clients had at least one ESU episode. NOTE: ESU episode/s could have occurred any time during the fiscal year; i.e., before, during or after the JFS STAT episode.
    - In FY 2016-17, 18 (45.0%) of the JFS STAT clients with at least one ESU episode also had at least one inpatient (IP) episode within the fiscal year. NOTE: IP episodes could include out-of-county FFS IP as well as Rady's CAPS. Aurora Behavioral Health or Sharp Mesa Vista hospital. NOTE: That the IP episode/s could have occurred at any time in relation to the JFS STAT episode and the ESU episode.

17. Where does "stabilization" occur?

    ESU stabilization services are offered at the new ESU site at 4309 Third Avenue, San Diego Ca 92103.

18. What percentage of "stabilizations" are not adequate?

    Data tracking hospitalization rates for youth at ESU who had been referred from a detention facility are not specifically tracked. Overall, ESU diverts approximately 75% of youth from psychiatric hospitalization by providing crisis stabilization services and ensuring access to appropriate follow-up.

19. How long does JFS/STAT team follow each youth with suicidal ideation?

    a. What determines the number of continued contacts?

       Youth who are on Suicide Watch are seen daily by a STAT-Team clinician with Sunday contact occurring via on-call status and face to face when indicated. Youth who were previously on Suicide Watch are seen as clinically indicated. Consideration is given to a youth's history, level of risk, and other factors.

20. Is there a TRU unit (Trauma Recovery/Rehabilitation Unit) at this facility?

    ☐ Yes ☐ No

    a. If no, when will a TRU unit be opened at this facility?

       The department of Probation manages the TRU unit.

F. Coordination of Care

1. Is BHS staff aware of the non-school programming available to youth in detention?

   ☒ Yes ☐ No

   Yes. The STAT-Team clinicians are aware of the non-school programming that is available to youth in the juvenile detention facilities. There are a variety of programs offered by community based agencies and volunteers to youth in detention.

2. Does BHS work with Probation to ensure that any such programming is appropriate for youth in detention, given the fact that many such youth have experienced trauma?

   ☒ Yes ☐ No

   Yes. The STAT-Team, in conjunction with Probation, have regularly scheduled Multi-Disciplinary Team meetings which identify the mental health needs of the youth in detention and are a conduit for making recommendations regarding what programming may be appropriate for a given youth. MDTs are now operational at all of the Juvenile Detention facilities.

   a. If no, who makes this determination? N/A

3. Does BHS ensure that program providers have appropriate training in the areas of trauma and cultural sensitivity? ☒ Yes ☐ No

   Yes. STAT-Team members receive routine training in trauma informed care and cultural sensitivity. Any program provider that is under contract with Behavioral Health Services (BHS) have training requirements in these areas that must be satisfied as part of their contractual agreement with BHS. Some examples of these trainings include: Gender Responsive Services for Men and Boys; Trauma Informed Care; Family Stress; Lesbian, Gay, Bi-sexual and Transgendered Communities; Various trainings regarding diversity in ethnic communities, such as African Americans, Latino's, the Pan Asian Communities, and Somali and Iraqi Refugee issues.

   a. If no, who does? N/A

4. Does BHS, or any other agency, evaluate the programming provided to make sure that such programming is appropriate, is available to all youth, and is the best use of the youth's time? ☒ Yes ☐ No

   Yes. BHS is available on a consultation basis and works collaboratively with the probation team. In addition to the STAT-Team, Probation has clinical expertise on their team

5. How often does BHS staff review Critical Incident Report's (CIRs) for each facility?

   CIRs are managed by the department of Probation. STAT Team and BHS are not involved in reviewing the CIR's that are internal to the department of Probation.

6. What is the format for this review and what actions are taken based on the information in CIR's? N/A

7. If a youth enters custody with a mental health history, how is this information shared with all departments including:

   a. BHS
   b. SDCOE
   c. Probation
   d. Onsite medical clinic staff
   e. Other

   During the intake process youth are screened by Probation, through the use of the MAYSI-2, and by CFMG. Any youth with a reported mental health history or current medications identified by Probation and/or CFMG are referred to the STAT-Team for triage, evaluation and continued care. The STAT Team utilizes an electronic health record (Cerner) where mental health history is captured for individuals served through the public behavioral health system through the County. The Multi-Disciplinary Teams are utilized for cross system information sharing to best serve minors

8. Is BHS staff familiar with Probation's policies and procedures regarding Administrative Separation and Room Confinement of mentally ill youth or youth with suicidal ideation? ☒ Yes ☐ No