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

A. Behavioral Health Staffing

The STAT Team is managed by two (2) Licensed Clinical Social Workers (LCSW) employed as Behavioral Health Program Managers. Primary staffing is as follows:

KMJDF
Number of staff: 16. There is one open position for a 30 hour psychologist.
Average staff hours per week at facility: 418

Staff assigned to KMJDF include:
- 1.5 FTE LCSW clinicians
- 2.25 FTE LMFT clinicians
- 4.5 FTE Licensed Psychologists (including vacant .75 FTE)
- 2.4 FTE Psychiatrists
- 1 FTE Psychiatric Nurse

EMJDF
Number of staff: 9. There are no open positions; one FT psychologist is on extended medical leave.
Average staff hours per week at facility: 235

Staff assigned to EMJDF includes:
- 2.5 FTE LMFT clinicians
- 1.5 FTE Licensed Psychologists
- .88 FTE Psychiatrist
- 1 FTE Psychiatric Nurse

GRF
Number of staff: 2. There are no open positions.
Average staff hours per week at facility: 50

Staff assigned to GRF includes:
- 1 FTE Licensed Psychologist
- .25 FTE Psychiatrist

Camp Barrett
Number of staff: 2. There are no open positions.
Average staff hours per week at facility: 70

Staff assigned to Camp Barret includes:
- 1.75 FTE Licensed Psychologists

The 5 Psychiatrists, working both full- and part-time, provide consultation, medication assessments and ongoing medication management services for KMJDF, EMJDF, Camp

Barrett and GRF. Tele-psychiatry is utilized to provide ongoing medication management to youth at Camp Barrett; initial medication evaluations are done face-to-face with Camp Barrett youth at East Mesa juvenile hall.

In addition to the licensed staff, there are 4 pre-doctoral interns providing services at the 4 juvenile detention facilities. The pre-doctoral interns each work an average of 40 hours per week. The services total 4 full-time equivalents (FTE). All are under the supervision of a STAT Team licensed psychologist.

B. Behavioral Health Statistics

In FY 14-15, the STAT-Team served a total of 1,391 unduplicated clients in the 5 detention facilities. Some of the youth transfer between facilities and obtain STAT services in multiple locations. In FY 14-15, the vast majority of STAT-Team clients (1,210) had one or more identified psychiatric diagnoses; the remaining (usually those who were seen very briefly) had not been formally diagnosed.

On 3/31/16, there were 133 youth prescribed psychotropic meds in all detention facilities; this was 31% of the total population of 424. Data by detention facility:

	Youth Prescribed Medication	**Total Population**	**Percentage**
KMJDF	36	147	24%
EMJDF	65	166	39%
Camp Barrett	20	86	23%
GRF	12	25	48%
Total	**133**	**424**	**31%**

An additional 32 youth were not prescribed medication but were receiving psychiatric oversight.

In FY 14-15, an average of 136 youth per month were prescribed psychotropic medications; this was, on average, 29% of the total population in the detention facilities per month.

In FY 14-15, a total of 713 unduplicated clients received a Medication Support service from the STAT-Team, which constitutes 51% of the total youth served in that time frame. A psychiatric encounter may or may not lead to psychotropic medications being administered during the youth's stay in the detention facility.

C. Behavioral Health Screening

1. Which MASI screening tool 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 the 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, and outpatient mental health services upon release from detention. For example, the Assertive Community Treatment (ACT) or Multi-systemic Therapy (MST) program may be utilized. The Probation Officer Case Manager receives the recommended referrals and works to coordinate care for the youth once discharged from the detention facilities.

3. Has the probation Department used the Columbia Suicide Severity Rating Scale (C-SSRS) instead of or in addition to the MAYSI?

   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 Re-admission 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?

   Intake workers use the J1005 Risk Screening Tool which asks: "Do you perceive yourself to be gay, lesbian, bisexual, transgender or gender nonconforming?"

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

      PREA programming includes anti-bullying/harassment information. We are all zero tolerance facilities for bullying and harassment of any kind as indicated by the various PREA Posters, orientation, pamphlet, assessment, weekly trainings, morning Sexual Harassment speech, etc…

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.

1. In 2015, individual and group therapeutic services/sessions were:

KMJDF

Type of Therapy	Average per month
Individual	343
Group	9

EMJDF

Type of Therapy	Average per month
Individual	231
Group	0

GRF

Type of Therapy	Average per month
Individual	80
Group	4

Camp Barrett

Type of Therapy	Average per month
Individual	102
Group	15

2. What are the procedures 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 CFMG asking to be seen by a mental health staff. This would be anonymous. 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, religious, 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.

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

   Yes. Please see response to D2 above.

E. Behavioral Health Emergency Referral Process

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

   See attached STAT-Team Suicide Watch Policy and Procedure.

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

      Behavioral Health Services, Probation Department, California Forensic Medical Group

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

   Suicide Prevention training includes an initial 8-hour class for new hires, and a 2-hour refresher class on a bi-annual basis.

   a. What topics are covered in this training**?**

      The suicide prevention course informs staff of the warning signs and symptoms, identification and management of suicidal youth, and components of the facility's formal suicide prevention policy.

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

4. Number of referrals of minors 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 2015 indicates there were 204 referrals for new instances of Suicide Watch; there are often several Suicide Watch referrals for one youth and one episode of suicidality, therefore 204 is not the total number of youth with a Suicide Watch referral.
   Data on Suicide Watch referrals at EMJDF for calendar year 2015 indicates there were 32 youth placed on Suicide Watch; similar to KMJDF, there are often several Suicide Watch referrals for one youth and one episode of suicidality, therefore 32 is not the total number youth with a Suicide Watch referral.

   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 (and previously JRF) 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, data is reflected in EMJDF data listed above.

5. On average, how long before a JFS/STAT member calls the institution to respond to suicidal ideation?

   When probation staff or other staff member identifies a youth who has or may have suicidal ideation, the youth is 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 evaluate youth on Suicide Watch.

6. What percentage of those calls result in JFS/STAT 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 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.

   Urgent Behavioral Health Care:
   Child will be 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

   b. If no, why not?

      The San Diego County Probation Department views the risk of suicide on a continuum. Each youth is different as well as their risk of suicide. Some youth with suicide ideation may require placement in a safety room, and others may not. The decision to place a youth in a safety room is on a case-by-case basis

10. Have tear-away bed sheets been installed in “suicide watch” rooms?

    San Diego County Juvenile Detention Facilities do not use tear away sheets. If a youth is on Suicide Watch (Prevention) status, they would only be provided a Suicide Prevention gown and blanket(s). They would not receive sheets of any kind for their safety

11. What happens if a youth does not meet the criteria to be seen in person?
    With regards to suicide watch, all youth are seen in person.

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

    When a youth is prescribed a psychotropic medication by a STAT-Team psychiatrist, the prescribing physician determines, based on the specific medication and other factors, how soon s/he will schedule a follow up visit. Follow up visits are typically between one and four weeks.

13. On average, how long before a psychiatrist reviews the medication impact?
    Please see response to #12.

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

    Please see response to #16.

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

    Please see response to #16.

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

    All youth transported to ESU receive crisis intervention and 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 2014-15, 45 (3.2%) 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 2014-15, 22 (48.9%) 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: 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?

    Please see response to #16.

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

    Please see response to #16.

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

    When a youth is on suicide watch they are seen daily by the STAT-Team clinician (excluding Sundays when a psychiatrist is available via on call status). Follow ups with youth who are no longer on suicide watch is individualized and contingent on overall clinical presentation and needs of the youth.

a. What determines the number of continued contacts?

Youth who are on Suicide Watch are seen daily by a STAT-Team clinician (except on Sundays when a psychiatrist is available via on call status). 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?

The Probation Department opened a TRU Unit at the Kearny Mesa Detention Facility on February 1st of 2016.

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

N/A

E. Coordination of Care

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

Yes. 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. 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.

i. If not, 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. 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 not, 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. 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 BH staff review CIR's for each facility?

   STAT-Team and BHS are not involved in reviewing CIR's that are internal to the Probation Department or any other provider at the Juvenile facilities.

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 minor 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 (Anasazi) 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.