“Costs of Incarcerating Youth with Mental Illness”
Final Report

Prepared for the
Chief Probation Officers of California
and the
California Mental Health Directors Association

By

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Costs of Incarcerating Youth with Mental Illness

Executive Summary

The "Costs of Incarcerating Youth with Mental Illness" project was conducted for the primary purpose of informing public policy development by analyzing the costs and contexts related to incarcerating youth with mental illness and co-occurring mental illness/substance use disorders in California detention facilities. This study was one of the products of ongoing collaboration between the Chief Probation Officers of California (CPOC) and the California Mental Health Directors Association (CMHDA). Information obtained from this study will serve to advocate for better services in order to prevent the inappropriate criminalization of youth who would be better served in mental health treatment settings, to improve services to youth who must be separated from the community, and to ensure continuity of mental health care upon re-entry of such youth to their communities.

BACKGROUND

It is estimated that between 50-75% of youth in juvenile detention facilities have diagnosable mental disorders[1,2]**.** Given the disproportionate use of juvenile detention facilities for youth of color [3] one explanation may be that the juvenile justice system has become a *de facto* mental health system for poor and minority youth who are unable to access care through the formal mental health system. Yet detention facilities are unable to provide adequate mental health treatment[4] and this has led to extended lengths of stay in these facilities for these youth[5]. There are no studies in California or elsewhere that include other costs beyond those of basic facility rates, such as mental health services, special staffing, education, legal expenses, and health care expenses. Including such costs and relevant contextual information, particularly about placement delay [6], is necessary in order to understand the full extent of the problem as well as the potential solutions.

METHODS

18 county probation departments were surveyed in 2007 about the contexts and associated costs of services for detained youth with mental disorders. Researchers also conducted site visits with probation and other agency staff in a subsample of fourteen counties. The county sample represented the state's diversity of populations, geography and county size. Table 1 shows the surveyed counties and site visits.

Table 1. Survey and Site Visit Sample

County Surveyed	Site Visit Occurred
Alameda	X
Butte	X
Contra Costa	X
Del Norte	
Fresno	
Glenn	X
Humboldt	X
Imperial	
Los Angeles	X
Merced	X

County Surveyed	Site Visit Occurred
Nevada	X
Orange	X
Placer	
San Bernardino	X
San Francisco	X
Santa Cruz	X
Solano	X
Stanislaus	X

The 215 item survey instrument, developed in collaboration with a multi-disciplinary expert Advisory Panel, was divided into eight sections: 1) basic facility costs, 2) characteristics of detained youth, 3) services and costs for mental health treatment, 4) substance abuse services and costs, 5) services and costs of general health care, 6) costs of educational services, 7) legal and court-related expenses, and 8) other costs. The survey instrument was emailed to the Chief Probation Officers in the sampled counties. The Officers were encouraged to use existing administrative data and to have sections of the instrument completed by mental health managers, data experts, healthcare vendors, County Office of Education, and staff from other agencies.

FINDINGS

Characteristics of youth served

Respondents estimated that at least 50% of youth in detention have a suspected or diagnosed mental disorder, though ambiguity exists about which youth actually need mental health services due to varying criteria. Youth with behavioral disorders are very common in the detained population and especially problematic for detention staff. There is recognition that a majority of youth require some mental health-related intervention along a continuum of need, ranging from those youth who have serious and disabling symptoms to those who are experiencing temporary adjustment problems or post-traumatic response as a result of life circumstances prior to confinement or as a result of the confinement experience itself. Also difficult though less common are youth with psychotic symptoms. Delays in placement continue to occur for certain youth whose behavioral or symptom profiles make it difficult to find suitable treatment settings. While most county data systems were unable to report accurate length of stay for these youth pre- and post-disposition, estimates from respondents indicated that post-disposition lengths of stay due to placement delays can average as much as 18 days longer for these youth than for those without mental disorders. Placement delays result from a lack of an appropriate continuum of care, ranging from community-based outpatient and transitional programs, to secure hospital and residential placement alternatives. Pre-disposition lengths of stay due to court-ordered evaluations are estimated at an additional 17 days more for these youth. At the current average daily facility rate of $206 reported in the survey, youth with these problems can cost up to $7,210 *more* per youth in facility rates alone (not counting other types of costs), compared to other youth in detention. During site visits case examples were given of youth staying well beyond this average—some as long as 1-2 years—extreme and costly stays for youth with especially severe symptoms of suicidality or psychoses. These youth require staffing resources that take away from the normal facility routines, disrupting daily programming and jeopardizing the overall safety of the facility. Case examples also illustrated the deleterious institutional effects on these youths' functioning by housing them in facilities not originally designed as treatment settings.

Mental health and substance abuse services
All 18 counties provide mental health screening to youth coming into detention. Many but not all facilities administer formal screening instruments such as the Massachusetts Youth Screening Instrument (MAYSI-2). Several respondents reported categorizing mental health need with a level system so as monitor risk potential and to allocate appropriate resources. Five counties (Alameda, Contra Costa, Orange, Stanislaus and Los Angeles) have dedicated mental health units with higher mental health or facility staff ratios in which youth with suspected or obvious mental health issues are housed. Psychoactive medications and medication monitoring visits are provided in all 18 counties, however the availability of on-site psychiatrists varies (only the medium and larger counties provide staff MDs; smaller counties rely on on-call doctors and telemedicine). Individual psychotherapy and crisis intervention are provided in all but two. Over half the counties provide group and family therapy and case management. Many counties use county behavioral health staff to provide services, however 11 rely on contracts with outside providers. The extent of coordination varied—both large and small counties reported differing philosophies with county mental health agencies, and some reported serious barriers to referral and triage as a result. One small county reported no involvement of county mental health, relying instead on the forensic health care vendor to provide limited psychiatric nursing and MD coverage.

There is limited or no availability of individual level mental health service information in probation data systems, and many counties cannot account for service use through their mental health data systems for these youth.

The annual cost of psychiatric medications was reported by Los Angeles to be $1,927,000. The other fourteen counties who answered this question reported a combined total of $597,000, averaging $42,586 per county. A major problem for all counties is continuity of care for both medication prescriptions and outpatient follow up after release.

Three counties (Orange, Stanislaus, and Fresno) reported providing separate substance abuse treatment units at their facilities. These units include among other services an “inpatient” treatment program with individual and group counseling, gender-specific services, case management, and in one county, a drug court program. Twelve of the 18 counties provide individual and/or group treatment and on-site AA or other community voluntary support groups. All but two counties provide some formal education program focused on substance abuse prevention and treatment. Despite the size of its three juvenile detention facilities, Los Angeles reported providing substance abuse-related programming to 100% of detained youth.

Healthcare, education and staff resources
A majority of counties (11 out of 18) contract with a private vendor to provide healthcare services to their juvenile detention facilities. Los Angeles County reported an annual cost of over $18,000,000 to its healthcare vendor and for the other seven counties that reported their annual vendor rates, the average annual cost was over $1,395,000. While many respondents view the healthcare status of youth with mental disorders as generally worse than others, costs for healthcare cannot be disaggregated for those youth. Educational services, provided in all facilities, include on-site classrooms, teaching staff from the county board of education or local

school district, and special education services. Per youth, per day costs of education range from $25 to $150 among the surveyed counties. Facility probation staff and counselors spend considerable time assisting in classroom management. Staff resources also include those needed to accompany youth outside the facility for hearings and appointments, and for closer monitoring of youth whose mental status has deteriorated or risk of danger has escalated. Transportation to psychiatric appointments or the emergency room is a daily occurrence in many counties. For many counties transportation time alone can take four hours, in addition to extra time for staff waiting at the hospital and monitoring high-risk youth. Counties with special mental health units can house youth there who need extra monitoring. For other counties, extra staff are required to monitor these youth. Respondents reported that these staff are required for an average of 18 days per 1:1 "episode." A few counties would instead make plans to transfer these youth to a hospital, if feasible. Staffing detention facilities has become challenging in general. Staff require specialized training and adequate resources. 12 counties reported significant injuries, traumatic reactions, and lost work time in the past year as a result of working with these youth.

The costs of incarcerating youth with mental illness

With the cost data obtained in this study[1], a youth with mental illness can cost at least $18,800 more than other youth, taking into account reported estimates of the average differences in length of stay from other youth. This estimate assumes the average reported facility rate, and provision of basic mental health services reported in the survey: once per week medication monitoring, twice per week individual psychotherapy, once weekly group therapy, substance abuse treatment, and substance abuse education groups. This cost also assumes outside trips to the hospital, court or appointments, daily costs of the education program, one 72-hour stay at a psychiatric hospital and 24 hours of extra staffing for crisis monitoring. This estimate can vary a great deal by county and youth based on differences in facility and program rates, the actual length of stay, the availability of more intensive mental health staffing, and the unique needs of the individual youth. Estimating the costs for youth with more extreme problems would require an individualized accounting of actual services and staff effort.

In addition, medications are a large expense. Using monthly report data collected by the California Department of Corrections and Rehabilitation (CDCR) on the number of youth receiving psychotropic medications and the annual cost of medications from our survey, for each stay the total cost of psychotropic medications averages $4,387 per youth.

Implications and Recommendations

The need for mental health services to youth in California's detention facilities has been steadily increasing.[7] The additional costs for housing these youth imply two important issues for policy makers and planners. First, even without specialized mental health services these youth would cost significantly more than other detained youth due to placement delays. Second, although they increase the short term cost of the stay, the provision of appropriate ongoing mental health services in detention facilities has the potential for improving the emotional and social functioning of these youth (thereby increasing their chances of more timely release) and reducing the burden on facility staff. However, placement delays are most affected by the lack of a continuum of care in prevention, outpatient, community-based and residential settings. In addition to improving services in facilities, improving those provided in the community and

[1] A detailed description of the methodologies used in estimating these costs can be found in the full Final Report.

reestablishing a residential continuum of care would directly reduce the inappropriate detention of youth who can be better served elsewhere.

We will summarize the priority recommendations that were emphasized in the surveys and site visits. These recommendations are categorized as

1. Services provided in detention facilities
2. Services provided in the community
3. Efforts to improve coordination among agencies
4. An adequate residential continuum of care to provide appropriate placement alternatives
5. Policy issues

1. Services provided in detention facilities

- Clarify criteria statewide for the use of mental health and substance abuse services so as to improve the quality of care and equity of the distribution of services among juvenile detainees. The development of formal levels of need would help facilities accurately match need with relevant services and allocate resources accordingly.
- Provide uniform standards of care for various types of mental illness diagnoses, responses to trauma, and the full continuum of emotional need of juvenile detainees. Include up-to-date medication practices based on the most available evidence. This would also include required adjustments to state-mandated staffing ratios to respond to these youth.
- Develop and provide training to facility staff to improve conditions in facilities by increasing staff understanding of emotional disorders and reactions in youth, maximizing consistent communication among staff and providers, and maximizing the rehabilitative opportunities of these facilities to improve social functioning and prevent subsequent recidivism.
- Host a forum with representatives from juvenile probation, mental health, child welfare, Regional Centers, and community-based organizations to highlight promising and evidence-based practices as well as innovations to address sub-populations (such as services to female offenders, gang interventions), the use of Therapeutic Behavioral Services (TBS) in this context, and others.

2. Services provided in the community

- Promulgate models for the assessment of gaps in community services and their impact on youth at risk for involvement in the criminal justice system.
- Take advantage of the opportunities afforded by the Mental Health Services Act to improve community services and supports, as well as early prevention services for at-risk youth, including those who may currently be detained.
- Develop more transitional services (such as those being piloted by MIOCR grants, The California Endowment's *Healthy Returns Initiative*, and in some counties' MHSA programs), so that youth leaving detention facilities and their families are provided coordinated and integrated services by community probation, formal agency services, and informal supports. Relevant housing alternatives and supports for educational attainment and vocational preparation should be included for those older adolescents about to "age out" of the juvenile justice system.

- Host forums to highlight county exemplars in the implementation and testing of community-based supports and preventive services for these youth.

3. Efforts to improve coordination among agencies

- Host formal regional or county convenings with representatives from probation, facilities, mental health, education and substance abuse services in order to highlight exemplars and lessons learned by counties attempting to bridge the gaps in agency cooperation, information sharing, policy planning, and coordinated care.
- Through state policy, encourage or require evidence of county agency coordination for these youth through regular forums such as interagency case review meetings and placement committees.
- Provide information and technical assistance to judges and court personnel to improve the coordination between the courts, agencies and facilities.

4. An adequate residential continuum of care to provide appropriate placement alternatives.

- Convene statewide and regional planning efforts to inventory gaps in residential and hospital alternatives, and develop recommendations for specific statewide, regional and local county alternatives. Include representatives from child welfare, mental health, juvenile probation, Regional Centers and psychiatric hospitals.
- Make available more alternatives for the following residential care alternatives covering the continuum of need:
    a) Psychiatric hospitals (or emergency assessment alternatives for rural counties) with the capacity to provide adequate and comprehensive psychiatric evaluations and crisis response for youth in detention facilities
    b) Short term crisis group homes to prevent inappropriate detentions or to provide "step-down" temporary placement for juveniles released from detention who meet criteria for this brief level of care
    c) Foster care homes and treatment foster care alternatives specifically geared towards youth involved in the juvenile justice system
    d) Mid-level or intermediate residential alternatives such as unlocked residential treatment facilities and locked therapeutic placements, and short term psychiatric hospitals for assessment and treatment. These could be regional placement facilities, either expanding the capacity of the current Community Treatment Facilities (CTFs) or developing other models. Evaluate the current capacity of CTFs and advocate for expansion or alternative placement options.
    e) Higher level alternatives for youth with extreme mental health needs who would otherwise remain detained for several months or years. These include regionally-based locked psychiatric hospitals that would not exclude admission for youth with developmental disabilities, violent behavior, and/or a history of fire setting behavior in addition to diagnosed mental disorders. Expand special treatment programs for youth sexual offenders.

2. Policy Issues

- Convene workgroups to continue efforts to influence "inmate exception" policies excluding services to pre-adjudicated youth for Medicaid reimbursement.

- Provide training and technical assistance to county probation departments and mental health agencies to ease the administrative burden of Medi-Cal billing for services to post-adjudicated youth. Take an inventory of counties whose youth experience breaks in Medi-Cal eligibility as a result of being detained, and initiate administrative policies and procedures to ensure uninterrupted Medi-Cal eligibility upon release from detention.
- Develop funding guidelines and highlight innovative funding strategies to sustain mental health and substance services to detained youth
- Monitor the impact of DJJ Realignment and its effect on local detention facilities

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Chief Probation Officers of California and California Mental Health Directors Association "Costs of Incarcerating Youth with Mental Illness" – Final Report

I. Introduction and Acknowledgements

A. Purpose of study

The "Costs of Incarceration for Youth with Mental Illness" project was conducted for the primary purpose of informing public policy development by analyzing the costs and contexts related to incarcerating youth with mental illness and co-occurring mental illness/substance use disorders in California detention facilities. This study was one of the products of ongoing collaboration between the Chief Probation Officers of California (CPOC) and the California Mental Health Directors Association (CMHDA). Information obtained from this study will serve to advocate for better services in order to prevent the inappropriate criminalization of youth who would be better served in mental health treatment settings, to improve services to youth who must be separated from the community, and to ensure continuity of mental health care upon re-entry of such youth to their communities.

The study began in 2005, and data collection continued until late 2007. This report summarizes data from surveys of eighteen counties and in-depth interviews during site visits to ten counties. Because of the variety of types of information we received, our recommendations range from the areas of services to these youth, policy issues, training, placement alternatives, strategies for interagency collaboration, and further research.

B. Collaborating organizations

This study was first conceptualized by the Multi-Association Joint Committee (MAJC) of CMHDA in response to a multitude of concerns raised by members of, CPOC, CMHDA and United Advocates for Children and Families (UACF), which includes parents of youth with mental illness who are incarcerated. The primary concerns related to appropriateness of services and the costs of such services. The "Waxman Report (U.S. House of Representatives Committee on Government Reform, 2005) findings further fueled the planning efforts. Once the study was underway, we benefited from the expertise of the Youth Law Center, whose attorneys shared with us information from their own work in the area of youth in detention with mental illness. Preliminary results were shared with a convening of the state's Chief Probation Officers, who offered very thoughtful comments and potential action items based on the findings.

C. Advisory Group

An Advisory Group was convened very early in the study. The Group consisted of experts in the major areas of interface with these youth: representatives from county mental health, parents, education, the courts, healthcare services, probation, facility management, and the study's funders. A complete list of the Advisory Group is appended as Attachment 1. The Advisory Group was convened for three meetings (one in-person and two telephone conferences) to

provide input into the study design and, later, to comment on the preliminary results. We appreciate their expertise and valuable assistance in this project.

D. Funders

This study was funded through joint grants and contracts to CPOC from The California Endowment and the Zellerbach Family Foundation. We wish to thank these organizations for their support of this project and their ongoing dedication to improving the lives of these youth.

We also wish to express our appreciation to the staff of all the county agencies and others who donated their valuable time to respond to the survey and the facility staff who hosted the site visits.

II. Background and Context

Anthony F. is a 16 year old African American male who has been housed in the juvenile detention facility for 10 months. He has been diagnosed at various times with bipolar disorder, schizoaffective disorder, and intermittent explosive disorder. He currently receives two psychoactive medications, one for mood stabilization and one anti-psychotic. Anthony has had multiple detentions in the past three years. His first offense was assaulting a teacher and another student at school when he became agitated after being harassed by students. After release from his first detention, Anthony refused appointments with his probation officer (despite the family's efforts to transport him), and he has not consistently been cooperative with follow up appointments with his county behavioral health psychiatrist and psychotherapist. Before his most recent detention, his family had been attempting to find a residential treatment alternative through the school district when he was re-arrested for property damage to a store and assaulting officers at the scene. He was hospitalized for one week, stabilized on medications, and returned to juvenile hall. Efforts to find a residential treatment placement as ordered by the court five months ago have been unsuccessful to date. His history of assaultive behavior and the difficulty in identifying a consistently effective medication regime have created barriers for his acceptance into unlocked residential programs. In addition, due to his stay in detention his functioning has been steadily deteriorating, to the point of increased self injurious behavior and suicidal thoughts. In addition to weekly visits by the staff psychiatrist and from a county behavioral health clinician, he now requires one to one nursing supervision at all times, including his time in his room. Whereas in the early stage of his detention Anthony was argumentative and uncooperative with efforts to find placement alternatives, he has more recently become despondent, expressing feelings of hopelessness that he will never be released.

This scenario based on a site visit to one of this project's participating counties illustrates the complexity and depth of an increasingly difficult problem—the incarceration of youth who have suspected or diagnosed mental disorders. While Anthony's extreme situation is not typical of the population of youth in juvenile detention, some version of this scenario was reported by nearly every county that participated in this project. When youth with emotional or psychiatric problems are detained, and when the community cannot adequately meet their needs there is a profoundly negative impact on their progress. There is also a high impact on facilities in terms of financial and human costs. This report is an attempt to document these costs.

Mental disorders and co-occurring mental and substance abuse disorders are more prevalent among detained juveniles than among youth in the general population. It is estimated that between 50-75% of youth in juvenile detention and correctional facilities have diagnosable mental disorders (Shufelt & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002)**.** For these youth, the co-occurrence of mental and substance use disorders has been measured as high as 61% (Shufelt & Cocozza, 2006) . Given the disproportionate use of juvenile detention facilities for youth of color (National Council on Crime and Delinquency, 2007) one explanation is that the juvenile justice system has become a *de facto* mental health system for poor and minority youth who are unable to access care through the formal mental health system.

Moreover, the inability of detention facilities to provide adequate mental health treatment (California Dept. of Corrections and Rehabilitation, 2005b) has led to extended lengths of stay in these facilities (U.S. House of Representatives Committee on Government Reform, 2004). In a 2003 survey of California county juvenile facilities, administrators reported that two-thirds of facilities hold youth waiting for mental health services due to the lack of appropriate residential treatment and community resources (U.S. House of Representatives Committee on Government Reform, 2005). During this survey, in a six-month period as many as 800 California juveniles, many without formal charges against them, waited for mental health services. Because of extended detention stays these youth are at higher risk for suicide attempts, danger to others, or serious decreases in their ability to function in the community. A combination of factors, including inadequate "front door" screening, lack of staff training, an over-reliance on isolation to control these youths' behavior, inadequacies of specialized mental health services, poor communication between probation and providers, and gaps in community services and placement alternatives deleteriously affect length of stay for these youth (Burrell & Bussiere, 2005). Detention facilities cannot say "no" when youth are brought in due to placement failures, behavioral problems, or more serious crimes yet most people would say that many of these youth could potentially be served in community settings if they were available.

"Mental disorders and co-occurring mental and substance abuse disorders are more prevalent among detained juveniles than among youth in the general population."

One attempt to quantify the cost of this problem was described in a report sponsored by U.S. Rep. Henry A. Waxman (U.S. House of Representatives Committee on Government Reform, 2005). It was estimated that at an average $116 per day per youth, it costs $10 million each year in California to house youth waiting for community mental health services. The California report and its multi-state counterpart may underestimate the extent of the problem—one quarter of facilities surveyed nationally did not respond, some of the quantitative data were unusable, and some respondents may have minimized their response fearing that negative responses would reflect poorly on their facilities (U.S. House of Representatives Committee on Government Reform, 2004).

There are no studies in California or elsewhere that include other costs beyond those of basic facility rates, such as mental health services, special staffing, education, legal expenses, and health care expenses. Including such costs, particularly those involved with placement delay (Burrell & Bussiere, 2005), is necessary in order to understand the full extent of the problem as well as the potential solutions. Valuing the array of costs is also a first step towards conducting cost-benefit analyses to support decisions to implement prevention and intervention programs (Hargreaves, Shumway, Hu, & Cuffel, 1998; Zhang, Roberts, & Callanan, 2006; Barnoski, 2004). In addition, there is a need for more contextual information about the experiences of these youth and the staff who care for them.

In preparation for this survey, we analyzed data submitted by county juvenile detention facilities to the state's Department of Corrections and Rehabilitation (CDCR). Counties are required to submit data on their detention facilities' average daily population census (ADP) and other population characteristics. In addition, counties also report a snapshot total of "open mental

health cases" during each month of the quarterly reporting period and the number of detainees on psychotropic medications.

In 2006, the most complete year of data available as of this report, the monthly ADP in California was 235, with a range from 14 to 1,913 (the latter being the ADP of Los Angeles County). For purposes of reporting, an "open mental health case" is defined as "an actual open chart or file with the mental health provider when a juvenile is in need of, or receiving, documented mental health care or services" (California Dept. of Corrections and Rehabilitation, 2005a). How actual open mental health cases are defined and counted varies widely among counties, as explained in the findings below. In the 2006 data, two counties did not report open mental health case data. The data from three other counties showed that for at least one month the number of open mental health cases *exceeded* the ADP of the counties' detention facilities, indicating that the counts may have also included juveniles placed in camps or other placement alternatives in addition to juveniles in detention facilities resulting in an inability to disaggregate youth solely in detention. Excluding these five counties (Del Norte, Fresno, Orange, San Francisco and Solano), the "snapshot" average monthly percentage of open mental health cases relative to the average monthly juvenile hall ADP in 2006 was 29%. The average monthly percentage of juvenile hall detainees receiving psychotropic medications was 12.5%. These rates must be interpreted with caution since, in addition to the validity problems caused by varied definitions of open mental health cases there may have been other counties combining data from detention and placement facilities. Nevertheless, a review of CDCR data over the past few years shows that there is a growing need for mental health services to these youth. There has been a gradual increase of the number of youth with open mental health cases since 2003 and an increase of youth on psychotropic medications since 2002 (California Dept. of Corrections and Rehabilitation, 2005a).

Given the growing need, how are detention facilities managing these youth and what differentiates these youth from others in detention? What are the monetary, organizational and human costs involved with managing these youth? From what we learned, what are the implications for practice, policy, training, and further analysis?

III. Study Methods

A. Target Population, Sampling Plan, and Response

The cost survey was designed to address juvenile detention facilities. Placement facilities such as camps, ranches or residential treatment programs were excluded from the study to the extent possible. (Some county facilities include both placement and detention populations, however data were requested that pertain to the detention population only.) We targeted the county's Chief Probation Officer as the primary contact and respondent. The Chiefs were encouraged to distribute sections of the survey to other agency representatives and facility staff to provide data.

The survey items mainly referred to youth who have a mental illness or co-occurring mental and substance use disorders. We defined "having a mental illness" broadly to include any youth with emerging or active mental or emotional disorders or behavioral signs of disorders that seem to require the assessment and/or intervention of mental health specialists. This would include youth who, to the knowledge of probation staff, are at risk for danger to themselves, danger to others due to a suspected emotional disorder, or who show evidence of a lack of capacity to care for themselves due to a severe emotional disorder. Our population of interest also included any youth who have already been diagnosed with a mental disorder and under the care of mental health specialists prior to detention, as well as youth with co-occurring mental health and substance abuse disorders (either already diagnosed or suspected substance use disorder). In other words, any youth with "open mental health cases" (see section II, Background and Context) would qualify in addition to the youth described above.

County survey sites were chosen in consultation with the Advisory Group. Criteria for inclusion were:

1. Los Angeles County is a "must have" due to the county's size
2. Counties must represent the CPOC regions (Northern, Bay Area, Sacramento, Southern, and Central)
3. Both rural and urban areas should be represented
4. Counties should represent those with and without private healthcare management vendors
5. The sample should include some counties with special juvenile detention mental health programs

In addition, we also included some of the counties surveyed by the Youth Law Center in their 2004-2005 survey of California facilities regarding placement delays for youth with mental illness (Youth Law Center, 2007, March/April).

The final sample of participating counties is shown in Attachment 2. We conducted site visits in fourteen counties.

B. Survey Measures and Pilot Testing

This instrument was developed at an in-person meeting with the Advisory Group and later revised with feedback from the Group. The instrument is divided into eight sections: 1) basic facility costs, 2) characteristics of detained youth, 3) services and costs for mental health treatment, 4) substance abuse services and costs, 5) services and costs of general health care, 6) costs of educational services, 7) legal and court-related expenses, and 8) other costs. These domains were considered by the Advisory Group to be critical areas of interface for youth in detention facilities, and thus important areas of costs. Survey items include those with dichotomous response ("Yes" or "No"), Likert scales, multiple response items, and narrative text. A draft survey was piloted by Stanislaus County. This resulted in several changes to the wording of questions and clarification of definitions. The final survey instrument containing 215 items is included as Attachment 5.

C. Procedures

1. Survey instructions

The instrument was designed to be self-administered by Chief Probation Officers and other agency representatives. Instructions for completing the instrument were provided as follows:

> "Due to the lack of consistent administrative data on costs and the involvement of multiple agencies in the care of detained youth, we have developed a survey instrument to obtain information from key informants. In the absence of readily available data, information should be estimated as best as possible. Feel free to make notes explaining your answers as needed. We encourage you to obtain information from others such as mental health managers, data experts, healthcare vendors, County Office of Education, and staff from other agencies. If this is the case in your county, please indicate who assisted in completing the survey in the Identifying Information section. Multiple copies of this instrument can be distributed as needed."

Items in the instrument contain other specific instructions for completion.

2. Survey distribution and support

The instrument was sent via email to the Chief Probation Officer in each of the targeted counties. The Chiefs were instructed to make contact with other agency representatives to provide information or complete their respective sections of the instrument, such as the county board of education or juvenile hall educational services coordinators, representatives from county mental health, healthcare vendors, etc. Assistance in making these linkages was offered by the study staff, as needed. The names and contact information of those supplementing the Officer's data were to be included in the survey instrument. The instrument was also made available for downloading at the CPOC website, to be completed either electronically via email or printed and completed in writing.

While every effort was made to write questions as clearly as possible, there were inevitable differences of interpretation or questions about how to answer some of the items. Technical assistance via email and phone was available by project staff to all respondents as needed. Respondents were instructed to return completed surveys within one month after receipt. Research staff tracked receipt and followed up with late responders.

3. Survey data management and analysis

Data were entered by research staff into SPSS statistical software for analysis. Analysis consisted of descriptive statistics (primarily frequencies of response) and summaries of narrative responses to questions. Notes from the site visits were reviewed and integrated into the report of the survey results. Counties were informed that they would be identified in reports as participating in the project, but for the most part the data would be aggregated for reporting averages, trends, overall costs etc. Findings from Los Angeles County were often reported separately due to the county's size since the data would skew that of other counties when aggregated. Some references to specific counties were given to highlight exemplar programs or unique issues. Names of specific people completing the survey would not be reported. Respondents were given an opportunity to review a final draft report for errors or inaccuracies. Preliminary findings were also presented to a convening of Chief Probation Officers, the Governing Board of the California Mental Health Directors' Association, and to the Advisory Group in a telephone conference call.

IV. Results—Surveys and Site Visits

In this section we will summarize the results of the 18 county surveys and also report on information learned in the site visits under each topic area.

A. Basic Facility Costs

We asked counties about facility rates to replicate the same information obtained by the Waxman study (U.S. House of Representatives Committee on Government Reform, 2005). The average basic facility daily rate reported by 17 counties in our study was $206, with a range from $90 per day to $356 per day. Compared to the Waxman study that reported a daily facility rate average of $116 reported by 48 California counties, the facility rate has almost doubled since 2005, thus increasing the overall costs for youth who experience placement delays. We also asked counties if this daily rate includes mental health and substance abuse (MH/SA) costs, and five counties reported rates that did include these costs. Facilities that included these costs reported an average *per diem* of $238 vs. an average *per diem* of $193 for those counties that do not include MH/SA costs, a difference of $45 per day.[2] For at least some counties, these rates do not include "overhead" or other indirect costs, as reported to us in site visits.

"Compared to the Waxman study that reported a daily facility rate average of $116 reported by 48 California counties, the facility rate has almost doubled since 2005, thus increasing the overall costs for youth who experience placement delays."

Five counties (Alameda, Contra Costa, Los Angeles, Orange, and Stanislaus) reported having separate mental health detention units. These units typically have a higher staff to youth ratio and mental health clinicians on site. Only Alameda reported having additional costs over and above the facility rate quoted in question 1, covering the 6.5 FTEs of augmented mental health staff in the unit. Alameda County designated two pods for special mental health units. Los Angeles designated a "Care Unit" at its Central facility, which houses 20 youth sent from all three detention facilities in the county. The Care Unit has enhanced staffing exceeding the state minimum ratio. In addition the unit has two mental health specialists. Los Angeles County also reported averaging 50 youth per day in each of its three facilities who meet "level three" criteria, i.e. those youth who display self harm, harm to others, or severe risk of harm but who would not meet the criteria for psychiatric hospitalization. Stanislaus County has a "Special Needs Unit" housing 40 youth that also exceeds the state minimum staffing ratio with mental health staff stationed on the unit. In those facilities we visited with higher staff to youth ratios, respondents commented that the state mandated ratios are insufficient to adequately handle youth with mental illness.

B. Characteristics of Detained Youth

Prevalence of Mental Disorders

Since the survey also focused on the contexts of facilities' experience with these youth, we wanted to know more about the perceptions of agency staff about these youths' characteristics

[2] The difference between means was not statistically significant.

and the impact of these youths on facility operations. Respondents (N=18) reported that more than 50% of their detained populations are estimated to be those suspected or diagnosed with a mental disorder. Most counties were unable to access data to report this: ten estimated from memory or obtained staff input, five retrieved data from their probation or mental health data systems, and three reviewed case records. (There were only minor differences in their respective responses, with the case record reviews yielding the lowest estimate of 36%, and the memory estimates yielding the highest of 55%.)

"...the state mandated ratios are insufficient to adequately handle youth with mental illness."

This survey question did not refer to the standard reporting requirement "open mental health cases" but instead asked respondents for their estimates.[3] During the site visits questions arose about how "youth with mental disorders" are defined and identified. For many of the site visit counties, these youth are identified at screening upon intake. Screening procedures range from the assessment of basic mental status and safety risk, to the use of more elaborate instruments such as the Massachusetts Youth Screening Instrument (MAYSI-2). A number of counties expressed the desire to develop improved assessment tools and processes in order to better match youth with needed services as well as predict potential risk issues.

In one county "open mental health cases" are defined as those youth taking psychotropic medications (and the data reported to CDCR for those two indicators are the same). One rural county defines it as anyone who either takes psychotropic medications or is currently involved in the county's mental health system of care. For some counties in which county mental health staff directly treat detained juveniles, a treatment episode record is opened in the county mental health information system when mental health staff become involved beyond the initial assessment and this is counted as an open mental health case, however this is not done uniformly in all counties. In one large county a new mental health episode is opened if the youth needs treatment beyond the initial assessment. In some counties mental health encounters are logged in the facility or probation information system. In many counties, it is difficult if not impossible to break down lengths of stay or other detention-related data for youth designated as "open mental health cases." The result is that there are county to county differences between how "open mental health cases," and how any youth receiving treatment are counted.

Discrepancies about how "open mental health cases" are counted may be due at least partly to ambiguity about which youth need mental health services. Responses from the site visits indicated that some staff view behavioral problems as a normal response to adolescence and not "diagnosable." Others suggested that behavioral problems are often indicative of underlying diagnosable disorders. Most respondents would agree that there is a continuum of emotional problems. At one end are youth who would not be considered to have a serious mental disorder but have had recent adjustment problems and/or traumatic events in their lives. Some would include the detention process itself as one of these traumatic events. At the other end of the continuum are youth with serious mental disorders (such as longstanding depression, anxiety disorders or psychoses) whose symptoms and functioning may at least partly explain their criminal behavior and whose functioning could be further jeopardized by the confinement. Youth

[3] Refer to the Background and Context section for an analysis of 2006 data on "open mental health cases" reported to the state's Board of Corrections.

categorized at any point along the continuum might need some mental health services as their behavioral and symptomatic responses become acute.

Length of Detention

Since previous reports focused on placement delays that increase the length of stay in detention, a section of the survey included questions about the length of stay (LOS) for these youth in comparison to youth without suspected or diagnosed disorders. We divided the questions between pre-dispositional and post-dispositional LOS. First we asked for estimated pre- and post-dispositional LOS for these youth. Thirteen counties gave an estimated average pre-dispositional LOS of 41 days for these youth, and an average post-dispositional LOS of 37 days. (Only five counties used data from their information systems to obtain this information. The other counties estimated the LOS.)

We then asked counties whether the LOS for pre- and post-disposition is longer, the same or shorter than that of other youth. Table 1 shows a comparison of the responses for pre- and post-dispositional LOS.

Table 1. Pre- vs. Post-Dispositional LOS Longer for Youth with Mental Illness?

Number of Counties:	LOS is longer	LOS is same or shorter	Total*
Pre-dispositional LOS	5	12	17
Post-dispositional LOS	8	9	17

*One county was unable to estimate the LOS.

Most counties reported shorter lengths of stay for these youth in both categories, however there is reason to think that the longer lengths of stay (particularly post-disposition) may have been under reported. Firstly, a majority of counties relied on estimates rather than data reports to answer these questions (11 counties for the pre-dispositional questions, and 12 for the post-dispositional questions did not rely on data reports). Secondly, three counties initially reporting the post-dispositional LOS as "the same or shorter for these youth" changed their responses to "LOS is longer" during the site visits, at which time agency managers had an opportunity to discuss the issue together during the group interviews. (Table 1. reflects the revised responses)

"Placement problems constitute the single largest reason for longer stays. Finding placements is especially difficult for youth who have a history of fire setting, those with cognitive functioning lower than a threshold IQ, and those who with violent behavioral problems."

For those counties reporting longer pre-dispositional stays for these youth, counties were asked to estimate how much longer their stays were compared to youth without mental disorders. Four counties answered this question, and the estimated average pre-dispositional LOS was 17 days longer for these youth. In the site visits counties reported that for these youth judges often issue continuances in order to obtain court-

"...detention facilities are still being used to compensate for reductions in local and statewide placement options that used to be available for these youth."

ordered evaluation, especially if there is a history of placement problems or a question about whether placement will be required.

For post-dispositional LOS, one county reported that the LOS is less than other youth, eight counties reported the LOS is about the same, and eight counties reported the LOS of these youth is longer. Of the latter counties, three reported that the average post-dispositional LOS of 18 days longer for these youth. These numbers reflect adjustments that were made at a few of the site visit meetings.

At the site visits respondents suggested the following contextual issues related to longer post-dispositional LOS:

- Hard to place youth—placement problems constitute the single largest reason for longer stays. Finding placements is especially difficult for youth who have a history of fire setting, those with cognitive functioning lower than a threshold IQ, and those who with violent behavioral problems. One county reported the "perfect storm" profile: a youth who is deemed incompetent to stand trial due to mental illness as well as cognitively impaired enough to be eligible for Regional Center services. A more typical profile is that of a youth in foster care who could not be managed in a foster home and came to the attention of juvenile justice, however there are also youth who came directly from parents' homes and have become placement problems. We consistently heard that detention facilities are still being used to compensate for reductions in local and statewide placement options that used to be available for these youth. While placement options such as Level 14 residential treatment centers and state hospitals are not considered ideal settings, they nevertheless served an important function before available beds were reduced. As in previous reports, detention facilities are still being used as a default placement option. In Los Angeles County, for example, recent closure of Metropolitan State Hospital and McClaren Hall (a shelter facility for children and youth removed from their homes by the Department of Social Services) has directly led to increases in the population of troubled youth at the county's three juvenile detention facilities. The county still relies on out-of-state facilities for youth needing Level 14 residential care.
- Court-ordered state Division of Juvenile Justice (DJJ) placement evaluations—these include residential assessments at placement facilities. In some counties respondents reported that judges use this to provide a brief placement experience for youth beyond the need to collect assessment information
- Other legal activities, such as parent & private attorney efforts to find alternative placements

Some (but not all) counties expressed concern that the recent changes in criteria for DJJ placement (previously called the California Youth Authority) known as "DJJ Realignment," requiring that only youth with the more serious offenses will be placed in DJJ facilities, will result in an increase of difficult-to-place youth in juvenile detention facilities. One mid-size county in particular had been a "high user" of DJJ placements, and expects to see a dramatic increase in the detention population as a result of the policy change. Another large county expects lengths of stay of detained youth to be longer as a result of DJJ Realignment.

In this section of the survey we asked counties whether, for youth who have had multiple detention admissions during the course of the year, the counties' data systems were able to report the length of each separate stay. This question was asked with the assumption that difficult-to-place youth might also have multiple detentions due to mismatched placements or placement failures, leading to recidivism. The capacity to disaggregate and track these stays would be important to understand the overall LOS impact of these youth. Ten counties checked "Yes"—their data systems had the capacity to disaggregate multiple detentions, and they reported an average (overall) LOS for these youth of 47 days per stay. (We did not ask for break downs of these LOS questions by pre- and post-disposition.) The other eight counties reported not having the ability to disaggregate multiple detentions. There was no apparent relationship between county size and this data function—small, midsize and very large counties share this limitation.

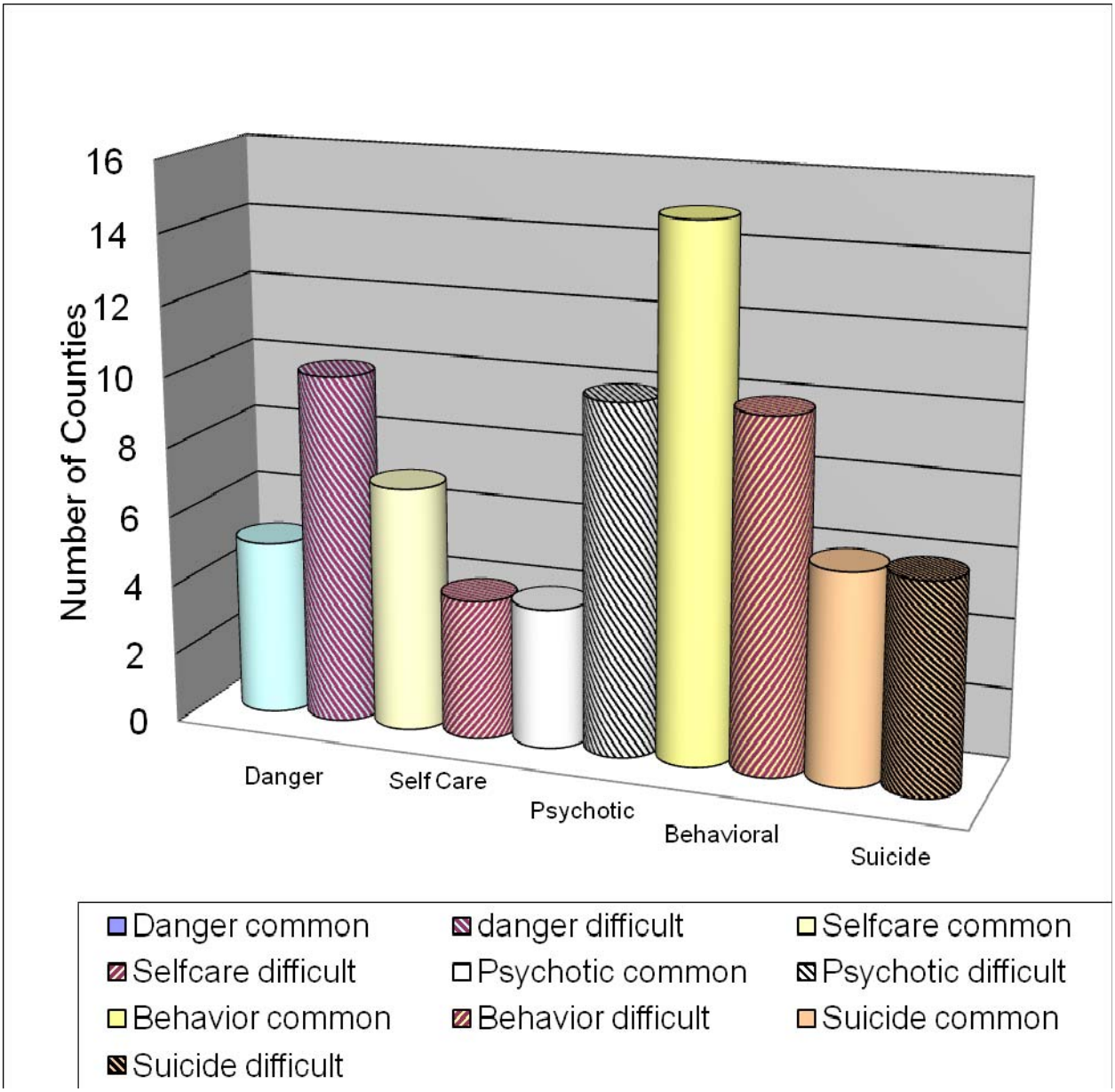
Management of Youth with Mental Disorders in Detention

To understand the problem areas that staff in detention facilities typically deal with and find difficult, we asked a series of questions about five general categories of mental health symptoms or behaviors. The categories were 1) Suicidal thinking, attempt, or intent, 2) Risk of danger towards others due to mental disorder, 3) Poor self care (such as eating, sleeping disturbances), 4) Psychotic thinking, hallucinations, unusual behavior, and 5) Poor behavior control (e.g. due to illicit substances, hyperactivity, or impulse control problem). For each category we asked the respondent to rate how common the problem is in the facility as well as how difficult for staff to deal with. The instructions for the question were as follows:

> Please rate how common and how difficult the following list of problems are in your facility. ("Common" refers to how often youth with these problems are present in your facility. "Difficult" refers to the level of staff effort over and above that needed for youth without mental and co-occurring disorders.) Rate each of the following five problem categories from <u>not</u> (1) to <u>very</u> (5) common in the second column, and from <u>not</u> (1) to <u>very</u> (5) difficult for your facility staff in the third column.

For this report we summarized the responses showing the number of counties that answered either 4 or 5 for these questions, shown in Figure 1.

Figure 1. Common and Difficult Mental Health Problems (N=18)



That youth with behavioral control problems are both commonly seen and difficult was endorsed by a majority of counties. Although not as commonly seen, youth who show signs of being dangerous to others also pose a problem for many facilities. Similarly, psychotic behavior was indicated as common only in four counties, however ten counties rated this as very difficult to deal with. Suicidal thinking or intent was neither considered common nor difficult by a majority of counties. The survey also asked an open-ended question about other types of problems not covered in these questions. The responses included post-traumatic

"...even one youth with serious problems can divert staff resources, interfere with daily programs and activities, and create safety concerns."

stress disorder, anxiety problems and stress.[4] Also added were 1) the management difficulties of youth "cheeking" medications and sharing them with others, 2) dealing with parents who may also have a mental illness.

At the site visits it was consistently reported that even one youth with serious problems can divert staff resources, interfere with daily programs and activities, and create safety concerns. These issues would not be apparent from the analysis of length of stay patterns alone. A facility may have been successful in reducing the average LOS for youth in general, however the lack of placement options for severe problems results in longer lengths of stays for certain youth. In almost every site visit we heard case examples of youth who stayed well beyond 90 days, and these youth exhibited problems such as psychoses and self harm on the more extreme end of the continuum. In some counties respondents pointed to the lack of interagency coordination that hampered efforts to develop alternative responses to these youth. Having stronger interagency relationships and judges taking a more active role in placement decisions result in more effective dispositions. In one small county, for example, for those small number of high-need cases the judge calls the placement officer for daily updates. One midsize county reported success in developing a local continuum of placement options that prevent longer lengths of stay for many youth, thereby lessening the burden on the detention facility to provide this role.

Nevertheless, detention facilities have had to adjust the milieu to accommodate these youth. Many are attempting to function as hospitals yet without adequate treatment resources and medical staff. For example, upon intake youth are screened to determine the level of safety concerns, level of functioning in various areas, and need for services. Site visits respondents pointed to the need for increased attention to mental health functioning and have developed level systems characterizing youth according to mental health functioning, beyond basic behavioral and safety indicators[5]. In some site visits respondents gave examples of iatrogenic effects of being confined that exacerbate mental symptoms. To compensate some facilities have retrained staff and restructured the milieu program in attempts to minimize these effects. In a few counties, respondents reported noticing a paradoxical reaction of some youth who prefer to stay in the facility rather than return to the community due to the level of structure, the positive attention from staff, and their success in the facility's school program. Respondents who mentioned this also expressed concern that these types of experiences are not available enough in existing community-based settings, and certainly not in the adult jail system. As one respondent put it "…the adult jail system is a rude awakening, compared to what they experience here." In one

"...respondents pointed to the lack of interagency coordination that hampered efforts to develop alternative responses to these youth. Having stronger interagency relationships and judges taking a more active role in placement decisions result in more effective dispositions."

[4] During a presentation of this finding to a convening of the state's Chief Probation Officers, it was pointed out that the structured questions also did not address less observable mental health problems such as depression and other internalizing disorders.

[5] As an example, Los Angeles County uses a four-point system: Level 1 youth require some counseling but are not considered having serious problems; level 2 indicates the need to see a mental health specialist every 72 hours; level three youth require 1:1 monitoring, and level 4 youth have serious enough problems to require hospitalization.

large county, the perception is that the system of care associated with the detention facility is better than one would expect at a psychiatric hospital.

Staff and Facility Resources

A major factor on the costs associated with these youth is their impact on staffing. We asked a series of questions throughout the survey about staffing patterns, especially the impact of these youth's special needs. In this section we asked about 1:1 staffing and intensive monitoring. Over the past year, an average of 49 youth per county required 1:1 staffing or intensive monitoring due to suspected or diagnosed mental illness[6]. This number excludes Los Angeles, who reported that there are an average of 14 youth requiring 1:1 attention on any given day in its three detention facilities.

When youth require 1:1 attention or monitoring at the facility, how long is it provided? Twelve counties reported an average of just over 18 days per 1:1 "episode" ranging from one day (Merced, San Bernardino and Fresno) to 180 days (Los Angeles). A majority of counties (15) require the use of extra staff over and above the normally scheduled facility staff for these special needs.

During the site visits the counties described their procedures for intensive monitoring of youth. Those counties that have special mental health units house youth who need closer monitoring there. Other counties with available space use one of the facility "pods" as an observation unit. For youth who are suicidal most counties used observation rooms with cameras. Facility staff make in-person checks on these youth regularly as per state requirements. Two counties reported that they keep their 1:1 time limited to one day "at the most." If youth require 1:1 for more than one day, other measures are taken such as involving mental health clinicians, or discharge to the hospital when feasible.

This monitoring also occurs outside the facility as youth are transported to other appointments, court hearings, etc. In this section we asked about transportation to psychiatric counseling, emergency screening and psychiatric hospitalization. Los Angeles reported that they transport at least one youth every day. The other 17 counties reported that they transport youth to psychiatric hospitals or appointments an average 4 days per month. It takes an average of two hours to transport youth to psychiatric appointments or a psychiatric hospital. For five counties, it takes longer than two hours (one county reported five hours) to transport youth to the nearest psychiatric hospital. This may also include waiting time—the time probation staff would wait for initial evaluations to be completed or for the patient to be seen.

During the site visits we consistently heard frustration about the facilities' relationship to psychiatric hospitals, with the exception of a few counties such as Los Angeles who reported building very good linkages with the nearby county/USC hospital, even establishing probation staffing at the hospital since it is used so frequently. Other counties' frustrations centered on the limitations of 72-hour involuntary holds. There are often disagreements between hospital medical staff and facility staff about the criteria by which an individual youth is deemed "holdable" for evaluation at a psychiatric hospital. As perceived by facility staff, youth are often

[6] The range was from "0" (Santa Cruz) to "536" (Fresno).

returned prematurely to the facility once the treating doctor establishes that the youth does not meet the strict criteria for involuntary hold, and either the youth is not willing to sign into the hospital voluntarily or the treating doctor does not believe hospitalization is indicated[7]. As perceived by probation facility staff, doctors use stringent criteria that assume there are other less restrictive treatment options available—not often the case for youth returning to detention. These disagreements can go beyond the issue of involuntary treatment. One county reported ongoing "philosophical differences" between probation and county mental health staff about diagnosing youth with a mental disorder vs. what the mental health staff assumed were typical behavioral reactions, thereby creating barriers to further assessment and treatment.

In this section we asked an open-ended question about other facility costs related to housing these youth. There were many costs reported for facility damage—such as destruction of cell fixtures and toilets (including plumbing costs), broken lights and windows, repairs or replacement of broken televisions and VCR machines, ripped bedding, broken fire sprinklers (often resulting in flooded cells), and destruction of school books and supplies. One small county estimated $8,000 in repair costs (a sizeable proportion of the overall budget) over the past year due to a relatively small number of these youth.

"One county reported ongoing 'philosophical differences' between probation and county mental health staff about diagnosing youth with a mental disorder vs. what the mental health staff assumed were typical behavioral reactions, thereby creating barriers to further assessment and treatment."

This section concluded with questions about staff injuries or stress-related illness as a result of caring for detained youth with mental disorders. Twelve counties responded that there may have been such injuries in the past year. Nine of these counties were able to report the number of staff injured—a total of 27 among the nine counties. Five counties further reported the average number of lost work days per injured staff member of 72 days in the past year, ranging from 15 to 180 days. During the site visits respondents reminded us that there can be subtle stress-related problems that do not necessarily result in measureable time off work. Facility staff working with these youth can have emotional reactions, as would be typical in psychiatric residential treatment or psychiatric hospital settings. In one facility a recent suicide "traumatized the staff" and required the provision of crisis debriefing. Facility staff are encouraged to become more sensitive to the needs of these youth while at the same time maintain security and safety for youth who must be separated from the community. For some staff, these objectives seem contradictory.

C. Services and Costs for Mental Health Treatment

In this section we asked about specific mental health services that are provided, the types of staffing and organizations that provide these services, and estimated costs for these services.

[7] In California court wards (Calif Welfare &Institutions Code 602) have the right to consent to or refuse voluntary psychiatric treatment independent of the parent or guardian's wishes.

Mental Health Services Provided

As mentioned in section IV. A. five counties have specialized mental health units. Stanislaus reported that in their Special Needs Unit there are two psychiatrists assigned. Assigned county mental health staff are placed on the unit, although only available on-call after regular hours. Services include family therapy provided on an as-needed basis and Aggression Replacement Therapy. At this time Medi-Cal is not billed for services to eligible post-disposition youth due to the administrative burden of data collection and billing.

Table 2 shows the number of counties providing each mental health service listed and the rates given in either minute or session units of service.

Table 2. Number of Counties Providing Mental Health Services in Detention Facilities with Rates

	Number of Counties Providing Service	*Ranges of Rates for Services**		*Number of Counties not Providing Service*
Mental Health Service		Per minute rate range	Per session rate range	
Diagnostic Assessment	18	$2.44 - $3.37 (N=7)	$50 - $75 (N=2)	0
Individual therapy	16	$2.44 - $3.37 (N=7)	$75 (N=1)	2
Group therapy	10	$1.20 - $2.96 (N=5)	$225 (N=1)	8
Family therapy	11	$2.44 - $2.96 (N=4)	$75 (N=1)	7
Medication monitoring	18	$2.27 – $6.23 (N=8)	N/A	0
Crisis intervention	16	$2.44 - $5.03 (N=6)	$75 (N=1)	2
Case management	11	$1.89 - $2.29 (N=5	$37 (N=1)	6

*Note: not all counties reported rates for each service provided at the facility.

As shown in Table 2 diagnostic assessments and medication monitoring visits are conducted in every surveyed county. All but two counties provide individual psychotherapy and crisis intervention visits, and a majority of counties provide group therapy, family therapy, and mental health case management services. In a few counties (especially the large ones) formal mental health assessments are conducted on 100% of all youth brought into custody.

Seven counties reported their current Medi-Cal (Medicaid) negotiated rate. It should be noted that since the majority of mental health services to detained youth cannot be reimbursed by Medicaid, these rates were provided as proxy costs. For some services "Per session" rates were reported. For some counties, individual services provided to detainees are not tracked and costs or rates are very difficult to determine. In one midsize county for example, mental health services are funded from county general funds and the probation department is not required to bill for services. For some facilities contracting for mental health services (see below), a global rate is paid to the vendor and individual encounter data are not available. In these counties costs are determined as staff FTE costs.

Two counties also reported providing day treatment services (not shown in table). One county reported a "half day" rate of $163.93, and the other county a "full day" rate of $184.39.

When asked how many youth who need ongoing mental health care receive it ("None", "Few", "Most" or "All"), eleven counties answered "All," five "Most" and two counties checked "Few" or "None." Both are small rural counties. In a site visit to one of them, respondents reiterated that only basic crisis and medication evaluation services are offered, except for informal counseling by facility staff. In at least one large county, mental health clinicians attending the site visit meeting reported that upon intake during the standard medical assessment youth are asked if they would like ongoing mental health counseling.

During the site visits we also heard about other services or initiatives not reported in the written survey. A few counties offer anger management groups. Some offer specialized services for girls in response to the growing number and unique issues of girls who are detained. There were also reports that placement alternatives for girls are more limited than for boys.

Who Provides Mental Health Services

To understand the organizational relationship of mental health services, we asked a series of questions about who provides them. Most counties provide services with a combination of county staff and contracted clinicians or organizations.[8] Fifteen counties provide services using county mental health staff, and three do not. All fifteen utilize licensed clinicians, while eleven use non-licensed county mental health staff, and ten utilize county mental health supervisors.

Having county mental health clinicians on site at the facility results in better coordination between probation and mental health for individual case management. During the site visits we heard that in three large counties staffing from the county's mental health or behavioral services department is considered adequate for providing assessment, triage, and some ongoing treatment. In one large county, the health care agency is perceived as providing adequate support and a commitment to increase resources for mental health services to detained youth. We heard case examples of how county mental health clinicians can effectively ensure continuity of care from previous open mental health "episodes" and provide ongoing care in the facility, despite limitations in Medi-Cal funding for detained youth. The ability to provide continuity of care

[8] There were no apparent patterns in the responses showing differences in rates between county-supplied and independently contracted services, however the sample may not have been large enough to illustrate any actual differences if they do exist.

upon release varies in these counties. Stanislaus County, for example, has an outpatient program that has built in a strong relationship with community probation by funding a probation officer at the outpatient site through AB3015 state system of care funds[9]. Solano County also reported having developed good interagency coordination as seen by its local continuum of residential treatment alternatives.

During a site visit at one mid-size county, respondents reported recently having a youth who was experiencing acute psychotic symptoms yet the facility staff had difficulty arranging the involvement of county mental health staff. In most counties we visited, there is a multi-agency forum for discussing placement problems. However, the effectiveness of these meetings varies depending on the availability of placement alternatives and the severity of the youth's problems.

In at least one other large county, staffing is inadequate. Here, mental health services are subsumed under a larger health care agency in which services to youth in detention constitute a very small percentage of the overall activity of the health care agency, hence the mental health needs are perceived as "under the radar." In a few counties (large and small) the limited amount of funding available for mental health services is vulnerable to cutbacks year to year. For example, in one large and one small county new grants for innovative services are viewed by some county administrators as redundant with available general funds, and hence the general funds are cut back. This provides a disincentive to seek grants for special or innovative programs. One county reported that in order to reimburse the county's mental health agency for placing clinicians at the facility the probation department is charged an exorbitant indirect rate, thereby making it much less expensive to purchase privately contracted services. This is justified by some county administrators since probation is such a large "consumer" of county general funds for all other core activities (such as basic facility costs and community probation services). Another factor resulting in inadequate staffing is the difficulty recruiting appropriate clinicians to work in these settings, even when the budget allows for the positions. One large county reported having licensed clinical positions designated for detention facilities remain unfilled for many months. This same county reported that in one of three detention facilities, there are six budgeted county mental health positions, adequate enough for 100 youth but inadequate for the current 200 youth in the facility. Another mid-size county reported that recruitment is made difficult by burdensome county personnel procedures rather than the unavailability of candidates.

The relationship between the probation and mental health departments is also reflected by the coordination at the level of agency policy decisions and cooperation. One indicator of the current state of interagency collaboration is the extent to which detention facilities are represented in planning for new services under the Mental Health Services Act (MHSA). Based on respondents' reports at the site visits, there seems to be a clear distinction between those counties that are engaged in collaborative planning for these youth, and those that are not[10]. In some counties

[9] Since the site visit occurred, funding for the probation officer has since been discontinued.

[10] This is at least partly due to statewide disagreements about whether MHSA funding should be used to provide services to detained youth vs. community-based prevention and support services. The MHSA's stated CSS policy allows for funds to be used for "reduction in involuntary services, reduction in institutionalization, and reduction in out of-home placements" for those on either voluntary or involuntary legal status (California Dept. of Mental Health, 2005) (p. 1). The PEI component allows for services to children and youth at risk of juvenile justice involvement **–"** those with signs of behavioral/emotional problems who are at risk of or have had any contact with

(large and small) probation was well represented in the planning for the Community Services and Supports phase (CSS). For example, Stanislaus County's Behavioral Health Services Department has staffed 25 Full Service Partnerships[11] to prevent jail recidivism for at-risk youth with mental illness. In others, either participation was minimal or the resulting county CSS plan ultimately did not reflect the needs of detained youth. At the time of the site visits, planning for the Prevention and Early Intervention phase of the MHSA was in the early stages and most respondents were hopeful that probation would be represented in the upcoming planning process. Another indicator of successful collaboration efforts can be seen in the implementation of Reintegration Programs designed to follow youth into the community after release. Several counties reported establishing this type of program. The use of Mentally Ill Offender Crime Reduction program grants (MIOCR) for juvenile offenders also has led to increased collaboration in several of the surveyed counties.

Eleven counties reported using independently contracted services or clinicians for some or all of their mental health services[12]. Of these, ten counties have contracted licensed clinicians, six utilize non-licensed contract staff, and three have the benefit of supervisors on site. Independent contracted organizations include the California Forensic Medical Group (CFMG), community-based organizations, private practice groups, and in some cases individual clinicians from the community.

Although we did not ask a direct question in the survey about the extent to which probation facility staff provide informal counseling and crisis intervention, in the site visits we consistently heard that facility staff are constantly called on to provide such services. By some reports this accounts for the criteria of staff who are hired at the facility—staff who have experience or are at least comfortable with these youth are more desired than those who do not understand the nature of mental illness and its effects on behavioral problems. Many facility managers expressed the desire to provide training for facility staff so that they can have a better understanding of these youth. Alameda County presented one model for training. They instituted ongoing training in Cognitive Behavioral Treatment for facility and behavioral health staff, resulting in more consistency of response to these youth and a strengths-based approach to rewarding positive behavior in the facility.

Use of Psychiatric Hospitals

In this section we asked what type of hospital is used for psychiatric emergencies. Seven counties use a community general hospital or university hospital. Thirteen counties use private psychiatric hospitals, six use county hospitals (one is a psychiatric health facility, or PHF), and three counties use non-hospital crisis programs or units. (Los Angeles County designates an emergency room unit solely for use of detention and placement facilities.)

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any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports (CSS)" (California Mental Health Services Oversight and Accountability Commission, 2007) (p. 4).

[11] "Full Service Partnerships" refer to those underserved adults, children and youth who are designated as priority populations for the MHSA's CSS funding.

[12] One county checked "no" for this question, however at the site visit reported using CFMG and a contracted Marriage and Family Therapist for mental health assessments, medication prescriptions, and some interventions.

For psychiatric inpatient admissions, Table 3 shows what types of hospitals are used and the average *per diem* rates.

Table 3. Psychiatric Hospitals Used for Admissions, and Rates

Number of counties*	Type of hospital	Range of *per diem* rates
5	Community general hospital or university hospital	$667 - $1133
13	Private psychiatric hospital	$565 - $1085
3	County hospital	$475 - $733
1	Non-hospital residential program	$1200 - $1500

*Note: some counties reported using more than one type of hospital

The average LOS for psychiatric hospitalization for youth in detention was reported as ten days (N=17 counties) with a range from 1 to 75 days. In the past year, Los Angeles County alone reported hospitalizing 400 detained youth. The other seventeen counties reported hospitalizing a total of 51 youth among them. Two counties reported hospitalizing no youth, and the other fifteen averaged 4 per county (ranging from 1 to 8). Nine counties used information systems to obtain this information (probation, county mental health, or private healthcare vendor data), one county relied on case files, and the other seven counties estimated from memory and consultation with staff. In at least one county, the unavailability of local hospitals has encouraged the development of alternatives and reductions in psychiatric admissions of detained youth.

Medications

As mentioned in the introduction, at least 12.5% of youth in detention receive psychotropic medications according to administrative reports. For the survey we were interested in the use of psychiatric medications for detained youth, and asked about the average cost per year of psychiatric medications. Los Angeles reported an annual cost of $1,927,000. The other fourteen counties who answered this question reported a combined total of $597,000, averaging $42,586 per county (range from $2,305 to $151,891). Most counties (N=9) relied on their health care vendor's information system for these data. Four counties used probation data, two used the mental health information system, and two estimated the costs from memory.

How are psychiatric medications funded for detained youth? Table 4 shows which sources of funding surveyed counties use to pay for psychiatric medications. (The survey question allowed for more than one source of funding to be checked.) As seen in the table, a majority of counties rely on county general funds to pay for psychiatric medications.

Table 4. Sources of Funding for Psychiatric Medications (N=17)

Source of Funding	*Number of Counties*
County mental health funds	7
County health or public health funds	4
County general funds	10
Other funds ("County jail", "Medi-Cal", or "County health provider")	3

In detention, prescribing medications is complicated by the wishes of other outpatient providers and by the parents. Often there are disagreements about medications when the treating doctor connected with the facility recommends one type of medication, but the family and/or outpatient provider recommends another or none at all. This sometimes results in either delays of prescribing or non-compliance with taking the new medication. At least one county categorizes some youth upon intake as "stable on medications," meaning that the facility doctor agrees with the current medication and dosage and provides infrequent monitoring. One large county reported rarely if ever having a youth refuse medications since the on-staff psychiatrists spend enough time working with the family and building a relationship with the youth.

During site visits we asked about the continuity of medications upon release. In some counties a very limited supply of medications (three days' worth) is provided. A few counties (including some large ones) only provide a written prescription and no actual medication upon discharge. In a few site visits counties reported that families are given the county mental health access line to arrange follow up appointments and prescriptions. From reports of the mental health clinicians at the site visits, continuity of care for medications is a serious problem for these families and youth due to a combination of factors. Among them are 1) the inability or unwillingness of some parents to follow up with recommended appointments, and 2) the lack of resources for families caused by temporary lapses in Medi-Cal eligibility and/or lack of available providers and appointment times for follow up medication monitoring visits. Respondents agreed that having access to accurate information about previous medications and adequate staff resources to coordinate decisions with providers and parents would improve continuity of care throughout detention and after release. [13]

In almost every county we visited, there are on call physicians (many of whom are psychiatrists) who are available 24 hours a day. Only in the largest counties are the psychiatrists staffed from county mental health services. Los Angeles County, for example, has psychiatrists who have strong affiliations with the county hospital and provide good coordination for referrals, involuntary hold decisions, and case management. (Los Angeles County also has designated non-medical mental health staff who are authorized to make 5150 involuntary

"Having access to accurate information about previous medications and adequate staff resources to coordinate decisions with providers and parents would improve continuity of care throughout detention and after release."

[13] Although this did not come up in the site visits, during a presentation of these findings to a convening of the state's Chief Probation Officers, one comment underscored the need to improve the quality of care related to psychiatric medications to minimize the potential for over- or under-medicating these youth.

hold decisions.) The other counties use contracted physicians from either CFMG or local hospitals. In the CFMG counties nurses oversee the distribution of medications. In most facilities nurses are not available on site 24 hours per day and non-medical facility staff is trained to hand out doses of medications.

D. Substance Abuse Services and Costs

This section covered the processes of substance abuse screening and the specific types of interventions available to detained youth. When asked to estimate what percentage of detained youth has co-occurring mental illness and substance abuse problems, seventeen counties reported an average of 48% (ranging from 1% in one county to 92% in another). Los Angeles County was not able to provide an estimate, instead indicating "Unknown" in the survey item.[14] An average of five youth per county require detoxification prior to admittance (range 0% to 21%, N=16). Los Angeles County answered "0%". Only two counties obtained this information from probation information systems; all other respondents estimated from memory or staff consultation. In the site visit, facility managers clarified that youth needing detoxification are not accepted into detention until medically cleared, and the number of those youth is unknown[15].

Counties were asked who provides screening for substance use, need for detoxification, or other related substance abuse issues. The majority of respondents (11 out of 17) reported that detention facility staff provide this screening. The same number of counties report that county mental health staff also provide this screening. (There may have been some overlap in defining county mental health staff as "facility staff" in their responses.) One county reported using contracted staff from a community-based organization to conduct this screening.

For youth requiring detoxification, eight counties indicated that detox occurs at the detention facility, ten counties use community or university hospitals, and three use county-run hospitals.

Three counties (Orange, Stanislaus, and Fresno) reported having separate substance abuse units for detained youth. In all three counties, youth with co-occurring disorders are accepted into the substance abuse unit. Only Fresno reported an additional rate ($53.39) per day per youth for this unit. Fresno County also further described the services: intensive in-patient dual-diagnosis therapeutic community model, including gender specific services, case management, family awareness class, family and individual counseling, life skills, art and recreational therapy, and anger management. The Stanislaus County substance abuse unit has a capacity of 60 youth of both genders, including both the "inpatient" program and outpatient, which is a Drug Court program enrolling 9-12 youth. This program also includes parenting classes and linkages with School Attendance Review Boards, and is funded out of JJCPA dollars.

Table 5 shows the number of counties providing substance abuse services—individual or group treatment, general education on substance abuse, and on-site AA or other community meetings. The majority of counties provide some type of substance abuse services, with all but two

[14] Although the survey did not ask for the source of data to estimate the number of youth with co-occurring disorders, it is unlikely that probation departments have data that would provide this type of report.

[15] There may have been confusion among the counties about the definition of "detoxification" since it was not defined in the survey instrument, e.g. the need for detox could be interpreted as the youth having symptoms of being "high" or inebriated, vs. being medically compromised and requiring 24 hour medical supervision.

providing general education. Very few counties reported rates for the services. Those that did are shown in the table. Some counties we visited are planning to increase the presence of AA groups for detained youth.

Table 5. Number of Counties Providing Substance Abuse Services in Detention Facilities, with Rate Ranges

	Number Counties Providing Service	*Ranges of Rates for Services*		
Substance Abuse Service		Per minute rate range	Per session rate range	Annual rate range
Individual or group treatment for substance abuse problems	12	$1.89 – $3.18 (N=2)	$75 (N=1)	$25,000 - $450,000 (N=2)
General education focusing on substance use problems	16		$60 - $65 (N=2)	$60,000 (N=1)
On-site AA or other type of community volunteer meetings	12	N/A	N/A	N/A

This series of questions included space for “Other” which two counties used to report the following services:

1) One county (without a separate substance abuse unit) reported having a contract with two full time substance abuse counselors at an annual cost of $173, 910.

2) Another county reported drug testing at $9/per test

When asked how many youth in detention receive substance abuse services, six counties reported “All who need care, ” nine reported “Most who need care” and two reported “Few who need care” or “None.”

At the site visit, Los Angeles County reported that 100% of detained youth have access to substance abuse-related programming such as the “LEAPS” life skills program, and any youth staying longer than three days will receive substance abuse services of some kind. (These are provided by a contracted community agency.) In some of the counties we visited, facilities provide some type of follow up care for substance abuse such as drop-in “outpatient” transitional services that involve substance abuse treatment support. At least one small county provides group counseling to detained youth by a contracted agency.

E. Services and Costs of General Healthcare

In this section we were interested in general healthcare costs and how they could be valued. The majority of counties (11 out of 18) contract with a private healthcare vendor.[16] Those counties that contract with healthcare vendors reported a slightly lower facility rate in question 1. In some counties, the vendor is shared by both adult jails and juvenile detention facilities. Los Angeles County contracts with a healthcare vendor and reported an annual cost of $18,142,000. For the other seven counties that reported their annual rates, the average was $1,395,175 with a range of $88,000 to $5,048,000.

We asked counties about whether specific healthcare services were included or not included in the facility rate quoted in question 1. Table 6 shows the number of counties answering "Yes" or "No" to this question.

Table 6. Are Healthcare Services Included in the Facility Rate?

Healthcare Service	*Number of Counties Reporting…*	
	Yes	No
Basic healthcare screening	7	8
Medications	9	6
Pharmacy	7	8
Doctor visits	9	6
Nursing care	9	6
Health screening	7	8

There were no apparent patterns in this distribution comparing facility counties that contract with vendors and those that do not, nor were there any apparent differences in average facility rates based on these findings.

Space was provided for respondents to write on other healthcare services. These items were added (without further clarification):

- Specialty care hospitalization
- 2nd opinion from doctors parents pay for, or medications provided by parents
- Sick call
- Lab, dental, acute hospital, outpatient special MD care
- Crisis response
- After hours/weekends/holidays medical pass

Only three counties have licensed pharmacists on site and only two have labs. Five counties reported having 24-hour nursing at the facility. Of the other thirteen, only one reported plans to implement 24-hour nursing.

[16] Counties were initially sampled to include many of those with private healthcare contractors, so this number may not represent the proportion of California counties that contract with private vendors. One major vendor, the California Forensic Medical Group (CFMG) currently has contracts in 23 counties.

Telemedicine is typically being used in the small rural counties, for both healthcare and mental health care encounters. We were interested in staff resources to transport youth to hospitals for either post-admission screening or hospitalization for physical healthcare. The question we asked was "How many days per month do you estimate that probation staff accompany a youth to a hospital…?" One county may have misunderstood the question, and answered "40" possibly referring to 40 youth. Another county reported "30" and in the site visit clarified that at least one youth per day is transported for hospital care. Excluding these two counties, the average number of days per month that youth are accompanied to a hospital is 5.4 days, ranging from 0 to 25.

When asked how the healthcare status of detained youth with suspected or diagnosed mental illness or co-occurring disorders compares with that of detained youth without such disorders, eight counties answered that the health status of these youth is generally worse than other youth and the other ten counties reported the health status is "about the same."

F. Costs of Educational Services

In this section we wanted to obtain a picture of educational services provided to juvenile detainees and, wherever possible, also examine the cost implications. Since we are focusing on youth with mental disorders, the special education needs are also addressed.

First, to get a sense of the overall cost of the educational program, we asked respondents "What is the average basic daily cost of the school program at your facility?" The responses were widely varied—they are listed individually in Table 7. (Counties 5 and 8 reported per day, per-youth costs.)

Table 7. Average Daily Costs of School Program at Facility

County	*Response*
1	$11,588
2	$2,720
3	$8,669
4	$510
5	$150
6	$1,595
7	$3,500
8	$46
9	$3,019
10	$702
11	$21,900
12	$450
13	No response
14	$9,467
15	$4,000
16	$7,423
17	$10,659
18	$1,400

Since detention facilities have on-site schools we were interested in the facility resources needed to support the school. One task, obtaining IEP information, was assumed to be time-consuming and administratively cumbersome. This varied among the counties and even among schools within the counties. One large county reported, for example, that some schools can respond to IEP requests within one day but for other schools it may take as long as six months. We asked respondents "who locates and obtains IEP information for detained youth?" Seventeen counties reported that IEP information is obtained by educational staff (i.e. school district or county Board of Education staff). In one county facility staff obtains IEP information, and in two counties mental health staff assist in obtaining this information. An average of less than one hour per week (range 0 – ten hours) is spent obtaining IEP information. In Butte County the assigned Special Ed Coordinator for the facility is able to access online IEP information from the county's school district. Some counties have limited access to this statewide system.

To address the use of facility staff in classroom management, we asked if additional facility staff are ever required in the classroom beyond normal staffing due to a youth's mental status. The majority of counties (10) answered "Yes." Facility staff also spend time assisting with other educational activities. An average of 16 hours per week is spent assisting with teaching (range 0 to 180 hours); six hours per week providing informal tutoring (range 0 to 25 hours); and nine hours assisting with other school administrative tasks (range 0 to 131 hours). Some counties (both large and small) reported intensive demands on facility staff to manage youth—movement to and from class, behavioral problems, etc.

Other educational-related activities involving facility staff include monitoring physical education (15 hours per week) and "discipline intervention" (.5 hours per week).

We asked whether the following services were provided, and if so the average annual cost, if known:

- Language interpreters
- IEP Functional Behavioral Assessments
- Speech and language therapy
- Other occupational therapy
- Other

Ten counties provide language interpreters in the school program. Five of these counties provided cost estimates. Four of the counties seem to have provided annual costs, averaging $17,400, with a range of $600 (small county) to $38,000 (large county). One other small county quoted a cost of $86, which might be a per-student cost.

Eleven counties provide IEP Functional Behavioral Assessments, and four provided cost information, averaging $14,621 (ranging from $700 for a small county to $54,287 for a large county).

Eight counties provide speech and language therapy and only two counties provided the annual cost ($1,000 and $2,757).

Only three counties provide some type of occupational therapy in the school program, and one large county provided an annual cost of $5,000.

Other services not listed in the survey question are listed as follows with associated annual rates if given:

- Resource Specialist ($75,000)
- Eye exams
- EO/RO
- School Psychologist ($7,500)
- Tobacco cessation program
- Girls' services

From the respondents' viewpoint, do these youth require more, less or about the same amount of special education services as youth without mental or co-occurring disorders? The majority of counties (N=14) reported that these youth require more special education services, confirmed in the site visits. A majority of respondents (N=14) also felt that all special education needs of these youth are met in facilities. Four counties responded that only partial needs are met (or only to some students). Estimations of rates of youth who need special educational services varied. In the site visits the reported rates ranged from 20% to 75%.

In their strategic planning process one large county is planning to implement special day classes for qualified youth. In one small northern county, educational services provided by the school district are not available in the summer. In that same county the school district has a very difficult time finding teachers and support staff willing to serve youth in the facility. Another small county, however, reports having more consistent staffing from the local school district.

G. Legal and Court-Related Costs

In the first Advisory Group meeting representatives from the courts suggested that court costs do not vary to a great extent based on caseload sizes in counties, however the number of 15-day reviews, which are required for youth awaiting placement, may be an indicator of the court's effort and that of other staff. The number of 15-day reviews was thought to be an indicator of length of stay in general. Consequently there were only two questions in the survey related to legal costs: 1) "On average, how many hours per week do probation/facility staff transport juveniles to court hearings?", and 2) "Are there any other legal or court-related costs unique to [these] youth…?"

An average of 34 hours per week (range 3 – 200 hours) is spent transporting youth to hearings. Two surveyed counties reported "none" since the courtroom is located at the facility and most youth do not require off-site transportation.

Counties listed a number of other potential costs. These include:

1. Court-ordered Psych evaluations (6 weeks to complete) (4 counties)
2. Time dealing with parents who visit (identifying & searching parents, monitoring visit)
3. Screening and diagnostic assessment for participation in Mental Health Court program
4. Placement staff need additional time to determine proper placement
5. WIC 741 evaluations, neuropsychiatric exams
6. Extra staff on hand at the courthouse to sit with children pending hearings
7. DJJ 90 day diagnostic evaluations, with an average LOS of 30 days (cost: $6,690); a 90-day evaluation can cost up to $20,000
8. Psychiatric evaluations @ $1,200
9. Court costs associated with cases involving mentally incompetent minors (delays and prolonged hearings)
10. Court-ordered acute hospitalization in isolated cases

H. Other Costs

The survey allowed counties to add other costs that may not have been covered in the instrument. A list of these other costs (unedited) is as follows:

1. Cost of emotional energy on staff
2. Additional staff to deal with violent/impulsive activity
3. Continuity of care challenges opportunity for mental health providers to connect with youth
4. Costs to train staff to deal with these youth
5. Psychological/psychiatric evaluation at court or county's expense
6. Daily room rate does not include cost to maintain facility, admin, support, overhead and medical service costs
7. Transportation costs by Probation Department
8. Costs of security during transportation to special appointments
9. "Major injury to staff almost always due to youth with mental illness"

V. Implications and Recommendations

Our study gathered various types of data related to the services offered to detained youth with suspected or diagnosed mental illness. We succeeded in eliciting information that addressed:

- The best estimates of actual services and their costs by probation and other agency staff who interface with these youth
- In the absence of cost data, a description of the types of services offered or utilized by these youth
- The contexts for these youth and their impact on the organizations and staff who serve them
- The limitations of the data that can potentially address better estimates of services and their costs, and
- Recommendations for practice, policy, training and further research recommended by key informants.

In this section we will summarize the implications of our findings for practice, policy and training, as well as summarize the recommendations from our site visit informants.

"Facilities have made adaptations in order to respond to the increasing numbers of youth with suspected or diagnosed mental disorders."

The Burden on Detention Facilities

As found in previous studies (U.S. House of Representatives Committee on Government Reform, 2004; Youth Law Center, 2007, March/April) the difficulty finding appropriate placements and community-based alternatives for these youth continues to result in longer than necessary lengths of stay in detention. While youth with the most serious problems (and the most difficult to place) may constitute a small percentage of the overall detention population, these youth continue to require extraordinary resources to maintain them in an environment that was not originally intended to provide an appropriate treatment response. Even one such youth can disrupt daily operations and divert resources from the facility population. This problem will continue since the number of youth with mental illness in detention facilities has been steadily increasing. In addition to this trend, DJJ Realignment is already having in impact on increasing the population of troubled youth in local detention facilities. For example, one county reported a recent court-ordered placement of such a youth in juvenile hall.

The Role of Detention Facilities in Providing Services

Facilities have made adaptations in order to respond to the increasing numbers of youth with suspected or diagnosed mental disorders. In some if not all facilities, there is recognition that a majority of youth require some mental health-related intervention along a continuum of need, ranging from those youth who have serious and disabling symptoms to those who are experiencing temporary adjustment problems or post-traumatic response as a result of life circumstances prior to confinement or as a result of the confinement experience itself. As a result, many counties have already initiated mental health screening for 100% of youth brought into detention. As the placement of

"San Francisco County is recommended as an exemplar in providing multi-disciplinary assessments of all youth brought into detention."

last resort, these facilities must constantly balance their responsibility to protect the community by providing secure locked settings, against the need to address emotional and psychiatric problems that can potentially disrupt the setting, compromise safety, and result in prolonged lengths of stay beyond legal requirements for individual youth. Facilities in this study use a combination of county or contracted mental health, substance abuse and healthcare services directed towards these youth as well as a significant proportion of general staff time. Alameda, Contra Costa, Los Angeles, Orange, and Stanislaus Counties are recommended as exemplars in the integration of county behavioral health staff into the facility milieu. In most of its contracted counties, CFMG provides 24-hour psychiatry coverage for medication prescriptions, to compensate for workforce gaps in county psychiatry staffing (especially in the rural counties). San Francisco County is recommended as an exemplar in providing multi-disciplinary assessments of all youth brought into detention.

"Alameda, Contra Costa, Los Angeles, Orange, and Stanislaus Counties are recommended as exemplars in the integration of county behavioral health staff into the facility milieu."

Gaps in Community and Placement Alternatives

Even for those respondents who categorized the services provided within their facility as high quality, there was also consensus that there are gaps in community-based services. Only one county (Solano) reported having an adequate local continuum of residential care. (We would recommend Solano County as an exemplar case study in developing a local continuum of care with various levels of group care.) All others pointed to a lack of residential treatment, psychiatric hospital, and transitional housing capacity. Having a psychiatric hospital or unit nearby with good collaborative linkages (as in Los Angeles County) enables the facility staff to triage youth with minimal disruption to the facility. As perceived by respondents, a reduction in capacity of any of these options as a result of budget cuts has the immediate effect of increasing the census of facility populations with similar increases in those youth who need mental health services.

"Solano County (is) an exemplar case study in developing a local continuum of care with various levels of group care."

Transitional housing alternatives were mentioned in several site visits. Youth who "age out" of the juvenile probation system when turning 18 have much in common with foster youth who emancipate from foster care[17]. Many of these youth who also have mental disorders have limited family support systems and few options for housing. A youth about to turn 18 and nearing release from detention with no legal reason to be held longer faces challenges if there are no reasonable living arrangements. The normative types of living arrangements for young adults in the general population (extended family, college dorms, apartment rentals) are even less accessible to youth with mental disorders (Davis & Vander Stoep, 1997). There is a need for group living alternatives or young adult group homes that can support normative educational and vocational objectives of this age group while helping them avoid re-entry into the criminal justice system. Continuity of mental health services would be a requirement in these settings.

"Butte County's relationship to the school district and consistent special education staffing is an exemplar of facility-based educational services."

[17] The two systems share many of these youth (Glisson & Green, 2006).

In our site visits other exemplars in various facility and community-based service areas were noted. Butte County's relationship to the school district and consistent special education staffing is an exemplar of facility-based educational services. Counties are using MIOCR grants to improve collaboration with county behavioral health staff, and they show promise in preventing recidivism. Specialized mental health units in Alameda, Contra Costa, Los Angeles, Orange, and Stanislaus separate those youth from the rest of the facility population and provide a more therapeutic experience. Counties with higher presence of mental health clinicians at the facility reported better coordination of care on a case by case basis. However, continuity of care after release as indicated by successful follow up with outpatient services and access to medication prescriptions is a serious problem for all counties.

"There is a need for group living alternatives or young adult group homes that can support normative educational and vocational objectives of this age group while helping them avoid re-entry into the criminal justice system. Continuity of mental health services would be a requirement in these settings."

Medi-Cal as a Major Policy Issue

While we did not conduct an exhaustive study of the funding issues underlying these services, the most consistently mentioned barrier to providing mental health services was the inability to use Medi-Cal (California's Medicaid program) for pre-disposition youth in detention, as the federal "inmate exception" law has been interpreted. Even for post-disposition youth whose services might be eligible for Medi-Cal reimbursement, many counties do not draw down federal Medicaid funds. There are two alternative strategies implied by our surveys. The first strategy is to take another look at the federal laws concerning limiting Medicaid to those in jails and take an inventory of any initiatives in other states that have successfully used Medicaid for pre-adjudicated youth in juvenile detention facilities. Another more immediate strategy is to raise the issue of Medi-Cal billing for post-adjudicated youth and explore the administrative reasons why many counties do not draw down reimbursement for necessary services. This could result in training to county administrators, proposed modifications to billing systems, and improved administrative processes. This project could be accomplished in collaboration with the Youth Law Center's continuing efforts to influence federal Medicaid legislation (Burrell & Bussiere, 2002).

"Counties with higher presence of mental health clinicians at the facility reported better coordination of care on a case by case basis. However, continuity of care after release as indicated by successful follow up with outpatient services and access to medication prescriptions, is a serious problem for all counties."

"Even for post-disposition youth whose services might be eligible for Medi-Cal reimbursement, many counties do not draw down federal Medicaid funds."

The Need for Interagency Collaboration

Another major policy issue for counties is the extent to which the county's behavioral health agency and detention facility staff collaborate in planning. In some counties there are philosophical differences in how these youth are viewed. This manifests itself in diagnostic formulations, e.g. does the youth have a "valid" diagnosis, or is the youth simply a behavior problem? This affects not only the case by case decision making and service flow (access to

timely services as well as placement decisions), but also the longer range planning about how to allocate limited resources. Philosophical differences can be dealt with by improving relationships between agencies. However, these relationships take time to build and require added costs of staff time. Some of our site visit respondents reported that it took several years to work out collaborative processes, and that these processes had to be institutionalized rather than personality-driven to be sustained over time. Nevertheless, forums to establish and build on inter-agency relationships are very important and would help create these linkages. The initial added costs to staff time may be worth the investment.

Although the survey did not contain questions about training, this issue came up in site visits as the respondents described the staffing resources needed to respond to these youth. Alameda County is an exemplar in how it adapted to facility staff needs by implementing ongoing joint training to facility and behavioral health staff. Such efforts can be replicated to other counties or provided regionally. Facility staff need training to better understand mental illness in adolescence, how to respond therapeutically to psychiatric and emotional reactions in youth while still maintaining safety in the facility, and how best to deal with families of these youth so as to engage them and elicit their cooperation.

Priority Recommendations

We will summarize the priority recommendations that were emphasized in the surveys and site visits. (See Attachment 3 for a list of all recommendations from site visit participants.) These recommendations are categorized as

1. Services provided in detention facilities
2. Services provided in the community
3. Efforts to improve coordination among agencies
4. An adequate residential continuum of care to provide appropriate placement alternatives
5. Policy issues

5. *Services provided in detention facilities*

- Clarify criteria statewide for the use of mental health and substance abuse services so as to improve the quality of care and equity of the distribution of services among juvenile detainees. The development of formal levels of need would help facilities accurately match need with relevant services and allocate resources accordingly.
- Provide uniform standards of care for various types of mental illness diagnoses, responses to trauma, and the full continuum of emotional need of juvenile detainees. Include up-to-date medication practices based on the most available evidence. This would also include required adjustments to state-mandated staffing ratios to respond to these youth.
- Develop and provide training to facility staff to improve conditions in facilities by increasing staff understanding of emotional disorders and reactions in youth, maximizing consistent communication among staff and providers, and maximizing the rehabilitative opportunities of these facilities to improve social functioning and prevent subsequent recidivism.
- Host a forum with representatives from juvenile probation, mental health, child welfare, Regional Centers, and community-based organizations to highlight promising and

evidence-based practices as well as innovations to address sub-populations (such as services to female offenders, gang interventions), the use of Therapeutic Behavioral Services (TBS) in this context, and others.

6. *Services provided in the community*

- Promulgate models for the assessment of gaps in community services and their impact on youth at risk for involvement in the criminal justice system.
- Take advantage of the opportunities afforded by the Mental Health Services Act to improve community services and supports, as well as early prevention services for at-risk youth, including those who may currently be detained.
- Develop more transitional services (such as those being piloted by MIOCR grants, The California Endowment's *Healthy Returns Initiative*, and in some counties' MHSA programs), so that youth leaving detention facilities and their families are provided coordinated and integrated services by community probation, formal agency services, and informal supports. Relevant housing alternatives and supports for educational attainment and vocational preparation should be included for those older adolescents about to "age out" of the juvenile justice system.
- Host forums to highlight county exemplars in the implementation and testing of community-based supports and preventive services for these youth.

7. *Efforts to improve coordination among agencies*

- Host formal regional or county convenings with representatives from probation, facilities, mental health, education and substance abuse services in order to highlight exemplars and lessons learned by counties attempting to bridge the gaps in agency cooperation, information sharing, policy planning, and coordinated care.
- Through state policy, encourage or require evidence of county agency coordination for these youth through regular forums such as interagency case review meetings and placement committees.
- Provide information and technical assistance to judges and court personnel to improve the coordination between the courts, agencies and facilities.

8. *An adequate residential continuum of care to provide appropriate placement alternatives.*

- Convene statewide and regional planning efforts to inventory gaps in residential and hospital alternatives, and develop recommendations for specific statewide, regional and local county alternatives. Include representatives from child welfare, mental health, juvenile probation, Regional Centers and psychiatric hospitals.
- Make available more alternatives for the following residential care alternatives covering the continuum of need:
    a) Psychiatric hospitals (or emergency assessment alternatives for rural counties) with the capacity to provide adequate and comprehensive psychiatric evaluations and crisis response for youth in detention facilities
    b) Short term crisis group homes to prevent inappropriate detentions or to provide "step-down" temporary placement for juveniles released from detention who meet criteria for this brief level of care

c) Foster care homes and treatment foster care alternatives specifically geared towards youth involved in the juvenile justice system
d) Mid-level or intermediate residential alternatives such as unlocked residential treatment facilities and locked therapeutic placements, and short term psychiatric hospitals for assessment and treatment. These could be regional placement facilities, either expanding the capacity of the current Community Treatment Facilities (CTFs) or developing other models. Evaluate the current capacity of CTFs and advocate for expansion or alternative placement options.
e) Higher level alternatives for youth with extreme mental health needs who would otherwise remain detained for several months or years. These include regionally-based locked psychiatric hospitals that would not exclude admission for youth with developmental disabilities, violent behavior, and/or a history of fire setting behavior in addition to diagnosed mental disorders. Expand special treatment programs for youth sexual offenders.

3. Policy Issues

- Convene workgroups to continue efforts to influence "inmate exception" policies excluding services to pre-adjudicated youth for Medicaid reimbursement.
- Provide training and technical assistance to county probation departments and mental health agencies to ease the administrative burden of Medi-Cal billing for services to post-adjudicated youth. Take an inventory of counties whose youth experience breaks in Medi-Cal eligibility as a result of being detained, and initiate administrative policies and procedures to ensure uninterrupted Medi-Cal eligibility upon release from detention.
- Develop funding guidelines and highlight innovative funding strategies to sustain mental health and substance services to detained youth
- Monitor the impact of DJJ Realignment and its effect on local detention facilities

VI. Limitations of Study and Recommendations for Further Research

Because of gaps in actual cost data for many of the domains in this survey, we were not able to rely on administrative data. For example, analysis of statewide data on "open mental health cases" has the potential to provide a good snapshot of those in detention who receive services, however as described in the report these data are problematic due to inconsistent definitions used across counties. Further research could, for example, involve brief surveys to counties to determine their methodology for reporting these data, as well as their current methods for documenting the intake and assessment information for mental health concerns. Such information would be helpful to CPOC to advocate to CDCR for better uniform reporting requirements.

Probation data systems are also not sophisticated enough to track service use. Indeed, some probation systems require enhancements simply to accurately count the number of facility admissions and releases for a particular youth. In some counties the mental health data system can track services to these youth, but this is the exception rather than the rule. Even in those counties where mental health services are tracked in the mental health data systems, it is difficult to identify youth who are served in (vs. "referred by") detention facilities. Without a more accurate record of actual services provided, the costs for these services cannot be determined with certainty. Surveys of counties can only provide limited information from respondents that is often based on incomplete case files or memory. The best and most cost-effective way to track prevalence and service use on an ongoing basis is to analyze administrative data. However, detention/probation and mental health data are tracked separately, making it very difficult to understand the mental health service use by youth in detention facilities. (For example, county mental health data systems do not currently contain enough information to identify youth who receive services while detained.) Further research to accurately identify the mental health services used by these youth would require merging both the probation and mental health services data sets, county by county. There is much interest at the federal level for projects that can merge these data sources in order to better understand such issues as 1) the correct matching of need for services to the available resources; 2) the actual use of services, by type of service, by intensity and length of service use, and by ethnicity to understand treatment disparities; 3) clinical correlates and the effectiveness of service in improving symptoms and presenting problems, and in reducing further recidivism and involvement with criminal justice; and 4) ultimately the cost-effectiveness of innovative treatments, programs and policies. Such topics might also include data about alcohol and other drug treatment. This type of project would be suitable for an academic partnership among CPOC, state agencies, county study sites, and academic researchers. The first step for such a project would be identify relevant federal funding sources (e.g. NIH, DOJ) that could provide exploratory grants as well as more sustained research grants.

An important limitation is the small sample of responses for some questions. This is especially problematic for cost estimates. Replication of this study to a larger sample of counties would improve the ability to accurately estimate these average costs. In addition, case studies of youth with extreme lengths of stay would better represent their experience with services and their costs. We did not gather data on the disproportionate use of juvenile detention facilities nor did we ask about disparities of mental health services use by minority youth. This would be an important

next step since there exist ethnic disparities in access to mental health services by vulnerable youth in the community (Yeh et al., 2002). These disparities extend to juvenile offenders. African American juvenile offenders in general have higher mental health needs than other ethnicities (Rawal, Romansky, Jenuwine, & Lyons, 2004), yet are less likely than white offenders to access mental health services, despite a positive assessment of severe psychopathology (Lopez-Williams, Vander Stoep, Kuo, & Stewart, 2006).

Addressing these issues would go a long way towards improving our understanding of the needs and services for these youth.

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Attachment 1: Advisory Group Members

Expert Consultant	Affiliation	Area of Expertise
William Arroyo, M.D.	Los Angeles County Mental Health Services (and Project Co-Chair)	Child and adolescent psychiatry, mental health services to juveniles in detention
Sandena Bader	Placer County Children's System of Care	Parent advocacy
Mike Bagnell	San Joaquin County Office of Education	Educational services
Sue Burrell, J.D.	Youth Law Center	Youth advocacy
Edward Cohen, Ph.D.	San Jose State University, School of Social Work	Mental health and child welfare services research; survey research
Gwen Foster, M.S.W.	The California Endowment	Program Officer, Mental Health
LaRon Hogg	Administrative Office of the Courts	Court administration, legal costs
Elaine Husted, R.N.	California Forensic Medical Group	Healthcare providers, health costs in jails & detention facilities
Pete Judy	Stanislaus County Probation Department	Juvenile hall administration, special programming
Shirlee Juhl	Tuolumne County Juvenile Probation	Juvenile probation, administration of detention facilities
Karen Pank	CPOC (Executive Director[18])	Probation administration, legislative and policy issues
Jane Pfeifer, M.P.A.	CPOC (and Project Director)	Criminal justice policy and research
Carole Shauffer, J.D.	Youth Law Center	Youth advocacy

[18] Norma Suzuki, former Executive Director, served on the panel until October 31, 2006

Expert Consultant	Affiliation	Area of Expertise
Dan Souza, M.S.W.	Stanislaus County Behavioral Health Services (retired)	Mental health administration, mental health and substance abuse services
Ellen Walker, M.P.H.	Zellerbach Family Foundation	Program Officer, Mental Health

Attachment 2: List of Participating County Sites for Surveys and Site Visits

Region	County	CFMG*	Site Visit Occurred	Youth Law Center**
Bay Area	Alameda		X	X
Bay Area	Contra Costa	X		X
Bay Area	San Francisco	X		
Bay Area	Santa Cruz			
Bay Area	Solano	X	X	
Central	Fresno			
Central	Merced	X	X	
Central	Stanislaus	X	X	
Northern	Butte	X	X	
Northern	Del Norte	X		
Northern	Glenn	X	X	
Northern	Humboldt	X		
Sacramento	Nevada	X	X	
Sacramento	Placer	X		
Southern	Imperial	X		
Southern	Los Angeles		X	X
Southern	Orange	X	X	X
Southern	San Bernardino		X	X

*CFMG: California Forensic Medical Group
**Youth Law Center: Counties included in the Youth Law Center survey (Burrell & Bussiere, 2005)

Attachment 3: Recommendations from Site Visits

These items were extracted from site visit interviews. There are not arranged in any order of priority, nor were they edited for redundancy or duplication.

Service needs:

1. Treatment foster care
2. Intensive day treatment—only resource in county is private
3. Transportation barriers for families
4. Need better resources in county for SED kids, in general
5. Improved mental health staffing for detention facilities
6. Increase staff so that every youth can be assigned a case manager
7. Gang intervention program
8. Non-juvenile justice alternatives , such as community development and broad based crime prevention
9. Community based alternatives such as Resource Foster Families
10. State staffing ratios are out of date and insufficient—still geared towards youth who offend but no mental health issues. Stanislaus' ratio is higher due to their maximum security unit staffing. MH unit has lower staffing, "but they should really have the highest ratio." Concerns about staff burnout and turnover. MH staff need lots of supervision.
11. The county will need increased capacity for preventive services due to the changes in the CYA admission criteria
12. Better communication between facility and field probation officers
13. Mental health "always understaffed"
14. Better coordination re: follow up with medications after release
15. Therapeutic Behavioral Services—could use it for placement kids who are Medi-Cal eligible
16. Continuity of medications is a problem
17. Lots of neuro-behavioral issues not addressed by current screening tools—it's a huge issue. Also, defense attorneys don't always want that mentioned in court records, so information gets lost.
18. Staff have to be more sensitive to learning problems of juveniles
19. Delays in getting youth to a hospital; nearest one is Sacramento
20. Poor continuity of care after release
21. We're not set up to see families despite the need for it
22. Need more non-mental health supportive services along with mental health related services
23. No MH services provided to detained youth by county Behavioral Health
24. Continuity of medications after release, beyond 3-day prescription
25. Services to youth ageing out of services—age 18, especially transitional housing
26. Field POs have very high caseloads
27. Education—hard to teach youth in detention

Placement needs:

1. CTF—locked mental health placements
2. Improvements in Interstate Placement Compact—it takes too long now
3. Regional placement facilities for youth with MH needs, such as the CTFs but more bed capacity, and more linkages with home community to facilitate transition
4. Placement alternatives for DD youth, which would involve collaborative planning with Regional Centers
5. Level 14 beds
6. Need level 14 CTF
7. Regional centers—facilities that specialize in mental health problems
8. The "old state hospital type of beds" where the most ill youth can be sent
9. Small placement facilities with high staff ratio for older adolescents, specialized in preparation for independent living
10. Prefer having placements locally rather than CTF model; enough capacity for about 20-25 high-risk placements per year

Policy issues:

1. "Incompetent to stand trial"—creates barriers locally (problems with local coordination and funding)
2. Medications—Reese Hearings limit use of meds in facility—need to send to hospital if youth refuses medications.
3. Better ability to share information between mental health and probation (resulting from a combination of legal limitations and staff training)
4. Increased availability of MHSA funding for detained youth (not just pre-detention prevention services)
5. Better coordination between probation and mental health agencies
6. Differing philosophy about treatment between probation and Behavioral Health
7. HCA "enormous bureaucracy" makes it hard to improve services and coordination—wards are a small percentage of HCA's target population
8. Medi-Cal unavailable for detained youth
9. Local issue—probation charged 100% for HCA overhead; also probation tends to lose general funds due to new grant money (i.e. facility staff tend to see more mental health issues than BH)
10. Medi-Cal—not only unavailable for detained youth, eligibility break creates barriers for continuity after release due to administrative procedures
11. Need more longitudinal research post-release
12. Barriers to sharing records across agencies due to confidentiality laws
13. Medi-Cal coverage
14. 1:10 ratio is inadequate, if you have just one youth with serious problems
15. Medi-Cal funding
16. Medi-Cal funding
17. DJJ 90-day diagnostic center referrals—comes out of probation budget
18. Not enough money—detained youth not getting enough attention from MHSA; need a more solid funding stream for their mental health services

Attachment 4: Costs of an Extended Detention Stay—Methodology and Limitations

The purpose of this cost estimate is to provide an expanded picture of the potential costs for detaining youth with suspected or diagnosed mental disorders. While the definition of "suspected or diagnosed mental disorder" remains problematic as described in the Final Report, most respondents would agree that there is a continuum of emotional problems, from the expectable emotional reactions to incarceration to, on the extreme end, the most serious and disabling mental disorders. While all youth along this continuum may need some type of intervention, this cost estimate addresses youth who may experience delays in release as a result of their condition or of dispositional issues that are related to their emotional condition. In contrast to the Waxman report's methodology, we developed a cost estimate for an individual youth case study rather than the state as a whole.

Length of Stay

From the survey, the respondents estimated that that these youth stay 35 days longer than youth without such emotional problems (17 days longer pre-disposition, and 18 days longer post-disposition). We used the respondents' estimation of 35 days as a basis for the cost estimate to arrive at the increased costs for these youth, noting that the youth with more extreme problems whose lengths of stay are much longer are more problematic for detention facilities. For the youth with extreme stays (several months or one or more years) these cost estimates would have to be adjusted to account for more or less intensive services during the length of stay in addition to the added costs of efforts to find suitable placements, and a more individualized accounting of actual services and staff effort would be required to represent their costs.

Mental Health and Substance Abuse Services in Detention

We used survey data on the costs of mental health and substance abuse services, averaged over the responses. Most respondents reported their counties' Medi-Cal State Maximum Allowance (SMA) minute rates as a proxy for costs, even though Medi-Cal is not billed for most services. Since it was beyond the scope of the project to obtain and analyze mental health administrative data to determine what actual services were provided, we developed the costs for a "typical" course of mental health treatment for a youth with a mental disorder (such as depressive disorder), based on the services that were reported being provided by most counties in detention facilities. We then averaged the SMA for each service from the survey data. This course of treatment for our case study includes

- A mental health assessment (30 minutes)

- A medication assessment and weekly medication monitoring visits by a psychiatrist (each 30 minutes)
- Twice weekly individual psychotherapy sessions (50 minutes)
- Once weekly group therapy session (each valued at the SMA for 15 minutes per youth per session)

We also assumed weekly substance abuse treatment groups and substance abuse educational groups, using the per-session rates from the survey.

Educational Costs

In the survey we asked for the "average annual educational costs" which we then divided by each county's average daily population census from 2006 (the most recent complete data available from the California Department of Corrections and Rehabilitation, or CDCR) to obtain an overall average per-youth per-day educational cost of $56.87.

Transportation and Intensive Monitoring—Staff Time

To assess the cost of extra staff time for these youth, we relied on salary information from the 2008 Salary Survey of California Probation Departments, Prepared by the Orange County Probation Department (Chief Probation Officers of California, 2008). The salary used was the median entry level facility salary (top of range) of $44,708 for positions such as Group Supervisor or Juvenile Hall Counselor (from p. 195 of the Salary Survey report). We then divided this salary by 2,080 hours to determine an hourly salary rate. We did not include a fringe benefits rate or other indirect personnel costs. We averaged the amount of time for tasks such as transporting youth to hospitals (e.g. using one driver plus two other accompanying staff) and transportation and accompaniment to two court hearings (assuming two "15-day reviews" during the post-dispositional stay). The number of hours for these tasks was averaged from survey responses.

Since these youth occasionally need extra staff monitoring for safety or protection, for our case example we assumed one 24-hour "episode" of 1:1 monitoring by one FTE facility staff, using the same salary methodology described above.

Psychiatric Hospitalization

For this case example we assumed one three-day stay in a psychiatric hospital at some point during the detention stay. We averaged the daily hospital rate from survey responses. We also included the costs of daily 60-minute psychiatrist sessions but we did not factor in other costs that might not be included in the daily hospital rate (such as psychological testing, outside lab testing, etc.)

Table 8 shows the cost estimate for this extended stay case example.

Medications

We did not include an average cost of medications in this table, since we could not use the same 35-day methodology. In the survey respondents reported the last year's annual cost of medications, which averages $168,198 over all respondents. To estimate an average per-youth, per-stay cost of medications we used data from surveyed counties' CDCR reports in 2006 on the "number of juveniles receiving psychotropic medications". For each county we determined the average monthly number of youth on medications, and divided the annual cost in the survey by that number. The overall average cost of medications per-youth, per-stay is $4,387.

Limitations

A major limitation of this cost estimate is that for some survey items the number of responses yielded a small sample from which to average length of stay and cost data—averages may change with a larger sample. In addition, some of the items for which administrative data were not available may have been subject to recall bias.

Table 8. Costs of an Extended 35-Day Detention Stay

Cost Item	Brief Description	Cost	Cost Method
Facility	Cost of daily rate for 35 days	$7,210	Average facility rate from survey ($206)* average LOS of 35 days longer for these youth
Psychiatrist medication visits	Initial 30 minute assessment and 5 follow up (30 minute)	1,121	Average Medi-Cal minute SMA from survey $6.23*30 minutes*6 weeks
MH Assessment	Initial 30 minute assessment by Mental Health Clinician	101	Average Medi-Cal minute SMA from survey $3.37*30 minutes
MH individual psychotherapy	Twice weekly individual psychotherapy	1,685	Average Medi-Cal minute SMA from survey $3.37*50 minutes*five weeks*2
MH group therapy	Once per week group therapy	222	Average Medi-Cal minute SMA for group treatment $2.96*15 minutes*5 weeks
Substance abuse group treatment	Once per week SA treatment group	375	Group rate of $75 from survey*5 weeks
Substance abuse education group/class	Once per week educational group	325	Group rate of $65 from survey*5 weeks
Transportation and staffing—hospital and appointments	One 4-hour trip per week for specialized MH or hospital appointments	1,290	Salary of three entry level facility staff*4 hours per week*5 weeks
Transportation and staffing—court hearings	Two post-disposition court hearings	172	Salary of two entry level facility staff (same salary as above)*2 hours*2 hearings
Education	Daily education program for 35 days	1,995	Average per-youth daily education cost from survey of $56.87*35 days
Extra staffing for monitoring	One 1:1 “episode” for 24 hours	516	Salary of one entry level facility staff (same salary as above)*24 hours
Psych hospital	One 3-day stay in a psychiatric hospital, per diem plus once daily 60 minute MD visits	3,881	Average daily hospital rate from survey of $920* 3 days plus daily 60-minute psychiatrist visits ($6.23*60*3days)
Total		$18,893	

Attachment 5: Final Survey Instrument

Chief Probation Officers Association
"Costs of Incarceration for Youth with Mental Illness"

Survey of County Detention Facilities and Agencies

Chief Probation Officers Association
"Costs of Incarceration for Youth with Mental Illness"

Survey of County Detention Facilities and Agencies

Chief Probation Officers Association
"Costs of Incarceration for Youth with Mental Illness"

Survey of County Detention Facilities and Agencies

Introduction

The "Costs of Incarceration for Youth with Mental Illness" Project directed by the Chief Probation Officers of California (CPOC) has as its mission to inform public policy development by analyzing the costs and contexts related to incarcerating youth with mental illness and co-occurring mental illness/substance use disorders in California detention facilities. Information obtained from this study will help us advocate for better services in order to prevent the inappropriate criminalization of youth who would be better served in treatment settings, improve services to youth who must be separated from the community and who also require mental health treatment, and improve services to ensure continuity of care once youth are released from detention.

Who Are 'Youth with Mental Illness'?

We define "mental illness" broadly to include any youth with emerging or active mental disorders or behavioral signs of disorders that seem to require the intervention of mental health specialists. This would include youth who, to the knowledge of probation staff, are at risk for danger to themselves, danger to others due to a suspected emotional disorder, or who show evidence of a lack of capacity to care for themselves due to a severe emotional disorder. Our population of interest also includes any youth who have already been diagnosed with a mental disorder who had been under the care of mental health specialists prior to detention, as well as youth with co-occurring mental health and substance abuse disorders. (Any youth with "open mental health cases" would qualify in addition to the youth described above.) *Note—the survey mainly focuses on juvenile detention facilities, so answers to questions should be related to those facilities or, for facilities with combined detention and placement beds, specifically to youth housed in detention beds.*

Organizations Involved

The collaborating organizations that have endorsed this CPOC effort include the California Mental Health Directors Association (CMHDA) in conjunction with the Multi-Association Joint Committee (MAJC), and United Advocates for Children of California (UACC), a child and family advocacy organization. In preparation for this study these organizations helped identify experts who assisted in the development of this survey instrument, and who will continue to serve in an advisory capacity throughout the study.

Instructions for Completing This Survey

Due to the lack of consistent administrative data on costs and the involvement of multiple agencies in the care of detained youth, we have developed a survey instrument to obtain

information from key informants. In the absence of readily available data, information should be estimated as best as possible. Feel free to make notes explaining your answers as needed. We encourage you to obtain information from others such as mental health managers, data experts, healthcare vendors, County Office of Education, and staff from other agencies. If this is the case in your county, please indicate who assisted in completing the survey in the Identifying Information section on page iv.

The survey is divided into sections (see the Table of Contents) that can be downloaded from a publicly available page of the CPOC website at www.cpoc.org/mhsurvey.htm. You may direct other agencies to this website URL to download their respective sections.

The survey can be completed electronically (make sure to save your changes), or in writing. Multiple copies of this instrument can be distributed as needed. We may send you email messages if questions or instructions need further clarification.

Other instructions for specific questions are ***bolded and italicized***, for example "***If Yes, go to 18a***."

Use of Data and Privacy of Information

Although your county may be identified in reports as a participating county, for the most part the data will be aggregated for reporting averages, trends, overall costs etc. Names of specific people completing the survey will never be reported. Where it is necessary to name your county in reports (i.e. to describe a case example), you will have an opportunity to review drafts for errors or inaccuracies.

Acknowledgements

This survey is made possible with funding from The California Endowment and The Zellerbach Family Foundation. We thank them for their support of this important work.

Questions about completing this survey? Contact:
Edward Cohen, Research Director
510-643-6556
cell: 510-847-6407
ecohen@berkeley.edu

Please return completed surveys ***within one month of receipt*** via postal mail, email or fax to:

Chief Probation Officers of California
1415 L Street, Suite 200
Sacramento, CA 95814
Attn: Jane Pfeifer, Policy Director
Email: jpfeifer@cpoc.org
Fax: 916-442-0850

Thank you very much for your help with this survey!

Respondent Information

County Name:
Date Survey Completed:

List all who completed survey or provided key data:		
Name of Respondent	**Agency**	**Phone/email**

CPOC Use Only

Date Survey Received	
Date data entered	

Table of Contents

Chief Probation Officers Association
"Costs of Incarceration for Youth with Mental Illness"

Survey of County Detention Facilities and Agencies

I. Basic Facility Costs

1. What is the basic daily room and board rate for your facility ***(see instructions on page i for "facility" definition)***?

2. Does this rate include any special mental health or substance abuse treatment costs (aside from basic health screening)?

X:

	1 Yes
	0 No

County _____

II. Characteristics of Detained Youth

3. a. On average over the course of a year, what percentage of your detained juvenile population are estimated to be those with suspected or diagnosed mental illness?

   ____ %

   3b. Is this your estimate, or were you able to obtain data from your information system or case records?

   X one:

	1 Estimate
	2 Data from information system
	3 Data from case records

4. From your available data on "open mental health cases" and youth on psychotropic medications reported for the "Juvenile Detention Survey" for the state's Corrections Standards Authority from the 2nd quarter ending June, 2006, please enter:

   4a. # of Open Mental Health Cases as of the 2nd quarter ending June, 2006:

   ____

   4b. # of Detained youth on psychotropic medications as of the 2nd quarter ending June, 2006:

   ____

5. On average over the course of a year, what percentage of your detained juvenile population would you estimate to be those with a co-occurring mental health and substance use disorder?

   ____ %

County _____

6. Question 6 pertains to your estimates of the average *pre-disposition* length of stay (LOS) for juveniles who have suspected or diagnosed mental illness or co-occurring disorders.

6a. The average length of stay *prior to disposition* (***Indicate days, weeks or months***):

Enter avg LOS pre-disposition:	***X one:***	
		1 Days
		2 Weeks
		3 Months

6b. Is this your estimate, or were you able to obtain data from your information system or case records?
X one:

	1 Estimate
	2 Data from information system
	3 Data from case records

6c. In your estimation, is the length of stay prior to disposition the same, less or more than that of other youth without mental illness or co-occurring substance use disorder?
X one:

	1 Less than other youth ***Go to 6d.***
	2 About the same as other youth ***Go to* 7.**
	3 More than other youth ***Go to 6e.***

6d. ***(Skip if "About the same" or "More" was checked)*** How much *less* is the pre-dispositional length of stay for these youth?

How much less?	***X one:***	
		1 Days
		2 Weeks
		3 Months

County _____

6e. ***(Skip if "Less" or "About the same" was checked).*** How much *more* is the pre-dispositional length of stay for these youth?

How much longer?	***X one:***	
		1 Days
		2 Weeks
		3 Months

7. Question 7 pertains to your estimates of the average *post-disposition* length of stay (LOS) for juveniles who have suspected or diagnosed mental illness or co-occurring disorders.

7a.. The average length of stay *post*-disposition (***Indicate days, weeks or months***):

Enter avg LOS post-disposition:	***X one:***	
		1 Days
		2 Weeks
		3 Months

7b. Is this your estimate, or were you able to obtain data from your information system or case records?
X one:

	1 Estimate
	2 Data from information system
	3 Data from case records

7c. In your estimation, is the length of stay post-disposition the same, less or more than that of other youth without mental illness or co-occurring substance use disorder?
X one:

	1 Less than other youth ***Go to* 7d.**
	2 About the same as other youth ***Go to 8.***
	3 More than other youth ***Go to* 7e.**

7d. ***(Skip if "About the same" or "More" was checked)*** How much *less* is the post-dispositional length of stay for these youth?

County _____

How much less?	***X one:***	
		1 Days
		2 Weeks
		3 Months

7e. ***(Skip if "Less" or "About the same" was checked).*** How much *more* is the post-dispositional length of stay for these youth?

How much longer?	***X one:***	
		1 Days
		2 Weeks
		3 Months

8. a. For youth who have multiple detention admissions during the course of the year, is your data system able to report the length of stay for each separate stay?

X:

	1 Yes
	0 No ***If No skip to9.***

8b. From the available data, what was the average length of stay for youth who had two or more admissions *for a two-year period* from January 2005 – December 2006 (e.g. excluding youth who were only admitted once)? Do not include those admissions in which youth were currently detained as of December 31, 2006.

9. Please rate how common and how difficult the following list of problems are in your facility. ("Common" refers to how often youth with these problems are present in your facility. "Difficult" refers to the level of staff effort over and above that needed for youth without mental and co-occurring disorders.) ***Rate each of the following five problem categories from <u>not</u> (1) to <u>very</u> (5) common in the second column, and from <u>not</u> (1) to <u>very</u> (5) difficult for your facility staff in the third column.***

Category of Problem	***Rate how common:*** ***1 = Not common*** ***5 = Very common***	***X:***	***Rate how difficult:*** ***1 = Not difficult*** ***5 = Very difficult***	***X:***
Suicidal thinking, attempt, or intent	9a. 1 = not common		9b. 1 = not difficult	
	2		2	
	3		3	
	4		4	
	5 = very common		5 = very difficult	
Risk of danger towards others due to mental disorder	9c. 1 = not common		9d. 1 = not difficult	
	2		2	
	3		3	
	4		4	
	5 = very common		5 = very difficult	
Poor self care (such as eating, sleeping disturbances)	9e. 1 = not common		9f. 1 = not difficult	
	2		2	
	3		3	
	4		4	
	5 = very common		5 = very difficult	
Psychotic thinking, hallucinations, strange behavior	9g. 1 = not common		9h. 1 = not difficult	
	2		2	
	3		3	
	4		4	
	5 = very common		5 = very difficult	
Poor behavior control (e.g. due to illicit substances, hyperactivity, or impulse control problem)	9i. 1 = not common		9j. 1 = not difficult	
	2		2	
	3		3	
	4		4	
	5 = very common		5 = very difficult	

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9k. Any other relevant problems not listed? ***Describe:***

10. Over the past year, how many youth required 1:1 staffing or intensive monitoring in the facility due to suspected or diagnosed mental illness?

11. For youth who require 1:1 staffing, what would you estimate to be the average amount of time that staffing is needed for a youth (report in days, weeks or months)?

Enter avg time 1:1 staffing:	***X one:***	
		1 Days
		2 Weeks
		3 Months

12. When youth require 1:1 attention, do you usually use existing scheduled staff, or more typically call in extra staff?

X one:

	1 Use regularly staff
	2 Call in extra staff
	3 Combination of regularly scheduled and called-in staff

13. How many days per month do you estimate that probation staff accompany a youth outside the facility for either psychiatric/counseling appointments, psychiatric emergency screening or psychiatric hospitalization?

	Days/month

13a. In your estimation, what is the average time in number of minutes or hours it takes to transport a youth for either psychiatric/counseling appointments, psychiatric emergency screening or psychiatric hospitalization?

Enter average time:	***Indicate minutes or hours:***	
		1 Minutes
		2 Hours

14. There may be other facility costs as a result of detaining youth with mental disorders or co-occurring disorders, such as damage to the facility, broken furniture, etc. Please describe your experience (and if possible, any estimated extra costs involved):

Describe:

15. In the past year have there been injuries to staff as a result of caring for detained youth with mental disorders or co-occurring disorders, or stress-related illness that you are aware of? If so, how many staff have been injured or otherwise compromised due to stress?

15a. ***X one:***

	1 Yes there were such injuries known to us	15b. Enter number of staff injured:	15c. Enter average number of lost work days per injured staff in the past year:
	2 Yes, there may have been such injuries but we do not know how many		
	3 No, there were no such injuries to our knowledge		

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III. Services and Costs for Mental Health Treatment

16. What mental health services are provided for detained youth (not including 24 hour residential)? ***Indicate cost per unit, if known, for those checked:***

X all that apply:	Mental health service	Estimated cost:	Per ***(X one type of unit)***: ***X:***
	16a. Mental health diagnostic assessment	16b.$	1 Minute 2 Session
	16c. Individual psychotherapy	16d.$	1 Minute 2 Session
	16e. Family therapy	16f. $	1 Minute 2 Session
	16g. Group psychotherapy or psychoeducation	16h.$	1 Minute 2 Session
	16i. Medication monitoring by M.D.	16j. $	1 Minute 2 Session
	16k. Case management	16l. $	1 Minute 2 Session
	16m. Mental health crisis intervention	16n.$	1 Minute 2 Session
	16o. Day treatment	16p.$	1 Half day 2 Full day
	16q. Other Specify:	16r. $	Describe unit of cost:

17. How many of the youth who need mental health services (see list above, 16) receive or are at least offered ongoing care (except for assessments and crisis interventions) throughout their stay in detention?

X one:

	1 None who need care
	2 Few who need care

County _____

	3 Most who need care
	4 All who need care

18. Does County Mental Health provide any of the mental health services at the facility?

X:

	1 Yes
	0 No ***If No go to 19.***

18a. What type of county staff provide services at the facility?

X all that apply:

	Licensed clinicians
	Non-licensed clinicians or paraprofessionals
	Licensed supervisor(s)

19. Are there independent contractors (e.g. county contractors or other non-county staff) who provide any mental health services at the facility?

19a. ***X:***

	1 Yes ***If Yes, describe and proceed to question 19c***
	0 No ***Go to 20.***

19b.

Describe:

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19c. What type of contract provider staff provide services at the facility?

X all that apply:

	Licensed clinicians
	Non-licensed clinicians or paraprofessionals
	Licensed supervisor(s)

20. Does your facility contain a special mental health detention unit?

20a. ***X:***

	1 Yes
	0 No ***If No go to 21***

20b. If so, is there an additional rate for this unit?

X:

	1 Yes ***If Yes, indicate rate:***	20c. $
	0 No	

21. What type of hospital is used for psychiatric emergencies?

X all that apply:

	Community general hospital or university hospital
	Private psychiatric hospital
	County hospital
	Non-hospital crisis program
	Other ***Specify:***

County _____

22. What type of hospital is used for psychiatric admissions and what is the average daily (*per diem*) cost, if known, for those checked?

X all That apply:		Average Per Diem Rate
	22a. Community general hospital or university hospital	22b. $
	22c. Private psychiatric hospital	22d. $
	22e. County hospital	22f. $
	22g. Non-hospital residential program	22h. $
	22i. Other Specify:	22j. $

23. On average, what would you estimate is the average length of hospital stay in days for psychiatric admissions of youth from detention?

24. Approximately how many children and youth were hospitalized for psychiatric reasons from your detention facility in the past year?

24a. What was your primary source of data for how many children and youth were hospitalized?

X one:

	1 Probation/facility information system
	2 Mental health information system
	3 Case files
	4 Estimate from memory or staff consultation
	5 Health care vendor information system or report

25. a. What is the average cost per year for psychiatric medications to youth in your facility?

$

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25b. What was your *primary* source of data for costs of psychiatric medications?

X one

	1 Probation/facility information system
	2 Mental health information system
	3 Case files
	4 Estimate from memory or staff consultation
	5 Health care vendor information system or report

26. How are psychiatric medications funded?

X all that apply:

	County mental health
	County health or public health department
	County general funds or other county dollars
	Probation or juvenile justice dollars
	Other ***Describe:***

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IV. Substance Abuse Services and Costs

27. Who provides screening for substance use, need for detoxification, or other related substance abuse issues?

X all that apply:

	Detention facility staff
	County mental health staff
	Contracted medical staff in detention facility
	Community general hospital or university hospital
	Private psychiatric or substance abuse facility
	County hospital or substance abuse facility
	Other ***Specify:***

28. For youth requiring detoxification, where does this occur?

X all that apply:

	Detention facility
	County mental health facility
	Community general hospital or university hospital
	Private psychiatric or substance abuse facility
	County hospital or substance abuse facility
	Other ***Specify:***

29. a. What is the percentage of detained youth who require detoxification prior to admittance?

%

29b. What was your *primary* source of data for the percentage who require detoxification?

X one:

	1 Probation/facility information system
	2 Mental health or alcohol and drug information system
	3 Case files
	4 Estimate from memory or staff consultation

30. Does your facility contain a special substance abuse detention unit?

30a. ***X:***

	1 Yes
	0 No ***If No, go to 31***

30b. If so, is there an additional rate for this unit?

X:

	1 Yes ***If Yes, indicate rate:***	30c. $
	0 No	

30d. Are youth with co-occurring mental health and substance abuse disorders eligible for this unit?

X:

	1 Yes
	0 No

County _____

31. What substance abuse services are available at your facility? Include costs if known (over and above basic facility rate):

X all that apply:	Services available	Estimated cost *if over and above basic facility rate*	Per (***X one type of unit)*** X:	
	31a. Individual or group treatment for substance abuse problems	31b. $		1 Minutes
				2 Sessions
	31c. General education focusing on substance use problems	31d. $		1 Minutes
				2 Sessions
	31e. On-site AA or other type of community volunteer meetings	31f. $		1 Minutes
				2 Sessions
	31g. Other ***Specify:***	31h. $	Describe unit of cost:	

32. How many youth with co-occurring mental health and substance use disorders receive these substance use services (see above, 31) in your facility?

X one:

	1 None who need care
	2 Few who need care
	3 Most who need care
	4 All who need care

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V. Services and Costs of General Healthcare

33. What healthcare costs are not included in the basic facility rate listed in question 1?

Check all that apply:

	Basic health screening
	Medications
	Pharmacy operations
	Doctor visits
	Nursing care
	Health screening
	Other ***Describe:***
	Other ***Describe:***

34. Does your county contract with a healthcare provider organization for services in your facility?

34a. ***X:***

	1 Yes ***If Yes, indicate 2006 annual contract amount, if known:***	34b. $
	0 No	

35. Is there a licensed pharmacist on-site at the facility?

X:

	1 Yes
	0 No

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36. Is there an on-site lab at the facility?

X:

	1 Yes
	0 No

37. Does your facility provide 24-hour nursing?

37a. ***X:***

	1 Yes ***If Yes go to 38.***
	0 No

37b.If not, are there plans to implement 24-hour nursing?

X:

	1 Yes
	0 No

38. How many days per month do you estimate that probation staff accompany a youth to a hospital for either post-admission screening or hospitalization for physical healthcare?

39. In your opinion, how does the healthcare status of detained youth with suspected or diagnosed mental illness or co-occurring disorders compare with that of detained youth without such disorders?

X one:

	1 Health status of these youth is generally worse
	2 Health status is about the same
	3 Health status of these youth is generally better

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VI. Costs of Educational Services

40. What is the average basic daily cost of the school program at your facility?

$

41. Who locates and obtains current IEP information from the previous school for detained youth?

X all that apply:

	Educational staff
	Facility probation staff
	Facility administrative or clerical staff
	Non-facility probation staff
	Mental health staff
	Other (specify: _____)

42. Are additional facility staff ever required in the classroom beyond normal staffing due to a youth's mental health status?

X:

	1 Yes
	0 No

43. What additional educational services are provided, and what are their average annual costs *over and above the basic daily cost of the school program*, if known?

X all that apply:

	Additional services:	Average annual cost for those checked:
	43a. Language interpreters	43b. $
	41c. IEP Functional Behavioral Assessments	43d. $
	43e. Speech and language therapy	41f. $
	43g. Other occupational rehab therapy	43h. $
	43i. Other service ***Describe:***	43j. $
	43k. Other service ***Describe:***	43l. $

44. The following questions pertain to support for facility educational activities provided by facility staff (as opposed to educational staff).

On average, how much time is spent per week assisting with the following educational activities?

Educational support activity in the facility	*Facility staff*, average time per week in hours	
Contacting schools for records	44a.	
Assisting with teaching	44b.	
Providing informal tutoring	44c.	
Assisting with coordination, scheduling, or other administrative tasks related to facility classroom	44d.	
Other activity ***Specify:***	44e.	
Other activity ***Specify:***	44f.	

45. In your opinion, do youth with suspected or diagnosed mental illness or co-occurring disorders require more, less or about the same amount of special education services as youth without these disorders?

X one:

	1 These youth require more special education services
	2 These youth require about the same special education services
	3 These youth require less special education services

46. How much are special education needs addressed by the school district to juveniles in the facility?

X one:

	1 All special education needs of student are addressed
	2 Partial special education needs are addressed (or only to some students)
	3 Almost no special education needs are addressed (or none at all)

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VII. Legal and Court-Related Expenses

47. On average, how many hours per week do probation/facility staff transport juveniles to court hearings?

48. Are there other legal or court-related costs unique to youth with suspected or diagnosed mental illness or co-occurring disorders? Please describe:[1]

[1] Note—We will also examine overall court costs in relation to length of stay and number of 15-day reviews.

VIII. Other Costs

49. Are there other relevant services and costs we have not asked about? Are there other effects on your facility or staff that we have not captured in this survey? Please describe: