DEPARTMENT OF MENTAL HEALTH

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SUBJECT: **REPORT RESPONSE ON THE OFFICE OF INSPECTOR GENERAL INVESTIGATION AND IMPROVING MENTAL HEALTH TREATMENT AND SAFETY IN THE JUVENILE FACILITIES (ITEM 7, AGENDA OF FEBRUARY 19, 2019)**

Purpose

On February 19, 2019, in response to findings from an Office of Inspector General (OIG) investigation into concerning incidents of use and force and pepper spray in juvenile justice facilities, the Board instructed the Director of the Department of Mental Health (DMH), in coordination with the Chief Probation Officer, Inspector General (IG), and community stakeholders to report back in writing in 60 days with an assessment of the mental health needs in the juvenile facilities, including areas to improve trauma-informed approaches and reduce use of force.

Summary

The County's juvenile justice system is the product of a juvenile incarceration model that is flawed and fundamentally fails to adequately meet the current developmental and mental health needs of youth and their families. Outdated facilities and high levels of use of force create an environment that is not conducive to the overall wellbeing of youth, and also frustrates efforts to provide effective services and programming. In order to complete

the transition to a more effective, community-based therapeutic model, a foundational overhaul is needed.

DMH received input from the Los Angeles County Probation Department (Probation) and the OIG in preparation of this report. DMH also is in the process of soliciting input from community stakeholders (e.g., community-based organizations, justice-system-impacted youth, and parents of these youth), as-well-as staff from various County agencies working in juvenile justice facilities.

DMH is also working with stakeholder groups with the help of the UCLA Prevention Training Center of Excellence (UCLA PTCE); which is conducting research into the mental health needs of youth in the County's juvenile justice facilities (primarily juvenile halls), areas to improve trauma-informed approaches and reduce use of force, and other related topics.

We look forward to increasing our collaboration with the full-range of County partners working in Los Angeles County's juvenile justice facilities as-well-as communities, end-users, and various advocates to optimize resources to improve the wellbeing of youth in need. Going forward we anticipate receiving and utilizing further information and data to help guide our ability to provide excellent care to youth in community-based alternatives to incarceration, or when needed, community-based residential facilities, as opposed to detention facilities, whenever possible.

Background

Over the past 15 years, in large part due to diversion initiatives pursued by the Board through various County departments, as-well-as declining juvenile crime rates, the number of youth housed in Probation facilities has decreased significantly, dropping from a high of approximately 4,000 youth in 2004, to approximately 800 in early 2019. Similarly, from 2005 to 2015, youth arrests declined sharply, from 56,286 to 13,665, a decrease of almost 76%. These have been remarkable and positive outcomes, as almost all of the existing scientific literature supports the notion that youth maintained in the community (vs. detained in a juvenile detention facility) and who avoid contact with the juvenile justice system at all (i.e., are diverted and/or not arrested) fare better in multiple domains and outcomes.

Concomitant with the prior and current, successful collaborative efforts of various County partners to reduce the number of youth arrested and/or detained, the availability of residential treatment options/placements (in lieu of incarceration) for more severely mentally ill youth or youth at high-risk of self-injurious behavior or violence has decreased

significantly over the past 10-15 years, as facilities have closed, downsized, or decided not to serve youth involved in the juvenile justice system.

As a result, youth who remain detained and housed in Probation facilities, particularly juvenile halls, are significantly more likely than youth from a decade ago to suffer from severe mental disorders, particularly trauma-related disorders and symptoms and substance use disorders, and therefore are more likely to be receiving ongoing mental health services. This is reflected in the table below:

Number/Percentage of Youth with Open Mental Health Cases
Juvenile Halls (2015-18)

Juvenile Hall Facility	Year	Average Daily # of Open MH Cases	Percentage (%) of Average Daily Population
Barry J Nidorf	2015	144	62%
Barry J Nidorf	2016	129	60%
Barry J Nidorf	2017	177	81%
Barry J Nidorf	2018	191	96%
Central	2015	192	80%
Central	2016	175	79%
Central	2017	204	86%
Central	2018	197	93%
Los Padrinos	2015	121	53%
Los Padrinos	2016	133	61%
Los Padrinos	2017	172	74%
Los Padrinos	2018	174	85%

Such youth also suffer from suicidal thinking, engage in self-injurious and/or aggressive behavior, and have a higher risk of repeat involvement in juvenile corrections. In addition, youth currently detained in juvenile halls are more likely to have experienced commercial sexual exploitation, homelessness, and a variety of other severe stressors and/or traumas, which can cause new or exacerbate underlying mental health issues.

Similarly, the percentage of youth in Los Angeles County juvenile justice facilities treated with psychotropic medication (including over-the-counter sleep medications increased from 26% in early 2018 to 35% in early 2019. These trends may serve as proxy measures of the severity of detained youths' mental health and substance use disorders.

The observed rates of general categories of mental disorders for youth in Los Angeles County juvenile halls is consistent with national rates and trends (i.e., high rates of mental disorders and substance use disorders, listed either as primary or secondary diagnoses) and are outlined below:

Diagnostic Profile of Current Open Mental Health Cases in the Juvenile Halls
Juvenile Justice Assessment – Primary Diagnosis Listed

Diagnostic Category	Percentage
Disruptive, Impulse Control and Conduct Disorders	39%
Mood Disorders	30%
Anxiety and Trauma/Stressor Related Disorders	29%
Psychotic Disorders	2%
Substance Related and Addictive Disorders	<1%

Juvenile Justice Assessment – Secondary Diagnosis Listed

Diagnostic Category	Percentage
Secondary Substance Related Disorders	48%
Secondary Anxiety and Trauma/Stressor Related Disorders	6%

The above rates likely significantly underestimate the mental health needs of the youth due to current assessment practices' not fully detecting disorders (particularly Trauma-related disorders, substance use disorders, and developmental disorders) and because the above rates do not reflect mental health symptoms that cause youth problems, but are not severe or pervasive enough so that the youth meets criteria for a formal diagnosis.

Current Mental Health Services and Supports in the Juvenile Halls

All newly admitted youth to the juvenile halls are screened and assessed by mental health professionals, utilizing clinical interviews, screening instruments, and questionnaires. Clinicians are required to complete assessments to identify youth who have mental health needs and may be the victims of human trafficking or other abuse. Youth who are identified as needing ongoing care are assigned to a treating clinician. Specialized units were developed to provide enhanced services for youth with acute mental health needs, including those with at-risk of self-harm and those with developmental disabilities. Because the average length of stay in the juvenile halls is approximately two weeks, short-term psychotherapy focused on stabilizing the youth's symptoms is typically used. Youth may be referred for psychiatric evaluation and/or treatment. Psychiatrists regularly follow-up with youth depending on the severity of the youth's symptoms or diagnosis. All

youth released from halls, camps, and Dorothy Kirby Center (DKC) on psychotropic medications are provided with release prescriptions. Youth may also be referred to the Juvenile Justice Transitional Outpatient Treatment Services Program (JJ-TOTS) to be seen within one to two weeks after release for continuity of care and hopefully, transition of care to community mental health providers. However, such youth are often lost to mental health follow up.

Physical Plant Limitations

Outside of a few more recently constructed buildings, the majority of the juvenile hall and probation camp facilities are an outdated linear design which only allows for intermittent supervision of youth. Research suggests that direct supervision and small group model facilities, such as Campus Kilpatrick, have lower levels of violence, decreased tension and stress, increased rehabilitative programs and decreased recidivism. Direct supervision provides for increased and ongoing interaction of youth and staff that allows for more effective programming, better management of interpersonal problems that may develop and proactive management of negative behavior before it occurs.

Current facilities provide environments that are often counter-therapeutic and negate efforts to stabilize and enhance the youth's functional abilities. As a result, the facilities likely contribute to the youth irritability and overall behavioral issues. The juvenile hall setting in particular is not conducive to providing effective treatment for mental health issues. Progress made in treatment is quickly eroded as the youth may be repeatedly triggered and re-traumatized by the environment. Because of a lack of privacy and a therapeutic treatment space, youth are not able to fully participate in treatment.

Staffing Limitations

Unfortunately, current DMH staffing is inadequate to address the current high mental health needs of youth in juvenile halls, particularly with the juvenile halls' physical design. DMH staffing would need to increase significantly from its current number of clinicians and psychiatrists assigned to provide mental health services in the juvenile halls. This increased staffing would allow for:

- Two clinicians on each living unit (e.g., so that one could assist with crisis de-escalation while another ran groups or did individual therapy with youth);
- Increased coverage time by mental health staff on early mornings, evenings, and weekends;
- Staffing ratios consistent with the Probation Department's proposed staffing ratio (i.e., 1:5) and generally consistent with proven models (e.g., Missouri Model); and
- DMH staff (including psychiatrists) to participate more fully in:

- Multidisciplinary treatment team (MDT) meetings;
- Probation training, both initial and ongoing;
- More comprehensive initial and ongoing assessment of youth;
- Individual and group mental health treatment;
- Working with Community Based Organizations (CBOs) and other entities on unit programming;
- Crisis de-escalation; and
- Identifying youth with mental illness who have significant difficulty functioning in detention facilities and assisting Probation in transferring these youth to other facilities.

Use of Force

Failure of the current system to fully meet the needs of the changing nature of the detained youth population may have, in part, contributed to an increased use of force (including oleoresin capsicum (OC) spray) in the juvenile halls over the past three to four years. Simultaneously, the increased use of force and residual elements of a punitive culture may be compounding the mental health conditions of youth. This has been detailed extensively in the OIG's reports to the Board on February 4, 2019 and March 8, 2019.

Potential dynamics of these use-of-force trends and the mental health needs of youth include the following:

- Inadequate treatment of higher-needs youth with developmentally-informed interventions that address youths' increased mental health needs:

  The current population of juvenile-justice involved youth are at significant risk of suffering from mental disorders that without adequate treatment may contribute to the use of force. These may include, but are not limited to:

  - Acute Stress Disorder (ASD), Posttraumatic Stress Disorder (PTSD), and exposure to adverse childhood experiences (ACEs) that may cause youth to overestimate risk and threat and react aggressively, particularly when that perceived threat is coupled with the youth's having experienced other very negative life events (e.g., being assaulted);

  - Attention Deficit/Hyperactivity Disorder (ADHD) and impulse control disorders that may contribute to youths' having difficulty following commands or sufficiently controlling their behavior; and

- Substance Use Disorders that may increase youths' risk of experiencing short- and long-term withdrawal symptoms (e.g., irritability, insomnia), displaying disinhibited (poorly regulated) physical behavior, and acting out in the context of acute intoxication, particularly on initial detention.

- Inadequate training/experience of Probation staff in dealing with youth with high mental health needs:

  Probation staff in the juvenile halls tend to be the most recently hired in the Department, and in general, have less experience in dealing with youth with mental illness than more seasoned staff. They typically are not as skilled in crisis response and utilizing de-escalation techniques, dialectical behavioral therapy (DBT) techniques, or other techniques to defuse situations that could otherwise escalate. In some situations, as noted in the OIG report, these and other staff also may be activating youth, inadvertently or not, rather than de-escalating and responding to crises effectively.

- Current detention environments that are counter-therapeutic and lead to poor mental and emotional functioning in youth, which can drive or worsen irritability and overall behavioral deterioration (including insomnia):

  The specific causes of insomnia are likely multifactorial and related to relatively early bedtime for age (adolescents have developmental changes in sleep systems that cause advanced sleep phase, i.e., falling asleep and then waking up later, even in the face of structured sleep cycles); a noisy, unfamiliar and uncomfortable environment, potentially triggering trauma-related hypervigilance and anxiety; rumination and worry about pending legal issues and ongoing events transpiring in local neighborhoods; and difficulty customizing their environment for sleep.

Fundamental Change in Treatment Paradigm/Model is Necessary

Throughout the nation, traditional correctional supervision models for juvenile justice youth are being replaced with fundamentally different models that better meet youths' mental health and developmental needs. There is growing recognition that applying adult-style incarceration models to youth results in high costs, continued (and even increased) recidivism, and poor outcomes overall. Moreover, traditional models may exacerbate many of the factors that led to a youth's involvement with the juvenile justice system at the outset. In short, our system is failing our youth and families, especially those with mental health needs, and must be foundationally overhauled.

Rather than larger detention facilities in locations that are often far-removed from youths' family and communities, more progressive models employ community-based diversion whenever possible, and when required, much smaller facilities and units that are closer to youths' support networks and neighborhoods to which they will return after discharge. Proximity of these facilities and units to a youths' home environments can promote family involvement, connections to the community, and more successful transition back home. The reduced size of units (12 youth/unit) and facilities allows for more caring, individualized attention, stronger youth-staff relationships, better development of prosocial skills and responsibilities, and a more home-like (e.g., bedrooms and family-style meals), rather than correctional and institutionalized environment.

Regardless of the model the Board ultimately chooses, capacity will need to be developed to house higher-mental-health need, higher-risk youth in secure, non-correctional, residential treatment facilities. At present, it is quite difficult to place justice-involved youth in these types of settings, particularly expediently. The County may wish to work with current contract agencies to develop such facilities or to encourage/convince them to allow justice-involved youth to be housed in existing facilities. Alternatively, and probably preferably, the County could develop its own facilities, either by building new or repurposing existing structures. The latter course of action obviously allows the County to precisely tailor the facilities' physical plant to the chosen model, and to strategically place such small, more homelike, secure residential treatment facilities in geographically diverse areas of Los Angeles County. This would allow all youth to remain relatively close to home, with all of the attendant benefits. Initial costs could be defrayed somewhat if Medi-Cal were able to be utilized for some or all of the services eventually provided.

Foundational Principles of Ideal Treatment Models

Many jurisdictions already have enacted revised juvenile justice approaches that illustrate components of ideal treatment models that could be employed in service of the Board's goals. Missouri, New York City, Virginia, and Washington, D.C. all have enacted major reforms with favorable changes and outcomes.

Potential models also currently exist outside of the juvenile justice setting. In California, for Los Angeles County youth involved with the Department of Children and Family Services (DCFS), the State has established short-term residential therapeutic programs (STRTPs). STRTPs are community care facilities tailored for DCFS-involved youth with high mental needs that cannot be met in a family setting. They provide an integrated program of specialized and intensive care and treatment for children and nonminor dependents, focusing on stabilizing high-needs youth to allow an expedient and successful transition to a family setting.

In continuing to develop the most appropriate model for Los Angeles County, the Board may wish to consider adopting common elements of other jurisdictions' successful community-based alternatives to juvenile detention settings. These elements generally include:

- Screening out lower-risk youth and diverting youth to non-residential, community-based alternatives whenever possible;
- Optimizing staffing and physical space logistics to promote a more rehabilitative and therapeutic process;
- Matching youths' needs and degree of supervision needed with effective options (risk, screening, and treatment assessment);
- Building on youths' strengths with a focus on successful transition to their communities
- Promoting healthy adolescent development (developmentally informed, fostering of decision-making skills, impulse control, future-orientation, and emotional maturity);
- Addressing youths' increased mental health needs (e.g., trauma-informed interventions, addressing substance use disorders);
- Best practices related to diversity and cultural competency of staff;
- Community-based services;
- Emphasizing evidence-based family intervention and engagement models;
- Building youths' connections to their communities;
- Connecting youth to school;
- Connecting youth to employment/vocational; and
- Connecting youth to prosocial adults (including youth-staff relationships), peers, and activities.

The L.A. Model, representing Los Angeles County's shift toward a more humane and effective treatment paradigm for juvenile justice youth, is currently being employed at Campus Kilpatrick.

Modifying the L.A. Model to include the above elements will allow the County to begin to reform its juvenile justice system and to place youth in small, more homelike, secure residential treatment facilities in geographically diverse areas of Los Angeles County.

Better Return on Taxpayer Investment

Under the current system, despite the high costs of youth incarceration, the desired outcomes are lacking. Implementation of a fundamental change to a more humane and effective, multilayered, community-based therapeutic model have significant fiscal implications, and obviously must be based on the will and priorities of the Board.

However, whether the benefits and costs of youth detention facilities are weighed on a scale of taxpayer investment, community safety, or youths' futures, the cost of incarceration is higher than treatment in the community, as evidenced by cost savings realized in jurisdictions that have implemented similar community-based, therapeutic models. Additionally, and as mentioned previously, a more therapeutic model may allow use of Medi-Cal payment services to help defray costs.

Moreover, financial costs of incarceration continue to accumulate long after youth are released from confinement, through the lifelong negative effects of incarceration's sequelae. Evidence indicates that youth who have been institutionalized: get into worse trouble; are more likely to commit more severe crimes; are less employable, are more likely to be on a path toward lifelong failure; and are more likely to pass their problems on to their children.

Conclusion and Recommendations

Based on the above, it is clear that in our current system we cannot achieve the goals of: 1) reducing the use of force; 2) successfully meeting the mental health needs of juvenile justice-involved youth; and 3) promoting these youths' healthy development. Despite our best efforts, the existing model is failing our youth and their families, in large part because the incarceration-based model is fundamentally flawed and antithetical to one that is "care first." Physical plant limitations and attempts to implement piecemeal changes, rather than embracing a comprehensive and fundamental plan for reform, have prevented Los Angeles County from keeping pace with other jurisdictions in realizing significant benefits from significant reforms.

To reap the rewards of any new model ultimately chosen by the Board, we must transition away from a juvenile hall-model to a multi-layered, community-based therapeutic model that would exist in smaller facilities throughout the County. This approach should provide multiple benefits, including reduced recidivism, improved safety of youth and staff, enhanced educational progress of youth, and positive transitions of youth back to the community. These benefits have been achieved in other jurisdictions that have implemented such therapeutic models. We look forward to realizing similar outcomes in Los Angeles County.

In order to effectuate this fundamental shift, we recommend the following:

1. A continued commitment to "moving away" from a juvenile hall and camp model, which represents an inherently flawed and outdated model that is incompatible with a "care-first" model; a model that often exacerbates youth trauma and mental health problems, and therefore cannot adequately support treatment-oriented programming and interventions. This move should include additional investments in diversion, closing juvenile halls and camps, creating alternative placement options that are smaller and developmentally appropriate for youth with mental health needs, and, in general, redirecting resources away from incarceration to treatment.

2. Utilizing a "sequential intercept model," where multiple points of opportunity exist to prevent youth from entering or having protracted stays at juvenile detention facilities. This model would include increasing diversion alternatives (which prevent youth from having contact with the delinquency court at all) for all youth, but particularly for those with mental health needs; establishing a more systemic risk-based assessment process (in collaboration with the juvenile courts); establishing a juvenile court linkage program; expanding the number of juvenile mental health courts to more effectively identify and redirect juvenile offenders with mental health diagnoses to therapeutic environments for treatment of mental health conditions; and identifying and/or developing non-institutional, therapeutic residential placements that are closer to youths' communities.

3. An analysis of the availability and sufficiency of current community-based and residential diversion alternatives to incarceration (the Office of Diversion and Reentry (ODR) appears to have already undertaken parts of this). This would include an assessment of existing County facilities that potentially could be repurposed to serve as residential treatment facilities for youth that, per court order, require this type of placement. If alternative residential placements are lacking, we recommend the County increase its ability to serve these youth, either by developing its own placement alternatives or by encouraging contracted agencies to accept Probation youth.

4. For youth with mental health needs that must remain detained, taking significant steps to reduce use of force against them (OC spray, physical restraints, any isolation, etc.). Use of force or punitive measures re-traumatize youth and have negative implications on recidivism and overall health.

5. For youth with mental health needs that must remain detained, increasing DMH staffing as mentioned previously and allow Probation to take a more supportive role.

6. Providing additional training and onsite coaching of County staff interfacing with youth in current detention facilities. UCLA PTCE staff will conduct trainings for Probation, Department of Health Services (DHS), Los Angeles Office of Education (LACOE), and DMH staff around de-escalation, general mental health issues, trauma-informed care, and other relevant subject areas. Other academic or consultant partners will conduct additional trainings and onsite coaching in different mental health subject areas.

7. Implementing best practices related to diversity and cultural competency of staff.

8. Providing enhanced assessment of juvenile justice-involved youth. Given the high rates of significant mental disorders in juvenile justice-involved youth, an improved mental health assessment is a core component of an ideal treatment model. These assessments would better screen for and identify trauma-based disorders, substance use disorders, developmental disabilities (e.g., Autism Spectrum Disorders, intellectual Developmental Disorder or intellectual deficits), and any other conditions impacting academic functioning.

9. Establishing more multilayered and robust programming for youth. An important component of rehabilitation is positive engagement in prosocial activities and protection against future participation in antisocial activities. Therefore, ideal treatment programming will also focus on engaging youth with education, vocational and employment training, and skills-based training. Academic counseling, credit recovery, and college preparation are all components of programming to promote engagement of youth with education. Skills-based training could include programming related to pro-social skills, moral reasoning skills, workforce development skills, independent living skills, and arts skills.

10. Establishing system-wide family engagement. Family-related factors (e.g., poor parent-child relationships, inconsistent parenting, parental substance abuse, familial antisocial behavior or values, family conflict, etc.) have consistently been implicated in juvenile justice involvement of youth.

11. Increasing peer and parental presence in the therapeutic process of addressing youths' mental health and other needs. This would include establishment of mentors, peer "buddies," and parent partners. (Experience from community organizations

that foster connections to prosocial peers and mentors (e.g., Big Brothers Big Sisters of America, Homeboy Industries, etc.) suggests that connection with a peer "buddy" and/or a mentor can help foster prosocial development of juvenile justice-involved youth).

12. Streamlining and enhancing the process of youths' reintegration to their communities. Case managers could help coordinate measures to help with youths' successful return to and reintegration into the community. This may include linkage to a variety of services, such as substance use disorders (SUDs) treatment, mental health treatment, and other resources. Additionally, a "transitioning home" pilot process, in which youth spend time at home in their family environment, could be established.

13. Improving data gathering and analysis, which is necessary to monitor effectiveness of interventions and to effectively modify and match screening, programming, and treatment to the evolving or changing needs of youth. Data tracking would broadly include the categories of service needs, service utilization, use of force, adverse events, and effectiveness at preventing relapse/recidivism.

14. Enhancing continuity and coordination of care system-wide to continue to reinforce therapeutic changes in youth across their entire contact with our systems and transition back to community and home environments. Youth encounters should reinforce prosocial and programming from youths' first contact with the juvenile justice system to the final stages of reintegration back to their communities.

15. Improving Information Technology (IT) systems. IT improvements, including a coordinated/shared Electronic Health Record system, would allow improved data gathering/analysis and continuity of care across settings and departments/disciplines.

16. Fostering collaboration among County departments' juvenile justice leadership and other stakeholders' leadership. To that end, we would recommend implementing and/or establishing the following:

    a. A Health and Human Services Governance Committee including leadership from DMH, DHS, Department of Public Health (DPH), LACOE, and an ex officio Public Defender (PD) representative, to establish and/or continuously review policy and monitor functioning and adherence to Los Angeles County goals of "care-first" and providing healing environment to all youth, including Probation youth. An executive level psychiatrist would serve as the coordinating leader for the provision of health services in juvenile probation facilities;

b. A Youth Advisory Council, comprised of youth currently housed in Los Angeles County juvenile justice facilities, youth who have recently been released from a Los Angeles County juvenile justice facility, and older youth from CBOs, such as Youth Justice Coalition and the Anti-Recidivism Coalition;

c. A Family Advisory Council, consisting of parents and guardians of youth previously detained in Los Angeles juvenile justice facilities; and

d. A Line-staff Advisory Council, which would include clinicians, probation officers, and teachers working in Los Angeles County juvenile justice facilities.

If you need additional information, please contact Dr. Jonathan E. Sherin, Director at (213) 738-4601 or jsherin@dmh.lacounty.gov.

JES:CT

c: Executive Office, Board of Supervisors
Chief Executive Office
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