

## Riverside County SB 439 Protocol

### I. Introduction

California State Senate Bill 439 mandates that effective January 1, 2020, Riverside County develop a process for determining the least restrictive response to minors under 12 years of age who come to the attention of law enforcement for behaviors or offenses as described in the existing law. With the exception of certain categories of offenses (murder, rape, sodomy oral copulation, or sexual penetration by force, violence or threat of great bodily harm) these minors will no longer be under the jurisdiction of the juvenile court nor will they be involved the juvenile justice system.

### II. Purpose of Protocol

This protocol is a guide for referring children under 12 years of age who have committed offenses as described in the existing law for intervention services. The protocol is to aid law enforcement, schools, and community-based organizations in referring participant children who qualify under SB 439 for assessment and services.

Students who have committed the following offenses do not qualify for services under the SB 439 Protocol:

- Murder
- Rape
- Sodomy oral copulation
- Sexual penetration by force
- Violence or threat of great bodily harm

### III. Protocol Agreement

The members of the Multi-Agency Team (MAT) have agreed that:

**Law Enforcement** will notify parents of minors under 12 years of age who come to the attention of law enforcement for behaviors or offenses as described in the existing law. Law enforcement will complete/upload the referrals for youth who qualify to RCOE's Secure ShareFile system.

**Schools in Riverside County** will access referrals from RCOE's Secure ShareFile system and upon receipt of the referral will screen the referral for assessment and services to be conducted by a multidisciplinary team (MDT). The schools will also keep a record of referrals.

**Riverside University Health System (RUHS)** will access referrals from RCOE's Secure ShareFile system and will participate as one of the MDT assessment and services and serve as an alternative assessment location. RUHS will also provide services for the SB 439 participant youth and families.

**Participating Community-Based Service Providers** will access referrals from RCOE's Secure ShareFile system and upon notification will participate as part of the MDT assessment and services. CBOs along with RUHS will provide services for the SB 439 participant youth and families.

### IV. Protocol Responsibilities

#### Law Enforcement

- Notification of parent
- Complete/Upload the referrals for youth who qualify to RCOE's Secure ShareFile system.

#### Riverside County Office of Education (RCOE)

- Manage Secure ShareFile System

## **Riverside County SB 439 Protocol**

- Serve as fiscal agent in partnership with Riverside County Probation for contracted service providers

### **Riverside Schools**

1. Access referrals from RCOE's Secure ShareFile system
2. Screen student referral
3. Develop with Multidisciplinary Team (MDT) a student/family service plan
4. Monitor and assess case plan progress
5. Track referrals

### **Riverside University Behavioral Health**

1. Access referrals from RCOE's Secure ShareFile system
2. Participate in the MDT
3. Develop with participant MDT members a student/family service plan
4. Provide services for student/family
5. Monitor and assess service plan progress
6. Serve as an alternative assessment location if needed

### **Participating Community-Based Service Providers**

1. Access referrals from RCOE's Secure ShareFile system
2. Participate in the MDT
3. Develop with participant MDT members a youth/family service plan
4. Provide services for student/family
5. Monitor and assess service plan progress
6. Serve as an alternative assessment location if needed

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### V. Riverside County Office of Education Secure ShareFile System

All users will receive a notification from RCOE's Sharefile system. This is a secure cloud environment where matters pertaining to senate bill 439 will be facilitated through a secure information exchange.

Each agency partner will upload referrals to the secure ShareFile system and access student information/referrals from the secure ShareFile.



**RIVERSIDE COUNTY  
OFFICE OF EDUCATION**

**Brian Sousa** has shared the folder **SB 439 Data** with you.

Note From Brian:

You now have Sharefile access for the AB 439 folder. Anything you upload to the folder will prompt an alert to the other users on the folder.

< /td>

[> Click here to view this folder](#)

ShareFile is a tool for sending, receiving, and organizing your business files online. It can be used as a password-protected area for sharing information with clients and partners, and it's an easy way to send files that are too large to e-mail.

Trouble with the above link? You can copy and paste the following URL into your web browser:

<https://rcoe.sharefile.com/f/fo0ee681-32f0-451d-86b6-dfeb851479ad>

Powered By Citrix ShareFile 2019

## Riverside County SB 439 Protocol

### SB 439 Referral

Please use this referral form to refer a child under the age 12 for services. A review of this form will be conducted by authorized agencies in order to provide youth with supports as defined in SB 439. With the exception of certain categories of offenses (murder, rape, sodomy oral copulation, or sexual penetration by force, violence or threat of great bodily harm) these minors will no longer be under the jurisdiction of the juvenile court nor will they be involved in the juvenile justice system.

Law Enforcement will notify parents of minors under 12 years of age who come to the attention of law enforcement for behaviors or offenses as described in the existing law. Law enforcement will complete and upload this referral for youth who qualify to RCOE's secure electronic data platform.

Referral Date: \_\_\_\_\_

Referral Name and Agency: \_\_\_\_\_

Referral Phone Information: \_\_\_\_\_ Email: \_\_\_\_\_

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Residing with (name and relationship): \_\_\_\_\_

Address: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

**Ethnicity:**

- Caucasian
- African American
- Hispanic
- Asian
- Other*

**Language other than English:** \_\_\_\_\_

**Reason For Referral:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Riverside County SB 439 Protocol

### SB 439 Budget Proposal

January 1, 2020 - June 30, 2020

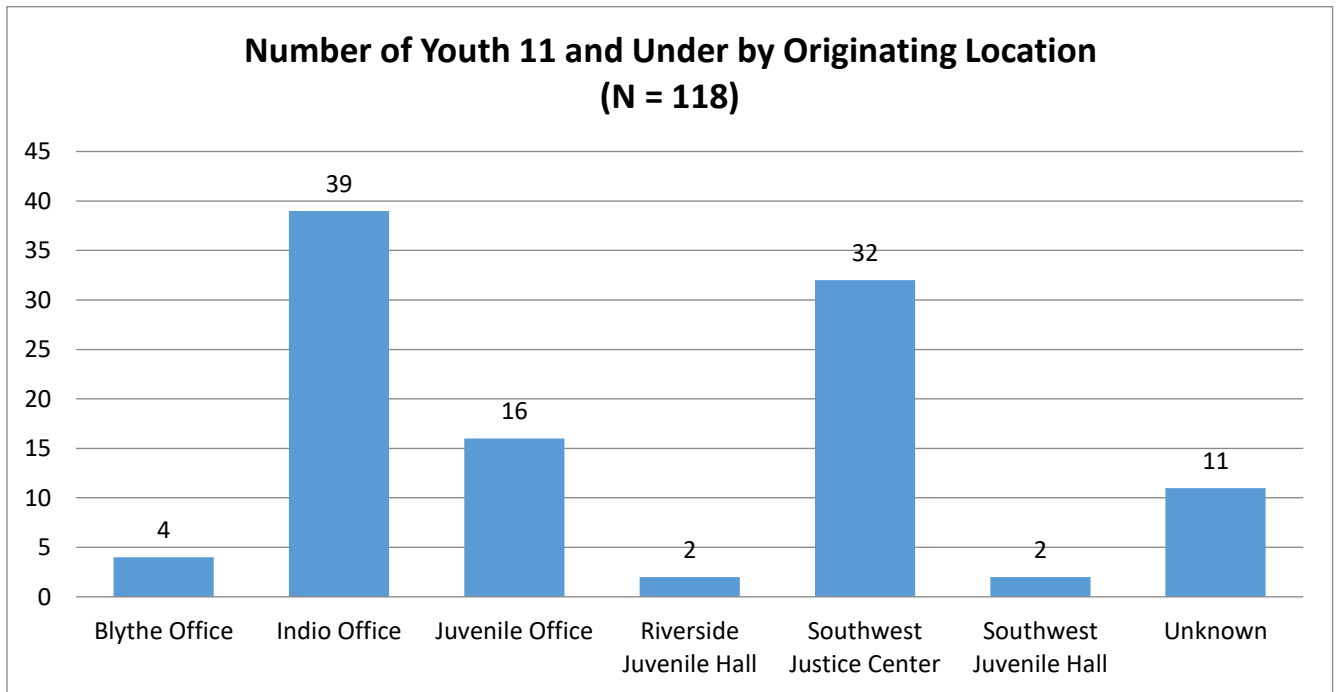
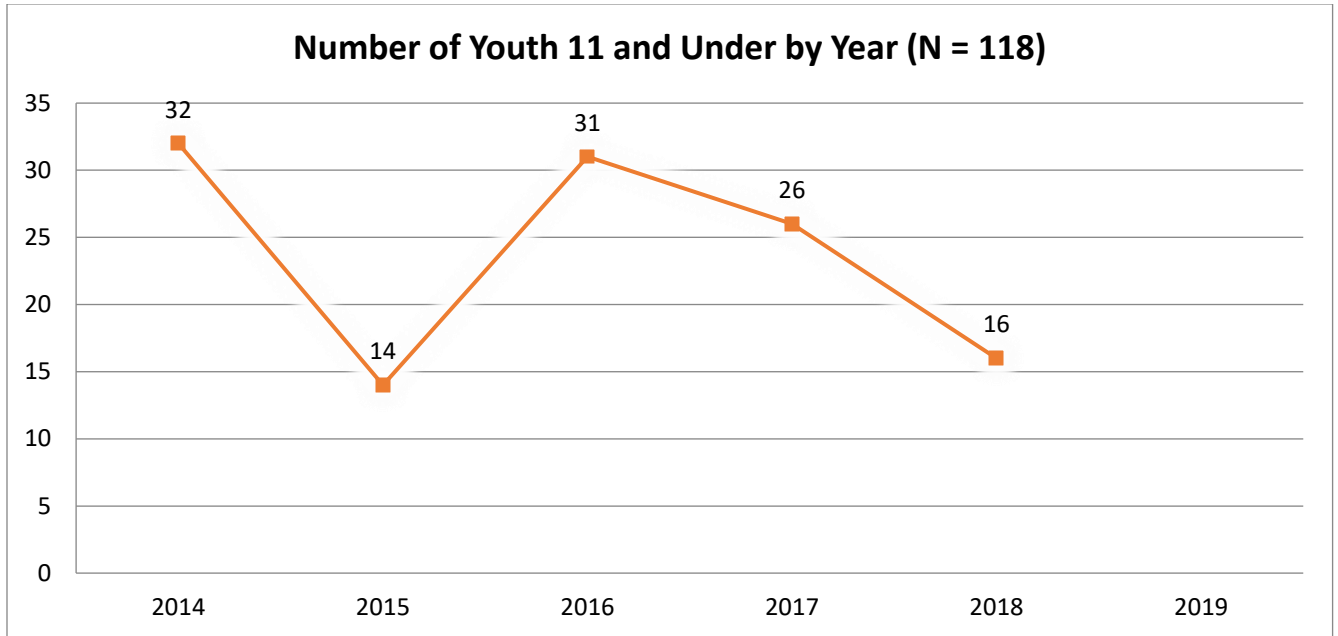
<b>RCOE Costs as Fiscal Agent</b> (Working with Proabtion Processing Invoices and Payments and Managing Secure ShareFile System)	
Three Hours per Quarter based on 2 CBOs = \$200 per quarter	\$400
Secure ShareFile System Data Management: 4 hours per month	2,525
<b>RCOE Total Estimated Costs</b>	<b>\$2,925</b>

<b>Student Nest</b>	
Student Hourly Rate=\$60.00	
Family Hourly Rate=90.00	
Cost of 10 students receiving 4 hours of service	\$2,400
Cost of 10 families receiving 4 hours of service	\$3,600
<b>Student Nest Total Estimated Costs</b>	<b>\$6,000</b>

<b>Wylie Center Counseling</b>	
Mid and West County Assessments = \$75 per assessment x 5 students	\$375
Desert County Assessments = \$150 per assessment x 5 students	\$750
Mid and West County Counseling Session = \$50 each/6 sessions x 5 students	\$1,500
Desert County Counseling Session = \$100 each/6 sessions x 5 students	\$3,000
<b>Wylie Center Total Estimated Costs</b>	<b>\$5,625</b>

Grand Total \$14,550

## Riverside County SB 439 Protocol



**Riverside County SB 439 Protocol**

<b>Number of Youth by Location by School Districts and by Year</b>								
<b>Location at Ref</b>	<b>School District Youth Attends</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>Total</b>
<b>Blythe Office</b>								
	Palo Verde Unified	1				1		<b>2</b>
<b>Indio Juvenile Office</b>								
	Desert Sands Unified	3	2	8	3	1		<b>17</b>
	Riverside County Office of Education	1	1	1	1			<b>4</b>
	Palm Springs Unified	5	1	4		3		<b>13</b>
	Coachella Valley Unified	1	1			3		<b>5</b>
<b>Juvenile Office</b>								
	Other		1		3			<b>4</b>
	Corona Norco unified			2				<b>2</b>
	Moreno Valley Unified			2	2	2		<b>6</b>
	Beaumont Unified	1		1				<b>2</b>
	Jurupa Unified				2			<b>2</b>
<b>Riverside Juvenile Hall</b>								
	Val Verde Unified	1						<b>1</b>
	Moreno Valley Unified	1						<b>1</b>
<b>Southwest Justice Center</b>								
	Val Verde Unified	1			2	1		<b>4</b>
	Murrieta Valley Unified	1	1					<b>2</b>
	Temecula Valley Unified	1	2	1				<b>4</b>
	Hemet Unified	3	1		2			<b>6</b>
	Elsinore Unified	4	2	2	1			<b>9</b>
	Other	2		6	2	2		<b>12</b>
	Menifee Union	2			1			<b>3</b>
	Moreno Valley Unified	1		1	1			<b>3</b>
<b>Southwest Juvenile Hall</b>								
	Non Public	1			1			<b>2</b>
<b>Unknown</b>								
	San Jacinto Unified	1	1	2	1			<b>5</b>
	Riverside Unified	1						<b>1</b>
	Banning Unified				3	1		<b>4</b>
	Nuview Union				1			<b>1</b>
	Romoland School District			1				<b>1</b>
	Jurupa Unified	1						<b>1</b>
	Other					1		<b>1</b>
<b>Total</b>		<b>33</b>	<b>13</b>	<b>31</b>	<b>26</b>	<b>15</b>	<b>0</b>	<b>118</b>

## Riverside County SB 439 Protocol



# BH Screening Form- Child/Adolescent

Revised 4-26-19

**CONFIDENTIALITY NOTICE:** I will need to ask you some additional screening questions in order to better assess the needs for you and link you to the appropriate services. Please note, the information you provide is strictly confidential and will not be shared without your permission. The exceptions to confidentiality are if you share you are having any thoughts to harm yourself or others, or report any child abuse or elderly abuse, I need to follow up with the appropriate persons to make sure you are safe and others are safe.

### SCREENING INFORMATION

Screening Date: \_\_\_\_\_ Screening Type:  Phone  Clinic Walk-in  
 Name of Screener: \_\_\_\_\_ Program Completing Screening: \_\_\_\_\_

### CALLER/REQUESTOR INFORMATION

How can I help you? (in consumer's words): \_\_\_\_\_

Consumer Requesting: (Check all that apply)  
 MH Counseling/Case Mgmt (No Meds)  Meds Only  Meds w/ MH Counseling/Case Mgmt  
 Substance Use Counseling  SU Residential Treatment  Other: \_\_\_\_\_

Can you please provide your name and phone number in case we get disconnected? Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Who referred you? \_\_\_\_\_

### CLIENT REGISTRATION

First Name:	Last Name:	Gender:	DOB:
Email Address:	Social Security #:	Medical Record/ELMR #:	
Home Phone #:	Cell Phone #:	Other Phone #:	
Address:			Primary Language:
Insurance:	Policy #:	Payee:	
Is Youth TAY- Aged 16-25? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent of the Court? <input type="checkbox"/> Yes <input type="checkbox"/> No	On Probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Guardian Status:	Name of Guardian:	Guardian Phone #:	

### SERVICE ELIGIBILITY

- Client does not reside in geographic catchment area, referral to local outpatient service provider(s).  Yes  No
- Client is eligible for Medi-cal.  Yes  No (If private insurance, referral to private insurance.)
- Client is eligible under ACT/CAST.  Yes  No (If indigent or other insurance, use County Pay guarantor to bill to DPSS carts contract)

### SCREENING QUESTIONS - MENTAL HEALTH

1. In the last 90 days, what mental health symptoms has youth been experiencing? (in consumer or caregiver's words): \_\_\_\_\_

Depression? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____	Hallucinations? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____
Anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____	Paranoia? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____
Panic Attacks? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____	Mania (elevated mood)? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____
Irritability? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____	Poor impulse control? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____
Nightmares? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____	Running Away? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____
Flashbacks? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____	Oppositional/Argumentative? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____
Intrusive thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____	Low Grades/School Failure? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____
Sleep Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____	ADHD Symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____
Appetite Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____	Obsessive/Compulsive bx? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe: _____

2. Does youth have any prior mental health history and/or has youth ever been diagnosed with a mental disorder?  Yes  No  
 If yes, describe: \_\_\_\_\_

### RISK ASSESSMENT

3. Are youth currently experiencing any thoughts to harm self or others?  Yes  No If yes, describe: \_\_\_\_\_

If yes, conduct Risk Assessment. Assess for:  SI  HI and  Plan  Means  Access to Means 5150?  Yes  No Tarasoff?  Yes  No

4. Has youth ever had any thoughts to hurt self or others?  Yes  No If yes, describe: \_\_\_\_\_

5. Has youth ever attempted suicide?  Yes  No If yes, describe: \_\_\_\_\_

6. Has youth ever been admitted to a psychiatric hospital?  Yes  No If yes, describe:  DTS  DTO  GD # of prev. admits: \_\_\_\_\_

If yes, describe approx. admit date(s), hospital names: \_\_\_\_\_



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SCREENING QUESTIONS - MEDICAL	
7. Is youth currently prescribed and/or taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, describe: _____	
8. Do youth have any medical problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	_____
SCREENING QUESTIONS - SUBSTANCE USE	
9. In the last 90 days, has youth used any alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe date of last use, frequency, amount:	_____
10. In the last 90 days, has youth used any illegal drugs or marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
If yes, describe drug type(s), date of last use, frequency, amount: _____	
11. In the last 90 days, has youth abused or misused any prescription medications included meds not prescribed to youth? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
If yes, describe: _____	
12. Has youth ever felt that youth ought to cut down on your drinking or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	_____
13. Have people annoyed youth by criticizing youth's drinking or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	_____
14. Has youth ever felt bad or guilty about youth's drinking or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	_____
15. Has youth ever had a drink or used drugs first thing in the morning to steady youth's nerves or get rid of a hangover? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
If yes, describe: _____	
16. Does youth have any history of substance use treatment (outpt, IOP, residential)? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
If yes, describe: _____	
SCREENING QUESTIONS - LEGAL	
16. Does youth have any history of arrests or frequent contact with law enforcement? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
If yes, describe approx. dates and offenses: _____	
SCREENING QUESTIONS - HOUSING	
17. What is youth's current living situation? <input type="checkbox"/> Lives with family <input type="checkbox"/> Foster Care <input type="checkbox"/> Group Home/STRTP <input type="checkbox"/> Homeless <input type="checkbox"/> Other:	_____
MENTAL HEALTH REFERRAL	
<input type="checkbox"/> MH Counseling/Case Mgmt (No Meds) (schedule 150 min clinical assessment w/CT)	<input type="checkbox"/> Meds Only* (schedule 120 min psych assessment w/MD)
<input type="checkbox"/> Meds w/ MH Counseling/Case Mgmt* (schedule 150 min clinical assessment w/CT)	
<input type="checkbox"/> Other: _____	
<b>SELECT ONE ONLY</b>	
• Youth denies any mental health symptoms. Provide referrals to community resources (e.g. support groups, hotlines). <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Youth is 0-15 years of age AND has mental health symptoms reported, referral to Children's Services. <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Youth is 16-25 years of age AND has mental health symptoms reported, referral to Transitional Aged Youth (TAY) services. <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Youth is 16-25 years of age AND has history of psychiatric hospitalizations, incarcerations related to mental health disorder, and/or homeless, referral to TAY FSP. <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Youth is 0 – 17 years of age AND has been psychiatrically hospitalized within the last 30 days, referral to YHIP <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Other: _____	
SUBSTANCE USE REFERRAL	
<input type="checkbox"/> Substance Use Counseling (refer to SU CARES for ASAM)	<input type="checkbox"/> SU Residential Treatment (refer to SU CARES for ASAM)
<input type="checkbox"/> MH & SU Services – Dual Diagnosis (refer to MH referral above; may link to SAPT)	
• Client reports "Yes" to <u>any</u> of the substance use questions, referral for substance use services. <input type="checkbox"/> Yes <input type="checkbox"/> No (If MH & SU referral, dual diagnosis)	
• Client reports "No" to <u>all</u> substance use questions. Provide referrals to community resources (e.g. support groups, hotlines). <input type="checkbox"/> Yes <input type="checkbox"/> No	
DISPOSITION COMMENTS *Remind to bring to appt: insurance card and medication info including prescription bottles.	
Date of First Assessment Appointment: _____	Time of Assessment: _____
Name of Clinic for Assessment: _____	Name of MD/CT conducting Assessment: _____
COMMENTS: _____	