



## Virginia Commission on Youth 2013 Legislative Studies and Initiatives

### ASSESSMENT OF MENTAL HEALTH NEEDS OF JUVENILE OFFENDERS DRAFT FINDINGS AND RECOMMENDATIONS

#### ADOPTED RECOMMENDATIONS IN BLUE

Findings/Conclusions	Adopted Recommendations
<p><b>Finding 1 – Social History Report</b> A social history is a report which may be ordered by the court following the adjudication of a juvenile. Pursuant to Department of Juvenile Justice (DJJ) regulation, a social history report must be prepared when:</p> <ul style="list-style-type: none"> <li>• ordered by the court;</li> <li>• for each juvenile placed on probation supervision with the unit;</li> <li>• for each juvenile committed to DJJ;</li> <li>• for each juvenile placed in a post-dispositional detention program for more than 30 days (pursuant to §16.1-284.1); or</li> <li>• upon written request from another unit, when accompanied by a court order.</li> </ul> <p>When a juvenile is committed to DJJ, a social history report must be completed within fifteen days pursuant to §16.1-278.7 of the <i>Code of Virginia</i>. The information contained in the social history is used at the dispositional hearing to assist the judge in determining appropriate services and sanctions.</p> <p>Judges report social histories as being very helpful and useful to them when they are making a dispositional decision. They want, and need, as much information as possible to make appropriate dispositional decisions. Despite the noted value of a completed social history, judges may not always have a</p>	<ol style="list-style-type: none"> <li>1. Amend §16.1-278.8 of the <i>Code of Virginia</i> to ensure judges have a completed social history prior to disposition for juveniles who may be committed to DJJ. This recommendation includes a delayed enactment date of October 1, 2014.</li> <li>2. Direct DJJ create a model social history and guidelines for CSUs to use in assisting the courts in making informed dispositional decisions. The model social history and guidelines may include information on obtaining individualized educational program (IEP) assessments and incorporate information about exposure to trauma in a juvenile's social history report. DJJ shall report its progress to the Commission on Youth prior to the 2015 General Assembly Session.</li> </ol>

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<p>completed social history prior to disposition. In FY 2012, 3,067 social histories were completed before disposition and 2,542 were completed post-disposition.</p> <p>The timing of social histories, or predisposition reports, varies in other states. In Florida, Louisiana, and Pennsylvania, a social history may only be completed post-adjudication. North Carolina requires a social history be completed “prior to a disposition hearing,” but provides an exception that allows a disposition to occur without the report where the court makes a written finding that one is not required. In Texas, a probation officer is required to begin a social history report as soon as charges are filed against a juvenile. Similarly, in Maryland, the court may direct a social history report after a petition or citation is been filed with the juvenile court.</p> <p>DJJ established policies and procedures as to what must be included in a social history. The following information is to be included in a social history:</p> <ul style="list-style-type: none"> <li>• identifying and demographic information on the juvenile;</li> <li>• current offense and prior court involvement;</li> <li>• social, medical, psychological, and educational information about the juvenile;</li> <li>• information about the family; and</li> <li>• dispositional recommendations, if permitted by the court.</li> </ul> <p>An issue that often arises as localities attempt to work together is variability of the information included in social histories. For some, a checklist may be sufficient, whereas others provide lengthy narratives. Local officials stated that it would be beneficial to have a guide and template when compiling a social history. Tennessee created a predisposition investigative (social history) report manual as well as a template social history. Minnesota incorporated social history requirements in its statutes to include mental health screening requirements, family history background, placement history, and strengths/risk factors.</p>	

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<p><b>Finding 2 – Court Services Units</b></p> <p>In Virginia, each juvenile and domestic relations court is served by a court services unit (CSU). DJJ operates 32 CSUs. In addition, 3 CSUs (Arlington, Fairfax, and Falls Church) function as locally operated entities. CSUs provide a variety of specialized services such as intake, screening, diversion, placement, pre- and post-adjudicatory case management, supervision, and parole planning and coordination. Juvenile intake services are provided 24-hours a day, and the intake officer at the CSU is authorized to receive, review, and process complaints.</p> <p>The investigations and reports primarily completed by CSU personnel are social history reports, but also include case summaries to local family assessment and planning teams (FAPTs), commitment packets for the Reception and Diagnostic Center (RDC), interstate compact reports, transfer reports, parole transition reports, ongoing case documentation, and transitional services referral packets.</p> <p>In FY 2012, over 60% of males and 80% of females committed to DJJ had significant symptoms of a mental health disorder. In addition, 63% of males and 58% of females had a history of psychotropic medication use. For juveniles served in detention centers, 45% had a least one mental health disorder and 25% are on psychotropic medication. Because of the number of juveniles with mental health disorders entering the juvenile justice system, it would be extremely valuable to have a person within the CSU to conduct mental health and substance abuse screenings, assessments, and evaluations. Assessing juveniles earlier in the process would enable judges to move forward with dispositional and other decisions, equipped with more information and a more complete understanding of what might be the appropriate action to take for the juvenile.</p> <ul style="list-style-type: none"> <li>• The 31st CSU (Manassas, Manassas City, &amp; Prince William) has a court psychologist who administers, scores, and interprets psychological and behavioral tests, reports on findings and makes recommendation for treatment plans. The court psychologist also conducts field visits to facilities pending court hearings or placements in treatment facilities and testifies in court to present the results of interviews and evaluations. The court psychologist attends FAPT meetings and assists in the development of service and treatment strategies.</li> <li>• The 29th CSU (Bland, Buchanan, Dickenson, Giles, Russell, &amp;</li> </ul>	<ol style="list-style-type: none"> <li>1. Introduce a budget amendment to fund up to one qualified mental health professional (QMHP) for each CSU that best suits their particular needs, including conducting mental health, substance abuse, and/or trauma screenings, assessments, and evaluations. Provide the CSU with the flexibility to hire the position or to enter into a Memorandum of Understanding with their local CSB.</li> <li>2. Introduce a budget amendment authorizing CSUs to contract with a QMHP for the provision of mental health, substance abuse, and/or trauma screenings, assessments, and evaluations. Provide the CSU with the flexibility to hire the position, to contract with the local CSB, or to contract with a private provider.</li> </ol>

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<p>Tazewell) has a psychologist on staff. Attorneys will request a psychological evaluation if they feel that it is necessary. Usually, a mental health evaluation has been completed before commitment is recommended.</p>	
<p><b>Finding 3—Community Services Board (CSB) Services in Juvenile Detention Centers</b></p> <p>In FY 2008, the General Assembly appropriated \$110,000 state general funds for the CSBs affiliated with a local detention facility so that the CSBs could provide mental health screening, assessment services, and community-based referrals for juveniles in detention. These programs began in 2003 with federal grant funds provided by the Department of Criminal Justice Services (DCJS) for approximately \$500,000.00. A 10% cash match from the grantee was required. Federal funds from DCJS were discontinued in 2008. Since that time, the Department of Behavioral Health and Developmental Services (DBHDS) assumed the costs of the program using state general funds.</p> <p>CSBs are to provide a licensed mental health therapist and a case manager employed by the CSB at each detention facility site. CSB staff provides consultation and mental health services for juveniles with mental health disorders and/or co-occurring substance use disorders who are detained in the center. Services include mental health and substance abuse assessment service. Other services may include individualized case planning and service coordination, individual and small group counseling, referral for specialized medical or psychiatric evaluations, consultation (with detention staff, probation staff, and parents/guardians), discharge planning, and post-release service coordination to facilitate service continuity through community resources.</p> <p>An informal survey of detention homes was conducted to receive information about this program. Survey results indicated that six detention homes had their CSBs' clinicians' hours reduced and/or diverted to perform duties at the CSB. However, data provided by the DBHDS revealed that, overall, state funds to CSBs for detention center services had not been significantly reduced.</p>	<ol style="list-style-type: none"> <li>1. Request DBHDS work with Virginia's detention home superintendents and CSB executive directors to facilitate a quantifiable agreement for the provision of mental health and substance use screening, assessment, and other services identified as necessary for juveniles in detention. DBHDS will provide guidance and technical assistance and assist in the creation of a model memorandum of understanding or other quantifiable arrangements between the detention homes and the CSBs. The agreement may include, but is not limited to, the duties of each position and expectations regarding the number of hours, services, and processes between local CSBs and detention centers. The agreement will also reflect the intent of the General Assembly that the state general funds be utilized for the provision of mental health services in local detention homes, providing a full-time mental health clinician and a case manager in each of the detention homes. The Virginia Council on Juvenile Detention (VCJD) and the VACSB shall be included in the process. DBHDS shall report its progress to COY prior to the 2015 General Assembly Session.</li> <li>2. Request DBHDS convene a training comprised of detention home and CSB representatives to clarify the role of each agency in the provision mental health and substance use services including assessment/evaluations, outpatient treatment, and crisis and case management services to juveniles in detention. Other topics include the purposes of the funding, the needs of juveniles in detention, model memorandums of understanding, and partnership opportunities. The VCJD and the VACSB shall be included in the process. DBHDS shall report its progress to COY prior to the 2015 General Assembly Session.</li> </ol>

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<p><u>Funding to CSBs</u> The state general funds distributed by DBHDS for CSB services in local detention homes were originally designated as “restricted”. These funds were later classified as “earmarked” meaning CSBs must spend the funds for the identified purpose, but CSBs do not have to report expenditures tied specifically to those funds.</p> <p>In FY 2012, total juvenile detention center costs for the 23 CSBs were \$3,552,897. The state general fund appropriation for these services was \$2,569,652. Local funds comprised the difference.</p> <p>Based on FY 2014 Letters of Notification to the 23 CSBs, DBHDS will disburse \$2,401,656 for mental health services in juvenile detention centers. Of the 23 CSBs, 17 will each receive approximately \$111,724. Six CSBs will receive lesser amounts. If all 23 CSBs received the full amount (\$111,724), the total disbursed would be \$2,569,652. Subtracting the total amount for the 23 CSBs (\$2,401,656) from the amount above (\$2,569,652) leaves a reduction of \$167,996 that would need to be offset.</p>	
<p><b>Finding 4 – Trauma</b> Trauma is a result of physical or sexual abuse, neglect or maltreatment, loss of a caregiver, witnessing violence, community violence, or disasters that induce feelings of powerlessness, fear, hopelessness, and include a constant state of alertness. Individuals who experience trauma as children are more likely to develop life-long mental health disorders.</p> <p>According to the Juvenile Policy Institute:</p> <ul style="list-style-type: none"> <li>• Approximately 75-93% of youth entering the juvenile justice system annually have experienced some degree of trauma.</li> <li>• Being abused or neglected as a child increases the likelihood of arrest as a juvenile by 59%.</li> <li>• Arrest rates for youth who have experienced trauma are 8 times higher than arrest rates of their non-traumatized peers.</li> </ul> <p>In Virginia, several localities reported an increasing awareness that trauma exposure was a crucial element in understanding and best serving juvenile offenders, but the lack of training and resources limits the work that can be done. Ideally, trauma-informed care would be diffused throughout the juvenile justice system. Screening for trauma exposure could occur at the</p>	<ol style="list-style-type: none"> <li>1. Request DJJ investigate the feasibility of implementing a formal screening method for trauma and developing a training program for all appropriate parties in recognizing trauma and appropriately handling youth when trauma is detected.</li> <li>2. Support the efforts of the Department of Criminal Justice Services (DCJS), the Office of the Executive Secretary for the Supreme Court, and DJJ in training appropriate parties, including police officers, judges, and other staff, in recognizing trauma and appropriately handling youth when trauma is detected.</li> </ol>

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<p>various entry points into the system.</p> <p>Court-ordered mental health assessments could include assessments of trauma. Qualified mental health professionals working with the juvenile justice system could be trained in evidence-based interventions for trauma.</p>	
<p><b>Finding 5 – Supporting Current Juvenile Justice Practices</b></p> <p>Juveniles involved in the juvenile justice system who also have a mental health disorder are more likely to continue to experience justice system involvement. Properly identifying youth in need and linking them with appropriate services will help facilitate their rehabilitation and likely reduce subsequent law violating behavior.</p> <p>Heightened awareness of mental health disorders has led to increased research and new treatment practices in the juvenile justice system. Among delinquent juveniles who receive structured, meaningful, and sensitive treatment, recidivism rates are 25% lower than those in untreated control groups and re-offense rates are reduced by as much as 80%.</p> <p>Virginia’s juvenile justice system allows for the diversion of juveniles consistent with the protection of public safety. Intake is a critical intervention point within the juvenile justice system and plays a vital role in determining whether a juvenile’s case is dismissed, diverted, or formally referred to the court.</p> <p>In Virginia, CSUs and juvenile justice officials strive to integrate community resources to meet the needs of the juvenile. These localities have begun to expand the role of probation officers to that of a “case manager” providing intensive case management and support to juveniles with identified mental health and substance use concerns. CSU officials who were interviewed noted that they would appreciate additional information on mental health, assessment, family engagement, trauma, and appropriate interventions/resources.</p>	<ol style="list-style-type: none"> <li>1. Request DJJ include in their ongoing training efforts information on the facilitation of case management of youth in the juvenile justice system. Training may incorporate best practices for juveniles with mental health, substance use, and co-occurring disorders as well as the impact of trauma.</li> </ol>

## SJR 358 (2003)

### UPDATE OF COLLECTION OF EVIDENCE-BASED PRACTICES FOR CHILDREN AND ADOLESCENTS WITH MENTAL HEALTH TREATMENT NEEDS

#### ADOPTED RECOMMENDATIONS IN BLUE

Findings/Conclusions	Adopted Recommendation
<p>In anticipation of the release of the American Psychiatric Association's <i>Diagnostic and Statistical Manual of Mental Disorders Fifth Edition</i> (DSM-5), the Commission on Youth directed staff at the April 2 meeting to:</p> <ul style="list-style-type: none"> <li>• Revise the <i>Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs 5th Edition</i> (the "Collection"). The Collection is to be revised biennially pursuant to Senate Joint Resolution 358 (2003);</li> <li>• Seek the assistance of the Study Advisory Group, the Secretary of Health and Human Resources, the Secretary of Public Safety, and the Secretary of Education;</li> <li>• Make the Collection available through web technologies; and</li> <li>• Develop a cost-effective and efficient dissemination method.</li> </ul> <p>The <i>Collection</i> summarizes mental health practices proven effective for children and adolescents. The <i>Collection</i> is a resource for parents, caregivers, educators, service providers, and others seeking current research on evidence-based practices. Since 2003, the Commission has updated the <i>Collection</i> every two years and made it available on the Commission on Youth's website and in print editions. It is currently in its fifth edition.</p> <p>The <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM) is the American Psychiatric Association's publication considered by practitioners throughout the world to be the definitive source by which to classify mental illnesses. The DSM was recently updated in May 2013. Changes to the newest edition (the DSM-5) are significant. The following are just a few of the changes included to the DSM-5:</p> <ul style="list-style-type: none"> <li>• Eliminates the category, "Disorders Usually First Diagnosed in Infancy, Childhood, and Adolescence"</li> <li>• Re-categorizes learning disorders;</li> <li>• Creates a single diagnostic category for autism and other socialization</li> </ul>	<p>The Commission on Youth will update the next biennial revision (6<sup>th</sup> Edition) of the <i>Collection of Evidence-Based Practices for Children and Adolescents with Mental Health Treatment Needs</i> to reflect the revisions in the DSM-5 and suggestions from the Advisory Group including:</p> <ul style="list-style-type: none"> <li>• adding family-specific information for each mental health/developmental disorder;</li> <li>• updating the sections on cultural competency; and</li> <li>• including information on early childhood issues.</li> </ul> <p>The Collection 6<sup>th</sup> Edition is scheduled to be completed in early 2014.</p>

disorders;

- Modifies the three ADHD subtypes;
- Eliminates "substance abuse" and "substance dependence" as disorders, to be replaced with a single "addiction and related disorders" category;
- Adds a new disorder in children, "temper dysregulation with dysphoria," describing negative mood with bursts of rage; and
- Revises criteria for some eating disorders, including creation of a separate "binge eating disorder" distinct from bulimia.

The Commission reconvened the Collection's Advisory Group to assist in the update and to provide feedback to the process. Commission on Youth staff is currently revising the Collection reorganizing the content based on the DSM-5. Staff is also developing a "crosswalk" to outline the changes from the DSM-IV to the DSM-5.