COMMISSION ON MENTAL HEALTH LAW REFORM

REPORT

OF THE

TASK FORCE ON CHILDREN AND ADOLESCENTS

DECEMBER 2008

COMMISSION ON MENTAL HEALTH LAW REFORM

PREFACE

The Commonwealth of Virginia Commission on Mental Health Law Reform ("Commission") was appointed by the Chief Justice of the Supreme Court of Virginia, The Honorable Leroy Rountree Hassell, Sr., in October 2006. Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups, including consumers of mental health services and their families, service providers, and the Virginia State Bar. The Commission was directed by the Chief Justice to conduct a comprehensive examination of Virginia's mental health laws and services and to study ways to use the law more effectively to serve the needs and protect the rights of people with mental illness, while respecting the interests of their families and communities. Goals of reform include reducing the need for commitment by improving access to mental health services, avoiding the criminalization of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers of mental health services to have greater choice regarding the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

During the first phase of its work, the Commission was assisted by five Task Forces charged, respectively, with addressing gaps in access to services, involuntary civil commitment, empowerment and self-determination, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. In addition, the Commission established a Working Group on Health Privacy and the Commitment Process ("Working Group"). Information regarding the Commission and its Reports is available at http://www.courts.state.va.us/cmh/home.html.

The Commission also conducted three major empirical studies during 2007 under the supervision of its Working Group on Research. The first was an interview study of 210 stakeholders and participants in the commitment process in Virginia. The report of that study, entitled *Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations*, was issued in April 2007. The study is available at http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf.

The second major research project was a study of commitment hearings and dispositions (the "Commission's Hearings Study"). In response to a request by the Chief Justice, the special justice or district judge presiding in each case filled out a 2-page instrument on every commitment hearing held in May 2007. (There were 1,526 such hearings). Findings from the Commission's Hearing Study served an important role in shaping the Commission's understanding of current commitment practice. The study can be found at http://www.courts.state.va.us/cmh/2007_05_civil_commitment_hearings.pdf.

Finally, the Commission's third project was a study of every face-to-face crisis contact evaluation conducted by Community Service Board ("CSB") emergency services staff during June 2007 (the "Commission's CSB Emergency Evaluation Study"). (There were 3,808 such evaluations.) Final reports of the Hearing Study and the CSB Emergency Evaluation Study will be released in late 2008.

Based on its research and the reports of its Task Forces and Working Groups, the Commission issued its *Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform* ("Preliminary Report") in December, 2007. The Preliminary Report, which is available on-line at http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf, outlined a comprehensive blueprint for reform ("Blueprint") and identified specific recommendations for the 2008 session of Virginia's General Assembly. The General Assembly enacted a major overhaul of the commitment laws in 2008, and the Commission moved into the second phase of its work. Three new Task Forces were established – one on Implementation of the 2008 reforms, another on Future Commitment Reforms, and one on Advance Directives.

This document is the Report of the Commission's Task Force on Children and Adolescents ("CA Task Force"). Although the Commission embraced many of the Recommendations of the CA Task Force in its Preliminary Report and will continue to consider the issues raised by the Task Force during future deliberations, this Report is the work of the CA Task Force and has not been adopted or endorsed by either the Commission or the Supreme Court. It was prepared as a resource for the Commission and for the public.

Richard J. Bonnie, Chair
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December 2008

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INTRODUCTION

Childhood is a critical time for the onset of behavioral and emotional disorders. In the U.S., 1 in 10 children and adolescents suffers from mental illness severe enough to cause some level of impairment at home, school or in the community.[1] Mental health impairments adversely affect how children and adolescents relate to their families and peers, their performance in schools, and if not treated, are precursors to dropping out of school, placements outside of the home, encounters with juvenile justice, suicide and other dangerous behaviors. The costs of failing to treat children and adolescents are high in both human and financial terms.

A sub-population of children and adolescents with mental health impairments are characterized with more severe functional limitations, known as serious emotional disturbance ("SED"), a term that refers to children under the age of 18 with a diagnosable mental health problem that severely disrupts their ability to function socially, academically, and emotionally. Approximately five to nine percent of children between ages 9 and 17 exhibit behaviors that meet the diagnosis of having an SED. [2]

To be diagnosed with SED children must meet the following specific functional criteria:[3]

- Problems in personality development and social functioning that have been exhibited over at least one year's time;
- Problems that are significantly disabling based on social functioning of most children of the child's age;
- Problems that have become more disabling over time; and
- Service needs that require significant intervention by more than one agency.

Virginia's Department of Mental Health, Mental Retardation, and Substance Abuse Services ("DMHMRSAS") estimates that between 92,346 and 110,815 Virginia children and adolescents have a SED, with between 55,407 and 73,877 exhibiting extreme impairment (2005).[4] In addition, 67,477 Virginians (age 6 and older) have mental retardation and 18,116 infants, toddlers, and young children (birth to age 5) have developmental delays requiring early intervention services.

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1 National Institutes of Health. (1999). *Brief Notes on the Mental Health of Children and Adolescents*. Available at: http://www.medhelp.org/NIHlib/GF-233.html.

2 (Friedman, as cited by InCrisis).

3 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000.

4 Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. (2005). *Comprehensive State Plan: 2006-2012*.

Aside from children who already exhibit SED characteristics, additional children may be "at risk" of developing SED. These at-risk youth are characterized by at least one of the following:

- The child exhibits behavior or maturity significantly different from most children of the child's age and is not due to a developmental disability or to mental retardation; or

- Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, that could result in the child's developing serious emotional or behavior problems; or

- The child has experienced physical or psychological stressors.[5]

Unfortunately, in any given year, it is estimated that fewer than 1 in 5 of children receives needed mental health treatment. [6] This is likely because such services are costly and not all children and adolescents in Virginia, even those with SED, have access to mental health services. In fact, such access varies by eligibility category, with severe emotional and behavioral disorders a necessary, but not sufficient, criterion for getting needed mental health services. Under Virginia's Comprehensive Services Act funding, only children who also are either (i) in or at risk of foster care placement or (ii) have special education needs beyond the classroom are assured of State funded-mental health services.[7]

As this CA Task Force Report will describe, one consequence of having limited access to mental health services is that far too many of children and adolescents come before Virginia's Juvenile and Domestic Relations Courts ("JDR Courts") either because desperate parents seek to relinquish custody of their children to get access to treatment, or because the youngster's behaviors require attention by the juvenile justice system, or because the court's authority to order treatment has been invoked.

Fortunately, unlike adult courts, the JDR Courts have the statutory mandate to construe the law "liberally and as remedial in character," which provides them with flexibility in dealing with children with mental health needs and their families.[8] To emphasize this point, the statute further states:

> This law shall be interpreted and construed so as to effectuate the following purposes:

[5] DMHMRSAS. (2005). *Comprehensive State Plan: 2006-2012*.
[6] NIMH (1999).
[7] Code of Virginia Section 2.2-5212.
[8] See Figure 1 of this Report and Virginia Code Section 16.1-226 et. seq.

1. To divert from or within the juvenile justice system, to the extent possible, consistent with the protection of the public safety, those children who can be cared for or treated through alternative programs…

Figure 1 sets out the relevant Virginia Code sections in full.

Figure 1. Virginia Statute Establishing the Juvenile and Domestic Relations District Court Law.

Virginia Code § **16.1-226**. Short title.

The short title of the statutes embraced in this chapter is "Juvenile and Domestic Relations District Court Law."

(Code 1950, § 16.1-139; 1956, c. 555; 1972, c. 708; 1973, c. 546; 1977, c. 559.)

§ **16.1-227**. Purpose and intent.

This law shall be construed liberally and as remedial in character, and the powers hereby conferred are intended to be general to effect the beneficial purposes herein set forth. It is the intention of this law that in all proceedings the welfare of the child and the family, the safety of the community and the protection of the rights of victims are the paramount concerns of the Commonwealth and to the end that these purposes may be attained, the judge shall possess all necessary and incidental powers and authority, whether legal or equitable in their nature.

This law shall be interpreted and construed so as to effectuate the following purposes:

1. To divert from or within the juvenile justice system, to the extent possible, consistent with the protection of the public safety, those children who can be cared for or treated through alternative programs;

2. To provide judicial procedures through which the provisions of this law are executed and enforced and in which the parties are assured a fair hearing and their constitutional and other rights are recognized and enforced;

3. To separate a child from such child's parents, guardian, legal custodian or other person standing in loco parentis only when the child's welfare is endangered or it is in the interest of public safety and then only after consideration of alternatives to out-of-home placement which afford effective protection to the child, his family, and the community; and

4. To protect the community against those acts of its citizens, both juveniles and adults, which are harmful to others and to reduce the incidence of delinquent behavior and to hold offenders accountable for their behavior.

(Code 1950, § 16.1-140; 1956, c. 555; 1977, c. 559; 1990, c. 554; 1991, c. 392; 1996, cc. 755, 914.)

It is critical for policy makers to understand the unique mandate of the JDR Courts and the resources that are needed to ensure that the mandate can be met. The challenge for JDR Courts is to follow this mandate when the community-based remedial resources to address the needs of juveniles with serious mental health needs are limited and often lacking altogether. As will be discussed in this Report, there is enormous variability across the Commonwealth in per capita expenditures for children's mental health services

(with a range of $.96 to $292 cited in a 2008 study by the Office of the Inspector General),[9] no doubt a factor contributing to the lack of child psychiatrists and other mental health professionals in some areas of the state. Insufficient resources often constrain the JDR Courts' options and many children end up in foster care or juvenile detention, results that are not only less effective but more costly than community-based services.

The CA Task Force has identified five goals specific to its mission, and has created three Subcommittees to examine the issues raised by each goal, to recommend possible solutions to the issues, and to consider the pros and cons of the possible solutions. These Subcommittees are the Subcommittee on Access to Services and Relinquishment of Custody, the Subcommittee on Children with Mental Health Needs in Juvenile Justice, and the Subcommittee on Civil Commitment. The CA Task Force's Goals, which were used to guide the Subcommittees' work, are the following:

1. Assure access to services for all children and adolescents with mental health and/or substance abuse service needs so that these juveniles and their families are not forced to seek judicial assistance to obtain needed services or go without services.

- **Assure community-based care system for all juveniles with mental health/substance abuse service needs with special consideration that certain early identification and intervention services are provided without regard to income or insurance status in schools, a place where most juveniles can be found.**
- **Investigate a recommendation that the law mandate additional services beyond emergency services and case management for juveniles who would otherwise have to be brought into the juvenile justice system through foster care or delinquency petitions in order to receive those services.**
- **Assure that adolescents in the juvenile justice system have access to mental health/psychiatric evaluations. This process will include a study of existing law to determine that the Juvenile and Domestic Relations Court cannot order these evaluations.**

2. Legal relinquishment of custody[10] by parents in order to obtain mental health services should be avoided, as such proceedings cause disruption of functional families and are not in the best interests of these children. Furthermore, these cases place an unnecessary burden on already crowded foster care court dockets. Issues to be addressed under this goal include:

a. Community diversion

[9] See Chapter I of this Report.

[10] Relinquishment of custody refers a parent's voluntarily transfer legal and physical custody of their child to the State in order to access publicly funded services. This requires the involvement of the Juvenile and Domestic Relations Courts and the placement of the child in foster care. Courts also must periodically review and approve a child's service plan.

b. School-based mental health and substance abuse services
c. Medicaid dollars flow
d. Examination of the statutory framework and effectiveness of the Comprehensive Services Act.
e. Continuity of care across the state. Money should follow the child and services if child moves or for any reason resides in different areas of the state.
f. Access to in-home and community-based mental health services.

3. Create conditions that will enable the Juvenile and Domestic Relations Court system to divert minors who need mental health and/or substance abuse services from the judicial system. Issues to be addressed under this goal are:

a. Create and strengthen CHINS diversion programs
b. Make structured decision-making a part of diversion
c. Examine and assess the effectiveness of current diversion statutes.

4. Assure appropriate treatment for those with mental health issues who remain under the JDR Court's jurisdiction and assure family engagement in services when services are needed.

a. Pretrial
i. **Mental health and substance abuse services at detention centers.**
ii. Access to psychiatric services for those in need.
iii. Competency restoration services provided by a community-based outpatient system as required by law.

b. Adjudication/disposition
i. Educate judges about community resources.
ii. Access to necessary services to include community based sex offender programs.
iii. Proper psychological assessment and evaluation before disposition.

c. Commitment discharge planning to facilitate successful parole supervision.

5. **Examine the process of the involuntary commitment of juveniles to psychiatric facilities to improve the quality of evaluation, to facilitate parental understanding and participation, and to improve the adjudication process of commitment when court intervention is necessary. Issues to be addressed under this goal are:**

a. Examine statutory framework of the involuntary commitment statutes for issues involving timelines, filing, and location of hearings.

b. Examine the issues involving Special Justices v. JDR Court judges handling these hearings.

c. Examine the issues involving the transportation and custodial treatment of the child so the child is not treated like a criminal and is given constitutional due process rights.

The CA Task Force has divided these goals, as appropriate, among its three Subcommittees. The Subcommittees have examined the underlying policy challenges for addressing the mental health needs of Virginia's children. Early intervention and treatment is key not only to minimizing the long-term health consequences to Virginia's youth but to reducing the unnecessary burdens on the courts in adjudicating issues related to terminating parental rights, foster care, juvenile justice and civil commitment.

The CA Task Force has reviewed and endorsed the Recommendations of its Subcommittees and in this Report has identified concrete Recommendations for the Commission to consider for modifying legislation and policies, collecting additional information, and promoting better collaboration across agencies to better serve the mental health needs of children in their communities, in schools, foster care and juvenile justice settings. The CA Task Force has also joined with the Commission's Task Force on Access to Services in advancing a Recommendation to expand the mandated services provided through Community Service Boards ("CSBs") available to children and families.[11]

[11] CSBs are local government agencies that operate under a contract with DMHMRSAS to provide mental health, mental retardation, and substance abuse services to their communities. One or more local governments can be represented by a single CSB, and these governments oversee and fund the CSBs. Thirty-nine CSBs (and one behavioral health authority) exist in Virginia, and all localities are members of one of these CSBs. Virginia Code § 37.2-500 establishes Community Services Boards as the single point of entry for the publicly funded Mental Health, Mental Retardation and Substance Abuse Services System. The statute sets forth the mandated core services to be provided by CSBs including:

- Emergency Services
  - Crisis intervention, stabilization, preadmission screening for hospitalization, discharge planning for consumers in acute inpatient settings, short-term counseling, and referral assistance
- Case Management (subject to availability of appropriations)
  - Assistance with locating, developing or obtaining services and resources for consumers; needs assessments and planning services; coordination of services with service providers, monitoring service deliver, identification of and outreach to individuals and families in need of services
- In addition, the statute also outlines a comprehensive system of services that *may* be provided by CSBs (§ 37.2-500) including
  - Inpatient services, outpatient services, day support services, residential, prevention and early intervention, and other appropriate mental health, mental retardation and substance abuse services.

CHAPTER I. ACCESS TO SERVICES AND RELINQUISHMENT OF CUSTODY

I. Background and Goals

The U.S. Center for Mental Health Services estimates that one in five children has a mental health problem and one in ten has at least one significant mental illness impairing them in home, school, or peer contexts.[12] Applying these estimates to Virginia, approximately 334,000 children aged 18 and younger have a mental health problem and 167,000 have severe emotional and behavioral disturbances and are in need of services. Although many children have private insurance, Medicaid, or access to the State Children's Health Plan, coverage for mental health services is often inadequate and many of Virginia's children are uninsured.[13]

An umbrella for organizing and funding services for children who have or are at risk of severe emotional disturbance is Virginia's Comprehensive Services Act ("CSA"), which provides for eight separate State funding streams to be combined and returned to local communities who match these sums to provide mental health services to certain eligible children and their families.[14] The CSA also provides that localities have the flexibility to implement and monitor CSA-funded services.[15]

Although funding associated with the CSA has been instrumental in providing care to many thousands of at-risk children and adolescents, many children with severe emotional and behavioral disturbances do not have access to needed services because only certain

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[12] SAMHSA, National Mental Health Information Center. Children and Mental Health Fast Facts. Available at: http://mentalhealth.samhsa.gov/publications/allpubs/fastfact5/default.asp. According to SAMHSA, serious emotional disturbances are defined as follows:

> Diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. Serious emotional disturbances affect one in 10 young people. These disorders include depression, attention-deficit/hyperactivity, anxiety disorders, conduct disorder, and eating disorders.

[13] FAMIS, Families Assurance of Medical Insurance Security, is Virginia's SCHIP program that provides children of eligible low-income families with access to health insurance. According to State Health Facts, 11% of children between 0 and 18 in Virginia (207,784) were uninsured in 2007, meaning they have neither private nor public health care coverage (including Medicaid and FAMIS). See: www.statehealthfacts.org.

[14] Comprehensive Services Act, Virginia Code §2.2-5200 et seq. See, also, JLARC. (2007). *Evaluation*. The CSA Pool Funds included funds from the Department of Education, the Department of Social Services State and Local Foster Care, the Department of Education, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Department of Juvenile Justice. CSA Pool Funds comprise about 2/3 of the total expenditures. Children who would have been served through any of these agencies are targeted by the CSA and receive priority for services. Additional funding sources are Medicaid and Title IV-E.

[15] CSA funding sources include the Department of Social Services, State and Local Foster Care Purchased Services, the Department of Juvenile Justice (286 Special Placements and 239 Special Placements), the Department of Education and the Department of Mental Health, Mental Retardation and Substance Abuse Services.

categories of high-risk children and adolescents are assured of having access to mental health services, and such services are provided disproportionately through high-cost residential placements, Furthermore, an extraordinary result of CSA policies is that many families, desperate to get care for their children, relinquish custody to the state so their children will become eligible for mandated mental health services. It is the consensus of the CA Task Force that this result skewers the underlying goals articulated for the CSA of promoting interventions in the least restrictive environment possible. Chapter I represents the work of the CA Task Force's Subcommittee on Access and Relinquishment of Custody, which was charged with examining issues related to the first two CA Task Force goals:

1. Assure access to services for all children and adolescents with mental health and/or substance abuse service needs so that these juveniles and their families are not forced to seek judicial assistance to obtain needed services or go without services.

a. Assure community-based care system for all juveniles with mental health/substance abuse service needs with special consideration that certain early identification and intervention services are provided without regard to income or insurance status in schools, a place where most juveniles can be found.

b. Investigate a recommendation that the law mandate additional services beyond emergency services and case management for juveniles who would otherwise have to be brought into the juvenile justice system through foster care or delinquency petitions in order to receive those services.

c. Assure that adolescents in the juvenile justice system have access to mental health/psychiatric evaluations. This process will include a study of existing law to determine that the Juvenile and Domestic Relations Court cannot order these evaluations.

2. Legal relinquishment of custody by parents in order to obtain services should be avoided as such proceedings cause disruption of functional families and are not in the best interests of these children. Furthermore, these cases place an unnecessary burden on already crowded foster care court dockets. Issues to be addressed include:

- **a. Community diversion**
- **b. School-based mental health and substance abuse services**
- **c. Medicaid dollars flow**
- **d. Examination of the statutory framework and effectiveness of the Comprehensive Services Act.**
- **e. Continuity of care across the state. Money should follow the child and services if child moves or for any reason resides in different areas of the state.**

f. Access to in-home and community-based mental health services.

The CA Task Force fully endorses the basic conclusions drawn and the Recommendations made by the Subcommittee on Access and Relinquishment of Custody:

- As applied in local communities, Virginia's law and policies addressing the needs of children with serious emotional and behavioral disorders, result in a disproportionate reliance on costly residential placements.
- Because of the high unit cost of serving the ten percent of children with serious emotional and behavioral disorders for whom federal and state law mandates services, there is an underdevelopment of local, community-based services and little funding remaining to provide services to "non-mandated" populations.
- Because foster children are a population for which mental health services are mandated, some parents relinquish custody to the State in order to get needed mental health services. This adds to CSA costs, since most of this care is provided through residential placements, and requires judicial involvement in what is fundamentally a health issue.
- Better coordination with schools would improve children's mental health and more effectively comply with the requirements of two federal laws—IDEA and NCLB.[16]

II. CSA Eligibility Criteria

Although the CSA has been in effect for 15 years, the community–based infrastructure for providing children's mental health services across Virginia remains significantly under-funded and underdeveloped. Why is this the case? The CSA is designed to use state funding to augment funding by local communities to develop mental health interventions for at-risk children and youth. However, only a subset of that population is entitled to state funding. Local communities who accept CSA funding are required to contribute matching funds for services for "mandated" populations. Local communities could also provide services to a broader group of children and youth in need of services (CHINS) but funding from the state is not guaranteed for these children and, as a result, services vary across the state and with economic conditions.

According to the CSA's eligibility criteria, children with severe emotional and behavioral problems are eligible for CSA-funded services.[17] Meeting the diagnostic criteria for SED, however, does not guarantee access to CSA-funded services. CSA provides sum-

[16] The Individuals with Disabilities Education Act (20 U.S.C. §§1400, et. seq.); The No Child Left Behind Act of 2001 (Public Law 107-110).

[17] According to JLARC, the eligibility criteria for CSA includes children and their families who have severe behavioral or emotional problems that either are persistent or critical in nature, are significantly disabling and present in several settings; require resources that are beyond the scope of normal agency services; or place the child in imminent risk of residential care.

sufficient funding *only* for those children who are at risk of entering foster care, children in foster care, and children needing special education services that extend beyond the classroom.[18] Because state and local governments are required by federal and/or state law to provide services to these children, this group is known as the "mandated children." The remaining population of children with severe emotional and behavioral problems falls into a category that is known as "non-mandated" children. As a practical matter this distinction means that after meeting the needs of the at-risk children mandated by the CSA, localities have the option of determining whether to use any remaining CSA funds for the non-mandated population of children. Clearly, to the degree that CSA funding is used for high-cost residential care, little additional funds remain to provide services to the non-mandated children.

A 2007 Joint Legislative Audit and Review Commission ("JLARC") study ("JLARC Custody Relinquishment Study") concluded that the level of non-mandated CSA funding for children's mental health services is inadequate.[19] JLARC noted that in 2005, the State and localities spent only $9.5 million to serve 1179 non-mandated children. This is compared to the $263.7 million spent to provide services for 16,276 mandated children. Data from the Office of Comprehensive Services ("OCS") for fiscal year 2006 demonstrates a similar distribution of funding with almost $8.4 million being spent for 1321 non-mandated children, while $286.7 million was spent on 17,558 mandated children. With twice as much per capita being spent on the mandated children, relatively few non-mandated children have access to services.

Two consequences of how the CSA is currently implemented are of particular concern to the CA Task Force. First, current CSA eligibility criteria skew treatment choices to residential care[20] for approximately one quarter of children receiving CSA-funded services. This residential care preference dramatically increases the unit cost of services and often takes children out of their communities and destabilizes their relationships.[21] Furthermore, large expenditures on residential care for some children starve communities of the resources needed to develop community-based services and supports. This not

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[18] Joint Legislative Audit and Review Commission. (August 2003). *The Design and Implementation of Virginia's Comprehensive Services Act*. Briefing for the Commission on the Revision of Virginia's Tax Code. Available at: http://dls.state.va.us/groups/sjr347TaxCode/Meetings/8_18_03/CSA_ppt.pdf.

[19] Joint Legislative Audit and Review Commission. (March 2007). *Follow-up Report: Custody Relinquishment and the Comprehensive Services Act.* Available at: http://jlarc.state.va.us/Reports/Rpt352.pdf.

[20] According to the Center for Mental Health Services, **Residential treatment centers** are defined as**:**

> Facilities that provide treatment 24 hours a day and can usually serve more than 12 young people at a time. Children with *serious emotional disturbances* receive constant supervision and care. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than *inpatient hospitalization*. Centers are also known as *therapeutic group homes*. See *Glossary of Terms, Child and Adolescent Mental Health*, available at: http://mentalhealth.samhsa.gov/publications/allpubs/CA-0005/default.asp.

[21] Joint Legislative Audit and Review Commission. (2007). *Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act.* Available at: http://jlarc.state.va.us/Reports/Rpt346.pdf.

only deprives other children access to mental health services but also jeopardizes the long-term recovery of children who were initially sent to residential care.

Second, because one of the high-priority eligibility categories for mandated CSA services is a child in foster care, some parents, unable to get needed services otherwise, relinquish custody of their children to ensure access to mental health services.

The Subcommittee on Access and Relinquishment of Custody reviewed the literature and consulted with representatives from several Virginia agencies, including the Department of Social Services (Therese Wolfe, Foster Care Supervisor), the Office of Comprehensive Services (Kim McGaughey, Executive Director, OCS), the Department of Education (Doug Cox, Pupil Services Administrator) and DMAS (Catherine Hancock). The discussion that follows sets forth some of the findings.

III. Basic Infrastructure Of Mental Health Services For Children

Under the CSA, each locality is required to have two interagency teams—a Community Policy and Management Team ("CPMT") and a Family Assessment Planning Team ("FAPT"). The CPMT is made up of at least one elected or appointed official and agency representatives from the local Department of Social Services, the School System, Community Services Board, the Department of Juvenile Justice's Court Services Units,[22] local Health Department, a parent not associated with any agency that receives CSA funds and a private provider. The CPMT has administrative and fiscal responsibility over the local pool funds and appoints members of the FAPT.

The FAPT includes staff from the same agencies as the CMPT, the family and a private provider and works to develop an individual family services plan. If the services needed are unavailable through the participating agencies, and there are no other family or community resources available, the FAPT may use local pool funds to purchase the services.

As noted earlier in this Report, a key element in identifying which children will receive services is the determination of whether they are in a statutorily mandated group. Under either Federal law and/or the Virginia Code, state and local governments are required to appropriate funds to provide services to these populations. Most CSA recipients are children in foster care or special education programs.[23] In 2005, 16,272 children, or about a tenth of the estimated number of Virginia children with severe emotional and behavioral disturbances in need of services, received services funded under the CSA.

According to the Casey Strategic Consulting Group (the "Casey Group"), who studied the residential placement of children receiving CSA funded services, residential

[22] Virginia's Department of Juvenile Justice (DJJ) operates 32 Court Service Units (CSUs) and supports three locally operated CSUs. All CSUs provide intake, predisposition investigation, probation supervision, and aftercare services. DJJ administers the state's juvenile corrections system.
[23] JLARC. (2007). Evaluation.

placements in Virginia in 2006 amounted to 24% of initial foster care placements, a figure exceeding the national average of 18% and more than doubling the recommended best practices of having less than 10% in residential care.[24] For teens, this figure was even higher -- the Casey Group reported that teens are placed in residential care more than half the time.

The stated purpose of the CSA is " to provide high quality, child centered, family focused, cost effective, community-based services to high-risk youth and their families."[25] However, relatively few dollars have been targeted to develop wrap-around services that could facilitate a child's ability to be treated in the community with family involvement. Instead, according to the JLARC Custody Relinquishment Study, these funds are disproportionately distributed to provide high-cost residential care to relatively few children. For example, in 2005, nearly half of CSA funds supported the residential care of only 25% of the children receiving CSA-funded services.[26]

Not all communities in Virginia follow the apparent preference for residential care. Some communities have focused on providing the services needed to avoid placements in residential care facilities. One of these is Hampton, Virginia. In May 2007, the CA Task Force met in Hampton, Virginia, and met with a local JDR Court judge and members of the CPMT and Department of Social Services ("DSS") to discuss Hampton's successful approach to minimizing residential care placements for children with mental illness. (See **Appendix A**). In the third quarter of 2005 only 2% of all CSA-funded juvenile mental health services in Hampton were for residential treatment services. Based on data from the Office of Comprehensive Services Data Ser for 2005, this was the lowest percentage of all Virginian communities. Key to Hampton's success is a strong interagency collaboration, predating passage of the CSA, which aims to keep children and families together in their communities. This collaboration has led to the development of innovative programs by all CPMT member agencies, including intensive care management, specialized foster care, the teaching parent approach, family reunification and intensive in-home services. The CA Task Force strongly supports similar CSA-supported infrastructure development in each community necessary to adequately serve children at risk of or with emotional disturbances.

The CA Task Force does not believe that Virginia's current CSA-funded system needs to be dramatically changed in terms of its stated goals, which include community-based mental health services, the agencies involved, or giving communities flexibility in crafting programs for high-risk youth and their families. Rather, it believes the CSA needs to refocus all parties on the importance of fostering community-based, least

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[24] Organization Overview and First Phase of Virginia/CSCG Partnership, October 2, 2007. The Casey Group presented its findings to the CA Task Force in 2007.

[25] From the Virginia.gov website describing the CSA and its purpose. Available at: http://www.csa.state.va.us/html/about_csa/about.cfm.

[26] JLARC. (2007). *Evaluation*. CSA expenditures (including state, local and federal dollars) totaled $416.4 million and served 16,272 children. Of that amount, 47% of the money was used for residential treatment for 25% of the children served.

restrictive systems of care even for children with the most serious emotional and behavioral need.

What children tend to end up in residential placements? We do not have a complete picture of this. In 2005, approximately one quarter of 16,272 children served through CSA funding received residential services.[27] Although the DMHMRSAS data set does not identify children in residential placements by their diagnosis, it does show that in 2007, 39% (7156 of 18,458 receiving services) did have a DSM-IV diagnosis. Anecdotally, it is reported that this population with more severe mental health needs is disproportionately represented in residential placements. Although this may be an appropriate placement for some, research indicates that community-based services can be effective even for these children.

Instead of this over-reliance on high-cost placements, which cost an estimated $47,689 per child in residential care,[28] the CA Task Force urges that community mental health systems be strengthened. CSA-funded residential treatment should be used only as a last resort when no less restrictive environment is appropriate. The CA Task Force's Recommendations suggest ways to improve the existing CSA-funded system, focusing on the infusion of resources into developing community mental health services and providing incentives to communities for decreasing reliance on CSA-funded residential services.

IV. Need For Community-Based Services

The General Assembly's stated intent in enacting the CSA was to "create a collaborative system of services and funding that is child-centered, family-focused and community based."[29] Unfortunately, CMPT coordinators across Virginia stress that they simply do not have the resources available to appropriately serve the children in their communities to fulfill this intent. The CA Task Force believes that Virginia could better utilize Medicaid to leverage the costs of expanding mental health services for low-income children. In fact, several states, including Texas, South Carolina, Oregon, Michigan, and Arizona, mandate a larger number of mental health services and receive Medicaid funds to help cover the costs of providing these services. In Virginia, however, CSBs' mandated services include only emergency services and case management. This limited menu of CSB-mandated services is a significant constraint on crafting effective treatment plans. The CA Task Force strongly supports the Access Task Force's Recommendations to expand the CSB- mandated core services to include, at a minimum, crisis stabilization, family support, respite care, in-home services and psychiatric care. Although the State would have to contribute funding to receive the federal matching funds, the leveraging of Medicaid dollars would be a cost-effective way of expanding services.

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[27] DMHMRSAS Children and Family Services Update. (March 2007). Available at: http://www.dmhmrsas.virginia.gov/documents/reports/CFS-Updates032007.pdf.

[28] Calculated from the figures given in DMHMRSAS, Children and Family Update (March 2001).

[29] Va. Code Ann. 2.2-5200(A)(2007).

By supporting the development of community-based mental health services in localities throughout Virginia, the General Assembly has an unprecedented opportunity to simultaneously promote CSA's original intent and reduce costs. According to the 2007 JLARC report, the most effective means of reducing future CSA spending is by "avoiding unnecessary residential placements, and when residential care is necessary, managing the type, duration, and daily cost of residential services."[30]

V. The Effectiveness Of Residential Treatment Versus Community-Based Services

There is ample evidence to support a preference for more community-based mental health services for children. The CA Task Force acknowledges that residential treatment placements should be in a continuum of care options. However, residential placements of so many of Virginia's children are unlikely to be medically necessary and for some children may be harmful.[31] Studies on the efficacy of residential treatment versus community-based mental health services "increasingly indicat[e] that community-based programs and day treatment are an effective alternative to residential treatment for most children with emotional and behavioral problems."[32]

The justifications often cited for placing so many of Virginia's children with emotional disturbances or behavioral problems in residential care vary but include protecting the community, particularly when interventions for older adolescents with aggressive behavioral problems are being considered, or protecting the children from harm. However, research fails to support either of these justifications for routine placement of children in residential placements.[33] In fact, research shows that many violent and aggressive adolescents not only show no long-term improvement when placed in residential treatment centers,[34] but community-based interventions and outpatient services are often more successful alternatives.[35]

Because a small percentage of children may be well served in residential treatment settings, residential care must be a part of the available treatment continuum. However, even in cases where residential treatment options are therapeutically necessary as a component of a child's treatment plan, Virginia's apparent bias toward residential

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[30] JLARC. (2007). *Evaluation*., Ch. 4.

[31] Jennifer Parsons. *Virginia's Children's Mental Health Dollars: Residential Treatment Centers and the Need for Community-Based Programs* (June 2007). Parsons is a student at Regent University School of Law and at the time of this report's preparation was an intern in the Office of Chief Staff Attorney at the Supreme Court of Virginia.

[32] *See* Parsons at 1.

[33] Joshi, P.K., and Rosenberg, L.A. (1997). "Children's Behavioral Response To Residential Treatment." Journal of Clinical Psychology, 53, 567-573.

[34] Loeber, R., and Farrington, D. P. (Eds.). (1998). *Serious and violent juvenile offenders: Risk factors and successful interventions*. Thousand Oaks, CA: Sage.

[35] Brestan, E.V., and Eyberg, S.M. (1998). Effective Psychosocial Treatments Of Conduct-Disordered Children And Adolescents: 29 Years, 82 Studies, And 5,272 Kids. *Journal of Clinical Child Psychology*, 27, 180-189; Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic Treatment Of Antisocial Behavior In Children And Adolescents*. New York: Guilford Press.

treatment results in under-development of community-based services. The lack of community-based treatment supports undermines the recovery of children released from residential treatment. Research indicates that the progress achieved through residential treatment is more likely to be sustained over the long-term if support is available to the child upon release from the residential treatment center.[36]

Focusing resources predominately on community-based programs instead of residential treatment is the approach strongly advocated by the United States Substance Abuse and Mental Health Services Administration ("SAMHSA").[37] SAMHSA's research indicates that communities that have implemented systems of care in their communities have experienced improvements on various fronts, including:

- Costs were reduced due to fewer days in inpatient care, with an average per child savings of $2,777;
- Emotional and behavioral problems were reduced or remained stable for nearly 90% of children after 18 months in systems of care;
- The percentage of children who deliberately harmed themselves or attempted suicide decreased by 32% after twelve months in systems of care;
- School attendance and achievement improved; and
- Juvenile detention placements were significantly reduced.[38]

JLARC also reported on research evaluating the CSA-supported residential services and reported that the success of residential treatment in Virginia is mixed (JLARC's CSA Evaluation Study").[39] While half of the children who received mental health services in residential placements were rated as doing better over time, 32% were doing worse, and 13% had not improved. In addition to not benefiting almost half of the children placed there, an unintended consequence is that residential treatment settings often become long-term placements far beyond the period needed for treatment, another likely consequence of limited community-based services. JLARC reports that 78% of children initially placed in residential settings in 2004 were still receiving care in residential facilities as of March 2006.[40]

JLARC's CSA Evaluation Study recommended the General Assembly take the following actions:

- Expand competitive grants to help localities to develop community-based services;

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[36] Wells, K. (1991). "Placement Of Emotionally Disturbed Children In Residential Treatment: A Review Of Placement Criteria." American Journal of Orthopsychiatry, *61*, 339–347.
[37] *Community-Based Care Leads to Meaningful Improvement for Children and Youth with Serious Mental Health Needs.* News Release May 8, 2006. U.S. Department of Health of Human Services.
[38] Id.
[39] Joint Legislative Audit and Review Commission. (2007). *Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act.* (House Document No. 12. 2007).
[40] Id.

- Allow localities to reinvest savings realized through expanded use of community services into the start-up of new services;
- Assume a portion of the financial risk of developing capital-intensive services such as crisis intervention, psychiatric assessment and family support services.[41]

What would it take to improve access to community-based services for children with mental health needs in Virginia? At a minimum, it would take a re-direction of CSA pool funding to limit residential placements and invest those resources in community-based services. This would better serve those children in the mandatory category of CSA services and free up funding to provide services to a larger proportion of non-mandated children as well. To ensure that all children with severe emotional and behavioral disorders receive services, however, may require additional funding. Together with redirected and augmented funding, a broader array of services should be developed.

Even with adequate funding, barriers to getting access to community-based care will remain. There will need to be additional workforce development, greater family involvement, and an active commitment of all stakeholders to the tenets of the CSA statute. The CA Task Force makes the following recommendations to improve access to community-based mental health services and supports in Virginia:

Recommendation I.1. The Secretary of Health and Human Services, the Secretary of Public Safety and the Secretary of Education should conduct a joint review of the current structure of children's services and to make specific suggestions for changes that would better achieve the goals of the Comprehensive Services Act on a statewide basis.

Recommendation I.2. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to create incentives to limit the use of residential treatment whenever possible, and use the money saved to create more community-based services.

Recommendation I.3. The General Assembly should amend the Virginia Code to mandate additional services for Community Services Boards beyond emergency services and case management, and include crisis stabilization, family support, respite, in-home services and psychiatric care. The General Assembly should also insure that funds are available to support these services.

Recommendation I.4. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to increase oversight of and technical assistance to communities that are over-reliant on residential care. The oversight policy should require that the Family Assessment and Planning team take specific steps prior to placement of any child in non-emergency residential care, such as:

[41] Id. Ch. 5.

- **Obtain a mental health evaluation of the child from the local CSB with recommendations for the least restrictive alternative;**
- **Explore all possible community-based services available to the child and family;**
- **Document that inadequate community-based services exist, and that no community-based services can be created;**
- **Develop a discharge plan with timelines for the child before placement in a residential facility;**
- **Report the rationale for the residential placement decision to the community policy and management team; and**
- **Policy should indicate that children with private insurance should also be able to receive mental health services at CSBs (which often provide the most comprehensive menu of services for the seriously mentally ill).**

Recommendation I.5. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to develop policies requiring Community Policy and Management Teams) to use Intensive Care Coordination as a mechanism for utilization and review for each child in residential care. The purpose of this additional review process is to safely and effectively transition a child to home, a relative's home, or a family setting at the earliest appropriate time that meets the child's needs.

Average citizens do not understand how to get help for their children. There is no clear way to access mental health services in Virginia, even though CSBs are given legal authority for that role.

Recommendation I.6. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to develop policies that facilitate access to mental health services by eligible children, adolescents and their families by: (1) removing impediments to discussions by a Family Assessment Planning Team (FAPT); (2) requiring CSBs to do an intake on every child who comes through CSA for behavioral health treatment; (3) making CSBs the front door for emotional and mental health treatment regardless of insurance status; and (4) making Intensive Care Coordination a function of CSB services, either directly or through monitoring of the program at CPMT and FAPT.

In order for CSBs to take on this "front door" role, the General Assembly and/or CSA should provide adequate funding. Most CSBs have very little outpatient service capability for children. Funding can come from CSA on a client specific basis, but capacity needs to be built.

Recommendation I.7. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to develop policy for an aggressive, clinically knowledgeable Intensive Care Coordination system through community service boards, especially with regard to use of residential services by CSA. The

presentation of a residential placement plan to the FAPT and CPMT should include specific, measurable goals for return to community as rapidly as possible, and a plan to monitor, evaluate, and assure progress on the goals while in residential care.

Recommendation I.8. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to develop a training academy that establishes collaboration between universities and CPMTs to develop local programs from promising practices models, and evaluate existing programs.

VI. Relinquishment Of Custody

As we have documented, mental health funding under the CSA for non-mandated children is limited throughout the Commonwealth. That average, however, masks the complete failure of services for these children in some areas of the State. JLARC's CSA Evaluation Study found that in 2005 one-third of local CSA programs provided no services for non-mandated children at all.[42] As a result, some parents with children having serious emotional and behavioral disturbances have resorted to relinquishing custody of their children to the State, for the sole purpose of placing them in a CSA mandated category and gaining access to mental health services. Concern about this practice, coupled with the JLARC CSA Evaluation Study, prompted the State Executive Council to prepare and release proposed guidelines for providing CSA services that are currently in the public comment period ("CSA Guidelines").[43] When adopted, the CSA Guidelines will provide that children who have emotional and behavioral problems and meet the definition of children in need of services (CHINS) must receive the needed services for the time required for their stability. Eligibility for services is to be determined by FAPT, or an approved alternative multi-disciplinary team, using the expertise of the members and, if necessary, an independent, clinical evaluation. Residential placement will be subject to court review.

The CSA Guidelines should eliminate, or at least dramatically reduce, the need for parents to relinquish custody of their children in order to access mental health services. The proposed guidelines are included as **Appendix D**.

VII. Non-Custodial Agreements

Until recently, parents entering into non-custodial arrangements with DSS so that a child can receive mental health services had to undergo a criminal background check in order to regain custody. Section 63.2-901.1, however, was amended in July 2007, so that birth parents entering into non-custodial agreements no longer have to undergo criminal background checks before having their children returned to them. It has come to the attention of CA Task Force members that the change did not include grandparents. In the

[42] JLARC. (2007). *Follow-up.*

[43] Proposed Revised Interagency Guidelines on Foster Care Services for Specific "Children in Need of Services" Funded through the Comprehensive Services Act, State Executive Council, October 5, 2007.

Commonwealth, there are many grandparents who serve as primary custodians for their grandchildren. Like parents, grandparents should not be required to have criminal background checks in order to have custody fully returned.

Recommendation I.9. The General Assembly should amend Virginia § 63.2-901.1 so that grandparents with legal custody do not have to undergo criminal background checks.

Each CPMT is required to establish policies to assess the ability of parents or legal guardians to contribute financially to the cost of services for their children. Current policies use a standard sliding scale based upon ability to pay using the federal poverty guidelines. In some instances, as modest as these fees may seem, they become a barrier for guardians in non-custodial agreements leading to the belief the only real alternative for the child to receive services is to relinquish custody.

Under the DSS support enforcement rules, social workers have the authority to waive fees under a claim of "good cause. For example, a good cause claim may be made when a parent asserts that his/her finances are limited to the degree that collection of a co-payment would interfere with the parent's ability to insure that a service plan is fully implemented. The CA Task Force believes that barriers to service should be eliminated and that all social workers need to understand the availability of this important option so that they can encourage guardians to use it if necessary.

Recommendation I.10. The Commissioner of the Department of Social Services should require that staff receive training regarding the "good cause" option for social workers involved in these cases.

VIII. Other Barriers to Access

A. Workforce

In 2007 JLARC conducted a study of the availability of psychiatric services in Virginia ("JLARC Availability Report") [44]and concluded that Virginia's capacity to provide community-based mental health services was limited stating that, "Virginia has a shortage of specially-trained child and adolescent clinicians, especially psychiatrists and psychologists."[45] According the JLARC Availability Report, 47 localities in Virginia have no psychiatrists, and 87 localities do not have any child psychiatrists.[46] Such an undersupply of mental health professionals jeopardizes any effort to expand community-based services. To increase the numbers of psychiatrists, JLARC recommended that the General Assembly continue the program funding four psychiatric fellowships as

[44] Joint Legislative and Audit Review Commission. (October 9, 2007) *Availability and Cost of Licensed Psychiatric Services in Virginia*. Available at: http://jlarc.state.va.us/Reports/Rpt365.pdf.
[45] Id. at 15.
[46] JLARC *Availabiity Report.*

established in 2007 but make them two-year fellowships. JLARC also recommended funding four additional fellowships in 2008 [47] so that four new fellowships are established annually. Recommendations for clinical psychologists are similar. The General Assembly established four clinical psychology internships in 2007. Based on the workforce shortages, DMHMRSAS recommends continued funding for those with the addition of two for a total of six internships.

In the JLARC Availability Report, JLARC also recommended establishing Centers of Teaching Excellence to: 1) train professionals working with children but who have minimal training; and 2) train pediatricians, family practitioners who handle behavioral health problems for children, and adult psychiatrists working with children (because of the shortage of child psychiatrists) and need training in the use of safe and effective medications and other treatment modalities.

The CA Task Forces agrees with the importance of addressing workforce issues and makes the following Recommendations:

Recommendation 1.11. Because of the shortage of child psychiatrists, many adult psychiatrists and other physicians end up working with children. The Department of Health Professions Board of Medicine should require any physician not certified in the care of children with psychiatric diagnoses to receive a specific amount of Continuing Medical Education credits, to be determined by the Board of Medicine, in the use of safe and effective medication for children and other treatment modalities.

Recommendation 1.12. The appropriate professional boards should require training on the evaluation of children with mental health needs by all psychologists, licensed clinical social workers, and licensed professional counselors who work with children.

B. <u>The Need for a Culturally Competent Workforce</u>

Access to mental health services requires more than funding of services and the availability of mental health professionals. It also requires that the service providers be attuned to the cultural variability of their clients. As DMHMRSAS noted in 2007:

> "Cultural competence is the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual's culture and increase the quality and appropriateness of health care and outcomes."[48]

[47] Clearly, these dates may need to shift but the recommendation was to have in the pipeline eight psychiatrists in the fellowship in each year—four in their first year and four in their second.
[48] Dr. King Davis, "A Market Based Approach to Cultural Competence," presented at DMHMRSAS Conference on October 24, 2007, in Newport News, VA.

Virginia's cultural diversity is growing rapidly. Between 1980 and 2005, the population of African Americans increased by 50% to 1.5 million; the population of Hispanic Americans increased by 468% to 450,000; the population of Asian Americans increased by 392% to 345,000 and the population of Caucasians increased by 28% to 5.4 million.[49]

Minority population growth has surged to almost a third of Virginia's population. Although an increasingly diverse populace increases the cultural richness of the State, it also presents challenges in addressing the needs of court-involved youth and their families. For judicial, mental health, and human service professional interactions with minority populations to be successful, multicultural awareness is essential.[50]

Cultural differences affect how mental illness is perceived, whether mental health services are sought, and the frequency at which members of different racial and minority populations are institutionalized (whether in hospitals or the justice system). For example, between 1990 and 1999, Caucasians made up 63.54% of the total admissions to public mental health hospitals, although this group made up 76.19% of Virginia's population during that time. African-Americans were disproportionately over-represented, making up 35.05% of the admissions, even though they were only 18.49% of the population. Asian Americans, who were 0.54% of the admissions, but 2.53% of the population, and Hispanics, who were 0.75% of the admissions but 2.55% of the population, were disproportionately under-represented.[51] It is likely that these patterns of inpatient mental health admissions reflect cultural differences and, perhaps, economic differences among these populations.

Studies indicate that African-Americans affected by major depression or bipolar disorder take longer to seek treatment than do Caucasians and, as a result, may more frequently be in a crisis when they do.[52] Although the percentages of persons seeking treatment in both groups is distressingly low, two years after the onset of major depression, 44.4% of Caucasians had made treatment contact, compared to only 31.7% of African Americans. The disparity for persons with a diagnosis of bipolar disorder is even greater. Two years after onset of symptoms, 44.3% of Caucasians had made treatment contact compared to 19.5%of African Americans.[53]

These treatment-seeking disparities may be explained by looking at some of the differences to care-seeking behaviors. There is often a greater fear of hospitalization and treatment in minority populations, as well as a greater sense of self-reliance and determination in these populations.[54] Furthermore, there is less participation by minority populations in consumer and advocacy groups, and higher levels of stigma associated

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[49] Id.
[50] Id.
[51] Id.
[52] Neighbors, Baser & Martin (2007). Unpublished data from the National Survey of American Life.
[53] Id.
[54] Dr. King Davis, "A Market Based Approach to Cultural Competence," presented at DMHMRSAS Conference on October 24, 2007.

with mental illness in their communities.[55] There may also be significant language barriers.[56] More than 11% of all Virginians speak a language other than English at home[57] and in Fairfax County over 32% of its residents do so.[58]

Additionally, recent immigrants to the U.S. often face poverty and lack of health insurance that adversely affect seeking treatment and also often have histories of trauma related to their leaving their countries in the first place.[59] As a result, immigrants are less likely to seek services than those born in the United States.[60] Asian immigrants are the least likely group to seek services, because the shame, stigma, and silence surrounding mental health treatment appear to be greater than among other ethnic groups.[61]

Given the impact of race, ethnicity, language, etc., reforms to Virginia's mental health system must address the current research, knowledge, skills, human resources, policy, and service gaps that surround ethnic, cultural, racial, and language disparities.[62] This is especially important when addressing the mental health needs of children. Understanding the child's culture and surroundings is crucial to achieving successful outcomes in the treatment of children with mental health needs.

The CA Task Force makes the following Recommendations related to promoting greater training in cultural diversity among the various stakeholders who interact with juveniles and their families:

Recommendation I.13. The Commonwealth should partner with relevant groups to ensure that students who enroll in academic programs leading to jobs in mental health reflect the diversity within the Commonwealth.

Recommendation I.14. Throughout this Report, the CA Task Force has made multiple Recommendations to the Commission that the various stakeholders in the system be given more training on the mental health issues affecting children and adolescents. The CA Task Force recommends that all training include a cultural competency component.

VIII. The Changing Roles Of Families And Professionals In Service Planning

It is important to engage families in the care of their children with mental health needs. Historically, mental health systems have operated as "professional centered," with

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[55] Id.
[56] Id.
[57] Sources: U.S. Census Bureau, 1980 and 1990 Decennial Censuses.
[58] Sources: U.S. Census Bureau, 1980 and 1990 Decennial Censuses and 2001 Decennial Supplementary Survey.
[59] Sandra G. Boodman, "Explaining Away Mental Illness," Washington Post, September 4, 2007.
[60] Id.
[61] Id.
[62] Dr. King Davis, "A Market Based Approach to Cultural Competence," presented at DMHMRSAS Conference on October 24, 2007.

parents often viewed as a problem. This approach often resulted in a tense, if not adversarial, relationship between professionals and families. However, there are other, more effective approaches. One is the family-focused model where families are allies to professionals who remain the experts and decision-makers. The next step on the continuum is the "family allied" model where families are customers and the family and professional work collaboratively to address mutually agreed upon goals. However, the approach the CA Task Force views as the most useful is the "team centered" model where the team, comprised of families, children, providers, other child-serving professionals jointly develop service plans.

FAPTs as well as each child-serving agency in a community should be required to develop partnerships with families and youth. Such partnerships require a concerted effort, dedicated resources and capacity building across all parties. Critical elements to a successful partnership include team building, communication, negotiation, conflict resolution, leadership development, mutual respect, skill building, and information sharing. The result should be a care management system that encompasses families and youth as partners and which incorporates the strengths of families and youth in the management structure.[63]

The CA Task Force makes the following Recommendations regarding the inclusion of the family in developing policies and service plans involving juveniles with mental health needs:

Recommendation I.15. The Secretary of Health and Human Services should develop policies, including use of incentives, to promote family involvement in service planning consistent with the Comprehensive Services Act.

Recommendation I.16. The Secretary of Health and Human Services should require that the Office of Comprehensive Services develop a policy regarding monitoring implementation of family involvement in a child's treatment options at the local level.

IX. School-Based Mental Health Services

Schools provide a significant opportunity for promoting the mental health of children, identifying problems early and providing interventions or referrals to mental health professionals. On any given weekday, virtually all of a community's children between the ages of five and eighteen can be found in schools. In Virginia, 86% of children attend its l800 public schools. Although the opportunity is there, the nature and availability of mental health services in Virginia's public schools is largely unknown. There is no systematic statewide tracking of such services, in part, because schools are generally

[63] Pires, Sheila. (2002). *Building Systems of Care: A Primer*. Georgetown University Center for Child and Human Development, Washington, DC. Available at: http://gucchd.georgetown.edu/programs/ta_center/object_view.html?objectID=2500,

viewed as a local concern. Investing public funds early in a child's life to prevent, identify, and treat mental health problems, however, would pay off many times over. Enhancing the role of our schools is a critical element of a strategy of providing mental health services for children and adolescents, and strong state leadership is needed to accomplish this goal.

This section will discuss two areas of school-based mental health services. The first, population-based mental health services, is a national effort targeting schools as a natural venue for promoting the mental health of all children. The second encompasses federal requirements for providing services to certain children entitled to such services under the Individuals with Disabilities Act and the No Child Left Behind Act.

A. Population-Based Mental Health Services

Psychological wellness is a precondition for student success in school. (See *Mental Health: A Report of the Surgeon General* below). Increasingly, public schools in this country have been responding to a national movement toward population-based mental health services for children. Population-based mental health services have at least four goals:

- to promote the psychological well-being of all students;
- to promote caretaking environments that nurture students;
- to provide protective support to students at high risk for developmental failure; and
- to remediate social, emotional, or behavioral disturbances so that students can develop competence.

Population-based mental health services are frequently conceptualized as a three-tiered structure with primary, secondary, and tertiary tiers of intervention. Primary mental health services are incorporated into systems for positive development and systems of prevention—general health education, enrichment and recreation activities, drug and alcohol education, conflict resolution, and parent involvement fit into this tier of activity. Secondary mental health services, on the other hand, are incorporated into systems of early intervention—for example, dropout prevention or pregnancy prevention. Tertiary mental health services, or systems of care, are treatments for severe and chronic problems, such as those provided by specialists.

The structure of schools and their programs—especially their emphasis on individual and communal safety, personal responsibility, encouragement of positive goal development and goal-direction, accountability, development of individual and group problem-solving skills, etc.—lead them to be seen mainly as providers of mental health services at the primary level of intervention (i.e., systems that foster positive development and prevention activities). However, guidance and counseling programs can also assist youngsters with developmental difficulties, especially those relating to adjusting to transition, trauma, and/or the aftermath of family and personal difficulties. In these contexts, schools can provide secondary levels of mental health service. Finally, for

students with developmental difficulties who need services from educational specialists and individualized education programs, schools are seen as serving a curative and rehabilitative mental health function, contributing to their being seen as providing tertiary levels of mental health care.

To effectuate these goals, mental health providers in schools are responsible for insuring that all students have the psychological competence needed for learning.[64] All school divisions in Virginia meet the three levels of mental health needs through their teachers, administrators, school counselors, school psychologists, and/or social workers/visiting teachers.

B. Relevant Federal and State Law Regarding Mental Health Services in Schools

In contrast with the goals of population-based mental health services, federal legislation targets two groups of high-risk children—those with disabilities and those at risk for school failure. Each school division in Virginia is accountable for complying with the Individuals with Disabilities Education Act ("IDEA")[65] and No Child Left Behind ("NCLB").[66] While neither statute was crafted specifically to address mental health services, there are provisions in each that could be used more effectively to provide such services.

Both IDEA and NCLB require schools to provide the services to promote the increased inclusion of children with disabilities in the mainstream and more attention to the needs of all children at risk for school failure. IDEA provides specialized education and related services to children with disabilities. NCLB provides some support specific to enhancing school-based mental health services.

When students have mental health problems that hinder their performance on NCLB assessments, schools are required to address those problems. Some of NCLB's provisions include: the possible expansion of counseling services as these are provided by school counselors, school social workers and school psychologists (Section 5421); several categories of character education that might assist in mental health development (Section 5431); the possibility of creating smaller learning communities within schools

[64] Doll, B., & Cummings, J.A., (2008). *Transforming School Mental Health Services: Population-Based Approaches to Promoting the Competency and Wellness of Children.* Thousand Oaks, CA: Corwin Press, pg. 3.

[65] Individuals with Disabilities Education Improvement Act, *20 U.S.C. § 1400* et seq. (2004). The IDEA is a federal law that governs how public agencies and schools provide early intervention, special education, and related services to children with disabilities up to age 21. Not all children with disabilities quality for interventions under IDEA. Under the IDEA, a "child with a disability" is a child . . . with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance . . ., orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; AND, who . . . [because of the condition] needs special education and related services." Children eligible under IDEA for special education must have an Individual Education Plan developed. Other children who may be disabled may qualify for some accommodations and modifications but are not ensured access to mental health or other services.

[66] No Child Left Behind Act, *20 U.S.C. § 6301* (2001).

(Section 5441); and allowance for the awarding of grants for physical activities designed to enhance the physical, mental, and social or emotional development of every student (Section 5503). Importantly, Sections 5541 and 5542 of NCLB authorize the U.S. Secretary of Education to award grants to State or local educational agencies for the purpose of increasing student access to quality mental health care in schools (Section 5541), and grants that would assist local educational agencies, local councils, and community-based organizations to assist eligible children to become ready for school in emotional, behavioral, and social spheres of functioning (Section 5542).

Although there are avenues in NCLB that can be used to enhance mental health services, some have cited its lack of specific guidance in critical mental health areas as a barrier in linking the need to assist children at risk for school failure to the need for school-based mental health services. While many studies have demonstrated the important relationship between academic performance and the emotional and social functioning of students,[67] funds are rarely earmarked specifically for mental health services.[68] Most school learning communities remain interested primarily in the curriculum and instructional provisions of NCLB.

Unlike the vague statutory language of the NCLB, IDEA acknowledges that mental health problems suffered by students may lead to a decrease in learning capacity. Its premise is that, unless mental health needs are accommodated, the educational achievements of students with disabilities may be undermined. IDEA requires schools to follow procedures designed to identify students with disabilities, and to provide services to meet the educational needs of students so identified.[69] Included in the statutory definition of a "child with a disability" are children with severe emotional disturbance. However, there is considerable variability in determining disability for children with behavioral and emotional problems some jurisdictions exclude those children where this is the presenting diagnosis.[70] As a result, children with severe emotional disturbance are believed by many to be the most "under-identified category of children" under the IDEA.[71] In addition, although the IDEA permits provision of services to children not

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[67] See, e.g., M.D. Weist, & H.S. Ghuman, Principle behind the proactive delivery of mental health services to youth where they are. In: M. Weist, H. Ghuman, & R. Sarles (eds.), *Providing Mental Health Services to Youth Where They Are: School- and Community-Based Approaches.* New York, NY: Taylor Francis; 2002, 1-14.

[68] B.P. Daly, R. Burke, I. Hare, C. Mills, C. Owens, E. Moore, & M.D. Weist. (2006). Enhancing No Child Left Behind-School Based Mental Health Connections, *Journal of School Health*, 76(9), 446-451, at 447.

[69] The IDEA requires schools to provide a full range of services to ensure children have a Free and Appropriate Public Education ("FAPE") provided they meet the statutory definition of a "child with a disability." See footnote 60 above. Included in the definition of a child with a disability are children with serious emotional disturbance.

[70] Garda, Robert A. (July 2006). Who Is Eligible Under the Individuals With Disabilities in Education Improvement Act? Journal of Law and Education (online journal). Available at: http://findarticles.com/p/articles/mi_qa3994/is_200607/ai_n17173176/pg_2?tag=artBody;col1. According to Garda, "The narrow meaning of "educational performance" applied by many authorities is one reason that emotionally disturbed children are the most under-identified category of disabled children. These children can often perform well academically but cannot form social relations, control their behavior or attend the regular classroom consistently."

[71] Id.

meeting the stringent IDEA eligibility standards, those services are available only at the school's option and such services are often unfunded or under-funded. As a result, IDEA is not a route to access for many children with mental health needs.

C. Reports and Studies Supporting Greater Access to Mental Health Services in Schools

Many reports and studies document the importance of schools in promoting children's mental health and providing early identification of mental health problems and connecting students to the appropriate services. The following are just a few.

1. **The Surgeon General's Report.** Ten years ago, the U.S. Surgeon General, Dr. David Satcher, issued a seminal mental health report that focused the country's attention and resources on ameliorating some of the country's most debilitating and silent diseases. The findings for children's and adolescent's mental health needs include the following:

- Approximately one in five children and adolescents experience the signs and symptoms of a DSM-IV disorder[72] during a year;
- Prevention is effective in reducing risk factors;
- Medication is effective in the treatment of a number of childhood disorders;
- Families are essential partners in the delivery of mental health services;
- Children and adolescents with "serious emotional disturbance" can be served effectively with a "systems" approach in which multiple service sectors work in an organized, collaborative way; and
- Schools are critical for recognizing mental disorders in children and adolescents.[73]

Furthermore, the 2000 Surgeon General's conference on children's mental health identified eight overarching goals:

- Reduce the stigma associated with mental illness;
- Develop, disseminate, and implement scientifically-proven prevention and treatment services;
- Improve the assessment and recognition of mental health needs in children;
- Eliminate racial/ethnic and socioeconomic disparities in access to mental healthcare services;
- Improve the infrastructure needed to support scientifically-proven interventions across professions;
- Increase access to and coordination of quality mental healthcare services;

[72] DMS-IV is the Diagnostic and Statistical Manual published by the American Psychiatric Association for the diagnosis of mental disorders.

[73] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

- Train frontline providers to recognize and manage mental health issues, and educate mental healthcare providers about scientifically-proven prevention and treatment services;
- Monitor the access to and coordination of quality mental healthcare services.[74]

2. **The Mental Health Services Study**. The first *bona fide* national study of mental health services in schools was *Mental Health Services in the United States, 2002-2003* ("Mental Health Services Study"). The Mental Health Services Study provided a baseline regarding traditional mental health services delivered to students who had been referred and identified as having psychosocial or mental health problems. It was the first source of information on the mental health services provided in the approximately 83,000 public elementary, middle, and high schools and school districts in the United States. The Mental Health Services Study's findings confirm that mental health services play an integral role in the school setting. It also found that needs for mental health services were increasing but adequate funding and availability of community resources are essential for schools to address the needs are often lacking.

The Mental Health Services Study's important findings include the following:

- One fifth of students received some type of school-supported mental health services in the school year prior to the study;
- More than 80 percent of responding schools provided assessments for mental health problems, behavior management consultation, and crisis intervention, as well as referrals to specialized programs.
- A majority of schools also provided individual and group counseling and case management;
- Districts reported three major funding sources for mental health services: IDEA, state special education funds, and local funds.

The Mental Health Services Study provides an important baseline from which to measure improvements in the system.

3. **The President's New Freedom Commission**. In 2003, President Bush's New Freedom Commission's ("NFC") issued its report on mental health, *Achieving the Promise: Transforming Mental Health Care in America (*"NFC Report").[75] It advocated using schools as a critical avenue for providing mental health services for children and their families[76] noting, "… mental health is essential to learning as well as to social and emotional development. Because of this interplay between emotional health and school success, schools must become partners in the mental health care of our children."[77]

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[74] U.S. Public Health Services. (2000). *Report of the Surgeon General's Conference on Mental Health: A National Action Agenda.* Washington, D.C., Department of Health and Human Services.
[75] New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report* (DHHS Pub. No. SMA-03-3832). Rockville, MD.
[76] *Id.* at 62.
[77] *Id.* at 58.

The NFC Report acknowledges that IDEA often has not adequately addressed the needs of students, one example being children as they move out of adolescence. NFC Recommendation 4.2 clearly articulates the goal of expanding the number and scope of mental health services available to children in schools. Using Columbia University's Teen Screen Program as a model,[78] the NFC Report ties together the NCLB and IDEA mandates and opportunities. In discussing the role of NCLB in providing mental health services to students, the NFC Report urges actions to improve access by:

- Ensuring that services to remove barriers that interfere with student's success are federally funded as health, mental health, and education programs; [79]
- Implementing empirically supported prevention and early intervention approaches; and [80]
- Creating a state-level leadership structure for school-based mental health services and collaboration between education, general health, and mental health systems.[81]

The NFC Report also recognizes that relationships must be forged between professionals in the schools and in the community. It encourages using IDEA funding to train teachers, mental health professionals, and parents to recognize signs of emotional and behavioral problems in children, make appropriate referrals for assessment and services, and evaluate evidence-based school mental health interventions.[82]

4. Center for Mental Health Services Report. A 2007 Center for Mental Health Services ("CMHS") report to Congress, *Promotion and Prevention in Mental Health: Strengthening Parenting and Enhancing Child Resilience* ("CMHS Report"), reviewed the effectiveness of programs that use a strength-based, family approach to promoting mental wellness and preventing mental health problems among at-risk children and youth. CMHS was also asked to identify opportunities and make recommendations related to the expanded use of such programs.

The CMHS Report described research and practices that have identified risk and protective factors that affect the vulnerability of children to mental health problems. While risk factors like poverty or community violence cannot be eliminated or ameliorated by a mental health program alone, many factors such as relationship skills, conflict management, and positive problem-solving can be taught to children, family members, teachers, and other caregivers. Noting that half of all lifetime cases of diagnosable mental illness begin by age 14, the report emphasizes that school settings

[78] *Id.* at 63.
[79] *Id*. at 63.
[80] *Id*. at 64.
[81] *Id.*
[82] *Id.*

present a key opportunity to reach out with evidence-based programs to parents and other caregivers.[83]

D. Mental Health Services and Virginia's Schools

Virginia's education policies have included efforts to promote the health and well-being of its students for almost two decades. A primary funding source for many mental health-related services in schools has been the Substance Abuse and Mental Health Services Act (SAMSHA) and its Safe and Drug-Free Schools dollars. Since 1992, Virginia has required each school division to establish a School Health Advisory Board ('SHAB') of no more than 20 members, with broad-based community representation including parents, students, health professionals, educators, and others. Each SHAB is required to meet at least semi-annually and to submit an annual report on the status and needs of student health in their school divisions to the Virginia Department of Education ("VDOE"), the Virginia Department of Health ("VDH"), the school board, and any relevant school.

In 2003, the Virginia Commission of Youth ("COY") issued a report ("COY Report") to the General Assembly about the important role of schools in enhancing the access to mental health services for children. COY reported that "Schools provide a setting for early identification of emotional and behavioral problems and provision of services, due to the crucial and daily role they play in the growth and development of children. Furthermore, services offered in the school environment are more convenient to children and families and therefore are far more likely to be utilized than many services in the community."[84]

The COY Report examined a variety of ways schools either directly provide mental health services or collaborate with other agencies and providers demonstrating that there is no single model. Effective systems can be adapted to the particular resources available in each community. This national picture of delivery mechanisms for school-based mental health programs is described briefly as follows:

- School-financed services in which school districts employ professionals to perform services related to behavioral health and psychosocial problems.
- School-district behavioral health units in which districts provide clinical facilities and consultation to individual schools.
- Formal connections with community mental health services as part of school-based health centers, school-linked service initiatives, or systems of care.
- Classroom-based curriculum and special "pull-out" interventions, which enhance social and emotional functioning through instructional activities.
- Comprehensive, multi-faceted and integrated approaches to address barriers that interfere with students having an equal opportunity to succeed at school.

[83] Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2007). *Promotion and Prevention in Mental Health: Strengthening Parent and Enhancing Child Resilience.* DHHS Publication No. CMHS-SVP-0175. Rockville, MD.

[84] Virginia Commission of Youth Report to the General Assembly, 2003 update, page 1.

Increasingly, Virginia is focusing on the mental health needs of its children and recently conducted a statewide survey to identify the services available. The Office of Inspector General of DMHMRSAS surveyed the mental health services for children and adolescents offered by Virginia's 40 CSBs (the "OIG Survey)[85] and found that many school-based mental health services are not offered by most CSBs:

Table 1. School-Based Mental Health Services Provided by CSBs[86]

	Not offered by CSB	Offered and adequate	Offered and not adequate	Private Providers Offer
School based 1:1 therapy	23	6	7	12
School based 1:1 behavioral specialist	29	4	4	21
School based therapeutic day treatment (mainstream)	26	10	1	10
School based therapeutic day treatment (self contained)	23	9	4	14
School based after school therapeutic day treatment	33	2	1	9

The OIG Survey found that although all CSBs provided some services to children and adolescents, the majority of CSBs did not provide *school-based* mental health services and among those that did the services were deemed inadequate. Generally, the OIG Survey found a startling variability in the per capita expenditures for child and adolescent services across the CSB catchment areas—ranging from a mere $0.96 to $292, with an average of $58. These differences in CSB expenditures are likely explained by the dramatic differences in the local contributions to CSBs for non-mandated mental health services for children and adolescents. At present, because school-based services are not CSB-mandated services local communities have the option to fund, or not fund, them. To a significant extent extent, inadequate funding of school-based services is a function of limited community resources. However, such extraordinary variability in access to mental health services for children also reflects a policy failure in not capitalizing on the opportunity provided by schools for interventions for these particularly vulnerable

[85] Office of the Inspector General (April 2008). Survey of Community Service Board Child and Adolescent Services. Available at: http://www.oig.virginia.gov/documents/SS-CACM-148-07.pdf.
[86] Id at page 54-55. Adapted from Section IX's table showing the Overall Service Array at CSBs.

children. It may be necessary to expand the statutorily mandated core services for CSBs to include better school-based mental health services.

Another mechanism that could be utilized to increase the availability of school-based mental health services is making access to mental health services a requirement of school accreditation. Virginia Standards of Accreditation already specify a student-to-school-counselor ratio requirement, but no such requirement exists for school psychologists or school social workers. In addition, there is no accreditation provision requiring school nurses, who would be important in mental health screening, to be available at each school.

The CA Task Force believes that school-based mental health services are critical to ensure the health of our youth. Mental health services including screening, prevention and early intervention, day-treatment, and case management provide mechanisms for students with mental health problems to have the greatest opportunity for success in school.

Not only are professional mental health services usually lacking in Virginia's schools, but also there is no requirement for teachers to receive any training on mental illness and behavioral disturbances. The lack of teacher training requirements is surprising since both IDEA and NCLB focus on academic performance and include children with serious emotional and behavioral disorders as within their purview and, under NCLB, schools are assessed on student performance. While teacher and administrator preparation programs do require coursework on child and adolescent health and development, this broad overview is inadequate to develop policies for or teach children with mental health needs. It is the consensus of the CA Task Force that periodic refreshers on mental illness in children, similar to those around child abuse and neglect that are required every five years, would prove helpful for the identification and referral of students and family members to either in-school or community resources.

The CA Task Force makes the following Recommendations regarding improving the information about the needs for mental health services in schools and the barriers to collaboration among the various agencies involved:

Recommendation I.17. The Secretary of Health and Human Resources and the Secretary of Education should collaborate to assess the barriers to statewide collaboration between community mental health and schools, and should develop a state-level policy regarding needed ingredients for successful collaboration. This task should be accomplished by July 2009.

Recommendation I.18. The General Assembly should direct the Joint Commission on Health Care, in conjunction with the Secretary of Health and Human Services and the Secretary for Education, to conduct a study in FY 2010 assessing the barriers to collaboration between community mental health and schools, and recommending benchmarks for local community practice and funding required for staffing collaborative activities.

CHAPTER II. CHILDREN WITH MENTAL HEALTH NEEDS IN THE JUVENILE JUSTICE SYSTEM.

I. Background and Goals

As is the case with adult jails and prisons, across the country juvenile detention centers have become the system of last resort for children with mental illness. Data from Virginia's Department of Juvenile Justice ("DJJ") show that 63% of juveniles in detention have a mental health disorder and over 60 percent have a substance abuse disorder.[87]

The prevalence of *serious* mental disorders is also higher among juveniles in detention than those in the general population. Estimates are that approximately 20 percent of juveniles in detention have a serious emotional or behavioral disturbance that impairs their ability to function at home, at school and in their communities. The prevalence of co-morbid disorders is also high with 56.6% of females and 45.9% of males meeting criteria for 2 or more of the following disorders: major depressive, dysthymic, manic, psychotic, panic, separation anxiety, overanxious, generalized anxiety, obsessive-compulsive, attention-deficit/hyperactivity, conduct, oppositional defiant, alcohol, marijuana, and other substance disorders.[88] It is important to note that co-occurring drug and alcohol addiction among children, as is often true with adults, may be a case of juveniles "self-medicating" and that such use would decrease with available treatment for the underlying mental health issue.

The consequences of not having access to early screening, diagnosis, and treatment of children with mental health needs are that too many of them end up in the juvenile justice system, straining the resources of the courts and the juvenile detention centers and increasing the trauma to the juveniles who are already suffering from mental health disorders. And, although juvenile detention centers have launched initiatives to be

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[87] Green, Barry; Abed, Sam. (August 2008). Juvenile Trends: Successes and Challenges. Presentation by the Department of Juvenile Justice at the Virginia Judicial Conference. Available at: http://www.djj.state.va.us/Resources/DJJ_Presentations/pdf/JDRTrainingConference-FinalPresentation-08112008.pdf. According to the DSM-IV diagnostic criteria, the percentage of juveniles with a mental health disorder increased 12% between FY2005 and FY2007. This includes juveniles with a depressive disorder and excludes those with Conduct Disorder, Oppositional Defiant Disorder, and Substance Abuse/Dependence Disorder.

[88] Abram, Karen; Teplin, Linda A.: McClelland, Gary M. and Dulcan, Mina K. (2003). "Comorbid Psychiatric Disorders in Youth in Juvenile Detention." Archives of General Psychiatry, 60:1097-1108. Generally, when two illnesses or disorders occur simultaneously in the same person they are called co-morbid or co-occurring. According to the National Institute of Mental Health, co-occurring substance abuse disorders and mental illness are very common with surveys showing six out of ten persons with a substance abuse disorder also having a mental illness. In this Report, co-morbid disorders refer to co-occurring psychiatric disorders. For example, childhood onset bipolar disorder and attention deficit disorder are often associated and certain mental disorders among children are associated with a higher risk of substance abuse. See, e.g. August, Gerald J.; Winters, Ken C.; Realmuto, George M.; Fahnhorst, Tamara; Botzet, Andria; Lee, Susanne. (July 2006). "Prospective Study Of Adolescent Drug Use Among Community Samples Of ADHD And Non-ADHD Participants." Journal of the American Academy of Child & Adolescent Psychiatry.

responsive to the mental health needs of the juveniles in their custody, few would argue that such detention is the ideal treatment setting.

The juvenile justice system bears enormous costs in intervening to address what is in many instances primarily, if not exclusively, a mental health issue. In addition to the costs to law enforcement in responding to situations involving the juvenile, there are court costs and the higher costs of incarceration. Juveniles with serious mental health impairments not only cost more per day than other juveniles during their incarcerations but their average length of stay is substantially longer than for juveniles without mental illness.

Chapter II addresses a range of public policy issues affecting two populations of juveniles with mental health and/or substance abuse disorders who, largely as a result of those disorders, come to the attention of Virginia's Juvenile and Domestic Relations Courts ("JDR Courts") (See **Appendix B**). The first group, known as "children in need of services," or "children in need of supervision" (together referred to as "CHINS"). A juvenile may be found to be a child in need of services if his or her "behavior, conduct or condition presents or results in a serious threat to the juvenile's well-being and physical safety. A child in need of supervision is a juvenile who is either (1) habitually, and without justification, absent from school, or (2) runs away from home or a residential facility."[89] The second group includes juveniles found to be "delinquent," defined as a juvenile who has committed an act that would be a crime if committed by an adult.

For both groups of children, the untreated or under-treated mental health issues result in problems with their relationships at home, schools and communities. The lack of access to mental health services too often sends these children on a trajectory of acting out, school truancy, or criminal acts, which propel them to the attention of law enforcement and the juvenile justice system, where some get mental health services for the first time. This outcome does not reflect good public policy in that it both traumatizes and stigmatizes children and their families when in many cases access to mental health provider would eliminate any contact with juvenile justice. It also drains law enforcement resources, burdens the courts, and adds unnecessary costs in the supervision and/or keeping children in detention.

The CA Task Force's *Subcommittee on Children With Mental Health Needs in the Juvenile Justice System* was charged with examining these issues and making Recommendations related to the CA Task Force's third and fourth goals:

3. Create conditions that will enable the Juvenile and Domestic Relations Court (JDR) system to divert minors who need mental health and/or substance abuse services from the judicial system. Issues to be addressed under this goal are:

a. Create and strengthen CHINS diversion programs

[89] From Virginia's Juvenile and Domestic Relations Court website. Available at: http://www.courts.state.va.us/jdrdc/jdrdc.htm.

b. Make structured decision-making a part of diversion
c. Examine and assess the effectiveness of current diversion statutes.

4. Assure appropriate treatment for those with mental health issues who remain under the court's jurisdiction and assure family engagement in services when services are needed.

a. Pretrial
i. Mental health and substance abuse services at detention centers.
ii. Access to psychiatric services for those in need.
iii. Competency Restoration services provided by a community-based outpatient system as required by law.

b. Adjudication/Disposition
i. Educate judges about community resources.
ii. Access to necessary services to include community based sex offender programs.
iii. Proper psychological assessment and evaluation before disposition.

c. Commitment discharge planning to facilitate successful parole supervision.

In this Chapter the CA Task Force discusses policy options and makes Recommendations for addressing the mental health needs of both groups of children – those meeting criteria for CHINS and those apprehended for delinquency. For children found to satisfy the CHINS criteria, the benefits and barriers to diversion to community-based mental health treatment will be examined. For children found to be delinquent, we will discuss the need for mental health services during the adjudication process, during detention and detention discharge planning.

II. The Goals of the Juvenile Justice System and The Importance of Diversion [90]

A. Some Basics about Juveniles and the Courts.

A consequence of the inadequate access to mental health screening and services in communities, in addition to the adverse effects on children, is that the Virginia DJJ has become the largest single provider of residential mental health services for children in the Commonwealth of Virginia. Fully 43% of the children committed by the courts to the DJJ due to delinquency are diagnosed with mental and emotional disorders, and 70% are diagnosed with a substance use disorder.

Two Virginia statutes address the approach to juveniles that come into contact with the state's juvenile justice system and together they establish a policy framework that is remedial in nature and focused on community-based interventions to provide the structure and services needed for children and their families.

[90] See **Appendix B** for a fuller description of the steps in the juvenile justice system.

The first, Section 16.1-227 of the Virginia Code, states that the law regarding the Juvenile and Domestic Relations Courts ("JDR Court(s)") is to be construed as "remedial in nature" and that "the welfare of the child and the family, the safety of the community and the protection of the rights of victims" are to be the paramount concerns in all JDR Court proceedings.

That Code section goes on to state that the law regarding JDR Courts is to be "interpreted and construed" to effectuate four specific purposes. The first of these is "to divert from or within the juvenile justice system, to the extent possible, consistent with the protection of the public safety, those children who can be cared for or treated through alternative programs." However, this overarching policy directive has not been well-implemented throughout the State, in part, due to a lack of specialized training of law enforcement and the courts about mental illness, particularly as it pertains to juvenile behaviors, and, in part, due to inadequate community-based mental health services for juveniles and their families.

To focus on the goals articulated in Code Section 16.1-227, professionals in the juvenile justice system should ask, not only at the initial contact but continuing through subsequent contacts with juveniles with serious mental health needs, the following three questions:

> (1) Is the child's acting out behavior related to a mental or emotional condition that can best be treated and resolved through diversion from the juvenile justice system, consistent with the protection of the public safety?
>
> (2) Are treatment services available in the community to divert the child from, or minimize a child's involvement with, the juvenile justice system?
>
> (3) If the child is charged and will remains within the juvenile justice system for a period of time, what are the least restrictive ways that the child's behaviors and underlying condition can be effectively treated, consistent with the protection of public safety?

These questions, however, are too often rhetorical, rendered moot for many children because the lack of effective community-based services undermines efforts at prevention, diversion, and the post-release stability of these at-risk children. As a result, many children with mental health and co-occurring substance abuse disorders end up committed to the DJJ where the provision of mental health services is not the primary mission. Although the DJJ has worked to improve the mental health screening and treatment available, without the participation of family and connection to communities, that treatment is not as effective as it could be. Moreover, the costs of those services, delivered in an institutional setting, are higher than the costs of community-based mental health services.

The second statute, enacted in 1995 by the General Assembly, is the Virginia Juvenile Community Crime Control Act ("VJCCCA"),[91] was established "to deter crime by providing immediate, effective punishment that emphasizes accountability of the juvenile offender for his actions as well as reduces the pattern of repeat offending." The VJCCCA goes on to elaborate the following goal:

> [T]o ensure the imposition of appropriate and just sanctions and to make the most efficient use of correctional resources for those juveniles before intake on complaints or the court on petitions alleging that the juvenile is a child in need of services, child in need of supervision, or delinquent, has determined that it is in the best interest of the Commonwealth to establish a community-based system of progressive intensive sanctions and services that correspond to the severity of offense and treatment needs.[92]

The VJCCCA also identifies diversion as one of the pre-disposition and post-disposition services communities can include for juveniles. No doubt recognizing the need for an expansion of available services in communities to make diversion an option, the statute states as core purposes the promotion of "an adequate level of services to be available to every juvenile and domestic relations district court" and providing "community-based services for juveniles and their families."[93]

To accomplish the remedial focus articulated in the Virginia Code, and to divert as many eligible children as possible, consistent with public safety, to community-based mental health treatment, two key assets are critical: (1) trained professionals in law enforcement, the courts and DJJ who are able to recognize children whose emotional and behavioral disorders can be more effectively treated and resolved by diversion, and (2) readily available mental health services for children in the local community to permit such diversion policies to be effectuated.[94]

Even with more community-based mental health services, not all encounters with juvenile justice will be prevented, so it is necessary to identify the key junctures in a child's involvement with the juvenile justice system where diversion resources should be deployed. Two key junctures are 1). the initial contact with law enforcement and 2). juvenile court intake. By law, both law enforcement and juvenile court intake officers have discretion to make decisions about juveniles taking into account their actions, their family situations, and community resources. We will examine the potential diversion

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[91] Virginia Code § 16.1-309.2. The VJCCCA community-based sanctions do not apply to juveniles who commit felonies and are tried and sentenced in Circuit Court as adults. However, because the Circuit Court has the option to impose juvenile sentences, VJCCCA funding for those juveniles is available. Participation in VJCCCA is voluntary for each community but all 134 cities and counties in Virginia opt to participate.

[92] Id.

[93] Id.

[94] As noted earlier, not all juveniles are appropriate candidates for community-based diversion. Juveniles who commit certain felonies will be adjudicated in Circuit Court as adults and some other juveniles may require a period in a secure facility. The remedial focus of the Virginia Juvenile Code is discussed more fully in Chapter I of this Report.

points and make Recommendations to enhance the likelihood and effectiveness of diversion at each.

B. Initial Contact And Referral: The Officer On The Street

Police officers make decisions daily about whether to charge a child for unlawful conduct or address the child's conduct informally. Such informal resolutions might include meeting with the parents and obtaining their agreement to follow through with action regarding the child or meeting with affected neighbors to resolve the problem presented by the child. Officers base those decisions on their training and their years of experience in the community, their understanding of how the juvenile justice system will respond to the child's case, and, as a practical matter, how quickly the officer needs to get back on the street to attend to other pressing demands.

Officers confronted with a child or family in crisis are often pressured to "do something" to de-escalate the situation. Unfortunately, when no emergency mental health services are available, that "something" is often the arrest of the child, or the officer advising the family to file a petition[95] against the child to place the child, thereby initiating a process whose result may criminalize the child's conduct instead of addressing the underlying mental health problems contributing to that conduct.[96]

To minimize the harmful impact of juvenile justice involvement for both the juvenile and juvenile justice at this initial contact with the officer on the street, it is important to strengthen law enforcement training about mental health and crisis intervention and couple that with expanded access to meaningful emergency mental health services to avoid arrest in situations where mental health intervention is needed.

First, given the discretion of the police officer who responds to calls involving juveniles with mental health disorders, it is important that law enforcement departments have the capacity for special mental health/crisis response teams. There are several models of such response teams—either police-based or community-based—but the underlying goals are to assess the situation and try to find interventions including treatment, rather than arrest, where statutes and public safety allow such options. Although a few such efforts are in place in Virginia, they are not yet common and, as a result, an officer may have to take a child into custody as the only means available to control the situation.

Currently, the most well-known and widespread model in the U.S. for improving the police response to mental health crisis situations is one developed for adults in Memphis, Tennessee. Under the Memphis Crisis Intervention Team ("CIT") Program, specialized training conducted by mental health providers, family advocates, and mental health consumer groups is provided to police volunteers to arm them with the knowledge and

[95] This might be a CHINS petition or a delinquency petition.

[96] Since we are talking about juveniles, engagement with the juvenile justice system is not actually *criminalizing* juvenile behavior but the concept is the same as for adults in jails and prisons. Research clearly shows involvement with juvenile justice is correlated with later involvement in adult corrections.

skills to respond more effectively to mental health crisis situations.[97] The Memphis CIT Program has been very successful, and has reduced physical confrontations and injuries and increased diversion of individuals from the criminal justice system and into mental health care.[98]

In Virginia, the New River Valley Crisis Intervention Team Program ("NRV CIT") is the first program to adapt the Memphis CIT Model to a rural, multi-jurisdictional region. The NRV CIT originated in 2002 when the Mental Health Association of the New River Valley received a community action grant from the Center for Mental Health Services. In 2005, the NRV CIT expanded to include a CMHS-funded Jail Diversion Grant, which established the Bridge Program, a multi-county *post*-booking jail diversion program.[99] The NRV CIT has shown impressive results so far with its adult-focus. It is the CA Task Force's view that similar projects that develop and evaluate enhanced and coordinated police/mental health responses to youth crisis situations should be considered and piloted in locations throughout Virginia.

For any crisis intervention program to work, however, it must operate in a community that has well-developed mental health resources, particularly resources attuned to the special needs of juveniles, and robust mental health and law enforcement collaborations. Under Virginia law, local CSBs are legally required to provide pre-screening services for persons who may need emergency psychiatric hospitalization (and provide those services on an around-the-clock basis). The CSB mandated services, however, are limited to emergency response and case management; other services cited in the statute are listed as optional and are provided at the discretion of each locality using local funds. As a result, in only a few, well-funded jurisdictions do CSBs provide mental health services for individuals whose presenting disorders do not include the likelihood of imminent hospitalization.[100]

To achieve the goals of promoting diversion at the initial police contact with a juvenile with serious mental health needs, the CA Task Force makes the following Recommendations:

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[97] The Memphis CIT model, established after a 1988 policy shooting of a man with serious mental illness, grew out of a collaboration among police, universities, advocacy organizations, and mental health professionals to improve police training and procedures in dealing with persons with mental illness. It is characterized by extensive specialized police training in how to interact with persons in psychiatric crisis and coordination with the mental health system to divert individuals to treatment at the pre-booking stage. Research shows significant reductions in the arrests and re-arrests of persons with mental illness. See, e.g., Steadman, H., Deane, M.W., Borum, R., & Morrissey, J. (2001). Comparing Outcomes Of Major Models Of Police Responses To Mental Health Emergencies. *Psychiatric Services*, 51,645-649. General information about CIT available at: http://www.nami.org/Template.cfm?Section=CIT&Template=/ContentManagement/ContentDisplay.cfm&ContentID=56149. See, also: http://www.cit.memphis.edu/USA.htm.

[98] Id.

[99] More information about the NRV CIT is included in **Appendix E.**

[100] OIG Study. See footnote 79 of this Report. CSB funding for children varies by CSB region from a low of $.96 per capita to $292 per capita.

Recommendation II.1. Regional and local law enforcement training academies should train police officers to recognize signs of possible mental and emotional disorders in children and to be aware of and encouraged to collaborate with emergency mental health services in their community so that they can divert a child to mental health care when appropriate. This training should be developed in consultation with licensed mental health professionals and should be offered in basic law enforcement training and in continuing education.

Recommendation II.2. The Community Service Boards should make emergency mental health services for children and adolescents available on a 24-hour basis for referral and intervention in crisis situations identified by police officers (and others) as needing immediate mental health services.

Recommendation II.3. The Crime Commission should consider recommending to the General Assembly that it authorize and fund pilot projects in urban, suburban and rural jurisdictions that incorporate police officer training and the development of emergency mental health intervention services, to study the efficacy of early diversion by the police.

III. Juvenile Court Intake: Decisions About Diversion, Charging And Detention.

A. Diversion Options. Intake diversion may be an option for some children who enter the juvenile justice system.[101] There are two primary routes for diversion at intake. One route involves children who are characterized as being children in need of supervision or children in need of services (together referred to as "CHINS").[102] Behaviors that may characterize a child as a CHINS include non-criminal behavior at home, truancy, running away, curfew violations, etc. In such cases the Intake Officer may proceed informally by diverting them to individual family counseling or other counseling solutions rather than judicial interventions.

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[101] See Virginia Code § 16.1-206, which provides: An intake officer may proceed informally on a complaint alleging a child is in need of services, in need of supervision or delinquent only if the juvenile (i) is not alleged to have committed a violent juvenile felony or (ii) has not previously been proceeded against informally or adjudicated delinquent for an offense that would be a felony if committed by an adult. A petition alleging that a juvenile committed a violent juvenile felony shall be filed with the court. A petition alleging that a juvenile is delinquent for an offense that would be a felony if committed by an adult shall be filed with the court if the juvenile had previously been proceeded against informally by intake or had been adjudicated delinquent.

[102] According to the Department of Juvenile Justice:

> "**Child in Need of Services**" or "**CHINS**" means a child whose behavior, conduct or condition presents or results in a serious threat to the well-being and physical safety of the child. A Child in Need of Services may include a child under the age of 14 whose behavior, conduct or condition presents or results in a serious threat to the well-being and physical safety of another person. To meet the definition of CHINS, there must be a clear and substantial danger to the child's life or health or to the life or health of another person. See Virginia Code § 16.1-228. A full glossary of DJJ terms is available at: http://www.djj.state.va.us/About_Us/Legislation/pdf/Legislation_glossary_djj_system.pdf.

The second route to diversion involves children whose behavior constitutes probable cause for a petition alleging a first time misdemeanor or non-violent felony and who might, as a result, be adjudicated delinquent. An Intake Officer may choose a non-judicial option for such children, once, for counseling, community service, apology letters, essays, and other remedial programs.

B. Intake. A child enters the juvenile justice system when an offense is committed and reported by a parent, citizen, agency complaint, or the police. The DJJ Intake Officer receives petitions from arresting officers and from citizens in the community. At that point, an Intake Officer at the Court Service Unit ("CSU") makes the decision whether to take informal action such as crisis-shelter care, detention outreach, or counseling; to take no action; or to file a petition.

Informal diversion is probation supervision *without* formal court action and can include a referral to services, and/or through brief, informal supervision. Juveniles are eligible for diversion if they are not alleged to have committed a violent juvenile felony or have not previously been proceeded against informally or adjudicated for an offense, which would be a felony if committed by an adult. With informal diversion, the Intake Officer's powers are commensurate with those that would be used by the judge. The Intake Officer must develop a plan for the juvenile, which may include restitution and the performance of community service. The juvenile and his parents must agree to the diversion plan.[103]

A significant number of delinquency petitions, and many of the CHINS petitions, are filed by the parents. With the exception of cases involving certain felonies, children who are repeat offenders, and truants, Intake Officers have considerable discretion about whether to accept a petition, and how to divert or hold a case in an effort to resolve a matter without having a trial in the JDR Court.[104] That discretion includes the authority to develop, with the child and family, a diversion plan that specifies the services in which the child and family will participate as a condition of the matter not resulting in a formal petition before the JDR Court.

When the nature of the offense, or the Intake Officer's assessment of the child's conduct and circumstances, leads the Intake Officer to accept and file a delinquency petition, the Intake Officer must then determine whether the child should be detained pending hearing before the JDR Court.

In deciding whether to charge and whether to detain, the Intake Officer must assess a variety of factors, including the mental condition of the child, the child's potential for acting out, and the availability of services. Because the Intake Officer's decisions are so critical to the future course of the child's involvement with the Juvenile Justice system,

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[103] Informal supervision is limited to 90 days (6 VAC 35-150-335).

[104] Juveniles under age 18 are adjudicated in the Domestic Relations and Juvenile Justice Courts except for cases involving juveniles fourteen years of age or older at the time of an alleged offense who are charged with an offense which would be a felony if committed by an adult. These juveniles may be transferred or certified for trial in the circuit court, which is the adult court of record, pursuant to Virginia Code § 16.1-269.1. The circuit court is also has jurisdiction over appeals from the JDR Courts.

the Intake Officer needs to have available the evaluation instruments that will help the officer make informed decisions about the child's condition. Because such a high percentage of the children who come into contact with the JDR Court system have mental health conditions, many of them severe, evaluation tools should include a validated mental health-screening instrument. Having validated evaluation instruments provides Intake Officers with structured decision-making tools to identify the needs of juveniles being considered for diversion.

In addition, when an Intake Officer identifies a child as having serious mental or emotional problems that need immediate response, emergency mental health treatment and referral services must be available so that further deterioration of the child can be avoided.

The General Assembly has already recognized the importance of the role of Intake Officers in exploring options to detention including diversion or other alternative resolutions, as well as the importance of facilitating open discussions between juveniles and intake officers. For example, in Section 16.1-261 of the Virginia Code, the General Assembly provides that any statements made by a child to the Intake Officer or probation officer during the intake process and prior to a hearing on the merits of the petition filed against the child shall not be admissible at any stage of the proceedings. It is vital that this protection be kept in place, since it affords the child the protection and the encouragement to be open with the Intake Officer about the child's experiences, feelings and needs, all of which can be vitally important to the decision made by the Intake Officer on how to process the child's case.

C. CHINS Petitions. How a particular Intake Officer will process a CHINS petition is often a function of what resources exist in the community to address the needs of a child who has serious acting out behaviors that do not rise to the level of delinquency, but which need to be addressed before they escalate into delinquency. While the apparent advantage of a CHINS petition is that it provides the opportunity for intervention before delinquent behavior develops, its disadvantage is that, in bringing a troubled and noncompliant child into the JDR Court system, it may result in a response that draws the child further into that system, rather than keeping the child out of it.

D. Truancy. One of the criteria for determining whether a child is subject to jurisdiction under CHINS is a pattern of absences from school, or truancy. Like running away from home, alcohol use, and curfew violations, truancy is a status offense—an act that would not be criminal if committed by an adult.

Truancy affects students of all ages, from all types of communities and socioeconomic backgrounds. Truancy is associated with school factors, family and community factors as well as student characteristics.[105] Interventions for children who are not attending school

[105] School factors may include an unsafe school environment or inadequate reporting of absences to parents. Family and community factors may include peer pressure or violence in the home or community. Student factors may include unmet mental health needs, poor student performance, and alcohol or drug

are absolutely necessary, as education is a primary and necessary task of childhood and truancy is a risk factor for both the child and for communities. In addition to the risk of educational failure, truant students are at risk for social isolation, substance abuse, unemployment, violence, adult criminal activity and incarceration. Truancy also has high social and financial costs including increased rates of daytime criminal activity and vandalism.

In addition to placing students at risk, truancy has harmful social and financial consequences. Communities with high rates of truancy are likely to have corresponding rates of daytime criminal activity and vandalism. Also high school dropouts claim more in government-funded social services than high school graduates.

Although clearly intervention is warranted, the limited sanctions available to most JDR Courts are blunt instruments with limited effectiveness for dealing with truancy cases. Research indicates that early identification of children with school avoidance/refusal problems and the use of therapeutic interventions, are usually more successful than trials and detention, and that children respond to interventions differently, depending upon the underlying causes for their school refusal. In many cases, those underlying causes may include depression, anxiety or other mental health problems being experienced by the child. The JDR Courts must be able to recognize the variety of factors that may contribute to truancy, and develop responses that take that variety into account.

E. Pre-Adjudication "Diversion." As noted in Section A, Intake Officers also have the discretion to proceed informally with juveniles who are alleged to be delinquent, although in this case, since the Intake Officer must file a petition with the JDR Court and the Intake Officer's recommendations for resolution must be approved, this is not considered a true "diversion."

One example of an innovative intervention for this population of children is Virginia Beach's Family Crisis Team ("FCT") approach, which is designed to minimize the use of secure detention for juveniles who are being detained for a misdemeanor or non-violent felony committed against a family member. Referrals to this program can be ordered by the Juvenile and Domestic Relations Court ("JDR") judge at the child's detention hearing upon the recommendation of the Intake Officer or another Court Services Unit ("CSU") officer.

Virginia Beach's FCT approach is a pre-adjudicatory program that places the child (defendant) in a non-secure shelter care placement and provides services in the home to which the child then returns. The goal of the program is to work out the family problems within six weeks and if such resolution is possible recommend that the JDR Court judge dismiss the charge(s) at the end of the six-week period. Virginia Beach's FCT is not a CHINS program although the issues and solutions are similar to some CHINS cases. In addition, it is not a true diversion program but rather semi-diversionary because the Intake Officer does issue a petition, which a JDR Court judge must resolve.

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abuse. See, e.g., Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, Truancy Prevention, Available at: http://ojjdp.ncjrs.org/truancy/index.html.

The CA Task Force makes the following Recommendations about diversion at the time of intake**:**

Recommendation II.4. The Department of Juvenile Justice should provide training to Intake Officers on recognizing possible signs of mental and emotional disorders in children, and on the use of brief validated mental health screening instruments or interview protocols to help them assess whether the child poses an immediate danger of harm and whether the child has significant but less serious mental health needs.

Recommendation II.5. The Department of Justice should require juvenile Intake Officers to employ a validated mental health screening instrument, specifically the Massachusetts Youth Screening Inventory (MAYSI-2)[106] or the Pre-Screen version of the Youth Assessment and Screening Instrument (YASI)[107] when a Intake Officer has a face-to-face meeting with the juvenile and/or his family prior to making a decision on whether to divert or proceed formally with a petition. The Department of Juvenile Justice should prepare guidance on how to respond to the screening results.

Recommendation II.6. For those children identified as having significant but non-emergency mental health needs, the Community Services Boards should provide a system for prompt assessment to ensure that a child's condition does not deteriorate during any wait for outpatient services.

Recommendation II.7. For those cases where the family situation has deteriorated to the point that the child's parents or custodians are unwilling to allow the child to return home, even though the child does not meet the criteria for detention, the Department of Social Services should have an array of services available in the community to address this placement crisis, ranging from intensive services in the home for the family to short-term alternative placement in the community for the child, with the child's parents/custodians being advised that they are responsible for the child's care and supervision. A protocol should be developed between the local court services unit and the local Department of Social Services for report by the intake officer and response by the department regarding possible child neglect when the parent or custodian is unwilling to accept responsibility for meeting the child's identified needs. Where local funding is available Court Services Units, in conjunction with local social services and mental health agencies, should consider

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[106] The Massachusetts Youth Screening Instrument-2 (MAYSI-2) is a brief screening instrument designed to identify potential mental health needs of youths as they make contact with the juvenile justice system. MAYSI-2 includes a combination of mental, emotional, and behavioral dimensions.

[107] Virginia's DJJ uses validated, structured decision making instruments in various aspects of community and institutional operations. The Youth Assessment and Screening Instrument, or YASI, assesses risk, need and protective factors and helps develop case plans for youth. The YASI includes a brief "pre-screening" version, which can be used at the time of intake to assist in early decision-making such as appropriateness and targets for diversion. The pre-screen arrives at an overall risk level as well as separate risk scores for legal history and social history (e.g., family, school and other adjustment domains).

developing programs to intervene at the intake level for Family Crisis Management.

IV. Detention: Screening And Services Pending Hearing

Section 16.1-248.2 of the Virginia Code already requires that, whenever a child is placed in a detention facility, staff of the facility must conduct a screening to determine the child's need for a mental health assessment by a mental health professional. If it is determined that the juvenile needs such an assessment, that assessment must be provided by staff of the local CSB within twenty-four hours of such determination.[108]

All juvenile detention centers in Virginia currently administer the Massachusetts Youth Services Inventory ("MAYSI"), a validated mental health-screening tool that assists the detention staff in determining the level of mental health needs of each child admitted to the facility. Additionally, because of new state funding, all detention centers in Virginia now have a mental health professional on site.

Studies have confirmed that a significant percentage of children in detention have mental health conditions of varying levels of seriousness. The presence of a mental health clinician in the facility enables the facility to provide a level of direct services to the children there and to make connections to services in the community, both for purposes of providing services that the in-house clinician cannot provide and providing ongoing treatment following discharge. It may also enable the detention facility to make significant findings regarding the child's mental health functioning and needs prior to the detention hearing in the JDR Court.

While funding the placement of mental health clinicians in detention facilities is an important step forward, there are a number of obstacles to ensuring that the work of those clinicians will be effective. First, at this time, there are no statewide standards for the responsibilities and activities of these clinicians and their appropriate caseload. In addition, although detention centers are able to work with a child's parents to obtain and administer medications that were prescribed for a child prior to the child's detention, often there is still no assured avenue through DJJ to obtain new medication, psychiatric or other mental health services in the community after an evaluation at the detention center finds that the child needs them. The lack of available resources for children's mental health needs is particularly acute in some rural areas of the State.[109]

Unfortunately, this lack of access to community-based services often remains the case for the child after release from detention.[110] It is important to note that, while funding for

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[108] As in the case of the intake process, statements made by the child during the screening and assessment process in detention cannot be used against the child in the proceedings in the Juvenile Court.

[109] See JLARC *Availability of Psychiatric Services* (2007) cited in footnote 43 above. According to JLARC, 87 communities in Virginia do not have a child psychiatrist and 47 have no psychiatrist at all. These communities are predominately rural.

[110] Children may be released from secure detention for a number of reasons including: 1. By a JDR judge during the pre-hearing period, at the detention hearing or on an appeal of that detention hearing. 2. At any

such services for these children was formerly available under Sections 16.1-286 and 16.1-289 of the Virginia Code, those funds were absorbed into funding for the CSA.[111] Under the CSA, delinquent children with mental health problems are not among the "mandated" children eligible to receive services under the CSA, while "CHINS" children with the identical, or lesser, mental health problems (but whose conduct has not resulted in their being charged and incarcerated) may be deemed to be "mandated" children. The CSA needs to be revisited by the General Assembly to broaden the scope of its coverage to include more children with mental health needs and to focus more of its resources to enhance the availability of community-based mental health services for children.

Finally, service providers must take a more active role in ensuring that children and families follow through with services. For example, in a number of medical specialties, the old model of making patients (parents) responsible for securing services on their own is no longer the standard. Instead, for many populations, medical facility staff and case managers make the appointments for a patient's individual and family follow up treatment in the community. Research confirms that there is more successful follow-up when these arrangements are made a routine part of the discharge process. Continuity of mental health services is critical to a child's long-term success. Therefore, building in protocols and having adequate numbers of trained case managers into the mental health system will help to ensure that continuity.

The CA Task Force makes the following Recommendations for improving mental health services for children in detention pending a hearing:

Recommendation II.8. The General Assembly should ensure that the Department of Mental Health, Mental Retardation, and Substance Abuse Services has sufficient funding for mental health clinicians assigned to juvenile detention facilities in the Commonwealth of Virginia.

Recommendation II.9. The Department of Mental Health, Mental Retardation, and Substance Abuse Services, in conjunction with the Virginia Council on Juvenile Detention, should develop standards regarding the qualifications, responsibilities and activities of detention center mental health clinicians, and establish appropriate caseload standards for them. These standards should include responsibility for those children released from detention.

Recommendation II.10. Community Services Boards should allow case managers and the Department of Juvenile Justice should allow court services staff to make appointments for children for outpatient follow-up.

V. Detention Hearing, Competency, And Pre-Trial Processing

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time in the process, pre-hearing, post adjudication, post disposition (after serving their sentence) or 3. On completion of the "Post-D" program (a six month local alternative to commitment where available. The child undergoes an intensive program while being securely detained in their locality.)

[111] See Chapter I, footnote 79, about the Comprehensive Services Act for At Risk Children and Families.

At the detention hearing, the JDR Court determines whether the child should remain in detention pending further hearing, or can be released, usually subject to certain conditions. In the case of children who have mental or emotional disorders, the detention hearing can become an important time for exploring the child's treatment needs and the benefits of moving the child out of detention and into a treatment setting more appropriate for the child's condition.

It is particularly important that the child's defense counsel have both the motivation and the opportunity to review the findings regarding the child's mental health screenings conducted both at intake and upon the child's admission to the detention facility. That information may provide the basis for defense counsel to advocate at the detention hearing for an alternative, treatment-based placement for the child.

Counsel should also be alert to whether the child is competent to understand what is happening and to meaningfully assist his attorney in preparing a defense and participating in a trial. In the seven years that the juvenile competency statute has been in effect, the number of cases in which the JDR Courts have ordered competency restoration services has been well below the numbers predicted prior to enactment of the juvenile competency legislation (based upon the percentage of the juvenile population with cognitive and mental health limitations and disorders). In addition, there has been a wide variation among jurisdictions in the number of cases in which the competency of a child has been raised as an issue and in which a child has been found to be incompetent to stand trial. Since 1999, 515 juvenile restoration orders have been issued, and 270 of those originated in the City of Richmond.[112]

This variation appears to have no connection with the characteristics of the children in the jurisdictions across the state, and indicates instead that some jurisdictions are sensitive to this issue while others apparently do not consider it to be an issue at all. Since competence – the capacity of the child to understand and meaningfully participate in the trial in which he is involved - is a fundamental requirement for affording due process to that child, the competence of a child should be consciously and intentionally considered by counsel and the court in every case.

In addition, for the juvenile competency legislation to have any practical meaning, there must be sufficient funding to support services to restore children to competency. However, it appears that the funding levels are inadequate. In fiscal year 2007, the budget for juvenile restoration was only $607,367, a sum that would only pay for inpatient competency restoration services for of 6.5 juveniles (based upon a cost estimate of a 30-day inpatient commitment at the per diem rate of the Commonwealth Center for Children and Adolescents).

The CA Task Force has the following Recommendations for improving mental health screening and treatment at the pretrial phase:

[112] Statistics provided by Jeannette DuVal, Director, Juvenile Competency Services, DMHMRSAS.

Recommendation II.11. The Office of the Executive Secretary, the Indigent Defense Commission, the Commonwealth's Attorney's Services Council, and the Virginia State Bar should provide training for judges, prosecutors, and defense attorneys regarding mental and emotional disorders of children. The training should also address how to make decisions regarding pre-trial placement and treatment for children before the Juvenile and Domestic Relations Court who have such disorders.

Recommendation II.12. The Office of the Executive Secretary, the Indigent Defense Commission, the Commonwealth's Attorney's Services Council, and the Virginia State Bar should provide training for judges, prosecutors, defense attorneys, and guardians *ad litem*, in regard to recognizing when a child may be incompetent to stand trial, and how mental and emotional conditions and disorders of children may affect competency. The rate at which competency issues arise, and the number of children found to be incompetent and in need of restoration to competency, should be monitored and studied in an effort to ensure that standards are being applied consistently among the jurisdictions in the state.

Recommendation II.13. The General Assembly should consider studying the issue of juvenile restoration of competency to ensure that there is adequate funding for restoration services so children can be evaluated and restored to competency in the least restrictive setting.

VI. The Transfer Hearing: Understanding The Child

When faced with a juvenile who has committed a serious offense, one policy response common across the U.S. is to try and punish the juvenile as an adult. This is appropriate in some cases, particularly for older juveniles and the most serious offenses. However, it is the position of the CA Task Force that to do so routinely for juveniles without assessing a juvenile's mental health accomplishes little for public safety and compounds what is fundamentally, for many, a serious health issue.

Since 1996, under Virginia law, juveniles aged 14 and older accused of an act that would be a felony if committed by an adult may be tried as adults. In such cases, the JDR will certify the case and send it to the Circuit Court for trial. There are two categories of offenses where certification to Circuit Court occurs.

The first, set out in Virginia Code Section 16.1-269.1(B), requires that children 14 years of age or older who are charged with capital murder, first or second degree murder, or aggravated malicious wounding must be certified by the JDR Court to the Circuit Court if the JDR Court finds probable cause to support those charges. The JDR Court does not have discretion to deny the transfer.

In the second category, under Section 16.1-269.1(C), in which a juvenile is accused of certain other serious felonies, the JDR Court will certify the case to Circuit Court if the Commonwealth Attorney asks to have the case certified and if the JDR Court finds

probable cause to believe the juvenile committed the act of which he is accused. The list of offenses cited in this Code Section includes felony homicide, certain abductions, robbery, carjacking, and a variety of felony sex offenses. Under these facts, it is the Commonwealth Attorney that has the discretion to make the decision to transfer the juvenile to the Circuit Court.

Prior to Virginia's 1996 Code amendments, the decision on whether to treat children as adults for these offenses rested with the JDR Court judge. The Juvenile Code at that time required the JDR judge to consider several factors in determining whether a juvenile charged with serious felonies should be tried as an adult. Those factors included: "[w]hether the juvenile can be retained in the juvenile justice system long enough for effective treatment and rehabilitation;" "[t]he appropriateness and availability of the services and dispositional alternatives in both the criminal justice and juvenile justice systems for dealing with the juvenile's problems;" "the number and nature of previous residential and community-based treatments," "[t]he extent, if any, of the juvenile's degree of mental retardation or mental illness;" and "[t]he juvenile's mental and emotional maturity."

The decision in Virginia to take this decision-making authority away from the JDR Court judges, and to treat serious juvenile offenders as adults without review of whether these juveniles are mentally ill or otherwise mentally disabled, reflected a nationwide trend in the 1990's. That trend argued that juveniles were not being made sufficiently accountable when they committed these very serious crimes, and that punishing juveniles as adults would both deter juveniles from committing such acts and would reduce repeat offenses, thus enhancing public safety. Developments in the law and the neuro-behavioral sciences since 1996, however, suggest that the certification and transfer process, at least for children with mental illnesses and other mental disabilities, should be reexamined. The General Assembly has already seen the need for such action, and has directed the Virginia Crime Commission[113] to study the entire juvenile code including the transfer process and its efficacy. The CA Task Force supports this effort. There are several lines of support for the General Assembly's interest in having the Crime Commission study this issue with regard to its effects on children with mental illness:

[113] The Virginia State Crime Commission is a criminal justice agency established in the legislative branch of government in accordance with Section 30-156 et seq. of the Code of Virginia. Its purpose is to study, report and make recommendations on all areas of public safety and protection. In 2006, House Joint Resolution 136 authorized a two year Juvenile Justice Study by the Crime Commission to study the Virginia Juvenile Justice System and examine recidivism, disproportionate minority contact with the juvenile justice system, improving the quality of and access to legal counsel based on American Bar Association recommendations, accountability in the courts, and diversion. The Commission was also tasked with analyzing Title 16.1 of the *Code of Virginia* to determine the adequacy and effectiveness of Virginia's statutes and procedures relating to juvenile delinquency

- A growing body of empirical evidence shows that trying most juveniles as adults actually increases recidivism, failing a central goal of protecting the public's safety;
- Prevalence studies show high levels of serious mental illness—often untreated for years—among the juveniles coming before the courts:
- A growing body of neuro-developmental evidence, as recognized by the United States Supreme Court, shows that children lack the cognition and judgment of adults, which raises questions about the fairness of routinely trying juveniles as adults.

We will examine each of these developments in turn. First, research on trying children as adults demonstrates that transferring juveniles to adult courts for trial and sentencing is more likely, rather than less likely, to result in recidivism.[114] Studies have shown that youth who are transferred from the juvenile court system are approximately 34% more likely than youth retained in the juvenile court system to be re-arrested for violent or other crimes.[115]

Second, the CA Task Force's research has found a high prevalence of serious mental illness among juveniles coming into contact with the juvenile justice system. Unfortunately, many of Virginia's children who come into contact with the juvenile justice system have not had access to meaningful and necessary mental health services, a fact reflected in data showing nearly two-thirds of children ending up in detention have serious emotional or behavioral disturbances and/or substance abuse disorders.[116] As a result, for many older children, a long history of missed opportunities for mental health interventions translates to a first contact with the juvenile justice system that sends them directly to the adult court. Unfortunately, the failure to address serious emotional and behavioral disorders often means that maladaptive behaviors and minor offenses escalate to more serious felonies. This represents a failure in preventive care and the consequences are enormous for all concerned.[117]

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[114]Redding, Richard. (1999). "Juvenile Offenders in Criminal Court and Adult Prison: Legal, Psychological, and Behavioral Outcomes, CORRECTIONS TODAY 95, 120; Winner, L., Lanza-Kaduce, L., Bishop, D., and Frazier, C. (October 1997). "The Transfer Of Juveniles To Criminal Court: Reexamining Recidivism Over The Long Term." Crime and Delinquency, 43(4) 548-563; Bishop, D., Frazier, C., Lanza-Kaduce, L., and White, H. (1996). "The Transfer Of Juveniles To Criminal Court: Does It Make A Difference?" Crime & Delinquency,42(2)171-191; Bush J. and Bankhead, W.G. (2002). "A DJJ Success Story: Trends in the Transfer of Juveniles to Adult Criminal Court." Florida Department of Juvenile Justice.

[115] CDC, Task Force on Community Preventive Services (April 2007) "Recommendations Against Policies Facilitating the Transfer of Juveniles from Juvenile to Adult Justice Systems for the Purpose of Reducing Violence." American Journal of Preventive Medicine, Vol. 33, No. 48.

[116] See supra

[117] There is a growing body of research that questions the biological capacity of children's brains to function like adult brains in terms of cognition and judgment. Brain imaging research has revealed significant differences between juvenile and adult brain functions that may have important legal implications in regards to due process and punishment for juveniles. See Lenroot, R.K. and Giedd, J.N. (2006)."Brain Development In Children And Adolescents: Insights From Anatomical Magnetic Resonance Imaging." Neuroscience and Biobehavior Review 30(6):718-29; Giedd J.N.; Clasen L.S.; Lenroot R.; et al. (July 2006) "Puberty-Related Influences On Brain Development." Molecular Cell Endocrinology 25;254-255:154-62. Epub.; Shaw P.; Greenstein, D.; Lerch, J, et al. (March 2006) "Intellectual Ability And Cortical Development In Children And Adolescents." Nature. 440(7084): 676-9; Casey B.J.; Giedd, J.N.;

Further underscoring the wisdom of reviewing the certification and transfer of juveniles to adult courts, is the recent opinion of the U.S. Supreme Court, in which it considered the qualitative differences in thinking, judgment and action between juveniles and adults, and the legal implications that these differences have for processing and punishing juvenile offenders. In 2005, the U.S. Supreme Court held that the juvenile death penalty violated the Eighth and Fourteenth Amendments. Roper v. Simmons, 543 U.S. 551 (2005). The Roper decision relied significantly upon three key differences between juveniles and adults, which the Court found, "demonstrate that juvenile offenders cannot with reliability be classified among the worst offenders." These include a lack of maturity and sense of responsibility leading to "impetuous and ill-considered actions and decisions;[118] the vulnerability of juveniles "to negative influences and outside pressures, including peer pressure;[119]and the character of a juvenile is not as well formed as that of an adult. The personality traits of juveniles are more transitory, less fixed. [120,121]

The Supreme Court went on to say "These differences render suspect any conclusion that a juvenile falls among the worst offenders. The susceptibility of juveniles to immature and irresponsible behavior means, "their irresponsible conduct is not as morally reprehensible as that of an adult." …. Their own vulnerability and comparative lack of control over their immediate surroundings mean juveniles have a greater claim than adults to be forgiven for failing to escape negative influences in their whole environment.[122]

There is ample evidence beyond that cited by the Supreme Court in Roper showing that for adolescents with serious mental health problems, their reasoning, understanding, judgment, and decision-making are likely to be particularly impaired. In a recent report, the authors conclude that:

> "Psychiatrically ill, neurologically impaired, and abused adolescents are even more handicapped than their normal peers. The question of ethics that their conditions pose is to what extent these impaired juveniles should be held accountable for their violent acts….

Thomas, K..M;. (2000). "Structural And Functional Brain Development And Its Relation To Cognitive Development." Biological Psychology 54(1-3):241-57.

[118] Supreme Court in Roper. "First, as any parent knows and as the scientific and sociological studies respondent and his *amici* cite tend to confirm, "[a] lack of maturity and an underdeveloped sense of responsibility are found in youth more often than in adults and are more understandable among the young. These qualities often result in impetuous and ill-considered actions and decisions…."

[119] Supreme Court in Roper: "juveniles are more vulnerable or susceptible to negative influences and outside pressures, including peer pressure…. This is explained in part by the prevailing circumstance that juveniles have less control, or less experience with control, over their own environment."

[120] Citing, generally, E. Erikson, *Identity: Youth and Crisis* (1968).

[121] See, e.g., Steinberg, Lawrence and Scott, Elizabeth. (2003). "Less Guilty by Reason of Adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty." 58 American Psychologist 1009, 1014. ("[A]s legal minors, [juveniles] lack the freedom that adults have to extricate themselves from a criminogenic setting").

[122] Supreme Court at 569-570, (internal citations omitted).

> Neuroscience, neuropsychiatry, and neuropsychology have taught us that such impaired youths may possess a theoretical understanding of right and wrong and still lack the capacity to reflect on and manage their aggressive feelings. We know that when frontal lobe immaturity is complicated by brain dysfunction, predispositions to severe mental illness and abusive, violent upbringings, they interact. This constellation diminishes judgment, increases emotional liability, and impairs impulse control."[123]

Children with significant mental health problems pose special challenges for policy makers, particularly in light of the many deficiencies in Virginia's current mental health delivery system for children. The current certification and transfer laws simply do not adequately take these children into account.[124] Given this, and the additional evidence of significant differences between juvenile and adult offenders, and the longitudinal studies which indicate that placing violent juveniles into adult corrections increases, rather than reduces, their recidivism and the danger they pose to public safety, a comprehensive study of the impact of Virginia's transfer and certification laws on children with mental illness appears warranted.[125]

For those felony cases in which the JDR Court judge still has the authority to make a decision on whether to transfer the prosecution of a juvenile to the adult system, Virginia Code Section 16.1-269.1 requires the judge to review specific factors in making a transfer decision, including whether the juvenile can be retained in the juvenile justice system long enough for effective treatment and rehabilitation; the appropriateness and availability of the services and dispositional alternatives in both the criminal justice and juvenile justice systems for dealing with the juvenile's problems; the extent, if any, of the juvenile's degree of mental retardation or mental illness; and the juvenile's mental and emotional maturity.

A fair review by a JDR Court of these factors in a transfer hearing requires not only a careful review of the available information regarding the child's condition and amenability to treatment and services, but also an understanding of mental and emotional disorders in children. It requires the same of the attorneys who have the obligation to present this information to the JDR Court. Moreover, there is an obligation on the part of

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[108] Lewis D.; Lovely R.; Yeager C.; et al. (1989). "Toward a Theory of the Genesis of Violence: A Follow-up Study of Delinquents." Journal of the American Academy of Child and Adolescent Psychiatry 28:431–6.

[124] Sridharan, Sanjeev; Greenfield, Lynette; and Blakely, Baron. (2004). "A Study of Prosecutorial Certification Practice in Virginia," Criminology and Public Policy, 3(4)605-632. The authors studied the impact of Virginia's certification laws between 1997 and 1998. This article raised a number of questions about Virginia's certification laws that are worthy of further study. Other than this article, there is a dearth of information available regarding the impact of the juvenile transfer and certification laws on Virginia's youth, or the extent to which Virginia's 1996 revisions to the transfer laws are achieving their goals.

[125] Lewis, D.: Yeager, C.; and Blake, P. et al. (2004). "Ethics Questions Raised by the Neuropsychological, Educational, Developmental, and Family Characteristics of 18 Juveniles Awaiting Execution in Texas," Journal of the American Academy of Psychiatry Law 32:408-29, at 427.

the justice system to have in place the services reasonably anticipated to be needed for children who have mental or emotional disorders and commit criminal acts.

Virginia Code Section 16.1-269.1 currently provides that a transfer decision by a JDR Court cannot be precluded or reversed on the grounds that the JDR Court "failed to consider any of the factors specified" in regard to making the transfer decision. It appears that, given the issues of substantive due process involved in the transfer decision, it may be worthwhile to require the JDR Court to show that it considered the factors relating to the juvenile's mental condition and maturity. Additionally, counsel for an indigent juvenile who is facing transfer should be able to obtain, through court order, an evaluation of the juvenile regarding the juvenile's mental retardation, mental illness, and mental and emotional maturity, and the availability of treatment for the juvenile. At a minimum, counsel should be able to obtain such an evaluation if counsel is able to show: (1) the juvenile has a history of mental illness or mental retardation, and (2) there is reason to believe that the juvenile's behavior was a reflection of this underlying condition. A strong argument can also be made that, given the potential consequences for the child if a decision to transfer is made, counsel for the child should have an automatic right to obtain such an evaluation.

The CA Task Force makes the following Recommendations concerning the transfer of juveniles, particularly those with mental health issues, to adult courts:

Recommendation II.14. The Crime Commission should recommend that the Office of the Executive Secretary and the Department of Justice document the availability of statewide data regarding children who are transferred for prosecution as adults. In the event no statewide data exists, the Crime Commission should consider recommending that the General Assembly amend the Code to require the reporting and analysis of transfer data and an annual report to the General Assembly.

Any data collection might focus on both the characteristics of these children and the outcomes of their cases. Key data would include the following:

- **the demographics of the children involved (both overall and for different crime categories) – age, sex, ethnicity, socioeconomic status, educational status (including placement in special education);**
- **mental health or developmental disability diagnosis; the nature and extent of mental health and related services provided to these children both before and during their involvement with the juvenile justice and adult criminal systems;**
- **delinquent/criminal history prior to the crimes for which the children are transferred; sentences received;**
- **conditions in jails and prisons where they are incarcerated; and**
- **rates of recidivism following completion of their sentences as adults.**

Recommendation II.15. The Crime Commission should consider evaluating Virginia's current transfer laws on the basis of the collected data, to determine whether more specific standards for transfer should be developed, so that those

children with mental illness and serious emotional disturbances who can benefit from rehabilitation are able to remain in the juvenile justice system, including giving juvenile court judges discretion to deny transfer when mental illness is a factor.

Recommendation II.16. The Office of the Executive Secretary, the Indigent Defense Commission, and the Virginia State Bar should provide training to Juvenile Court judges, prosecutors, defense attorneys, and guardians ad litem on mental and emotional disorders in children, and the cognitive and emotional development of children, as they relate to children's decision-making capacity and their resulting appropriateness for being tried and sentenced in the adult criminal justice system.

Recommendation II.17. The Crime Commission should consider recommending an amendment to Section 16.1-269.1(A) of the Virginia Code to require Juvenile and Domestic Relations Court judges making transfer decisions to specify the basis for their findings regarding the following: (1) whether the juvenile can be retained in the juvenile justice system long enough for effective treatment and rehabilitation; (2) the appropriateness and availability of the services and dispositional alternatives in both the criminal justice and juvenile justice systems for dealing with the juvenile's problems; and (3) the extent, if any, of the juvenile's degree of mental retardation or mental illness.

Recommendation II.18. The Crime Commission should consider recommending that Code Section 16.1-269.1(A) be revised to allow appellate review if the juvenile court does not consider the juvenile's degree of mental retardation or mental illness when making a transfer decision.

Recommendation II.19. The General Assembly should amend the Virginia Code to authorize and enable counsel for an indigent juvenile who is facing transfer to obtain, through a Juvenile and Domestic Relations Court order, an evaluation of the juvenile regarding the juvenile's mental retardation, mental illness, and mental and emotional maturity, and the availability of treatment for the juvenile, if counsel is able to show: (1) that the juvenile has a history of mental illness or mental retardation, and (2) there is reason to believe the juvenile's behavior was a reflection of this underlying condition.

Furthermore, the Commonwealth should pay the costs for the clinician providing such evaluation under the provisions of Section 16.1-275 upon a showing of indigency. Such an evaluation report would be attorney-client privileged. However, if counsel for the indigent juvenile intends to introduce this evaluation report in the transfer proceedings, the report must be produced to the Commonwealth in advance of the proceeding, along with copies of psychiatric, psychological, medical or other records obtained during the course of such evaluation.

VII. Adjudication And Disposition: Services And Sentencing

A key problem for a significant percentage of children with mental illnesses in the juvenile justice system is substance abuse. Studies have shown that a majority of the children in the system who have a mental or emotional disorder also have a substance abuse problem, which exacerbates many of the symptoms of the child's other disorder. Children with "co-occurring disorders" of mental illness and substance abuse may, in many cases, be using alcohol and/or drugs as a form of self-medication for their underlying mental health problem.

The importance of intervening effectively as early as possible to stop substance abuse cannot be overstated. Brain imaging research is revealing the more toxic effects of substance abuse on the immature, developing brain than on the mature adult brain. That toxicity can cause permanent negative changes in the brain and its capacity to function. Such permanent damage in the young brain can have devastating consequences for a person's future.[126]

In 2000, the General Assembly made specific provision in the Juvenile Code at § 16.1-278.8:01 for all juveniles who were before the JDR Court on charges of delinquency to undergo a screening for substance abuse, and to participate in treatment if they were found to have a substance abuse problem. Funding was provided under the Substance Abuse Reduction Effort ("SABRE") program to hire certified substance abuse counselors to conduct the screenings and provide the treatment.[127] Unfortunately, SABRE funding was discontinued in 2002, and all of those counselor positions were terminated. This section remains in the Code, but was placed in abeyance under the Appropriations Act.

While the SABRE program was not in existence long enough to generate data to demonstrate its efficacy, it received favorable reviews from attorneys, judges, court services officers, parents and counselors throughout the state. The substance abuse problems of children in the juvenile justice system have not abated since the dismantling of the SABRE program and a system-wide focus on identifying and treating substance abuse should be supported.

Several JDR Courts in Virginia have taken the initiative to develop "drug courts", in which the juveniles before the court participate, with their families, in more intensive treatment, case management, and support services, and in more frequent review of their status by the JDR Court.[128] The mission of juvenile courts, generally, has been to correct and rehabilitate children, who violate the law, to protect the community from their

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[126] Windle M.; Spear. L.P.; Fuligni, A.J., et al. (2008). "Transitions Into Underage And Problem Drinking: Developmental Processes And Mechanisms Between 10 And 15 Years Of Age." Pediatrics, Supplement 4: S273-289.

[127] SABRE was short-lived. The General Assembly enacted the SABRE legislation in 2000 as an anti-drug initiative proposed by the Governor and subsequently de-funded it in 2002.

[128] According to the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, between 1995 and 2001 more than 140 juvenile drug courts had been established and more than 125 more were planned. See, e.g., U.S. Department of Justice (2002). Juvenile Drug Courts: Strategies in Practice. Monograph. Available at: http://www.ncjrs.gov/pdffiles1/bja/197866.pdf.

delinquent behavior and to strengthen the family. Having specialized courts for juveniles involved with drugs is a particularly good fit. According to the U.S. Department of Justice, the goals of juvenile drug courts are to:

- Provide immediate intervention, treatment, and structure in the lives of juveniles who use drugs through ongoing, active oversight and monitoring by the drug court judge.
- Improve juveniles' level of functioning in their environment, address problems that may be contributing to their use of drugs, and develop/strengthen their ability to lead crime- and drug-free lives.
- Provide juveniles with skills that will aid them in leading productive substance free and crime-free lives—including skills that relate to their educational development, sense of self-worth, and capacity to develop positive relationships in the community.
- Strengthen families of drug-involved youth by improving their capability to provide structure and guidance to their children.
- Promote accountability of both juvenile offenders *and* those who provide services to them.[129]

According to the Drug Court Clearinghouse of the U.S. Department of Justice, most current juvenile drug courts are *post*-adjudication programs that operate after the guilt of a child has been determined, either through trial or plea. The case disposition process varies and may entail suspending a sentence of commitment, pending successful program completion; deferring sentencing, depending upon a child's performance; and/ dismissing the charge if the program is successfully completed.[130] A full evaluation of juvenile drug courts is pending, in part, because they are relatively new and there is variability in the courts' approaches, the community resources available, the therapeutic models, as well as variability with the child's level of drug involvement and the family dynamics, but preliminary reports indicate high retention rates in such programs throughout the country.[131]

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[129] Id.

[130] *Juvenile Drug Courts: Preliminary Assessment of Activities Underway and Implementation Issues Being Addressed*. (No date provided). Prepared by the Drug Court Clearinghouse and Technical Assistance Project A Program of the Drug Courts Program Office, Office of Justice Programs, U.S. Department of Justice. Available at: http://spa.american.edu/justice/documents/2042.pdf.

[131] Id. Retention rates reported in the therapeutic programs ordered by juvenile drug courts were between 87% and 95%.

There is no single model for such juvenile drug courts in Virginia and each "drug court" program differs from the others in significant ways, from the eligibility criteria for juveniles to be accepted into the program, to the treatment modalities used, to the standards for remaining in or leaving the program. Those differences, and the efficacy of the different models, merit ongoing study, to determine what key features should be replicated.[132]

While there is a growing body of evidenced-based practices[133] and program models for the treatment of adolescents with substance abuse disorders, these programs have not been definitively studied for their efficacy with court-involved adolescents. It is significant that certain broader treatment and service models, such as Multi-Systemic Therapy and Functional Family Therapy, which address the conduct disorders of children and their families more globally, have had promising outcomes in regard to reduced substance abuse along with other behavior improvements. (See Appendix E)--).\ It may be that the success of any substance abuse treatment program will depend upon success in addressing the constellation of problems that a child and family often present in CHINS and delinquency cases.

Many of the children who come before the JDR Court on delinquency matters have mental and emotional problems that are similar to those of children who come before the local Family Assessment and Planning Team for services under the Comprehensive Services Act. As described in detail in Chapter I of this Report, the CSA combines several funding sources and targets certain children with serious mental health disorders for interventions. CSA funds are sent to localities, which are required to match state funding to provide services for a subset of children with serious mental health needs—the so-called "mandated children."[134] Other children, the "non-mandated children" may also receive services but that is a local option and the numbers of non-mandated children receiving services varies by jurisdiction and the economy.

Delinquent children coming before the JDR Court, however, normally are not "mandated" for services under the CSA and because of the budget limitations faced by most communities administering the CSA few if any "non-mandated" children receive

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[132] In 2007, the Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention posted an RFP for the evaluation of Juvenile Drug Court Programs so data about the efficacy of such courts may be forthcoming. The RFP's purpose was stated as: "an independent evaluation of the strategies employed in juvenile drug courts and their impact on the behavior of participating youth. The evaluation's findings should contribute to a more comprehensive assessment of juvenile drug courts and their role in assisting substance-abusing youth involved in the juvenile justice system." See: http://ojjdp.ncjrs.org/grants/solicitations/2006juvdrugcts.pdf.

[133] Evidence-based practice refers to a body of scientific knowledge about treatment practices and their impact, in the context of this Report, their impact on children with emotional or behavioral disorders. Evidence-based practice refers to treatment approaches, intervention and services, which have been researched and shown to make a positive difference for children. For more information see *Evidence Based Practice, Beliefs, Definition, Suggestions for Families*, a report developed by The Association for Children's Mental Health, available at: http://www.acmh-mi.org/41447_ACMH_Booklet.pdf.

[134] CSA provides sum-sufficient funding *only* for those children who are at risk of entering foster care, children in foster care, and children needing special education services that extend beyond the classroom. These are CSA's "mandated children."

CSA-funded services. The result is that many children with severe emotional and behavioral disorders may be committed to the DJJ, in part, because they cannot access community-based mental health services or alternative residential services, through the CSA. Ending up committed to the custody of the DJJ based on a lack of appropriate mental health services in the community is not only unfair and particularly stigmatizing to the child but it also associates treatment with punishment, and isolates the child from family and community. None of this contributes to the well being of the child. Rather, it undermines the value of any treatment the child may receive while in DJJ custody and increases the likelihood of recidivism and life-long problems for those incarcerated. Public policies should be crafted to promote the mental health of children and reduce their contact with juvenile justice to the extent required for public safety.

The CA Task Force makes the following Recommendations concerning services needed at sentencing:

Recommendation II.20. The Department of Juvenile Justice should screen children who have been adjudicated by the Court as CHINS or delinquent for substance abuse and mental health problems when there is any indication of such problems. The results of these screenings shall be provided to the JDR Court or Court Services Unit for appropriate referral.

VIII. Re-Entry: The Return Of Children From Commitment To The Community

The General Assembly has recognized that a number of children committed to the DJJ have significant mental health, substance abuse, and other therapeutic treatment needs, and that the capacity of these children to live successfully in the community upon their discharge from the DJJ depends in large part upon these children receiving appropriate services for their condition following their discharge. Through Section 16.1-293.1 of the Virginia Code, enacted in 2005, the General Assembly requires the DJJ to develop regulations for planning and providing post-release services for children "identified as having a recognized mental health, substance abuse, or other therapeutic treatment need." Each child's pre-release plan must be in writing and completed prior to release from the DJJ. "The purpose of the plan," says the statute, "shall be to ensure continuity of necessary treatment and services."

Subsection B of Section 16.1-293.1 states that "[a]ppropriate treatment providers and other persons from state and local agencies or entities, as defined by the Board, shall participate in the development of the plan," along with family members and caregivers.

The DJJ has published regulations to comply with this Code requirement. The introduction to these regulations notes that of the 1000 juveniles the DJJ releases from commitment each year most have a mental health disorder. Specifically, the DJJ cites the following statistics:

- 60% of the males and 90% of the females have diagnosed mental health treatment needs (with 41% of males and 59% of females having "severe emotional disturbances");
- 50% had taken psychotropic medications prior to commitment;
- 25% had been psychiatrically hospitalized prior to commitment; and
- 70% had been identified as having "high treatment needs" for substance abuse services.

In spite of the clear mental health needs of the juveniles being released from its care and custody, the DJJ's introduction to its regulations notes that the DJJ lacks the authority to require other state or local agencies needed in the provision of services to these juveniles upon their release and state law does not require that collaboration.

Often, the only local authority even potentially capable of impacting the delivery of services to these children is the local JDR Court. Because of the remedial purposes of the JDR Court, it is appropriate that the JDR Court should have some ongoing jurisdiction over children returning to the community with a mental health services transition plan, to ensure that the services these children need are being provided. A hearing held in the JDR Court of the jurisdiction to which the child is released from the DJJ, within 45 days of that release, could ensure that the child is receiving needed services, and would serve to assess the child's condition and progress. As a matter of public policy, it is extraordinarily inefficient and ineffective to expend judicial and DJJ time, talent and resources on juveniles with mental health needs and then release them without the mental health infrastructure or oversight to assure they receive the mental health services needed to maintain their recovery and function well in their communities. However, until there are more mental health treatment resources in place for children, even the involvement of the JDR Court as a reviewing authority may have limited impact.

Although it is possible that other State and local departments and agencies involved in children's services will cooperate with the DJJ to provide the integrated ongoing treatment and services for children returning from commitment to the community set out as the policy goal of Virginia Code Section 16.1-293.1, it is likely that such cooperation will not be uniform across the State. If that goal cannot be realized through voluntary cooperation, the General Assembly should consider a statutory mandate for review of the status of these children and the implementation of their service plan by the JDR Court.

The CA Task Force makes the following Recommendations related to the release of juveniles from detention:

Recommendation II.21. Given the Department of Juvenile Justice's new regulations for the development and implementation of transition plans and services for children with mental health needs who return home from Department of Juvenile Justice commitment, the only Recommendation at this time is that the efficacy of those regulations be thoroughly reviewed by the Department of Juvenile Justice.

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CHAPTER III. INVOLUNTARY COMMITMENT

I. Background and Goals.

Children are subject to involuntary psychiatric in-patient commitment or mandatory outpatient treatment just as adults are. Children have the same constitutional rights of due process as adults since a child's liberty interests are implicated in the commitment process just as an adult's are. However, the juvenile commitment process, both from a policy perspective and from a procedural technical perspective, is very different for a number of reasons. Clearly, one difference is that juveniles are still within the custody of their parents or guardians whose rights then become involved in the child's commitment process. However, children who are aged 14 or older, are recognized by the law, in some respects, to have reached the age of reason and thus are given the right to object to involuntary commitment.

Procedurally, a child's commitment to in-patient psychiatric treatment or mandatory outpatient treatment may be initiated, like in an adult case, through an emergency or a temporary detention order issued by a magistrate. This action triggers the commitment hearing if the child or if the parent objects. Alternatively, unlike the case with an adult, a juvenile already held in secure detention can have a petition for involuntary commitment reviewed by a JDR judge.

The procedures for a child's commitment are detailed in a statutory scheme separate from that for adults (Virginia Code Section 16.1-3 et seq.). However, although some of the commitment and hearing procedures for children are unique, other procedures parallel those for adults. As a result, the juvenile statutes sometimes explicitly "bridge" to the adult statutes (by cross reference) rather than restate the procedure in the juvenile code. Although this effort was, no doubt, to promote efficiency in the Code, "bridging" frequently results in confusion in statutory interpretation. The need to bridge the juvenile and adult commitment statutes, which requires juggling different statutes located in different Code volumes, results in variability in interpretation among JDR Court judges and judicial officers. As a result, the CA Task Force recommends amending the juvenile commitment code to a freestanding statutory section with the "bridges" eliminated.

In addition to the need to re-examine the bridge statutes, there are other provisions of the juvenile commitment statute that should be revisited. One is the required location for a commitment hearing discussed in detail in Section II below.

Furthermore, although there is a general awareness of the problems with applying the juvenile commitment statutes, there is little information available regarding how juvenile commitment hearings are held and their outcomes. In order to prepare this Report, the Subcommittee on Involuntary Commitment interviewed JDR Court judges who conduct commitment hearings, spoke to representatives from the Commonwealth Center for

Children and Adolescents, and reviewed the Commission's Hearings Study.[135] The Subcommittee also reviewed the juvenile commitment statutes and procedures from numerous other states. The CA Task Force charged its *Subcommittee on Involuntary Commitment*, with examining issues related to the juvenile commitment process according to the CA Task Force's fifth goal:

5. Examine the process of the involuntary commitment of juveniles to psychiatric facilities to improve the quality of evaluation, to facilitate parental understanding and participation, and to improve the adjudication process of commitment when court intervention is necessary. Issues to be addressed under this goal are:

- **a. Examine statutory framework of the involuntary commitment statutes for issues involving timelines, filing, and location of hearings.**
- **b. Examine the issues involving special justices v. judges handling these hearings.**
- **c. Examine the issues involving the transportation and custodial treatment of the child so the child is not treated like a criminal and is given constitutional due process rights.**

Editorial Note: The Subcommittee made several recommendations for changes to the Virginia Code as part of the Commission's proposed reform package in December 2007. Those proposals were approved by the Task Force and by the Commission and were subsequently enacted by the General Assembly during its 2008 session. Because the CA Task Force Report was not completed until the fall of 2008, the rationale for the earlier changes is also included in this report.

II. Location Of Involuntary Commitment Hearing

There are at least two problems relating to the location of a juvenile mental commitment hearing. The first is the hearing's physical location, which can be either a courthouse or a mental health facility. The second problem involves the hearing's jurisdictional location, which, theoretically, could be either in the jurisdiction in which the child resides (as under the former statute or in the jurisdiction of the treatment facility where the child is being held pursuant to the TDO.[136] The latter location issue arises when a child is committed to a treatment facility away from his or her city or county of residence, which frequently happens due to the paucity of juvenile psychiatric beds in Virginia. Often,

[135] The Commission's Study of Commitment Hearings, May 2007, (the "Commission's Hearings Study") assessed the practices and outcomes of over 1500 civil commitment hearings in Virginia and found significant variation in the use of personnel, whether CSB representatives or Independent Examiners were present at the commitment hearings, whether family members were involved, what kind of evidence was used, how long the hearings took and the outcomes of commitment hearings.

[136] In July 2006, Virginia Code § 16.1-340 was amended so that involuntary commitment hearings are held by the court in the jurisdiction where the child is located, rather than where the child resides, which was the previous practice.

when a child is committed to the "nearest" facility, that facility is many miles and hours away from the child's home.

The benefit of the 2006 amended statute is that a juvenile no longer has to travel from the treatment facility where he or she is being detained to the home jurisdiction for the commitment hearing. The consensus is that it is less emotionally disruptive for the child to have to travel any distance for the commitment hearing, including travel from the treatment facility to the courthouse. Transportation often involves police cars and handcuffs, circumstances themselves that can generate behavioral problems. However, according to a survey conducted on behalf of the Commission, in May 2007, 71.8% of children's commitment hearings took place in courthouses; only 25.6% took place in treatment facilities.[137] So, while the 2006 Code amendment may have decreased the length of travel, it did not completely eliminate the problems generated by any travel by law enforcement. It is possible, however, that the routine transport of children to courthouses for commitment hearings will change now with the 2007 Code amendments to permit juvenile commitment hearings to be held by Special Justices, who are more likely to travel to treatment facilities.

Another location concern is that many of the mental health facilities where juveniles subject to civil commitment proceedings are taken are located some distance from the juvenile's home jurisdiction, especially in western Virginia. The statutory requirement that the commitment hearing be held where the child is detained, although having some benefits, also results in judicial inefficiency for making determinations concerning children who have a history of contacts with their home JDR Court. Often this location requirement means that the JDR Court judge who presides at a juvenile's commitment hearing is unfamiliar with the juvenile and his family circumstances and, additionally, lacks critical information about the mental health services available to the child in the locality where the child lives. This mismatch of hearing location and knowledge of the child and the available resources in the child's home community may impair a JDR Court's ability to make a meaningful choice between in-patient psychiatric commitment or mandatory outpatient treatment.

The location requirement for the juvenile commitment hearing creates other judicial and oversight issues as well. In many instances, JDR Court judges in the juvenile's home jurisdiction have dealt with the juvenile previously and would like to hear the commitment case as well since future judicial interventions may be warranted. For some juveniles, the location requirement for commitment hearings is even more problematic because they are already under supervision through their home jurisdiction's Court Services Unit.

An unequal burden has also been placed on the few jurisdictions where children's psychiatric hospitals are located. These few JDR Courts are now hearing almost all of the

[137] Commission's Hearings Study.

juvenile commitment hearings. Even with Special Justices presiding over some of the hearings, the burden on the clerk's office in these JDR Courts is significant.

For many juveniles detained in a psychiatric facility and who may require a period of inpatient treatment, even moving the juvenile to the nearest JDR Court, rather than conducting the hearing on site, is disruptive and may further disrupt the child's mental stability. Having Special Justices hear these cases in the psychiatric facility addresses part of this problem.

The CA Task Force agrees that the best solution to these various problems is to have the option of holding juvenile commitment hearings by video-conferencing, a procedure already allowed by Virginia statute but impractical in many jurisdictions because some psychiatric facilities and JDR Courts either do not have the technical capability to make video-conferencing possible or are unwilling to use it.

Recommendation III.1. The General Assembly should amend Virginia Code § 16.1-340 so that the commitment hearing could be held in either the home court or the court where the juvenile is located, keeping both options open. If the law is so amended the default jurisdiction should be where the child is located. The home court would have 24 hours, or until the next business day if the 24-hour period ends on a holiday or weekend, to claim jurisdiction, otherwise the hearing would be held in the jurisdiction where the juvenile is located.

The CA Task Force would prefer to see Recommendation III.1 enacted immediately but realizes that that is impractical until video-conferencing juvenile commitment hearings is a real choice for judges. Because some of the juvenile psychiatric facilities are state facilities and some are private, the incentives to accommodate video-conferencing may have to be varied. One option to consider is that hospitals with psychiatric beds be required to have the capability to hold commitment hearings by video-conferencing.

Recommendation III.1 will also require that Office of the Executive Secretary study whether the timelines allowed for the juvenile commitment hearing process will be sufficient to give a home jurisdiction time to set up a hearing and provide notice to the parties if the home jurisdiction judge opts to hear the commitment by video-conferencing. It is our sense that those timelines may not be sufficient because our Recommendation gives a JDR Court 24-hours to claim jurisdiction, a period that would be subtracted from the total TDO period.

Recommendation III.2. When feasible, the Juvenile and Domestic Relations Court in the jurisdiction where the juvenile resides should use video-conferencing to avoid having to transport the juvenile back to the home jurisdiction.

III. Transportation

Unless the commitment hearing is conducted in the facility where the child will receive treatment, the child will have to be transported. However, since a child may be in crisis or have serious behavioral issues, there is often no safe means of transporting a child to a facility, even for voluntary treatment. As a result, a temporary detention order ("TDO") is often issued, which will guarantee that law enforcement will transport the child.[138] However, having law enforcement involved is often traumatizing since such transport often includes transporting a child in handcuffs. According to a survey of CSBs in June 2007, of the 106 juveniles transported in police custody, restraints were used on 44.8% of those juveniles.[139] If safe, alternate transportation were available, it is expected that the number of children where TDOs are issued to access transportation for juveniles will be reduced. The Subcommittee has reviewed the transportation proposal prepared by the Commission's (Adult) Civil Commitment Task Force, and hereby endorses the three-tiered approach envisioned by that group with some modifications appropriate for children:

1. Low level of risk (no restraints):
    - A family member or friend could transport the child.

2. Medium level of risk, the child could be transported by:
    - Ambulance attended by CSB staff or by personnel specially trained in the use of techniques and restraints necessary to meet an emergency; or
    - Ambulances or other vehicles for transport would be unmarked to eliminate the stigma associated with the commitment process.

All such vehicles would be equipped with necessary medical equipment.

3. High level of risk, children could be transported by:
    - Law enforcement where danger is a serious risk under the circumstances (this would include children coming from detention); or
    - Officers trained in CIT approaches and using secure but unmarked vehicles would provide the transportation.

The Magistrate, Special Justice, or JDR Court judge upon the advice of CSB screeners/experts would make designation of the appropriate level of transport.

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[138] By statute, throughout the civil commitment process, upon an ECO, a TDO, or commitment order, law enforcement must transport the individual. Virginia Code §§ 37.2-809, 37.2-810 and 37.2-813 through 829.
[139] The Commission's CSB Emergency Evaluation Study.

The following have been identified as transportation needs for juveniles in the treatment and/or commitment process:

- voluntary treatment not involving admission to a facility;
- voluntary admissions before an emergency custody order ("ECO")[140] or temporary detention order[141] is issued;
- transport for an ECO evaluation;
- transport to a holding facility pursuant to a TDO;
- transport to commitment hearing;
- transport for transfers between treatment facilities;
- return home after disposition of an ECO, TDO or commitment proceeding.

IV. Temporary Detention Orders

Under Virginia law, after a prescreening by a mental health professional (usually with the CSB) and a finding that the civil commitment criteria are likely met, the civil commitment process is triggered with the issuance of a TDO. A TDO provides an individual (adult or juvenile) may be held for a more extensive clinical evaluation to determine whether he or she meets the statutory criteria of either an inpatient admission or mandatory outpatient treatment.[142]

Juvenile commitment hearings held pursuant to Virginia Code § 16.1-340 and 341 involve two situations:

a) children who are already in detention and are TDO'd from a detention facility: or

b) children who are at home or in the community who are TDO'd because their parents cannot safely transport them, their parents have not been contacted, or their parents have not given consent to the commitment.

These two situations trigger an involuntary commitment hearing. Due to the short time period within which the involuntary commitment hearing must be held, court clerks have difficulty getting information about the juvenile quickly enough to notify all necessary and interested parties so they can participate in the hearing.

For juveniles coming from detention, the court clerk has to determine the juvenile's home court and contact the home court to get the names of the juvenile's attorney, the Commonwealth's Attorney, and contact information for the juvenile's parents or guardian. The home JDR Courts, especially certain large JDR Courts, often do not

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[140] Code of Virginia § 37.2-808. Under certain circumstances a person suspected of having a severe mental illness may be briefly taken into custody for an evaluation and assessment of the need for treatment. Under Virginia law, upon a determination that there is probable cause to believe a person meets the statutory civil commitment criteria, is in need of hospitalization or treatment, and is unwilling to *volunteer* for that treatment, a magistrate may issue an ECO for a police officer to take the person into custody.

[141] Va. Code Ann. §§ 37.2-815 and 37.2-817. See Section IV of this Chapter.

[142] The 2008 General Assembly extended the 72 hour TDO period to 96 hours.

respond in a timely manner, making it very difficult to properly notify the necessary parties.

Recommendation III.3. The clerk of each Juvenile and Domestic Relations Court should designate a specific person in the clerk's office to deal with juvenile involuntary commitment hearings. The Supreme Court's Office of the Executive Secretary should maintain a master list of these contacts.

Recommendation III.4. The General Assembly should amend the Virginia Code so that detention homes are required to send pertinent information they possess to the court (names of attorneys, guardian ad litem, home court, judge, etc.). This way the information travels with the juvenile.

Recommendation III.5. The General Assembly should revise the Virginia Code so that the 72-hour time frame of a TDO is extended to 96 hours (including an additional 24 hours for weekends and holidays). [Note: this Recommendation was accepted and became law on July 1, 2008].

Recommendation III.6. The General Assembly should revise Virginia Code § 16.1-340 and 341 so that the 96-hour period starts with the filing of the petition for civil commitment, not the issuance of the TDO (as currently written, the Code is inconsistent on what starts the 72 hour time period). [Note: the Code was amended as of July 1, 2008, so that the 96 hour period now starts with either the filing of the petition or the issuance of the TDO, whichever is later.]

V. Involuntary Commitment Versus Voluntary Admission

Currently the Virginia Code does not permit juveniles in detention to be *voluntarily* admitted to psychiatric facilities (§ 16.1-345). Instead, they first must be TDO'd and an involuntary commitment hearing must be held. Changing the Virginia Code to permit the voluntary admission of a juvenile would alleviate some of the burden on JDR Courts since it would not trigger the 96-hour hearing requirement. There is a concern, however, that some children in detention might seek to be voluntarily admitted to a hospital so as to get out of detention.

Recommendation III.7. The General Assembly should amend Virginia Code § 16.1-345 to delete the language: "In no event shall a minor who has been properly detained by a juvenile and domestic relations district court, and who meets criteria for involuntary commitment, have the right to make application for voluntary admission and treatment as may otherwise be provided for in this section."

Recommendation III.8. The General Assembly should also amend Virginia Code §§ 16.1-338 and 339 to include this language: "A minor who has been hospitalized while properly detained for a criminal offense by a Juvenile and Domestic Relations Court shall be returned to the detention home following completion of a period of

inpatient treatment, unless the court having jurisdiction over the criminal case orders that the minor be released from custody."

VI. Monitoring Of Involuntary Out-Patient Treatment

Although involuntary outpatient treatment orders (also called mandatory outpatient orders or "MOT") for juveniles are rare (only 5% of all involuntary commitment orders issued),[143] recent events in Virginia have demonstrated the need to better monitor court-ordered involuntary outpatient treatment. Unfortunately, the infrastructure for monitoring that MOT is not well developed. If a JDR Court orders MOT, it is difficult for the judge to monitor whether the juvenile complies with the MOT and actually undergoes treatment. And, although CSBs are required to monitor the outpatient treatment for juveniles on Medicaid, no state entity is responsible for monitoring juveniles with private insurance, and it is very difficult for JDR Courts to enforce monitoring with private practitioners. The latter category, juveniles with private health insurance, is not insignificant. Of the juveniles assessed by the CSBs in June 2007, 28.1% had private insurance.[144]

A JDR Court judge does have the authority to issue a show cause contempt summons and to periodically call the juvenile back to court in order to monitor the child's compliance with the MOT order. However, to do this routinely would take considerable court time. In addition, it is unclear whether Special Justices, who since July 2007 are authorized to conduct involuntary commitment hearings for juveniles, have this authority to issue a show cause contempt summons or to order review of an MOT order.

The CA Task Force believes that JDR Court judges should address all compliance issues, even if a Special Justice issues the initial outpatient commitment order. Compliance issues involving children are unique because often the child is not complying because their parent or legal guardian is not transporting them to appointments. A Special Justice may not have the power to order the parents to do anything, but a JDR Court judge clearly does.

One problem with continued monitoring by the JDR Court is that commitment proceeding are civil in nature, and individuals with mental illness and their families would often prefer to have as little contact with the JDR Courts as possible and the perception of mental health treatment as a criminal process.

In 2008, the General Assembly amended the adult civil commitment code to include extremely detailed procedures for monitoring mandatory outpatient treatment for adults. These new procedures, however, do not apply to juveniles. Although there are many helpful elements of these new procedures that can be modified to apply to juveniles, the CA Task Force does not recommend their wholesale adoption and their application to

[143] The Commission's Hearings Study.
[144] The Commission's study of CSBs across Virginia, June 2007 ("The CSB Emergency Evaluation Study").

juveniles. First, juveniles are not adults in their mental development and there are also clear differences in the status of juveniles with their families. In addition, there are differences in the broader adult and juvenile commitment codes that make such a wholesale adoption impractical.

One such impracticality is that, as previously discussed, under current law commitment hearings for juveniles must be held where the child is located, which is often different from the child's home jurisdiction. This complicates the issue of mandatory outpatient treatment in that to develop a detailed treatment plan, the JDR Court may not be familiar with the availability of mental health services and providers in the child's jurisdiction. As a result of this location rule, it will be very difficult for a JDR Court judge or Special Justice to issue and monitor a mandatory outpatient order. This problem will be circumvented, however, if the General Assembly endorses CA Task Force's Recommendation III.1 to allow the hearing court to transfer the MOT to the jurisdiction where the child will reside.

Regardless of where the juvenile commitment hearing is conducted, the JDR Court judge or Special Justice who is considering ordering outpatient treatment must have sufficient information at the time of the hearing as to whether the home community has resources available to provide the necessary outpatient treatment. If the location rule is not modified, the best way to obtain information would be to have a designated CSB or DSS representative from the hearing location be required to coordinate with the home jurisdiction to assess the available resources. That representative should be present at all hearings where outpatient commitment is discussed. Additionally, to assess the feasibility of outpatient treatment for a juvenile a preliminary treatment plan should be presented at the commitment hearing. Furthermore, it is critical that a willing provider be identified in this preliminary treatment plan. No Juvenile Court judge or Special Justice should be permitted to order outpatient treatment unless a provider agrees at the time of the juvenile's commitment to provide such treatment.

The guidelines that a JDR Court judge or Special Justice should consider when deciding whether to order MOT for *adults* can be adopted and used for juveniles, with a few modifications. One clear difference from the adult guidelines is that a juvenile's parents or legal guardian must be involved in the development of and must agree to help implement the outpatient treatment plan. In addition, if a juvenile is 14 years old, or older, the juvenile must also agree to the treatment plan.

The Subcommittee and the CA Task Force spent a great deal of time discussing the thorny issue of monitoring compliance with the outpatient treatment order and determined that CSBs were best positioned to assume this task. There was consensus that parents should not be required to "police" their children since this may well interfere with the mental health treatment itself and adversely affect family dynamics. In addition, having the child's therapist be the party responsible for monitoring compliance might inhibit the confidentiality and trust necessary for this relationship to be productive. CSBs already have the legal responsibility to monitor compliance with MOT orders for adults, so it makes sense to require them to monitor MOT orders for juveniles as well. It must

be stressed, however, that this will be an additional responsibility for CSBs and CSBs will require additional staffing and funding.

As with MOT orders for adults, monitoring compliance with juvenile MOT orders will involve several elements. First, the CSBs must keep in contact with the juvenile's mental health provider to confirm appointments are being kept and progress is being made. If material problems with compliance with the MOT emerge, CSBs will have to file a petition for review in the JDR Court. Further, in instances where there is material noncompliance coupled with a danger of harm to self or others, the CSB may have to seek an emergency custody order ("ECO") or a TDO.

The CA Task Force and Subcommittee agreed that only JDR Court judges, not Special Justices, should preside over hearings to assess a juvenile's noncompliance with a treatment plan and the JDR Court is where the CSB should file the motion to review for a non-compliance hearing. This is a departure from the adult review proceedings, which permit either a district court judge or Special Justice to deal with noncompliance issues. However, it is the consensus of the CA Task Force that JDR Court judges are better situated to oversee juvenile compliance with MOT for several reasons. First, not only are they are more readily available to review a non-compliance issue on short notice, but their extensive experience with and knowledge of juvenile behavior make them better equipped to assess whether the facts of non-compliance in particular cases reach the level of "materiality." Secondly, Juvenile Court judges also have more legal tools available to them to deal with noncompliance than do Special Justices.

In cases of non-compliance, the CA Task Force considered having the CSB file a petition to show cause instead of a petition for review. However, since a show cause petition carries criminal connotations, a motion for review is better suited to deal with questions of a juvenile's compliance with an outpatient treatment plan. When a motion for review of an MOT order is deemed necessary, it should be filed in the clerk's office and docketed by the JDR Court as soon as possible with notice to all parties including the juvenile, the parent or legal guardian, the petitioner, and the providers listed in the MOT order. Upon the filing of a motion for review, an attorney and a guardian ad litem should be appointed for the juvenile, if the juvenile does not already have one.

At the MOT review hearing, the JDR Court judge will hear from the parties regarding the issue of noncompliance and make a determination of whether the juvenile is materially non-compliant with the treatment plan. However, if such a finding is made the JDR Court judge may only order inpatient commitment if there is a determination that juvenile meets the statutory commitment criteria at the time of this review hearing.

Since our Recommendation is that the CSB be the entity responsible for monitoring compliance with a juvenile's outpatient treatment plan, the question arises whether anyone other than the CSB should be able to file a petition for review of an MOT order. In certain cases it might be appropriate for a parent or guardian *ad litem* to file such a petition, but the consensus of the CA Task Force is that the inclusion of these parties in the statute might encourage frivolous filings. As a result, the CA Task Force's

Recommendation is the statute should identify the CSB as the solely responsible party for filing review petitions. Limiting the party responsible for filing such petitions, however, would not preclude another party from filing a petition for review, if the circumstances in a particular case so warranted it.

Recommendation III.9. The General Assembly should require the presence of a CSB or DSS representative at all hearings where juvenile outpatient commitment is being considered.

Recommendation III.10. The General Assembly should require the CSB to file a preliminary treatment plan at the commitment hearing where juvenile outpatient commitment is being considered.

Recommendation III.11. The General Assembly should specify that no Juvenile and Domestic Relations Court or Special Justice should have the discretion to order mandatory outpatient treatment for a juvenile unless the provider in the home jurisdiction has the resources and agrees to provide them.

Recommendation III.12. Before reaching a decision on whether to issue an order for mandatory outpatient treatment for a juvenile, a Juvenile and Domestic Relations Court or Special Justice must make the following findings: a) less restrictive alternatives to involuntary *inpatient* treatment have a genuine potential for improving the juvenile's mental health condition; b) the available outpatient resources have been investigated and determined to be appropriate; c) the juvenile has sufficient capacity to understand the stipulations of his outpatient treatment plan; d) the juvenile and the juvenile's family have expressed an interest in the juvenile remaining in the community; and e) the juvenile and the juvenile's family have agreed to comply with the treatment. Upon such findings, the Juvenile and Domestic Relations Court may conclude that the outpatient treatment set forth in the outpatient treatment plan can be delivered by the Community Services Board or other designated provider and the Juvenile and Domestic Relations Court or Special Justice shall by written order and specific findings so certify and order that the juvenile be admitted involuntarily to mandatory outpatient treatment.

Recommendation III.13. If the Juvenile and Domestic Relations Court or Special Justice determines that mandatory outpatient treatment is appropriate in a particular case, the mandatory outpatient order must include the following: a) specific information describing the ordered outpatient treatment plan and name the providers that have agreed to provide the services; b) the specific responsibilities of the juvenile as well as the parent or legal guardian in complying with the mandatory outpatient treatment order; c) if the hearing is not conducted in the juvenile's home jurisdiction, a transfer of jurisdiction from the court where the juvenile is located and hearing conducted, to the court of the juvenile's home jurisdiction; d) direction that enforcement of the mandatory outpatient treatment order take place in the juvenile's home jurisdiction by a Juvenile and Domestic Relations Court, not a Special Justice; e) a provision for the appointment of a guardian ad litem in the

juvenile's home jurisdiction; f) identify the entity responsible for monitoring the juvenile mandatory outpatient treatment order (presumably the CSB); and g) the ordered length of treatment, which cannot exceed 90 days.

Recommendation III.14. The CSB in the juvenile's home jurisdiction should be responsible for monitoring compliance with juvenile mandatory outpatient treatment orders. The CSB should notify the Juvenile and Domestic Relations Court of any possible material noncompliance by filing a motion for review. In situations where there is both material noncompliance and the likelihood that civil commitment criteria exist, the CSB should immediately petition for an ECO or TDO.

Recommendation III.15. The General Assembly should provide additional funding to CSBs commensurate with their additional responsibilities for developing mandatory outpatient treatment plans and monitoring the compliance of juveniles to these plans

Recommendation III.16. Juvenile and Domestic Relations Court Judges, not Special Justices, should handle all petitions for review of mandatory outpatient treatment orders.

Recommendation III.17. Juvenile and Domestic Relations Courts may only order in-patient commitment at mandatory outpatient treatment review hearings if the juvenile meets commitment criteria at the time of the review hearing.

Recommendation III.18. The CSB may file a petition for rescission of the mandatory outpatient treatment order or a petition for renewal of the mandatory outpatient treatment order, as it can for such adult orders, but any renewal would not exceed 90 days for juveniles.

Recommendation III.19. The DMHMRSAS pre-admission screening form, used by CSBs in assessing whether an individual meets the criteria for civil commitment, should include a question to indicate whether a juvenile is under a mandatory outpatient treatment order.

Recommendation III.20. When enacting the legislation proposed by the CA Task Force, the General Assembly should specify whether any new mandatory outpatient treatment procedures should apply retroactively to any orders in effect on when the new legislation takes effect.

VII. Timelines[145]

[145] Note: on July 1, 2008, the General Assembly amended the timeline to 96 hours in accordance with the Recommendations in this section.

As discussed above, JDR Courts are required to hold an involuntary commitment hearing within 72 hours of a TDO and it can be very difficult to prepare for a hearing in such a short period. It can also be difficult to have the independent evaluation performed within this short time period. This is especially problematic when a child is admitted over the weekend or on a holiday.

It does not appear that a 24-hour extension of the commitment timeline will violate the due process clause, as there is a reasonable basis for this brief and limited extension. Statutes from other states have been affirmed in which hearings were held as long as 7-45 days after admission. Numerous other jurisdictions have timelines much longer than Virginia's. Some examples are set forth below.

- Ohio law requires the initial judicial hearing to be held within 5 days of a juvenile's detention, but the full court hearing only needs to be held within 30 days of the initial hearing (Ohio Code §§ 5122.141 and 5122.15).
- New York law allows a juvenile to held up to 15 days based on medical certification alone, and a hospital can hold the patient based on two certifications for another 60 days without a court order (New York Code §§ 9.39, 9.27, 9.33).
- In South Carolina, the juvenile involuntary commitment hearing needs to be held with 15 days of the petition being filed (South Carolina Code § 44-17-410).
- In Delaware, the juvenile involuntary commitment hearing must be held within 8 days of the filing of the complaint (Delaware Code § 5008).
- In Kentucky, a juvenile can be held for 7 days before a hearing is held (Kentucky Code §§ 645-060 and 645.120). In Maryland, the juvenile involuntary commitment hearing must be held within 10 days of the filing of the petition (Maryland Code § 10-632).
- In North Carolina, all juveniles who are admitted to the hospital, whether voluntary or involuntary, must have a hearing within 15 days of admittance (North Carolina Code § 122C-224(a)).

The CA Task Force makes the following Recommendation to extend the TDO period to permit more time to assess the juvenile and review other materials pertinent to the hearing:

Recommendation III.21. The General Assembly should amend the commitment legislation to extend the 72-hour TDO deadline by 24 hours in all cases. (Amended to 96 hours as of July 1, 2008).

VIII. Magistrates Versus Intake Officers

Currently in Virginia, magistrates have the authority to issue TDOs for juveniles (although some Magistrates will not do so). The CA Task Force questions whether,

without a requirement for specific training on juvenile mental health issues, it is appropriate to permit magistrates to perform this function. The CA Task Force also concludes that the bridge language in Virginia Code § 16.1-340 to the adult TDO section of the Code be removed because such bridges foster confusion in interpreting the juvenile commitment requirements. Instead, the consensus of the CA Task Force is that all TDO requirements for juveniles should be written directly into the juvenile code. In addition to some confusion generated by having bridge language, a key reason for this recommended legislative change is that by having the statutory bridge to the adult civil commitment language, magistrates apparently must apply adult criteria to juveniles when deciding whether to issue a TDO. The CA Task Force does not view this as appropriate.

Recommendation III.22. The General Assembly should amend the Virginia Code to require Intake Officers to issue temporary detention orders relating to the inpatient treatment of minors. Intake Officers currently make determinations on whether juveniles should be detained, and are familiar with many issues specific to juveniles. The Intake Officers may even know the juveniles already. To support Intake Officers in this additional responsibility, however, they will need significant additional training and funding.

Recommendation III.23. If magistrates continue to have the authority to issue TDOs for juveniles, the CA Task Force recommends that the Office of the Executive Secretary should provide training directed at mental health issues specific to children and adolescents. Magistrates should also be required to gather the same information that intake officers gather about the juveniles, which is listed in detail in Virginia Code § 16.1-260.

Recommendation III.24. The General Assembly should amend the Virginia Code to remove the bridge language in § 16.1-340 to §§ 37.1-67.01 or 37.1-67.1. It should also amend the juvenile Code to include procedures for issuing TDOs. Because of the existing bridge to the adult statute, magistrates must apply inappropriate adult commitment criteria to juveniles when deciding whether to issue a TDO.

IX. Oversight And Training Of Special Justices

The General Assembly passed a bill in 2007, SB738, which permits Special Justices to conduct involuntary commitment hearings for juveniles. In light of this recent change in the law, the CA Task Force recommends additional oversight and training for Special Justices.

Recommendation III.25. The Office of the Executive Secretary should survey consumers on a regular basis to determine their level of satisfaction with the juvenile involuntary commitment process.

Recommendation III.26. The Office of the Executive Secretary should require ongoing training for Special Justices every two years (the training could be for Continuing Legal Education credit so as to encourage attendance).

Recommendation III.27. The General Assembly should amend the Virginia Code to require that the Chief Judge of the Circuit Court consult with the Chief Justice of the Juvenile and Domestic Relations Court on appointments of Special Justices who will be hearing juvenile mental commitment cases.

Recommendation III.28. The General Assembly should amend the Virginia Code to have the Chief Judge the Juvenile and Domestic Relations Court be the supervising judge for special justices appointed to hear Juvenile and Domestic Relations Court hearings.

X. Other Recommended Statutory Changes

The CA Task Force also makes the following Recommendations (some of which were made to the General Assembly prior to the final release of this Report):

Recommendation III.29. The Virginia Code is unclear regarding whether the independent examiner must be present during the commitment hearing so the statute should be clarified. Section 16.1-342 states that the independent examiner shall attend the commitment hearing as a witness, but § 16.1-344 says that the parties may stipulate to the examiner's report. As a result of this conflict, some courts are requiring their presence and other courts are not if the parties stipulate to the report. Based on the results of Commission's Hearings Study, it appears that independent examiners attend 70% of the commitment hearings.

Recommendation III.30. Paragraph 4 of Virginia Code Section16.1-341 should be amended so that "dismissed" is changed to "withdrawn," since the petition cannot be dismissed until the commitment hearing is held. (Note: this change was made by the General Assembly and went into effect on July 1, 2008).

Recommendation III.31. The General Assembly should amend Virginia Code § 16.1-339 so that it includes minors who are not capable of giving informed consent. Section 16.1-339(C) should be amended so that the word "immediately" is taken out. This term does not give a specific time frame and when a patient is admitted over the weekend, a petition cannot be filed until the next business day. This Section should read, "the facility shall file a petition for judicial approval within 24-96 hours of admission with the juvenile and domestic relations district court…" (Note: this change was made by the General Assembly and went into effect on July 1, 2008)

Recommendation III.32. The General Assembly should amend Virginia Code, Section 16.1-341 so that a guardian ad litem is appointed for the juvenile just as they are in hearings conducted under §16.1-339. Another option would be to amend both § 16.1-339 and 341 so that a court could appoint a court appointed attorney and a

guardian ad litem when appropriate in both situations. (Note: the General Assembly amended these sections so that counsel and guardians ad litem are appointed in both situations. This change went into effect on July 1, 2008).

Recommendation III.33. The General Assembly should amend the Virginia Code to remove or amend all statutes from the juvenile mental commitment chapter that "bridge to the adult mental commitment chapter to create a free-standing statutory scheme for the psychiatric treatment of minors.

CONCLUSION

Children with mental health needs are among the most vulnerable members of society. The failure to provide early screening, diagnosis and treatment of their disorders is a missed opportunity to intervene and not only promote the health of affected children and their families but, also, to minimize or even prevent poor school performance, truancy, engagement with foster care and the juvenile justice system. Furthermore, inadequate access to community-based mental health services simultaneously increases the likelihood of a child coming before a JDR Court—whether under a foster care, CHINS, juvenile justice, or involuntary commitment proceedings—and constrains the options available to Intake Officers and JDR Courts in determining the appropriate disposition of a case. This result is skewing public policy toward judicially orchestrated interventions that, too often, are institutionally based.

This is a tragic and costly outcome. Tragic because, according to the Surgeon General's Report on Children's Mental Health,[146] the President's New Freedom Commission on Mental Health,[147] and countless other studies, early screening and intervention enables the vast majority of children with mental health needs to successfully live in their communities, complete school, and avoid judicial involvement as well as the stigma associated with it. It is costly, because judicial and institutional interventions have a higher price tag in the short run and, for many children, a lower success rate. In addition, the long–term costs of not treating or under-treating children with mental health needs includes higher rates of school drop-outs and substance abuse, repeated inpatient hospitalizations and encounters with juvenile justice, and a higher likelihood of graduating to the adult criminal justice system.

The CA Task Force examined the policy barriers and made Recommendations that would enable Virginia to more effectively address children with mental health needs by promoting mental health interventions, minimizing judicial involvement and enabling JDR Courts to better achieve their statutory mandate to construe the law "liberally and as remedial in character."

[146] See footnote 73 of this Report.
[147] See footnote 75 of this Report.

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APPENDIX A

System of Care for Children and Families
Comprehensive Services Act
Hampton, Virginia

Multiple child-serving agencies in Hampton entered into a collaborative relationship several years before the implementation of the Comprehensive Services Act. The City was lauded in an article in the magazine *Governing* (1997) and also received national recognition for the Healthy Families Partnership, begun in 1992 as part of Healthy Families America, a program designed to support new families in helping their children get off to a good start. It was the beginning of community collaboration that continues today.

Trust and positive working relationships had been established and were easily transferred to the CSA process. Leaders mention that as they entered into CSA, they were FAPT and CPMT members, first, and agency representatives, second. In addition, many of those leaders also believed that children have better outcomes when served in their homes and their communities.

Like most communities, Hampton's CSA got off to a rocky start, with residential treatment being utilized quite frequently. After a period of time, the City Manager intervened and told CPMT leaders that they must make changes that provided appropriate services for children and reduced the rising costs of sending children to congregate care. This led CPMT members to commit themselves to the development of community-based services.

There are several common themes among those early leaders when asked why Hampton has had such success. These themes include:

1. The trust and strong working relationships between and among child serving agency department leadership.

2. The trust and strong working relationships among elected officials and city government staff before the implementation of CSA.

3. City government's belief in innovation and best practices in serving children and families including viewing families as primary "natural" community resource.

4. Local leaders, department directors and program staff's firm belief that children had better outcomes served in the community rather than in out-of-home and out-of-community placements.

5. Selection of the private provider representative as the first CPMT chair.

6. Selection of the Hampton Department of Social Services Chief of Services as

the manager of the program.

7. Significant and consistent leadership and support from Hampton Juvenile and Domestic Relations Court Judges.

8. Development of a FAPT dedicated to CSA and co-located at DSS.

9. Designation of quality staff to FAPT who also served as CSA ambassadors at their agencies and in the community.

10. Clear focus, from the beginning, on creating innovative community-based services and brining children home from out-of-community residential treatment centers.

11. Development of a FAPT support team including a strong CSA coordinator.

12. The commitment of member agencies to offer additional resources to support CSA including the development of robust children's mental health system by the Community Services Board; utilization of 297 Funding and VJCCA funding by the Court Services Unit; the development of a regional school approach for special needs students by Hampton City Schools; commitment of a dedicated FAPT by the Health Department and the development of a significant number of private agencies that provided strengths-based, community-based alternatives to out-of- home and out-of community placements.

In 2007, the Hampton FAPT commissioned an evaluation and a report of the progress made. Conducted by Triad Training and Consulting Services, the Hampton Report provides a review of the growth and progress of Hampton's community-based mental health approach for children and adolescents as well as several significant findings resulting from the strong collaborative system of care that has been developed for children through this process. These findings are:

- Hampton seldom utilizes residential treatment as a service option. Only 2% of all mental health services for children and adolescents funded by Hampton in the third quarter of 2005 were for residential treatment services. This was the lowest percentage allocated for residential services of all communities measured for the Hampton Report utilizing the Office of Comprehensive Services Data Set information for third quarter of 2005.

- Hampton significantly utilizes community-based services as an alternative to out-of-home and out-of-community placement. 36% of all services funded by Hampton in the third quarter of 2005 were community-based services. It should be noted that the total, 100% of CSA Expenditures, includes categories such as foster care maintenance, day care etc.

- Hampton's rate of increase in CSA funded services has been significantly lower

than Virginia's statewide increases. From 1994-2005 the cumulative statewide increases in CSA expenditures were 161%. The Hampton cumulative increases for the same time period were 39%.

- Hampton and Newport News were the only localities reviewed for the Hampton Report that had **no** children placed out of state as reported by the third quarter 2005 CSA Data Set.

- There has been a strong commitment to multi-agency collaboration since 1993 to support children and families remaining together in the community. Multiple collaborations have resulted in the development of innovative programs by all CPMT member agencies. Projects include intensive care management, specialized foster care, the teaching parent approach, family reunification and intensive in-home services.

- Hampton has long emphasized prevention and early intervention services. The Hampton Healthy Family Partnership has played a significant role in inter-agency collaboration and reducing the need for intervention services.

- Even high needs children do well with community placements. For example, the Specialized Foster Care Project has supported children with significant needs remaining in the community as evidenced by 84% of the youth having academic problems; 80% of the youth having physical aggression issues; 61% of the youth having depressive symptoms; and 30% of the youth having suicidal or self harmful behaviors.

- The Specialized Foster Care Project has shown significant success as evidenced by the fact that 92% of the children in the project during the past 12 months remaining in their specialized foster home, moving to a less restrictive environment or being adopted.

- Another success was measured by the fact that one specialized foster home "closed" last year after the family adopted the children in the specialized home.

- The Specialized Foster Care project serves children and families with complex needs. One year ago 38% of children in specialized foster homes had a CAFAS score of 100 or higher. 42% of children in specialized foster homes at the time of this report had CAFAS scores of 100 or higher. This demonstrates the Hampton CPMT and FAPT's ability to support children who need mental health and behavioral health services in community settings.

(From ***Historical Perspectives, Data, Outcomes and Practice Improvement Project,*** by Triad Training and Consulting Services, 2007. Commissioned by the Hampton Community Policy and Management Team).

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APPENDIX B

Steps in the Virginia Juvenile Justice System[148]

- The juvenile enters the system when an offense is committed and reported by a parent, citizen, agency complaint, or the police.

- If the juvenile entered the system through police contact, a decision is made whether to counsel and release the youth back to the community or to arrest. If a parent, citizen, or agency made the complaint, then the complaint goes to intake.

- An intake officer at the court service unit makes the decision whether to take informal action such as crisis-shelter care, detention outreach, or counseling; to take no action; or to file a petition. In some cases, a police officer or the original complainant will appeal to the magistrate if they disagree with the intake officer's decision. The magistrate must certify the charge and the matter is returned to intake to file a petition.

- Once a petition has been filed, an intake officer decides if the juvenile should be detained or released to his or her parents/guardians. The decision is based on the juvenile's risk to self, community, or flight.

- If the decision is made to detain the juvenile, a detention hearing is held within 72 hours in the Juvenile and Domestic Relations District Court to determine the need for further detention and examine the merits of the charges.

- A preliminary hearing is held to ensure that the case has enough merit to carry it to trial. Issues of competency, insanity, subpoenas, and witnesses are also addressed. If no probable cause exists, the case is dismissed. If cause is determined then the case moves to the adjudicatory hearing. Also during this phase issues of transfers and waivers are addressed by the court. If certification is ordered or a direct indictment issued, the case goes to the circuit court (see sections 12-13).

- Innocence or guilt is determined at the adjudicatory hearing. Witnesses and testimony are presented similar to an adult trial. If found not guilty, the case is dismissed. If found guilty, a dispositional hearing is held.

- At the dispositional hearing, the pre-disposition report (social history) is used to assist in selecting appropriate sanctions and services. The court decides if the juvenile will be committed to DJJ or face community sanctions such as warnings, restitutions, or fines. A conditional disposition may be imposed such as probation, which includes participation in CSU programs, referral to local services or facilities, to other agencies, to private or boot camp placement, or to post-dispositional detention. Once the requirements have

[148] Taken from the Virginia Department of Juvenile Justice's website. Available at: http://www.djj.state.va.us/About_Us/JuvenileProcess.aspx.

been met, the juvenile is released by the court.

- If committed to DJJ, the juvenile must undergo psychological, educational, social, and medical evaluations conducted at RDC.

- From RDC, the juvenile may go to a privately operated residential facility or a juvenile correctional center (JCC). At the JCC, a committed juvenile receives 24-hour supervision, education, treatment services, recreational services, and a variety of special programs.

- After completion of the commitment period, a juvenile may be placed on parole or directly released. During parole, the juvenile transitions to the community through agency program efforts and is afforded local services. Some juveniles may need 24-hour residential care and treatment services provided by a halfway house. Upon completion of parole or entry into the adult criminal justice system, the youth is discharged from the system.

(Appeals Process and Circuit Court Cases) A case may be sent into the appeals process following the dispositional hearing. After presentation to the circuit court, the case is reconsidered and the issue of guilt is examined. If the juvenile is found not guilty, the case is dismissed. If found guilty, the circuit court judge administers an appropriate juvenile disposition.

- If the circuit court received the case through a direct indictment, a trial will take place. If found not guilty, the case is dismissed. If found guilty, the judge will decide whether to render a juvenile disposition or an adult sentence.

APPENDIX C

Virginia Beach
Family Crisis Team Information Sheet[149]

The following is an outline of Virginia Beach's Family Crisis Team ("FCT") approach to minimize the use of secure detention for juveniles who are being detained for a misdemeanor or non-violent felony committed against a family member. Referrals to this program can be ordered by the Juvenile and Domestic Relations Court ("JDR") judge at the child's detention hearing upon the recommendation of the Intake Officer or another Court Services Unit ("CSU") officer.

Virginia Beach's FCT approach is a pre-adjudicatory program that places the child (defendant) in a non-secure shelter care placement and provides services in the home to which the child then returns. The goal of the program is to work out the family problems within six weeks and if such resolution is possible recommend that the JDR Court judge dismiss the charge(s) at the end of the six-week period. Virginia Beach's FCT is not a CHINS program although the issues and solutions are similar to some CHINS cases. In addition, it is not a true diversion program but rather semi-diversionary because the Intake Officer does issue a petition which a JDR Court judge must resolve.

Target Population[150]

- Juveniles removed from the home because of aggressive behavior
- Juveniles charged with domestic violence, destruction of property or disturbing the peace.

Goals

- To provide youth and family with anger management tools
- To provide modeling, role-playing and performance feedback to youth and family regarding anger management skills
- To successfully return youth home within six weeks.

Referral Process

1. Intake makes the initial referral by contacting a less secure facility for placement and informing staff the case is being referred to FCT. Intake writes on shelter care order: "Refer to Family Crisis Team."
2. The facility contacts the Challenge Outreach Program ("COP")[151] regarding the referral.
3. COP assigns the case to a worker who will meet with the family within 24 hours of placement.

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[149] From an outline prepared by the Court Services Unit.

[150] The target population for Virginia Beach's FCT intervention is not the CHINS population.

[151] The Challenge Outreach Program is a pre-trial supervisory program usually coupled with Home Electronic Monitoring.

4. The youth and family appear in court for a detention hearing. The court enters the FCT order.
5. The court refers the family to the CSU case manager who will explain the program and verify all client information.
6. The CSU case manager contacts COP to confirm the referral and fax copy of court order to COP.

FCT Process-Tentative

1. FCT meets youth and family within 24 hours of placement to explain the FCT program.
2. Develops safety plan to include a plan to manage disagreements.
3. House rules and expectations are developed to include: Home is to be a safe place free from put-downs, intimidation and subtle bullying. All parties to show respect and work to develop anger management skills.
4. Assess risk and protective factors to identify skills needed by youth and family.
5. Incentives and consequences developed to encourage the use of anger management skills.
6. Home passes (1-4 hours) will be allowed to transition youth back into the home.
7. Youth will remain in the secure facility a minimum of 72 hours.
8. COP will submit bi-weekly reports to CSU case manager.
9. Once the youth is released on COP, he can be returned to less secure prior to the court date.
10. The COP worker will call Intake to notify Intake of the need to have the youth return to less secure.
11. The COP worker will transport the youth back to less secure without coming to intake if thee is not a threat of the youth running away or being violent. If the youth is returned by the COP worker, Intake is to fax a new shelter care order to the facility. If the return occurs while the Intake Officer is on call, the order can be faxed the next day.
12. If the youth cannot be transported back to the facility by the COP worker and police assistance is needed, Intake will come out and complete a new shelter care order so the police can transport.
13. A youth being terminated my not necessarily return to the same facility he left. Population will still be the determining factor, but call the initial facility first.
14. Once the youth is returned to the facility, there is not detention hearing unless there are new charges filed.
15. The youth can be released from and returned to the facility multiple times and the goal is successful family reunification.
16. FCT will submit a final report to the court.

APPENDIX D

State Executive Counsel of the Comprehensive Services Act Guidelines for Relinquishment of Services[152]

FY 2005 Taskforce Recommendations

1. Recommend consideration of a "Section 1" bill or Joint Resolution establishing the intent of the Commonwealth to make behavioral health services available to children who need them without requiring parents to relinquish custody. Consider requiring reports to the Commission on Youth and/or the JCHC Behavioral Health Care Subcommittee on progress made in achieving this goal.

2. Establish a taskforce to review and recommend revisions to all sections of the *Code of Virginia* related to the implementation of non-custodial agreements with the intent of making these agreements less adversarial and onerous for families, to include but not limited to the following issues:

    - Criminal background checks
    - Co-payments
    - Child support payments

3. Amend the *Code of Virginia* to eliminate required criminal background checks of parents with children under non-custodial foster care agreements and temporary entrustments when children are returning home from placements (including residential placements, group homes, respite or treatment foster homes).

4. Through *Code* revisions or policy interpretation, ensure that children who receive CSA services through mandated special education eligibility and who have a diagnosis of a serious emotional disturbance receive the necessary behavioral health treatment services, supports, and case management specified in the individualized family services plans as approved by the Community Policy and Management Teams through CSA mandated funds.

5. Explore federal funding options allowable under Medicaid (including the Home and Community–Based Waiver, Katie Beckett Option, and EPSDT), FAMIS, and through Title IV-E waivers to expand access and availability of services for children. Ensure that the same eligibility and benefits, to the extent allowed by federal law, are

[152] *Report Of The State Executive Council Workgroup On The Relinquishment of Custody for the Purpose of Accessing Behavioral Health Treatment,* (November 2005). Full Report Available at: http://pn.psychiatryonline.org/cgi/content/full/40/2/8.

available for children under both Medicaid and FAMIS.

6. Increase access to community services through expanding the number of demonstration projects implementing system of care models focusing on evidence-based practices and incorporating the use of diversion protocols.

7. Funding Recommendations:

• Increase funding and fiscal incentives to encourage the development of community services statewide for mandated and non-mandated children.

• Increase funding for serving non-mandated children through the various state • Provide access to start up funds for localities to develop community services to prevent or return children from out of community placements.

• Incorporate the use of diversion protocols as community-based services are expanded in communities.

Conclusion

The primary conclusion initially reached by this workgroup in 2004 has not changed. The problem of parents being faced with the decision to give up custody of their child in order to obtain behavioral healthcare services is a direct result of inadequate access to and availability of prevention, early intervention, and intensive mental health and substance abuse treatment services for children and adolescents.

While the work of this taskforce concludes with this report, the State Executive Council and participating child serving agencies will continue to address the underlying causes of this practice and to implement improvements in Virginia's child serving system to improve access to care. Likewise, the Commonwealth should continue to support all efforts to make a full array of affordable behavioral health services available to children and adolescents based on their level of service need rather than their "mandated" or "non-mandated" status under the Comprehensive Services Act.

APPENDIX E

Crisis Intervention Teams and Other Police-Based Diversion and Intervention Programs for Persons with Mental Illness

The following overview of the Crisis Intervention Team ("CIT") program (Memphis model) is from the Memphis Police Department's web site.[153]

In 1988, the Memphis Police Department joined in partnership with the Memphis Chapter of the Alliance on Mental Illness ("AMI"), mental health providers, and two local universities (the University of Memphis and the University of Tennessee) in organizing, training, and implementing a specialized unit. This unique and creative alliance was established for the purpose of developing a more intelligent, understandable, and safe approach to mental crisis events. This community effort was the genesis of the Memphis Police Department's Crisis Intervention Team.

The Memphis CIT is made up of volunteer officers from each Uniform Patrol Precinct. CIT officers are called upon to respond to crisis calls that present officers face-to-face with complex issues relating to mental illness. CIT officers also perform their regular duty assignment as patrol officers.

The Memphis Police Department has approximately 225 CIT officers who participate in specialized training under the instructional supervision of mental health providers, family advocates, and mental health consumer groups. Due to the training, CIT officers can, with confidence, offer a more humane and calm approach. These officers maintain a 24 hour, seven day a week coverage.

The CIT Model has been instrumental in offering:

1. Special trained officers to respond immediately to crisis calls
2. Ongoing training of CIT officers at no expense to the City of Memphis
3. Establishments of partnerships of police, National Alliance on Mental Illness/Memphis, mental health providers, and mental health consumers.

The Crisis Intervention Team program is a community effort enjoining both the police and the community together for common goals of safety, understanding, and service to the mentally ill and their families. It is to these goals the Memphis Police Department stands committed.

MAJ Sam Cochran, the Memphis CIT Coordinator, also provides an overview of the program and his experiences with its impact on officers and the community in his article

[153] Available at: http://www.memphispolice.org/Crisis%20Intervention.htm.

"In My Opinion" found on the Police Department's web site http://www.memphispolice.org/Crisis%20Intervention%20Team%202.htm.

Although CIT programs are focused on a general population of persons with mental illness, CIT training has modules that address specific issues around special populations including juveniles. CIT provides the officer an opportunity to realistically assess the individual, the causes for the behavior and to consider options other than criminal charges.

Multiple studies, including some funded through SAMSHA and some funded through the National Institute of Justice, have shown positive outcomes for persons with mental illness whose crisis calls were handled by CIT trained personnel. These benefits include increased referrals for mental health care and reduced arrest rates at the law enforcement interface with individuals who are seriously mentally ill (Memphis CIT 2%, nationwide 20%).[1] Officer injury rates in Memphis have also declined drastically (1/7th of rate when CIT implemented); during the same period, injury rates for officers responding to disturbance of the peace calls had no such reduction. As of 2000, there was no quantitative data on citizen injuries; however, reports from the emergency service indicate that injuries to persons with mental illness appear to have decreased as well. Use of the TACT unit (similar to a SWAT team) has continued to decrease since CIT went into effect in Memphis. The rate for the four-year period prior to CIT implementation was .042 per 1000 events. For the 4 years from 1996-2000, the rate was .019 per 1000 events.[2]

CIT requires fairly significant culture changes for both the mental health and law enforcement systems. "For law enforcement, CIT focuses on training only as an adjunct to creating expertise within the patrol division. For mental health, it requires a willingness to take responsibility for the patients without preconditions. While these requirements might seem fairly basic in theory, they are often difficult to meet in practice."[3]

The Memphis model has been widely recognized and has been adopted by localities as diverse as New London (CN), Columbus (OH), Bloomington (IN), Albuquerque, Ventura County (CA), Arlington (TX) Chicago, Fort Lauderdale, Houston, Kansas City, Louisville, Montgomery (AL), Portland (OR), San Jose, Seattle, and in the New River Valley of Virginia.

The New River Valley Crisis Intervention Team (CIT) Program is the first program to adapt the Memphis model to a rural, multi-jurisdictional region. The program originated in 2002 when the Mental Health Association of the New River Valley received a community action grant from the Center for Mental Health Services. In 2005, the program expanded to include a CMHS funded Jail Diversion Grant which established the Bridge Program, a multi-county post-booking jail diversion program.

The New River Valley CIT program has trained nearly 160 officers from 13 local area law enforcement agencies and officers representing 25 agencies throughout the Commonwealth. The program also offers a two and a half day CIT Train the Trainer

program.

The **Consensus Project Report**, (June 2002) was authored by the Council of State Governments Justice Center and representatives of leading criminal justice and mental health organizations. This report, particularly Chapter II, is of interest in consideration of options. Chapter II reflects not only the CIT model, but also other intervention models that may be utilized when the person with mental illness first comes into contact with law enforcement. Although this document does not focus on children and adolescents as a separate target population, it does acknowledge that police encounter persons with mental illness of all ages as both victims and possible offenders, as witnesses and as persons who may present as a danger to themselves or others. The introduction of Chapter II sets forth many of the issues and concerns that have dominated discussions of the workgroup and set policy recommendations for addressing these issues.
Available at: http://consensusproject.org/the report/downloads.

Council of State Governments. *Criminal Justice / Mental Health Consensus Project*. New York: Council of State Governments. June 2002.

The National GAINS Center operates as a point for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system. The TAPA Center for Jail Diversion and the Center for Evidence-Based Programs in the Justice System, funded by the Center for Mental Health Services (CMHS) in 2001 in 2004 respectively, comprise the National GAINS Center.

"The GAINS Center's primary focus is on expanding access to community-based services for adults diagnosed with co-occurring mental illness and substance abuse disorders at all points of contact with the justice system. … The National GAINS Center in the Justice System is committed to the goal of transforming the nation's fragmented mental health system and developing a recovery-oriented, consumer-driven system of care… To accomplish this, the GAINS Center will develop a comprehensive plan of information dissemination, knowledge application and technical assistance strategies to further the implementation of evidence-based programs in the justice system"
http://www.gainscenter.samhsa.gov/html/about/

The following publications provide useful background on police-based diversion programs for persons with mental illness. These publications and the programs they report were funded through the Substance Abuse, Mental Health Services Administration (SAMHSA).
http://www.gainscenter.samhsa.gov/pdfs/jail_diversion/PERF.pdf.

Reuland, M. (2004) ***A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness.*** Delmar, NY: GAINS Technical Assistance and Policy Analysis Center for Jail Diversion. This work was conducted under SAMSHA funding.
http://www.gainscenter.samsha.gov/pdfs/jail_diversion/PERF2.pdf.

Reuland, M. & Cheney, J. (2005). ***Enhancing Success of Police-Based Diversion Programs for People with Mental Illness.*** Delmar, NY: GAINS Technical Assistance and Policy Analysis Center for Jail Diversion. This work was conducted under SAMSHA funding.

[1] Clay, Rebecca A. "Jail Diversion Programs Enhance Care," SAMSHA News, Volume VII, No. 2, Spring 2000.

[2] Dupont, Randolph & Cochran, Sam. "Police Response to Mental Health Emergencies-Barriers to Change", *Journal of the American Academy of Psychiatry Law* 28:338-44, 2000.[3] Dupont and Cochran, op. cit.

APPENDIX F

COMPREHENSIVE SERVICE PROGRAMS FOR DELINQUENT YOUTH

For more information on the conceptual underpinnings of Multi-Systemic therapy (MST), and its demonstrated effectiveness in reducing dysfunctional behavior in children and families, review the MST website at:
http://www.mstservices.com/

For more information on the nature of Functional Family Therapy (FFT), and how it has been used effectively in school settings in multiple jurisdictions here and abroad to reduce aberrant behaviors by children, review the FFT web site at:
http://www.fftinc.com/.

Two key programs that are studying and supporting the development of community-based service delivery systems that are effective in addressing the substance use problems of youth in the justice system are:

The Reclaiming Futures initiative sponsored by the Robert Wood Johnson Foundation (www.reclaimingfutures.org), and

The Juvenile Justice Integrated Treatment Networks sponsored by the U.S. Center for Substance Abuse Treatment (CSAT, see *Strategies of Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide, CSAT, 1999*).

Each of these models describes the key components and operating principals of effective service delivery systems.

Effective re-entry/transition/aftercare models for juvenile offenders returning to the community after a period of incarceration are among the most vexing issues facing juvenile justice systems. The most prominent and well-respected work in this area has been done under the umbrella of the Intensive Aftercare Program (IAP) developed by Dr. David Altschuler of Johns Hopkins University. The IAP model comprehensively describes a desired set of practices and principles aimed at reducing re-offending by the provision of re-integration oriented incarceration and risk and needs driven services in both the institution and the community. Additional information can be found at www.csus.edu/ssis/cdcps/iap.htm.

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APPENDIX G

ACRONYMS

CHINS	Child in Need of Supervision or Child in Need of Services
COY	Virginia's Commission on Youth
CPMT	Community Policy and Management Team
CSA	Comprehensive Services Act
CSB	Community Service Board
CSU	A DJJ Court Services Unit
CIT	Crisis Intervention Teams
DJJ	Department of Juvenile Justice
DMHMRSAS	Department of Mental Health, Mental Retardation, and Substance Abuse Services
ECO	Emergency Custody Order
FAPT	Family Assessment Planning Team
FCT	Family Crisis Team
IDEA	Individuals with Disabilities Act
JDR	Juvenile and Domestic Relations, often used as JDR Court
JLARC	Joint Legislative Audit and Review Commission
MOT	Mandatory Outpatient Treatment
NCLB	No Child Left Behind
NFC	The President's New Freedom Commission on Mental Health
NIMH	National Institute of Mental Health
OIG	Office of the Inspector General
SAMHSA	Substance Abuse and Mental Health Services Administration
SABRE	Substance Abuse Reduction Effort
SED	Serious Emotional Disturbance
SHAB	School Health Advisory Board
TDO	Temporary Detention Order
VACSB	Virginia Association of Community Service Boards
VDH	Virginia Department of Health
VDOE	Virginia Department of Education

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APPENDIX H

RECOMMENDATIONS

CHAPTER I. ACCESS TO SERVICES AND RELINQUISHMENT OF CUSTODY

Recommendation I.1. The Secretary of Health and Human Services, the Secretary of Public Safety and the Secretary of Education should conduct a joint review of the current structure of children's services and to make specific suggestions for changes that would better achieve the goals of the Comprehensive Services Act on a statewide basis.

Recommendation I.2. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to create incentives to limit the use of residential treatment whenever possible, and use the money saved to create more community-based services.

Recommendation I.3. The General Assembly should amend the Virginia Code to mandate additional services for Community Services Boards beyond emergency services and case management, and include crisis stabilization, family support, respite, in-home services and psychiatric care. The General Assembly should also insure that funds are available to support these services.

Recommendation I.4. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to increase oversight of and technical assistance to communities that are over-reliant on residential care. The oversight policy should require that the Family Assessment and Planning team take specific steps prior to placement of any child in non-emergency residential care, such as:

- **Obtain a mental health evaluation of the child from the local CSB with recommendations for the least restrictive alternative;**
- **Explore all possible community-based services available to the child and family;**
- **Document that inadequate community-based services exist, and that no community-based services can be created;**
- **Develop a discharge plan with timelines for the child before placement in a residential facility;**
- **Report the rationale for the residential placement decision to the community policy and management team; and**
- **Policy should indicate that children with private insurance should also be able to receive mental health services at CSBs (which often provide the most comprehensive menu of services for the seriously mentally ill).**

Recommendation I.5. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to develop policies requiring Community Policy and Management Teams to use Intensive Care Coordination as a mechanism for utilization and review for each child in residential care. The purpose of this

additional review process is to safely and effectively transition a child to home, a relative's home, or a family setting at the earliest appropriate time that meets the child's needs.

Recommendation I.6. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to develop policies that facilitate access to mental health services by eligible children, adolescents and their families by: (1) removing impediments to discussions by a Family Assessment Planning Team (FAPT); (2) requiring CSBs to do an intake on every child who comes through CSA for behavioral health treatment; (3) making CSBs the front door for emotional and mental health treatment regardless of insurance status; and (4) making Intensive Care Coordination a function of CSB services, either directly or through monitoring of the program at CPMT and FAPT.

Recommendation I.7. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to develop policy for an aggressive, clinically knowledgeable Intensive Care Coordination system through community service boards, especially with regard to use of residential services by CSA. The presentation of a residential placement plan to the FAPT and CPMT should include specific, measurable goals for return to community as rapidly as possible, and a plan to monitor, evaluate, and assure progress on the goals while in residential care.

Recommendation I.8. The Secretary of Health and Human Services should direct the Office of Comprehensive Services to develop a training academy that establishes collaboration between universities and CPMTs to develop local programs from promising practices models, and evaluate existing programs.

Recommendation I.9. The General Assembly should amend Virginia § 63.2-901.1 so that grandparents with legal custody do not have to undergo criminal background checks.

Recommendation I.10. The Commissioner of the Department of Social Services should require that staff receive training regarding the "good cause" option for social workers involved in these cases.

Recommendation 1.11. Because of the shortage of child psychiatrists, many adult psychiatrists and other physicians end up working with children. The Department of Health Professions Board of Medicine should require any physician not certified in the care of children with psychiatric diagnoses to receive a specific amount of Continuing Medical Education credits, to be determined by the Board of Medicine, in the use of safe and effective medication for children and other treatment modalities.

Recommendation 1.12. The appropriate professional boards should require training on the evaluation of children with mental health needs by all psychologists,

licensed clinical social workers, and licensed professional counselors who work with children.

Recommendation I.13. The Commonwealth should partner with relevant groups to ensure that students who enroll in academic programs leading to jobs in mental health reflect the diversity within the Commonwealth.

Recommendation I.14. Throughout this Report, the CA Task Force has made multiple Recommendations to the Commission that the various stakeholders in the system be given more training on the mental health issues affecting children and adolescents. The CA Task Force recommends that all training include a cultural competency component.

Recommendation I.15. The Secretary of Health and Human Services should develop policies, including use of incentives, to promote family involvement in service planning consistent with the Comprehensive Services Act.

Recommendation I.16. The Secretary of Health and Human Services should require that the Office of Comprehensive Services develop a policy regarding monitoring implementation of family involvement in a child's treatment options at the local level.

Recommendation I.17. The Secretary of Health and Human Resources and the Secretary of Education should collaborate to assess the barriers to statewide collaboration between community mental health and schools, and should develop a state-level policy regarding needed ingredients for successful collaboration. This task should be accomplished by July 2009.

Recommendation I.18. The General Assembly should direct the Joint Commission on Health Care, in conjunction with the Secretary of Health and Human Services and the Secretary for Education, to conduct a study in FY 2010 assessing the barriers to collaboration between community mental health and schools, and recommending benchmarks for local community practice and funding required for staffing collaborative activities.

CHAPTER II. CHILDREN WITH MENTAL HEALTH NEEDS IN THE JUVENILE JUSTICE SYSTEM.

Recommendation II.1. Regional and local law enforcement training academies should train police officers to recognize signs of possible mental and emotional disorders in children and to be aware of and encouraged to collaborate with emergency mental health services in their community so that they can divert a child to mental health care when appropriate. This training should be developed in consultation with licensed mental health professionals and should be offered in basic law enforcement training and in continuing education.

Recommendation II.2. The Community Service Boards should make emergency mental health services for children and adolescents available on a 24-hour basis for referral and intervention in crisis situations identified by police officers (and others) as needing immediate mental health services.

Recommendation II.3. The Crime Commission should consider recommending to the General Assembly that it authorize and fund pilot projects in urban, suburban and rural jurisdictions that incorporate police officer training and the development of emergency mental health intervention services, to study the efficacy of early diversion by the police.

Recommendation II.4. The Department of Juvenile Justice should provide training to Intake Officers on recognizing possible signs of mental and emotional disorders in children, and on the use of brief validated mental health screening instruments or interview protocols to help them assess whether the child poses an immediate danger of harm and whether the child has significant but less serious mental health needs.

Recommendation II.5. The Department of Justice should require juvenile Intake Officers to employ a validated mental health screening instrument, specifically the Massachusetts Youth Screening Inventory (MAYSI-2)[154] or the Pre-Screen version of the Youth Assessment and Screening Instrument (YASI)[155] when a Intake Officer has a face-to-face meeting with the juvenile and/or his family prior to making a decision on whether to divert or proceed formally with a petition. The Department of Juvenile Justice should prepare guidance on how to respond to the screening results.

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[154] The Massachusetts Youth Screening Instrument-2 (MAYSI-2) is a brief screening instrument designed to identify potential mental health needs of youths as they make contact with the juvenile justice system. MAYSI-2 includes a combination of mental, emotional, and behavioral dimensions.

[155] Virginia's DJJ uses validated, structured decision making instruments in various aspects of community and institutional operations. The Youth Assessment and Screening Instrument, or YASI, assesses risk, need and protective factors and helps develop case plans for youth. The YASI includes a brief "pre-screening" version, which can be used at the time of intake to assist in early decision-making such as appropriateness and targets for diversion. The pre-screen arrives at an overall risk level as well as separate risk scores for legal history and social history (e.g., family, school and other adjustment domains).

Recommendation II.6. For those children identified as having significant but non-emergency mental health needs, the Community Services Boards should provide a system for prompt assessment to ensure that a child's condition does not deteriorate during any wait for outpatient services.

Recommendation II.7. For those cases where the family situation has deteriorated to the point that the child's parents or custodians are unwilling to allow the child to return home, even though the child does not meet the criteria for detention, the Department of Social Services should have an array of services available in the community to address this placement crisis, ranging from intensive services in the home for the family to short-term alternative placement in the community for the child, with the child's parents/custodians being advised that they are responsible for the child's care and supervision. A protocol should be developed between the local court services unit and the local Department of Social Services for report by the intake officer and response by the department regarding possible child neglect when the parent or custodian is unwilling to accept responsibility for meeting the child's identified needs. Where local funding is available Court Services Units, in conjunction with local social services and mental health agencies, should consider developing programs to intervene at the intake level for Family Crisis Management.

Recommendation II.8. The General Assembly should ensure that the Department of Mental Health, Mental Retardation, and Substance Abuse Services has sufficient funding for mental health clinicians assigned to juvenile detention facilities in the Commonwealth of Virginia.

Recommendation II.9. The Department of Mental Health, Mental Retardation, and Substance Abuse Services, in conjunction with the Virginia Council on Juvenile Detention, should develop standards regarding the qualifications, responsibilities and activities of detention center mental health clinicians, and establish appropriate caseload standards for them. These standards should include responsibility for those children released from detention.

Recommendation II.10. Community Services Boards should allow case managers and the Department of Juvenile Justice should allow court services staff to make appointments for children for outpatient follow-up.

Recommendation II.11. The Office of the Executive Secretary, the Indigent Defense Commission, the Commonwealth's Attorney's Services Council, and the Virginia State Bar should provide training for judges, prosecutors, and defense attorneys regarding mental and emotional disorders of children. The training should also address how to make decisions regarding pre-trial placement and treatment for children before the Juvenile and Domestic Relations Court who have such disorders.

Recommendation II.12. The Office of the Executive Secretary, the Indigent Defense Commission, the Commonwealth's Attorney's Services Council, and the Virginia

State Bar should provide training for judges, prosecutors, defense attorneys, and guardians *ad litem*, in regard to recognizing when a child may be incompetent to stand trial, and how mental and emotional conditions and disorders of children may affect competency. The rate at which competency issues arise, and the number of children found to be incompetent and in need of restoration to competency, should be monitored and studied in an effort to ensure that standards are being applied consistently among the jurisdictions in the state.

Recommendation II.13. The General Assembly should consider studying the issue of juvenile restoration of competency to ensure that there is adequate funding for restoration services so children can be evaluated and restored to competency in the least restrictive setting.

Recommendation II.14. The Crime Commission should recommend that the Office of the Executive Secretary and the Department of Justice document the availability of statewide data regarding children who are transferred for prosecution as adults. In the event no statewide data exists, the Crime Commission should consider recommending that the General Assembly amend the Code to require the reporting and analysis of transfer data and an annual report to the General Assembly.

Any data collection might focus on both the characteristics of these children and the outcomes of their cases. Key data would include the following:

- **the demographics of the children involved (both overall and for different crime categories) – age, sex, ethnicity, socioeconomic status, educational status (including placement in special education);**
- **mental health or developmental disability diagnosis; the nature and extent of mental health and related services provided to these children both before and during their involvement with the juvenile justice and adult criminal systems;**
- **delinquent/criminal history prior to the crimes for which the children are transferred; sentences received;**
- **conditions in jails and prisons where they are incarcerated; and**
- **rates of recidivism following completion of their sentences as adults.**

Recommendation II.15. The Crime Commission should consider evaluating Virginia's current transfer laws on the basis of the collected data, to determine whether more specific standards for transfer should be developed, so that those children with mental illness and serious emotional disturbances who can benefit from rehabilitation are able to remain in the juvenile justice system, including giving juvenile court judges discretion to deny transfer when mental illness is a factor.

Recommendation II.16. The Office of the Executive Secretary, the Indigent Defense Commission, and the Virginia State Bar should provide training to Juvenile Court judges, prosecutors, defense attorneys, and guardians ad litem on mental and emotional disorders in children, and the cognitive and emotional development of

children, as they relate to children's decision-making capacity and their resulting appropriateness for being tried and sentenced in the adult criminal justice system.

Recommendation II.17. The Crime Commission should consider recommending an amendment to Section 16.1-269.1(A) of the Virginia Code to require Juvenile and Domestic Relations Court judges making transfer decisions to specify the basis for their findings regarding the following: (1) whether the juvenile can be retained in the juvenile justice system long enough for effective treatment and rehabilitation; (2) the appropriateness and availability of the services and dispositional alternatives in both the criminal justice and juvenile justice systems for dealing with the juvenile's problems; and (3) the extent, if any, of the juvenile's degree of mental retardation or mental illness.

Recommendation II.18. The Crime Commission should consider recommending that Code Section 16.1-269.1(A) be revised to allow appellate review if the juvenile court does not consider the juvenile's degree of mental retardation or mental illness when making a transfer decision.

Recommendation II.19. The General Assembly should amend the Virginia Code to authorize and enable counsel for an indigent juvenile who is facing transfer to obtain, through a Juvenile and Domestic Relations Court order, an evaluation of the juvenile regarding the juvenile's mental retardation, mental illness, and mental and emotional maturity, and the availability of treatment for the juvenile, if counsel is able to show: (1) that the juvenile has a history of mental illness or mental retardation, and (2) there is reason to believe the juvenile's behavior was a reflection of this underlying condition.

Furthermore, the Commonwealth should pay the costs for the clinician providing such evaluation under the provisions of Section 16.1-275 upon a showing of indigency. Such an evaluation report would be attorney-client privileged. However, if counsel for the indigent juvenile intends to introduce this evaluation report in the transfer proceedings, the report must be produced to the Commonwealth in advance of the proceeding, along with copies of psychiatric, psychological, medical or other records obtained during the course of such evaluation.

Recommendation II.20. The Department of Juvenile Justice should screen children who have been adjudicated by the Court as CHINS or delinquent for substance abuse and mental health problems when there is any indication of such problems. The results of these screenings shall be provided to the JDR Court or Court Services Unit for appropriate referral.

Recommendation II.21. Given the Department of Juvenile Justice's new regulations for the development and implementation of transition plans and services for children with mental health needs who return home from Department of Juvenile Justice commitment, the only Recommendation at this time is that the efficacy of those regulations be thoroughly reviewed by the Department of Juvenile Justice.

CHAPTER III. INVOLUNTARY COMMITMENT

Recommendation III.1. The General Assembly should amend Virginia Code § 16.1-340 so that the commitment hearing could be held in either the home court or the court where the juvenile is located, keeping both options open. If the law is so amended the default jurisdiction should be where the child is located. The home court would have 24 hours, or until the next business day if the 24-hour period ends on a holiday or weekend, to claim jurisdiction, otherwise the hearing would be held in the jurisdiction where the juvenile is located.

Recommendation III.2. When feasible, the Juvenile and Domestic Relations Court in the jurisdiction where the juvenile resides should use video-conferencing to avoid having to transport the juvenile back to the home jurisdiction.

Recommendation III.3. The clerk of each Juvenile and Domestic Relations Court should designate a specific person in the clerk's office to deal with juvenile involuntary commitment hearings. The Supreme Court's Office of the Executive Secretary should maintain a master list of these contacts.

Recommendation III.4. The General Assembly should amend the Virginia Code so that detention homes are required to send pertinent information they possess to the court (names of attorneys, guardian ad litem, home court, judge, etc.). This way the information travels with the juvenile.

Recommendation III.5. The General Assembly should revise the Virginia Code so that the 72-hour time frame of a TDO is extended to 96 hours (including an additional 24 hours for weekends and holidays). [Note: this Recommendation was accepted and became law on July 1, 2008].

Recommendation III.6. The General Assembly should revise Virginia Code § 16.1-340 and 341 so that the 96-hour period starts with the filing of the petition for civil commitment, not the issuance of the TDO (as currently written, the Code is inconsistent on what starts the 72 hour time period). [Note: the Code was amended as of July 1, 2008, so that the 96 hour period now starts with either the filing of the petition or the issuance of the TDO, whichever is later.]

Recommendation III.7. The General Assembly should amend Virginia Code § 16.1-345 to delete the language: "In no event shall a minor who has been properly detained by a juvenile and domestic relations district court, and who meets criteria for involuntary commitment, have the right to make application for voluntary admission and treatment as may otherwise be provided for in this section."

Recommendation III.8. The General Assembly should also amend Virginia Code §§ 16.1-338 and 339 to include this language: "A minor who has been hospitalized

while properly detained for a criminal offense by a Juvenile and Domestic Relations Court shall be returned to the detention home following completion of a period of inpatient treatment, unless the court having jurisdiction over the criminal case orders that the minor be released from custody."

Recommendation III.9. The General Assembly should require the presence of a CSB or DSS representative at all hearings where juvenile outpatient commitment is being considered.

Recommendation III.10. The General Assembly should require the CSB to file a preliminary treatment plan at the commitment hearing where juvenile outpatient commitment is being considered.

Recommendation III.11. The General Assembly should specify that no Juvenile and Domestic Relations Court or Special Justice should have the discretion to order mandatory outpatient treatment for a juvenile unless the provider in the home jurisdiction has the resources and agrees to provide them.

Recommendation III.12. Before reaching a decision on whether to issue an order for mandatory outpatient treatment for a juvenile, a Juvenile and Domestic Relations Court or Special Justice must make the following findings: a) less restrictive alternatives to involuntary *inpatient* treatment have a genuine potential for improving the juvenile's mental health condition; b) the available outpatient resources have been investigated and determined to be appropriate; c) the juvenile has sufficient capacity to understand the stipulations of his outpatient treatment plan; d) the juvenile and the juvenile's family have expressed an interest in the juvenile remaining in the community; and e) the juvenile and the juvenile's family have agreed to comply with the treatment. Upon such findings, the Juvenile and Domestic Relations Court may conclude that the outpatient treatment set forth in the outpatient treatment plan can be delivered by the Community Services Board or other designated provider and the Juvenile and Domestic Relations Court or Special Justice shall by written order and specific findings so certify and order that the juvenile be admitted involuntarily to mandatory outpatient treatment.

Recommendation III.13. If the Juvenile and Domestic Relations Court or Special Justice determines that mandatory outpatient treatment is appropriate in a particular case, the mandatory outpatient order must include the following: a) specific information describing the ordered outpatient treatment plan and name the providers that have agreed to provide the services; b) the specific responsibilities of the juvenile as well as the parent or legal guardian in complying with the mandatory outpatient treatment order; c) if the hearing is not conducted in the juvenile's home jurisdiction, a transfer of jurisdiction from the court where the juvenile is located and hearing conducted, to the court of the juvenile's home jurisdiction; d) direction that enforcement of the mandatory outpatient treatment order take place in the juvenile's home jurisdiction by a Juvenile and Domestic Relations Court, not a Special Justice; e) a provision for the appointment of a guardian ad litem in the

juvenile's home jurisdiction; f) identify the entity responsible for monitoring the juvenile mandatory outpatient treatment order (presumably the CSB); and g) the ordered length of treatment, which cannot exceed 90 days.

Recommendation III.14. The CSB in the juvenile's home jurisdiction should be responsible for monitoring compliance with juvenile mandatory outpatient treatment orders. The CSB should notify the Juvenile and Domestic Relations Court of any possible material noncompliance by filing a motion for review. In situations where there is both material noncompliance and the likelihood that civil commitment criteria exist, the CSB should immediately petition for an ECO or TDO.

Recommendation III.15. The General Assembly should provide additional funding to CSBs commensurate with their additional responsibilities for developing mandatory outpatient treatment plans and monitoring the compliance of juveniles to these plans

Recommendation III.16. Juvenile and Domestic Relations Court Judges, not Special Justices, should handle all petitions for review of mandatory outpatient treatment orders.

Recommendation III.17. Juvenile and Domestic Relations Courts may only order in-patient commitment at mandatory outpatient treatment review hearings if the juvenile meets commitment criteria at the time of the review hearing.

Recommendation III.18. The CSB may file a petition for rescission of the mandatory outpatient treatment order or a petition for renewal of the mandatory outpatient treatment order, as it can for such adult orders, but any renewal would not exceed 90 days for juveniles.

Recommendation III.19. The DMHMRSAS pre-admission screening form, used by CSBs in assessing whether an individual meets the criteria for civil commitment, should include a question to indicate whether a juvenile is under a mandatory outpatient treatment order.

Recommendation III.20. When enacting the legislation proposed by the CA Task Force, the General Assembly should specify whether any new mandatory outpatient treatment procedures should apply retroactively to any orders in effect on when the new legislation takes effect.

Recommendation III.21. The General Assembly should amend the commitment legislation to extend the 72-hour TDO deadline by 24 hours in all cases. (Amended to 96 hours as of July 1, 2008).

Recommendation III.22. The General Assembly should amend the Virginia Code to require Intake Officers to issue temporary detention orders relating to the inpatient

treatment of minors. Intake Officers currently make determinations on whether juveniles should be detained, and are familiar with many issues specific to juveniles. The Intake Officers may even know the juveniles already. To support Intake Officers in this additional responsibility, however, they will need significant additional training and funding.

Recommendation III.23. If magistrates continue to have the authority to issue TDOs for juveniles, the CA Task Force recommends that the Office of the Executive Secretary should provide training directed at mental health issues specific to children and adolescents. Magistrates should also be required to gather the same information that intake officers gather about the juveniles, which is listed in detail in Virginia Code § 16.1-260.

Recommendation III.24. The General Assembly should amend the Virginia Code to remove the bridge language in § 16.1-340 to §§ 37.1-67.01 or 37.1-67.1. It should also amend the juvenile Code to include procedures for issuing TDOs. Because of the existing bridge to the adult statute, magistrates must apply inappropriate adult commitment criteria to juveniles when deciding whether to issue a TDO.

Recommendation III.25. The Office of the Executive Secretary should survey consumers on a regular basis to determine their level of satisfaction with the juvenile involuntary commitment process.

Recommendation III.26. The Office of the Executive Secretary should require ongoing training for Special Justices every two years (the training could be for Continuing Legal Education credit so as to encourage attendance).

Recommendation III.27. The General Assembly should amend the Virginia Code to require that the Chief Judge of the Circuit Court consult with the Chief Justice of the Juvenile and Domestic Relations Court on appointments of Special Justices who will be hearing juvenile mental commitment cases.

Recommendation III.28. The General Assembly should amend the Virginia Code to have the Chief Judge the Juvenile and Domestic Relations Court be the supervising judge for special justices appointed to hear Juvenile and Domestic Relations Court hearings.

Recommendation III.29. The Virginia Code is unclear regarding whether the independent examiner must be present during the commitment hearing so the statute should be clarified. Section 16.1-342 states that the independent examiner shall attend the commitment hearing as a witness, but § 16.1-344 says that the parties may stipulate to the examiner's report. As a result of this conflict, some courts are requiring their presence and other courts are not if the parties stipulate to the report. Based on the results of Commission's Hearings Study, it appears that independent examiners attend 70% of the commitment hearings.

Recommendation III.30. Paragraph 4 of Virginia Code Section16.1-341 should be amended so that "dismissed" is changed to "withdrawn," since the petition cannot be dismissed until the commitment hearing is held. (Note: this change was made by the General Assembly and went into effect on July 1, 2008).

Recommendation III.31. The General Assembly should amend Virginia Code § 16.1-339 so that it includes minors who are not capable of giving informed consent. Section 16.1-339(C) should be amended so that the word "immediately" is taken out. This term does not give a specific time frame and when a patient is admitted over the weekend, a petition cannot be filed until the next business day. This Section should read, "the facility shall file a petition for judicial approval within 24-96 hours of admission with the juvenile and domestic relations district court…" (Note: this change was made by the General Assembly and went into effect on July 1, 2008)

Recommendation III.32. The General Assembly should amend Virginia Code, Section 16.1-341 so that a guardian ad litem is appointed for the juvenile just as they are in hearings conducted under §16.1-339. Another option would be to amend both § 16.1-339 and 341 so that a court could appoint a court appointed attorney and a guardian ad litem when appropriate in both situations. (Note: the General Assembly amended these sections so that counsel and guardians ad litem are appointed in both situations. This change went into effect on July 1, 2008).

Recommendation III.33. The General Assembly should amend the Virginia Code to remove or amend all statutes from the juvenile mental commitment chapter that "bridge to the adult mental commitment chapter to create a free-standing statutory scheme for the psychiatric treatment of minors.