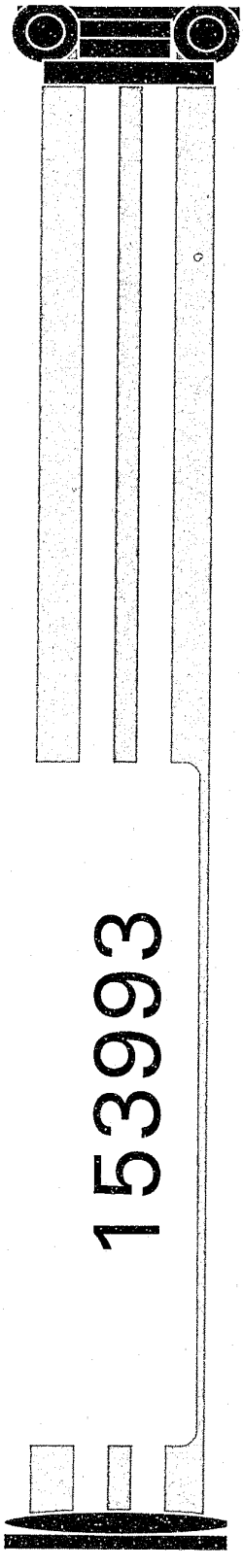

Mental Health Needs of Youth in Virginia's Juvenile Detention Centers

153993

Report of the
Policy Design Team

Mental Health Needs of Youth in Virginia's Juvenile Detention Centers

December 1994

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PREFACE

Acknowledgements

This project represents the work of many individuals who have contributed immeasurably to the success of this effort. The opportunity presented by the National Coalition for the Mentally Ill in the Criminal Justice System was an important catalyst in causing a team to be organized, and in providing technical assistance and support through the Design Academy.

Judge Lawrence Janow stepped in as chair after the resignation of Deputy Secretary for Public Safety T. Twitty. Judge Janow lead the team through difficult negotiations and contentious discussion. He was able to keep a human face on these issues by constantly grounding the discussion in the very real circumstances which come before his court on a daily basis.

Nirbhay Singh, John Curtis, Dennis Waite, Bill Brock and Gary MacBeth developed the data collection strategy. Dennis Waite and the staff of the Behavioral Science Unit of the Department of Youth and Family Services were responsible for data collection on site at Virginia's Detention Centers. John Curtis of the Institute for Child Studies of the Medical College of Virginia, was responsible for the analysis of data. The hospitality and cooperation of the superintendents and staff of the detention centers made the data collection go smoothly. The young people, who shared their troubled lives and mental health problems, must be gratefully and respectfully acknowledged above all others.

There is no question that this final document represents the work of a team and a consensus crafted from their many points of view. Martha Woodruff of Sweet Briar College generously provided final editing and made the words of many authors read as one.

Introduction

This is a report prepared by the Virginia Policy Design Team. The report studies the mental health needs of youth in the Virginia Juvenile Justice System, presents findings and offers recommendations. The Team focused specifically on the mental health needs of youth in the 17 secure detention homes in Virginia.

Virginia was selected by the National Coalition for the Mentally Ill in the Criminal Justice System as one of five states to participate in a State Policy Design Academy. The mission of the Academy was to design and implement a strategy of response to the mental health needs of youth in the Juvenile Justice System.

Definition of Mental Illness and Collection of Data

Mental illness is defined in §16.1-336 of the *Code of Virginia* (Psychiatric Inpatient Treatment of Minors Act). The team further qualified the definition, for the purpose of data collection, by defining mental illness based on the degree of functional impairment and the need for intervention by a qualified mental health professional in order to prevent further decompensation.

In order to form a credible data base for the report, an assessment of the mental health status of detained youths was conducted during one week in April of 1994. There were approximately 677 youth in detention (127% occupancy); a total of 605 youths participated in the study. This is the first census of its type to be conducted nationally.

The assessment consisted of a combination of individual psychological interviews, and standard clinical assessment instruments, as well as a search of facility records. Using this approach, youth were assigned to these five categories, representing their assessed level of mental health problems:

None — does not need mental health treatment at this time;
Minimal — does not need mental health treatment, but could benefit from treatment;
Moderate — needs mental health treatment but it is not required while indetention;
Severe — needs immediate mental health treatment to prevent further deterioration;
Urgent — needs immediate mental health care at a level consistent with inpatient psychiatric hospitalization.

The results of the evaluations and the analysis of the data, indicate that, on any given day, 8-10% (52) of youths in secure detention homes have serious mental health problems which require immediate attention. The data also shows that few (14%) of the youths requiring immediate mental health treatment were receiving any services.

In addition, there is a need for mental health services for the additional 39% (234) youths in the "moderate" category, who do not need immediate intervention, but will require mental health services in association with their continuing involvement with the juvenile justice system or as part of the larger continuum of community services.

Neither the Community Services Boards nor the secure detention homes, have sufficient fiscal and staff resources, staff training and system response mechanisms to address the needs of these youths uniformly and adequately.

It was the consensus of the Team that a uniform, effective and coordinated delivery of services for even the youth in the most immediate need of intervention could not be accomplished within the present funding level and staffing resources.

The Team identified 13 problem statements, and made 13 recommendations to address them.

There are no state general funds specifically earmarked for this purpose. With reductions in block grant funding, costs to the localities have increased. This in turn jeopardizes the quality and the continuum of services affordable to localities.

Funding and Cost Proposal

There was Team consensus regarding the need to provide assessment and evaluation, crisis intervention, counseling, and medical services in the 17 secure detention homes, as well as staff consultation and training for secure detention homes, community service boards, and mental health residential providers. The costs for providing these crisis services, directed at meeting the mental health needs of youth in the severe and urgent ranges, would be approximately $535,404.

There was further agreement that cost allocations for treatment planning and follow-through to community care services for these youth would require an additional $524,160. The total annual cost for the full proposal is $1,059,564. This would fund implementation of improved mental health services for detained youths in the severe and urgent categories.

Conclusion

The work to this point and the report herein are only a beginning of the overall effort needed to improve mental health services for youth in the juvenile justice system. There is much more study and effort which will be required if the vision statement of the team is to be realized. There is particular concern that priority be assigned to two areas: 1) development of an intake or community based method of addressing the mental health needs of youth who were identified in the moderate category, and 2) monitoring progress toward implementation of recommendations related to providing services to severe and urgent need youth while in detention.

Purpose

The purpose of this document is to assess the mental health needs of youth in secure detention homes, make preliminary recommendations on improving mental health services for detained youth, and to identify areas needing further work. It reports the efforts of a Policy Design Team that began its work in June of 1993. The process and background of the team's work are described; and recommendations are presented to assure these youths receive mental health care in the most appropriate setting and manner possible that does not jeopardize public safety.

A broad vision statement was established to guide the Team's deliberations:

> ***We seek to create a continuum of mental health services in the juvenile justice system. These services should be available at the earliest possible point in the process, and in the least restrictive setting. Such services must be consistent with the needs of both the youth and his/her family; and must be accessible, culturally sensitive, fairly administered and consistent with public safety.***

Background

Virginia has long been concerned with how to address the mental health needs of youth in its juvenile justice system. In 1993, an opportunity became available to participate in The State Policy Design Academy, a group to be sponsored by the National Coalition for the Mentally Ill in the Criminal Justice System, which is an education and policy development organization. The Commonwealth of Virginia prepared an application to participate; its stated purpose was to design and implement a strategy for responding to the mental health needs of youth in the juvenile justice system. Virginia was selected as one of five states to participate in the State Policy Design Academy. Other states selected were New York, Maryland, Kentucky and Georgia.

The Academy held its first meeting at the Carter Center in Atlanta, Georgia, June 17-19, 1993. A team of ten persons was appointed to represent Virginia. The team's mission was to make recommendations on improving mental health services available for youth in the state's juvenile justice system. The first Academy focused on policy planning, and provided an opportunity to identify model programs and systems of service delivery.

A second national Design Academy was held in January 1994, in Washington, D.C. The focus of this second Academy was on alternative financing strategies, legislative strategies and current perspectives on violent juvenile crime, particularly in relationship to the pending federal Omnibus Crime Bill.

Virginia's effort has built on a strong record of multiple agency systems reform, most recently evidenced by the Comprehensive Services Act for At-Risk Youth and Families (§2.1-745-759.1). (Referenced citation may be found in Appendix II on this and all subsequent citations.) This is a statewide restructuring of the financing and delivery of services for youths, and the families of youths, with serious emotional and behavioral problems. The Commonwealth of Virginia is also a participant in the federal Child and Adolescent Services System Program (CASSP), and has an Annie E. Casey Foundation site for an Urban Minority Mental Health Initiative in the East End of Richmond. These two initiatives focus on interagency strategies for empowering families and communities to take better responsibility for meeting the needs of troubled and at-risk children and youth. Many of these troubled children and youth are involved in the juvenile justice system.

Scope

The Virginia Team has held a series of meetings, focusing on definitions, service gaps, and funding options. In its initial assessment of the need for improved mental health services for the juvenile justice population, the Team assigned the needs of youth in secure detention as its highest priority. The Team also focused on how mental health and juvenile justice systems can best work collaboratively with youths who require interventions by both systems.

While the Virginia Team chose to narrow its initial focus to securely detained youth, the service issues involved are quite broad. These issues have an impact on the whole mental health, and juvenile justice, systems. The focus of the Team was not on "mental health" per se, but on addressing the needs arising from the mental health problems of securely detained youth — including the issues of their safety and the public's safety. In identifying areas for investigation, the Team found it necessary to distinguish the mental health needs of these youth from their other social and rehabilitative needs. The Team defined significant mental illness as a degree of illness requiring immediate intervention from a qualified mental health professional. The level of a youth's functional impairment became the basic criteria for determining his/her degree of mental illness.

There was no reliable data for identifying how many securely detained youths had mental health problems, so such data had to be collected. Once both definitions and data collection were complete, the Team examined the current system of care and proposed improvements.

Currently, both the mental health and juvenile justice systems provide limited response to detained youth with identified mental health problems. Neither system is designed, by itself, to handle these youths. For example, emergency prescreening, as required by the *Code of Virginia* (§16.1-338), is available from Community Services Boards across the state. Mental health services provided through Community Services Boards are unable to meet public demand. Of the forty Community Services Boards, 53% have waiting lists of over one month for the initial assessment of adolescents. Once assessed, there are further waiting lists and other limitations on the availability of treatment services. These waiting lists are a barrier to meeting the mental health needs of youth in the juvenile justice system, and also to meeting their further mental health needs once they return to their home communities.

The Team identified ways of improving mental health services for these youth by expanding collaboration between the two service systems, and by training detention home staff to manage young people with mental health problems more effectively.

Descriptions of Secure Detention Homes, State Psychiatric Hospitals and Community Services Boards

• Secure Detention Homes

There are 17 secure detention homes across the Commonwealth. These homes provide physically secure placement of juveniles pre-dispositionally (§16.1-248.1 A) and, in some facilities, post dispositionally (§16.1-284.1.A.). The *Code of Virginia* (§16.1-310) requires detention homes to be "reasonably accessible to each court."

Pursuant to §16.1-248.1.A., a child taken into custody maybe placed in a secure detention home pending a detention hearing.

". . . upon a finding by the judge, intake officer, or magistrate that there is probable cause to believe that the child committed the act alleged, and that at least one of the following conditions is met:

1) The child is alleged to have committed an act which would be a felony or Class 1 misdemeanor if committed by an adult, and there is clear and convincing evidence that:

a. The release of the child constitutes an unreasonable danger to the person or property of others;
b. The release of the child would present a clear and substantial threat of serious harm to such child's life or health; or
c. The child has threatened to abscond from the court's jurisdiction during the pendency of the instant proceedings or has a record of willful failure to appear at a court hearing within the immediately preceding twelve months.

2) The child has absconded from a detention home or facility where he has been directed to remain by the lawful order of a judge or intake officer.

3) The child is a fugitive from a jurisdiction outside the Commonwealth and subject to a verified petition or warrant, in which case such child may be detained for a period not to exceed that provided for in § 16.1-323 of this chapter while arrangements are made to return the child to the lawful custody of a parent, guardian or other authority in another state.

4) The child has failed to appear in court after having been duly served with a summons in any case in which it is alleged that the child has committed a delinquent act, is in need of services or is in need of supervision: *however a child alleged to be in need of services or in need of supervision may be detained for good cause pursuant to this subsection only until the next day upon which the court sits within the county or city in which the charge against the child is pending,* and under no circumstances longer than *seventy-two hours* from the time he or she was taken into custody."

Detention homes are locally controlled, and receive block grant funds from the state. The community block grant program provides grants and reimbursements to localities for pre- and post-dispositional programs for their youth known to the juvenile justice system. Over the years, the portion of state funds allocated to the whole operating costs of these homes has decreased significantly — from 66.6% in 1988 to an average of 40% in 1993. Remaining operating costs are covered through local budgets and per diem charges to localities. Currently, secure detention homes have a rated capacity of 532 beds. Since 1988, secure detention homes have been operating at over their rated capacities. For FY 93, the utilization rates for secure detention homes fluctuated from 110% to 124% of their rated capacities. While overcrowding is experienced throughout the state, it is most extreme in those homes serving the urban areas.

In secure detention homes, there are currently no uniform standards or requirements for assessing the mental health status of detained youth. The State Board of Youth and Family Services is authorized and directed to prescribe Minimum Standards for Secure Detention Homes (§16.1-311). The current

standards were issued on April 13, 1983. Revisions have been proposed. The proposed standards include provisions for detoxification, emergency psychiatric services, medication administration and management, and suicide prevention. The proposed standards require secure detention homes to have written policies and procedures, but do not provide specific guidance regarding their content.

• State Psychiatric Hospitals

Four state psychiatric facilities provide short-term services for children and adolescents who require hospital-level care in the public sector: Central State Hospital; Virginia Treatment Center for Children (a Medical College of Virginia Facility); DeJarnette Center; and Southwestern Virginia Mental Health Institute. There are a total of 128 beds in these facilities. Each year, there are approximately 1200 children and adolescents admitted to these facilities. Children and adolescents have an average length of stay of 31 days.

Admissions of children and adolescents to psychiatric hospitals are governed by the *Code of Virginia*, and each facility requires that admissions follow the procedures in the Inpatient Psychiatric Hospital Treatment of Minors Act (§§16.1-335 through 348). All public hospital admissions must be prescreened, using the eligibility requirements and procedures in the Act, by the Community Services Board serving the area where the minor is located.

• Community Service Board

Forty Community Services Boards cover all 132 Virginia localities. These Boards provide a range of mental health, mental retardation, and substance abuse services for children and families. Community Services Boards provide mental health services for approximately 15,000 children and adolescents each year. This represents a fraction of the demand for their services. The quickness of access to mental health services and the array of services available at each Community Services Board vary tremendously. Historically — despite well-documented need — few appropriations of state general funds have been made for mental health services for children and families.

Definitions of Mental Illness

There are different definitions of mental illness in the *Code of Virginia*. Definitions vary based upon the degree of the illness' intrusiveness into a child's life, and the locus of service delivery.

• Inpatient Psychiatric Hospital Treatment

The most intrusive level of illness (to a child and his/her family) necessitates the involuntary commitment of a minor to a psychiatric hospital, pursuant to §16.1-345, which provides as follows:

1. Because of mental illness, the minor
   i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or
   ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;
2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and
3. If inpatient treatment is ordered, such treatment is the least restrictive alternative that meets the minor's needs. If the court finds that inpatient treatment is not the least restrictive treatment, the court may order the minor to participate in outpatient or other clinically appropriate treatment.

• Community Services Board Priority Population

Children and adolescents, who are accessing mental health services through Community Services Boards, must meet a much broader definition of mental illness, as set by State Board policy of DMHMRSAS. Priority for services is given to children and youth, ages 0-18, with the most serious impairments characterized by:

1. A defined mental health problem that can be diagnosed under DSM-IV; and/or
2. Problems in personality development and social functioning that have been exhibited over at least one year's time; and
3. Problems that are significantly disabling based upon the social functioning of most children their age; and
4. Problems that have become more disabling over time; and
5. Service needs that require significant intervention by more than one agency.

• Comprehensive Services Act

Virginia has been a national leader in developing collaborative systems of services across the Virginia child serving agencies. The Comprehensive Services Act for At-Risk Youth and Families (§2.1-745-759.1) was enacted by the 1993 General Assembly to ensure coordination across agencies in the delivery and funding of services for children with serious emotional and behavioral problems.

The Comprehensive Services Act provides a mechanism to access and fund services for eligible youth through interagency community teams. An **eligible** youth is defined in §2.1-758 as:

1. The child or youth has emotional or behavior problems which:
   a) Have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted;
   b) Are significantly disabling and are present in several community settings, such as at home, in school or with peers; and
   c) Require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at east two agencies.
2. The child or youth has emotional or behavior problems, or both, and currently is in, or is at imminent risk of entering, purchased residential care. In addition, the child or youth requires services or resources that are beyond normal agency services or routine

collaborative processes across agencies, and requires coordinated services by at least two agencies.

3. The child or youth requires placement for purposes of special education in approved private school educational programs.
4. The child or youth has been placed in foster care through a parental agreement between a local social services agency or public agency designated by the community policy and management team and his parents or guardians entrusted to a local social services agency by his parents or guardian or has been committed to the agency by a court of competent jurisdiction for the purposes of placement as authorized by §63.1-56.

Eligibility to receive services does not mean that a youth will receive services. This is dependent upon a local decision-making process and the availability of local funds. There is a distinction made between eligible, targeted and mandated youth as related to the use of State Pool funds (§2.1-757-758). In general, "eligible youth" (§2.1-758) encompasses the broadest vision of the Act. "Targeted" (§2.1-757) youth narrows this population to those who were receiving services prior to the pooling of funds. And "mandated" youths are those who must be provided services per federal and state regulation related to the receipt of funds.

"Non-mandated" refers to youth who meet the eligibility criteria of the Comprehensive Services Act, but are not in the population that is qualified for federal sum-sufficient (mandated) funding. Most mental health and juvenile justice (targeted) populations are non-mandated.

• Mental Health Policy Design Team Study

The Team decided not to reinvent the wheel by trying to come up with a new definition of mental illness. Rather, the Team decided to accept an already available definition (i.e., *Code of Virginia* §16.1-336), but qualify that definition to define mental illness based on the degree of functional impairment.

Using the definition in the Psychiatric Inpatient Treatment of Minors Act (§16.1-336), mental illness:

"...means a substantial disorder of the minor's cognitive, volitional, or emotional processes that demonstrably and significantly impairs judgement or capacity to recognize reality or to control behavior. "Mental illness" may include substance abuse, which is the use, without compelling medical reason, of any substance which results in psychological or physiological dependency as a function of continued use in such a manner as to induce mental, emotional, or physical impairment and cause socially dysfunctional or socially disordering behavior. Mental retardation, head injury, a learning disability, or a seizure disorder is not sufficient, in itself, to justify a finding of mental illness within the meaning of this article."

The Team defined mental illness, as relative to the degree of functional impairment, and the level of mental health service needed to prevent further decompensation. Mental health services were limited to specialized mental health services which must be provided by a qualified mental health professional.

In order to determine the numbers of youths in secure detention homes who have mental health problems, the Team used a combination of individual psychological interviews and standard clinical assessment instruments. Using this definition and approach, youths were assigned to five categories that represent assessed levels of mental health problems:

None — those demonstrating no need for mental health treatment;
Minimal — those who could benefit from treatment, but did not need it to sustain functioning;
Moderate — needs mental health treatment to improve functioning but can wait till released from detention;
Severe — needs mental health treatment while in detention to prevent further decompensation; and
Urgent — needs immediate mental health services at a level consistent with hospitalization.

Study Data on the Mental Health Needs of Youth in Secure Detention Homes

An assessment of the mental health needs of youth in secure detention homes was conducted between April 11, and April 15, 1994. There were approximately 677 youths in detention (127% occupancy) during this time. A total of 605 youths participated in the study. There were 15 youths who refused voluntary participation, and 58 youths who were unavailable because they were in court, with their lawyers, or sick at the time of the study. The assessment was conducted by twenty clinical staff members selected from the Behavioral Services Unit of the Department of Youth and Family Services. All clinical staff had at least a Masters degree in a mental health field and had an average of 10.7 years of experience in working with adolescents. The assessment consisted of a review of detention records, a mental health status examination, and the administration of two standardized tests to the youths.

One of the tests, The Derogatis Symptom Checklist-90, was administered by the clinician. The other test, a self-report instrument called The Achenbach, was completed by a sample of the detained youth. A thirty-minute period was allowed for each subject. Analysis of the data was contracted to the Commonwealth Institute for Child and Family Studies of Virginia Commonwealth University. Funding was provided by the Juvenile Justice and Delinquency Prevention Act Funds through the Department of Criminal Justice Services. (See Appendix I for a more complete report)

TABLE 1

	Male	Female	White	Black	Hispanic	Other
Number	502	103	224	352	23	6
Percent	82.6%	17.4%	37.0%	58.2%	3.8%	1.0%

The sex, race, and length-of-stay characteristics for the youth in this assessment appear to be consistent with aggregate reports for 1993; therefore, we conclude that the population is representative of youth in detention.

Table 1 presents a demographic breakdown of the youth who participated in the assessment. The length of detention time was, on the average, 30 days. A total of 10 youths had been in detention more than 180 days. There were 82 youths (13.6%) in detention less than 72 hours.

Pursuant to §16.1-250.A. of the *Code of Virginia*:

> "A. When a child has been taken into immediate custody and not released as provided in §16.1-247 or §16.1-248.1, such child shall be brought before a judge on the next day on which the court sits within the county or city wherein the charge against the child is pending. In the event the court does not sit within the county or city on the following day, such child shall be brought before a judge within a reasonable time, not to exceed seventy-two hours, after he has been taken into custody. If the seventy-two hour period expires on a Saturday, Sunday or other legal holiday, the seventy-two hours shall be extended to the next day which is not a Saturday, Sunday or legal holiday."

Also, 284 youths (47%) had been in detention more than 72 hours, but less than 21 days.

Pursuant to §16.1-277.1 of the *Code of Virginia*, there are time limitations for juveniles to be held in the secure detention homes.

> "Time limitation. - A. When a child is held continuously in secure detention, he shall be released from confinement if there is no adjudicatory or transfer hearing conducted by the court for the matters upon which he was detained within twenty-one days from the date he was first detained. B. If a child is not held in secure deten-

tion or is released from same after having been confined, an adjudicatory or transfer hearing on the matters charged in the petition or petitions issued against him shall be conducted within 120 days from the date the petition or petitions are filed. C. When a child is held in secure detention after the completion of his adjudicatory hearing or is detained when the juvenile court has retained jurisdiction as a result of a transfer hearing, he shall be released from such detention if the disposition hearing is not completed within thirty days from the date of the adjudicatory or transfer hearing. D. The time limitations provided for in this section may be extended by the court for a reasonable period of time based upon good cause shown, provided that the basis for such extension is recorded in writing and filed among the papers of the proceedings. (1985, c. 260; 1988, c. 220.)"

There was excellent cooperation with the study by the staff of the secure detention homes, and by the youths within the homes. Participation in the study was voluntary. Only 22 youths (3%) housed in detention that week were uncooperative; 527 (90%) were rated as having good cooperation. Not all data sets were complete on all children. In such instances, the total number that appears at the bottom of the related table reflects the total number of youths in the study for which the data on the chart was complete.

TABLE 2

Mental Health Assessment of Youth's Need for Mental Health Treatment	Frequency	Percent
NONE: youth had no mental illness at the time of the census	127	21.5%
MINIMAL: youth does not need treatment at this time but could benefit from treatment	178	30.1%
MODERATE: youth is in need of mental health services but not required while in detention	234	39.6%
SEVERE: youth requires treatment while in detention to prevent further deterioration	50	8.5%
URGENT: youth needs psychiatric hospitalization	2	0.3%
Number of youth = 591		

Mental Health Needs of Youth in Detention

Table 2 presents the results of the clinician's assessment. The definition of mental illness used in this assessment was related to the degree of functional impairment that required mental health intervention. Specifically:

- Youth who were assessed as having no demonstrated need for mental health treatment were assigned to the ***none*** category;
- Youths assigned to the ***minimal*** category were seen as those who could benefit from mental health treatment, but did not need it to sustain functioning. Examples of this category were youths with family problems or school adjustment problems;
- The ***moderate*** category included youths who needed mental health treatment to improve their functioning, but could wait to get those services until released from detention. These services will be required in association with rehabilitation in the juvenile justice system or as a part of the larger continuum of community services. Examples of this category include substance abuse treatment and sex offender treatment. These services may require residential placement in some instances;
- Youths who needed immediate mental health treatment to avoid further decompensation of emotional or cognitive functioning were assigned to the ***severe*** category. These included

those with symptoms of major depression or anxiety, and those in need of psychotropic medication to deal with their symptoms; and

- Finally, youths in the ***urgent*** category were seen as needing immediate services consistent with levels available through inpatient mental health treatment because of psychotic-like symptoms or the potential for suicide. These were youths seen as being beyond the scope of the mental health services that can currently be provided in detention.

At the time of the study, records documented that 80 youths (13.4%) were on suicide watch. A history of suicide attempts was reported by 98 youths in the study. Most homes have a written policy, following professional corrections group standards, that require youths on suicide watch to be monitored at least every 15 minutes.

Based on the administration of the Derogatis Symptom Checklist-90 and a brief mental status evaluation, the clinicians were asked to identify youths they thought would qualify for a DSM III-R diagnosis. These diagnoses are used to delineate specific mental disorders. Four hundred fifty-nine youths (77%) were thought to qualify for at least one such diagnosis. The most frequently used diagnostic category was conduct disorder (52%), although many of these youths qualified for more than one diagnosis. Ninety-six youths (16%) were thought to qualify for a diagnosis without accompanying conduct disorder or substance abuse disorder (e.g., mood disorder, adjustment disorder, etc.).

Of the 50 youths in the ***severe*** category of mental health treatment need, only 7 youths (15%) were currently receiving mental health services. Across all categories 46 youths had received a mental health evaluation while in detention; 7 of these youths were in the severe/urgent category. There were 12 youths who had been admitted to detention directly from a psychiatric facility; 3 were in the severe/urgent category. The most frequent offense category for youth in the severe/urgent ranges were violations of court orders, probation or parole (19 youths) followed by property offenses (15 youths).

Medication inspection identified 39 youths who were receiving psychotropic medications. In the clinical interview, 54 youths reported they were currently being prescribed psychotropic medication for a mental health problem. The discrepancy between inspection records and self-report reflects the number of youths who reported taking medications prior to detention, but were not taking it while in detention.

A significant percentage of youths scored above the clinical cut-off level on the Derogatis Symptom Checklist-90 verifying that mental health symptomatology was present. This provides statistical validation of the clinicians' perceptions of the number of youth who would qualify for a diagnosis of an Axis I disorder under DSM-III-R.

Table 3 shows that females had a more severe mental health profile than their male counterparts. Age was not found to be significant.

There were 334 youths (55.5%) who reported (self-report) a history of mental health treatment. The majority, 291 youths (48.3%), reported outpatient treatment, while 120 youths (19.9%) reported inpatient treatment. Records at the detention homes reported significantly lower numbers. However, this is thought to be an indicator of the inadequacy of information reported to the detention homes.

In summary, the data suggests that a range of 8-10% of the youths in secure detention homes, on any given day, have serious mental health problems that must be addressed while the youth are in detention. In addition, 39% of youths are in the "moderate" needs range, requiring mental health services at some point.

Information contained in the records of the youths in secure detention homes was noted by the examiners to be incomplete. Staff of the secure detention homes do not routinely receive information about the mental health status or history of youths under their care. Staff expressed the need for consultation on the management of youths with severe and/or urgent mental health problems.

TABLE 3

RATING	MALE N=502	FEMALE N=102
NONE	23.2%	13.7%
MINIMAL	30.7%	27.5%
MODERATE	38.7%	43.1%
SEVERE/URGENT	7.4%	15.7%

Clinical Rating by Gender

Funding Issues

Lack of available funding for services emerged as a major barrier to the delivery of mental health services to youth in the juvenile justice system. The Team concluded that the expansion of services in the community, or in secure detention homes, cannot be accomplished with available funding. Present resources are already used to capacity.

Funding for mental health services in secure detention homes was not conceptualized as a need when secure detention was first begun in Virginia; therefore, no state general funds were designated for this purpose. Furthermore, reductions in available block grant funding has made it difficult for secure detention homes to add mental health services.

The impact of cuts in the block grant program has reduced the state dollars available to local juvenile justice programs. In the majority of instances, the block grant cuts have been absorbed by local budgets. These increased local costs have often necessitated cuts in other areas of local budgets. As further cuts in the block grant program are contemplated, localities will have to continue to make difficult funding choices. These choices will affect their local continuum of care.

Community Services Boards, who are responsible for meeting the mental health needs of children and youth, are unable to meet the demands for these services. Over one-half of Virginia Community Services Boards have waiting lists of more than one month for services, and the available services vary by locality. Historically, few state general funds have been appropriated to Community Services Boards for the provision of children's services. Budget cuts over the past few years have effectively reduced available services.

The Comprehensive Services Act has limited funding. This funding is prioritized for use by the children who are mandated by federal law to receive services: children in special education, foster care, and foster care prevention programs. Most children and youths who require services through Community Services Boards and the juvenile justice system are not part of the mandated population. These youths receive services through the Comprehensive Services Act only as funding is locally available.

Localities expressed concern that the identification of mental health problems among youth in secure detention homes will increase the financial burden of the locality — including match requirements.

Localities have expressed interest in the state's expanding Medicaid reimbursable services; but they also expressed a hope to the Team that increased Medicaid reimbursements could be used to increase the number of children being served, rather than simply to replace state general funds. The replacement of state general funds with Medicaid reimbursements would leave localities with inadequate resources to meet demands for services.

The Judiciary has consistently reported that there are both insufficient resources and no specific funding for the provision of mental health services to youth in the juvenile justice system.

Problem Statements

The Policy Design Team identified several issues in the mental health and juvenile justice systems that limit effective response to those youth in secure detention homes with immediate mental health problems.

1. Overcrowding has a negative impact on the mental health of youth in secure detention homes.
2. In the procedures for admission to secure detention homes, there are no standard, system-wide mental health screening mechanisms to identify mental health problems.
3. There are youth in secure detention who have severe or urgent mental health needs that require immediate intervention.
4. Once a youth in a secure detention home is identified as having mental health problems, it is unclear who has the responsibility to intervene.
5. Mental health residential facilities are not able to manage the aggressive behaviors of some youths. Secure detention homes are not routinely able to handle youth who have severe mental health needs.
6. Community mental health and secure detention home services are not coordinated in a uniform fashion across the state.
7. Access to mental health services for youth in secure detention homes is not consistent across the state.
8. Available community mental health services are not routinely meeting the needs of youth with severe or urgent mental health problems in secure detention homes.
9. Secure detention homes rarely have adequate information regard ing the prior mental health history, pre-existing conditions, and current mental health status of admitted youth.
10. There is no designated source of funding specifically to provide services in secure detention homes for youth with severe or urgent mental health needs.
11. There is disagreement regarding the appropriate amount and intensity of non-emergency mental health services that should be provided for youth in secure detention homes.
12. Most secure detention home staff do not have the training or professional support available to manage effectively youth with severe or urgent mental health problems.
13. The difficulties are compounded when youth — because of over crowding at their local facility — are placed outside of their local jurisdictions. Such distances further compound difficulties in the transition of youth back into the care of services in their home communities.

Recommendations

The Policy Design Team makes the following recommendations.

1. The placement or retention of youth in secure detention homes, solely to receive mental health evaluation or treatment, should be prohibited.
2. At the point of admission to secure detention homes, all youth should receive a screening for severe or urgent mental health needs.
3. All youth in secure detention homes, found to have severe or urgent mental health needs, must be delivered appropriate services. Agreement on providing services should be developed by the Department of Youth and Family Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and other appropriate state agencies. This process should involve the Community Services Boards and secure detention homes, as well as their commissions or boards.
4. Treatment plans should be developed for detained youth with mental health needs. Treatment plans should address the provision and monitoring of needed services, by both clearly identifying services to be provided and the agency responsible for its provision. Plans should also provide instruction to secure detention home staff on the management of the youth in their care.

5. Local interagency protocols, in keeping with existing statutes, should be developed for the timely transfer of youth between secure detention homes and inpatient psychiatric hospitals.

6. The *Code of Virginia* (§16.1-346.1) should be amended to require that the secure detention home to which a youth is discharged be specified as a recipient of pre-discharge plans.

7. If there is an issue about the appropriateness of the placement, a detention review hearing should be requested by the appropriate party prior to the discharge of a youth from a psychiatric hospital to a secure detention home.

8. Training should be provided to juvenile justice staff, especially secure detention home staff, on how to screen and respond to the mental health problems of youths in their care.

9. Training on how to control and intervene in the assaultive behaviors of youths should be developed and made available for mental health residential providers.

10. To the extent practical, parents or guardians should be involved in all phases of treatment. Parents or guardians — again, to the extent practical — should also be financially responsible for the mental health treatment of detained youths. Protocols should be developed to support this role. This should include follow-through to community care services.

11. A case review and consultation process should be available to secure detention home staff when emergency pre-screening does not result in hospitalization. Pre-screeners and other persons who will provide these services should receive specialized training.

12. The Department Mental Health, Mental Retardation and Substance Abuse Services should determine whether existing staff resources in Community Service Boards are sufficient to provide the treatment and community follow through services required by youth in Secure Detention Centers who have severe and urgent mental health problems and whether Community Service Board procedures support this role. If it is found that additional resources are required to provide necessary treatment and community follow through services, then The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Youth and Family Services should submit budget requests to the General Assembly to support the assessment, treatment planning, service, case follow-up, and staff training recommendations in this report. For the 1995 budget cycle, funding should be requested from the General Assembly to support the recommendations in this study. A cost proposal is presented in the next section of this report.

13. The administration should consider options to take these recommendations into action, to monitor the implementation of these recommendations, and to work at further meeting the mental health needs of youth in the larger juvenile justice system. Options for ways to accomplish these goals include a legislative study, a reappointed policy design team, or other executive branch mechanisms.

Costs of Providing Mental Health Services for Youth Who are in Secure Detention Homes

• What the Proposal Includes

This proposal represents the minimum cost of implementing the report recommendations.

Services identified in this proposal are for youth in secure detention homes with severe or urgent mental health problems. These services include mental health assessments, treatment planning, counseling, crisis intervention, staff consultation and training, and follow-through to community care.

This proposal does not include the costs of a full course of treatment for youth with severe or urgent mental health problems. The services proposed are meant to assure that youth are stabilized and properly controlled while in detention. Interventions are proposed that are regarded as emergency in scope, consistent with IJA-ABA Juvenile Justice Standards Related to Interim Status.

The costs of providing mental health services for youths in secure detention homes with moderate or minimal mental health problems are not addressed in this proposal. These are the youths with non-acute, non-emergency needs. The team supports enhancing a community-based delivery system for the completion of any emergency services initiated in secure detention. This system should provide a full range of services for these youths.

• Data Background to the Cost Proposal

In FY 93-94, there were 12,376 admissions to secure detention homes. The average daily secure detention home population was 655 youths, which was 123% of bed capacity. This study found that approximately 10% of detained youths have such severe or urgent mental health problems that they required intervention to prevent further deterioration. Services needed by these youths ranged from further evaluations, to intensive short term treatment, to arranging for hospitalization. At the time of the study, 46 youths (8.5%) had received a mental health evaluation. Seven (7) of these 46 youths had severe or urgent mental health problems. Only 14.3% (7 of 52) of the youths in the severe and urgent categories had received a mental health evaluation while in detention.

Fifteen percent of the youths in secure detention homes with severe or urgent mental health problems were receiving treatment services either on-site or off-site. Thirty-eight percent of these youths had prior outpatient mental health treatment. Fifty-four youths provided the information (self-reported data) that they had been taking medications prior to admission to detention. Of this number, 72% had medications on premises. In the severe and urgent range, 19 youths self-reported having been prescribed medication. Twelve (63%) were actually receiving dosages at the secure detention home.

• The Cost Proposal

The annual cost for the full proposal is $1,059,564.

The cost proposal is divided into two parts. The first part displays the costs of providing a minimal level of assessment and evaluation, crisis intervention, counseling, medication and staff consultation and training services for the seventeen secure detention homes. These services are directed toward youths in secure detention homes with severe or urgent mental health problems. The annual cost is $535,404.

The second part of the proposal displays the costs of providing treatment planning and follow through to community care for those youths with severe and urgent mental health problems who leave secure detention homes. The annual cost is $524,160.

PART ONE: Assessment and Evaluation, Crisis Intervention, Counseling, Medication and Staff Consultation and Training Services

Total Annual Cost: $535,404

Service Provider: Community Services Boards through a targeted appropriation.

Cost Basis:

- 20% of secure detention center youth to be assessed for services.
- 10% of secure detention center youth to receive services.
- 2 hours per week service for each 10 beds in a secure detention center X 52 weeks per year.
- 80% of hours provided for $60 per hour and 20% of hours provided for $90 per hour.

PART TWO: Treatment Planning and Follow Through to Community Care Services

Total Annual Cost: $524,160

Service Provider: Community Services Boards through a targeted appropriation.

Cost Basis:

- 10% of secure detention center youth to receive community follow through into services.
- 4 hours per week service for each 10 beds in a secure detention center X 52 weeks.
- All service hours provided at $35 per hour.

COST TABLE I

Secure Detention Home Service Cost All Locations for Evaluation, Crisis Intervention, Counseling, Medication and Staff Consultation and Training Services

Center	Filled Beds	Hours/Week	Allocation Per Year
Highlands	18-20	4	$13,728
New River	23-25	5	$17,160
Roanoke	25-30	6	$20,592
W.W. Moore	30	6	$20,592
Lynchburg	20	4	$13,728
Shenandoah	30	6	$20,592
Northern Va	50-55	11	$37,752
Prince William	40	8	$27,456
Fairfax	75-80	16	$54,912
Rappahonnock	25	5	$17,160
Tidewater	85-90	18	$61,776
Norfolk	55-60	12	$41,184
Newport News	55-60	12	$41,184
Chesterfield	40	8	$27,456
Crater	20-25	5	$17,160
Henrico	30	6	$20,594
Richmond	55-60	12	$41,184
STATE TOTAL		144 hours/week	$535,404/year

COST TABLE II

Secure Detention Home Service Cost All Locations for Treatment Planning and Follow Through to Community Care Services

Center	Filled Beds	Hours/Week	Allocation Per Year
Highlands	18-20	8	$14,560
New River	23-25	10	$18,200
Roanoke	25-30	12	$21,840
W.W. Moore	30	12	$21,840
Lynchburg	20	8	$14,560
Shenandoah	30	12	$21,840
Northern VA	50-55	22	$40,040
Prince William	40	16	$29,120
Fairfax	75-80	32	$58,240
Rappahannock	25	10	$18,200
Tidewater	85-90	36	$65,520
Norfolk	55-60	24	$43,680
Newport News	55-60	24	$43,680
Chesterfield	40	16	$29,120
Crater	20-25	10	$18,200
Henrico	30	12	$21,840
Richmond	55-60	24	$43,680
STATE TOTAL		288 hours/week	$524,160/year

APPENDICES

ASSESSMENT OF MENTAL HEALTH TREATMENT NEEDS

IN

VIRGINIA'S DETENTION CENTERS

September 1994

A Report to
Virginia's Policy Design Team

Submitted by:

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ACKNOWLEDGEMENTS

This study was the accomplishment of a concerted effort by a number of people. First of all, I would like to thank the Behavioral Services Unit clinicians who volunteered to participate in this project. For some staff, this meant being on the road most of the week. Dr. Bill Brock was instrumental in designing the study, developing the Mental Status Evaluation Form and helping to coordinate the study. I would also like to thank the other staff of the Policy Design Team : Marion Kelly who secured funding to pay for the staff expenses and consultation from the Commonwealth Institute for Child and Family Studies, also helped in the coordination of the project and data analysis, and Gary MacBeth, who provided consultation to the design of the study.

INTRODUCTION

Virginia's Policy Design Team, which was established in the summer of 1993 to evaluate state policies as they relate to the provision of mental health services within the juvenile justice arena, determined that the most pressing mental health treatment need was related to those youth housed in secure detention. However, there was little reliable data available about the scope of the problem. Therefore, the Policy Design Team decided that an assessment of the mental health treatment needs of youth in Virginia's secure detention centers was the logical first step in addressing this issue.

The Department of Criminal Justice Services was able to obtain funding to support the project and the Department of Youth and Family Services agreed to commit staff from its Behavioral Services Unit (BSU) to conduct clinical assessments. The data was to be processed on a contractual basis through the Institute for Child and Family Studies due to short time tables.

One of the major obstacles to be overcome was simply the magnitude of the project. There are 17 secure detention facilities in Virginia ranging in size from a design capacity of 20 to 55 youth. In actuality, most of the facilities operate above capacity, some significantly. It was estimated that there would be in excess of 650 youth in detention during the time of the study. Another logistical problem was the fact that these 17 facilities are located across the state from Bristol in the western part of the state, to Alexandria in the north and Chesapeake in the east.

The goal of this assessment project was to evaluate all the youth in detention during one week as a point-in-time study which would yield a snapshot picture of the mental health needs of youth in detention. The week of April 11-14 was chosen to accommodate the scheduling of BSU staff. Specifically, all youth who were

detained in a particular facility during the scheduled visit of BSU staff were to be included. The only exceptions were: youth who were not available during the visit (e.g., in court) or who refused to participate.

The mental health assessment of individual youth would consist of: a Mental Status Evaluation (MSE) conducted by a trained mental health clinician, an individually administered Symptom Check List (SCL-90-R), and a Juvenile Demographic and Information Form to be completed by detention home staff. In addition, approximately one third of the youth would be given an Achenbach Youth Self-Report for Ages 11-18 to be completed and returned to the interviewers prior to their leaving the facility. The interviews were expected to last about 30 minutes per youth.

Twenty staff were selected from the Behavioral Services Unit (BSU) to conduct the mental status evaluations. These 20 staff were divided into four teams which were assigned to facilities on a regional basis (i.e., Western, Northern, Eastern and Capitol). These 20 staff had an average of 10.7 years of experience in working with adolescents and all had at least a Masters degree (3 MSW's, 7 Ph.D.'s in Psychology and 10 MS's in Psychology).

Table 1 is a list of detention facilities by the four regions and the projected population for the week of April 11-14.

TABLE 1

Region/Facility	Projected Population
WESTERN REGION	146-155
Highlands	18-20
New River	23-25
Roanoke	25-30
W. W. Moore	30
Lynchburg	20
Shenanoah	30

Region/Facility	Projected Population
NORTHERN REGION	190-200
Northern Virginia	50-55
Prince William	40
Fairfax	75-80
Rappahannock	25
EASTERN REGION	195-210
Tidewater	85-90
Norfolk	55-60
Newport News	55-60
CAPITOL REGION	145-155
Chesterfield	40
Crater	20-25
Henrico	30
Richmond	55-60

PROCEDURES

The size of the four regional assessment teams was based on the projected number of youth in detention for each region during the week of April 11-14. It was anticipated that each clinician would be able to conduct 10 interviews per day (an MSE and administration of the SCL-90-R). Copies of the Juvenile Demographic and Information Form were sent to each of the detention facilities the week prior to the study week along with the specific dates of the team's visit during that week. All of the youth in the small facilities could be interviewed in one day while some of the larger facilities would require up to three days of interview time. In part, the amount of time it would take to complete the assessment at each facility was dependent on the amount of time available to interview youth and the number of private interview spaces that could be provided.

The assessment teams would interview each youth in the facility during the time the team was at that facility. Each youth was brought by detention staff to the interview room and read a standard set of instructions (Appendix A). If the youth agreed to participate, the staff would give the youth a copy of the response scale (Appendix B) and orally administer the SCL-90-R, record the responses on the designated form and conduct an abbreviated MSE and then return the youth to detention supervision. While waiting for the next youth the interviewers would complete the Mental Status Evaluation Form (Appendix C). If the youth chose not to participate he/she was returned to detention supervision.

There was no need to randomize the selection of youth for the interviews as it was the intent to interview all the youth in detention. Staff were instructed to give the Achenbach to approximately every third youth. The selection of youth to take the Achenbach was not completely random as the staff eliminated

youth who were not motivated or who would have difficultly completing the items (clinician's judgement).

In addition to the interviews, the assessment teams collected information on use of psychotropic medication with the detention population. All medications in a detention facility are kept in a secure location. The assessment teams completed a Psychotropic Medication Form (Appendix D) for each youth in the facility who had psychotropic medication stored in this location. In order to ensure the accuracy of this data, the information was taken directly from the medication bottles.

All the information related to a youth was collected and collated: MSE form, Juvenile Demographic and Information Form, Psychotropic Medication Form and the Achenbach (if administered). These forms were stapled together and coded with a subject number. All identifying information was removed from the packets prior to their being sent to the Institute for Child and Family Studies for data entry. A master list of subject numbers and names is maintained in a secure file cabinet by DYFS.

INSTRUMENTS

The following instruments/forms were used:

Mental Status Evaluation Form (APPENDIX C):

This form was developed by staff of the Behavioral Services Unit as a means for structuring the MSE's. Staff checked specific items related to the youth's attitude and general manner during the interview, asked questions about loss of consciousness and their mental health history and finally, determined the probable AXIS I diagnosis if applicable and rated the individual's need for mental health services.

Juvenile Demographic and Information Form (APPENDIX E):

This form was developed for detention facility staff to complete. It is designed to provide basic demographics and assess the kind of mental health information available to detention staff on the youth entrusted into their care.

SCL-90-R

The SCL-90-R is a 90 item self-report symptom inventory developed by Leonard R. Derogatis, Ph.D. It is designed to reflect the psychological symptom pattern of psychiatric and medical patients. Each item (i.e., symptom) is rated by the individual on a 5 point distress scale from 0 to 4.

0 = NOT AT ALL
1 = A LITTLE BIT
2 = MODERATELY
3 = QUITE A BIT
4 = EXTREMELY

The 90 items are scored and interpreted in terms of 9 primary symptom dimensions and 3 global indices of distress. The 9 primary symptom scales are:

1. Somatization
2. Obsessive-Compulsive
3. Interpersonal Sensitivity
4. Depression
5. Anxiety
6. Hostility
7. Phobic Anxiety
8. Paranoid Ideation
9. Psychotocism

The 3 global indices of distress are:

1. Global Severity Index
2. Positive Symptom Distress Index
3. Positive Symptom Total

Administration instructions call for providing the individual with a standard one week time set for rating the symptoms ("...7 days including today"). Test-retest reliability coefficients for

psychiatric outpatients for the 9 clinical scales run from .78 for Hostility to .90 for Phobic Anxiety.

Achenbach Youth Self-Report for Ages 11-18

Pages 3 and 4 of the Youth Self-Report for Ages 11-18 were selected for use in this study. These two pages present 119 problem statements which describe adolescents. Respondents are asked to rate the items as they might apply to themselves either now or within the past 6 months on a 3 point scale:

0 = Not True
1 = Somewhat or Sometimes True
2 = Very True or Often True

These 119 items are scored on 8 problems scales (103 items) and a social desirability scale (16 items). The 8 problems scales are:

I = Withdrawn
II = Somatic Complaints
III = Anxious/Depressed
IV = Social Problems
V = Thought Problems
VI = Attention Problems
VII = Delinquent Behaviors
VIII = Aggressive Behaviors

Psychotropic Medication Form (APPENDIX D)

This form was developed to record the name of the psychotropic medication, the dosage, and the frequency of administration.

RESULTS

The assessment of mental health needs of the youth detained in Virginia's secure detention facilities was conducted during the week of April 11-14, 1994. Of the approximately 670 youth who were in secure detention that week (the actual number varies from day to day) 605 youth were interviewed (92%). Of the youth who were not interviewed, only 15 (2%) were refusals. The remaining youth who were not interviewed were not available during the scheduled visit of the interviewers (e.g., in court, sick, etc.).

Table 2 presents a demographic breakdown of the youth who participated in the assessment:

TABLE 2

	Male	Female	White	Black	Hispanic	Other
Number:	502	103	224	352	23	6
Percent:	82.6	17.4	37.0	58.2	3.8	1.0

These figures are consistent with other demographic assessments of the detention population. The mean age of the assessment population was 15.5 years and the median number of days in detention was 17. The median was chosen as a more appropriate measure of "average" number of days in detention because of a small number of youth who spent unusually long periods of time in detention.

FIGURE 1

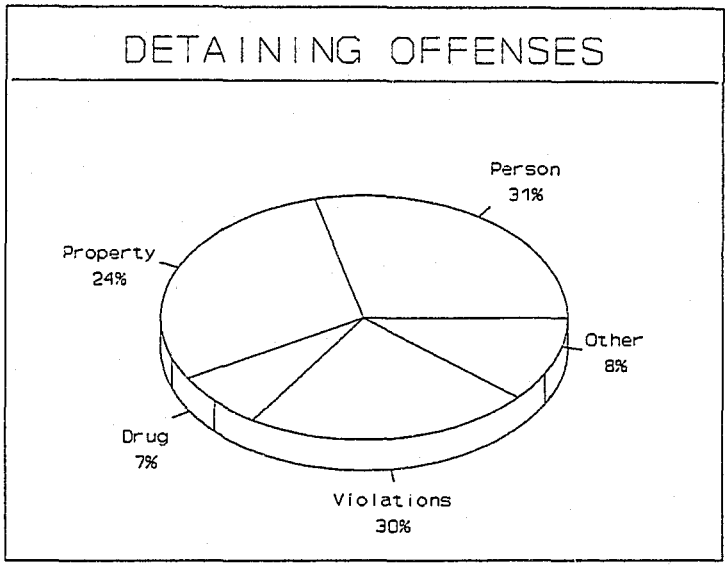


Figure 1 shows the groupings of the actual offenses for which the youth were detained by type of offense. As can be seen, the two largest groupings were for offenses against persons and technical violations (i.e., violation of probation, parole, or a court order). Property offenses comprised the next largest grouping (24%).

The data collected from the Juvenile Demographic and Information Forms, which were completed by the detention home staff, are more important for what they say about the quality of information available to detention home staff than they are for what they contribute to the knowledge of the mental health needs of the youth. In general, there is little documentation of prior history available at the detention facilities, though this does vary from facility to facility. At some facilities the only history data (including prior mental health treatment) available was self-report data collected from the youth on admission.

Table 3 displays the results collected from the Juvenile Demographic and Information Form.

TABLE 3

Item	Frequency	Percent	Frequency Unknown
Admitted from a psychiatric facility (N=565)	12	2.1	0
Youth has record of mental illness (N=550)	75	13.6	137
Youth has documented prior psychiatric hospitalization (N=556)	66	11.7	110
Youth has documented prior outpatient mental health treatment (N=549)	91	16.6	117
Youth has received a mental health evaluation while in detention (N=544)	46	8.5	0
Youth is receiving mental health treatment in detention (N=543)	27	5.0	1
Youth is on suicide watch (N=596)	80	13.4	0

These percentages are artificially low and indicate the poor quality of information which accompany a youth into detention. In part this is understandable because youth are brought into detention at all hours of day and night. However, the information does not seem to improve significantly as the duration of the youth's stay in detention increases. This finding is supported by the high frequency of "unknown" responses used on this form. The percentages of "unknown" as a response to the items related to the youths' histories range from 20% to 25%.

It is interesting to compare the data from Table 2 with the data collected by the clinicians from the youth during the interviews (See Table 4).

TABLE 4

Item	Frequency (N=602)	Percent
Youth reports a history of mental health treatment	334	55.5
Youth reports a history of inpatient mental health treatment	120	19.9
Youth reports a history of outpatient mental health treatment	291	48.3
Youth currently engaged in outpatient mental health treatment	57	9.5
Youth currently taking psychotropic medication	54	9.0
Youth reports a history of suicide attempts	98	16.3

These percentages reflect the youths' self report of prior mental health treatment, and if more accurate, indicate how often information regarding prior intervention efforts are not available for detention staff. More than half (55.5%) of the youth interviewed had indicated that they had had mental health treatment; whereas, even assuming there was no overlap in the items from Table 3, only 28.3% had documentation in the detention records of prior mental health treatment. Youth with prior mental health treatment might be expected to have more problems adjusting to detention and these findings would indicate that almost half of these youth are not identified when admitted to detention.

As part of the Mental Status Evaluation (MSE), the clinicians made judgements about the overall demeanor and behavior of the youth they were interviewing. What is most striking about this data is the degree of cooperativeness and absence of gross symptomatology. Table 5 displays these findings.

Upon inspection, Table 5 shows that few of the youth were uncooperative. There were only 7 youth who agreed to participate who were described by the clinicians as demonstrating poor

cooperation. Coupled with the 15 youth who refused to participate this means that only 3% of the youth housed in detention that week were openly uncooperative. Further inspection of this data reveals how few youth displayed symptomatology associated with serious mental health problems.

TABLE 5

Observation	Frequency	Percent
Physical Appearance:		
Appropriate	546	91.8
Disheveled	47	7.9
Unusual	3	0.5
Degree of Cooperativeness:		
Good	527	89.9
Fair	53	9.0
Poor	7	1.2
General Manner During Interview:		
Suspicious	31	5.2
Hostile	12	2.0
Preoccupied	13	2.2
Withdrawn	33	5.5
Anxious	39	6.6
Other	30	5.0
Appropriate	510	85.7
General Activity Level During Interview:		
Hyperactivity	21	3.5
Motor Retardation	0	0.0
Ritualized Behavior	1	0.2
Tics	1	0.2
Unusual Mannerisms	4	0.7
Other	9	1.5
Within Normal Limits	565	95.0
Speech Pattern:		
Abnormal Rate	2	0.3
Abnormal Rhythm	3	0.5
Bizarre Content	1	0.2
Within Normal Limits	584	98.8

Over 90% of the youth were seen as being dressed appropriately at the time of the interview but it should be remembered that this is a structured environment and the youth are issued specific clothing and required to perform basic personal hygiene activities. As was stated earlier, 98.9% of the youth were described as demonstrating good (89.9%) or fair (9.0%) degree of cooperation. Eighty-five percent displayed appropriate affect, 95.0% had a general activity level within normal limits and 98.8% showed no evidence of bizarre or unusual speech patterns. These findings are not surprising in that this was not a psychiatric inpatient setting.

Based upon the oral administration of the SCL-90-R and the clinical interview, the clinicians were asked to determine if the youth would qualify for a DSM-IIIR Axis I disorder. Seventy-seven percent of the youth interviewed were determined to meet this criteria. If the clinicians felt the youth would qualify they were then asked to check which of several listed DSM-IIIR diagnoses would apply. Table 6 details the distribution of these diagnoses.

TABLE 6

DSM-IIIR Diagnosis	Frequency	Percent (N =605)
Conduct Disorder/ Oppositional Defiant Disorder	317	52.4
Substance Abuse Disorder	133	22.0
Mood Disorder	105	17.4
Adjustment Disorder	80	13.2
Anxiety Disorder	34	5.6
Thought Disorder	12	2.0
Mental Retardation	11	1.8
Organic Disorder	5	0.8
Other Disorder	38	6.3

These are not unduplicated counts (a youth may have more than one diagnosis) but 459 individual youth (77%) were seen by the clinicians as qualifying for an AXIS I disorder. The high number of youth in the Conduct Disorder category (52.4%) is not surprising and as a matter of fact may be an under representation of youth who would have qualified. Youth in the juvenile justice system often meet the criteria for this diagnosis and a number of the clinicians reported that due to the emphasis on mental health treatment needs, they were not as likely to pursue specific diagnostic criteria for this category because it did not transfer into a need for "mental health" treatment. The same can be said for the Substance Abuse Disorder category (22.0%). The clinicians were focusing their attention on those diagnoses which often translate into a need for mental health treatment (e.g., Mood Disorder). Therefore, the Substance Abuse Disorder category is likely a conservative estimate of the percentage of youth who would actually qualify for this diagnosis. The clinicians identified 96 youth (15.9%) who were thought to qualify for an AXIS I diagnosis other than Conduct Disorder or Substance Abuse Disorder (e.g., Mood Disorder, Adjustment Disorder, etc.).

Perhaps the most important data obtained from this project relates to the clinicians' perceptions regarding the youths' needs for mental health services. While only 9% of the youth were determined to need immediate mental health services (2 youth were evaluated to need psychiatric hospitalization and the remaining 50 youth were thought to need mental health treatment while in detention), another 40% were seen as needing mental health services upon release from detention. (See Table 7)

Civil commitment procedures were initiated for the 2 youth who were identified as needing psychiatric hospitalization (A third youth was also referred for civil commitment pre-screening but that youth chose not to participate in this study). Of the 50 youth

who were identified as needing mental health treatment while in detention, only 13 (26%) were actually receiving this treatment. Due to the small number of youth in the "Urgent" category (N = 2) they were combined with the youth in the "Severe" category for additional analyses. This combination yields approximately 9% of the youth interviewed who were in need of immediate mental health treatment.

TABLE 7

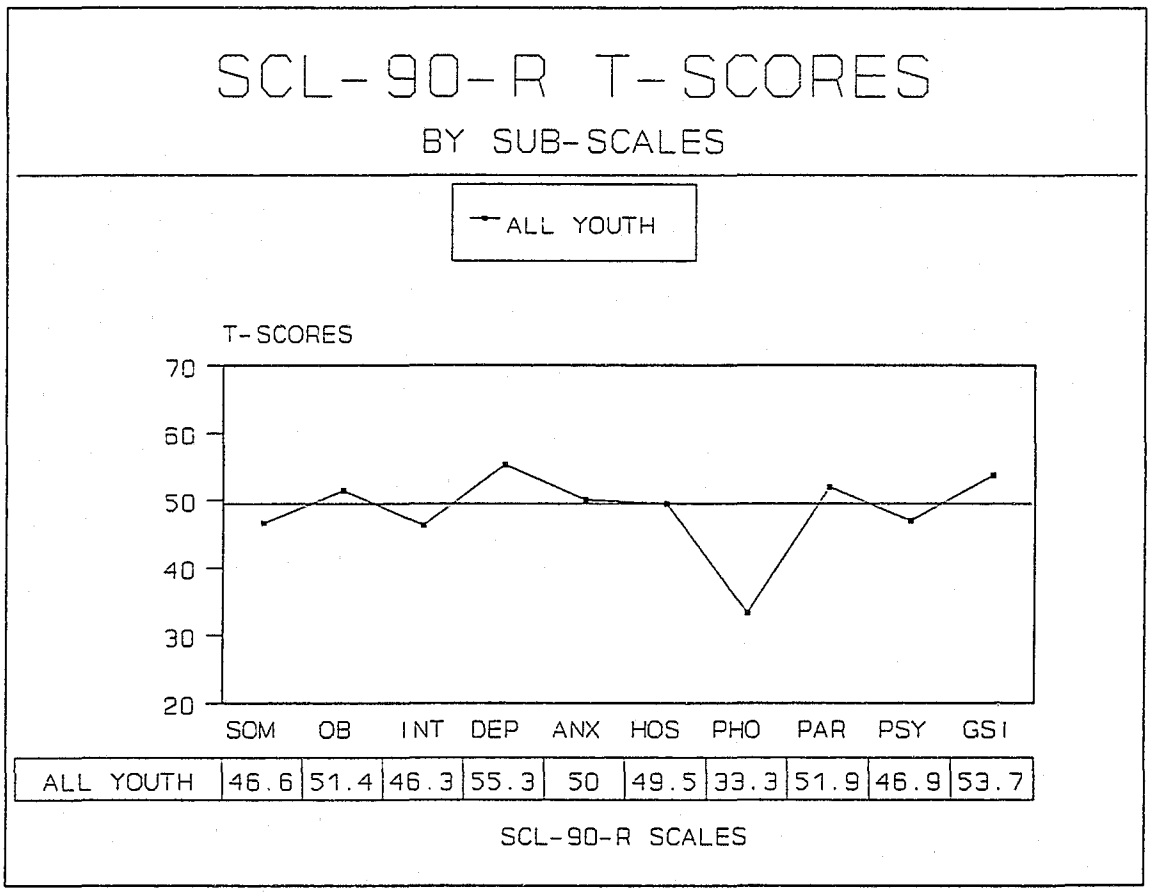
Need for Mental Health Treatment	Frequency	Percent
None (does not need)	127	21.5
Minimal (does not need but could benefit)	178	30.1
Moderate (needs but can wait till out of detention)	234	39.6
Severe (needs while in detention)	50	8.5
Urgent (needs hospitalization)	2	0.3

Standardized T-scores were computed for the 9 clinical scales and the Global Severity Index of the SCL-90-R for each youth. These scales are: somatization (SOM), obsessive-compulsive (OB), interpersonal sensitivity (INT), depression (DEP), anxiety (ANX), hostility (HOS), phobic anxiety (PHO), paranoid ideation (PAR), psychoticism (PSY) and global severity index (GSI).

Figure 2 provides a visual display of these T-scores. T-scores are conversions of the raw scores into a standardized scale with a mean of 50 and a standard deviation of 10. Analysis of this graph indicates that the mean T-scores for the population as a whole are very close to the mean scores of the standardization sample. Only the phobic anxiety scale differs to any extent. This scale

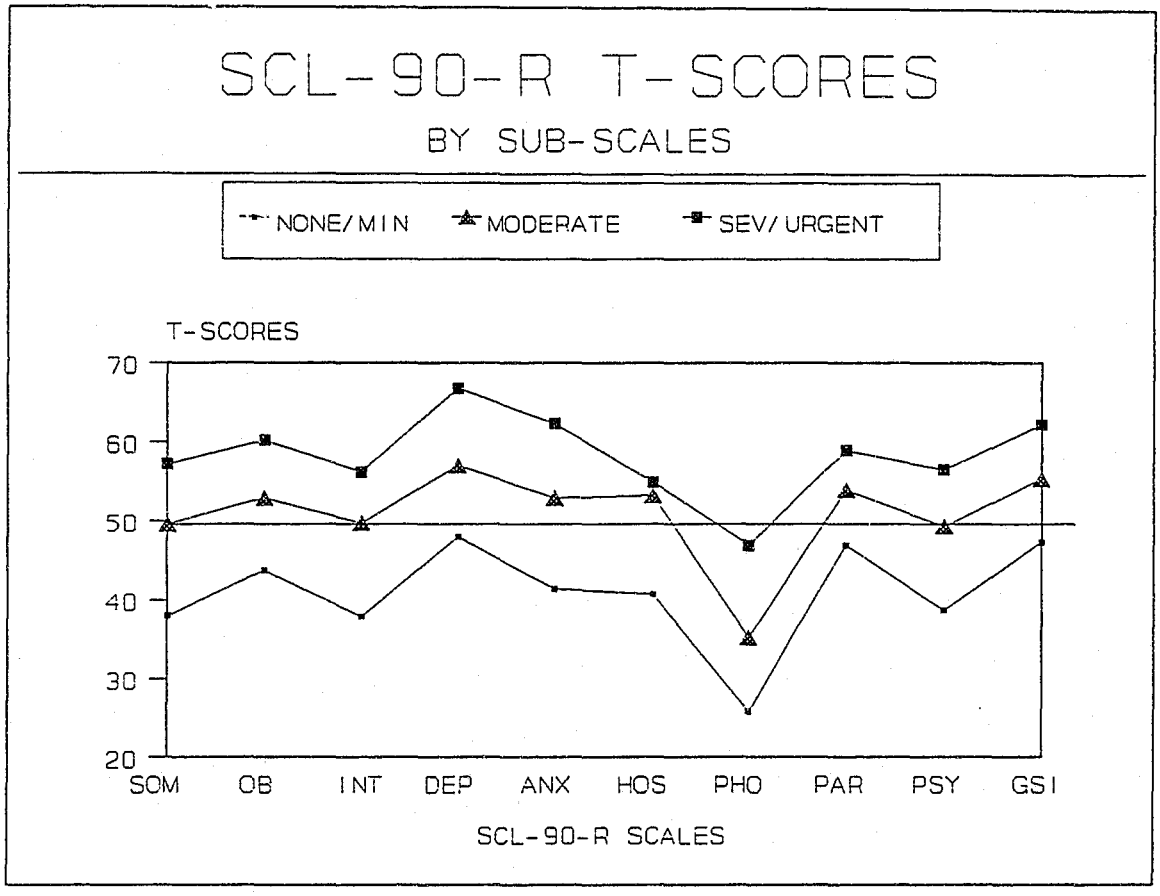
reflects endorsement of items associated with specific irrational fears (e.g., feeling afraid to travel on buses, subways, or trains). The T-score of 33.3 indicates that our overall sample of detention youth did not admit to such fears nearly as much as the adolescents who comprised the standardization sample.

FIGURE 2



Analyses of the data and discussions with the clinicians resulted in collapsing the 5 treatment need categories (none, minimal, moderate, severe and urgent) into 3 categories (none/min, moderate and sev/urgent). There appeared to be more personal bias associated with the decision to classify the youth's mental health

FIGURE 3



treatment need as either "none" or "minimal" than actual differences in their perceived needs and only 2 youth were classified as urgent. There was more agreement concerning those youth who needed mental health treatment and the timing of that treatment (either immediately or upon release from detention).

Figure 3 displays the detention population T-scores grouped according to the clinicians' perceptions of mental health treatment needs using the 3 category scale (none/min, moderate/sev/urgent). What is most noteworthy about this graph is the symmetry of the lines and the almost uniform progression of ascribed symptomatology associated with a higher mental health treatment need. The

none/min category shows T-scores which are all below the standardized mean whereas the means for the clinical scales in the sev/urgent category are all above the mean except for one (PHO). Interestingly, the moderate category falls almost on a mid-point between the two extremes.

Utilizing the DSM-IIIR diagnoses as a classification variable it is possible to compare various diagnostic categories with respect to their mean T-scores on SCL-90-R clinical scales. The classifications of NONE (did not qualify for an AXIS I diagnosis), CONDUCT (qualified for only conduct disorder), SUBSTANCE (qualified for only substance abuse disorder) and OTHER (qualified for an Axis I disorder other than conduct disorder or substance abuse disorder) were selected for this analysis. In addition, those youth on suicide watch at the detention facilities were also selected for a separate category (SUICIDE).

TABLE 9

SCL-90-R SCALE	NONE	CONDUCT	SUBSTANCE	OTHER	SUICIDE
SOM	36.1	38.9	45.4	46.8	51.3
OB	40.6	46.1	50.3	52.0	53.7
INT	37.1	40.3	40.8	47.2	49.4
DEP	46.5	48.6	54.0	55.9	57.9
ANX	40.6	41.1	46.3	50.3	53.1
HOS	38.9	42.9	47.0	51.0	51.9
PHO	24.5	28.6	29.1	34.2	39.4
PAR	46.9	46.5	46.4	53.2	52.8
PSY	36.1	41.6	44.3	47.4	48.1
GSI	45.4	48.6	51.2	54.1	55.6

Examination of this table indicates consistent patterns of SCL-90-R clinical scale T-scores within the individual diagnostic categories. Youth who were on suicide watch (SUICIDE) endorse the most symptom pathology of the selected categories followed by those youth with a DSM-IIIR AXIS I diagnosis other than substance abuse or conduct disorder (OTHER). In fact, the T-scores for the conduct

disorder diagnosis (CONDUCT) most resemble the youth who did not qualify for an AXIS I diagnosis (NONE).

The global severity index (GSI) is described by Derogatis as "... the most sensitive single numeric indicator of the respondent's psychological distress, combining information on the numbers of symptoms and intensity of distress". Again we see the progression of mean T-scores for the GSI from a low of 45.4 for the NONE category to a high of 55.6 for the SUICIDE category. The CONDUCT group also obtained a mean T-score (48.6) below the standardization sample mean while the OTHER group's mean T-score (54.1) was above that mean.

When these same diagnostic categories are examined with respect to the classification of perceived mental health treatment needs the same pattern appears. Table 10 shows the ratings of mental health treatment needs by the percentage of youth within each of these categories.

TABLE 10

Category	Treatment Need None/Min	Moderate	Sev/Urgent
No Disorder	94.2%	5.1%	0.7%
Conduct Disorder	72.8%	25.9%	1.3%
Substance Abuse Disorder	19.2%	80.8%	-
Other DSM-IIIR Disorder	19.3%	59.7%	21.0%
Suicide Watch	28.2%	44.9%	26.9%

Only 5.8% of the youth seen as not qualifying for an AXIS I diagnosis were perceived to need mental health treatment (either while in detention or after release from detention), but 80.7% of the youth with an AXIS I diagnosis other than conduct disorder or substance abuse disorder and 71.8% of those youth on suicide watch

were seen as needing such treatment. None of the youth who were thought to qualify for a diagnosis of substance abuse disorder were thought to need mental health treatment immediately (while in detention) but 80.8% were seen as needing this treatment upon release from detention.

As part of the clinical interview, each youth was questioned regarding any head traumas which led to a loss of consciousness. Twenty-five percent of the youth interviewed reported some form of a head trauma (e.g., falls, accidents, etc.) resulting in a loss of consciousness. Of those youth, 28.2% reported being knocked unconscious more than once (22.5% = 2X, 5.6% = 3X or more). Medical attention was reported needed in 54% of the incidents.

Data was collected about the number of youth in detention who were taking psychotropic medication and the types of these medications. In order to ensure accuracy, the interviewers collected the information about the psychotropic medication directly from the drug containers at each of the facilities. All prescribed medications are kept in a secure location and were made accessible to the project staff.

Thirty-nine youth were taking psychotropic medication at the time of this assessment (6.4%). Table 11 provides a summary of these medications by drug type. There were a total of 56 prescriptions taken by these 39 youth.

TABLE 11

Drug Type	Number of Prescriptions
Antidepressant	17
CNS Stimulants	12
Antimanic/Mood Stabilizer	8
Neuroleptics	6
Antihypertensive	3
Antiepilectic	2
Antiparkinsonian	1

When questioned by the clinicians, 54 youth reported currently taking psychotropic medication. In part, this discrepancy is due to the fact that some youth reported that they were taking psychotropic medication but that it had not yet been brought to the facility by their parents.

Finally, separate analyses were performed to investigate any gender differences. It is a general assumption that females within the juvenile justice system have more emotional problems than their male counterparts. Table 12 shows the clinicians' perceptions of mental health treatment needs by gender.

TABLE 12

Mental Health Treatment Need

	None	Minimal	Moderate	Severe/Urgent
Male (502)	23.2%	30.7%	38.7%	7.4%
Female (103)	13.6%	27.2%	43.7%	15.5%

While there was essentially no difference between the percentages of each gender which would qualify for an Axis I diagnosis (males = 76.1% and females = 74.8%) there were some differences in the type of diagnosis. For example, 53.8% of the males were thought to qualify for a diagnosis of Conduct Disorder but only 45.6% of the females and more than a third (35%) of the females were thought to suffer from a mood disorder but only 13.7% of the males. The next largest gender difference occurred in the category of Substance Abuse Disorder where 23.1% of the males were thought to meet the diagnostic criteria but only 16.5% of the females. Gender differences in the other diagnostic categories were all less than 4 percent.

DISCUSSION

The main purpose of this assessment of the mental health needs of youth in detention was to determine if service gaps existed and how great those gaps were. Anecdotal data about the "numbers" of youth who are housed in detention facilities with severe mental health needs abounded. It begged the question, how bad is the problem?

This assessment clearly indicated that there are youth with pressing mental health needs who are not being provided services while housed in detention. However, the data indicates that the number of youth who had severe (need mental health service now) or urgent (need psychiatric hospitalization) mental health treatment needs is manageable. Approximately, 9% of the youth in Virginia's detention centers were seen by experienced clinicians to be in immediate need of mental health treatment. Currently, only a quarter (26%) of those youth were actually receiving such services.

The data collected in this assessment is unique in a number of ways. First of all, an attempt was made to interview all the youth who were housed in each of the 17 detention facilities during a specific week (April 11-14). Secondly, the Department of Youth and Family Services committed staff from its Behavioral Services Unit, which ensured the consistency of having experienced clinicians familiar with a delinquent adolescent population, to conduct the interviews. And finally, the project came off almost as planned.

The population interviewed during the week of the assessment was representative of the general detention population with regards to basic demographic data (e.g., gender, ethnic origin, age, etc.). But more importantly, 92% of the youth housed in detention were actually included in the study. For this reason alone, we can feel comfortable in our findings that they are at least representative of the youth who were in detention that week.

While the high percentage of the detained youth included in the assessment provides us with a degree of confidence in the results, we must also remember that the data is based on a 30 minute interview. Classifications into specific DSM-IIIR diagnostic categories are estimates. One would never propose to routinely make such diagnostic decisions in such a short time. But the main purpose of this study was to assess the mental health needs of the youth and identify relevant service gaps. The DSM-IIIR classifications may not be 100% accurate but the consistency of the various elements of the data suggest that the overall findings are sound.

Youth who have emotional problems (i.e., mental health needs) present special problems to detention staff. Their behavior will tend to be more unpredictable, they will be more susceptible to the stress of overcrowding, they will demand more staff attention, they will likely be at higher risk for self-injurious behavior and they will generally be more disruptive in the normal detention routine. As a result of these youth, staff will experience more stress and find it difficult to provide regular supervision to the other youth. When these conditions occur, the liability for everyone associated with detention increases.

In addition to the 9% of youth who need immediate mental health services there are an estimated 40% who need mental health treatment but were thought to be capable of waiting to receive these services until they left detention. However, individual mental health needs fluctuate as a function of the environment and relative stress. Youth who were seen as needing mental health treatment, but not immediately, could very well move up to the immediate category for any number of reasons (e.g., increased stress, when notified of the disposition of their case, etc,). While not an immediate concern to detention staff these youth in the moderate category will eventually need services.

During the week of this assessment the detention homes were not as overcrowded as they sometimes are. Had this study been conducted during a more crowded time period there could have been a higher percentage of youth in the category that needed immediate mental health services.

Data collected from the detention home records is abysmally weak. Youth who have not had prior contact with the juvenile justice system will quite likely have little information available; but youth who have had numerous contacts with the juvenile authorities should have better information provided to the detention facilities. Detention staff should know, whenever possible, that a youth has had a previous mental health treatment. Whereas, only 25-30% of the youth admitted to detention had any documentation of prior mental health treatment in their records, 55.5% of the youth interviewed report prior mental health treatment efforts. Detention home staff could have youth with serious emotional problems in their care and have no knowledge of their history even though in some cases this information is available to court service unit staff.

It is precisely because of this reason that staff in the detention centers should be trained on how to identify youth with mental health problems and how to deal with youth who have a history of mental health treatment. Besides the obvious need to prevent self-injurious behavior or even suicide, training on how to deal with these youth can improve the daily interactions and functioning of these youth within the detention center program and lower stress levels for both youth and staff.

Classification of youth into discrete categories of mental health treatment needs, diagnoses, or symptom patterns serves little functional value. Comparing the relationships among these variables does provide a form of convergent validity for the findings. The relatively high rates of concordance between the

clinicians ratings of mental health treatment needs and diagnostic categories coupled with supporting evidence from the SCL-90-R clinical scales clearly demonstrate that there are youth housed in our detention facilities with significant mental health problems. The numbers of these youth may not be as devastatingly high as previously thought but they are still sufficiently high to indicate the need for an interdepartmental response.

Analysis of the data is still being conducted. Response patterns from the Achenbach Youth Self Report have not yet been analyzed due to the need to verify the validity of the protocols. A more thorough report will be issued when these analyses are complete.

APPENDIX A

INSTRUCTIONS

HELLO, MY NAME IS _____. WE'RE HERE TODAY TO ASSESS THE SERVICE NEEDS OF YOUTH IN DETENTION. WE WILL BE INTERVIEWING EVERY YOUTH IN DETENTION AROUND THE STATE THIS WEEK.

YOUR ANSWERS TO THE QUESTIONS I'M GOING TO ASK WILL BE KEPT CONFIDENTIAL. ANYTHING YOU TELL ME WILL BE KEPT SECRET, UNLESS YOU THREATEN TO HURT SOMEONE OR YOURSELF. YOUR NAME WILL NOT BE USED IN ANY REPORT. AS A MATTER OF FACT, ONCE WE HAVE ALL OF YOUR INFORMATION WE WILL TAKE YOUR NAME OFF THE FORMS. WE'RE INTERESTED IN THE INFORMATION FROM ALL THE YOUTH IN DETENTION NOT JUST YOUR ANSWERS.

YOU ARE NOT REQUIRED TO BE PART OF THIS SURVEY. IF YOU CHOOSE TO NOT PARTICIPATE WE CAN STOP AT ANY TIME.

NOW, I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT PROBLEMS YOU MIGHT HAVE. FIRST, I'M GOING TO READ A LIST PROBLEMS PEOPLE SOMETIMES HAVE. PLEASE LISTEN TO EACH ONE CAREFULLY. I WANT YOU TO THINK ABOUT HOW MUCH THAT PROBLEM HAS BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. USING THIS SCALE (hand youth scale) I WOULD LIKE YOU TO GIVE ME A NUMBER FOR EACH PROBLEM I READ. (go over scale with youth).
IF YOU HAVE ANY QUESTIONS PLEASE ASK THEM.

APPENDIX B

0 = NOT AT ALL

1 = A LITTLE BIT

2 = MODERATELY

3 = QUITE A BIT

4 = EXTREMELY

APPENDIX C

YOUTH'S NAME: _____ D.O.B._____

****

DETENTION FACILITY: _____ INTERVIEWER: _____

I. ATTITUDE AND GENERAL BEHAVIOR:
(check all that apply but at least one per item)

A. Physical Appearance:
( ) appropriate ( ) disheveled ( ) unusual_____

B. Degree of cooperativeness:
( ) good ( ) fair ( ) poor

C. General Manner:
( ) suspicious ( ) hostile
( ) preoccupied ( ) withdrawn
( ) anxious ( ) other
( ) appropriate

D. General Activity:
( ) hyperactivity ( ) motor retardation
( ) ritualized behaviors ( ) tics
( ) unusual mannerisms ( ) other
( ) within normal limits

E. Speech Pattern:
( ) abnormal rate ( ) abnormal rhythm
( ) bizarre content ( ) within normal limits

II: HAS YOUTH EVER LOST CONSCIOUSNESS DUE TO HEAD TRAUMA?
( ) yes ( ) no

If yes:
How many times:_____
Did it require medical attention? ( ) yes ( ) no

Evidence of organic dysfunction by history or current evaluation: ( ) yes ( ) no
If yes, explain:_____

_____

_____

III: MENTAL HEALTH HISTORY:
Based on the youth's report, the evaluator suspects that the youth:

( ) does not have a history of mental health treatment

( ) has a history of inpatient mental health treatment

( ) has a history of outpatient mental health treatment

( ) is currently engaged in outpatient mental health treatment

( ) is currently prescribed psychotropic medication for a mental health problem

( ) has a history of suicide attempts

IV: EVIDENCE SUGGESTS THAT THIS INDIVIDUAL WOULD QUALIFY FOR AN **AXIS I** DISORDER:

( ) yes ( ) no

If yes, which of the following do you suspect:
(check all that apply)

( ) Conduct Disorder/ODD
( ) Adjustment Disorder
( ) Mood Disorder
( ) Thought Disorder
( ) Anxiety Disorder
( ) Mental Retardation
( ) Organic Disorder
( ) Substance Abuse Disorder
( ) Other, specify:_____

V: MENTAL HEALTH ASSESSMENT:
In the evaluator's opinion, this youth's need for mental health treatment is: (circle one)

0	1	2	3	4
none	minimal	moderate	severe	urgent

none	= does not need
minimal	= does not need but could benefit
moderate	= needs but can wait till out of detention
severe	= needs while in detention
urgent	= needs hospitalization

COMMENTS:

APPENDIX D
PSYCHOTROPIC MEDICATION

FACILITY:_____

NAME:_____ D.O.B._____/____/_____

****

DRUG:_____ DOSAGE:_____ FREQUENCY:_____

PHYSICIAN:_____

DRUG:_____ DOSAGE:_____ FREQUENCY:_____

PHYSICIAN:_____

DRUG:_____ DOSAGE:_____ FREQUENCY:_____

PHYSICIAN:_____

DRUG:_____ DOSAGE:_____ FREQUENCY:_____

PHYSICIAN:_____

DRUG:_____ DOSAGE:_____ FREQUENCY:_____

PHYSICIAN:_____

APPENDIX E

Juvenile Demographic and Information Form

Facility:_____ Today's Date:____/____/____ (mm/dd/yy)

Youth's Name:_____

****

Information on Youth

Date Admitted to Detention:____/____/____ (mm/dd/yy) D.O.B.:____/____/____ (mm/dd/yy)

Gender (check one): ( ) male ( ) female

Race (check one): ( ) Caucasian ( ) African-American
( ) Hispanic ( ) Asian-American ( ) Mixed Race ( ) Other

Offenses for which youth is being detained: 1.____ 2.____ 3.____
(enter the DYFS code for each offense)

Youth was admitted to detention directly from a psychiatric facility: ( ) yes ( ) no

Does youth have a record of mental illness: ( ) yes
( ) no
( ) unknown

Documented prior Psychiatric Hospitalization: ( ) yes
( ) no
( ) unknown

Documented prior outpatient mental health treatment: ( ) yes
( ) no
( ) unknown

Has the youth received a mental health evaluation while in detention: ( ) yes ( ) no

Is youth receiving mental health treatment in detention: ( ) yes
( ) no

If yes: ( ) on site ( ) off site

Condition if known:_____
(e.g., depression, sex offender, etc.)

Is youth on suicide watch: ( ) yes ( ) no

If, in your estimation, this youth requires placement in a setting other than detention, specify:

_____

Appendix II

Code of Virginia Section Citations

§ 16.1-335. Short title. — The provisions of this article shall be known and may be cited as "The Psychiatric Inpatient Treatment of Minors Act." (1990, c. 975.)

§ 16.1-336. Definitions. — When used in this article, unless the context otherwise requires:

"Consent" means the voluntary, express, and informed agreement to treatment in a mental health facility by a minor fourteen years of age or older and by a parent or a legally authorized custodian.

"Inpatient treatment" means placement for observation, diagnosis, or treatment of mental illness in a psychiatric hospital or in any other type of mental health facility determined by the State Mental Health, Mental Retardation and Substance Abuse Services Board to be substantially similar to a psychiatric hospital with respect to restrictions on freedom and therapeutic intrusiveness.

"Least restrictive alternative" means the treatment and conditions of treatment which, separately and in combination, are no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the minor or others from physical injury.

"Mental health facility" means a public or private facility for the treatment of mental illness operated or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"Mental illness" means a substantial disorder of the minor's cognitive, volitional, or emotional processes that demonstrably and significantly impairs judgment or capacity to recognize reality or to control behavior. "Mental illness" may include substance abuse, which is the use, without compelling medical reason, of any substance which results in psychological or physiological dependency as a function of continued use in such a manner as to induce mental, emotional, or physical impairment and cause socially dysfunctional or socially disordering behavior. Mental retardation, head injury, a learning disability, or a seizure disorder is not sufficient, in itself, to justify a finding of mental illness within the meaning of this article.

"Minor" means a person less than eighteen years of age.

"Parent" means (i) a biological or adoptive parent who has legal custody of the minor, including either parent if custody is shared under a joint decree or agreement, (ii) a biological or adoptive parent with whom the minor regularly resides, (iii) a person judicially appointed as a legal guardian of the minor, or (iv) a person who exercises the rights and responsibilities of legal custody by delegation from a biological or adoptive parent, upon provisional adoption or otherwise by operation of law. The director of the local department of social services, or his designee, may stand as the minor's parent when the minor is in the legal custody of the local department of social services.

"Qualified evaluator" means a psychiatrist or a psychologist licensed in Virginia by either the Board of Medicine or the Board of Psychology who is skilled in the diagnosis and treatment of mental illness in minors and familiar with the provisions of this article. If such psychiatrist or psychologist is unavailable, any mental health professional (i) licensed in Virginia through the Department of Health Professions or (ii) employed by a community services board who is skilled in the diagnosis and treatment of mental illness in minors and who is familiar with the provisions of this article may serve as the qualified evaluator.

"Treatment" means any planned intervention intended to improve a minor's functioning in those areas which show impairment as a result of mental illness. (1990, c. 975; 1991, c. 159.)

§ 16.1-337. Inpatient treatment of minors; general applicability. — A minor may be admitted to a mental health facility for inpatient treatment only pursuant to §§ 16.1-338, 16.1-339, or § 16.1-340 or in accordance with an order of involuntary commitment entered pursuant to §§ 16.1-341 through 16.1-345. The provisions of Article 12 (§ 16.1-299 et seq.) of Chapter 11 of this title relating to the confidentiality of files, papers, and records shall apply to proceedings under §§ 16.1-339 through 16.1-345. (1990, c. 975; 1992, c. 539.)

§ 16.1-338. Parental admission of minors younger than fourteen and nonobjecting minors fourteen years of age or older. — A. A minor younger than fourteen years of age may be admitted to a willing mental health facility for inpatient treatment upon application and with the consent of a parent. A minor fourteen years of age or older may be admitted to a willing mental health facility for inpatient treatment upon the joint application and consent of the minor and the minor's parent.

B. Admission of a minor under this section shall be approved by a qualified evaluator who has conducted a personal examination of the minor within forty-eight hours after admission and has made the following written findings:

1. The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; and

2. The minor has been provided with a clinically appropriate explanation of the nature and purpose of the treatment; and

3. If the minor is fourteen years of age or older, that he has been provided with an explanation of his rights under this Act as they would apply if he were to object to admission, and that he has consented to admission; and

4. All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor.

If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide the examination required by this section and shall ensure that the necessary written findings have been made before approving the admission. A copy of the written findings of the evaluation required by this section shall be provided to the consenting parent and the parent shall have the opportunity to discuss the findings with the evaluator.

C. Within ten days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the admission and to the minor. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured. A copy of the plan shall be provided to the minor and to his parents.

D. If the parent who consented to a minor's admission under this section revokes his consent at any time, or if a minor fourteen or older objects at any time to further treatment, the minor shall be discharged within forty-eight hours to the custody of such consenting parent unless the minor's continued hospitalization is authorized pursuant to §§ 16.1-339, 16.1-340, or § 16.1-345.

E. Inpatient treatment of a minor hospitalized under this section may not exceed ninety consecutive days unless it has been authorized by appropriate hospital medical personnel, based upon their written findings that the criteria set forth in subsection B of this section continue to be met, after such persons have examined the minor and interviewed the consenting parent and reviewed reports submitted by members of the facility staff familiar with the minor's condition.

F. Any minor admitted under this section while younger than fourteen and his consenting parent shall be informed orally and in writing by the director of the facility for inpatient treatment within ten days of his fourteenth birthday that continued voluntary treatment under the authority of this section requires his consent. (1990, c. 975; 1991, c. 159.)

§ 16.1-339. (For effective date — See note) Parental admission of an objecting minor fourteen years of age or older. — A. A minor fourteen years of age or older who objects to admission may be admitted to a willing facility for up to seventy-two hours, pending the review required by subsections B and C of this section, upon the application of a parent. If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide the examination required by subsection B of § 16.1-338 and shall ensure that the necessary written findings, except the minor's consent, have been made before approving the admission.

B. A minor admitted under this section shall be examined within twenty-four hours of his admission by a qualified evaluator designated by the community services board serving the area where the facility is located who is not and will not be treating the minor and who has no significant financial interest in the minor's hospitalization. The evaluator shall prepare a report which shall include written findings as to whether:

B. A minor admitted under this section shall be examined within twenty-four hours of his admission by a qualified evaluator designated by the community services board serving the area where the facility is located who is not and will not be treating the minor and who has no significant financial interest in the minor's hospitalization. The evaluator shall prepare a report which shall include written findings as to whether:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of inpatient treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. Inpatient treatment is the least restrictive alternative that meets the minor's needs. The qualified evaluator shall submit his report to the family court for the jurisdiction in which the facility is located.

C. Upon admission of a minor under this section, the facility shall immediately file a petition for judicial approval with the family court for the jurisdiction in which the facility is located. A copy of this petition shall be delivered to the minor's consenting parent. Upon receipt of the petition and of the evaluator's report submitted pursuant to subsection B, the family court judge or special justice appointed pursuant to § 37.1-88 shall appoint a guardian ad litem for the minor. The court and the guardian ad litem shall review the petition and evaluator's report, and shall ascertain the views of the minor, the minor's consenting parent, the evaluator, and the attending psychiatrist. The court shall conduct its review in such place and manner, including the facility, as it deems to be in the best interests of the minor. Based upon its review and the recommendations of the guardian ad litem, the court shall order one of the following dispositions:

1. If the court finds that the minor does not meet the criteria for admission specified in subsection B, the court shall issue an order directing the facility to release the minor into the custody of the parent who consented to the minor's admission. However, nothing herein shall be deemed to affect the terms and provisions of any valid court order of custody affecting the minor.

2. If the court finds that the minor meets the criteria for admission specified in subsection B, the court shall issue an order authorizing continued hospitalization of the minor for up to ninety days on the basis of the parent's consent.

Within ten days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the admission and to the minor. A copy of the plan shall also be provided to the guardian ad litem. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured.

3. If the court determines that the available information is insufficient to permit an informed determination regarding whether the minor meets the criteria specified in subsection B, the court shall schedule a commitment hearing which shall be conducted in accordance with the procedures specified in §§ 16.1-341 through 16.1-345. The minor may be detained in the hospital for up to seventy-two additional hours pending the holding of the commitment hearing.

D. A minor admitted under this section who rescinds his objection may be retained in the hospital pursuant to § 16.1-338.

E. If the parent who consented to a minor's admission under this section revokes his consent at any time, the minor shall be released within forty-eight hours to the parent's custody unless the minor's continued hospitalization is authorized pursuant to § 16.1-340 or § 16.1-345. (1990, c. 975; 1991, c. 159; 1993, c. 930.)

Section set out twice. — The section above is effective July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2. For this section as effective until July 1, 1996, if such funds are provided, and after July 1, 1996, if such funds are not provided, see the preceding section, also numbered 16.1-339.

Editor's note. — Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, provides that the amendment to this section by Acts 1993, c. 930, cl. 1, shall become effective July 1, 1996, "if state funds are provided to carry out the purposes of this bill by the General Assembly."

The 1993 amendment substituted "family court" for "juvenile and domestic relations district court" throughout the section. For effective date, see the Editor's note.

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of inpatient treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. Inpatient treatment is the least restrictive alternative that meets the minor's needs. The qualified evaluator shall submit his report to the juvenile and domestic relations district court for the jurisdiction in which the facility is located.

C. Upon admission of a minor under this section, the facility shall immediately file a petition for judicial approval with the juvenile and domestic relations district court for the jurisdiction in which the facility is located. A copy of this petition shall be delivered to the minor's consenting parent. Upon receipt of the petition and of the evaluator's report submitted pursuant to subsection B, the juvenile and domestic relations district court judge or special justice appointed pursuant to § 37.1-88 shall appoint a guardian ad litem for the minor. The court and the guardian ad litem shall review the petition and evaluator's report, and shall ascertain the views of the minor, the minor's consenting parent, the evaluator, and the attending psychiatrist. The court shall conduct its review in such place and manner, including the facility, as it deems to be in the best interests of the minor. Based upon its review and the recommendations of the guardian ad litem, the court shall order one of the following dispositions:

1. If the court finds that the minor does not meet the criteria for admission specified in subsection B, the court shall issue an order directing the facility to release the minor into the custody of the parent who consented to the minor's admission. However, nothing herein shall be deemed to affect the terms and provisions of any valid court order of custody affecting the minor.

2. If the court finds that the minor meets the criteria for admission specified in subsection B, the court shall issue an order authorizing continued hospitalization of the minor for up to ninety days on the basis of the parent's consent.

Within ten days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the admission and to the minor. A copy of the plan shall also be provided to the guardian ad litem. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured.

3. If the court determines that the available information is insufficient to permit an informed determination regarding whether the minor meets the criteria specified in subsection B, the court shall schedule a commitment hearing which shall be conducted in accordance with the procedures specified in §§ 16.1-341 through 16.1-345. The minor may be detained in the hospital for up to seventy-two additional hours pending the holding of the commitment hearing.

D. A minor admitted under this section who rescinds his objection may be retained in the hospital pursuant to § 16.1-338.

E. If the parent who consented to a minor's admission under this section revokes his consent at any time, the minor shall be released within forty-eight hours to the parent's custody unless the minor's continued hospitalization is authorized pursuant to § 16.1-340 or § 16.1-345. (1990, c. 975; 1991, c. 159.)

§ 16.1-339. (Delayed effective date — See notes) Parental admission of an objecting minor fourteen years of age or older. — A. A minor fourteen years of age or older who objects to admission may be admitted to a willing facility for up to seventy-two hours, pending the review required by subsections B and C of this section, upon the application of a parent. If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide the examination required by subsection B of § 16.1-338 and shall ensure that the necessary written findings, except the minor's consent, have been made before approving the admission.

§ 16.1-340. (For effective date — See note) Emergency admission. — A minor may be taken into custody and admitted for inpatient treatment pursuant to the procedures specified in § 37.1-67.1. If the minor is admitted to a willing facility in accordance with § 37.1-67.1, the temporary detention order shall be effective until such time as the juvenile and domestic relations district court schedules a hearing. The juvenile and domestic relations district court shall schedule a hearing pursuant to § 16.1-341 no sooner than twenty-four hours and no later than seventy-two hours from the time of the issuance of the temporary detention order. If the seventy-two hour period expires on a Saturday, Sunday or other legal holiday, the seventy-two hours shall be extended to the next day which is not a Saturday, Sunday or legal holiday. In no case may the time period between the filing of the petition and the hearing under § 16.1-344 exceed ninety-six hours. (1990, c. 975; 1991, c. 159; 1992, c. 884.)

§ 16.1-340. (Delayed effective date — See notes) Emergency admission. — A minor may be taken into custody and admitted for inpatient treatment pursuant to the procedures specified in § 37.1-67.1. If the minor is admitted to a willing facility in accordance with § 37.1-67.1, the temporary detention order shall be effective until such time as the family court schedules a hearing. The family court shall schedule a hearing pursuant to § 16.1-341 no sooner than twenty-four hours and no later than seventy-two hours from the time of the issuance of the temporary detention order. If the seventy-two hour period expires on a Saturday, Sunday or other legal holiday, the seventy-two hours shall be extended to the next day which is not a Saturday, Sunday or legal holiday. In no case may the time period between the filing of the petition and the hearing under § 16.1-344 exceed ninety-six hours. (1990, c. 975; 1991, c. 159; 1992, c. 884; 1993, c. 930.)

§ 16.1-341. (For effective date — See note) Involuntary commitment; petition; hearing scheduled; notice and appointment of counsel. — A. A petition for the involuntary commitment of a minor may be filed with the juvenile and domestic relations district court by a parent or, if the parent is not available or is unable or unwilling to file a petition, by any responsible adult. The petition shall include the name and address of the petitioner and the minor and shall set forth in specific terms why the petitioner believes the minor meets the criteria for involuntary commitment specified in § 16.1-345. The petition shall be taken under oath.

If a commitment hearing has been scheduled by a juvenile and domestic relations district judge pursuant to subdivision 3 of subsection C of § 16.1-339, the petition for judicial approval filed by the facility under subsection C of § 16.1-339 shall serve as the petition for involuntary commitment as long as such petition complies in substance with the provisions of this subsection.

B. Upon the filing of a petition for involuntary commitment of a minor, the juvenile and domestic relations district court may schedule a hearing which shall occur no sooner than twenty-four hours and no later than seventy-two hours from the time the petition was filed. If the seventy-two-hour period expires on a Saturday, Sunday or other legal holiday, the seventy-two hours shall be extended to the next day that is not a Saturday, Sunday or legal holiday. In no case may the time period between the filing of the petition and the hearing under § 16.1-344 exceed ninety-six hours.

If the petition is not dismissed, copies of the petition, together with a notice of the hearing, shall be served immediately upon the minor and the minor's parents, if they are not petitioners. No later than twenty-four hours before the hearing, the court shall appoint counsel to represent the minor, unless it has determined that the minor has retained counsel. Upon the request of the minor's counsel, for good cause shown, and after notice to the petitioner and all other persons receiving notice of the hearing, the court may continue the hearing once for a period not to exceed seventy-two hours. (1990, c. 975; 1991, c. 159; 1992, c. 539.)

Section set out twice. — The section above is effective until July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, and after July 1, 1996, if such funds are not provided. For this section as effective July 1, 1996, if such funds are provided, see the following section, also numbered 16.1-341.

§ 16.1-341. (Delayed effective date — See notes) Involuntary commitment; petition; hearing scheduled; notice and appointment of counsel. — A. A petition for the involuntary commitment of a minor may be filed with the family court by a parent or, if the parent is not available or is unable or unwilling to file a petition, by any responsible adult. The petition shall include the name and address of the petitioner and the minor and shall set forth in specific terms why the petitioner believes the minor meets the criteria for involuntary commitment specified in § 16.1-345. The petition shall be taken under oath.

If a commitment hearing has been scheduled by a family court judge pursuant to subdivision 3 of subsection C of § 16.1-339, the petition for judicial approval filed by the facility under subsection C of § 16.1-339 shall serve as the petition for involuntary commitment as long as such petition complies in substance with the provisions of this subsection.

B. Upon the filing of a petition for involuntary commitment of a minor, the family court may schedule a hearing which shall occur no sooner than twenty-four hours and no later than seventy-two hours from the time the petition was filed. If the seventy-two-hour period expires on a Saturday, Sunday or other legal holiday, the seventy-two hours shall be extended to the next day that is not a Saturday, Sunday or legal holiday. In no case may the time period between the filing of the petition and the hearing under § 16.1-344 exceed ninety-six hours.

If the petition is not dismissed, copies of the petition, together with a notice of the hearing, shall be served immediately upon the minor and the minor's parents, if they are not petitioners. No later than twenty-four hours before the hearing, the court shall appoint counsel to represent the minor, unless it has determined that the minor has retained counsel. Upon the request of the minor's counsel, for good cause shown, and after notice to the petitioner and all other persons receiving notice of the hearing, the court may continue the hearing once for a period not to exceed seventy-two hours. (1990, c. 975; 1991, c. 159; 1992, c. 539; 1993, c. 930.)

Section set out twice. — The section above is effective July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2. For this section as effective until July 1, 1996, if such funds are provided, and after July 1, 1996, if such funds are not provided, see the preceding section, also numbered 16.1-341.

§ 16.1-342. (For effective date — See note) Involuntary commitment; clinical evaluation. — Upon the filing of a petition for involuntary commitment, the juvenile and domestic relations district court shall direct the community services board serving the area in which the minor is located to arrange for an evaluation, if one has not already been performed pursuant to subsection B of § 16.1-339, by a qualified evaluator who is not and will not be treating the minor and who has no significant financial interest in the facility to which the minor would be committed. The petitioner, all public agencies, and all providers or programs which have treated or who are treating the minor, shall cooperate with the evaluator and shall promptly deliver, upon request and without charge, all records of treatment or education of the minor. At least twenty-four hours before the scheduled hearing, the evaluator shall submit to the court a written report which includes the evaluator's opinion regarding whether the minor meets the criteria for involuntary commitment specified in § 16.1-345. The evaluator shall attend the hearing as a witness. (1990, c. 975.)

Section set out twice. — The section above is effective until July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, and after July 1, 1996, if such funds are not provided. For this section as effective July 1, 1996, if such funds are provided, see the following section, also numbered 16.1-342.

§ 16.1-342. (Delayed effective date — See notes) Involuntary commitment; clinical evaluation. — Upon the filing of a petition for involuntary commitment, the family court shall direct the community services board serving the area in which the minor is located to arrange for an evaluation, if one has not already been performed pursuant to subsection B of § 16.1-339, by a qualified evaluator who is not and will not be treating the minor and who has no significant financial interest in the facility to which the minor would be committed. The petitioner, all public agencies, and all providers or programs which have treated or who are treating the minor, shall cooperate with the evaluator and shall promptly deliver, upon request and without charge, all records of treatment or education of the minor. At least twenty-four hours before the scheduled hearing, the evaluator shall submit to the court a written report which includes the evaluator's opinion regarding whether the minor meets the criteria for involuntary commitment specified in § 16.1-345. The evaluator shall attend the hearing as a witness. (1990, c. 975; 1993, c. 930.)

§ 16.1-343. Involuntary commitment; duties of attorney for the minor. — As far as possible in advance of a hearing conducted under § 16.1-344, or an appeal from such a hearing, the minor's attorney shall interview the minor; the minor's parent, if available; the petitioner; and the qualified evaluator. He shall interview all other material witnesses, and examine all relevant diagnostic and other reports. The obligation of the minor's attorney during the hearing or appeal is to interview witnesses, obtain independent experts when possible, cross-examine adverse witnesses, present witnesses on behalf of the minor, articulate the wishes of the minor, and otherwise fully represent the minor in the proceeding. Counsel appointed by the court shall be compensated in an amount not to exceed $100. (1990, c. 975; 1993, c. 344.)

§ 16.1-344. (For effective date — See note) Involuntary commitment; hearing. — The court shall summon to the hearing all material witnesses requested by either the minor or the petitioner. All testimony shall be under oath. The rules of evidence shall apply; however, the evaluator's report required by § 16.1-342 shall be admissible into evidence by stipulation of the parties. The petitioner, minor and, with leave of court for good cause shown, any other person shall be given the opportunity to present evidence and cross-examine witnesses. The hearing shall be closed to the public unless the minor and petitioner request that it be open. Within thirty days of any final order committing the minor or dismissing the petition, the minor or petitioner shall have the right to appeal de novo to the circuit court having jurisdiction where the minor was committed or where the minor is hospitalized pursuant to the commitment order. The juvenile and domestic relations district court shall appoint an attorney to represent any minor desiring to appeal who does not appear to be already represented. (1990, c. 975; 1992, c. 539.)

§ 16.1-345. Involuntary commitment; criteria. — The court shall order the involuntary commitment of the minor to a mental health facility for treatment for a period not to exceed ninety days if it finds, by clear and convincing evidence, that:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;
2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and
3. If inpatient treatment is ordered, such treatment is the least restrictive alternative that meets the minor's needs. If the court finds that inpatient treatment is not the least restrictive treatment, the court may order the minor to participate in outpatient or other clinically appropriate treatment.

If the parent or parents with whom the minor resides are not willing to approve the proposed commitment, the court shall order inpatient treatment only if it finds, in addition to the criteria specified in this section, that such treatment is necessary to protect the minor's life, health, or normal development, and that issuance of a removal order or protective order is authorized by § 16.1-252 or § 16.1-253.

Upon finding that the best interests of the minor so require, the court may enter an order directing either or both of the minor's parents to comply with reasonable conditions relating to the minor's treatment.

If the minor is committed to inpatient treatment, such placement shall be in a mental health facility for inpatient treatment designated by the community services board which serves the political subdivision in which the minor was evaluated pursuant to § 16.1-342. If the community services board does not provide a placement recommendation at the hearing, the minor shall be placed in a mental health facility designated by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. The judge shall order the sheriff to transport the minor to the designated mental health facility as specified in § 37.1-71. The transportation of the committed minor by the minor's parent may be authorized at the discretion of the judge. (1990, c. 975; 1992, c. 539.)

§ 16.1-346. Treatment plans; periodic review of status. — A. Within ten days of commitment ordered under § 16.1-345, the director of the facility to which the minor was committed shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and, if applicable, has been communicated to the parent. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured. A copy of the plan shall be provided to the minor and to his parents.

B. A minor committed to inpatient treatment shall be discharged from the facility when he no longer meets the commitment criteria as determined by appropriate hospital medical staff review. (1990, c. 975; 1991, c. 159.)

§ 16.1-346.1. Predischarge plan. — Prior to discharge of any minor admitted to inpatient treatment, a predischarge plan shall be formulated, provided and explained to the minor, and copies thereof shall be sent to the minor's parents or, if the minor is in the custody of the local department of social services, to the department's director or the director's designee. If the minor was admitted to a state facility, the predischarge plan shall be prepared and implemented in accordance with § 37.1-98.2. The plan shall, at a minimum, (i) specify the services required by the released patient in the community to meet the minor's needs for treatment, housing, nutrition, physical care, and safety; (ii) specify any income subsidies for which the minor is eligible; (iii) identify all local and state agencies which will be involved in providing treatment and support to the minor; and (iv) specify services which would be appropriate for the minor's treatment and support in the community but which are currently unavailable. (1991, c. 159.)

§ 16.1-347. Fees and expenses for qualified evaluators. — Every qualified evaluator appointed by the court to conduct an evaluation pursuant to § 16.1-342 who is not regularly employed by the Commonwealth shall be compensated for fees and expenses as provided in § 37.1-89. The cost of an evaluation conducted pursuant to § 16.1-338 or § 16.1-339 shall be considered for all purposes a cost of treatment and shall be compensated as a professional fee billed by or on behalf of the qualified evaluator to the patient or any responsible third party payor. (1990, c. 975.)

§ 16.1-348. (For effective date — See note) Availability of judge. — The chief judge of every juvenile and domestic relations district court shall establish and require that a judge, as defined in § 37.1-1, be available seven days a week, twenty-four hours a day, for the purpose of performing the duties established by this article. (1990, c. 975.)

Section set out twice. — The section above is effective until July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, and after July 1, 1996, if such funds are not provided. For this section as effective July 1, 1996, if such funds are provided, see the following section, also numbered 16.1-348.

§ 16.1-348. (Delayed effective date — See notes) Availability of judge. — The chief judge of every family court shall establish and require that a judge, as defined in § 37.1-1, be available seven days a week, twenty-four hours a day, for the purpose of performing the duties established by this article. (1990, c. 975; 1993, c. 930.)

CHAPTER 46.

COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES.

§ 2.1-746. State executive council; members; duties. — The members of the state executive council shall be the Commissioners of Health, of Mental Health, Mental Retardation and Substance Abuse Services and of Social Services; the Superintendent of Public Instruction; the Executive Secretary of the Virginia Supreme Court; the Director of the Department of Youth and Family Services; and a parent representative. The parent representative shall be appointed by the Governor for a term not to exceed three years and shall not be an employee of any public or private program which serves children and families. The council shall annually elect a chairman who shall be responsible for convening the council. The council shall meet, at a minimum, semiannually, to oversee the administration of this chapter and make such decisions as may be necessary to carry out its purposes.

The state executive council shall:

1. Appoint the members of the state management team in accordance with the requirements of § 2.1-747;

2. Provide for the establishment of interagency programmatic and fiscal policies developed by the state management team, which support the purposes of this chapter, through the promulgation of regulations by the participating state boards or by administrative action, as appropriate;

3. Oversee the administration of state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

4. Provide for the administration of necessary interagency functions which support the work of the state management team;

5. Review and take appropriate action on issues brought before it by the state management team; and

6. Advise the Governor and appropriate Cabinet Secretaries on proposed policy and operational changes which facilitate interagency service develop-

§ 2.1-746. State executive council; members; duties. — The members of the state executive council shall be the Commissioners of Health, of Mental Health, Mental Retardation and Substance Abuse Services and of Social Services; the Superintendent of Public Instruction; the Executive Secretary of the Virginia Supreme Court; the Director of the Department of Youth and Family Services; and a parent representative. The parent representative shall be appointed by the Governor for a term not to exceed three years and shall not be an employee of any public or private program which serves children and families. The council shall annually elect a chairman who shall be responsible for convening the council. The council shall meet, at a minimum, semiannually, to oversee the administration of this chapter and make such decisions as may be necessary to carry out its purposes.

The state executive council shall:

1. Appoint the members of the state management team in accordance with the requirements of § 2.1-747;

2. Provide for the establishment of interagency programmatic and fiscal policies developed by the state management team, which support the purposes of this chapter, through the promulgation of regulations by the participating state boards or by administrative action, as appropriate;

3. Oversee the administration of state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

4. Provide for the administration of necessary interagency functions which support the work of the state management team;

5. Review and take appropriate action on issues brought before it by the state management team; and

6. Advise the Governor and appropriate Cabinet Secretaries on proposed policy and operational changes which facilitate interagency service develop-

ment and implementation, communication and cooperation. (1992, cc. 837, 880.)

Editor's note. — Acts 1993, cc. 232 and 283, cls. 1 and 2 add to Acts 1992, cc. 837 and 880, which enacted this section, a cl. 6 which provides: "That the funding formula to carry out the purposes of this act is as follows:

"That the funding formula to carry out the purposes of this act is as follows:

"1. Base year funds for localities. — No locality shall ever receive less state funds in accordance with § 2.1-757 of the Code of Virginia than it received in the base year which is defined as Fiscal Year 1992. The match for a locality to draw this base year allocation of state funds shall be the same dollar amount as the locality paid in Fiscal Year 1992 to match state funds.

"2. Formula for state funds. — The following formula shall be used to compute a locality's allocation of state dollars in excess of the amount it received in the base year which is defined as Fiscal Year 1992: total youth population age 0-17 years as reported in the United States Census (33.33 percent); food stamp recipients in households with a child under the age of eighteen as reported by the Department of Social Services (33.33 percent); founded and reason to suspect child protective services complaints as reported by the Department of Social Services (17.75 percent); seriously emotionally disturbed or learning disabled children as reported by the Department of Education (10.34 percent); and juvenile court intake complaints as reported by the Department of Youth and Family Services (5.25 percent).

"The data used to compute this formula shall be updated annually based on the latest available information.

"Every locality shall receive the larger of $25,000 or an amount determined by computing a locality's formula allocation. The amount to be allocated by formula is defined as appropriations in excess of Fiscal Year 1992 expenditures.

"3. Allocation adjustment. — Any locality whose total allocation for Fiscal Year 1994 through the state pool of funds, established by § 2.1-757, is less than the expenditures it incurred in Fiscal Year 1993 to meet the same service needs for youth and families, shall have its Fiscal Year 1994 allocation increased by the State Executive Council, established by § 2.1-746, if the Council determines the locality's expenditures for Fiscal Year 1993 reflect a more accurate level of expenditures over time. Any such adjustments shall be made by October 1, 1993.

"4. Local match. — A locality's match for all state funds that exceed the amount it received in Fiscal Year 1992 shall be computed by using each locality's per capita revenue capacity as determined by the Commission on Local Government divided by the statewide per capita revenue capacity. The resulting ratio for each locality shall be multiplied by an aggregate local share of forty-five percent. Each local share shall then be adjusted according to income in each locality, as determined by dividing the median adjusted gross income for all state income tax returns in each locality by the median adjusted gross income for all income tax returns statewide. Local shares shall not exceed forty-five percent of the total new funds allocated by the formula established by this act.

"The data used to compute local match rates shall use the most recent information published by the Commission on Local Government and shall be updated once each biennium.

"5. Definition. — For the purposes of this sixth enactment clause, "locality" means any county of city.

Effective date. — This section is effective July 1, 1992.

§ 2.1-747. (For effective date — See note) State management team; appointment; membership. — The state management team is hereby established to better serve the needs of troubled and at-risk youths and their families by managing cooperative efforts at the state level and providing support to community efforts. The team shall be appointed by and be responsible to the state executive council set out in § 2.1-746. The team shall include one representative from each of the following state agencies: the Department of Health, Department of Youth and Family Services, Department of Social Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Education. The team shall also include a parent representative who is not an employee of any public or private program which serves children and families; a representative of a private organization or association of providers for children's or family services; a juvenile and domestic relations district court judge; and one member from each of five different geographical areas of the Commonwealth and who is representative of the different participants of community policy and management teams. The nonstate agency members shall serve staggered terms of not more than three years, such terms to be determined by the state executive council.

The team shall annually elect a chairman who shall be responsible for convening the team. The team shall develop and adopt bylaws to govern its operations which shall be subject to approval by the state executive council. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.1-639.15 of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.). Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act. (1992, cc. 837, 880.)

Section set out twice. — The section above is effective until July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, and after July 1, 1996, if such funds are not provided. For this section as effective July 1, 1996, if such funds are provided, see the following section, also numbered 2.1-747.

§ 2.1-747. (Delayed effective date — See notes) State management team; appointment; membership. — The state management team is hereby established to better serve the needs of troubled and at-risk youths and their families by managing cooperative efforts at the state level and providing support to community efforts. The team shall be appointed by and be responsible to the state executive council set out in § 2.1-746. The team shall include one representative from each of the following state agencies: the Department of Health, Department of Youth and Family Services, Department of Social Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Education. The team shall also include a parent representative who is not an employee of any public or private program which serves children and families; a representative of a private organization or association of providers for children's or family services; a family court judge; and one member from each of five different geographical areas of the Commonwealth and who is representative of the different participants of community policy and management teams. The nonstate agency members shall serve staggered terms of not more than three years, such terms to be determined by the state executive council.

The team shall annually elect a chairman who shall be responsible for convening the team. The team shall develop and adopt bylaws to govern its operations which shall be subject to approval by the state executive council. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.1-639.15 of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.). Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act. (1992, cc. 837, 880; 1993, c. 930.)

Section set out twice. — The section above is effective July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2. For this section as effective until July 1, 1996, if such funds are provided, and after July 1, 1996, if such funds are not provided, see the preceding section, also numbered 2.1-747.

Editor's note. — Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, provides that the amendment to this section by Acts 1993, c. 930, cl. 1, shall become effective July 1, 1996, "if state funds are provided to carry out the purposes of this bill by the General Assembly."

The 1993 amendment substituted "family court judge" for "juvenile and domestic relations district court judge" in the next to the last sentence of the first paragraph. For effective date, see the Editor's note.

§ 2.1-748. State management team; powers and duties. — The state management team is authorized to:

1. Develop and recommend to the state executive council interagency program and fiscal policies which promote and support cooperation and collaboration in the provision of services to troubled and at-risk youths and their families at the state and local levels;

2. Develop and recommend to the state executive council state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

3. Provide for training and technical assistance at the state level and to localities in the provision of efficient and effective services that are responsive to the strengths and needs of troubled and at-risk youths and their families; and

4. Serve as liaison to the participating state agencies which administratively support the team and which provide other necessary services by serving as fiscal agent, designing and administering the interagency tracking and evaluation system, and providing training and technical assistance. (1992, cc. 837, 880.)

Effective date. — This section is effective July 1, 1992.

§ 2.1-749. Duties of agencies represented on state management team. — The state agencies represented on the state management team shall provide administrative support for the team in the development and implementation of the collaborative system of services and funding authorized by this chapter. This support shall also include, but not be limited to, the provision of timely fiscal information, data for client- and service-tracking, and assistance in training local agency personnel on the system of services and funding established by this chapter. (1992, cc. 837, 880.)

Effective date. — This section is effective July 1, 1992.

§ 2.1-750. Community policy and management team; appointment; fiscal agent. — Every county, city, or combination of counties, cities, or counties and cities shall establish a community policy and management team in order to receive funds pursuant to this chapter. Each such team shall be appointed by the governing body of the participating local political subdivision establishing the team. In making such appointments, the governing body shall ensure that the membership is appropriately balanced among the representatives required to serve on the team in accordance with § 2.1-751. When any combination of counties, cities or counties and cities establishes a community policy and management team, the board of supervisors of each participating county or the council in the case of each participating city shall jointly establish the size of the team and the type of representatives to be selected from each locality in accordance with § 2.1-751. The governing bodies of each participating county and city served by the team shall appoint the designated representatives from their localities. The participating governing bodies shall jointly designate an official of one member city or county to act as fiscal agent for the team.

The county or city which comprises a single team and the county or city whose designated official serves as the fiscal agent for the team in the case of joint teams shall annually audit the total revenues of the team and its programs. The county or city which comprises a single team and any combination of counties or cities establishing a team shall arrange for the provision of legal services to the team. (1992, cc. 837, 880.)

§ 2.1-751. (For effective date — See note) Community policy and management teams; membership; immunity from liability. — The community policy and management team to be appointed by the local governing body shall include, at a minimum, the local agency heads or their designees of the following community agencies: community services board established pursuant to § 37.1-195, juvenile court services unit, department of health, department of social services and the local school division. The team shall also include a representative of a private organization or association of providers for children's or family services if such organizations or associations are located within the locality and a parent representative who is not an employee of any public or private program which serves children and families. Those persons appointed to represent community agencies shall be authorized to make policy and funding decisions for their agencies.

The local governing body may appoint other members to the team including, but not limited to, a local government official, a local law-enforcement official and representatives of other public agencies.

When any combination of counties, cities or counties and cities establishes a community policy and management team, the membership requirements previously set out shall be adhered to by the team as a whole.

Persons who serve on the team shall be immune from any civil liability for decisions made about the appropriate services for a family or the proper placement or treatment of a child who comes before the team, unless it is proven that such person acted with malicious intent. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.1-639.15 of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.). Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act. (1992, cc. 837, 880.)

Section set out twice. — The section above is effective until July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, and after July 1, 1996, if such funds are not provided. For this section as effective July 1, 1996, if such funds are provided, see the following section, also numbered 2.1-751.

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, as amended by Acts 1993, cc. 232 and 283, cls. 1 and 2, provides that this section shall become effective July 1, 1993.

§ 2.1-751. (Delayed effective date — See notes) Community policy and management teams; membership; immunity from liability. — The community policy and management team to be appointed by the local governing body shall include, at a minimum, the local agency heads or their designees of the following community agencies: community services board established pursuant to § 37.1-195, family court services unit, department of health, department of social services and the local school division. The team shall also include a representative of a private organization or association of providers for children's or family services if such organizations or associations are located within the locality and a parent representative who is not an employee of any public or private program which serves children and families. Those persons appointed to represent community agencies shall be authorized to make policy and funding decisions for their agencies.

The local governing body may appoint other members to the team including, but not limited to, a local government official, a local law-enforcement official and representatives of other public agencies.

When any combination of counties, cities or counties and cities establishes a community policy and management team, the membership requirements previously set out shall be adhered to by the team as a whole.

Persons who serve on the team shall be immune from any civil liability for decisions made about the appropriate services for a family or the proper placement or treatment of a child who comes before the team, unless it is proven that such person acted with malicious intent. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.1-639.15 of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.). Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act. (1992, cc. 837, 880; 1993, c. 930.)

Section set out twice. — The section above is effective July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2. For this section as effective until July 1, 1996, if such funds are provided, and after July 1, 1996, if such funds are not provided, see the preceding section, also numbered 2.1-751.

Editor's note. — Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, provides that the amendment to this section by Acts 1993, c. 930, cl. 1, shall become effective July 1, 1996, "if state funds are provided to carry out the purposes of this bill by the General Assembly."

The 1993 amendment substituted "family court services" for "juvenile court services" in the first sentence of the first paragraph. For effective date, see the Editor's note.

§ 2.1-752. Community policy and management teams; powers and duties. — The community policy and management team shall manage the cooperative effort in each community to better serve the needs of troubled and at-risk youths and their families and to maximize the use of state and community resources. Every such team shall:

1. Develop interagency policies and procedures to govern the provision of services to children and families in its community;
2. Develop interagency fiscal policies governing access to the state pool of funds by the eligible populations including immediate access to funds for emergency services and shelter care;
3. Coordinate long-range, community-wide planning which ensures the development of resources and services needed by children and families in its community;
4. Establish policies governing referrals and reviews of children and families to the family assessment and planning teams and a process to review the teams' recommendations and requests for funding;
5. Establish quality assurance and accountability procedures for program utilization and funds management;
6. Establish procedures for obtaining bids on the development of new services;
7. Manage funds in the interagency budget allocated to the community from the state pool of funds, the trust fund, and any other source;
8. Authorize and monitor the expenditure of funds by each family assessment and planning team;
9. Have authority to submit grant proposals which benefit its community to the state trust fund and to enter into contracts for the provision or operation of services upon approval of the participating governing bodies; and
10. Serve as its community's liaison to the state management team, reporting on its programmatic and fiscal operations and on its recommendations for improving the service system, including consideration of realignment of geographical boundaries for providing human services. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, as amended by Acts 1993, cc. 232 and 283, cls. 1 and 2, provides that this section shall become effective July 1, 1993.

§ 2.1-753. (For effective date — See note) Family assessment and planning team; membership; immunity from liability. — Each community policy and management team shall establish and appoint one or more family assessment and planning teams as the needs of the community require. Each family assessment and planning team shall include representatives of the following community agencies who have authority to access services within their respective agencies: community services board established pursuant to § 37.1-195, juvenile court services unit, department of health, department of social services, local school division and a parent representative who is not an employee of any public or private program which serves children and families. The family assessment and planning team may include a representative of a private organization or association of providers for children's or family services and of other public agencies.

Persons who serve on a family assessment and planning team shall be immune from any civil liability for decisions made about the appropriate services for a family or the proper placement or treatment of a child who comes before the team, unless it is proven that such person acted with malicious intent. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.1-639.15 of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.). Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act. (1992, cc. 837, 880.)

Section set out twice. — The section above is effective until July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, and after July 1, 1996, if such funds are not provided. For this section as effective July 1, 1996, if such funds are provided, see the following section, also numbered 2.1-753.

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, as amended by Acts 1993, cc. 232 and 283, cls. 1 and 2, provide that this section shall become effective July 1, 1993.

§ 2.1-753. (Delayed effective date — See notes) Family assessment and planning team; membership; immunity from liability. — Each community policy and management team shall establish and appoint one or more family assessment and planning teams as the needs of the community require. Each family assessment and planning team shall include representatives of the following community agencies who have authority to access services within their respective agencies: community services board established pursuant to § 37.1-195, family court services unit, department of health, department of social services, local school division and a parent representative who is not an employee of any public or private program which serves children and families. The family assessment and planning team may include a representative of a private organization or association of providers for children's or family services and of other public agencies.

Persons who serve on a family assessment and planning team shall be immune from any civil liability for decisions made about the appropriate services for a family or the proper placement or treatment of a child who comes before the team, unless it is proven that such person acted with malicious intent. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.1-639.15 of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.).

§ 2.1-756. Information sharing; confidentiality. — All public agencies which have served a family or treated a child referred to a family assessment and planning team shall cooperate with this team. The agency which refers a youth and family to the team shall be responsible for obtaining the consent required to share agency client information with the team. After obtaining the proper consent, all agencies shall promptly deliver, upon request and without charge, such records of services, treatment or education of the family or child as are necessary for a full and informed assessment by the team.

Proceedings held to consider the appropriate provision of services and funding for a particular child or family or both who have been referred to the family assessment and planning team and whose case is being assessed by this team or reviewed by the community management and planning team shall be confidential and not open to the public, unless the child and family who are the subjects of the proceeding request, in writing, that it be open. All information about specific children and families obtained by the team members in the discharge of their responsibilities to the team shall be confidential.

Demographic, service and cost information on youths and families receiving services and funding through this chapter which is of a nonidentifying nature may be gathered for reporting and evaluation purposes. (1992, cc. 837, 880.)

§ 2.1-757. (For effective date—See note) State pool of funds. — A. Effective July 1, 1993, there is established a state pool of funds to be allocated to community policy and management teams in accordance with the appropriations act and appropriate state regulations. These funds, as made available by the General Assembly, shall be expended for public or private nonresidential or residential services for troubled youths and families.

The purposes of this system of funding are:

1. To place authority for making program and funding decisions at the community level;

2. To consolidate categorical agency funding and institute community responsibility for the provision of services;

3. To provide greater flexibility in the use of funds to purchase services based on the strengths and needs of youths and families; and

4. To reduce disparity in accessing services and to reduce inadvertent fiscal incentives for serving children according to differing required local match rates for funding streams.

B. The state pool shall consist of funds which serve the target populations identified in subdivisions 1 through 5 below in the purchase of residential and nonresidential services for children. References to funding sources and current placement authority for the targeted populations of children are for the purpose of accounting for the funds in the pool. It is not intended that children be categorized by individual funding streams in order to access services. The target population shall be the following:

1. Children placed for purposes of special education in approved private school educational programs, previously funded by the Department of Education through private tuition assistance;

2. Children with disabilities placed by local social services agencies or the Department of Youth and Family Services in private residential facilities or across jurisdictional lines in private, special education day schools, if the individualized education program indicates such school is the appropriate placement while living in foster homes or child-caring facilities, previously funded by the Department of Education through the Interagency Assistance Fund for Noneducational Placements of Handicapped Children;

Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act. (1992, cc. 837, 880; 1993, c. 930.)

Section set out twice. — The section above is effective July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2. For this section as effective until July 1, 1996, if such funds are provided, and after July 1, 1996, if such funds are not provided, see the preceding section, also numbered 2.1-753.

Editor's note. — Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, provides that the amendment to this section by Acts 1993, c. 930, cl. 1, shall become effective July 1, 1996, "if state funds are provided to carry out the purposes of this bill by the General Assembly."

The 1993 amendment substituted "family court services" for "juvenile court services" in the second sentence of the first paragraph. For effective date, see the Editor's note.

§ 2.1-754. Family assessment and planning team; powers and duties. — The family assessment and planning team shall assess the strengths and needs of troubled youths and families who are approved for referral to the team and identify and determine the complement of services required to meet these unique needs.

Every such team, in accordance with policies developed by the community policy and management team, shall:

1. Review referrals of youths and families to the team;

2. Provide for family participation in all aspects of assessment, planning and implementation of services;

3. Develop an individual family services plan for youths and families reviewed by the team which provides for appropriate and cost-effective services;

4. Refer the youth and family to community agencies and resources in accordance with the individual family services plan;

5. Recommend to the community policy and management team expenditures from the local allocation of the state pool of funds; and

6. Designate a person who is responsible for monitoring and reporting, as appropriate, on the progress being made in fulfilling the individual family services plan developed for each youth and family, such reports to be made to the team or the responsible local agencies. (1992, cc. 837, 880.)

§ 2.1-755. **Referrals to family assessment and planning teams.** — The community policy and management team shall establish policies governing the referral of troubled youths and families to the family assessment and planning team. These policies shall include which youths and families are to be assessed by the family assessment and planning team and shall consider the criteria set out in § 2.1-758 A 1 and 2.

The community policy and management team shall also establish policies governing the circumstances under which youths and families are not required to be assessed by a family assessment and planning team, but for whom funds from the state pool may be directly accessed to pay for specified services. (1992, cc. 837, 880.)

§ 2.1-756. **Information sharing; confidentiality.** — All public agencies which have served a family or treated a child referred to a family assessment and planning team shall cooperate with this team. The agency which refers a youth and family to the team shall be responsible for obtaining the consent required to share agency client information with the team. After obtaining the proper consent, all agencies shall promptly deliver, upon request and without charge, such records of services, treatment or education of the family or child as are necessary for a full and informed assessment by the team.

Proceedings held to consider the appropriate provision of services and funding for a particular child or family or both who have been referred to the family assessment and planning team and whose case is being assessed by this team or reviewed by the community management and planning team shall be confidential and not open to the public, unless the child and family who are the subjects of the proceeding request, in writing, that it be open. All information about specific children and families obtained by the team members in the discharge of their responsibilities to the team shall be confidential.

Demographic, service and cost information on youths and families receiving services and funding through this chapter which is of a nonidentifying nature may be gathered for reporting and evaluation purposes. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, as amended by Acts 1993, cc. 232 and 283, cls. 1 and 2, provides that this section shall become effective July 1, 1993.

§ 2.1-757. **(For effective date—See note) State pool of funds.** — A. Effective July 1, 1993, there is established a state pool of funds to be allocated to community policy and management teams in accordance with the appropriations act and appropriate state regulations. These funds, as made available by the General Assembly, shall be expended for public or private nonresidential or residential services for troubled youths and families.

The purposes of this system of funding are:

1. To place authority for making program and funding decisions at the community level;

2. To consolidate categorical agency funding and institute community responsibility for the provision of services;

3. To provide greater flexibility in the use of funds to purchase services based on the strengths and needs of youths and families; and

4. To reduce disparity in accessing services and to reduce inadvertent fiscal incentives for serving children according to differing required local match rates for funding streams.

B. The state pool shall consist of funds which serve the target populations identified in subdivisions 1 through 5 below in the purchase of residential and nonresidential services for children. References to funding sources and current placement authority for the targeted populations of children are for the purpose of accounting for the funds in the pool. It is not intended that children be categorized by individual funding streams in order to access services. The target population shall be the following:

1. Children placed for purposes of special education in approved private school educational programs, previously funded by the Department of Education through private tuition assistance;

2. Children with disabilities placed by local social services agencies or the Department of Youth and Family Services in private residential facilities or across jurisdictional lines in private, special education day schools, if the individualized education program indicates such school is the appropriate placement while living in foster homes or child-caring facilities, previously funded by the Department of Education through the Interagency Assistance Fund for Noneducational Placements of Handicapped Children;

3. Children for whom foster care services, as defined by § 63.1-55.8, are being provided to prevent foster care placements, and children placed through parental agreements, entrusted to local social service agencies by their parents or guardians or committed to the agencies by any court of competent jurisdiction for purposes of placement in suitable family homes, child-caring institutions, residential facilities or independent living arrangements, as authorized by § 63.1-56;

4. Children placed by a juvenile and domestic relations district court, in accordance with the provisions of § 16.1-286, in a private or locally operated public facility or nonresidential program; and

5. Children committed to the Department of Youth and Family Services and placed by it in a private home or in a public or private facility in accordance with § 66-14.

C. The General Assembly and the governing body of each county and city shall annually appropriate such sums of money as shall be sufficient (i) to provide special education services and foster care services for children identified in subdivisions B 1, B 2 and B 3 of this section and (ii) to meet relevant federal mandates for the provision of these services. The community policy and management team shall anticipate to the best of its ability the number of children for whom such services will be required and reserve funds from its state pool allocation to meet these needs.

D. When a community services board established pursuant to § 37.1-195, local school division, local social service agency, court service unit, or the Department of Youth and Family Services has referred a child and family to a family assessment and planning team and that team has recommended the proper level of treatment and services needed by that child and family and has determined the child's eligibility for funding for services through the state pool of funds, then the community services board, the local school division, local social services agency, court service unit or Department of Youth and Family Services has met its fiscal responsibility for that child for the services funded through the pool. Each agency shall continue to be responsible for providing services identified in individual family service plans which are within the agency's scope of responsibility and which are funded separately from the state pool.

E. In any matter properly before a court wherein the family assessment and planning team has recommended a level of treatment and services needed by the child and family, the court shall consider the recommendations of the family assessment and planning team. However, the court may make such other disposition as is authorized or required by law, and services ordered pursuant to such disposition shall qualify for funding under this section. (1992, cc. 837, 880; 1993, c. 567; 1994, cc. 854, 865.)

Section set out twice. — The section above is effective until July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, and after July 1, 1996, if such funds are not provided. For this section as effective July 1, 1996, if such funds are provided, see the following section, also numbered 2.1-757.

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, as amended by Acts 1993, cc. 232 and 283, cls. 1 and 2, provides that this section shall become effective July 1, 1993.

Acts 1993, cc. 232 and 283, cls. 1 and 2 add to Acts 1992, cc. 837 and 880, a cl. 6 which provides:

"That the funding formula to carry out the purposes of this act is as follows:

"1. Base year funds for localities. — No locality shall ever receive less state funds in accordance with § 2.1-757 of the Code of Virginia than it received in the base year which is defined as Fiscal Year 1992. The match for a locality to draw this base year allocation of state funds shall be the same dollar amount as the locality paid in Fiscal Year 1992 to match state funds.

"2. Formula for state funds. — The following formula shall be used to compute a locality's allocation of state dollars in excess of the amount it received in the base year which is defined as Fiscal Year 1992: total youth population age 0-17 years as reported in the United

States Census (33.33 percent); food stamp recipients in households with a child under the age of eighteen as reported by the Department of Social Services (33.33 percent); founded and reason to suspect child protective services complaints as reported by the Department of Social Services (17.75 percent); seriously emotionally disturbed or learning disabled children as reported by the Department of Education (10.34 percent); and juvenile court intake complaints as reported by the Department of Youth and Family Services (5.25 percent).

"The data used to compute this formula shall be updated annually based on the latest available information.

"Every locality shall receive the larger of $25,000 or an amount determined by computing a locality's formula allocation. The amount to be allocated by formula is defined as appropriations in excess of Fiscal Year 1992 expenditures.

"3. Allocation adjustment. — Any locality whose total allocation for Fiscal Year 1994 through the state pool of funds, established by § 2.1-757, is less than the expenditures it incurred in Fiscal Year 1993 to meet the same service needs for youth and families, shall have its Fiscal Year 1994 allocation increased by the State Executive Council, established by § 2.1-746, if the Council determines the locality's expenditures for Fiscal Year 1993 reflect a more accurate level of expenditures over time. Any such adjustments shall be made by October 1, 1993.

"4. Local match. — A locality's match for all state funds that exceed the amount it received in Fiscal Year 1992 shall be computed by using each locality's per capita revenue capacity as determined by the Commission on Local Government divided by the statewide per capita revenue capacity. The resulting ratio for each locality shall be multiplied by an aggregate local share of forty-five percent. Each local share shall then be adjusted according to income in each locality, as determined by dividing the median adjusted gross income for all state income tax returns in each locality by the median adjusted gross income for all income tax returns statewide. Local shares shall not exceed forty-five percent of the total new funds allocated by the formula established by this act.

"The data used to compute local match rates shall use the most recent information published by the Commission on Local Government and shall be updated once each biennium.

"5. Definition. — For the purposes of this sixth enactment clause, "locality" means any county or city.

The 1993 amendment added subsection E.

The 1994 amendments. — The 1994 amendment by c. 854, substituted "Children with disabilities" for "Handicapped Children" at the beginning of subdivision B 2.

The 1994 amendment by c. 865, inserted "placed through parental agreements" in subdivision B 3.

§ 2.1-757. (Delayed effective date—See notes) State pool of funds. — A. Effective July 1, 1993, there is established a state pool of funds to be allocated to community policy and management teams in accordance with the appropriations act and appropriate state regulations. These funds, as made available by the General Assembly, shall be expended for public or private nonresidential or residential services for troubled youths and families.

The purposes of this system of funding are:

1. To place authority for making program and funding decisions at the community level;

2. To consolidate categorical agency funding and institute community responsibility for the provision of services;

3. To provide greater flexibility in the use of funds to purchase services based on the strengths and needs of youths and families; and

4. To reduce disparity in accessing services and to reduce inadvertent fiscal incentives for serving children according to differing required local match rates for funding streams.

B. The state pool shall consist of funds which serve the target populations identified in subdivisions 1 through 5 below in the purchase of residential and nonresidential services for children. References to funding sources and current placement authority for the targeted populations of children are for the purpose of accounting for the funds in the pool. It is not intended that children be categorized by individual funding streams in order to access services. The target population shall be the following:

1. Children placed for purposes of special education in approved private school educational programs, previously funded by the Department of Education through private tuition assistance;

2. Children with disabilities placed by local social services agencies or the Department of Youth and Family Services in private residential facilities or across jurisdictional lines in private, special education day schools, if the individualized education program indicates such school is the appropriate placement while living in foster homes or child-caring facilities, previously funded by the Department of Education through the Interagency Assistance Fund for Noneducational Placements of Handicapped Children;

3. Children for whom foster care services, as defined by § 63.1-55.8, are being provided to prevent foster care placements, and children placed through parental agreements, entrusted to local social service agencies by their parents or guardians or committed to the agencies by any court of competent jurisdiction for purposes of placement in suitable family homes, child-caring institutions, residential facilities or independent living arrangements, as authorized by § 63.1-56;

4. Children placed by a family court, in accordance with the provisions of § 16.1-286, in a private or locally operated public facility or nonresidential program; and

5. Children committed to the Department of Youth and Family Services and placed by it in a private home or in a public or private facility in accordance with § 66-14.

C. The General Assembly and the governing body of each county and city shall annually appropriate such sums of money as shall be sufficient (i) to provide special education services and foster care services for children identified in subdivisions B 1, B 2 and B 3 of this section and (ii) to meet relevant federal mandates for the provision of these services. The community policy and management team shall anticipate to the best of its ability the number of children for whom such services will be required and reserve funds from its state pool allocation to meet these needs.

D. When a community services board established pursuant to § 37.1-195, local school division, local social service agency, court service unit, or the Department of Youth and Family Services has referred a child and family to a family assessment and planning team and that team has recommended the proper level of treatment and services needed by that child and family and has determined the child's eligibility for funding for services through the state pool of funds, then the community services board, the local school division, local social services agency, court service unit or Department of Youth and Family Services has met its fiscal responsibility for that child for the services funded through the pool. Each agency shall continue to be responsible for providing services identified in individual family service plans which are within the agency's scope of responsibility and which are funded separately from the state pool.

E. In any matter properly before a court wherein the family assessment and planning team has recommended a level of treatment and services needed by the child and family, the court shall consider the recommendations of the family assessment and planning team. However, the court may make such other disposition as is authorized or required by law, and services ordered pursuant to such disposition shall qualify for funding under this section. (1992, cc. 837, 880; 1993, cc. 567, 930; 1994, cc. 854, 865.)

Section set out twice. — The section above is effective July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2. For this section as effective until July 1, 1996, if such funds are provided, and after July 1, 1996, if such funds are not provided, see the preceding section, also numbered 2.1-757.

Editor's note. — Acts 1993, c. 930, cl. 3, as amended by Acts 1994, c. 564, cl. 2, provides that the amendment to this section by Acts 1993, c. 930, cl. 1, shall become effective July 1, 1996, "if state funds are provided to carry out the purposes of this bill by the General Assembly."

The 1993 amendments. — The 1993 amendment by c. 567 added subsection E.

The 1993 amendment by c. 930 substituted "family court" for "juvenile and domestic relations district court" in subdivision B 4. For effective date, see the Editor's note.

The 1994 amendments. — The 1994 amendment by c. 854, substituted "Children with disabilities" for "Handicapped Children" at the beginning of subdivision B 2.

The 1994 amendment by c. 865, inserted "placed through parental agreements" in subdivision B 3.

§ 2.1-758. Eligibility for state pool of funds. — A. In order to be eligible for funding for services through the state pool of funds, a youth, or family with a child, shall meet one or more of the criteria specified in subdivisions 1 through 4 below and shall be determined by policies of the community policy and management team to have access to these funds.

1. The child or youth has emotional or behavior problems which:

a. Have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted;

b. Are significantly disabling and are present in several community settings, such as at home, in school or with peers; and

c. Require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies.

2. The child or youth has emotional or behavior problems, or both, and currently is in, or is at imminent risk of entering, purchased residential care. In addition, the child or youth requires services or resources that are beyond normal agency services or routine collaborative processes across agencies, and requires coordinated services by at least two agencies.

3. The child or youth requires placement for purposes of special education in approved private school educational programs.

4. The child or youth has been placed in foster care through a parental agreement between a local social services agency or public agency designated by the community policy and management team and his parents or guardians, entrusted to a local social services agency by his parents or guardian or has been committed to the agency by a court of competent jurisdiction for the purposes of placement as authorized by § 63.1-56.

B. For purposes of determining eligibility for the state pool of funds, "child" or "youth" means (i) a person less than eighteen years of age and (ii) any individual through twenty-one years of age who is otherwise eligible for mandated services of the participating state agencies including special education and foster care services. (1992, cc. 837, 880; 1994, c. 865.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, as amended by Acts 1993, cc. 232 and 283, cls. 1 and 2, provide that this section shall become effective July 1, 1993.

The 1994 amendment inserted the language beginning "placed in foster care" and ending "guardians" in subdivision A 4.

§ 2.1-759. State trust fund. — A. Effective January 1, 1993, there is established a state trust fund with funds appropriated by the General Assembly. The purposes of this fund are to develop:

1. Early intervention services for young children at risk of developing emotional or behavior problems, or both, due to environmental, physical or psychological stress, and their families; and

2. Community services for troubled youths who have emotional or behavior problems, or both, and who can appropriately and effectively be served in the home or community, or both, and their families.

The fund shall consist of moneys from the state general fund, federal grants, and private foundations.

B. Proposals for requesting these funds shall be made by community policy and management teams to the state management team. The state management team shall make recommendations on the proposals it receives to the state executive council, which shall award the grants to the community teams in accordance with the policies developed under the authority of § 2.1-748 of this chapter. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 3, provide: "That § 2.1-759 shall become effective January 1, 1993, if state funds are provided to carry out the purposes of this section during the 1992 Session of the General Assembly." Since this event has occurred, this section is effective January 1, 1993.

§ 2.1-759.1. Rates for purchase of services; service fee directory. — The rates paid for services purchased pursuant to this chapter shall be determined by competition of the market place and by a process sufficiently flexible to ensure that family assessment and planning teams and providers can meet the needs of individual children and families referred to them. To ensure that family assessment and planning teams are informed about the availability of programs and the rates charged for such programs, the state executive council shall oversee the development of and approve a service fee directory which shall list the services offered and the rates charged by any entity, public or private, which offers specialized services for at-risk youth or families. The state executive council shall designate one state agency to coordinate the establishment, maintenance and other activities regarding the service fee directory. (1993, c. 110.)

§ **16.1-248.1. Criteria for detention or shelter care.** — A. A child taken into custody whose case is considered by a judge, intake officer or magistrate pursuant to § 16.1-247 shall immediately be released, upon the ascertainment of the necessary facts, to the care, custody and control of such child's parent, guardian, custodian or other suitable person able and willing to provide supervision and care for such child, either on bail or recognizance pursuant to Chapter 9 (§ 19.2-119 et seq.) of Title 19.2 or under such conditions as may be imposed or otherwise. However, a child may be detained in a secure facility, pursuant to a detention order or warrant, only upon a finding by the judge, intake officer, or magistrate, that there is probable cause to believe that the child committed the act alleged, and that at least one of the following conditions is met:

1. The child is alleged to have committed an act which would be a felony or Class 1 misdemeanor if committed by an adult, and there is clear and convincing evidence that:

a. The release of the child constitutes an unreasonable danger to the person or property of others;

b. The release of the child would present a clear and substantial threat of serious harm to such child's life or health; or

c. The child has threatened to abscond from the court's jurisdiction during the pendency of the instant proceedings or has a record of willful failure to appear at a court hearing within the immediately preceding twelve months.

2. The child has absconded from a detention home or facility where he has been directed to remain by the lawful order of a judge or intake officer.

3. The child is a fugitive from a jurisdiction outside the Commonwealth and subject to a verified petition or warrant, in which case such child may be detained for a period not to exceed that provided for in § 16.1-323 of this chapter while arrangements are made to return the child to the lawful custody of a parent, guardian or other authority in another state.

4. The child has failed to appear in court after having been duly served with a summons in any case in which it is alleged that the child has committed a delinquent act, is in need of services or is in need of supervision; however, a child alleged to be in need of services or in need of supervision may be detained for good cause pursuant to this subsection only until the next day upon which the court sits within the county or city in which the charge against the child is pending, and under no circumstances longer than seventy-two hours from the time he or she was taken into custody.

B. Any child not meeting the criteria for placement in a secure facility shall be released to a parent, guardian or other person willing and able to provide supervision and care under such conditions as the judge, intake officer or magistrate may impose. However, a child may be placed in shelter care if:

1. The child is eligible for placement in a secure facility;

2. The child has failed to adhere to the directions of the court, intake officer or magistrate while on conditional release;

3. The child's parent, guardian or other person able to provide supervision cannot be reached within a reasonable time;

4. The child does not consent to return home;

5. Neither the child's parent or guardian nor any other person able to provide proper supervision can arrive to assume custody within a reasonable time; or

6. The child's parent or guardian refuses to permit the child to return home and no relative or other person willing and able to provide proper supervision and care can be located within a reasonable time.

C. The criteria for continuing the child in detention or shelter care as set forth in this section shall govern the decisions of all persons involved in determining whether the continued detention or shelter care is warranted pending court disposition. Such criteria shall be supported by clear and convincing evidence in support of the decision not to release the child.

D. Nothing in this section shall be construed to deprive the court of its power to punish a child summarily for contempt for acts set forth in § 18.2-456, other than acts of disobedience of the court's dispositional order which are committed outside the presence of the court.

E. A detention order may be issued pursuant to subdivision 2 of subsection A by the committing court or by the court in the jurisdiction from which the child fled or where he was taken into custody. (1977, c. 559; 1979, c. 701; 1985, c. 260; 1986, c. 517; 1987, c. 632; 1989, c. 725; 1990, c. 257.)

The 1989 amendment added subsection D.

The 1990 amendment deleted "or" at the end of subdivisions 1 through 4 in subsection B; and added subsection E.

Law Review.

For survey on legal issues involving children in Virginia for 1989, see 23 U. Rich. L. Rev. 705 (1989).

§ 16.1-292. (Delayed effective date — See notes) Violation of court order by any person. — A. Any person violating an order of the family court entered pursuant to §§ 16.1-278.2 through 16.1-278.20, including a parent subject to an order issued pursuant to subdivision 3 of § 16.1-278.8, may be proceeded against (i) by an order requiring the person to show cause why the order of the court entered pursuant to §§ 16.1-278.2 through 16.1-278.20 has not been complied with, (ii) for contempt of court pursuant to § 16.1-69.24 or as otherwise provided in this section, or (iii) by both. Except as otherwise expressly provided herein, nothing in this chapter shall deprive the court of its power to punish summarily for contempt for such acts as set forth in § 18.2-456, or to punish for contempt after notice and an opportunity for a hearing on the contempt except that confinement in the case of a juvenile shall be in a secure facility for juveniles rather than in jail and shall not exceed a period of ten days for each offense. However, if the person violating the order ~~was a juvenile at the time of the original act and is eighteen years of age or~~ older when the court enters a disposition for violation of the order, the judge may order confinement (i) in jail, or (ii) in a secure facility for juveniles provided the judge finds from the evidence that the presence of the person in such a facility is consistent with assuring the safety of the children confined in the facility and the staff of the facility and the finding is in writing and included in the order.

B. Upon conviction of any party for contempt of court in failing or refusing to comply with an order of a family court for spousal support or child support under § 16.1-278.15, the court may commit and sentence such party to confinement in a jail, workhouse, city farm or work squad as provided in §§ 20-61 and 20-62, for a fixed or indeterminate period or until the further order of the court. In no event, however, shall such sentence be imposed for a period of more than twelve months. The sum or sums as provided for in § 20-63 shall be paid as therein set forth, to be used for the support and maintenance of the spouse or the child or children for whose benefit such order or decree provided.

C. Notwithstanding the contempt power of the court, the court shall be limited in the actions it may take with respect to a child violating the terms and conditions of an order to those which the court could have taken at the time of the court's original disposition pursuant to §§ 16.1-278.2 through 16.1-278.10, except as hereinafter provided. However, this limitation shall not be construed to deprive the court of its power to (i) punish a child summarily for contempt for acts set forth in § 18.2-456, or (ii) punish a child for contempt for violation of a dispositional order in a delinquency proceeding after notice and an opportunity for a hearing regarding such contempt, including acts of disobedience of the court's dispositional order which are committed outside the presence of the court.

D. In the event a child in need of services is found to have willfully and materially violated for a second or subsequent time the order of the court pursuant to § 16.1-278.4, the dispositional alternatives specified in subdivision 9 of § 16.1-278.8 shall be available to the court.

E. In the event a child in need of supervision is found to have willfully and materially violated an order of the court pursuant to § 16.1-278.5, the court may enter any of the following orders of disposition:

1. Suspend the child's motor vehicle driver's license;

2. Order any such child fourteen years of age or older to be (i) placed in a foster home, group home or other nonsecure residential facility, or, (ii) if the court finds that such placement is not likely to meet the child's needs, that all other treatment options in the community have been exhausted, and that secure placement is necessary in order to meet the child's service needs, detained in a secure facility for a period of time not to exceed ten consecutive days for violation of any order of the court arising out of the same petition. The court shall state in its order for detention the basis for all findings required by this section. When any child is detained in a secure facility pursuant to this section, the court shall direct the agency evaluating the child pursuant to § 16.1-278.5 to reconvene the interdisciplinary team participating in such evaluation as promptly as possible to review its evaluation, develop further treatment plans as may be appropriate and submit its report to the court for its determination as to further treatment efforts either during or following the period the child is in secure detention. A juvenile may only be detained pursuant to this section in a detention home or other secure facility in compliance with standards established by the State Board. Any order issued pursuant to this subsection is a final order and is appealable to the circuit court as provided by law.

F. Nothing in this section shall be construed to reclassify a child in need of services or in need of supervision as a delinquent. (1977, c. 559; 1983, c. 501; 1985, cc. 1, 260; 1987, c. 632; 1988, c. 771; 1989, c. 725; 1990, c. 110; 1991, c. 534; 1993, cc. 632, 929; 1994, c. 21.)

Section set out twice. — The section above is effective July 1, 1996, if funds are provided pursuant to the provisions of Acts 1993, c. 929, cl. 3, as amended by Acts 1994, c. 564, cl. 1. For this section as effective until July 1, 1996, if such funds are provided, and after July 1, 1996, if such funds are not provided, see the preceding section, also numbered 16.1-292.

Editor's note. — Acts 1993, c. 929, cl. 3, as amended by Acts 1994, c. 564, cl. 1, provides that the amendment to this section by Acts 1993, c. 929, cl. 1, shall become effective July 1, 1996, "only if state funds are provided by the General Assembly sufficient to provide adequate resources for the court to carry out the purposes of this act and to fulfill its mission to serve children and families of the Commonwealth."

The 1993 amendments. — The 1993 amendment by c. 632, inserted "including a parent subject to an order issued pursuant to subdivision 3 of § 16.1-278.8" in the first sentence of subsection A.

The 1993 amendment by c. 929, in subsection A, in the first sentence, substituted "family court" for "juvenile court," substituted "§§ 16.1-278.2 through 16.1-278.20" for "§§ 16.1-278.2 through 16.1-278.19" in two places; and substituted "family court" for "juvenile court" in the first sentence of subsection B. For effective date, see the Editor's note.

The 1994 amendment substituted "ten consecutive days" for "thirty consecutive days" near the end of the first sentence of subdivision E 2.

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