VIRGINIA COMMISSION ON YOUTH

Study of Juvenile Offender Re-entry
MENTAL HEALTH AND SUBSTANCE ABUSE SUBCOMMITTEE

5th Floor Conference Room
General Assembly Building
August 4, 2010
11:00 a.m.

MINUTES

Members Attending:
Becky Bowers-Lanier, Margaret Crowe, Stacie Fisher, Janet Fuller-Holden, Catherine Hancock, Katherine Hunter, Debbie Nedervelt, Janet Van Dyke, Patrick Plourde,

Participating Electronically:
Elizabeth Murtagh, Wanda Walker, Lisa Peacock (*scheduled to participate electronically, but there were technical difficulties*)

Staff Attending:
Amy M. Atkinson, Leah Hamaker, Lindsey Strachan

Members of the Public:
Rita Evans, Sarah Stanton, Richard Gergley, Erika Fischer, Shanee Harmon

Amy Atkinson, Commission on Youth Executive Director, called the meeting to order at 11:00 a.m., followed by a review of the meeting agenda and the meeting's objectives. This subcommittee is one of four which has been formed by the Commission to address focus topics identified the Advisory Group. Each subcommittee is comprised of Advisory Group members and others having special interest and expertise.

The subcommittee identified and discussed the following issues related to mental health and substance abuse:

General Discussion

Medicaid

- In Virginia, Medicaid is terminated upon commitment, based on federal requirements prohibiting federal Medicaid funds from being used on inmates of public institutions, including the Department of Juvenile Justice (DJJ). Virginia elects to terminate, rather than suspend, Medicaid because of the requirement that any status changes be reported.
- Federal rules require determinations of financial eligibility for Medicaid must be made within 45 days from the date of application. Forty-five days prior to release, DJJ begins to prepare for re-enrolling juveniles back into Medicaid. There is often, however, a problem with re-determination. Usually, a parent or guardian must be involved.
- There is variability among local DSS offices regarding Medicaid re-determinations. Some offices may not accept an application for Medicaid until the juvenile is released, whereas others do not accept the application because there is uncertainty about who can apply on behalf of the juvenile. The Department of Medical Assistance Services (DMAS) and DJJ are working to address this.

- Often, because juveniles have shorter length of stays (LOS), they might not even lose their eligibility initially.
- There is a difference between terminating and suspending but, either way, the re-determination phase at DSS is required. It was noted that re-determination is state law and could be changed.
- The main goal of Virginia's Mental Health Transition Plan is to avoid juveniles' not receiving essential/required medications. There aren't statistics on this, so it is hard to know how big of a problem this is.
- Medicaid may not be terminated for juveniles in detention because typically, their length of stay is short.

For Research/Consideration

- Research systemic, legal, and budgetary impact of suspending Medicaid rather than terminating Medicaid.
- Receive an update from DMAS and DJJ on what is being done to make local DSS' re-enrollment practices more consistent.

Guardianship

- Foster care services terminate upon commitment, so DSS no longer has custody when a juvenile is committed to DJJ. Further, DJJ does not act as a guardian over the juvenile while in custody. This creates a problem for a juvenile who comes from DSS and, upon release, is under age 18, because the juvenile has no guardian to reapply for Medicaid on their behalf.
- DSS receives 30 days' notice prior to release, but Medicaid can be applied for up to 45 days before exiting.
- At 30 days prior to release, DJJ and DSS should talk about reenrollment into Medicaid.
- If a juvenile has private medical insurance, this is identified at initial meetings at DJJ's Reception and Diagnostic Center and at 90 days prior to release. However, only a small percentage of the juvenile population actually has private health insurance.
- The Code of Virginia does not specify which agency is responsible for starting the application process/paperwork.

For Research/Consideration

- Research policies to determine whether additional guidance is needed to define which agency is responsible for which role.

Mental Health Transition Plans

- The Mental Health Transition Plan is helpful; however, implementing the Plan is problematic. What can a Parole Officer (PO) do if the services written into the Mental Health Transition Plan don't actually exist? This is especially problematic in rural areas.
- There is a shortage of child psychologists in the state. If juveniles must access a psychiatrist for medication management, it is problematic.
- There are differences among the 40 Community Services Boards (CSBs) services across the Commonwealth. DJJ's Court Services Units (CSUs) negotiate agreements with them. Evaluations take place at the Reception and Diagnostic Center. The PO takes the plan and then schedules a follow-up meeting in the community to arrange for eservices if the juvenile has private health insurance.
- If the Plan indicates the juvenile needs substance abuse services and if there are not substance abuse services available for the juvenile in the community, there is no mandate to require that the juvenile receive these services. This is a barrier. Juveniles "fall down" when they return home because services they were receiving while in the custody of DJJ are not available to them in their communities.
- If the juvenile has Medicaid, transportation services are covered to the nearest Medicaid provider. A large percentage of released juveniles do not fit into any mandated mental health category.
- Released juveniles are given a 30-day supply of medication. However, they will often request refills in addition to the mandated 30-day supply, because they could not find a provider or an appointment time slot soon enough.
- Medicaid will pay for transportation to distant providers if there are none locally.

For Research/Consideration

- Research changing the status of juvenile offenders with mental health needs as a mandated population under the Comprehensive Services Act.

Telemedicine

- Telemedicine is considered a covered service under Medicaid. However, there are specific requirements which must be fulfilled in order for the service to be reimbursed.
- In Virginia localities not having psychiatric services, telemedicine was modeled after that in Danville, PA.
- Billing is always an issue.

Confidentiality

- There are confidentiality restrictions on mental health records and plans, but there is an exception when obtaining or providing services.
- A juvenile cannot override specific provisions of §16.1-300 in the *Code of Virginia*, which requires that health care providers are allowed to get information from DJJ.
- A federal statute prohibits talking about substance abuse.

The subcommittee identified and discussed the following barriers related to Mental Health and Substance Abuse which were on the handout "*BARRIERS - outlined by the Commission on Youth Advisory Group on July 7, 2010 unless otherwise noted."*

Barrier 2

There are limitations on the range of services, program and service content, social environment, and capacity.

- Juveniles without health insurance have no money to pay for any services.
- For juveniles aged 18-21, the problem is access. For instance, many without health insurance use the emergency room instead a private physician. They may then accumulate debt from emergency room and ambulance bills.

Barrier 4

Services should be linked both upon release from a facility and upon release from parole. The youth or family might not always have the appropriate skills and resources to make this happen.

- Even though DJJ tries to involve family members, a number of youth don't have families involved. Without families, there are significant limitations on what can be done in terms of re-entry. This brings up the issue of continuity of care: a) issues need to be identified early and b) services need to be wrapped around the juvenile.
- Juveniles who turn 18 while in DJJ custody must subsequently find a job and health insurance on their own, which usually involves a waiting period that can interfere with seamless services.

Barrier 5

These youth may be exposed to harmful experiences while in the custody of DJJ. *(DCJS comment)*

- Computer/TV/Internet access should not available in mental health facilities. Further, this should not be occurring within state facilities because the only Internet access the juveniles have is within the education context. Even this access is tightly monitored.
- There can be abusive situations caused by officers or other juveniles. DJJ, however, strives to be aware of these situations. DJJ conducts trauma assessments on juveniles receiving mental health services.
- Over half of the juveniles in the custody of DJJ are in need of mental health services and a large proportion of these juveniles are involved with therapists. (This is a significantly higher percentage than that for the general population.)

Barrier 6

Multiple systems make things difficult to coordinate and provide best results. There are issues with regards to turf, responsibility and accountability, and resources. With the Department of Juvenile Justice (DJJ) and/or local detention centers, the Department of

Correctional Education (DCE), the Department of Education (DOE) and/or local school boards and schools, the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Social Services (DSS), possible community organizations/players are often overlooked.

- When all systems are involved, it creates a problem. Fragmentation can likewise be problematic.
- There needs to be a mapping of available services.

Barrier 7

Many service professionals lack training in developmental issues.

- All professionals must go through an 8-week basic skills training, which includes training specifically for developmental issues such that the professionals develop familiarity with those issues.
- Some people in this profession, however, don't regard themselves as child care workers.
- DJJ is trying to make a training (especially in evidenced-based practices) required.

Identification and discussion of the issues led to an informal listing of suggestions for improvement and/or Commission staff assistance needed to guide the process.

For Research/Consideration

- Restorative family projects can engage youth in services.
- Family engagement is key.
- Community Policy & Management Teams (CPMTs) make sure that contracts are being followed through.

Ms. Atkinson reviewed the Commission's next steps in conducting the study and thanked the subcommittee members for their contribution.

The meeting was adjourned at 12:45 p.m.