



COMMONWEALTH OF VIRGINIA

Commission on Youth

Special Population Workgroup

October 28, 2014

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Background

- The Virginia Commission on Youth was established by the 1989 General Assembly Session in response to the two-year study examining issues related to chronic status offenders (HJR 247).
- Enacted in 1989, the Commission began operations in 1991. The goal of the Commission is to provide a legislative forum in which the complex policy issues related to youth and their families can be explored and resolved.



Role

- Virginia Code § 30-174 defines the role and function of the Commission as “to study and provide recommendations addressing the needs of and services to the Commonwealth’s youth and families.” The Commission’s areas of concern include, but are not limited to, child welfare, juvenile justice, education, child health and mental health. Through legislative study resolutions, budget language or at the direction of standing committees, the Commission establishes the scope of studies each year. The Commission conducts its studies through research and data analysis and generally with guidance from Task Forces and/or Advisory Groups providing subject expertise.

Virginia Commission on Youth



Membership

- The Commission is composed of six delegates, three senators and three citizens.
 - Delegate Christopher K. Peace, Chair
 - Delegate Mamye E. BaCote
 - Delegate Richard P. Bell
 - Delegate Peter F. Farrell
 - Delegate Mark Keam
 - One vacancy in the House
 - Senator Barbara A. Favola, Vice-chair
 - Senator Dave W. Marsden
 - Senator Stephen H. Martin
 - Deirdre Goldsmith
 - Frank Royal, M.D.
 - Charles Slemper, III, Esq.



2014 Studies and Initiatives

- Early Childhood Education – Workgroup on Quality
- Use of Restraint and Seclusion in Schools
- The Use of Federal, State, and Local Funds for the Private Educational Placements of Students with Disabilities (Year One)
- Court-Appointed Attorneys in Child Welfare Cases
- Unlawful Adoption of a Child
- Three Branch Institute on Child Social and Emotional Well-Being (Year Two)
- Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs (Biennial Update)



Early Childhood Education – Workgroup on Quality

- At the May 7, 2014 meeting, the Commission adopted a work plan for staff to convene a workgroup to assess approaches for improving quality in Virginia’s early childhood education programs. The workgroup met on June 17 at the Capitol. An update on the progress of the workgroup and draft recommendations was reported at the Commission’s September 16 meeting. The Commission will vote on the proposed recommendations at the Commission’s November 17th meeting.



Use of Restraint and Seclusion in Schools

- HB 1106 (Hope) directs the Commission on Youth, in consultation with the Department of Education and the Department of Behavioral Health and Developmental Services, to review statewide policies and regulations related to seclusion and restraint in public and private elementary and secondary schools and methods used in other states to reduce and eliminate the use of seclusion and restraint. An update on the study activities and draft recommendations was reported at the Commission's September 16th and October 20th meetings. The Commission will vote on the proposed recommendations at the Commission's November 17th meeting.



The Use of Federal, State, and Local Funds for Private Educational Placements of Students of Students with Disabilities (Year One)

- HJR 196 (Adams) directs the Commission on Youth to examine the use of Comprehensive Services Act for At-Risk Youth and Families (CSA) and Medicaid funds for private day and private residential special education placements. The Commission is gathering local and statewide data on the extent to which youth are placed in settings that are segregated from nondisabled students and determine the feasibility and cost-effectiveness of more integrated alternatives to provide special education services to students.



Court-Appointed Attorneys in Child Welfare Cases

- In a letter received April 28, 2014, Senator George Barker requested that the Commission on Youth study legal representation for parents in child welfare cases. This study will review Virginia's existing system for providing counsel in these cases and ascertain whether modifications or improvements to the system would advance Virginia's efforts to increase permanency. An update on the progress of this study will be reported to the Commission on Youth prior to the 2015 General Assembly Session.



Unlawful Adoption of a Child

- During the 2014 General Assembly session, Senator Jeffrey L. McWaters introduced SB 411. It provided that any parent, guardian, or other person responsible for the care of a child who transfers physical and legal custody of a child with the intent to do so permanently without following established adoption procedures is guilty of a Class 6 felony. Members of the Senate Courts of Justice Committee reviewed the bill and determined that further study would be appropriate. The Committee passed the bill by indefinitely and requested that the Commission on Youth study the provisions set forth in Senate Bill 411 and report findings and recommendations prior to the 2015 General Assembly Session.



Three Branch Institute on child Social and Emotional Well-being (Year Two)

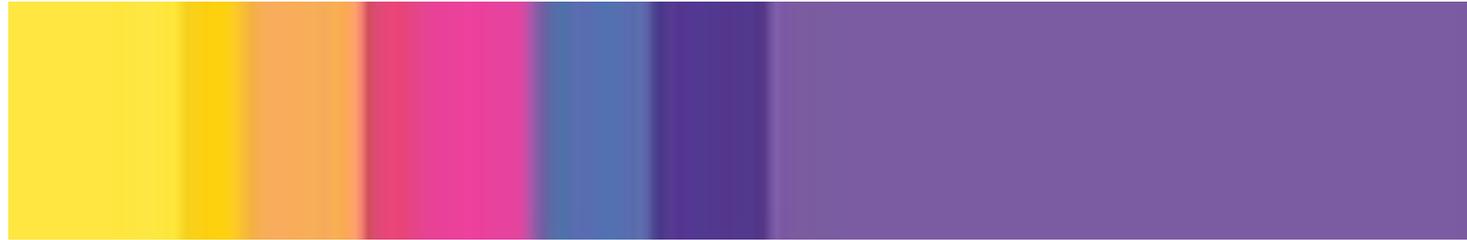
- At the May 7, 2014 meeting, the Commission adopted a work plan for Virginia's Three Branch Institute on Child Social and Emotional Well-being . The Commission on Youth is collaborating with the executive and judicial branches as part of Virginia's participation in the National Governors Association's Three Branch Institute to improve the social and emotional well-being of foster care children in Virginia. Virginia is one of only seven states selected to participate in the institute.



Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs (Biennial Update)

- SJR 358 (2003) directed the Commission on Youth to update biennially its publication, *the Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs (Collection)*. The purpose of the *Collection* is to identify effective treatment modalities for children, including juvenile offenders, with mental health treatment needs. Utilization of evidence-based practices in the field of children's mental health promotes better patient outcomes and may offer the Commonwealth some cost savings.

Collection of Evidence-based Practices



Virginia Commission on Youth

- *The Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs (Collection)*
- Currently in its 5th Edition

Current State of Child Mental Health



- Mental health disorders affect 1 in 5 children.
- More children suffer from mental health disorders than leukemia, diabetes, and AIDS combined.
- 1 in 100 children is diagnosed with Bipolar Disorder or Schizophrenia.
- 1 in every 68 children [one in every 42 boys] has an Autism Spectrum Disorder.
- Children with untreated ADHD drop out of high school 10 times more often than other children.
- Half of all adults with a mental health disorder reported that the disorder started before age 14.
- Only 1 in 4 of children diagnosed with a mental health disorder receive treatments which are based on scientific evidence.

Challenges Addressed



- Countless options
- Difficulty accessing information about evidence-based practices
- Research constantly evolving
- No central clearinghouse for service providers/families to access information



Evidence-based Practices Defined



- Scientifically tested
- Demonstrate improved outcomes for children with mental health disorders
- Serve as a guide for clinicians, policymakers, and families

Background – Evidence-based Practices



- Data supports particular treatments for specific disorders—“evidence-based practices”
- Evidence-based practices are not always used in the public mental health setting

Why it Exists



- HJR 119 (2001) directed COY to study children and youth with serious emotional disturbance requiring out-of-home placement (SED-OH).
 - Finding: The need for improved data collection, evaluation, and information sharing about child mental health services.
- SJR 99 (2002) directed COY to:
 - Coordinate the collection of effective practices for children with mental health treatment needs, including juvenile offenders; and
 - Seek the assistance from an Advisory Group of experts.
- SJR 358 (2003) directed COY to:
 - Biennially update the *Collection*; and
 - Make the *Collection* available through web technologies.

Advisory Group for *Collection 5th Edition*



- DJJ
- DBHDS
- DSS
- DMAS
- DOE
- VDH
- Office of Comprehensive Services (CSA)
- CSBs
- COY Members
- Local CSA
- Advocacy Representatives
- Parents/Family Members
- One Child Psychiatrist
- Two Clinical Psychologists
- School Psychologist
- Parent Representatives
- Virginia Tech University
- Virginia Commonwealth University
- Private Providers
- Area Health Education Centers (AHEC)
- Independent Living Providers

What are the benefits of Evidence-based Practices?



- improved school attendance and performance
- improved family and peer relationships
- decreased involvement with law enforcement & the juvenile justice system
- decreased rates of substance use & abuse
- reduction in self-injurious behaviors
- prevention of more intensive service use
 - decreased hospital admissions, institutional care & out-of-home placement

5th Edition Highlights



- Updated listing of evidence-based practices for treating youth with mental health disorders
 - Psychosocial & pharmacological treatments
- Suggested assessment tools
- Co-occurring disorders
- Developmental disabilities & co-occurring mental health disorders
- Promising practices & contraindicated treatments
- Assists in prioritizing treatment options
- Tailored for diverse audience, e.g., providers and families

Collection of Evidence-based Practices



- What Works – Meet all of the following criteria:
 - Tested across two or more randomized controlled trials (RCTs);
 - At least two different investigators;
 - Use of a treatment manual in the case of psychological treatments; and
 - At least one study demonstrates that the treatment is superior to an active treatment or placebo.
- What Seems to Work – Meet all but one of the criteria for “What Works.”
- What Does Not Work – Meet none of the criteria above but also meets either of the following :
 - Found to be inferior to another treatment in an RCT; and/or
 - Demonstrated to cause harm in a clinical study.
- Not Adequately Tested – Meet none of the criteria for any of the above categories, but have been tested. It is possible that such treatments have demonstrated some effectiveness in non-RCT studies, but their potency compared with other treatments is unknown. These treatments may be helpful, but would not be currently recommended as a first-line treatment.
- Untested – Meets the criteria for none of the above categories because it is untested. The benefits and risks are unknown and caution is suggested.

What you will find in the *Collection*



- Adjustment Disorders
- Behavior Disorders
 - Attention Deficit Hyperactivity Disorder
 - Conduct Disorder
 - Oppositional Defiant Disorder
- Maladaptive Behaviors
 - Juvenile Sexual Offending
 - Eating Disorders
 - Fire Setting
 - Non-suicidal Self-injury
- Developmental Disabilities & Co-occurring Mental Health Disorders
 - Autism Spectrum Disorders
 - Intellectual Disabilities
- Substance Use Disorders

**Mental Health
Disorders discussed in
*Collection 5th Edition***

What you will find in the *Collection*



- Anxiety Disorders
- Trauma
- Habit Disorders
- Mood Disorders
 - Pediatric Depression & Dysthymia
 - Pediatric Bipolar Disorder
- Early Onset Schizophrenia
- Other Topics Discussed
 - Juvenile Offenders & Mental Health Treatment Needs
 - Antidepressants and the Risk of Suicidal Behavior
 - Youth Suicide

**Mental Health
Disorders discussed
in *Collection 5th
Edition***

What you will find in the *Collection*



Summary of Evidence-based Practices for Youth with Posttraumatic Stress Disorder (PTSD)

What Works	Description
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Treatment that involves reducing negative emotional and behavioral responses related to trauma, by providing psychoeducation on trauma, addressing distorted beliefs and attributes related to trauma, introducing relaxation and stress management techniques, and developing a trauma narrative in a supportive environment
What Seems to Work	Description
School-based Group Cognitive Behavioral Therapy (CBT)	Similar components to TF-CBT, but in a group, school-based format
Not Adequately Tested	Description
Child-centered Play Therapy	Therapy that utilizes child-centered play to encourage expression of feelings and healing
Psychological Debriefing	An approach in which youth talk about the facts of the trauma (and associated thoughts and feelings) and then are encouraged to reenter into the present
Pharmacological Treatments	Treatment with selective serotonin reuptake inhibitors (SSRIs)
What Does Not Work	Description
Restrictive rebirthing or holding techniques	Restrictive rebirthing or holding techniques may forcibly bind, restrict, coerce, or withhold food or water from children and have resulted in some cases of death and are not recommended.

What you will find in the *Collection*



Summary of Evidence-based Practices for Juvenile Offenders – What Works

What Works	Description
Multisystemic Therapy (MST)	An integrative, family-based treatment with a focus on improving psychosocial functioning for youth and families.
Functional Family Therapy (FFT)	A family-based program that focuses on delinquency, treating maladaptive and acting out behaviors, and identifying obtainable changes.
Multidimensional Treatment Foster Care (MTFC)	As an alternative to corrections, MTFC places juvenile offenders who require residential treatment with carefully trained foster families who provide youth with close supervision, fair and consistent limits, consequences and a supportive relationship with an adult.
Cognitive Behavioral Therapy (CBT)	A structured, therapeutic approach that involves teaching youth about the thought-behavior link and working with them to modify their thinking patterns in a way that will lead to more adaptive behavior in challenging situations.
Dialectical Behavior Therapy	A therapeutic approach that includes individual and group therapy components and specifically aims to increase self-esteem and decrease self-injurious behaviors and behaviors that interfere with therapy.

What you will find in the *Collection*



Summary of Evidence-based Practices for Juvenile Offenders – What Seems to Work

What Seems to Work	Description
Family Centered Treatment (FCT)	FCT seeks to address the causes of parental system breakdown while integrating behavioral change. FCT provides intensive in-home services and is structured into four phases: joining and assessment; restructuring; value change; and generalization.
Brief Strategic Family Therapy	A short-term, family-focused therapy that focuses on changing family interactions and contextual factors that lead to behavior problems in youth.
Aggression Replacement Therapy (ART)	A short-term, educational program that focuses on anger management and provides youth with the skills to demonstrate non-aggressive behaviors, decrease antisocial behaviors, and utilize pro-social behaviors.

What you will find in the *Collection*



Suggested Assessment Tools for Trauma

Measure Type	Name of Measure	Who Completes	What is Learned
Clinical Interview	Anxiety Disorders Interview Schedule – Child (ADIS-C) and parent versions (ADIS-P)	Child, Parent	Whether a child meets criteria for PTSD based on DSM-IV criteria
Clinical Interview	Schedule for Affective Disorders and Schizophrenia-Children’s Present and Lifetime Version (K-SADS-PL)	Child, Parent	Whether a child meets criteria for PTSD based on DSM-IV criteria
Clinical Interview	Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)	Child/Adolescent (ages 8-15 years)	Whether child has been exposed to trauma, overall symptom severity, and whether a current or lifetime diagnosis of PTSD/ASD is indicated based on DSM-IV criteria
Rating Scale	UCLA PTSD Reaction Index (Child, Adolescent, and Parent versions)	Child, Adolescent, Parent	Whether a child has trauma exposure, PTSD symptoms (including duration of symptoms) based on DSM-IV criteria
Rating Scale	Child PTSD Symptom Scale (CPSS)	Child/Adolescent (ages 8-18 years)	Frequency of all DSM-IV-defined PTSD symptoms in children and DSM-IV diagnosis
Symptom Checklist	Trauma Symptom Checklist for Children (TSCC)	Child/Adolescent (ages 8-16 years)	Whether a child has acute and chronic posttraumatic symptoms; includes clinical scales and validity scales; measure does not assess DSM-IV criteria specifically
Symptom Checklist	PTSD Checklist – Child and Parent Report versions (PCL-C/PR)	Child, Parent	Whether child has symptoms of PTSD; measure does not assess for traumatic events or child functioning

Upcoming Changes to the *Collection*



- DSM-5 published May 2013
- Significant changes to categorization of disorders
- Examples:
 - A single Autism Spectrum Disorder
 - New – Hoarding Disorder
 - Revised criteria for Eating Disorders
 - Substance Use Disorder criteria combined and strengthened
- The 6th Edition of the *Collection* will be updated in 2015



Questions/Comments?

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Collection 5th Edition

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