CHAPTER 4

Many Court-Ordered Youth Need, But Do Not Get, Clinical Assessments

Chapter Summary

National research, best practice standards, and other states' systems are in agreement in supporting clinical assessment of troubled youth who show signs of emotional or behavioral problems. Experts agree that if a child is going to receive effective treatment for problems, the nature of the underlying problem must be accurately diagnosed. Because of the high incidence in this population of emotional and mental health problems, as well as developmental and learning disabilities, many COPs youth should be receiving clinical assessments to inform placement and treatment decisions.

DFS rules require that all children be screened and, if necessary, assessed.

Although DFS rules require youth to be screened using a tool the agency developed, only some of these youth receive an initial screening that might pick up on deeper issues. Even fewer receive independent clinical assessments, and those who do are not necessarily receiving the evaluations in time to inform courts' placement decisions. Often, providers themselves carry out the only evaluation the youth get**,** after the youth is placed.

The consequences of not assessing children prior to placing them in RTCs can be great: children may be improperly placed, and the cost may be greater and the treatment less effective than necessary. Children in this system should be uniformly screened, and those being considered for placement in therapeutic facilities should be independently assessed using a recognized mental health assessment tool.

Assessments Provide Critical Information

Assessments are essential to determine whether a child needs to be in an out-of-home placement in the first place, to identify the treatment approaches to which the child will most likely respond,

and to identify a provider with a treatment approach that meets the child's needs. Proper assessments also produce data that establish behavioral and clinical baselines by which to measure the child's progress while in treatment.

Not every provider's program is appropriate for every child.

Because Wyoming RTCs have developed some degree of specialization, they differ in the variety of services provided, the intensity of those services, and the types of problems they treat. This means that not every provider's program may be appropriate and effective for each child in need of treatment. Initial screening and proper assessment can help to assure a proper match of needs to services.

DFS Rules Require All COPs Youth To Be Screened, But Many Are Not

DFS rules require youth to be screened at intake, within defined time lines related to their legal category. The screening indicates what assessments may be necessary. DFS may pay for up to 45 days of interim placement, during which time information can be gathered for the predisposition report that assists the court and the MDT in formulating a proper disposition for the youth.

Screening identifies children who need more in-depth assessments.

Caseworkers are to use a series of safety and risk screens on abuse and neglect children as part of child protective services investigations, while a single tool, the Youth and Family Screen (YFS) is used with CHINS and delinquent youth. Screening instruments flag potential problems that may require more in-depth evaluation in order to accurately identify the problem. For example, a high overall YFS score, or a high YFS community protection, competency development, or accountability score is required to consider RTC placement.

Our review of case files suggests that DFS caseworkers are not administering the YFS screening instrument on every CHINS or delinquent, and further, that screening results do not appear to be a determiner for RTC placement. We reviewed files for 101 children adjudicated as CHINS or delinquents; only 52 percent (53) of the files contained YFS scores or references to them. If nearly half of this population is not being screened, a critical step to "flag" the youth in need of clinical assessment is missing.

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Without Screening, Children Needing Assessments May Not Be Identified

Clinical assessments, as compared to screening instruments, are tools designed to assemble a comprehensive clinical understanding of a child's problems, needs, and strengths. DFS does not expect caseworkers to have the clinical training necessary to identify and diagnose mental health problems. Because of the recognized vulnerability of abused and neglected children, DFS rules require that mental health assessments be performed by physicians or mental health professionals when screening instruments indicate they are needed.

Caseworkers do not have the clinical training to diagnose mental health problems.

This presumption is not apparent in DFS rules and procedures for juvenile offenders, even though this population is known to have a higher percentage of mental health issues than the juvenile population at large. National studies estimate between 20 and 70 percent of juvenile offenders may have mental health disorders, and this population is also at a higher risk for learning disabilities and mild mental retardation. DFS could not estimate the extent of these problems in Wyoming's juvenile offender population, but providers told us that they are pervasive in the RTC population and in no way dependent on adjudication category.

DFS is not the only entity ordering assessments. By statute, after a petition or motion is filed, the court may order assessment either on an outpatient basis or by temporarily placing the youth in a facility it designates to conduct the assessment. After placement, in order to develop treatment plans, service providers may also perform assessments.

Providers may need to do additional assessments once children are placed with them.

Our case file review showed that fewer than 40 percent of case plans indicated an evaluation was done in time to inform the placement decision (see Figure 4.1). Many of the case files contained insufficient information to determine whether the date of the assessment was current enough to be useful.

Our sample included a case in which the juvenile had been in 19 separate placements without documentation of ever having been clinically assessed. Of the 22 juveniles in the sample who were adjudicated as abused and neglected, only 10 files contained evidence that a court had ordered an assessment.

Figure 4.1
Case Plans Indicating Child was Assessed at Some Point

Assessments	Total files reviewed	Number	Percent of all cases reviewed
Done in order to determine appropriate placement	135	49	37
Children specifically placed for assessment	135	30	22
Providers performed additional evaluations	135	67	49

Source: LSO analysis of case file review data

Youth may be placed specifically for evaluation

Very few children receive independent assessments.

Courts may temporarily place youth in an RTC for evaluation, or the youth may be adjudicated and then placed at the facility. However, based on documents in the case files, we found that of the 49 cases where children had been assessed prior to their '03 placement, only 27 received an independent assessment, meaning the assessment was performed by a facility different from the one where the youth was ultimately placed. An additional three files indicated that the same RTC in which a child was placed for assessment became the RTC for the child's placement.

More often than not, if assessments are done, providers do them after placement

Interviews indicated a perception that RTC providers assess children soon after placement. Providers say they conduct assessments for a number of reasons: the information provided upon placement may be inadequate; an earlier evaluation may be outdated; they assess all youth on intake to meet specific accreditation standards; or they need assessments to properly fit the child within their facilities' different programs. We found this

perception to be somewhat optimistic: altogether, only 67 of the files contained evidence that providers completed additional assessments of youth during treatment.

DFS does not require the use of a uniform assessment tool.

Further, we learned that while some youth did not seem to receive any form of assessment, others were repeatedly assessed upon each move to a new RTC. With each new placement, the provider needs to know why the youth has been sent to them and how that youth is likely to fit into their treatment regimen. Since DFS does not require providers to use a uniform assessment tool, assessment information is not easily transferable among facilities, and some may not readily accept the evaluation of others.

Assessments are necessary because legal categories are not diagnostic

Juvenile justice legal or adjudication categories are not indicative of the underlying condition of the youth in question. Adjudication to a specific category (abuse and neglect, CHINS, or delinquent) appears to be more a function of how the youth first came into the legal or DFS system, rather than an indication of the youth's underlying problem or problems.

Without Assessments, Treatment Effectiveness Cannot Be Determined

According to a 1999 report by the U.S. Surgeon General, "residential treatment centers are the second-most restrictive form of care (next to inpatient hospitalization) for children with severe mental disorders." The outlay of DFS funds in FY '03, just for room, board, and treatment at RTCs, was over $12 million. Despite large expenditures for residential treatment, there is no way to determine if the treatment delivered was both warranted and beneficial.

Some children are placed in inappropriate facilities

Assessments are not uniformly provided to all youth prior to their being placed in RTCs, and not all programs are suitable for all types of youth. Under these circumstances, the placement process gives no assurance that problem youth and treating facilities are correctly matched.

Inappropriate placements may be disruptive or even dangerous.

Providers told us youth may be quiet, non-expressive or street-smart, any of which can mask the true problem and result in an improper placement. Additionally, providers told us that inappropriate placements may be more than a disservice to the misplaced youth: housing a sexual offender with a sexual victim may be dangerous, and treating a high-functioning conduct disorder child in the same setting as low IQ emotionally disturbed children may disrupt treatment progress for all children involved.

Multiple and unusually long placements suggest that some placements are not appropriate; inappropriately placed children may not benefit from the treatment they receive and in fact, may be harmed. In 2003, six youth from our sample were finally placed at BOCES, which are specialized facilities serving severely emotionally disturbed and developmentally disabled children. Each of these youth had from 2 to 11 prior out-of-home placements. That these six children were ultimately found to need BOCES services suggests there was a need for early clinical assessment to properly diagnose and place them, to avoid the cumulatively disruptive effects of multiple placements.

Multiple placements and long stays are common

According to DFS data on all children whose placement in an RTC began in FY ’03, 29 percent had more than one RTC placement in that year. Our case file review showed similar results: 30 percent of the children had more than one RTC placement in FY ’03, and some were sent to as many as six different RTCs (see Appendix D).

DFS is currently trying to determine why some children's treatments take so long.

We identified several COPs cases that have been in and out of placements since the 1990’s, one since 1992. DFS is currently reviewing all youth in treatment for longer than one year to determine the reasons for the extended treatment duration.

The problems, needs, and behaviors of children in residential treatment can change during the course of treatment, making it important to conduct supplementary assessments during treatment. A youth’s progress towards resolving problems needs to be monitored and evaluated in order to adjust protocols and services as necessary. DFS does not require RTCs to administer assessments during placement and does not require current

assessment results to accompany a recommendation for discharge. Our file review shows that some providers conduct interim assessments, but there was little documentation showing that pre-discharge assessments are done.

System relies on provider decisions

Caseworkers lack basic information about service decisions.

The lack of independent assessment data at all stages (pre-placement, during-placement, and at the end of placement), encourages a provider-driven RTC service infrastructure rather than one responsive to individual needs. Under these circumstances, the services that providers choose to offer may tend to become, by default, the services children need. Given the lack of basic information, caseworkers have little basis either for objectively evaluating whether a child has made progress in treatment, or for justifying a recommendation that treatment is complete and the child should be released.

Time Constraints and Procedural Ambiguities Appear to Impede the Assessment Process

Complete assessments take time to perform. The generally accepted time-frame for complete evaluation, as suggested in professional literature, is one to two months. We found that many youth, particularly CHINS and delinquents, are rushed through Wyoming's legal system too quickly to allow for in-depth assessments.

Few children in predisposition detention are assessed.

Even when they are in predisposition detention long enough to allow for thorough assessments, few youth are receiving them. In our review, 34 of the 135 cases were in predisposition placements for longer than two months, although there may have been more that we could not identify because of incomplete date information in the case files. Of these 34, only 13 had references to evaluations having been used as part of the placement decision. An additional 22 youth were in predisposition detention on average for almost three months; these youth were not assessed.

When a youth is in predisposition detention for more than 45 days, payment responsibility becomes unclear. DFS limitations on

interim cost payments may discourage the use of much needed assessments and treatments. The system's ambiguity as to who is financially responsible for additional detention time or services such as assessments provided during this period, may deter caseworkers, courts, and providers from ordering or performing what may be non-reimbursable expenses.

Financial responsibility for predisposition assessment is not clear.

Providers say moving a youth from one facility to another can be difficult, even if the provider has assessed the youth and determined that the placement is inappropriate. The system does not facilitate easy movement of youth within it, since according to some providers and DFS officials, changing a placement often involves obtaining a court order. This process can be difficult and time-consuming, as well as stressful for the youth.

Other states take more systematic approaches

Other states have not settled on a single approach to ensure informed placement decisions and to eliminate inconsistency in assessments. Solutions range from requiring the use of a prescribed assessment instrument or instruments, to a mandatory assessment by an independent licensed and certified entity, to a mandatory stay in a centralized or regional assessment center. Utah is one of several states that have adopted the state of Washington's assessment tool in an effort to implement standardized assessments; Montana and New Mexico are developing their own uniform assessment tools. Florida, Utah, Arizona, and Ohio require youth to be assessed in designated facilities prior to placement.

Some states require independent assessments prior to placement.

States using regional assessment centers place youth immediately on contact with the system, for a specified period of time. These centers provide a clinical and diagnostic, rather than detention type, environment for the purpose of comprehensive assessment. There is a recognition that comprehensive assessment prior to placement gives decision makers the precise information they need to make appropriate and cost-effective placements.

Many previous studies of DFS have stressed that accurate assessment is essential for the proper placement and treatment of juveniles. As long ago as 1979, a report suggested creating,

Previous studies identified the absence of assessments as a system shortcoming.

testing, and if feasible, implementing multi-purpose regional youth service centers to provide inpatient psychological evaluation and treatment, as well as halfway house components for pre- and post-institutional screening. Many of the prior studies indicate the "state" (without specifically suggesting DFS be the proactive entity) should initiate changes, including establishing a uniform assessment unit. More recently, a 1996 report stated that the lack of uniform assessment tools may result in inappropriate placements, which ultimately increases costs without benefiting youth.

Recommendation: DFS should develop rules and procedures to ensure that children receive uniform, independent clinical assessments prior to being placed in RTCs.

Many states have acknowledged that putting children in residential treatment is restrictive and expensive, and that intensive out-of-home treatment is not necessary for all troubled youth. One of the key factors they consider is clinical evidence of the need for behavioral or mental health treatment. They require all youth to be screened and further assessed if screens generate "flags" that there are underlying clinical problems. The assessment results guide placement decisions.

Historically, DFS' interest in uniform assessments has met with resistance, but we believe the agency can take the lead in identifying a tool that is valid, reliable, and acceptable to RTC providers. DFS then needs to propose a system in which assessments are conducted by an independent entity, one that does not have a financial or professional interest in a particular treatment approach or facility. DFS can make ordering such assessments a standard part of its casework requirements for those children being considered for residential treatment.

Decision makers need objective information to inform placement decisions and evaluate treatment effectiveness.

This will provide decision makers such as judges and MDTs with the necessary information to place the youth based on objective and timely evidence-based clinical evaluations. Collectively, the

assessment data will also provide a baseline of information on which to begin building a system to evaluate the effectiveness of various forms of treatment for different types of cases.