School and Campus Safety Taskforce Meeting

West Reading Room, Patrick Henry Building
June 20, 2013

AGENDA

1:00 pm – 1:15 pm	**Introduction and Approval of Minutes** Chairmen
1:15 pm – 2:00 pm	**Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs** Amy Atkinson, *Executive Director, Commission on Youth*
2:00 pm – 2:15 pm	**Education and Public Safety Workgroup Joint Recommendation** Laura Fornash, *Secretary of Education* Marla Decker, *Secretary of Public Safety*
2:15 pm – 2:30 pm	***Break***
2:30 pm – 3:00 pm	**Education Workgroup Recommendations** Laura Fornash, *Secretary of Education*
3:00 pm – 3:30 pm	**Mental Health Workgroup Recommendations** Dr. Bill Hazel, *Secretary of Health and Human Resources*
3:30 pm – 4:00 pm	**Public Safety Workgroup Recommendations** Marla Decker, *Secretary of Public Safety*
4:00 pm – 4:15 pm	**Public Comment**
4:15 pm – 4:30 pm	**Next Steps**

COMMONWEALTH OF VIRGINIA
Commission on Youth

Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs

June 20, 2013

Amy Atkinson

Collection of Evidence-based Practices

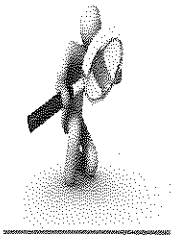
- *The Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs* (Collection)
- Currently in its 5th Edition

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 88 children [one in every 54 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.

Sources: Virginia Treatment Center for Children, 2010; American Psychological Association, 2003.

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

Sources: Weisz et al., 2000; Weisz et al., 1992.

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

Source: National Alliance for Mental Illness, 2007.

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

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*

- 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*

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
Psychodynamic Psychotherapy	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
SSRI medication Treatment	Treatment with selective serotonin reuptake inhibitors (SSRIs)
Do Not Seem to Work	**Description**
Restrictive restraining or holding techniques	Restrictive restraining 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

Assessment Type	Name of Measure	Who Completes	What It Assesses
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 8-18 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
Screening Tool	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 (PTSD-C/P)	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 5th Edition of the *Collection* will be updated in 2013

Questions/Comments?

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Collection 5th Edition

http://vcoy.virginia.gov

COLLECTION OF EVIDENCE-BASED PRACTICES FOR CHILDREN AND ADOLESCENTS WITH MENTAL HEALTH TREATMENT NEEDS
5TH EDITION

For parents, caregivers, service providers and others seeking current research on evidence-based practices

To access the Collection, published as House Document 7 (2013), please visit the Commission on Youth website.
http://vcoy.virginia.gov

• General Assembly Building, Suite 269 • Richmond, Virginia 23219 • 804-371-2481 •

Summary
Education and Public Safety Workgroup Recommendation
June 20, 2013

Recommendation Number	Proposal
ED-PS 01	*Recommends that law enforcement officers complete the School Resource Officer training curriculum provided by either the Virginia Center for School Safety or equivalent training provided through their local departments prior to assignment as an SRO or within 12 months of being assigned to the position.*

Governor's Taskforce on School and Campus Safety
2013 Recommendation Format

Peter Blake	SCHEV
Submitted By	**Agency**

Recommendation: *That an appropriation be made in the amount of $310,000 to the Virginia Department of Emergency Management (VDEM) to facilitate the development and sustainment of the Campus Community Emergency Response Team (C-CERT) program on all public higher education institution campuses in Virginia and to expand the availability of campus CERT training to all seven VDEM regions.*

Summary: *Explain the legal, program and policy changes proposed. Describe actions involved and elaborate why the proposal is critical or important.*

Competing priorities for the limited funds available to campus safety departments most often means foregoing safety training for the campus community at large in favor of safety training for campus police and security officers. However, the bombing in Boston, the tragedy at Virginia Tech, and more recently at Sandy Hook Elementary in New Haven, Connecticut justify the establishment of a team of individuals on our public campuses who are able to use the life-saving skills provided through CERT training in response to an emergency on campus.

Background: *Explain the history, including any relevant legislative history, relating to the issue or problem. Provide citation to data, research and other supporting materials relating to the recommendation.*

The CERT program is a nationwide effort to equip citizens to be more prepared for man-made and natural disasters. The Virginia CERT program is coordinated through the Virginia Citizen Corps housed within VDEM's Preparedness Division. The CERT curriculum delivers training in the basic emergency skills needed in the event of a major disaster or other events when emergency services may not be readily available and individuals may have to rely on each other for life-saving and life-sustaining needs. CERT members also support emergency response agencies by taking a more active role in emergency preparedness outreach initiatives in their community, by spreading the word about preparedness and in assisting agencies during response operations. The original and primary concept trained individuals to be capable of helping themselves and neighbors after a disaster in their homes and neighborhoods and became ideal to initiate in the workplace to include IHE campuses.

While the CERT is primarily a volunteer program, in 2011, Governor McDonnell issued Executive Order No. 41 which directed each agency of the Commonwealth, including institutions of higher education, to continue to include emergency preparedness planning and training as a core competence of their mission and required that all Emergency Coordination Officers take CERT training. However, it has become evident that a team of trained faculty, staff and students serving as "boots on the ground" should an emergency occur, is a tremendous asset to campus safety as trained CERT members help fill a vital role in the moments immediately following an emergency before first responders arrive on scene.

Need: *Explain the problem, issue or improvement and how the proposed recommendation will address it. Describe the anticipated results and objectives that your Work group expects to accomplish.*

The primary funding source for the Citizen Corps Programs (which include CERT), derives from the Department of Homeland Security, FEMA preparedness grant program. This program was designed to implement Citizen Corp programs at the state and local level, it was never meant to be a sustainment funding source. In fiscal year 2010 FEMA discontinued this program thereby creating a gap in direct funding.

The State Homeland Security Program (SHSP) is another source of FEMA funding that allows these types of activities. This is still an active program in fiscal year 2012; however, the continuation into FFY13 is unknown and the funding level has continually dropped each year since FFY 2010.

A number of Virginia's public institutions of higher education already have several individuals on campus who have participated in CERT training and some institutions have established CERT teams. Of the 15 public 4-year institutions, only Virginia Tech has an established a CERT team. However, Christopher Newport University (CNU), James Madison University (JMU), Longwood University (LU), Old Dominion University (ODU), University of Virginia (UVA), and Virginia Commonwealth University (VCU) have individuals on campus who have completed the Campus CERT Train the Trainer curriculum. Of the 24 public 2-year institutions, only Danville, Northern Virginia, and Patrick Henry Community College have established a CERT team. However, Thomas Nelson Community College, Central Virginia Community College, Dabney Lancaster Community College, Germanna Community College, Piedmont Community College, Blue Ridge Community College, Tidewater Community College, and New River Community College have individuals on campus who have completed CERT Train the Trainer. While 19 of Virginia's 39 public higher education institutions have staff meeting the requirements set by VDEM to start a Campus CERT program, 21 have no staff known to have this training.

To enable the establishment of CERT teams on all public higher education institution campuses, working in conjunction with SCHEV and VCCS, VDEM is proposing the

offering of a series of regionalized CERT training sessions which would include a Train-the-Trainer component. The goal of this training would be to:

- Ensure that Campus CERT coordinators who have not taken the 20.5 hour classroom CERT training are given an opportunity to complete the mandated training.
- Assist Campus CERT coordinators in coordinating their first class by helping connect to local/regional resources for the development of their cadre of CERT trainers.
- The public higher education CERT offerings would also be open to state agency Emergency Coordination Officers (ECO) and localities starting new CERT programs in need of this training to further strengthen relationships between public higher education personnel, state agencies, and their respective host communities.

VDEM is able to provide CERT adjuncts to facilitate the recommended regionalized training and 575 Campus CERT backpacks at no cost. However, VDEM would need to hire a full-time Campus CERT Coordinator to maintain ongoing oversight and connectivity to all public higher education Campus CERT programs to support the goals of the proposal. The costs anticipated with the hiring of the Coordinator for a minimum 3-year contract is $210,000 ($70,000 per year including salary and benefits). An additional $100,000 would be required to create a fund to support public higher education institutions' efforts to establish and sustain their CERT programs. The fund would be administered according to guidelines to be developed by VDEM, SCHEV, and the VCCS. Institutions would submit applications for funding as needed.

Discussed Pros and Cons to Implementation of Recommendation(s): *Explain arguments "for and "against" the proposal. What are some of the challenges in implementing the recommendation What groups are likely to support or oppose the recommendation and why?*

The anticipated challenge with implementing this recommendation is insufficient general funds to support the costs associated with the proposal.

Proposed Amendment or Legislation: *If the recommendation involves a change in the law, please provide a draft of the proposed changes to the Code of Virginia in the legislative bill format. Strike through language to be deleted and underline new language.*

N/A

Fiscal Impact: *Does this proposal require financial or personnel resources? If so, what are the estimates and what agencies, stakeholder groups, etc. are impacted? Will it generate revenue? If so, what is the estimate? Will a Budget Amendment be necessary? If so, what is the estimated cost?*

There is a fiscal impact associated with the implementation of this proposal.

VDEM requires $210,000 to hire a CERT program coordinator for a minimum of 3 years at an annual salary with benefits of $70,000, to manage the expansion and administration of setting up and executing training sessions across the Commonwealth. An additional $100,000 is needed to establish a fund to help mitigate the costs to public higher education institutions as they work to establish and sustain their CERT programs.

Total allocation: $310,000.

Result: *Did the recommendation pass the workgroup?* Yes
When? May 30th, 2013

Taskforce?

When?

Were any concerns raised? *If so, what were they?*

Was there any resulting legislation or budget amendment? If so, please identify by Code Section and bill number, or budget item number.

Next Steps: *Are there any "next steps" associated with this recommendation?*

If so, what agency (or agencies), stakeholder group, or other entity is responsible for these next steps?

Timeline for implementation:

Document prepared by: Peter Blake

Date: June 12, 2013

Governor's Taskforce on School and Campus Safety
Mental Health Workgroup

Mental Health Workgroup Recommendations
Summary

Proposal	Status
Suicide Prevention – Expand a comprehensive statewide program of public education, evidence-based training, health and behavioral health (BH) provider capacity-building, and suicide (and related homicide) prevention activities in collaboration with VDH, DOE, DVS, DARS, and other partners. Target audiences will include CSB and private BH providers; health and social service providers; and community gatekeepers including teachers, clergy, law enforcement, youth leaders, military and veteran advocates, and parents and families.	WG: Passed 1/24/13 TF: Passed 1/31/13 GA: Included $500,000 in budget
Mental Health First Aid – Five-day instructor training and certification on how to recognize and respond to mental or emotional distress. Some trained instructors will be clinicians who also act as community resource staff for consultations and interventions and will build networks through Virginia 211 referrals. Subsequent 12 hour trainings will target peers, teachers, clergy, health professionals, community agency personnel, military and veteran service organizations and advocates, and other first responders and "gatekeepers" who have extensive public contact.	WG: Passed 1/24/13 TF: Passed 1/31/13 GA: Included $600,000 in budget
CIT Law Enforcement Assessment (Drop-off) Centers – Develop new sites for police drop off where an officer can take a person in crisis for access to treatment and quickly return to their regular law enforcement duties. Individuals will receive clinical assessments for possible civil commitment and linkage to services for acute and sub-acute mental health treatment needs 24 hours per day.	WG: Passed 1/24/13 TF: Passed 1/31/13 GA: Included $900,000 in budget
CSB Child/Adolescent Outpatient and Psychiatric Outpatient Services Expand access to child/adolescent outpatient clinicians and child psychiatrists (direct, consultative, and tele-psychiatry) for behavioral health conditions such as depression, anxiety, disturbing thoughts, interpersonal or relationship problems, substance abuse etc., in a one-to-one, counselor-client setting, as early as possible to the onset of the problem to reduce the likelihood that manageable mental health problems become full-blown crises.	WG: Passed 1/24/13 TF: Passed 1/31/13 GA: Not included in budget
CSB Adult Outpatient and Psychiatric Services – Expand access to adult outpatient clinicians and psychiatrists (direct, consultative, and tele-psychiatry) for behavioral health conditions such as depression, anxiety, disturbing thoughts, interpersonal or relationship problems, substance abuse etc., in a one-to-one, counselor-client setting, as early as possible to the onset of the problem to reduce the likelihood that manageable mental health problems become full-blown crises.	WG: Passed 1/24/13 TF: Passed 1/31/13 GA: Not included in budget
Temporary Detention Order (TDO) Extension – Amends the *Code of Virginia* to require a minimum 24-hour period of temporary detention and allow a maximum 72-hour period of temporary detention for adults with mental illness who are involved in the involuntary admission process.	WG: Passed 3/28/13

Governor's Taskforce on School and Campus Safety
2013 Recommendation Format

Recommendation: Temporary Detention Order (TDO) Extension – This is a proposal to amend the *Code of Virginia* to require a minimum 24-hour period of temporary detention and allow a maximum 72-hour period of temporary detention for adults with mental illness who are involved in the involuntary admission process.

Summary: *Explain the legal, program and policy changes proposed. Describe actions involved and elaborate why the proposal is critical or important.*

The goal is to ensure that detained individuals can receive at least 24 hours of treatment, and up to 72 hours of care (excluding weekends and holidays) prior to the court hearing for involuntary admission. Extending the minimum required and maximum allowable times of temporary detention also allows more time for the independent examiner and CSB preadmission screening evaluator, as well the detained individual, to prepare for the hearing. Amending the laws in this way will reduce the need for and likelihood of court ordered inpatient treatment following the commitment hearing, and will increase opportunities to use mandatory outpatient treatment (MOT) or voluntary care in lieu of involuntary hospitalization. These outcomes are consistent with the Commonwealth's goals of providing high quality services, minimizing the unnecessary use of involuntary treatment, and providing services in the least restrictive manner.

Virginia has one of the shortest periods of temporary detention in the country. Studies conducted for the Commission on Mental Health Law Reform documented several benefits that would result from the proposed change. Specifically, a longer detention period provides more time for a more thorough assessment, allows the person's condition to improve, and increases the likelihood that voluntary hospitalization, discharge to outpatient care, or release from court oversight will occur. A longer stay in temporary detention is also associated with shorter post-hearing length of stay and a shorter total episode of care.

Background: *Explain the history, including any relevant legislative history, relating to the issue or problem. Provide citation to data, research and other supporting materials relating to the recommendation.*

The idea originated in the deliberations of the Commission on Mental Health Law Reform, but has been revisited several times thereafter, most recently with the unanimous support of the Mental Health Workgroup of the Governor's Task Force on School and Campus Safety.

Over the past six years, extensive revisions have been made to Virginia's involuntary mental health treatment laws to enact reforms recommended by the Supreme Court's Commission on Mental Health Law Reform, the Virginia Tech Review Panel and the recommendations of the Inspector General for Behavioral Health and Developmental Services. Despite widespread support for the proposed change, this important reform has not been accomplished to date. The proposed amendment has already been enacted without controversy for juveniles (juvenile law has a 24-hour

Proposed Amendment or Legislation: *If the recommendation involves a change in the law, please provide a draft of the proposed changes to the Code of Virginia in the legislative bill format. Strike through language to be deleted and underline new language.*

This proposal is to amend §37.2-809 and related sections of the Code of Virginia (i.e., §§19.2-169.6 as it is currently effective and as it shall become effective after July 1, 2014; 19.2-182.9; and 37.2-814) to require a minimum 24-hour period of temporary detention and allow a maximum 72-hour period of temporary detention for adults with mental illness who are involved in the involuntary admission process.

Fiscal Impact: *Does this proposal require financial or personnel resources? If so, what are the estimates and what agencies, stakeholder groups, etc. are impacted? Will it generate revenue? If so, what is the estimate? Will a Budget Amendment be necessary*? If so, what is the estimated cost?

The fiscal impact is between $1.2 million and $1.8 million. There is not specific data available to analyze all cost variables, including:

- Hospital and medical costs of temporary detention are paid from several sources, including private insurance, Medicaid, and the Department of Medical Assistance Services (DMAS)-managed Involuntary Mental Commitment Fund (IMCF) and other sources. It is not possible to track all expenditures, by source, for all hospitalizations, but when HB 1680 (Yost) and SB 996 (Barker) were introduced in the 2013 Session of the General Assembly to extend the maximum time period to 72 hours (these bills did not include the 24-hour minimum), DMAS estimated fiscal impact of $1.2-1.5 million on the ICMF.
- The DMAS estimate above did not include potential saving that would result from shorter post-TDO hospitalizations. These potential savings could erase any costs added to the IMCF.
- A recent University of Virginia (Wancheck & Bonnie, 2012) estimated extending the TDO period to 72 hours would result in an additional 873 TDO hospital days charged to the Involuntary Mental Commitment Fund. In addition, in FY11, the cost was $781 per day. At this rate, this will result in $681,813 additional charges to the IMCF.
- The number of executed TDOs varies by year, but has declined over the past two years.

It should also be noted that the IMCF has always been funded on a "sum-sufficient" basis annually, regardless of appropriations (i.e., any expenditures that exceed appropriated amounts are reconciled through the caboose bill). In light of this, the Commonwealth should enact the 24 hour minimum and 72 hour maximum period of temporary detention because this would improve the law.

Summary
Public Safety Workgroup Recommendations
June 20, 2013

Recommendation Number	Proposal
PS-17	***Directs the Virginia Center for School Safety to host the following conferences:*** • ***Bullying Prevention Forum.*** *Coordinate with VDH, DOE and DCJS a statewide Bullying Prevention Forum to highlight evidence-based programs designed to address bullying and other forms of student conflict. Scheduled for* June 17, 2013. • ***National School Safety Summit.*** *Virginia to host a National Summit inviting school safety center directors from states across the nation to share resources, best practices, legislation and curricula in roundtable event.* • ***School Safety and Technology Vendor Fair.*** *Highlight latest technology and private industry safety standards available to school personnel to include cost benefits of access control systems, electronic notifications, and fencing.* •
PS-18	***Directs the Virginia Center for School Safety to host the following trainings:*** • ***Mental Health 101 Training.*** *Develop and offer Mental Health 101 courses for law enforcement. Also a recommendation from MH Workgroup (MH-03) – Provide a train the trainer session for law enforcement officers on how to recognize and respond to mental or emotional distress. These instructor officers will subsequently train school and campus personnel gate keepers.* • ***School Safety Audit Team Training.*** *Provide annual statewide training on conduct of school safety audit inspections for new safety audit team members – training will include PS Recommendation 08: Security and Vulnerability Checklists.*
PS-19	***Directs the Virginia Center for School Safety to provide the following resources:*** • ***Best Practices.*** *Produce and disseminate best practices information to school divisions through conferences, trainings, and specialized forums – the VCSS will collect and collate best practices and recommendations for school and campus safety personnel and disseminate through trainings, conferences and via the web site.* • ***Educators' Guide to Conducting Emergency Drills.*** *Review and update the "Educators' Guide to Conducting Emergency Drills" – the VCSS will update and disseminate this guide to reflect current practices and PS-02 which mandates lockdown drills.* • ***Juvenile Law Handbook .*** *Review and update the Juvenile Law Handbook – the Handbook was created in 1997 to assist school administrators in differentiating between criminal violations and Student Code of Conduct violations. The Handbook has typically been updated bi-annually but will now be updated annually in conjunction with the OAG and the Virginia Rules Program.*

School & Campus Safety Task Force Meeting

June 20, 2013

Task Force Members Present:
The Honorable Marla Graff Decker
The Honorable Laura Fornash
The Honorable Bill Hazel, M.D.
The Honorable Kenneth Cuccinelli
The Honorable Joseph Yost
The Honorable George Barker
Patricia Wright, Ed.D.
Donna Michaelis
Garth Wheeler
Mark Gooch
Michael Cline
Marissa Levine, M.D. (for Maureen Dempsey, M.D.)
Peter Blake
Sarah Gross
Deborah Pettit. Ph.D.
Dianne Smith
Regina Blackwell Brown
Meg Gruber
Judy Lynch, Ph.D.
Charles Klink
Chief Don Challis
Captain Steve Carey
Gene Deisinger, Ph.D.
Alexa Rennie

The meeting was called to order at 1:00PM by Secretary Decker.

The minutes from the January 31, 2013 Task Force meeting were approved as written. Motion by Mark Gooch, seconded by Meg Gruber. The motion passed unanimously.

The first item on the agenda was a presentation by Amy Atkinson, Executive Director of the Commission on Youth, on the *Collection of Evidence-Based Practices for Children and Adolescents with Mental Health Treatment Needs, 5th Edition* (published as House Document 7-2013) (see handouts provided in packet). The Collection summarizes current research on those mental health treatments that have been proven to be effective in treating children and adolescents. The Collection is intended for parents, caregivers, service providers and others seeking current research on evidence-based mental health practices for youth. The Collection was compiled by the Commission on Youth with the

assistance of an Advisory Group of experts pursuant to SJR 99 (2002). The Collection was originally published as House Document 9 and presented to the Governor and the 2003 General Assembly.

To ensure the information remained current and reached the intended audience, the 2003 General Assembly passed SJR 358, which requires the Commission to update the Collection biennially. The Secretaries of Health and Human Resources, Public Safety, and Education, along with the Advisory Group, were requested to assist the Commission in updating the Collection, as were various state and local agencies. The Collection is available on the Commission on Youth website.

The next item on the agenda was the **Education and Public Safety Workgroup Joint Recommendation**. Secretary Fornash explained this recommendation came out of the March 4, 2013 joint meeting of the two workgroups. The proposal (ED-PS 01) recommends that law enforcement officers complete the School Resource Officer (SRO) training curriculum provided by either the VCSS or equivalent training provided through their local departments prior to assignment as an SRO, or within 12 months of being assigned to the position.

A motion was made by Secretary Fornash that the Task Force approve the recommendation as written. The motion was seconded and passed unanimously.

The next item on the agenda was the **Education Workgroup Recommendations**. Secretary Fornash called on Mary Savage to explain the two recommendations submitted by SCHEV (see handouts provided in packet). Both recommendations passed the Education Workgroup on May 30, 2013.

The first recommendation was that a $2 million appropriation be made annually to establish a competitive grant program to support and sustain crime prevention and campus safety programs and initiatives at public higher education institutions in Virginia. Garth Wheeler noted that the statement in the Recommendation Summary is untrue that indicates 'campus security departments are unable to access vital training from the Department of Criminal Justice Services'. It was agreed this statement would be removed from the recommendation.

The second recommendation was that an appropriation be made in the amount of $310,000 to VDEM to facilitate the development and sustainment of the Campus Community Emergency Response Team (C-CERT) program on all public higher education institution campuses in Virginia, and to expand the availability of campus CERT training to all seven VDEM regions.

A motion was made that the Task Force approve both recommendations as written, with the exception of the change to the first recommendation regarding DCJS. The motion was seconded and passed unanimously.

The next item on the agenda was the **Mental Health Workgroup Recommendations** (see handouts provided in packet). Attorney General Kenneth Cuccinelli explained the first recommendation would amend the *Code of Virginia* to require a minimum 24-hour period and a

maximum 72-hour period of temporary detention for adults with mental illness who are involved in the involuntary admission process. The Fiscal Impact of this recommendation would be between $1.2 and $1.8 million. This recommendation passed the Mental Health Workgroup on March 28.

A motion was made that the Task Force approve the recommendation as written. The motion was seconded and passed unanimously.

The last item on the agenda was the **Public Safety Workgroup Recommendations** (see handouts provided in packet). Donna Michaelis provided a brief overview and updates related to Recommendation Numbers PS-17, PS-18 and PS-19.

PS-17 directs the Virginia Center for School Safety (VCSS) to host a Bullying Prevention Forum, a National School Safety Summit, and a School Safety & Technology Vendor Fair. The Fiscal Impact of this proposal would be $50,000.

PS-18 directs the VCSS to host Mental Health 101 Training and School Safety Audit Team Training. The Fiscal Impact of this proposal would be $50,000.

PS-19 directs the VCSS to produce and disseminate best practices information to school divisions via conferences, trainings and specialized forums; to review and update the *Educator's Guide to Conducting Emergency Drills*; and to review and update the Juvenile Law Handbook. In addition, PS-19 recommends the recommendations as set forth in *HJR 122 Final Report: Study on Campus Safety* be reviewed to review strategies for implementation of relevant recommendations to enhance school or campus safety; and that the 2004 Secure Virginia Panel recommendations be reviewed and evaluated to determine relevancy of recommendations for school safety. The Fiscal Impact of this entire proposal would be $25,000.

Motions were made that the Task Force approve all three recommendations as written. The motions were seconded and passed unanimously.

Public Comment

None

Next Steps

Per Secretary Decker, three more full Task Force meetings are scheduled for July 31, August 13 and September 23 in the West Reading Room of the Patrick Henry Building. Each meeting will be scheduled from 1:00 PM – 5:00 PM.

By September, the work of the Task Force should be wrapping up, and there should be a plan in place for the future of the Task Force.

The meeting concluded at 2:30 PM.