Mental Health Evaluations Required Prior to Delinquency Dispositions

Last week the Court of Appeals breathed new life into a decades-old law that requires district courts to refer juveniles who have been adjudicated delinquent, prior to disposition, to the area mental health, developmental disabilities, and substance abuse services director for an interdisciplinary evaluation if any evidence that the juvenile is mentally ill has been presented. This new decision, In the Matter of E.M., __ N.C.App. __ (January 15, 2019), raises many questions like, does it really mean any evidence of mental illness? And does it matter if the juvenile has already received mental health services? And who is the area mental health, developmental disabilities, and substance abuse services director anyways?

G.S. 7B-2502(c) – the statutory requirement

G.S. 7B-2502(c) requires a referral from the court to the area mental health, developmental disabilities, and substance abuse services director for appropriate action if the court believes or if there is evidence presented to the effect that the juvenile is mentally ill or developmentally disabled. The statute then requires the area mental health, developmental disabilities, and substance abuse services director to arrange an interdisciplinary evaluation of the juvenile and to mobilize resources to meet the juvenile's needs.

In *E.M.,* the juvenile was committed to the YDC and placed in the custody of the Department of Social Services as a result of probation violations. Relying on G.S. 7B-2502(c), the court held that "Evidence of mental illness compels further inquiry by the trial court *prior to entry of any final disposition*." Slip Op. at 6, quoting *In re Mosser*, 99 N.C.App. 523 at 529 (1990). The disposition in *E.M.* was vacated and the case remanded because this required referral to mental health was not made prior to disposition. While the decision does not address what exactly the interdisciplinary evaluation must entail or what constitutes adequate resource mobilization, the court is clear that the statute is intended to engage the area mental health services director's involvement in crafting the juvenile's disposition. Slip Op. at 8.

This statute has been around for decades. S.L. 1971-1180, §3 took away the then existing power of the court to directly order mental health commitment at disposition and, instead, allowed the court to order the area mental health director to arrange an interdisciplinary evaluation of the child and make recommendations to the court. S.L. 1973-1157 shifted that new permissive language into a mandate, replacing the "may" with a "shall" in terms of the referral, expanded the mandate to apply to cases "in which there is evidence presented to the effect that the child is mentally ill or mentally retarded," and added the requirement that the area mental health director also mobilize resources to meet the child's needs. Those amendments from the early 1970's are the core of today's statute.

Is there a threshold amount of evidence of mental illness that triggers the referral requirement?

Juvenile justice researchers have consistently found that prevalence rates of mental illness among youth in contact with the juvenile justice system are extremely high. Studies have found that somewhere between 50 and 75 percent of youth who encounter the juvenile justice system meet criteria for a diagnosable mental health disorder, *see, e.g.,* Lee A. Underwood and Aryssa Washington, *Mental Illness and Juvenile Offenders*, International Journal of Environmental Research and Public Health; Basel Vol. 13, Issue 2 (Feb. 2016); 1-14. Is a referral to mental health required under 7B-2502(c) for all of these juveniles?

In *E.M.* there was a significant body of evidence presented to the court regarding the juvenile's mental illness. This included three risk and needs assessments filed between October 2017 and January of 2018 that indicated both a history of and continuing need for mental health services, a clinical disposition report that indicated major behavioral issues and a history of four previous diagnosis, and testimony that chronicled a history of significant mental health treatment and ongoing need presented at the hearing.

However, in the case relied on by the court in *E.M*, *In the Matter of Mosser*, 99 N.C.App. 523 (1990), far less evidence of mental illness was presented. In *Mosser* the court relied on the statement of the juvenile's mother indicating that the juvenile had been diagnosed as manic-depressive and was being treated with medication to trigger the required referral for an interdisciplinary evaluation under G.S. 7B-2502(c). The statute itself provides no threshold that must be met in order to trigger the referral requirement. It simply states that "If the court believes, or if there is evidence presented to the effect that the juvenile is mentally ill or is developmentally disabled" then the referral shall be made.

What if the juvenile has already received mental health services?

In both *E.M.* and *Mosser* the juvenile had already received mental health services. In fact, *E.M.* appears to have received a wide range of services that included in-home, outpatient, and inpatient services. The holding in *E.M.* requires referral for an interdisciplinary evaluation despite this history. It seems then that courts must make the referral for evaluation prior to issuing a disposition even if the juvenile has previously been evaluated and has received mental health services.

Wait, my county doesn't have an "area mental health, developmental disabilities, and substance abuse services director." Who is that?

You are right if you have discovered that your locality doesn't have an area mental health, developmental disabilities, and substance abuse services director. Remember that this part of the statute was enacted in 1971? Well, the mental health system has undergone many substantial changes since that time and those changes are not reflected in the language of G.S. 7B-2502(c).

The definitions provided in G.S. 122C-3 (in the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985) provide the legal bridge from the “area director” referenced in G.S. 7B-2502(c) to the actual entity now performing this function, the “Local management entity.” G.S. 122C-3(2a) explains that the “area director” is the administrative head of the “area authority” and G.S. 122C-3(20b) provides that the “Local management entity” (LME) means an area authority. Because of the way the mental health services system is currently structured, all LME’s are also currently “managed care organizations” (MCO’s), making the entity to whom the referral under G.S. 7B-2502(c) must go the “LME/MCO.”

If you don’t know who your local LME/MCO is, you can go here to access the DHHS LME/MCO directory.

Implications

Given the high prevalence rates of mental illness among justice-involved youth, this decision has the potential to significantly increase the number of referrals to LME/MCOs for evaluation prior to delinquency dispositions. While this might slow the time to disposition and raise concerns about funding to support interdisciplinary evaluations, it could also provide a basis for continuing to turn to the mental health system to meet the mental health needs of justice-involved youth with mental health disorders.