Juvenile Justice Services Assessment Protocol

ELIGIBLE YOUTHS

- The youth is adjudicated on a misdemeanor or felony and needs an assessment prior to final disposition; and
- The youth is placed in detention or is ordered on home detention; and
- The youth lacks a recent, valid assessment as determined by a JJS Clinician.

AVAILABLE ASSESSMENTS

Mental Health Assessment (MHA)/Substance Use Disorder (SUD)

The MHA consists of a face-to-face interview, which may be conducted via telehealth with a youth. Collateral information will be gathered from the youth's parent/guardian. The assessment will include a comprehensive review of available background documentation. The MHA/SUD is used to diagnose mental health conditions and the report provides recommendations for future interventions specific to diagnoses.

Psychological (if indicated following a MHA)

The MHA has identified specific concerns about a youth's cognitive functioning, or developing personality characteristics that requires more in-depth testing, including intelligence testing.

Sexual Behavior Risk Assessment (SBRA)

The SBRA is administered to a youth who has been identified as a perpetrator of a sexual offense. It will identify problems, recommended level of NOJOS treatment, progress and reduction of risk for sexual offenses.

PROCESS

1. The court orders a MHA or SBRA.
2. The probation officer, case manager or DCFS worker will electronically submit a completed referral packet, including the request form to: JJSClinicalAssessments@utah.gov.
3. Upon receipt of the packet, a JJS Clinical Supervisor will determine the youth's eligibility. If eligible, an assignment is made to a JJS Clinician for a MHA or to a contracted provider for an SBRA.

   The assigned JJS Clinician will complete a MHA and electronically submit the report to the worker within 7 calendar days. If the youth is placed on Home Detention, then the clinician will electronically submit the report to the worker within 14 calendar days.

   or

   The assigned provider will complete an SBRA and electronically submit the report to the worker within 30 calendar days.
4. If the MHA indicates a youth needs a psychological, the JJS Clinician will notify the worker and make an assignment to a contracted provider. The assigned provider will complete the psychological and electronically submit the report to the worker within 30 calendar days.

Contact the Clinical Bureau at JJSClinicalAssessments@utah.gov

utah department of human services

Revised 11-6-17

State of Utah

Department of Juvenile Justice Services

ASSESSMENT REQUEST FORM

☐ MHA ☐ SBRA

TO BE COMPLETED BY THE CASEWORKER/PROBATION OFFICER

Complete this form and forward it with all supporting documentation to the MHA Coordinator at JJSClinicalassessments@utah.gov. MHA Coordinator will respond with approval status in One business day.

1. Person Evaluation Requested For

Youth's Name: Case # Today's Date:

Youth's Address:

City State Zip Code

Date of Birth Age ☐ Male ☐ Female

Medicaid ID# Insurance Name: Policy # Group #

Placement: (check box) ☐ Foster/Proctor Care ☐ Home of Relative ☐ Other ☐ Home of Parent ☐ Group Home

Date of Adjudication: Adjudicated charges:

2. Parent / Guardian Information

Name	Phone #	
Address	City	Zip Code

Additional Comments:

3. Probation Officer/JJS or DCFS Case Worker Information

Name	Phone #	Ext
Supervisor	Phone #	Ext
Email Address	Region	
Agency/Residential Facility Name		
Address	City	Zip Code

4. Reason for Referral

ADMINISTRATIVE REASON(S) FOR REQUESTING EVALUATION (Please check all that apply/include documentation)

☐ **Court Ordered** ☐ Child & Family Team ☐ Clinical Staffing

☐ Other: (describe)

CLINICAL REASON(S) FOR REQUESTING EVALUATION (Please check all that apply)

☐ Concern about emotional functioning
☐ Concern about social functioning
☐ Concern about behavioral functioning
☐ Concern about intellectual/cognitive functioning
☐ Recommendation from current mental health service
☐ Change in functioning unexplained by current events
☐ Not progressing in mental health treatment
☐ Concern about appropriate mental health treatment
☐ Diagnosis unclear
☐ Sexual Offender
☐ Other:

Presenting Problems, specific symptoms, behaviors, duration, severity, history and any complicating factors (please give complete details):

5. CURRENT MEDICATION TREATMENT

Current Medication(s)	Dose	Frequency	Concerns about medication? ☐ No ☐ Yes, describe:

List outpatient psychologist/therapist currently seeing or ☐ check if NEVER ☐ check if PRIOR, NOT CURRENT

Name (with credentials)	Reason for Visit	Date started/Estimated # Visits

Progress in Treatment: ☐ Improved ☐ Little or No Progress ☐ Regressed due to event ☐ Near Completion

6. Inpatient Psychiatric Treatment or ☐ check if NEVER ☐ check if any OVER 2 YEARS AGO

Total Number of Inpatient Psychiatric Hospitalizations: ☐ 1 - 3 ☑ 4 – 6 ☐ 7 – 9 ☐ >10

List all inpatient treatment for mental health/psychiatric symptoms within the past 2 years

Facility	Reason for Hospitalization	Dates of Stay

7. Demographic and Special Considerations Race (check all that apply)

African-American ☐ Asian-American ☐ Asian-Pacific American ☐ Caucasian ☐ Hispanic-American ☐ Native American ☐ Biracial / or other (specify)

Language? Language spoken at home? Interpreter Needed? ☐ No ☐ Yes

LGBTQ? ☐ No ☐ Yes If yes, indicate any concerns

8. Substance Abuse

Most recent positive drug test date: Positive substance:

Do you believe the client is actively using substances? No ☐ In Treatement ☐ Yes ☐ (check below all that apply)

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Cocaine Other: ☐

Indicate type, frequency, duration

8. Services Involved in or Completed & Date

☐ Mentoring _____ ☐ Recreation _____ ☐ Vocational Training _____

☐ Parenting Classes _____ ☐ Parent Coaching _____ ☐ Substance Abuse Treatment _____

9. Developmental History

Concern about developmental delay? ☐ No ☐ Yes

Details:

Receiving/received any of the following services? ☐ None

☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy

Details:

10. Educational History Check all that apply or ☐ check if NONE

☐ Special Education Services?	☐ IEP?	☐ Suspension?	☐ Expulsion?
☐ Social Problems with peers?	☐ Teacher has concerns?		☐ Parent has concerns?

Details:

11. Impairment Check all that apply or ☐ check if NONE

☐ Visually Impaired ☐ Hearing Impaired ☐ Physically Impaired

Details:

12. Medical History If YES, describe

☐ Yes	☐ No	Head Trauma?		☐ Yes	☐ No	Medical illnesses?	
☐ Yes	☐ No	Seizure Disorder?		☐ Yes	☐ No	Surgeries?	
☐ Yes	☐ No	Pregnant?	Due Date:	Number of Pregnancies:			Number Live Births:

☐ Other:

Details:

13. Legal Involvement (court appearance, probation, etc) If YES, describe

☐ Yes	☐ No	Current?	☐ Yes	☐ No	History?

Details:

14. Attach Additional Documentation **Please indicate if information is available in C.A.R.E. . Only information accessible in C.A.R.E** will be included in the evaluation, unless submitted with this form. (check all that apply)

☐ **All previous psychological or other professional evalutations, including psychosexual, mental health assessments.**
☐ Court order for evaluation.
☐ Court Report.
☐ Current grades, IEP or other educational information.
☐ If the client is or has been in mental health treatment, a progress report, treatment plan or summary, psychiatric hospital discharge summary & current medication list**.**
☐ Medical report, including neurological exam report.
☐ Staffing Report from Child & Family Team Meeting, SOC Staffing , MAS.
☐ Other documentation such as an Incident Report.

15. ADDITIONAL INFORMATION

Signature of Caseworker	Signature of Supervisor
Date	Date