Mental Health 101 for Non-Mental Health providers
Intensive Mental Health Services for Youth

Brief Description of the Child and Adolescent Continuum of Mental Health Services

1. **Community Based Services (non-residential)**

**Family support** offers parent and youth advocacy, support groups, informational workshops, referral and linkage to services by trained family and youth advocates who have experience as consumers of mental health services. No eligibility requirements – appropriate for any family or youth seeking information or referral and support related to mental health needs. Services are offered free of charge.¹

**Outpatient clinics** offer mental health assessment; individual, group and family therapy; and medication management. Services are offered by mental health clinicians such as psychiatrists, social workers, psychologists and nurse practitioners. Outpatient clinics generally provide treatment for youth 5-18 years old (some may treat children younger than 5) at risk for or with mental health diagnoses who can be maintained in the community. Services are reimbursed through insurance or self pay on a sliding fee scale.¹

**Day Treatment** provides intensive mental health treatment and special education services in an integrated school program. Day treatment is appropriate for youth with a mental health diagnosis and functional impairment who are unable to function in a less restrictive school setting. They are approved by the Committee on Special Education (CSE) as needing the most restrictive classroom setting in order to achieve academic goals. Services are offered through the Department of Education and Medicaid.¹

**Intensive Day Treatment** provides highly structured, short-term mental health treatment in a Department of Education milieu setting. This program provides short term assessment and respite for youngsters who are challenged, in crisis, or who are temporarily unable to be maintained in a more traditional academic, and/or treatment setting. It is appropriate for youth with current community living arrangements in place. CSE approval is not needed. This program is available in Queens and the Bronx and referrals are made directly.²

**Case Management** offers assessment, support and coordination of services based on child and family’s individual needs. The case manager links the child/family to services, coordinates services among different providers and service systems, ensures that child’s appointments are maintained and needs are being met. Case management can be intensive (minimum of 4 monthly contacts) or supportive (minimum of 2 monthly contacts). This service is appropriate for 5-18 year olds with a mental health diagnosis and functional impairment who can be maintained in the community with this additional support. Case management is accessed through the Children’s Single Point of Access (CSPOA)³ and is Medicaid reimbursable.

**Home and Community Based Services Waiver** provides a range of home-based supportive services for youth at risk of hospitalization or out of home placement. Services include care coordination, respite, skill building, crisis management, family counseling and family support. Waiver allows for Medicaid eligibility determination so youngsters can receive services regardless of parents’ income. This service is for youth 5-18 with a mental health diagnosis, functional impairment and risk for institutional placement whose families are willing to maintain them at home and participate in intensive supportive interventions. Waiver is accessed through CSPOA.²
2. **Community Based Residential Programs**

**Community Residence** is an 8 bed therapeutic environment providing 24 hour supervision. The program promotes youth integration into the community and preparation for community life roles and independent functioning. The aim is also to assist youth in developing a natural support network and to utilize services in the community. Families are included in community residence activities and expected to participate in their child’s daily lives such as attending school meetings and clinic appointments. Community residences serve youth 5-18 with mental health diagnosis who can be maintained in the community – attend school and utilize other community services – but who would benefit from a group living situation rather than a family setting. Access is through CSPOA.²

3. **Institutional – non community based – services**

**Residential Treatment Facility (RTF)** offers inpatient psychiatric type services such as comprehensive mental health treatment in a self-contained therapeutic setting where youth receive all services including school, recreational, vocational, and medical care. The RTF is appropriate for youth 5-18 with a mental health diagnosis who need long term treatment and who cannot be served in the community in less restrictive settings. The RTF is accessed through a Preadmission Certification Committee.⁴ Youth must be Medicaid eligible.

4. **Emergency and Crisis Services**

**Hospital emergency room /psychiatric emergency room** – available for urgent evaluation to determine need for hospitalization in the event of a mental health emergency via 911.

**Mobile crisis teams** consist of a team of mental health professionals (e.g., nurses, social workers, psychiatrists, psychologists, mental health technicians) who come to the home and provide a range of services including assessment, crisis intervention, supportive counseling, information and referrals, linkage with appropriate community based mental health services for ongoing treatment, and follow up for a person experiencing a psychological crisis, and who requires mental health intervention and support to overcome resistance to treatment.¹

**Home Based Crisis Intervention** offers home-based crisis services to stabilize a child at imminent risk of psychiatric hospitalization. This intervention is short term (4-6 weeks) and available 24/7 to help a family avoid a psychiatric hospital admission. The HBCI team refers the child for ongoing services after stabilization is accomplished.¹

**Intensive Crisis Stabilization and Treatment** provides home-based crisis services as well as short term psychotherapy for up to 3 months. This service is only available in the Bronx and Brooklyn.¹

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¹ Call LIFENET at 1800 LIFENET or at www.800lifenet.org to get information on and access to these services.

² Call Directly. Bronx: Michael Harrigan 718 742-6164; Queens: Lisa Romano 718 264-4586

³ CSPOA – Children’s Single Point of Access is a single referral point for all children’s intensive mental health services. CSPOA reviews applications, determines level of care and refers to most appropriate available service. CSPOA is reached at 888-CSPOA-58 or 888-277-6258. The Universal Referral Form is at www.childfamilyinstituteny.org/slservices/cmhs/UniversalReferralForm.pdf

⁴ PACC- Pre-Admission Certification Committee reviews all RTF referrals to determine need for this level of intensive mental health treatment. PACC coordinator may be reached at 212-330-6398.
Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems

John Petrila, JD, LLM

The CMHS National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness

February, 2007

Recently, police arrested an individual with a long arrest record. During the arrest, he was injured and police took him to an area hospital for care. When the police came to check on him the next day, he had been released. The hospital spokesperson said that the Health Insurance Portability and Accountability Act (HIPAA) made it impossible for the hospital to communicate with the police regarding the individual’s release.

This 2006 newspaper story is notable for two reasons. First, it illustrates one of the many types of interactions between law enforcement officials and health care providers that occur every day across the United States. Second, it illustrates the many misunderstandings regarding HIPAA that continue to exist years after its enactment.

These misunderstandings are sometimes so deeply ingrained that they have assumed the status of myth. These myths have serious negative consequences for persons with mental illness who are justice-involved. They can bring efforts at cross-system collaboration to a halt and they can compromise appropriate clinical care and public safety. In fact, these myths are rarely rooted in the actual HIPAA regulation. HIPAA not only does not create a significant barrier to cross-system collaboration, it provides tools that communities should use in structuring information sharing arrangements.

What is HIPAA?

Congress enacted HIPAA in 1996 to improve the health care system by “encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.”

The HIPAA “Privacy Rule” (which establishes standards for the privacy of information and took effect on April 14, 2003) has received most of the attention from those concerned about the impact of HIPAA. However, as important, the Department of Health and Human Services adopted the Rule on Security Standards in 2003, to govern the security of individually identifiable health information in electronic form. An Enforcement Rule was also adopted, effective March 2006. Most of the myths about HIPAA concern the Privacy Rule, while too often ignoring the potentially more troublesome area of electronic security.

Who does the HIPAA Privacy Rule cover?

The Privacy Rule establishes standards for the protection and disclosure of health information. The Privacy Rule only applies to “covered entities,” which are health plans (such as a group health plan, or Medicaid); health care clearinghouses (entities that process health information into standard data elements); and health care providers. Other entities may be

1 Department of Mental Health Law & Policy • University of South Florida at Tampa
affected by HIPAA if they are “business associates” (discussed briefly, below).

Contrary to myth, HIPAA-covered entities do not include the courts, court personnel, accrediting agencies such as JCAHO, and law enforcement officials such as police or probation officers. There are special rules for correctional facilities, discussed briefly below.

**What does the Privacy Rule require before disclosure of protected health information?**

The Privacy Rule permits disclosure of health information in many circumstances without requiring the individual’s consent to the disclosure. These circumstances include the following:

- Disclosures or uses necessary to treatment, payment, or health care operations. This means, for example, that a care provider may release information necessary to another treatment provider at discharge, because the disclosure is necessary for treatment. In addition, “health care operations” is defined broadly and includes quality improvement, case management, and care coordination among other things.

- HIPAA also permits other disclosures without the individual’s consent. Those relevant here include disclosures for public health activities; judicial and administrative proceedings; law enforcement purposes; disclosures necessary to avert a serious threat to health or safety; and disclosures mandated under state abuse and neglect laws.

In the example provided at the beginning of this fact sheet, the hospital properly could have notified law enforcement of the presence of the arrestee in the hospital under the provision of HIPAA that permits a covered entity to disclose protected health information to a law enforcement official’s request for “information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person” (164.512(f) (2)). While this section limits the type of information that may be disclosed for this purpose, it is clear that identifying information can be disclosed.

- In the case of correctional facilities, HIPAA permits health information to be shared with a correctional institution or law enforcement official with custody of the individual, if the information is necessary for the provision of health care to the individual; the health and safety of the inmate, other inmates, or correctional officials and staff; the health and safety of those providing transportation from one correctional setting to another; for law enforcement on the premises of the correctional facility; and for the administration and maintenance of the safety, security, and good order of the facility. This general provision does not apply when the person is released on parole or probation or otherwise released from custody.

**Does this mean that consent is never required in these circumstances?**

While HIPAA permits disclosure without consent in many situations, it does not mean that unlimited disclosure is permissible or that obtaining consent is unnecessary or inappropriate. First, confidentiality and privacy are important values in health care. Obtaining consent may be a way of demonstrating respect for the individual’s autonomy, whether or not it is legally required. Second, other laws may mandate that consent precede disclosure even if HIPAA does not. If a state law provides more stringent protection of privacy than HIPAA, then the state law must be followed. The same is true of the Federal rules.
on the confidentiality of alcohol and drug abuse patient records (commonly referred to as Part 2). These rules, enacted more than 30 years ago, have strict requirements for the release of information that would identify a person as an abuser of alcohol or drugs. Another example illustrates this point: HIPAA permits disclosure of information in response to judicial and administrative subpoenas that many state laws limit. If state law has more procedural protection for the individual in that circumstance, then state law applies. Finally, HIPAA incorporates the principle that in general disclosures should be limited to the “minimal necessary” to accomplish the purpose for which disclosure is permitted.

**Are there tools that can be used in cross-system information sharing?**

There are several tools systems can adopt in creating an integrated approach to information sharing.

- **Uniform consent forms.** While HIPAA does not require prior consent to many disclosures, consent may still be necessary for legal (i.e., other state law) reasons, or because it serves important values. One barrier to collaboration is that most agencies use their own consent forms and consent is obtained transaction by transaction. In response, systems can adopt uniform consent forms that comply with Federal and state law requirements.

  Such forms have several features. First, they permit consent to be obtained for disclosure throughout the system at whatever point the individual encounters the system. Second, the forms can be written to include all major entities in the collaborative system; the individual can be given the option to consent to disclosure to each entity in turn, by checking the box next to that entity, or consent can be presumed with the individual given the option of withholding information from a particular entity.

- **Standard judicial orders.** Courts and court officers (state attorneys, public defenders) are not covered entities under HIPAA. However, in some jurisdictions care providers have been reluctant to share health information with the courts, or with probation officers, on the ground that HIPAA prohibits it. In response, some judges have created judicial orders with standard language mandating the sharing of information with certain entities, for example probation officers. Such orders do not concede that courts or court officers are covered by HIPAA; rather they are designed to eliminate mistaken assumptions that care providers may have regarding HIPAA.

- **Business associate agreements.** A “business associate” is a person or entity that is not a covered entity but that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. Examples include the provision of accounting, legal, or accreditation services; claims processing or management; quality assurance; and utilization review. Entities or persons providing these and other services described in the regulation must sign a business associate agreement with the covered entity for which the services are provided.

HIPAA does not discuss uniform consent forms or standard judicial orders, but it is evident that both will assist in easing sharing of information within and across systems. HIPAA does require the use of business associate agreements in some circumstances, and so knowledge of the requirements for such agreements is important. 42 CFR Part 2, on the confidentiality of alcohol and substance use information, has an analogous though not identical provision permitting the sharing of information with “qualified services organizations.”

**Will HIPAA violations lead to severe penalties?**

The fear of liability far outstrips the actual risk of liability in providing mental health care. This is true generally, and particularly true with confidentiality, where there have been few
lawsuits in the last three decades alleging a breach of confidentiality.

There is also great fear regarding the possibility of punishment for violating HIPAA. Certainly, HIPAA provides for significant penalties, including civil and criminal fines and incarceration. However, there are two reasons that penalties for minor HIPAA violations, in particular, are unlikely. First, if an individual's health information is disclosed inappropriately under HIPAA, that individual cannot bring a lawsuit for the violation. Rather, enforcement of HIPAA is done entirely through regulatory agencies, with primary enforcement the responsibility of the Office of Civil Rights of the Federal Department of Health and Human Services. Second, although, there had been 22,664 complaints received by OCR through September 30, 2006, not a single penalty has been imposed.

In fact, only 5,400 (or 23%) complaints required further investigation, and these were resolved either by informal action (for example, a letter) or no further action. Therefore, the actual, as opposed to perceived, risk for being severely punished for a HIPAA violation is remote.

A note on the Rule on Security Standards

As noted above, this rule was adopted in 2003 but has received comparatively little attention in discussions of cross-system collaboration. Yet while concerns regarding the Privacy Rule have been exaggerated in many jurisdictions, security issues may sometimes receive too little attention. For example, while protected health information may be shared in most circumstances, if it is done electronically steps must be taken to secure the information, for example by encrypting email exchanges. As systems get beyond the myths regarding sharing of information under HIPAA, it will be important to focus on the requirement of the Security Standards, particularly since the most egregious violations of individual privacy over the last few years have resulted from intrusions into electronic data.

Summary

HIPAA has become the reason many conversations regarding cross-system collaboration have come to a stop. Yet HIPAA provides no significant barrier to sharing information within and across systems. While confidentiality and privacy of health information are important and legally protected values, HIPAA has become subject to myths that have no foundation in the text of the regulation. It is important that all parties involved in efforts to create integrated systems for people with mental illnesses in the criminal justice system put HIPAA aside as a reason these efforts cannot succeed.

Useful Resources

www.hhs.gov/ocr/hipaa
This is the home page for the Office of Civil Rights of the US Department of Health and Human Services. OCR has primary enforcement authority for HIPAA. This page has a wealth of information regarding HIPAA — it’s the first place to go with questions.

www.hipaas.samhsa.gov/download2/SAMHSAHIPAAComparisonClearedPDFVersion.pdf
This page links to a document prepared by SAMHSA that compares Part 2 (the Federal regulations on the confidentiality of substance use and alcohol information) with the HIPAA Privacy Rule.

www.hhs.gov/ocr/combinedregtext.pdf
This link provides the full text of the Privacy Rule and Security Standards for the Protection of Electronic Protected Health Information.

www.gainscenter.samhsa.gov/html/resources/presentations.asp
This page includes an audio replay and materials from a CMHS TAPA Center for Jail Diversion net/tele-conference: HIPAA and Information Sharing. A sample uniform consent form is included.
The Changing Borders of Juvenile Justice: Transfer of Adolescents to the Adult Criminal Court

Through much of the 20th century, the juvenile court was the primary legal forum to respond to children who broke the criminal laws. With the rise in youth crime beginning in the late 1970s, legislators and commentators spoke ominously of a nation under siege by a rising generation of violent young criminals. These fears led many Americans to blame the juvenile court and demand that legislators “get tough” with violent and chronic offenders.

In response to recurring epidemics of youth violence over the past three decades, 46 states made significant changes in laws that lowered the age and broadened the circumstances under which young defendants could be prosecuted in the criminal courts. Prosecution in the criminal court was designed to punish young offenders more harshly and for longer periods of time, thereby deterring them and other youths from further crimes.

But have these efforts been effective? Does the prospect of harsher sentences and adult time deter youth from committing crimes? Although there are strong proponents on each side of the argument, new evidence has raised questions about the effectiveness of the new laws.

Network researchers have examined whether the prosecution of adolescents as adults reduces crime and recidivism. Their research capitalizes on unique conditions in the New York City region, where the laws of two states, New York State and New Jersey, span the border of a single metropolitan area. On the New York side of the border, juveniles as young as 13 are charged in adult court, while on the New Jersey side, nearly all cases of juvenile offenders below the age of 18 are processed in juvenile court. By comparing similar offenders in the two settings who were arrested and charged with the same felony offenses during the same time period, the researchers were able to determine whether treating juveniles as adults in the legal system is an effective deterrent to crime.

They find that adolescents processed in the New York adult courts were more likely to be re-arrested, they were re-arrested more often and more quickly and for more serious offenses, and they were re-incarcerated at higher rates than those in the New Jersey juvenile courts. The results suggest that harsher sentences and adult punishment are ineffective deterrents to crime among the juveniles in this sample.

Teens Prosecuted in Adult Courts at Greater Risk of Repeat Offenses

The study examined more than 2,000 adolescents who committed one of three types of serious crimes (aggravated assault, armed robbery, burglary) during 1992 and 1993. The youth were tracked through 1999 to determine re-arrest rates for several types of crimes. By using the two groups from the same metropolitan area, with similar economic opportunity, access to weapons, drug use, gang influences, and other influences on crime, any differences in re-arrest between the two groups can be assumed to be due to the different court systems. The re-arrest rates were calculated after controlling for time on the street.

Table 1 shows that youth prosecuted in the adult courts in New York were 85% more likely to be re-arrested for violent crimes than those prosecuted in the New Jersey juvenile courts, and 44% more likely to be re-arrested for felony property crimes. The odds of re-arrest
were greatest for those youths with no prior arrest record who were prosecuted and sentenced as adults. Only for one type of crime, drug offenses, were youths in the adult courts less likely to be re-arrested. The chances of being re-incarcerated were 26% greater for youths prosecuted as adults. When the researchers compared the number of each type of offense during the follow-up period, the results were nearly identical.

Youths who received lighter sanctions — those whose cases were either dismissed or who received lighter sentences—also were less likely to be re-arrested; this was true in both states. In other words, teens whose cases are diverted from court or dismissed are less likely to be arrested again. More work is needed to determine whether this stems from the courts’ ability to identify those youth at greater risk for reoffending and give them a sanction, or if the mere fact of a sanction causes an adolescent to feel more like a criminal and then act more like one after release.

The research also showed that longer sentences did not reduce the likelihood of rearrest either in the juvenile or the adult court. But, the research did show that a history of prior arrests and re-arrests is a reliable predictor of future re-arrests. So too are several demographic factors: males are more likely to be re-arrested than females, and African-Americans are more likely to be re-arrested than other race-ethnicities. More study is needed to determine whether these differences stem from different behaviors of the individuals in the groups or from different arrest policies.

**Teens in Adult Corrections Face Harsher Settings and Experience More Developmental Problems**

In a related study, network researchers compared the correctional experiences of 425 adolescents placed in juvenile versus adult correctional facilities in 2000-2001. This research sought clues that might explain why adolescents adjudicated and sentenced in the criminal courts often have higher re-arrest rates and are more often returned to jail or prison. The research used a similar design in which youth in juvenile corrections were compared with matched samples of youths in nearby states where they were incarcerated as adults. The incarcerated youths were interviewed within three months of their scheduled release date and asked about their correctional experiences, the therapeutic and rehabilitative services they received, and their mental health and social outcomes. Four states were included in the study, each with varying programs and facilities where teenage offenders were incarcerated. The experiences of youth in juvenile correctional facilities in New Jersey and California were compared with those of similar groups of youth placed in adult correctional facilities in New York and Arizona.

The results suggest clear differences in the therapeutic and service contexts of each of these settings. Figure 1 shows that youths placed in adult correctional settings reported significantly weaker correctional climates along four critical dimensions: fairness, counseling and therapeutic services, educational and job training services, and program structure, compared with matched groups of youths placed in juvenile facilities. At the same time, the juvenile facilities were more chaotic. Adolescents in the juvenile programs reported higher rates of witnessing violence and violent victimization. They also reported higher rates of involve-
ment in several types of crimes while incarcerated as well as more drug use. Despite these unruly settings, they reported greater feelings of safety compared with youths placed in adult settings. This paradox may reflect the social networks that were dominant in the two different types of placements: older criminal offenders in more organized prison gangs were the dominant social group in the adult facilities, compared to the loosely organized groups of peers that populated the juvenile facilities.

This greater sense of danger, then, perhaps explains the higher rates of mental health problems reported by youths in the adult facilities. Figure 2 shows that the current levels of mental health symptoms of youths in adults corrections were significantly worse on two dimensions of mental health functioning compared with rates reported by youths in juvenile facilities. The significant dimension includes the important Global Severity Index, a scale that spans all of the dimensions of mental health in this assessment tool.

The same youths also reported higher rates of three dimensions of post-traumatic stress disorder. Figure 3 shows that youths in adult corrections had higher rates the same types of mental health problems experienced by soldiers returning from war and survivors of natural disasters.

There were also differences across the juvenile corrections facilities. Youths placed in larger juvenile justice facilities with a wider age range of inmates had similar outcomes to youths placed in the adult facilities. Youths sentenced as adults who spent some time in juvenile facilities before being administratively transferred to adult placements experienced fewer mental health problems and reported better service environments. These differences suggest that the size and diversity of populations in correctional placements are important dimensions of the correctional experience that interacts with the broader adult-juvenile legal categories to shape the correctional experiences of youths punished as adults.

**Policy Implications**

Policymakers and others advocating for harsher youth sentences argue that the threat of “adult time for adult crime” is a sound deterrent. The first study, however, shows the opposite: recidivism among 15- and 16-year-olds prosecuted in adult courts in New York is actually more common and more serious than it is in New Jersey, which refers adolescents who have committed similar offenses to juvenile courts. Youths sentenced in the criminal courts in New York were more likely to be re-arrested, their re-arrests were more frequent and their new offenses more serious, and they were more likely to be re-incarcerated within a few years.

The study also suggests that the longer sentences in adult courts are not responsible for the differences in re-arrest rates or in correctional outcomes. Rather, the second study finds that the adult courts may expose adolescents to harsher incarceration settings
and less effective probation supervision in the criminal justice system. One reason may be that a felony conviction has a more harmful effect on subsequent employment, citizenship, or other positive adult roles, factors that otherwise could lessen the tendency to return to crime. Another possibility is that prosecution in an adult court communicates to the adolescent that he or she is unsalvageable, and hence repeat offenses become a self-fulfilling prophecy. A third reason is the stark differences in correctional experiences for those youths who are incarcerated as adults. Not only do they receive fewer and weaker services, but they are confined with adult offenders during the critical developmental period of the transition from adolescence to adulthood. This environment obviously has its effects on mental health. But also, teens in adult corrections have limited exposure during this critical developmental stage to a broader set of social norms and a more diverse behavioral toolkit from the wider social networks of family, school or work, and community. Network researchers are not the only ones to reach these conclusions. Studies in Florida, for example, show similarly elevated risks of re-arrest for juveniles in adult court, and similarly toxic environments for those youths placed in adult correctional facilities.

Network researchers recommend that authority for making transfer decisions be returned to court judges who can consider criteria other than age and offense in determining how to prosecute an adolescent. Policies that result in a wholesale transfer of adolescents from juvenile to adult courts often fail to deter repeated instances of serious and violent crime. Although some of the most extreme cases may still need to be prosecuted in adult court, these should be the exception and not the rule. However, return of decision-making authority to judges must be accompanied by new models for decision-making. In the past, judges have not been able to consistently identify the most serious offenders, and there has been a tendency toward harsher sentencing that often reflected racial discrimination. If new models are not offered to judges, the same problems will recur. What is needed is a better method to distinguish between cases in which the community must be protected from predatory youth and those in which delinquent youth must be protected from negative effects of incarceration.

For more information
MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice
Temple University, Department of Psychology
Philadelphia, PA 19122
www.adjj.org

The Research Network on Adolescent Development and Juvenile Justice is an interdisciplinary, multi-institutional program focused on building a foundation of sound science and legal scholarship to support reform of the juvenile justice system. The network conducts research, disseminates the resulting knowledge to professionals and the public, and works to improve decision-making and to prepare the way for the next generation of juvenile justice reform.
Mental Health Screening within Juvenile Justice: The Next Frontier

by the National Center for Mental Health and Juvenile Justice

Models for Change
Systems Reform in Juvenile Justice
Models for Change

Models for Change is an effort to create successful and replicable models of juvenile justice reform through targeted investments in key states, with core support from the John D. and Catherine T. MacArthur Foundation. Models for Change seeks to accelerate progress toward a more effective, fair, and developmentally sound juvenile justice system that holds young people accountable for their actions, provides for their rehabilitation, protects them from harm, increases their life chances, and manages the risk they pose to themselves and to the public. The initiative is underway in Illinois, Pennsylvania, Louisiana and Washington.
Chapter 1 Introduction

Kathleen R. Skowyra and Joseph J. Cocozza, Ph.D.

Over the last decade, there has been a steady increase in the awareness of the unmet mental health needs of many youth in the juvenile justice system. This attention has led to the development of improved strategies for responding to these youth. One of the most important responses to have emerged within the field is that of systematic mental health screening. Mental health screening is now routinely performed within many juvenile justice agencies and programs throughout the country. This is important progress in the overall effort to better identify and respond to youth with mental health treatment needs. Many agencies have now answered basic questions about whether screening should be performed, and with what tools. However, with this progress, a new set of issues has arisen around mental health screening, focusing on questions about the process and how its results should be used. These issues and questions require clarification to allow the field to move forward. The purpose of this paper is to explore these new issues and offer policy and practice clarification to the juvenile justice community.

Background

Recent research has established that a large proportion of youth involved with the juvenile justice system in this country have significant mental health problems (Shufelt & Cocozza, 2006). Findings from a number of mental health prevalence studies conducted within the last five years among youth in a variety of juvenile justice settings—community-based, detention, corrections—are remarkably consistent. Approximately 65 percent to 70 percent of youth in the juvenile justice system have a diagnosable mental health disorder (Shufelt & Cocozza, 2006; Wasserman, McReynolds, Lucas, Fisher & Santos, 2002; Wasserman, Ko, & McReynolds, 2004; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Further, the results from a recent multi-state, multi-site mental health study conducted for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) indicate that the percentage of youth in the juvenile justice system experiencing severe mental health disorders is even higher than was previously thought. Severe mental disorders (i.e., meeting criteria for certain severe disorders or having been hospitalized for a mental disorder) were thought to be found among approximately 20 percent of youth in juvenile justice settings (Cocozza & Skowyra, 2000). The results of the most recent study suggest a figure closer to 27 percent, indicating that more than one quarter of all youth in the juvenile justice system are in significant need of mental health treatment (Shufelt & Cocozza, 2006). These new studies on the prevalence of mental health disorders among the juvenile justice population have helped spur the development and application of new responses to help the field better identify and respond to these youth.

One of the most important first steps to respond to the mental health treatment needs of youth in the juvenile justice system is to systematically identify the mental health needs of youth as they become involved with the juvenile justice system (Skowyra & Cocozza, 2006). In order to do this, it is critical that mental health screening measures and procedures be in place to identify mental health needs among youth at their earliest point of contact with the system. Although this may seem obvious, it has not always been so; one only needs to look back a decade or two to see just how much things have changed.

In the early 1990’s, mental health screening within the juvenile justice system was virtually nonexistent, as documented in the monograph, Responding to the Mental Health Needs of Youth in the Juvenile Justice System (Cocozza, 1992). Otto and colleagues (1992), in their review of the research literature on the prevalence of mental disorder among the juvenile justice population, found significant inadequacies in the research and cited the critical need for improved mental
health screening and evaluation of youth in contact with the juvenile justice system. They found that the mental health screening that was performed in juvenile justice systems was often the exception rather than the rule. It tended to be superficial, non-standardized, and not performed at critical points of intervention. In large measure, this was due to the juvenile justice field lacking a simple, scientifically-sound, and easily administered instrument that could be used by non-clinical juvenile justice staff to identify potential mental health problems among youth entering the system.

Much has changed in the field since the release of that report. Awareness of the needs of these youth has steadily increased, stirring enormous public interest and governmental efforts to respond to what has been widely identified as a crisis (Grisso, Vincent, & Seagrave, 2005). These efforts to respond have led to:

**More and better research.** Most of the limitations of the earlier research, cited by Otto in the 1992 monograph, have been addressed through the development of carefully designed, scientifically sound and thoughtfully executed research methodologies used to collect the most recent mental health prevalence data on youth in the juvenile justice system (Shufelt & Cocozza, 2006). As a result, we now have consistent data, documenting the extent of the problem and providing further justification for the deployment of new screening, assessment, and treatment resources to respond to youths’ mental health needs.

**Greater advocacy for mental health screening within juvenile justice systems and programs.** Concerted efforts by national organizations to promote awareness of the unmet mental health needs of this population of youth and to advocate for improved mental health identification, diversion, and treatment strategies have pushed this issue to the forefront of public discussion. Organizations like the National Center for Mental Health and Juvenile Justice, the Coalition for Juvenile Justice, the Council of Juvenile Correctional Administrators, and the National Association of State Mental Health Program Directors, among others, have worked at the national, state, and local levels to influence policy and encourage the adoption of standardized mental health screening protocols within juvenile justice programs and settings.

**The availability of scientifically sound mental health screening tools.** Systematic mental health screening of youth in the juvenile justice system was not occurring 10 years ago largely because the field lacked the appropriate tools and methods to achieve this. The recent development of a wide range of mental health screening tools for juvenile justice (Grisso, Vincent & Seagrave 2005) represents a major step forward for the field and fills a long-standing gap by offering easy-to-use screening tools for juvenile justice staff. One of the most widely used mental health screening tools developed in recent years is the Massachusetts Youth Screening Instrument-- Second Version (MAYSJ-2) (Grisso & Barnum, 2006), a 52 item self-report instrument that identifies potential mental health and substance use problems among youth. It has been adopted for use in facilities in 49 states and for statewide use in probation, detention, or juvenile corrections programs in 39 states (NYSAP, website). Examples of other screening tools that are being used with youth in the juvenile justice system include:

- The Child and Adolescent Functional Assessment Scale (CAFAS), which is designed to assess the degree of impairment in children and adolescents with emotional, behavioral, or substance use symptoms or disorders (Hodges, 2005);

- The Global Appraisal of Individual Needs Short Screener (GAIN-SS), which is a self-administered instrument used to quickly identify individuals who would have a disorder
on the full GAIN. Its four subscales test for internal disorders, behavioral disorders, substance use disorders and crime/violence (GAIN website), and

- The Substance Abuse Subtle Screening Inventory for Adolescents—Second Version (SASSI-A2), which is a 15-minute screen that addresses four types of ongoing problematic uses of alcohol or other drugs (Miller & Lazowski, 2001).

The Next Frontier: Where Are We Now?

These combined efforts have reversed the previous trend so that mental health screening within juvenile justice programs is quickly becoming the rule rather than the exception. Nearly every state in the country is now implementing mental health screening measures within some of its juvenile justice programs. This is significant and important progress in the overall effort to improve mental health care for youth in the juvenile justice system.

As a result of this progress, however, the field is just beginning to recognize and contend with a completely new set of issues related to mental health screening. These new issues represent the next frontier of mental health screening and reflect new practice and policy challenges that have emerged in the field. These questions go beyond the scope of many of the earlier technical assistance documents that were developed to provide guidance around the selection of an appropriate instrument (Grissos & Underwood, 2004) or the implementation process (Wasserman et al., 2003). The issues that have now surfaced are generally more complex, often involving multiple systems, and require clarification to allow the field to refine its efforts and to continue its progress. In many ways, this is the natural evolution of the process: As more and more juvenile justice systems and programs perform systematic mental health screening, new, and in some ways unanticipated, issues arise that have the potential to compromise the original intent of the screening effort.

The purpose of this paper is to examine some of the new issues that have emerged in the field as a result of widespread mental health screening within juvenile justice systems and programs and offer guidance and clarification for responding to them. However, it is important to note that this paper does not seek to address or resolve every policy or practice question that pertains to mental health screening within juvenile justice systems. For example, while there are assumed relationships between mental health screening and referrals for evaluation, the provision of appropriate services, and better outcomes, the field is only now beginning to systematically examine these relationships. Until then, it is important to provide clarification on those issues where enough information currently exists to offer recommendations for future practice. The issues explored in this paper include:

Mental Health Screening Procedures and Policies: Good Practice and Appropriate Uses of Screening Results. The widespread adoption of mental health screening in a range of juvenile justice settings under real-world time and resource constraints has brought to light important questions about how to make screening work in a way that allows programs to achieve the full value of the process. In addition, confusion has arisen over the appropriate clinical purposes of a mental health screen as distinguished from a mental health assessment, as well as the appropriate use of mental health screening results. Chapter 2 provides guidelines for good mental health screening practices as well as recommendations for the development of policies to avoid inappropriate uses of mental health screening information once it is obtained from a youth.
Implementing Mental Health Screening Within a Juvenile Justice Program. Juvenile justice administrators face a complex task when trying to implement routine mental health screening within their programs or facilities. Even selecting a tool requires prior considerations of one's purposes and specific facility needs. After a tool is selected, a host of questions arise regarding how, when, and by whom screening will be done. Chapter 3 provides a comprehensive "ten-step" description of procedures for planning and ultimately implementing an effective and purposeful mental health screening process.

Conclusion

The number of juvenile justice programs across the country performing routine mental health screening on youth has increased substantially over the last ten years. As this has occurred, it has become critically important to address new policy and practice questions that have emerged. This paper is designed to answer these questions by offering clarification and guidance. In some instances, the clarification provided is based on "lessons learned" from the field. Throughout the paper, case examples are provided that illustrate how existing communities and programs have developed policies or procedures that facilitate mental health screening within juvenile justice settings. Because the MAYS1-2 is one of the most widely used mental health screening instruments within juvenile justice settings, the examples included in this paper are largely drawn from communities or states that are using the MAYS1-2. It is hoped that these case examples, as well as the recommended actions described in this paper, will result in better mental health screening processes for youth in the juvenile justice system.
Chapter 2  Procedures and Policies: Good Practice
and Appropriate Uses of Screening Results

Valerie Williams, M.A., M.S.

Over the past five years, mental health screening has become a standard procedure in many juvenile justice programs across the nation. Its rapid spread has given rise to practice and policy questions that need clarification to allow the field to move forward. This chapter:

- clarifies the distinct purposes of a mental health screen and a mental health assessment,
- describes the importance of the selection of appropriate screening instruments,
- reviews guidelines for good mental health screening practices, and
- provides recommendations for the development of policies to avoid inappropriate uses of mental health screening results.

What Is Mental Health Screening?

Mental health screening is a relatively brief process carried out by non-clinical staff using a standardized mental health screening tool. Some tools offer structured questions that youth answer about their current or recent thoughts, feelings, or behaviors. Others ask staff to make ratings based on past records or caretakers’ reports of youths’ behavior. In any case, mental health screening is a triage process that is employed with every youth during an initial probation intake interview, within a few hours after intake in pretrial detention or upon entrance into juvenile justice placement.

The purpose of mental health screening is to identify youth whose mental or emotional conditions suggest that they might have a mental disorder, might have suicide potential, or might present a risk of harm to others in the immediate future. The term “screened in” is used to refer to youth who are identified by the screening method as needing further attention.

When youth are “screened in” for possible mental and emotional problems, it does not necessarily mean that they have mental disorders or that they are suicidal or likely to harm others. It indicates the need for a follow-up response by staff. Often this involves obtaining further evaluation to determine whether mental disorders or suicide and aggression risks actually exist or to engage in precautionary interventions—for example, to obtain an immediate emergency clinical intervention and/or to make some program response to assure a youth’s safety while in immediate custody (e.g., suicide watch).

Mental health screening is different from clinical assessment. Assessment is a follow-up for youth whose screening scores suggest that they might have mental and emotional problems. Assessments are performed by clinicians, and they offer more comprehensive, individualized evaluation of youth providing descriptions and recommendations that will be useful for long-range treatment and dispositional planning. The assessment process may include psychological testing, clinical interviewing, and obtaining past records from other agencies for review by the clinician assessor.

Mental Health Screening Practices and Policies

The value of mental health screening procedures is limited to the purpose described above—an initial identification of youth with possible mental and emotional problems needing immediate response and further assessment. It is unlikely that this value would be achieved without careful attention to the quality of the screening tool chosen and to the proper implementation of screening procedures. This section presents guidelines for good mental health screening practices and recommendations for the development
of policies to assure appropriate use of mental health screening results.

**Good Mental Health Screening Practices**

Programs should use mental health screening tools that have been developed for adolescents and can be administered in the same (standardized) way for all youth. Two important aspects of instrument quality should be considered in the choice of a screening tool. First, it is essential to select a tool that has been developed for use with adolescents, because instruments developed for use with adults are unlikely to be sensitive to mental health problems of youth. Second, it is critical to choose a standardized tool. "Standardized" means that there is a uniform way the tool is administered and scored and that this method is used with all youth exactly the same way every time. Usually, the things one needs to know in order to use the tool in a standardized way are described in the tool's manual. This provides the potential for uniformity in administration across staff who give or introduce the screen, across all youth being screened, and across all settings in which the tool is used. In addition, standardized screening tools typically produce scores or ratings that can then be used to make clear decision rules about which youth get "screened in" or identified as needing some kind of further follow-up. Standardized screening tools allow for the development of standardized decision rules regarding how to respond to youth, as well as the creation of uniform electronic databases that can be used for administrative purposes.

Programs should use mental health screening methods that have established evidence for their ability to provide reliable and valid information about youth. Quality screening tools should have the backing of research that establishes their measurement dependability (reliability) and whether they actually measure the symptoms or problems they claim to measure (validity). When they do, they are called "evidence-based" tools. If one chooses a tool that has been demonstrated by research to be reliable and valid and then uses the tool just as it was used in the research, one can have confidence that the tool is providing reliable results about what it is supposed to measure. Time and resources are likely to be wasted if there is no evidence that the method used for mental health screening dependably measures the psychological conditions or psychiatric symptoms that it is intended to identify. The references listed in Appendix A provide information on the evidence base of a range of mental health screening tools available for use in juvenile justice settings. These references can serve as a useful resource when selecting an instrument.

**Mental health screening tools must be administered according to procedures described in the manual accompanying the tool, by persons who have received sufficient in-service training to be able to administer the tool in the manner described in the manual.** When reviewing the procedural features of a standardized screening tool, one should recognize that once a tool is selected for use, its procedures must be implemented just as they are described in the manual. Altering the administration procedures of a tool, or changing the items in any way, compromises the validity and reliability of the screening results. Thus, complete and accurate in-service training of staff in the tool's administration procedures is essential for consistent ("standardized") implementation.

Mental health screening should occur as soon after a youth's admission to a program or facility as possible—preferably within the first few hours after intake. Delays in the administration of screening carry risks of failing to identify potential crisis conditions for certain youth. Typically, the best time...
for mental health screening is a couple of hours after admission. The first hour or so after admission is usually chaotic and taken up with a variety of identification and health screening questions, safety issues, descriptions of rules, and so forth. This is generally not the best time to get thoughtful answers from youths about their feelings and behaviors. A good time for mental health screening is after the admission process is completed and things have “calmed down.” However, the longer one waits after this point to administer a screening tool, the greater the risk that a youth’s mental or emotional condition might not be detected before the youth engages in harmful behaviors associated with that condition.

Youth should receive an appropriate description of the purpose and uses of mental health screening, and they should have access to screening results if requested (e.g., by parents or counsel) in accordance with applicable laws pertaining to access to personal medical information. A standard set of instructions should be developed for use when introducing youth to the screening tool. It is important that the introduction be done in a uniform way that engages youth in the task and is straightforward and factual about why they are being asked to participate in screening. For example, tell the youth that you want to know these things because it will help you know whether the youth has any special needs and to keep the youth safe while s/he is in the program. A good introduction should also include a clear description of how the results will and will not be used. This will differ somewhat from one program to another, depending on the program’s policies for uses of screening results. It is recommended that mental health screening results are for the use of the program in which the screening was done and that only program staff see the results. If this recommendation is followed, youth would be told that “only staff in this program will see your answers to the questions.” This point will be discussed further in the subsequent section on recommendations for policy to avoid misuse of screening results.

The instructions need to be conveyed in a helpful, non-threatening, and respectful manner using language that is simple and easily understood by youth. Ignoring these guidelines may yield screening results of questionable value and wasteful of resources. The Juvenile Detention Centers’ Association of Pennsylvania (JDCAP) helped develop guidelines for appropriately introducing the MAYSI-2 to youth entering detention. These guidelines are included in Appendix B. Even after a clear and respectful introduction, some youth may refuse to participate. There is nothing gained by pressuring or forcing a youth to complete a mental health screening. If the youth complies because of pressure or perceived threats, the screening is likely to result in invalid data.

If parents or the youth themselves ask for the results of mental health screening, the juvenile justice program should be prepared to give them access to this information. Being prepared for such requests requires a readiness to explain the dimensions of the tool and the meaning of the results.

Mental health screening results should not be interpreted as psychiatric diagnoses or personality descriptions. Results describe youths’ mental and emotional states at a particular point in time, not youths’ mental disorders or personality traits. Mental health screening does not produce a psychiatric diagnosis and does not substitute for obtaining the opinions of mental health professionals when youth are “screened in.” Mental health screening results might indicate a youth has symptoms of depression, but this may or may not mean that the youth has the mental disorder called “depression”. Screening results simply identify which youths are in need of professional mental
health opinions or require precautions to avoid harm to themselves or to others.

Mental health screening results should not be presumed to describe a youth’s mental or emotional condition beyond approximately 2-4 weeks after the results are obtained. Some conditions may persist longer, but some screening results might represent temporary emotional states that change over time. Beyond a few weeks, mental health screening results should not be trusted as much as they were when they were first obtained. This is because youths’ moods may change, their stress level may change, and many things happen in the lives of young people. Mental health screening tools are not psychological tests that identify the youth’s set of personality traits. These tools just measure symptoms at a given point in time. This “snapshot” becomes less valid over time. Given this time-limited value, mental health screening results do not have clinical value beyond their stated purpose to identify youths’ short-term mental or emotional needs at the time of intake.

Youth who “screen in” should receive staff responses or clinical assessments as determined by clear policies developed by the agency. Juvenile justice programs need to develop policies regarding how the mental health screening results (e.g., scores or ratings) will be used by staff to determine responses to youths’ mental health needs. These policies should clearly describe the decision rules regarding which scores serve as cut-offs for “screening in” a youth for further follow-up, as well as the specific program responses that will occur when a youth meets the decision rule. In addition, it is important that these policies define staff roles and responsibilities with regard to the decision rules and program responses. Chapter 3 (Step #5) provides an overview of this important step in the implementation of mental health screening.

Recommendations for Policy to Avoid Misuses of Screening Results

Mental health screening results obtained during juvenile justice intake or in pretrial detention should not be used alone by probation for informal or formal dispositional planning. Disposition hearings take place after adjudication and involve judicial decisions about longer-term placement, rehabilitation, and treatment of the youth. These decisions require the kinds of information about a youth (e.g., diagnosis, personality traits, clinical details of the psychopathology) that assessment—not mental health screening—provides. Mental health screening tools measure symptoms at a given point in time and produce a “snapshot” of what might be the temporary moods and emotions of the youth. These moods and emotions are important in assessing the youth’s needs for a period of 2 to 4 weeks after screening. Moreover, they may identify youth who need further assessment in order to determine whether mental health services should be part of their dispositional plans. But the screening results alone are not valid for determining the youth’s needs over the long term. Therefore, it is entirely inappropriate to use the results of a brief mental health screen as the primary basis for determining that a youth should receive medication or any specific type of psychiatric treatment as part of his/her dispositional planning. Basing these sorts of long-range treatment decisions exclusively on the results of tools that were not developed for that purpose can lead to treatment that is detrimental to the youth and a poor use of resources.

Developing policies that restrict the use of mental health screening results to short-range (within a few
days or weeks of screening) mental health decisions can help avoid this problem. However, certain policies might need to be put in place at different points within the juvenile justice continuum where screening occurs. For example, detention centers may share mental health screening results with probation officers who are assigned to youth during the pre-trial process. Often it is the job of these probation officers to make disposition recommendations to courts after a youth’s trial. In this situation, it would be necessary for detention to collaborate with the probation department to develop a policy that would be effective in preventing the use of screening data alone for long-range treatment planning.

**Staff should not provide specific screening results (e.g., scores) to outside parties when they use these results to obtain clinical services outside the facility.** It is strongly recommended that specific scores based on mental health screening stay within the juvenile justice agency or program in which they were obtained and not be communicated with outside parties whose intention is to use the information to acquire clinical services in the community. In many cases it would be sufficient simply to describe to outside parties what triggered the referral (e.g., “Screening indicated suicidal thoughts suggesting suicide risk”).

**Mental health screening results should not be filed in a youth’s permanent or individual file. They should be filed in a facility’s “mental health screening file” (either paper file or a computer-based electronic file).** Juvenile justice programs should develop a policy around the storage (either paper or electronic) and retention of mental health screening results. Once processed screening results (e.g., scores or ratings) are printed out, there is a temptation to place these results in a youth’s file. Unless there is a policy stating that the file does not “travel” with the youth’s own individual files, this information could be misused in ways already discussed. Many screening tools are available as software allowing for automatic databasing of screening results. In cases where screening software is used, it may be advisable simply to keep results stored in the database.

**Mental health screening results should not be used in any hearing on a youth’s adjudication or disposition.** It is important to avoid the use of screening results in ways that might jeopardize the legal interests of youths as defendants. This risk is greatest when screening takes place before adjudication on current charges, as happens during pre-trial first contact with an intake probation officer or at a pre-trial detention center.

Because of growing concern around potential self-incrimination risks associated with mental health screening for youth, the Juvenile Law Center (JLC) recently undertook a comprehensive review of current law on this issue to determine what protections exist for youth (Rosado & Shah, 2007). This review highlighted the fact that some screening instruments used with youth in the juvenile justice system elicit information that could be self-incriminating by asking questions about a variety of illegal activities, including drug use, assaultive behaviors, and weapons possession. Without appropriate legal safeguards, this information could be used against a youth in court, to find him or her guilty of an offense or to enhance punishment. The JLC review also examined states that have enacted statutes or court rules that prohibit the admission of any self-incriminating statements or information when gathered from court-involved youth who participate in mental health screening in any delinquency adjudication or criminal trial. They identified the following four states as offering protections to youth that could serve as models for other states:

- **Texas.** The Texas Human Resources Code requires mental health screening of all youth
who have been referred to the probation department. This statute also provides that “[a]ny statement made by a child and any mental health data obtained from the child during the administration of a mental health screening instrument under this section is not admissible against the child at any other hearing.”

- **Maryland.** A Maryland statute offers language that protects youths' due process rights during intake and court-ordered evaluations. The statute provides that information obtained during what is known as a 3-A8-17 study, including court-ordered mental health evaluations, is not admissible as evidence in any “adjudicatory hearing or peace order proceeding except on the issue of the respondent's competence to participate in the proceedings....where a petition alleging delinquency has been filed or in a criminal proceeding prior to conviction”. Information gathered during a routine intake procedure or preliminary inquiry is also inadmissible at any adjudicatory hearing or peace order proceeding (with similar exceptions as noted above).

- **Connecticut.** Connecticut statute provides that any information concerning a youth that is obtained during any mental health screening or assessment of such youth shall be used solely for planning and treatment purposes and shall otherwise be confidential and retained in the files of the entity performing such screening or assessment. Such information may be further disclosed only for the purposes of any court-ordered evaluation or treatment of the youth or the provision of services to the youth. The information is not subject to subpoena or other court process for use in any other proceedings or purpose.

To guard against pre-adjudicatory self-incrimination, it is important that policymakers and juvenile justice stakeholders develop policies or advocate for the enactment of legislation to limit the use of pre-trial mental health screening information to the primary use for which it is intended.
Chapter 3 Implementing Mental Health Screening

Thomas Grisso, Ph.D.

As communities across the country have begun to perform systematic mental health screening in juvenile justice programs, they have found that a number of preliminary steps are necessary to set up the process and assure that it will run smoothly when screening actually begins. This chapter describes a series of steps for juvenile justice administrators and clinicians to guide them through the process of implementing mental health screening. This guide offers ten steps for implementing screening. These include:

1. Review needs and options
2. Review resources and demands
3. Educate program staff
4. Select the method and procedure
5. Develop decision rules and response policies
6. Build response resources
7. Develop information-sharing policies
8. Pilot and train
9. Create a database
10. Monitoring and maintenance

Step 1: Review Needs and Options

The first step is to develop a clear rationale for the facility's or program's mental health screening, and to review options regarding available mental health screening methods.

1a. Identify Reasons for Mental Health Screening

Developing a clear, concise view of the program's need for mental health screening has two values. First, administrators are likely to be asked to explain their need to others fairly early in the process of implementation: for example, to those who control financial resources necessary for implementing and maintaining screening, and to staff who ultimately will be responsible for day-to-day screening operations. Second, this statement of needs will guide the selection of available screening methods. There are several tools available, and they vary in their format and content, so that some may suit a program's needs better than others. But that selection process will require first a clear view of the program's reasons for implementing screening.

Figure 1 offers many good reasons for having mental health screening in juvenile justice facilities. Typically it is best to select two or three that seem most important for one's program. Some reasons refer to possible symptoms of mental disorders, some focus on specific problems (e.g., suicide, safety), while others focus on meeting the system's legal or regulatory obligations.

While reviewing Figure 1, it is important to be aware of some potential reasons that are not listed because they are not appropriate reasons for mental health screening (see Chapter 2). Screening is a process designed to separate youth into two categories—those that present "high" risk of having mental health problems and those that represent "low" risk. Most youth with mental health problems will end up in the "high" risk group that the screening tool identifies, but so will some other youth who do not actually have serious mental health problems. As noted in Chapter 2, further evaluation (usually called "assessment" rather than "screening") is needed to determine which of the youth identified by screening as "high" risk actually have mental health problems requiring clinical attention, and to determine the specific nature of their problems. Therefore, one should not expect screening to "diagnose" youths' mental disorders.

In addition, mental health screening results are not appropriate as the sole basis for developing delinquency dispositions or long-range treatment plans. When
considering why one wants to employ mental health screening, one should not presume that screening by itself will lead to "treatment plans" for all youth whom screening identifies as "high" risk for mental health problems. Screening is only one step toward those objectives.

1b. Review Mental Health Screening Options

It is premature at this point to actually select a mental health screening tool or method. But it is important to review what is available in preparation for the next several steps in the process. There are a significant number of mental health screening tools for adolescents, although only some of them were developed specifically for youth in juvenile justice custody. Moreover, tools tend to have been developed to be more useful in some settings than in others. For example, some tools were developed with intake probation interviews in mind, while others were designed especially for admission to detention centers.

References that include descriptions of the range of available mental health screening tools for juvenile justice settings can be found in Appendix A. These sources provide reviews of the characteristics of specific tools that distinguish their various strengths, weakness, and degree of appropriateness for a program's objectives. Figure 2 provides a list of the ways that mental health screening tools differ, offering various considerations for narrowing one's focus to those tools that best fit the needs of one's program.

Step 2: Review Resources and Demands

Having decided on the program's reasons for mental health screening and reviewed the range of options, one must turn to practical matters—determining the financial and personnel resources necessary for the task, as well as the demands and limits posed by everyday circumstances in a particular facility or program. These matters will differ considerably across

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<tr>
<th>Figure 1. Reasons for Implementing Mental Health Screening</th>
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<tr>
<td>Identifying youth who may have mental health problems requiring attention—to avoid those problems getting worse</td>
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<tr>
<td>Reducing the risk of self-harm by identifying youth who present an imminent risk of suicide or self-injury</td>
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<tr>
<td>Identifying youth with potential substance use problems that require immediate attention</td>
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<tr>
<td>Increasing safety for youth and staff of the program by identifying youth whose mental health problems present an imminent risk of harm to self or others</td>
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<tr>
<td>Obtaining mental health information as part of a program of diversion of youth to community services that might best meet their ongoing mental health needs and public safety interests</td>
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<tr>
<td>Identifying youth who require further assessment to determine whether they might have longer-range treatment needs that should be taken into consideration in disposition planning</td>
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<tr>
<td>Documenting the level of need for mental health services in your program by developing screening-based data on all youth admitted to the program</td>
</tr>
<tr>
<td>Fulfilling Federal, state, or local regulatory obligations to identify and respond to serious mental health needs of youth in juvenile justice custody</td>
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<tr>
<td>Avoiding legal liability associated with youths’ injurious behaviors that might have been avoided if mental health screening had been in place</td>
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juvenile justice contexts in which screening is being considered. For example, different demands arise in the context of the initial interview by an intake officer after a youth has been referred to the juvenile court, than in the context of screening of every youth soon after admission to a detention center.

Often the personnel in these different settings want to know different things about youth. For example, while intake officers, as well as detention staff, may wish to screen for possible symptoms of mental health problems, intake officers typically are responsible for developing a broader picture of a youth's social problems (e.g., family, school, and peer problems) than is necessary for fulfilling the obligations of detention centers. Beyond the content of screening, however, several other demand characteristics of the juvenile justice context should be considered when selecting tools and developing screening procedures. Below are a few of the more important demands to consider.

2a. Informant Availability

Screening methods vary regarding the types of information that are needed to complete them. Some require a review of past records on the youth, others require participation by parents or caretakers, and some rely (partly or solely) on information provided by the youth. Some of these sources of information will be available at some screening points in juvenile justice processing but not at others. For example, youth themselves usually are the only source of information early in the detention admission process. This will narrow the range of tools appropriate for that setting to those that rely on youths' own reports of their thoughts and feelings.

2b. Expertise of Staff

Many screening tools have been designed for use by non-mental-health professionals, although some require a mental health background (e.g., specialized social work training or a master's degree in psychology). For those designed to be used by general juvenile justice program staff, most require some type of in-service training, but tools differ in the amount and depth of in-service training required to use them properly. One type of in-service training, focusing on an in-depth understanding of screening procedures, may be appropriate for staff who will actually administer screening, while others in the facility can receive training that simply familiarizes them with the purpose of screening and the use of the results.

2c. Efficiency of Administration

Some juvenile justice settings require more or less attention to the amount of time that screening requires. Generally, screening tools range from 10 to 30 minutes in administration and scoring time. Some tools rely

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<th>Figure 2. Ways in Which Mental Health Screening Tools Differ</th>
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<tr>
<td>Format (e.g., paper and pencil; computer-administered/scored)</td>
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<tr>
<td>Content (e.g., single-scale versus multiple scales; scales focusing on symptoms; scales focusing on social problem areas)</td>
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<td>Length (e.g., number of items)</td>
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<td>Time required for administration and scoring)</td>
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<td>Training required to administer (e.g., minimal in-service training; training to become certified)</td>
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<td>Administration cost (e.g., cost of manual only; fee per case)</td>
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<tr>
<td>Evidence-base (e.g., quality and extent of research establishing reliability and validity)</td>
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on youths’ answers to paper-and-pencil questions, while others require more staff involvement because they rely on youths’ answers to interview questions. Some offer computer-assisted administration in which youth answer on-screen questions without much staff involvement. Sometimes shorter administration times are acquired at the cost of other desirable features. The degree of efficiency required by a setting should be carefully reviewed when making screening plans.

2d. Financial Costs of Implementation

The basic costs associated with screening typically involve (a) manuals, (b) paper forms or computer software, (c) computer hardware for computer-assisted systems, and (d) databasing costs. Tools differ considerably in these costs, as well as in the cost of staff training and in staff time per administration. Some larger detention facilities find it necessary to add one or two full-time staff positions dedicated solely to mental health screening. Juvenile justice programs, of course, vary in financial resources that can be devoted to screening, and decisions sometimes require compromises. Fortunately, this is usually possible without sacrificing basic quality, because costs of methods typically are associated with their degree of efficiency, not their reliability or validity.

Step 3: Educate Program Staff

This is a good point in the process to discuss administration’s ideas and intentions with program staff who will eventually be responsible for employing mental health screening. There are several reasons why this is appropriate early in the process, rather than waiting until all administrative decisions about screening have been made. Staff sometimes are resistant to new procedures. Getting them involved early in the process helps to identify (and often reduce) resistance by engaging staff in the process of developing the screening capacity. In addition, staff often can raise questions about feasibility that administrators might not have anticipated, thus providing ample opportunity to solve those problems or adjust expectations. One strategy used by some administrators has been to schedule a brief in-service training session to familiarize staff with mental health issues among juvenile justice youth, as well as the role of mental health screening in helping staff handle youths’ needs in the course of their day-to-day work.

This is also a good time to consult with others in the organization who might have special information needed to make later decisions. This might include the program’s information technology specialist, who can be of assistance when deciding on the feasibility of computer-assisted screening (e.g., if internet access is required) and issues of information security.

Step 4: Select the Method and Procedure

The method for mental health screening can now be selected. The decision typically will be based on the factors considered in the earlier steps: the program’s specific reasons for wanting to implement mental health screening, the available methods, available financial resources, and questions of feasibility for the specific program or facility. Two things need to be selected: a tool, and a procedure for administering and using it.

Selecting a tool requires attending to its proven value, as well as matching its administration demands with the program and envisioning how it will work in a practical sense. While selecting the tool, one should envision how it will be applied on an everyday basis, and one should plan for that method of application to be standardized—that is, that it will occur in that manner for all youth. For example, for a juvenile pretrial detention center, one must decide:
• the specific time when screening will occur (e.g., 2-4 hours after admission to a detention center)

• the specific location within the facility where the screening method will be administered

• who will administer the screening to the youth

• how the screening task will be introduced to the youth by the screener

• when and how the results will be scored, examined, and filed

Step 5: Develop Decision Rules and Response Policies

Screening tools typically provide scores or ratings, often on several symptom or problem scales, that indicate various degrees of need or likelihood of mental and emotional problems. Like a thermometer tells us temperature in degrees above or below “normal,” mental health screening tools inform staff about “degrees” of a problem or symptom. But it will not tell staff when a youth’s problem is “serious enough” to require a response, nor will it tell staff how to respond. Juvenile justice programs themselves must develop policies regarding how the screening tool’s scores will be used by staff to determine a response to certain youths’ apparent mental health needs.

This requires two considerations. First, programs must establish as a matter of policy, what scores, on what scales of the tool, will be used to signal that a youth is in need of a staff response. This is called the “decision rule.” The scores that these rules identify then become the staff’s automatic “decision to respond” whenever a youth’s scores match the decision rule (requiring no staff judgment). Some tools provide built-in guides that are helpful in establishing decision rules. For example, the MAYS1-2 provides “cut-off scores,” called “Caution” and “Warning” cut-offs, as indicators that youth are scoring “high” on the instrument’s scales. Even so, the program needs to establish by policy whether to use the “Caution” cut-offs or the higher “Warning” cut-offs, and whether staff should respond to scores above the cut-offs on any single scale of the MAYS1-2 (versus more than one scale, or only on specific scales).

Administrators who make these decisions must be aware that different decision rules will identify different proportions of youth as being in need of a response. Therefore, these decisions may require technical assistance from professionals who can describe what to expect based on various possible decision rules.

Second, administrators must establish what “program response” will occur for youth meeting the decision rule. In general, these responses might include further assessment that is more individualized and thorough than screening methods can provide, and various efforts to respond to emergency situations. Different responses may be appropriate for different types of mental health problems associated with a program’s various decision rules. Some examples of potential responses to youth who meet decision-rule screening criteria include:

• Further assessment, which may involve various conditions:
  • Immediately, or at earliest available time
  • By specialized non-mental health staff, or by a mental health professional
  • With structured interview tools or psychological/psychiatric tests and methods

• Immediate staff precautions: for example,
  • Implementing a program’s standard suicide prevention procedures
Step 6: Build Response Resources

Once decision rules for responses to screening results are determined, administrators must plan for ways to accomplish those responses. For example, staff must be prepared to implement suicide watches in a systematic way. If clinical consultation will be a response to particular types of screening results, the program must develop the resources and relationships that are necessary to make these consultations available. Building response resources, therefore, involves both internal preparations of staff, as well as external preparations for developing linkages and partnerships—often with community mental health service providers.

Step 7: Develop Information Sharing Policies

Mental health screening information typically is intended for use by the agency, program or office that must make a response to the youth's mental health needs. Yet administrators must anticipate that others outside the program or office are likely to seek this information. Administrators must develop policies regarding the degree to which they will share the information with others and, if it is shared, for what limited purposes.

This is important for two reasons. First, mental health screening information is health information that is protected by various Federal and state laws from unauthorized disclosure to others. Second, interview or clinical information obtained from youth during

Following Through: Establishing Protocols to Guide the Mental Health Screening Process.

Some juvenile justice agencies or programs with established mental health screening processes have developed detailed instructions and guidelines specifying what should happen during and after the mental health screen. These protocols clarify and specify important details, ensuring that all staff involved with the mental health screening process clearly understand what to do in terms of administering, scoring, interpreting, acting on, and protecting information collected during a mental health screen. The New Jersey Juvenile Justice Commission developed a protocol to provide guidance to all staff involved with administration of the MAYS-I-2 to youth entering any of the state's 17 juvenile detention centers. The protocol addresses administration, subscales, results and responses; storage, dissemination, and confidentiality; and database issues in an easy to use format. The Texas Juvenile Probation Commission developed a MAYS-I-2 Reference Card to provide guidance to juvenile probation officers who are responsible for administering the MAYS-I-2 to youth entering juvenile probation. The Reference Card includes descriptions of each of the MAYS-I-2 subscales, instructions for what to do before, during, and after administration of the instrument, and post-scoring recommendations for services. Complete versions of the New Jersey and Texas protocols can be found in Appendix C.
legal processing cannot be used against them in the adjudication of their cases unless they are informed at the time of interviewing that their answers may have consequences for their adjudication or legal placement. If told this, many youth would not respond forthrightly to screening questions, thus defeating the purpose of mental health screening.

Therefore, administrators must develop policies that limit the sharing of mental health screening information with others in the juvenile justice or community mental health system. Typically the process of forming these policies will require consultation with administrators in other juvenile justice offices. For example, a detention center administrator may reach an agreement with the probation office that detention staff may communicate broad screening results to a youth’s probation officer when necessary to obtain services (e.g., “This youth might have a problem with depression, which is serious enough to require an immediate psychiatric consultation”). Providing scores on specific scales has no value in such circumstances and is not recommended.

Information sharing policies also should take into consideration that mental health screening early in a youth’s legal processing should not be used to make long-range treatment plans. Such plans require a more individualized assessment than can be provided by screening methods. Therefore, sharing the information with the court during dispositional hearings should be avoided, since screening data have little or no value for that purpose.

Step 8: Pilot and Train

Having selected methods and determined policies for mental health screening, many programs have found it useful to perform a brief “pilot” study, during which the method is implemented on a small scale within the program. This might involve one staff member doing the mental health screening procedure with all youth for a few days or weeks. The purpose is to assure that the procedures can be managed, given the real, everyday demands of the setting, and to make any adjustments to procedure that those demands suggest. Once the mental health screening method has been piloted and necessary adjustments have been made, staff training is then necessary.

Training should involve all staff—not only those who will administer the screening, but also those who need to know how and why screening is being done. Typically this training will include not only the details of administration and scoring of the screening method, but also general education of staff regarding the mental health needs of youth in juvenile justice settings, and specifically how they are expected to respond to youth whose screening suggests mental health needs. Administrators usually will want to obtain training services from professionals who are familiar with the screening methods that have been selected. Suggestions for finding training resources may be obtained from the technical assistance groups identified in Appendix A.

Step 9: Create a Database

One of the great benefits of systematic mental health screening is the opportunity to create a database that describes the needs of youths served by a program or agency. This can easily be done when screening is computer-assisted, because it allows each youth’s data to be archived automatically in a database. Paper-and-pencil forms of screening will require a data entry process, usually on a monthly basis. As data accumulate, they can be analyzed on a monthly or semi-annual basis, providing a profile of the proportion of youth with various types of mental health problems. Administrators can use these data as a management tool to make program adjustments.
and to seek resources for improving the program’s response to youths’ mental health needs. Developing and maintaining a database typically requires consulting the agency’s information technology specialist for assistance.

**Step 10: Monitoring and Maintenance**

Like all functions of a juvenile justice program, screening practices need to be monitored periodically for their quality. There is a tendency for any program function to “drift” from its initial level of quality across time. One must also anticipate staff turnover, not only of those who are responsible for screening, but also other staff who need to know how to use screening information in working with youth in the program. Administrators, therefore, should plan for training new screeners when necessary, as well as providing annual continuing education for staff to refresh and increase their knowledge of youths’ mental health needs.


National Youth Screening Assistance Project. www.umassmed.edu/nysap/ or www.maysiware.com/


Appendix A: Resources for Identifying and Reviewing Mental Health Screening Tools

References


- Offers one-page reviews of a large number of tools used in juvenile justice
- Programs to screen for mental health and substance use problems.


- Introductory chapters provide detailed guidance for mental health screening and assessment in juvenile justice programs, followed by detailed chapter reviews of the properties, values, and limitations of the more frequently-used screening and assessment tools.

Technical Consultation

Two public-service organizations provide assistance to help you learn about mental health screening and assessment tools in juvenile justice and make decisions about your options:

National Center for Mental Health and Juvenile Justice
www.ncmhjj.com
518-439-7415
Policy Research Associates
Delmar, NY

National Youth Screening Assistance Project
www.umassmed.edu/nysap
508-856-8564
University of Massachusetts Medical School
Worcester MA
Appendix B: Pennsylvania Guidelines for Introducing the MAYS1-2 to Youth

Introducing Youths to the MAYS1-2

Instruments like the MAYS1-2 must be introduced to youths appropriately. How youths respond to the questions on such instruments depends a lot on what they think the instrument is for. Therefore, when youths are approached to take the MAYS1-2, we recommend that the person giving the MAYS1-2 take one or two minutes to introduce youths to the MAYS1-2 by providing them information about it.

There is no one way to do this. Certainly this calls for something more than simply handing the form to the youth and saying, “Please complete this.” On the other hand, it does not require a lengthy or detailed description. What is needed is some basic information, offered in a nonthreatening manner and in a way that youths can understand.

The wide range of ages of youths in juvenile justice facilities makes it difficult to write one “script” that would be understandable or appropriate for all youths. Moreover, conditions are different from one juvenile justice facility to another. Some may strictly limit how mental health screening data will be used, while others may have broader policies for who sees a youth’s MAYS1-2 results.

Below we provide a list of guidelines describing the types of information that should be included when introducing youths to the MAYS1-2, while leaving it to the facility and its staff to decide what is appropriate to say in addressing each guideline.

List of Things to Include in the Introduction

1. That the questions will help staff understand the youth better

Let youths know that you would like to give them a set of questions to answer that will help staff to understand them better. Describe them as questions about who they are—their thoughts and feelings about things or themselves. Tell them this includes about 50 yes/no questions. The youth should be told that this helps the staff learn whether they might have special needs that staff should know about. References to the MAYS1-2 as a test should be avoided as youth may think this means there are right and wrong answers to the questions.

2. Who will (or will not) see the youth’s answers and use them for certain purposes

Youths should be told who will see their answers and/or scores. This may differ across programs. For example, one detention center might allow only detention staff to see the youths’ answers and scores, so that they can determine whether the youth has special needs that require an immediate response for the youth’s safety. Whatever the potential uses, the youth should be told about them. This does not have to be detailed, but it should be honest. It might include indicating that “the results will not go to the judge or the D.A.” But it might require informing the youth that “this goes to your probation officer as well,” if that is actually the program’s policy.

3. Voluntary nature of the MAYS1-2

Taking the MAYS1-2 is always “voluntary” in that youths may choose not to answer the questions, and it is inappropriate to make their participation mandatory or to punish them for not answering. The MAYS1-2 is routine (like other health and identity questions) and
5. Check for special needs of youth in completing the procedure

Once the youth is ready to take the MAYSII-2, staff should assist the youth in getting started. If the program uses MAYSIIWARE, this is a matter of entering the youth's background information in the computer and then, after putting the headphones on the youth, sitting with the youth while the computer program is giving the youth the initial instructions about answering the questions on the keyboard. The staff person then steps aside when the youth begins to respond, so that the youth does not feel that the staff person is looking at the responses.
## Appendix C: Texas MAYSİ-2 Protocol

Massachusetts Youth Screening Instrument Second Version (MAYSİ-2)©

### REFERENCE CARD

<table>
<thead>
<tr>
<th>MAYSİ-2 Scale</th>
<th>Description of Scale/Measurement Components</th>
<th>Questions on Scale</th>
</tr>
</thead>
</table>
| Alcohol/Drug Use | • Frequent use of alcohol/drugs  
• Risk of substance abuse or psychological reaction to lack of access to substances | 10. Have you done anything you wish you hadn’t, when you were drunk or high?  
19. Have your parents or friends thought you drink too much?  
23. Have you gotten in trouble when you’ve been high or have been drinking?  
24. If yes [to #23], has the trouble been fighting?  
33. Have you used alcohol or drugs to help you feel better?  
37. Have you been drunk or high at school?  
40. Have you used alcohol and drugs at the same time?  
45. Have you been so drunk or high that you couldn’t remember what happened? |
| Angry-Irritable | • Experiences frustration, lasting anger, moodiness  
• Risk of angry reaction, fighting, aggressive behavior | 2. Have you lost your temper easily, or had a “short fuse”?  
6. Have you been easily upset?  
7. Have you thought a lot about getting back at someone you have been angry at?  
8. Have you been really jumpy or hyper?  
13. Have you had too many bad moods?  
35. Have you felt angry a lot?  
39. Have you gotten frustrated easily?  
42. When you have been mad, have you stayed mad for a long time?  
44. Have you hurt or broken something on purpose, just because you were mad? |
| Depressed-Anxious | • Experiences depressed and anxious feelings  
• Risk of impairments in motivation, need for treatment | 3. Have nervous or worried feelings kept you from doing things you want to do?  
14. Have you had nightmares that are bad enough to make you afraid to go to sleep?  
17. Have you felt lonely too much of the time?  
21. Has it seemed like some part of your body always hurts you?  
34. Have you felt that you don’t have fun with your friends anymore?  
35. Have you felt angry a lot?  
41. Has it been hard for you to feel close to people outside your family?  
47. Have you given up hope for your life?  
51. Have you had a lot of bad thoughts or dreams about a bad or scary event that happened to you? |
<table>
<thead>
<tr>
<th>MAYSI-2 Scale</th>
<th>Description of Scale/Measurement Components¹</th>
<th>Questions on Scale¹</th>
</tr>
</thead>
</table>
| **Somatic Complaints** | • Experiences bodily discomforts associated with distress  
                         • Risk of psychological distress not otherwise evident | • When you have felt nervous or anxious…  
                         • 27. …have you felt shaky?  
                         • 28. …has your heart beat very fast?  
                         • 29. …have you felt short of breath?  
                         • 30. …have your hands felt clammy?  
                         • 31. …has your stomach been upset?  
                         • 43. Have you had bad headaches? |
| **Suicide Ideation**   | • Thoughts and intentions to harm oneself  
                         • Risk of suicide attempts or gestures | • 11. Have you wished you were dead?  
                         • 16. Have you felt like life was not worth living?  
                         • 18. Have you felt like hurting yourself?  
                         • 22. Have you felt like killing yourself?  
                         • 47. Have you given up hope for your life? |
| **Thought Disturbance**| • (Boys Only) Unusual beliefs and perceptions  
                         • Risk of thought disorder | • 9. Have you seen things other people say are not really there?  
                         • 20. Have you heard voices other people can’t hear?  
                         • 25. Have other people been able to control your brain or your thoughts?  
                         • 26. Have you had a bad feeling that things don’t seem real, like you’re in a dream?  
                         • 32. Have you been able to make other people do things just by thinking about it? |
| **Traumatic Experiences** | • Lifetime exposure to traumatic events (e.g., abuse, rape, observed violence). Questions refer youth to “ever in the past,” not “past few months.”  
                         • Risk of trauma-related instability in emotion/perception | **Girls**  
                         • 48. Have you EVER IN YOUR WHOLE LIFE had something very bad or terrifying happen to you?  
                         • 49. Have you ever been badly hurt, or been in danger of getting badly hurt or killed?  
                         • 50. Have you ever been raped, or been in danger of getting raped?  
                         • 51. Have you had a lot of bad thoughts or dreams about a bad or scary event that happened to you?  
                         • 52. Have you ever seen someone severely injured or killed (in person—not in movies or on TV)?  
                         **Boys**  
                         • 46. Have people talked about you when you’re not there?  
                         • 48. Have you EVER IN YOUR WHOLE LIFE had something very bad or terrifying happen to you?  
                         • 49. Have you ever been badly hurt, or been in danger of getting badly hurt or killed?  
                         • 51. Have you had a lot of bad thoughts or dreams about a bad or scary event that happened to you?  
                         • 52. Have you ever seen someone severely injured or killed (in person—not in movies or on TV)? |
Before Administering the Instrument

- Introduce the Test by saying: "These are some questions about things that sometimes happen to people. For each question, please answer 'yes' or 'no' to whether that question has been true for you in the past few months. Please answer these questions as well as you can."

- Give the legal warnings by saying: "Any statement you make or any answer you give to the questions on this test cannot be used against you in any other hearing in juvenile or criminal court. Do you understand? Do you have any questions?"

- Give the confidentiality warnings by saying: "What you reveal when answering these MAYS1 questions is confidential. Nothing that you reveal can be used against you in any juvenile or criminal court hearing. However, there is one exception to this. If you disclose that you are the victim of child abuse or neglect or if you disclose that you have committed an offense involving child abuse or neglect, that information must be reported to law enforcement."

During Administration

- Monitor and supervise the room where the juvenile(s) are completing the instrument. If administered in a group setting, ensure a quiet setting, adequate separation of youth, and limited distractions.

- Answer questions by the juvenile as necessary and ensure that you are available for any assistance needed to successfully complete the questionnaire.

- If administering the manual version (paper and pencil version) of the MAYS1-2, it is helpful to point to the right side of the MAYS1 and say to the juvenile, “Circle ‘Y’ for ‘yes’ or ‘N’ for ‘no’.” In addition, point out that there are more questions that need to be answered on the back of the questionnaire.

- If using the automated/computerized version of the MAYS1-2, please ensure that you have completed the section entitled "TO BE COMPLETED BY STAFF ONLY" prior to administration.

After Administration

- Check to see if all questions have been answered.

- If all questions have not been answered, ask the juvenile to complete any unanswered questions.

- Score the MAYS1-2.

- Record the scores and conduct appropriate follow-up actions and procedures.

### MAYS1-2 Post-Screening Recommended Services

<table>
<thead>
<tr>
<th>SECONDARY SCREENING</th>
<th>PRIMARY SERVICES</th>
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<tbody>
<tr>
<td>(by Juvenile Justice Staff)</td>
<td>(by Mental Health Professionals)</td>
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</table>

**A. Monitoring of the Juvenile.** Probation and/or detention staff should exercise greater vigilance and attention to the juvenile in order to conduct relevant behavioral observations. Complete Follow-Up Questionnaire

**B. Interviewing and Collateral Contacts.** Staff should engage in focused discussions with the juvenile, or with the juvenile’s family and/or past service providers. The focus should explore the reasons for the juvenile’s responses on relevant items of the MAYS1-2, as well as outside information that contradicts or is consistent with what the youth reported on the instrument. Complete Follow-Up Questionnaire

**C. Clinical Consultation.** Staff should seek expertise from clinical professionals/mental health professionals who can intervene to provide brief evaluations or emergency care.

**D. Evaluation Referral.** Staff should arrange for a more comprehensive psychiatric or psychological evaluation to determine the nature and source of the youth’s self-reported distress or disturbance.

### Recommended Actions By Juvenile Justice Staff

<table>
<thead>
<tr>
<th>Suicide Ideation Scale Only</th>
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<tbody>
<tr>
<td>Warning</td>
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<tr>
<td>Caution</td>
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<table>
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<tr>
<th>Angry-Irritable Scale Only</th>
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<tbody>
<tr>
<td>Warning</td>
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<table>
<thead>
<tr>
<th>Any Combination of Scales (Except Suicide Ideation Scale)</th>
</tr>
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<tbody>
<tr>
<td>Warning + Warning</td>
</tr>
<tr>
<td>Warning + Caution</td>
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<td>Caution + Caution</td>
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<td>Caution + Caution</td>
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26 Mental Health Screening Within Juvenile Justice: The Next Frontier
Appendix C:
New Jersey MAYSi-2 Protocol

NJ Juvenile Justice Commission Office of Specialized & Interagency Services

Massachusetts Youth Screening Instrument Version 2: Instructions & Protocols

1. INTRODUCTION

The Massachusetts Youth Screening Instrument-Version 2 (MAYSi-2) is a brief screening tool designed to assist juvenile justice facilities in identifying youth 12 to 17 years old who may have special mental health needs. It is intended for use at any entry or transitional placement point in the juvenile justice system. These MAYSi protocols are the minimum requirements for responding to elevated MAYSi scores. Social services and designated staff are not limited to the parameters described below. Comprehensive descriptions and follow up suggestions may be found in the MAYSi-2 User’s Manual & Technical Report. Relevant pages are noted next to the scale descriptions.

* Indicates suggested responses

2. ADMINISTRATION

A. Design- The MAYSi software reads the items to the youth at a 5th grade reading level. The Spanish version of the MAYSi is not automated; therefore, the paper/pencil version is located at the back of the manual and on the c: drive of the laptop. You may administer the MAYSi to juveniles over the age of 18. The MAYSi itself is NOT safeguarded from falsified answers. If a youth is clicking ‘Yes’ or ‘No’ for all items, stop them from taking the screen. At a later time you may ask that juvenile to take it honestly, otherwise consider it a ‘refusal’.

B. Screeners- The MAYSi site coordinator and trained staff at each detention center are responsible for administering the MAYSi and facilitating follow-up. The MAYSi does not require the expertise of a mental health professional for scoring and interpretation.

C. Time- The MAYSi must be administered between 24 – 72 hours of admission to the detention center. If a juvenile leaves the detention center within 24 hours, the MAYSi need not be given. If a juvenile leaves the detention center and returns shortly thereafter, for example, 2 weeks, the MAYSi should be re-administered. Remember, the MAYSi is supposed to be administered within 24 – 72 hours of admission. If a juvenile comes in on a Friday afternoon, it is more appropriate to wait until Monday morning than to rush and administer the tool on Friday night. Note: the MAYSi does not replace the suicide screen at intake.
D. Hardware: Screenings should be administered individually with the laptop and headphones. The only instance in which the MAYSI is administered in groups is when there are multiple laptops and headphones. Each county has been provided with 1 laptop, 10 headphones, 1 mouse, and 1 MAYSI manual.

E. Materials Provided: Understanding the content of the MAYSI manual is essential for effective use of the MAYSI. The manual includes comprehensive descriptions of each scale as well as an explanation of cutoff scores and suggested follow-up. Refer to the MAYSI manuals for the above, information about the design of the tool, and MAYSI research studies and validations. The National Youth Screening Assistance Project (NYSAP) has provided MAYSI users with ‘Second Screening Forms’. Second screening forms are not mandatory but are strongly recommended for detention centers that do not have clinical staff or as a standardized template for caution and warning follow up.

F. Refusals: Again, the MAYSI should become a part of the daily routine in the facility. The MAYSI is intended to assist in managing youth with “potential special needs”, so if a youth is irritable and opposed to taking the screening, wait awhile and see if he/she will take it later. Staff should explain that the results do not go to judges or attorneys before administering a MAYSI. It may be useful to develop incentives for youth who cooperate with the intake process. If a youth refuses to take a MAYSI, it should be treated like any other refusal in the facility.

G. Interruptions: The MAYSI consists 52 questions, which on average takes 8 - 10 minutes to complete. The MAYSI should become a part of the daily routine; therefore a juvenile should finish the MAYSI before moving on to school, rec, etc. If the juvenile has to go to the restroom, leave the program running and have him/her resume upon their return. If the juvenile has to go off site (e.g., court), or has an emergency, shut down the program and restart it when you can see him/her again.

3. SCALES

A. Alcohol/Drug Use: The alcohol drug use scale is designed to represent the various negative consequences of substance use as well as identify risk factors for abuse. Because substance abuse problems are more prevalent among juvenile offenders than other adolescents, overall the scale does not reflect experimental use only. A potential reason for high scores includes recent excessive use, which has impaired everyday functioning. Potential risks associated with high scores include substance dependence or abuse, and emotional and physical symptoms associated with withdrawal. Pages 12, 29

B. Angry/Irritable: The angry/irritable scale is designed to identify angry moods and thoughts, irritability and risk of impulsive reactions and behavioral expressions of anger. Though an angry mood is not a symptom of any particular disorder, it is found in association with a number of clinical conditions such as
depression, history of trauma, Attention-Deficit/Hyperactivity Disorder (ADHD), oppositional behavior and conduct problems. High angry/irritable scores increase the risk that youth will impulsively react in ways that can hurt others or themselves. Youth who are depressed frequently also experience intense anger; therefore, one potential reason for high scores in this area may be related to some psychiatric disorder. Other potential reasons include recent events that have made the youth very angry, youth perceiving others as a threat in response to stressors, or anger is typical of this youth. Youth who score high in this area are at risk for fights and/or injuries to self or others, feeling threatened or threatening others. Pages 13, 30

C. Depressed-Anxious - The depressed-anxious scale is intended to elicit symptoms of mixed depression and anxiety. Feelings of depression and anxiety are often experienced with feelings of anger and suicide ideation. For some youth, high depressed/anxious scores may be indicative of an enduring problem, while for others the high scores may be the result of emotional reactions to immediate events. Potential reasons for high scores in the area of Depressed-Anxious are long-standing problems with serious depression or anxiety and reaction to situational stressors. Potential risks include self-harm, anger, irritability and low motivation to participate in treatment and program activities. Pages 14, 31

D. Somatic Complaints - Somatic complaints tend to co-occur with depression and anxiety and can sometimes be associated with trauma history and thought disorder. It is uncommon to see an elevation on this scale without seeing elevations on other MAYS! scales. All of the items in this scale are concerned with the physical sensations associated with nervousness or anxiety. Somatic complaints do sometimes reflect emotional distress that is not immediately apparent in other ways. Potential reasons for high scores in the area of Somatic Complaints include long standing problems with depression and anxiety, physical symptoms of depression and anxiety, recent traumatic experiences and actual physical illness. A medical practitioner upon admission always screens youth; however, somatic complaints as they relate to depression and anxiety may not be disclosed to a physician by youth. Potential risks associated with high scores include unanticipated self-harm and undetected physical illness. Pages 15, 32

E. Suicide Ideation - The suicide ideation items do not ask for information specifically regarding self-destructive behavior but rather focus entirely on recent and current subjective states. The intent of this scale is to elicit specific thoughts and feelings about suicide, in that they are relevant for suicidal intent and risk. Potential reasons for high scores in the area of suicide ideation include the following: long-standing problems with serious depression, anxiety, and/or anger, intention to commit suicide or harm themselves, attempt to inform someone of the need for help/attention, or having felt these feelings in the past, though not currently. Potential risks include suicide attempts and/or self-harm. Pages 16, 33

F. Thought Disturbance (Boys) - Positive responses to several of the thought disturbance items may indicate a psychotic illness such as schizophrenia or a major depressive episode with psychotic
features. It may reflect some abnormalities of perceptions sometimes seen in Post Traumatic Stress Disorder (PTSD), or may be the result of an organic brain disorder. A youth may endorse a particular item for reasons unrelated to the above-mentioned disorders such as powerful and intrusive thoughts, knowledge of manipulative behavior, culturally specific superstitions and recollection of experiences under the influence of drugs and alcohol. Potential reasons for high scores in the area of thought disturbance for boys include: Psychotic/non-psychotic disorders, organic brain disorders, sensory or thought experiences associated with substance use, intrusive thoughts, unusual fantasies. A potential risk associated with a high score in this area is presence of an underlying disorder that offers potential for unorganized and unpredictable behavior. Pages 17, 34

G. Traumatic Experiences (Boys)- Boys who have traumatic experiences have a tendency to be more concerned with what others may be planning to do to them, therefore the items in this scale do not address specific incidents (e.g., rape). The other items in this scale are designed to address experiences that might not have been addressed in the earlier questions. High scores in the area of traumatic experiences do not necessarily indicate Post Traumatic Stress Disorder (PTSD). This scale includes items that simply indicate incidents of traumatic experiences. Page 18

H. Traumatic Experiences (Girls)- Unlike the other MAYS1 scales, the traumatic experiences items refer to experiences the youth has had in ‘their whole life’ as opposed to recent weeks and months. For girls, the items address specific traumatic events such as abuse, beatings and rape as well as other experiences the youth might identify as ‘terrifying’.

4. RESULTS AND RESPONSES: CAUTION

When a youth scores above the caution cut-off score on a given scale, the youth has scored at a level that can be said to have "possible clinical significance." The caution cut-off scores simply mean that youths scoring above the MAYS1-2 cutoffs would probably score high enough on other tests of similar adolescent disturbances to require special attention of some kind. Page 21

1. If a youth scores in the warning range on the angry/irritable scale, any staff managing the unit where the youth is being detained (e.g., custody) should be advised of elevated scores to ensure appropriate supervision.
2. If a youth scores in the caution range on the depressed-anxious scale, in sight supervision must be ensured and the screener must interview the youth immediately.
3. If a youth scores in the caution range on the suicide ideation scale, special attention must be given to the intake suicide screen. Note: the MAYS1 items the youth endorsed are not listed when the youth scores in the caution range. A determination is needed on whether suicide prevention procedures need to be initiated, e.g., special watch status.
4. If a youth scores in caution range on ANY four scales concurrently, that youth must be referred
to on site clinical staff, contracted clinical staff or any clinical services within the county that typically provide services to the detention center.

5. If a youth scores in caution range on ANY four scales concurrently, and there are no on site clinical staff, contracted clinical staff or any clinical services within the county that typically provide services to the detention center, that youth must be referred to the Division of Child Behavioral Health Services (DCBHS) for a needs assessment.

SUGGESTED RESPONSES
Social Services may check to see if a youth has already been referred to DCBHS from another agency, source.

* For youth referred to clinical staff in lieu of a referral to the DCBHS for assessment, a determination should be made on whether referral to DCBHS is indicated for planning for release/supports in the community or placement.
* Social services may also make contact with family members and/or past service providers.
* Youth may be referred for anger management counseling within the facility.
* Youth may be referred for substance abuse education/counseling within the facility.

5. RESULTS AND RESPONSES: WARNING

Warning scores are intended to alert staff that the youth scored exceptionally high in comparison to other youth in the juvenile justice system. Warning scores identify a subset of all of the youth above the caution cut-off who are most in need of attention. NOTE: When a youth scores in the warning range on the MAYS1-2, the items the youth endorsed will be listed on the individual report.

1. If a youth scores the area of warning on any MAYS1 scales, special attention must be given to those scales and responses. Second Screening forms are strongly suggested, especially in the absence of clinical staff.

2. The youth should be referred to the most immediate clinical staff available. (If a level risk has been determined by the 2nd screening forms).

3. If a youth scores in the warning range on the angry/irritable scale, any staff managing the unit where the youth is being detained (e.g., custody) should be advised of elevated scores to ensure appropriate supervision.

4. If a youth scores in the warning range on the depressed/anxious scale, and there are no on site clinical staff, contracted clinical staff or any clinical services within the county that typically provide services to the detention center, the youth must be referred to DCBHS for a needs assessment.

5. If a youth scores in the warning range on the suicide ideation scale, in sight supervision must be ensured and the screener must interview the youth immediately.

6. Internal detention center policies must be followed pertaining to 'close watch status'.

7. Special attention must be given to relevant items on the MAYS1 suicide ideation scale and those
answers must be compared with those from the intake suicide screen to check for consistency as well as conflicting responses. The youth must be questioned about those responses.

8. If a youth scores in the warning range on the *suicide ideation* scale and there are no on site clinical staff, contracted clinical staff or any clinical services within the county that typically provide services to the detention center, the youth must be referred to DCBHS for a needs assessment. This is in addition to following procedures related to suicide prevention strategies, e.g., special watch status, possible screening for psychiatric hospitalization.

9. If a youth scores in the warning range on the *thought disturbance* scale and there are no on site clinical staff, contracted clinical staff or any clinical services within the county that typically provide services to the detention center, the youth must be referred to the DCBHS for a needs assessment.

10. Interview the youth to determine if he/she is experiencing these thoughts right now, if there are explanations for the thoughts and if there is a history of thought disturbance.

11. If a youth scores in warning range on any four scales concurrently and there are no on site clinical staff, contracted clinical staff or any clinical services within the county that typically provide services to the detention center, that youth must be referred to DCBHS for a needs assessment.

**6. STORAGE, DISSEMINATION AND CONFIDENTIALITY**

A. *Within the Detention Center and to youth themselves*: The MAYS1-2 is a tool designed primarily to assist detention center staff in identifying and responding to youth who may be in need of special attention/management. The MAYS1-2 is not a diagnostic tool and must not be used to make a clinical diagnosis. In New Jersey, the MAYS1 in an internal management tool used to ensure the immediate safety of youth and alert appropriate staff to potential special, emotional and behavioral needs.

1. Youth must be advised at the time of the MAYS1 screening that the results will be shared with detention center staff so that they may properly assist the youth. Further written consent is not needed to release the scores to health providers WITHIN the facility who are acting as agents of the detention center.

2. Information yielded from the MAYS1-2 may be used to obtain additional services or assistance; however, the MAYS1-2 itself is not shared with others.

3. MAYS1-2 results must NOT be stored in a juvenile's permanent folder. They must be maintained in the social service office or other designated area. Information regarding follow up, referrals, or treatment that resulted from the MAYS1-2 may be documented in the juvenile's folder.

4. MAYS1-2 Second Screening Forms must NOT be stored in a juvenile's permanent folder. They must be maintained in the social service office or other designated area. Information regarding follow up, referrals, or treatment that resulted from the MAYS1-2 may be documented in the juvenile's folder.

5. Electronic and hard files are to be in a secured area with limited authorized access.
6. Electronic files housed on a computer are to be password protected to prevent unauthorized access.

7. Upon the request of a youth 14 years or older, the detention center must provide the youth access to his/her scores unless the center's director thinks that such disclosure would be detrimental to the resident. For youth under the age of 14, consent is needed from parents/guardians to access the scores.

8. In any case in which the juvenile or the juvenile's parent(s) or legal guardian is requested to consent to the release of the juvenile's mental health record or is seeking the release of those records, the juvenile's attorney of record in the pending delinquency proceeding must be notified and given an opportunity to consult with the parent/guardian and juvenile prior to the release of such records.

9. As per the Manual of Standards for Juvenile Detention Facilities N.J.A.C. 13:92-6.2(c), all records shall be preserved until the juvenile's 18th birthday, provided that at least two years have lapsed since his/her last discharge from the facility.

B. Outside the Detention Center, specifically attorneys and judges- All information and records directly or indirectly identifying any person currently or formerly receiving services from an agency shall be treated as confidential, and may be disclosed only under specific circumstances. These requests must immediately be brought to the attention of the JJC, Office of Specialized and Interagency Services and to the attorney of record in any pending delinquency proceeding.

C. Transfer of MAYS1 data and forms

1. The "MAYS1Data" file must be renamed and sent to the JJC project coordinator via email between the 1st and the 15th of the month.
2. Data will be (re) moved only by the project coordinator quarterly.

7. Log on, Admission and Data Instructions

A. Log on- (Example: Camden County)

1. User Name- Camden County
2. The MS Windows password for each county is mt929. Please limit password access to the individual(s) authorized to use the laptops and administer the MAYS1.
3. When the password expiration warning for Windows appears, change the password before the expiration date.
TO BE COMPLETED BY STAFF ONLY

Juvenile ID Number
Ca011234

Juvenile Admission Number
1234

Type of Facility
Detention
Residential Program
Secure Facility
Other

Name of Facility
Camden YDC

DONE

B. Screen 1 - Use the list to identify the appropriate county number. The Juvenile ID number is for data collection purposes. Therefore, preface the admission number with the first two initials of the county and its 2-digit numerical assignment

Screen 1

1. The default Juvenile ID Number and Juvenile Admission Number (in the event that you are doing a test screening) is TEST. DO NOT falsify admission numbers if you are doing a test, or need to “redo” a MAYS1.

2. Administer the MAYS1 to juvenile. The MAYS1-2 folder icon is on the desktop. Upon completion of the MAYS1 the youth's individual report will automatically be saved in a notebook file labeled MAYS1-2. The MAYS1-2 folder is found in the c: drive.

3. To open a resident's individual screening scores, open the MAYS1-2 folder, found on the desktop. The individual reports will be named by Juvenile ID Number. Example: sca041234

C. Sending the data-

1. In the MAYS1-2 folder there is a notebook file named “MAYS1Data”. Before sending the data, right click the file one time and rename the MAYS1Data file. Name the file for the month of data you are sending. Example: ca04January05. Rename the file on the last day of every month.

2. All data should be sent to the project coordinator between the 1st and the 15th of the following month. Example: January data should be sent between February 1 – 15. Attach the document to an email as you would any other file. If you do not have the laptop hooked up to a printer, you may save the data to a floppy disk and email it from another workstation.
Acknowledgements

This paper was produced by the National Center for Mental Health and Juvenile Justice (NCMHJJ), a member of the National Resource Bank, which is the association of national organizations providing technical assistance to states through Models for Change. The NCMHJJ focuses exclusively on the intersection of mental health and juvenile justice, promoting awareness of the issue and helping the field develop improved policies and programs based on the best available research, practice and information.

The NCMHJJ thanks Dr. Thomas Grisso and Valerie Williams, M.A., M.S., from the National Youth Screening and Assessment Project (NYSAP) for their authorship of Chapters 2 and 3 of this paper. NYSAP is a juvenile justice and mental health technical assistance center that provides assistance to juvenile justice programs nationwide in their implementation of mental health screening and assessment, and a member of the National Resource Bank.

For more information, contact:
National Center for Mental Health and Juvenile Justice
Policy Research Associates
345 Delaware Avenue
Delmar, NY 12054
866-9NCMHJJ
www.ncmhjj.com
A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System

Kathleen Skowyra
Joseph J. Cocozza, Ph.D.

1. Setting the Stage

Over 2.3 million youth are arrested each year. Approximately 600,000 of these youth are processed through juvenile detention centers and more than 100,000 are placed in secure juvenile correctional facilities (Sickmund, 2004). Until the last decade, there was a lack of data and information available documenting the degree to which youth involved with the juvenile justice system were experiencing mental illness. New research, conducted over the last ten years, has expanded our collective understanding of the nature and prevalence of mental disorders among the juvenile justice population and has provided the field with a more precise assessment of the problem.

It is now well established that the majority of youth involved with the juvenile justice system have mental health disorders. For example, we now know that youth in the juvenile justice system experience substantially higher rates of mental disorder than youth in the general population (Otto, Greenstein, Johnson & Friedman, 1992; Wieson, Forchand & Frame, 1992). Studies consistently document that anywhere from 65% to 70% of youth in the juvenile justice system meet criteria for a diagnosable mental health disorder (Shufelt & Cocozza, in press): Teplin, Abram, McClelland, Dulcan & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher & Santos, 2002; Wasserman, Ko. & McReynolds, 2004). Further, recent estimates suggest that approximately 25% of youth experience disorders so severe that their ability to function is significantly impaired (Shufelt & Cocozza, in press).

In a recent multi-state mental health prevalence study conducted by the National Center for Mental Health and Juvenile Justice on youth in three different types of juvenile justice settings, over 70% of youth were found to meet criteria for at least one mental health disorder. Disruptive disorders were most common, followed by substance use disorders, anxiety disorders and mood disorders. The majority of youth had multiple diagnoses. For example, over 90% of youth with conduct disorder also met criteria for another disorder (Shufelt & Cocozza, in press).

Many of these youth are detained or placed in the juvenile justice system for relatively minor, non-violent offenses but end up in the system simply because of a lack of community-based mental health treatment. A review in Louisiana by the Annie

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E. Casey Foundation (2003) found that more than 75 percent of Louisiana's incarcerated youth were locked up for non-violent and drug offenses. A 1999 survey by the National Alliance for the Mentally Ill (2001) found that 36% of respondents reported having to place their children in the juvenile justice system in order access mental health services that were otherwise unavailable to them. More recently, a report issued by Congress in July 2004 documenting the inappropriate use of detention for youth with mental health needs found that in 33 states, youth were reported held in detention with no charges—they were simply awaiting mental health services (US House of Representatives, 2004).

The growing crisis surrounding these youth is further underscored by a plethora of independent reports and media accounts over the last several years drawing attention to the unmet needs of these youth. Investigations by the US Department of Justice into the conditions of confinement in juvenile detention and correctional facilities throughout the country have repeatedly found a failure on the part of the facilities to adequately address the mental health needs of youth in their care (US Department of Justice, 2005). In addition, media inquiries and reports documenting the mental health crisis within the juvenile justice systems in numerous states including New Jersey, Arizona, California, Michigan and Pennsylvania, among others, have drawn national attention to an issue that has traditionally not received much consideration from the media. This unprecedented exposure has put new public pressure on elected officials, policy makers and practitioners to develop more effective responses for these youth.

As a result of this pressure and attention, significant energy has been directed to the development of new tools, policies and strategies to help the field better identify and respond to the mental health needs of these youth. These developing resources and trends include:

- Greater recognition, on the part of both the juvenile justice and the mental health systems, of the extent of the problem and the need for both systems to respond;
- The wider use of standardized mental health screening and assessment procedures for justice-involved youth, such as the MAYS1-2 and the Voice DISC-IV;
- The increasing reliance on evidence-based and promising practices, such as Multi-Systemic Therapy and Functional Family Therapy, to treat mental disorders among youth in the juvenile justice system; and

The development of collaborative programs and strategies, involving both juvenile justice and mental health agencies, across the country.

Yet, despite these trends and improvements, there had been no attempt made to date to systematically examine these existing efforts, summarizing what it is we now know about the best way to identify and treat these disorders among youth at key stages of juvenile justice processing, and comprehensively package this information as a tool that provides guidance and direction to the field.

II. A Blueprint for Change: The Comprehensive Model

Recognizing this, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) launched their largest investment ever in mental health research in 2001, aimed at providing the field with guidance to help address the problem and to improve the lives of children and youth with mental health needs who end up involved with the juvenile justice system. Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System (Skovvara & Coccoza, in press), offers a conceptual and practical framework for juvenile justice and mental health systems to use when developing strategies and policies aimed at improving mental health services for youth involved with the juvenile justice system.

The Model was developed by the National Center for Mental Health and Juvenile Justice in partnership with the Council of Juvenile Correctional Administrators, with guidance from an advisory group of key national experts, and reviewed by a panel of mental health and juvenile justice administrators, practitioners, advocates and youth. It is designed to capture the current state of the field and present it in a way that examines the juvenile justice system as a continuum, identifying the best ways to respond to youth with mental disorders at key points of contact and providing recommendations, guidelines and examples for how best to do this. The key features of the Model are illustrated in Figure 1 and are described more fully below.

Key Features of the Model

A. Underlying Principles

The Model is centered around a set of Underlying Principles that represent the foundation on which a system can be built that is respectful of youth and responsive to their mental
Figure 1. Conceptual Framework of the Comprehensive Model

Underlying Principles
As the basis for the development of

Cornerstones
That provide the infrastructure and reflect key areas for improvements at

Critical Intervention Points

Program Examples
Used to supplement and provide concrete examples of the implementation of key elements at each critical intervention point
Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System (Skowyra & Cocozza, in press), offers a conceptual and practical framework for juvenile justice and mental health systems to use when developing strategies and policies aimed at improving mental health services for youth involved with the juvenile justice system.

7. Whenever possible, families and/or caregivers should be partners in the development of treatment decisions and plans made for their children.
8. Multiple systems bear responsibility for these youth. While at different times, a single agency may have primary responsibility, these youth are the community's responsibility and all responses developed for these youth should be collaborative in nature, reflecting the input and involvement of the mental health, juvenile justice and other systems.
9. Services and strategies aimed at improving the identification and treatment of youth with mental health needs in the juvenile justice system should be routinely evaluated to determine their effectiveness in meeting desired goals and outcomes.

B. Cornerstones

From the principles emerged four Cornerstones that form the infrastructure of the Model and provide a framework for putting the underlying principles into practice. The Cornerstones reflect those areas where the most critical improvements are necessary to enhance the delivery of mental health services to youth involved with the juvenile justice system, and include Collaboration, Identification, Diversion and Treatment. The Model includes a discussion of each Cornerstone, as well as detailed Recommended Actions that provide direction on how to implement or address each of these four issues. A brief summary of each Cornerstone is presented below, along with the accompanying Recommended Actions.

Collaboration. In order to appropriately respond and effectively provide services to youth with mental health needs, the juvenile justice and mental health systems should collaborate in all areas and at all critical intervention points.

Despite the large numbers of youth with mental health needs in the juvenile justice system, the current landscape of service delivery for these youth is often fragmented, inconsistent and operating without the benefit of a clear set of guidelines specifying responsibility for the population. In the absence of such direction, a balanced solution is required. one that recognizes that an effective response must include the development of collaborative approaches involving both the mental health and juvenile justice systems.

The Recommended Actions for addressing Collaboration include:
1. The juvenile justice and mental health systems should recognize that many youth in the juvenile justice system are experiencing significant mental health problems and that responsibility for effectively responding to these youth lies with both the mental health and juvenile justice systems.

2. The juvenile justice and mental health systems should engage in a collaborative and comprehensive planning effort to thoroughly understand the extent of the problem at each critical stage of juvenile justice processing and to identify joint ways to respond.

3. Any collaboration between the juvenile justice and mental health systems should include family members and caregivers.

4. The juvenile justice and mental health systems should jointly identify funding mechanisms to support the implementation of key strategies at critical stages of juvenile processing to better identify and respond to the mental health needs of youth.

5. The juvenile justice and mental health systems should collaborate at every key stage of juvenile justice processing, from initial contact with law enforcement to re-entry.

6. Cross-training should be available for staff from the juvenile justice and mental health systems to provide opportunities for staff to learn more about each system to understand phrases and terms common to each system and to participate in exercises and activities designed to enhance systems collaboration.

Identification. The mental health needs of youth should be systematically identified at all critical stages of juvenile justice processing.

The development of a sound screening and assessment capacity is critical in order to effectively identify and ultimately respond to mental health treatment needs. Screening and assessment should be routinely performed at a youth's earliest point of contact with the system and be conducted using standardized instruments. Further, the results of any mental health assessment should be linked to the results of any risk assessment performed to help guide decisions about a youth's suitability and need for diversion to community-based services.

The Recommended Actions for addressing Identification include:

1. Every youth who comes in contact with the juvenile justice system should be systematically screened for mental health needs to identify conditions in need of immediate response, such as suicide risk, and to identify those youth who require further mental health assessment or evaluation.

2. The mental health screening process should include two steps: the administration of an emergency mental health screen as well as a general mental health screen.

3. Access to immediate, emergency mental health services should be available for all youth who based on the results of the emergency screen or the mental health screen indicate a need for emergency services.

4. A mental health assessment should be administered to any youth whose mental health screen indicates a need for further assessment.

5. Instruments selected for identifying mental health needs among the juvenile justice population should be standardized, scientifically sound, have strong psychometric properties, and demonstrate reliability and validity for use with youth in the juvenile justice population.

6. Mental health screening and assessment should be performed in conjunction with risk assessments to inform referral recommendations that balance public safety concerns with a youth's need for mental health treatment.

7. All mental health screens and assessments should be administered by appropriately trained staff.

8. Policies controlling the use of screening information may be necessary to ensure that information collected as part of a pre-adjudicatory mental health screen is not used inappropriately or in a way that jeopardizes the legal interests of youth as defendants.

9. Mental health screening and assessment should be
performed routinely as youth move from one point in the juvenile justice system to another, for example, from pre-trial detention to a secure correctional facility.

10. Given the high rates of co-occurring mental health and substance use disorders among this population, all screening and assessment instruments should target mental health and substance abuse needs, preferably in an integrated manner.

**Diversion.** Whenever possible, youth with identified mental health needs should be diverted into effective community-based treatment.

Many youth end up in the juvenile justice system for behavior brought on by or associated with their mental disorder. Some of these youth are charged with serious offenses: many, however, are in the system for relatively minor, non-violent offenses. Given the needs of these youth and the documented inadequacies of their care within the juvenile justice system, there is a growing sentiment that whenever possible and matters of public safety allow, youth with mental health needs should be diverted into effective community treatment. Mental health experts agree that it is preferable to treat youth with mental disorders outside of juvenile correctional settings (Koppleman, 2005). At the same time, however, a youth’s mental illness and level of risk to community safety must both be taken into account when determining whether a youth can be safely diverted into community-based treatment. It is also recognized that diversion into community-based treatment sometimes involves ongoing monitoring or supervision on the part of the juvenile justice system in order to ensure compliance with the terms of the referral or court order.

**The Recommended Actions for addressing Diversion include:**

1. Whenever possible, youth with mental health needs should be diverted to community treatment.
2. Procedures must be in place to identify those youth who are appropriate for diversion.
3. Effective community-based services and programs must be available to serve youth who are diverted into treatment.
4. Diversion mechanism should be instituted at virtually every key decision-making point within the juvenile justice processing continuum.
5. Consideration should be given to the use of diversion programs as alternatives to traditional incarceration for serious offenders with mental health needs.
6. Diversion programs should be regularly evaluated to determine their ability to effectively and safely treat youth in the community.

**Treatment.** Youth with mental health needs in the juvenile justice system should have access to effective treatment to meet their needs.

Enormous advances have been made in this area over the last decade and there are now evidence-based interventions that are well-documented and proven effective for treating mental disorders among youth (Hoagwood, 2005). These include psychosocial approaches such as Cognitive Behavioral Therapy (Rhode, Clarke, Mace, Jorgensen & Seeley, 2004); community-based approaches such as Multi-Systemic Therapy (Elliot et al., 1998) and Functional Family Therapy (Alexander & Sexton, 1999); and medication therapy (Jensen & Potter, 2003). Currently, however, the vast majority of mental health services and programs available to treat youth involved with the juvenile justice system are not evidence-based. More work is necessary to promote the wider use of evidence-based practices with justice-involved youth.

**The Recommended Actions for addressing Treatment include:**

1. Youth in contact with the juvenile justice system who are in need of mental health services should be afforded access to treatment.
2. Regardless of the setting, all mental health services provided to youth should be evidence-based.
3. Responsibility for providing mental health treatment to youth involved with the juvenile justice system should be shared between the juvenile justice and mental health systems, with lead responsibility varying depending on the youth’s point of contact with the system.
4. Qualified mental health personnel, either employed by the juvenile justice system or under contract through the mental health system should be available to provide mental health treatment to youth in the juvenile justice system.
5. Families should be fully involved with the treatment and rehabilitation of their children.
Figure 2: Critical Intervention Points

6. Juvenile justice and mental health systems must create environments that are sensitive and responsive to the trauma-related histories of youth.

7. Gender-specific services and programming should be available for girls involved with the juvenile justice system.

8. More research is necessary to ensure that evidence-based interventions are culturally sensitive and designed to meet the needs of youth of color.

9. All youth in the juvenile justice system should receive discharge planning services to arrange for continuing access to mental health services upon their release from placement.

C. Critical Intervention Points and Program Examples

The Cornerstones of the Model were then applied to the juvenile justice processing continuum to identify places within the entire continuum—from intake to re-entry—where opportunities exist to make better decisions about mental health needs and treatment. This examination resulted in the identification of seven Critical Intervention Points, shown in Figure 2, where the Cornerstones could be addressed or implemented. These points include:

Initial Contact and Referral: Often, a youth's disruptive or delinquent behavior is the result of a mental health problem that has gone undetected and untreated. The problem may manifest itself in behavior that brings the youth to the attention of law enforcement. Police response at this initial contact has significant implications in determining what happens next. An opportunity exists at this point for law enforcement, upon an encounter with a youth who appears to have a mental health problem, to connect the youth with emergency mental health services or refer the youth for follow-up mental health screening and assessment.

Program Example: The Rochester, NY Community Mobile Crisis Team responds to calls from the police, as well as parents and schools, regarding youth experiencing a mental health crisis in order to provide these youth with immediate access to mental health services. They perform assessments and facilitate access to a range of intensive and coordinated mental health services that are available through Youth Emergency Services (YES) including outpatient, home-based, and mobile mental health services. The team also conducts follow-up with the youth.
Intake: Intake is very often viewed as the “gatekeeper” to family court and represents an ideal opportunity to intervene early and identify the need for mental health and other types of rehabilitative services. Considering the potential influence that intake decisions can have on subsequent juvenile justice processing, it constitutes one of the most critical points within the juvenile justice continuum for applying prevention and early intervention strategies (Kelly & Mears, 1999). These strategies include the use of standardized mental health screening and assessment measures on all youth entering intake, as well as the institution of diversion mechanisms and programs so that youth in need of mental health services can be appropriately diverted into community-based treatment.

Program Example: Family Intervention Specialists (FIS) of Georgia provide intensive family intervention services to youth with mental health disorders, who are at risk of out of home placement. At intake, specialized probation officers, who are trained to identify mental health and substance use disorders among youth, use the MAYSI-2 to screen all youth at intake. Youth diverted to the program undergo further evaluation and receive Brief Strategic Family Therapy as the primary intervention. Services are provided by FIS staff who work closely with probation throughout the period of involvement.

Detention: Juvenile detention can be a traumatic experience for all youth but the situation can be much worse for youth with mental health needs. Feelings of depression, anxiety and hopelessness are heightened for all youth in detention, some of whom are experiencing their first separation from parents or caregivers, but can be more intense for youth with mental health problems. Detention can also mean an interruption in both medication and therapeutic services for youth who receive these things in the community. Employing standardized mental health screening and assessment measures for all youth entering detention is critical. The institution of diversion mechanisms at detention is also recommended to identify those youth who could be safely diverted to community-based treatment. Finally, in order to ensure access to treatment, linkages between the detention center and community-based mental health providers should be established to provide treatment to youth while they are in detention.

Program Example: The Bernalillo County, New Mexico Juvenile Detention Center (BCJDC) developed an intake process that identifies youth with mental health needs and diverts these youth to a community mental health clinic, the Children’s Community Mental Health Clinic, which is located 200 yards away from the detention center. The clinic serves all youth in the county and accepts referrals from the juvenile detention center, care providers, parents and others, thereby reducing any incentive to refer youth to detention simply in order to access mental health services. Youth brought to the detention center undergo a comprehensive intake screen to identify any mental health problems. Youth identified as in need of immediate services or further evaluation are walked to the clinic, where they receive a variety of clinical services including individual therapy, medication management, substance abuse services and case management. Services are provided to youth while they are in detention, as well as in their homes after they are released.

Judicial Processing: It is of critical importance that judges have sufficient information about a youth’s mental health treatment history and current needs in order to determine how a youth’s mental health disorder may have contributed to the problem behavior or offense, and to make an informed dispositional decision. Ideally, information on a youth’s mental health status should be collected prior to the youth’s case being referred to the court for an adjudicatory hearing, and the information used to divert the youth to treatment earlier in the process. However, for many youth, these diversion opportunities do not exist and the first attempt to identify any mental health concerns come at the time when a youth has been adjudicated and intake staff are developing recommendations to the court. Every effort must be made to ensure that a youth’s mental status is thoroughly evaluated at this stage so that this information can be presented to the court and considered as part of the dispositional plan.
Program Example: The Cook County, Illinois Juvenile Court Clinic is responsible for providing a variety of services to judges and court personnel regarding clinical information in juvenile court proceedings. A multidisciplinary staff of psychologists, psychiatrists, social workers, and lawyers provide consultation regarding requests for clinical information, forensic clinical assessments, and information regarding community-based mental health resources. With a clinical coordinator present in the courtroom, the Court Clinic is able to provide guidance to judges and probation staff about whether an evaluation is necessary and whether a youth's needs can be met in a community-based program or setting.

Secure Correctional Placement: The most restrictive sanction a juvenile court can impose entails committing a youth to a secure juvenile correctional facility. Traditional juvenile correctional facilities have not been found to be effective in running rehabilitative programs (Greenwood, Model, Rydel & Chiesa, 1996), or at reducing recidivism (Howell, 1998). Further, recent government investigations have documented the failure of many facilities to meet even the most basic of mental health needs of youth in their care (US Department of Justice, 2005). It is critical that future efforts focus on the development and implementation of evidence-based mental health treatments that can be provided to youth during their incarceration.

Probation Supervision: Probation supervision is the sanction most often applied to adjudicated youth in a dispositional hearing. Often, a judge will impose a period of probation with other conditions, such as participation in treatment, as well as restitution or community service. This represents an ideal opportunity to link a youth with treatment, while at the same time, affording the leverage of the juvenile court to ensure that the youth complies with the terms of the disposition.

Program Example: Recognizing the sizable population of youth with mental health needs in their system, the Washington State Juvenile Rehabilitation Administration (JRA) created a program that incorporates best practice interventions for youth with mental health needs. The Integrated Treatment Model (ITM) takes the evidence-based components of Functional Family Therapy, Cognitive Behavioral Therapy, and Dialectical Behavior Therapy and uses these therapies to provide individual treatment and skill development to youth from the point that they are admitted to the facility through their release back to the community (Juvenile Rehabilitation Administration, 2002). Staff within the facilities are extensively trained to use cognitive-behavioral treatment interventions to address the multiple needs of youth and prepare them for their return home. JRA also redesigned its aftercare program, creating a new service delivery model based on Functional Family Therapy, which gears aftercare services to the entire family, not just the youth.

Re-Entry: The goal of a placement is to successfully rehabilitate youth for their eventual return home. Critical to this is recognizing a youth's need for mental health services while in custody, providing effective treatment.
while a youth is in care, and ensuring that linkages are securely in place to allow for continued access to mental health care upon release. Ideally, planning for a youth’s re-entry into the community should begin shortly after a youth’s arrival in the facility, and should include efforts to ensure a youth’s enrollment in Medicaid or some type of insurance plan to pay for services once the youth is released.

Program Example: Project Hope, originally supported by a federal Systems of Care grant, is an aftercare program in Rhode Island that targets youth with serious emotional disturbances who are returning to their communities from the Rhode Island Training School (RITS). All youth with a mental health diagnosis are eligible to participate. Project Hope services are accessed by youth transitioning out of the training school through the RITS clinical social worker 90 to 120 days prior to the youth’s discharge. Family service coordinators work closely with the clinical social worker while the youth is incarcerated and with the youth’s probation officer when the youth returns to the community. Individualized service plans are modified as necessary and a case manager is assigned to ensure implementation of the plan for a period of 9 to 12 months following discharge.

III. Affecting Change: What Happens Next?

The Comprehensive Model provides a conceptual and practical framework for responding to the large numbers of youth in the juvenile justice system with mental health needs. This challenging project has culminated in the first ever systematic review of the juvenile justice system in its entirety to identify ways in which mental health service delivery strategies can be strengthened. While the document is targeted to state and county administrators and program directors from the juvenile justice and mental health systems, all staff within those systems can benefit from the information and examples provided. The Model also serves a dual role. It offers a blueprint for how mental health issues can be better addressed within the juvenile justice system as a whole; it also compartmentalizes the system into discreet points of contact, allowing jurisdictions to consider implementing individual components of the Model as a first step in improving their system.

The premise of the Model is not complicated: stronger partnerships between the juvenile justice and mental health systems can result in better screening and assessment mechanisms at key points of juvenile justice system contact; enhanced diversion opportunities for youth with mental health needs to be treated in the community; and increased access to effective mental health treatment. The Model provides a detailed blueprint for how to achieve these goals. What it cannot do, however, is actually affect the change. That must come from the leaders in the juvenile justice and mental health fields who have been struggling to develop solutions for these youth. The Model provides the tool to move forward. The energy, hard work and political will to make this happen must come from them. [1]

(For an electronic copy of the Model, please visit the National Center for Mental Health and Juvenile Justice website at www.ncmhjj.com).

References


About the authors...

Kathleen Skowrya is a Senior Consultant to, and previous Associate Director of, the National Center for Mental Health and Juvenile Justice at Policy Research Associates. Joseph J. Cocozza, Ph.D. is the Director of the National Center for Mental Health and Juvenile Justice and Vice President for Research at Policy Research Associates. Ms. Skowrya and Dr. Cocozza are the authors of the Center’s report Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Justice System.
About the National Center for Mental Health and Juvenile Justice

Recent findings show that large numbers of youth in the juvenile justice system have serious mental health disorders, with many also having a co-occurring substance use disorder. For many of these youth, effective treatment and diversion programs would result in better outcomes for the youth and their families and less recidivism back into the juvenile and criminal justice systems. Policy Research Associates has established the National Center for Mental Health and Juvenile Justice to highlight these issues. The Center has four key objectives:

- Create a national focus on youth with mental health disorders in contact with the juvenile justice system
- Serve as a national resource for the collection and dissemination of evidence-based and best practice information to improve services for these youth
- Conduct new research and evaluation to fill gaps in the existing knowledge base
- Foster systems and policy changes at the national, state and local levels to improve services for these youth

For more information about the Center visit our website at www.ncmhjj.com.

Joseph J. Cocozza, PhD
Director

For more information...
about the Blueprint, contact:

National Center for Mental Health and Juvenile Justice
345 Delaware Avenue
Delmar, NY 12054
Phone: 518-439-7415
Email: ncmhjj@prainc.com
Website: www.ncmhjj.com

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
810 7th Street, NW
Washington, DC 20531
Phone: 202-514-9395
Health Care for Youth in the Juvenile Justice System
Committee on Adolescence
Pediatrics 2011;128;1219; originally published online November 28, 2011;
DOI: 10.1542/peds.2011-1757

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/128/6/1219.full.html
Health Care for Youth in the Juvenile Justice System

abstract
Youth in the juvenile correctional system are a high-risk population who, in many cases, have unmet physical, developmental, and mental health needs. Multiple studies have found that some of these health issues occur at higher rates than in the general adolescent population. Although some youth in the juvenile justice system have interfaced with health care providers in their community on a regular basis, others have had inconsistent or nonexistent care. The health needs of these youth are commonly identified when they are admitted to a juvenile custodial facility. Pediatricians and other health care providers play an important role in the care of these youth, and continuity between the community and the correctional facility is crucial. This policy statement provides an overview of the health needs of youth in the juvenile correctional system, including existing resources and standards for care, financing of health care within correctional facilities, and evidence-based interventions. Recommendations are provided for the provision of health care services to youth in the juvenile correctional system as well as specific areas for advocacy efforts. Pediatrics 2011; 128:1219–1235

INTRODUCTION
Youth in the juvenile correctional system are a high-risk population who, in many cases, have unmet physical, developmental, and mental health needs. Multiple studies have found that some of these health issues occur at higher rates than in the general adolescent population. Although some youth in the juvenile justice system have interfaced with health care providers in their community on a regular basis, others have had inconsistent or nonexistent care. The health needs of these youth are commonly identified when they are admitted to a juvenile custodial facility. On-site correctional health care providers must not only try to identify these health issues but also determine if there has been active medical management in the community. Pediatricians and other health care providers play an important role in the care of these youth, and continuity between the community and the correctional facility is crucial.

EPIDEMIOLOGY OF JUVENILE ARRESTS
In 2008, 11 million juveniles younger than 18 years were arrested. Two-thirds of those arrested were referred to juvenile court, and 10% were referred to the adult criminal court system. One-third of all juveniles arrested were female. Gender differences exist in patterns of arrest-related charges such that adolescent girls are more likely to have runaway and prostitution/vice offenses, whereas boys have a
higher proportion of arrests in all other categories (e.g., violent and property crimes). Girls are also more likely than adolescent boys to fight with family members and become involved in domestic disturbances. Racial differences were seen in juvenile arrest patterns. Although black youth only represent 16% of the 10- to 17-year-old population in the United States, they represented 52% of the Violent Crime Index arrests and 33% of the Property Crime Index arrests (see Table 1). The greatest racial disparities were seen with some of the most serious crimes—murder, robbery, and assault.

Reasons for these racial disparities are complex and involve social context as well as individual characteristics and are not well understood. When comparing minority youth to white youth, differing opinions exist about the relative contributions of several factors including possible differential involvement in various offenses and inequalities in the treatment of minority youth compared with white youth once within the juvenile justice system. Youth arrests and delinquent behavior have been related to lower socioeconomic status (SES), family disruption (marital separation, divorce), living in households with only 1 biological parent, less residential stability (length of time living in 1 location), poorer neighborhood collective efficacy (capacity of residents to achieve social control over the environment), and educational failure. Overall, poverty is likely to be the underlying factor that most influences trends in juvenile crime.

SES plays a significant role for black and Hispanic youth, because they are more likely to live in poverty than their white counterparts. Educational failure is correlated with unemployment/underemployment. Studies have found that employment can prevent or reduce delinquent behavior. Lower educational attainment is most likely to affect black and Hispanic youth, who have higher dropout rates than their white counterparts. Family structure influences youth socialization and the capability to control the youth’s behavior. Family structure, itself, is not the cause of a youth’s behavior. Rather it is linked to other factors, as illustrated by the correlation between single-parent households and increased probability of living in poverty.

Black youth are most likely to be living in a single-parent household, and Hispanic youth are less likely than white youth to be living with both parents.

Not all juvenile arrests result in a custodial placement in either a short-term detention facility (usually ≤6 months) awaiting adjudication or a longer-term postadjudication residential facility. Custody rates are higher for male adolescents than female adolescents. Girls are more likely to be held for technical violations, such as violating the terms of probation, or status offenses, such as running away, rather than more serious illegal activities (see Table 1). Data on custody rates are similar to data on arrest rates, which demonstrate disproportionate contact of minority youth with law enforcement. Although minority youth represent only 39% of the US juvenile population, they represented 65% of the national juvenile custody population in 2006. These data become particularly relevant when considering unmet mental and physical health needs, because poorer health status is related to lower SES, and lower SES is more likely to be found among minority youth (see Sociodemographic Factors and Health Status).

In 2006, the median time in custodial placement was 65 days, including both short-term and long-term facilities. Eighty percent of postadjudicated youth were in the facility for at least 30 days, and 57% were in the facility for at least 90 days. Twelve percent were still in placement at 1 year. A significant number of youth are incarcerated for a period of time that would permit health care providers to diagnose, assess, and treat them for identified health problems.

### TABLE 1 Definitions of Crimes, Offenses, and Violations

<table>
<thead>
<tr>
<th>Violent Crime Index</th>
<th>Murder and nonnegligent manslaughter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forcible rape</td>
<td>Robbery</td>
</tr>
<tr>
<td>Aggravated assault</td>
<td>Property Crime Index</td>
</tr>
<tr>
<td>Burglary</td>
<td>Larceny theft</td>
</tr>
<tr>
<td>Motor vehicle theft</td>
<td>Arson</td>
</tr>
<tr>
<td>Status offense: an offense that is illegal for a minor but would not be criminal if committed by an adult</td>
<td></td>
</tr>
<tr>
<td>Runaway</td>
<td>Truancy</td>
</tr>
<tr>
<td>Curfew violation</td>
<td>Underage drinking</td>
</tr>
<tr>
<td>Technical violation: violation of a court order</td>
<td></td>
</tr>
<tr>
<td>Probation violation</td>
<td>Curfew violation</td>
</tr>
</tbody>
</table>

SOCIODEMOGRAPHIC FACTORS AND HEALTH STATUS

The categories of health needs of youth in the correctional system are similar to those of their peers in the community. They include dermatologic, respiratory, dental, gastrointestinal, genitourinary, and metabolic problems as well as developmental and mental health issues. Other categories are influenced, in part, by the youth’s engagement in high-risk behaviors such as violence, substance abuse, and sexual activity, which may be more prevalent than those of their peers in the general population. Some health issues result from living in impoverished and abusive environments (e.g., traumatic brain injury [TBI], lead exposure, positive tuberculosis [TB] test results, and poor dental care). Others are acquired health problems (e.g., hy-
pertension, diabetes) that are neglected or remain undiagnosed. In some instances, youth have had inadequate health care, because they have been runaways or living in inconsistent living situations that do not allow for continuity of care.

Underlying the poorer health status of youth in the juvenile justice system is SES. Just as lower SES is correlated with juvenile delinquency, lower SES—specifically, income inequality—has been shown to correlate with teen births, overweight, and mental health problems. Minority youth, including black and Hispanic youth, who are overrepresented in the juvenile justice system in the United States, are more likely to live in lower-SES environments and have been found to have overall poorer health care than their white counterparts. Studies have shown significant disparities between white and minority youth aged 0 through 17 years in insurance coverage, lack of a usual source of care, use of the emergency department, and not receiving adequate mental health care, dental care, or prescription medications. Factors other than SES may also be important. A recent review of the literature confirmed racial/ethnic disparities in adolescent health care. However, the results also suggested that some disparities are not totally understood and seem to be independent of SES.

EXTENT OF MEDICAL PROBLEMS

Few studies have provided a broad national perspective on the health needs of youth in the juvenile correctional system in the United States. The most recently published information is from the Survey of Youth in Residential Placement (SYRP). The findings in this report are based on interviews with a nationally representative sample of 7073 youth in custody during the spring of 2003. The information was obtained by using audio computer-assisted self-interview methodology and included youth at both short-term detention and longer-term residential treatment facilities. The survey revealed high rates of mental health and substance abuse problems as well as traumatic experiences with documented rates that exceeded those of the general adolescent population. More than two-thirds of youth in this survey reported a health care need, including injury, problems with vision or hearing, dental needs, or "other illness." Although more than 20 years old, another study with a national scope was conducted in 1991 by the National Commission on Correctional Health Care (NCCHC). The study included 1801 youth from 39 short-term or long-term correctional facilities in the United States. These youth had higher rates of substance abuse, trauma, unprotected sexual activity, history of sexually transmitted infections (STIs), suicidal ideation, and reported violence than those in a general high school population.

In the following sections, the data regarding general physical health issues are reviewed, and mental health and substance use/abuse diagnoses are addressed.

GENERAL PHYSICAL HEALTH ISSUES

In addition to the SYRP and NCCHC studies, 3 other studies that involved either a single facility or a region have provided important information. Two studies similarly found that approximately half of youth in these facilities had an identified medical problem. The first study, the results of which were published in 1990, included youth admitted during an 11-year period to a secure detention facility in New York; the second study, the results of which were published in 2000, included youth from 15 detention and longer-term facilities in the Maryland Juvenile Justice System. The third study involved youth admitted to a detention center in Alabama in the mid-1990s and found that although most youth (76.9%) denied preexisting conditions or complaints at the time of admission, 10.6% had a medical condition that required medical follow-up after release. There are a few specific health concerns that require particular attention in this population.

Dental

The preponderance of dental needs was documented in a 30-year-old study in a detention center in New York, in which almost all of the youth (90%) required dental care. A more recent study of youth in a juvenile detention center in Dallas County, Texas, conducted between 1999 and 2003, found that among a random sampling of 419 dental screenings of 12- to 17-year-olds, half of them had untreated decay and fewer than one-fifth had preventive sealants. High-urgency dental problems defined as infection, tooth or jaw fracture, pulpite, or severe periodontal disease with bleeding were found in 6.2% of the subjects. Moderate-urgency conditions, including cavitated asymptomatic decay or moderate gingivitis were found in 13.1%. One of the challenges noted by the authors was the inability to provide comprehensive treatment plans except in the case of long-term detainees.

Injury

Traumatic injuries are commonly identified in this population. These injuries are caused by multiple etiologies that range from accidental to deliberate. The Maryland study found that almost one-fifth of the youth experienced an injury including burns, head trauma, and musculoskeletal
injury, and that 12% of these youth had not had previous treatment. As demonstrated in the NCCHC study, interpersonal violence is an important cause of injury in this population. Approximately 70% of the surveyed youth had been involved in at least 1 fight during the previous year, and one quarter of them had experienced an injury that required medical attention. Three-quarters of youth in the NCCHC study reported fights that involved a weapon. There was a relationship between substance use and physical fights, use of weapons, and gang membership.

More details are described in the report of a study from a secure residential facility in North Carolina that examined the types of traumatic injuries experienced by 10- to 17-year-old youth. More than half of the youth had an injury that required medical attention. One-third of the injuries were related to sports, 20% related to fights, 13% self-inflicted, 9% related to suicide attempts, 8% vocational, 3% related to horseplay, and 11% attributed to “other.” The most common traumatic injury was musculoskeletal (one-third). One-quarter of the injuries were significant enough to necessitate referral for further evaluation to an outside facility.

A previous history of TBI is particularly significant in this population, because it can affect mental health and behavioral issues. Studies of detained adolescents have found high rates of TBI. Compared with youth without TBI, those with a positive history were more likely to have a psychiatric diagnosis, report earlier onset of criminal behavior and substance use, have more lifetime substance use problems, have more previous-year criminal acts, report lifetime suicidality, and demonstrate impulsivity or fearlessness in the year preceding incarceration.

**Tuberculosis**

Residents of correctional facilities have among the highest rates of TB infection and are housed in an environment with an increased risk of exposure. For those reasons, it is recommended that adolescents in correctional facilities be screened annually for TB. A positive Mantoux skin test result is considered to be 10 mm or greater, which is a lower threshold than that for an adolescent without additional risk factors.

**Reproductive Health**

**Sexual Activity/Contraception**

The 1991 NCCHC study remains one of the best nationally representative samples evaluating sexual activity and contraceptive use among incarcerated youth. The study used a survey method based on the Centers for Disease Control and Prevention (CDC)’s Youth Risk Behavior Surveillance System, which allowed for comparison with a general high school population.

Incarcerated youth reported higher rates of sexual activity and were more likely to report 4 or more lifetime sexual partners. Incarcerated youth also had much lower self-reported use of contraception or condoms at their most recent sexual intercourse.

**STIs/HIV**

Data from the CDC’s 2009 Sexually Transmitted Disease Surveillance Report demonstrated that youth in the juvenile detention system have among the highest rates of STIs. Table 2. Similar data were collected in another study that represented 12 juvenile correction facilities in 5 jurisdictions between 1996 and 1999. Because of unprotected sex with multiple partners, prostitution, or injection drug use, youth in correctional facilities are also at increased risk of HIV and hepatitis C virus infection. In addition, they are at risk of hepatitis B virus infection when the vaccination series is incomplete. High rates of STIs, alcohol and drug use, and lack of consistent condom use also contribute to increased risk of HIV infection.

Although the risk of STIs/HIV infection is high in incarcerated youth, many facilities fail to screen for either STIs or HIV. A study that used 2004 data from the Juvenile Residential Facility Census found that only 18.5% of the facilities offered STI testing for all adolescents on admission and that 8.3% of the facilities did not even have STI testing available. Some facilities only provided STI testing services when requested by the youth or deemed medically necessary, which is especially problematic, because STIs are commonly asymptomatic. Even fewer facilities tested all youth for HIV or hepatitis C virus infection, and these tests were much less likely to be available. One of the challenges associated with HIV testing by traditional methods is that it involves a blood draw and use of an outside laboratory. Youth may refuse phlebotomy and can be released from a short-term detention setting before obtaining the results. Currently available rapid HIV tests provide the option of a less invasive oral test and can provide results within 20 minutes while the youth waits. Providing opt-out HIV testing is recommended by the CDC as a part of routine health care, even in correctional facilities.
Pregnancy/Fatherhood

The SYRP found that 14% of incarcerated youth have children, males (15%) were more likely to have fathered a child compared with 9% of females who reported having a child. This rate is much higher than that of the general population of 12- to 20-year-olds, in which 2% of males and 6% of females have children. In addition, 12% of incarcerated youth were expecting a child. Overall, one-fifth of youth were currently a parent or expecting a child.

These recent national data confirm previous reports in which incarcerated teenagers report higher pregnancy rates than those in the general adolescent population; more than one-third of the females report ever having been pregnant. An analysis of data from the 2004 Juvenile Facilities Census revealed that at least 2.1% of girls are pregnant while in juvenile justice residential facilities at any particular point in time. One study found that one-quarter of males had fathered a pregnancy, and 40% of those fathers reported responsibility for more than 1 pregnancy. The 2004 Juvenile Facilities Census found that only 15% to 17% of facilities test all girls for pregnancy on admission. Although a small proportion (4.5%–6.6%) fail to even provide pregnancy tests, the remainder of the facilities test only when it is medically necessary or requested by the adolescent.

For youth who are pregnant while incarcerated, there are additional challenges. As found in the 2004 Juvenile Facilities Census, almost one-quarter of the facilities do not offer access to obstetric services. Similarly, another study that involved 430 short-term and long-term facilities from 41 states found that prenatal services were lacking in one-third of them, and 60% reported at least 1 obstetric complication. Pregnancy among incarcerated teenagers is complicated by other existing problems including substance abuse, posttraumatic stress disorder, previous sexual abuse, and additional considerations regarding postdelivery options. In addition to altered activity schedules and changes in menu options related to the higher caloric requirements of pregnancy, postpartum depression and other psychological problems require particular attention. Because most juvenile justice facilities do not have arrangements for infant residency or visitation, the adolescent and her family may be expected to make a plan for foster care placement.

MENTAL HEALTH

Overview

The available literature indicates that the prevalence of psychiatric and substance abuse disorders among youth in correctional facilities exceeds that of the general adolescent population. In a review of the worldwide literature from the 1960s through the 1990s, Roberts et al determined that the mean prevalence of psychiatric disorders in the general adolescent population was 16.5% (range: 6.2%–41.5%). In comparison, prevalence rates in the juvenile justice population range from 50% to 100% when disruptive behavior disorders are included.

Inclusion of disruptive behavior disorders, such as conduct disorder, in the psychiatric disorder prevalence estimates is controversial, because most teenagers would not be incarcerated unless they came to the attention of authorities because of significant disruptive behaviors. To some extent, engaging in disruptive behavior is part of normal adolescent development. Multiple studies have found that most adolescents in the general population participate in behaviors that would be considered delinquent. These behaviors, which include imitation of antisocial models/styles and social reinforcement, are usually transient. Most of the adolescent offenders (85%) known to the criminal justice system stop offending by the age of 28 years. Furthermore, severe, persistent antisocial behavior over time is only found in approximately 5% of males.

The wide range in the prevalence of mental health disorders among youth in the juvenile justice system is indicative, in part, of the limitations of the studies in the literature. These limitations include the use of nonstandardized measures and different diagnostic tools, noncomparable sociodemographic variables, data that are not generalizable because they are specific to an individual facility, state, or other locale; variation in the timing of the evaluation from the detention setting to after adjudication; and bias when samples only include youth referred for psychiatric evaluation. It is also important to consider the fact that for some youth, when mental health resources in the community are not sufficient, the juvenile justice system may be the placement of last resort by default.

Prevalence of Psychiatric and Substance Use Disorders

Until the SYRP report, the 1991 NCCHC study was the only published study that included a national sampling of multiple juvenile custodial sites in the United States. In the NCCHC study, all of the mental health and substance use behaviors were self-reported through a modified version of the CDC's Youth Risk Behavior Surveillance instrument. The data from that survey are summarized in Table 3. The more recent SYRP study found that at least half of youth reported problems with anxiety, anger, and loneliness, and approximately one-fifth had a previous suicide attempt. In addition, only 56% of the general population of 12- through 20-year-olds report a lifetime use of alcohol.
TABLE 3 Mental Health and Substance Use Data From the 1991 NCCYC Study

<table>
<thead>
<tr>
<th>Category</th>
<th>Male (n = 1574), %</th>
<th>Female (n = 219), %</th>
<th>Total Sample (N = 1801), %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal ideation previous year</td>
<td>19</td>
<td>40</td>
<td>87</td>
</tr>
<tr>
<td>Suicidal plan previous year</td>
<td>17</td>
<td>37</td>
<td>51</td>
</tr>
<tr>
<td>Suicide attempt previous year</td>
<td>13</td>
<td>35</td>
<td>87</td>
</tr>
<tr>
<td>Tried smoking</td>
<td>—</td>
<td>—</td>
<td>49</td>
</tr>
<tr>
<td>Smoked whole cigarette by age 12 y</td>
<td>—</td>
<td>—</td>
<td>40</td>
</tr>
<tr>
<td>Alcohol use, &gt;20 d lifetime</td>
<td>49</td>
<td>55</td>
<td>51</td>
</tr>
<tr>
<td>Cocaine use</td>
<td>30</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Marijuana use, &gt;40 times</td>
<td>10</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Use of other illegal drugs*</td>
<td>15</td>
<td>26</td>
<td>26</td>
</tr>
</tbody>
</table>

*Not all youth indicated gender on the survey.

Other illegal drugs used 10 or more times in lifetime: LSD, phenylcyclidine (PCP), ecstasy, hallucinogenic mushrooms, speed, ice, heroin, and pills without prescription.

with a psychiatric diagnosis had 2 or more diagnoses. In another study with youth in the juvenile justice system, McClelland et al found that approximately 50% of the youth had multiple substance use disorders; 80% of those with an alcohol use disorder also abused other drugs, and half of those with a drug disorder also abused alcohol. Co-occurring psychiatric and substance use disorders were found in the Shufelt and Coccoza study, in which 60.8% of those with a psychiatric diagnosis also had a substance use disorder. In that study, co-occurring substance use and psychiatric disorders were more common when there was a history of disruptive behaviors or symptoms suggestive of mood disorders. Because co-occurring major psychiatric and substance use disorders are common and develop in a close time frame, more dual-diagnosis treatment programs are needed to simultaneously address both issues.

Racial/Ethnic Differences

Racial/ethnic differences in the diagnosis of mental health disorders have been found in multiple studies. The well-designed study by Teplin et al found that incarcerated black youth have the lowest rate of mental health diagnoses, non-Hispanic white youth have the highest rate, and the rate for Hispanic youth falls between that of these 2 groups. However, as discussed in the literature, interpreting rates of mental health diagnoses and then evaluating racial/ethnic disparity within the juvenile justice system may be problematic. Concern has been raised that minority youth may be more likely to have their behavior interpreted as criminal rather than in need of mental health services. In addition, minority youth may be more reluctant to admit to experiences with mental illness, or they or their families may have a cultural bias against seeking care.

TABLE 4 Lifetime Substance Use Data From the SYRP

<table>
<thead>
<tr>
<th>Substance</th>
<th>% of Youth in Custody</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>74</td>
</tr>
<tr>
<td>Marijuana or hashish</td>
<td>84</td>
</tr>
<tr>
<td>Cocaine or crack</td>
<td>30</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>36</td>
</tr>
<tr>
<td>Acid or lysergic acid</td>
<td>19</td>
</tr>
<tr>
<td>DL-lysergic acid (LSD)</td>
<td>19</td>
</tr>
<tr>
<td>Inhalants</td>
<td>19</td>
</tr>
<tr>
<td>Heroin</td>
<td>7</td>
</tr>
</tbody>
</table>

racially diverse samples. These studies yielded a smaller prevalence range of 45.7% to 70.4% for having either a psychiatric and/or substance use disorder (see Tables 5 and 6). The studies by Teplin et al and Shufelt and Coccoza, specifically, were able to show that the high rates of psychiatric illness were not just a reflection of disruptive behavior disorders. Both studies found similar results: 60.9% (Teplin et al) and 66.3% (Shufelt and Coccoza) had either a psychiatric or substance use disorder when conduct disorder was not included among the diagnoses. When Shufelt and Coccoza removed substance abuse disorders from the analysis, 45.5% of the youth still had a mental health diagnosis. In general, substance abuse is concerning, because youth who start using and abusing drugs during early adolescence are more likely to have serious delinquency and longer deviant careers, antisocial personality disorders later in life, and more risk behaviors. Overall substance abuse is associated with poor academic performance and more psychiatric disorders.

Multiple studies worldwide have found that youth with psychiatric diagnoses can have more than 1 psychiatric diagnosis (comorbidly) or co-occurring psychiatric and substance abuse disorders. The study by Shufelt and Coccoza found that 79% of those compared with 74% of youth in custody, and only 40% of the general population has used any illegal drug compared with 85% of youth in custody. Details from the SYRP are summarized in Table 4.

Although the NCCYC and SYRP reports have provided information on youth from multiple sites across the United States, these 2 studies are limited by only providing information based on youth self-report rather than from diagnostic evaluation tools. Between 2002 and 2006, the results of several studies that were designed to eliminate some of the previous study design problems were published. The authors of these reports, Teplin et al, Wasserman et al and Shufelt and Coccoza, used randomly selected youth, the Diagnostic Interview Schedule for Children (DISC) as a standardized screening and assessment instrument; and included more ethnically/
Gender Differences

Gender differences are also evident. Females are more likely than males to have any psychiatric diagnosis and, specifically, to have higher rates of mood and anxiety disorders (Table 6). With respect to substance use disorders, in general, males and females have similar rates, but the study by Teplin et al. found that females are more likely than males to use substances other than alcohol and marijuana. Although both genders experience sexual (10%-24%) and physical (11%-58%) abuse, all forms of abuse, including emotional abuse, are more common in girls. As such, posttraumatic stress disorder is also more commonly diagnosed in females. Long-term outcomes for delinquent adolescent females reveal greater persistence of emotional problems and worse outcomes complicated by relationship and parenting issues, drug problems, and suicidality. 

Suicide

Suicide and suicidality have been a long-standing concern for juveniles in confinement. The 1991 NCCHC report and the 2003 SYRP both revealed high rates of suicidal ideation among incarcerated youth. In addition, 2 nationally representative studies explored suicidality in more detail. One study, the results of which were published in 2006, found that suicide was the leading cause of death in juvenile justice facilities in the United States between 2000 and 2002. A second report, published in 2009 and entitled “Characteristics of Juvenile Suicide in Confinement,” described the results of a retrospective evaluation of all identifiable juvenile deaths in confinement from 1995 to 1999. For the deaths related to suicide, the mechanism was hanging in all but 1 case. There were several important findings in this report. Sixty percent of the suicides occurred between 3 AM and midnight, which included a time frame in which youth were most likely to be around other people. Suicides were also most common during waking hours for those confined to their rooms. In addition, the potential for suicidality among these youth should have been recognized by staff, because 70% had been assessed by a mental health professional—half of them within the previous 6 days. Two thirds of them had a diagnosis of depression, and half were taking a psychotropic medication. Seventy percent of the youth had a history of suicidal ideation, and almost half had had a previous suicide attempt. Precipitating factors were identified more than half of the time and included fear of transfer or placement, recent death of a family member, failure in the program, recent suicide in the facility, and parental failure or threats not to visit.

Recent studies found that facilities with suicide-prevention training and suicide risk screening shortly after admission to the facility had a lower suicide rate. This is an area for improvement, because the 2009 study found that only one-fifth of the facilities had the 7 key components deemed necessary for suicide prevention. These components include written protocols, intake screening, suicide-prevention training, safe housing, observation, mortality review, and cardiopulmonary resuscitation certification. The report also discussed the need to further evaluate room confinement, including the role of isolation in suicidal behavior.

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TABLE 6 Estimated Rates of Mental Health Disorders in Incarcerated Youth From Studies Conducted Between 1995 and 2006

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Rate Males %</th>
<th>Rate Females %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mental health disorder</td>
<td>45-69</td>
<td>50-81</td>
</tr>
<tr>
<td>Any mood disorder</td>
<td>6-19</td>
<td>15-29</td>
</tr>
<tr>
<td>Major depressive</td>
<td>5-15</td>
<td>11-22</td>
</tr>
<tr>
<td>Any anxiety disorder*</td>
<td>17-26</td>
<td>29-56</td>
</tr>
<tr>
<td>Generalized anxiety</td>
<td>2-7</td>
<td>3-7</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>0-5</td>
<td>2-3</td>
</tr>
<tr>
<td>Obsessive compulsive</td>
<td>5-8</td>
<td>6-11</td>
</tr>
<tr>
<td>Separation anxiety disorder*</td>
<td>13-25</td>
<td>19-33</td>
</tr>
<tr>
<td>Any disruptive behavior*</td>
<td>20-45</td>
<td>20-51</td>
</tr>
<tr>
<td>ADHD</td>
<td>1-17</td>
<td>0.5-21</td>
</tr>
<tr>
<td>Oppositional defiant</td>
<td>3-15</td>
<td>11-18</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>18-58</td>
<td>17-41</td>
</tr>
<tr>
<td>Any substance abuse</td>
<td>26-51</td>
<td>22-55</td>
</tr>
</tbody>
</table>

*Only Teplin et al. (2002) included “separation anxiety” in the data for the “any anxiety” category.

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All subcategories under the “any” headings are from refs. 10, 11, and 12. ADHD indicates attention-deficit/hyperactivity disorder.
Psychotropic Medications

National data are lacking on the use of psychotropic medications for youth in the juvenile justice system. However, as summarized by Desai et al., 2 studies representing data from 2 states found that psychotropic medications were used for approximately half of the youth in detention facilities and more than two-thirds of youth in longer-term facilities. The fact that the majority of youth are prescribed these medications emphasizes the need for psychiatric services to appropriately diagnose and manage these youth. Mental health services are needed at the time of admission to a correctional facility for youth who are already on psychotropic medications and to evaluate youth who may need to initiate medications. In addition, subsequent evaluation is needed to decide whether ongoing use is needed during confinement. Attitudes of the parents and youth need to be considered when prescribing these medications, and continuity of care between community prescribing physicians and the juvenile justice facility is crucial.

The American Academy of Child and Adolescent Psychiatry has published a document that addresses mental health assessment and treatment for youth in the correctional system. 9 In this document, the authors recommend that psychotropic medication should only be used as part of an individually developed comprehensive treatment plan. Medication should augment other treatment interventions including individual, group, and family therapy along with behavioral interventions such as regular exercise, improved sleep hygiene, and staff/family support. The need for previously prescribed medications should be assessed on the basis of current symptoms and level of functioning. New medications should be used cautiously after review of potential risks and benefits, adverse effects, and alternatives with the youth and the parent/guardian when the youth is a minor.

SCREENING AND ASSESSMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

Ideally, youth with mental health and substance abuse problems would be identified and treated within the community rather than being first identified and addressed within the juvenile justice system. One recent study found that improvement in mental health services could reduce involvement with the juvenile justice system, particularly among youth with the most serious offenses. 10 One author 11 suggested that substance use screening before admission to detention might allow community diversion of some youth, optimize treatment choice, and minimize restrictive detention. However, optimal screening procedures have not been established, and many communities have limited availability of psychiatric and substance abuse services.

To better address the mental health needs of youth in the juvenile justice system, a panel of experts 2 was convened to create guidelines and a road map for best practices in the juvenile justice setting. The recommendations included a (1) valid and reliable mental health screening within 24 hours of admission, (2) a more extensive assessment by a mental health professional as soon as possible to determine needs, (3) use of multiple sources of information (records, family, schools, etc.), (4) rescreening before release and preparation for transition out of custody, and (5) regular repeat screenings while in custody. These recommendations are consistent with existing standards from the NCCHC.

One of the commonly used screening tools for mental health and substance abuse specifically developed for the juvenile justice system is the Massachusetts Youth Screening Instrument—Second Version (MAYSI-2). This 52-item screening instrument takes 10 minutes to complete and is validated as a self-report response tool that requires no clinical expertise to administer, score, or interpret, is low cost and can be used by a range of ages, different ethnic groups, and both genders, and has good psychometric properties. 13 This tool can be completed by using audio computer-assisted technology for youth who have literacy problems. The MAYSI-2 is designed as a screening tool only, and staff trained in mental health should be available for further assessment. This tool should never take the place of well-trained staff who can recognize symptoms of mental health disorders and substance use withdrawal.

There is no standardized approach used in the juvenile justice system to screen for substance use/abuse. It is important to screen for the use of abuse of alcohol, tobacco, and the gamut of other drugs, including illicit, prescription, and nonproprietary substances. Possible methods include self-report, which is the least expensive method but requires youth to understand the questions and have accurate recall and honest disclosure. Bioassays with urine or hair are most commonly used by detention facilities and are easy to collect. However, although these tests provide objective data, urine is only sensitive for most drugs used in the previous 2 to 3 days. Hair analysis has significant problems including external contamination, which can lead to false-positive results and differences in binding for different drugs and with different types of hair. 14

Specific screening for substance use was addressed in a recent report from the Office of Juvenile Justice and Delin-
Only 61% of juvenile facilities screened all youth for substance abuse, and 19% reported no screening. An additional 20% only screened youth identified by court or probation officers or facility staff. Other reasons to assess were if they had drug- or alcohol-related charges or by parent/youth request. Approximately one-third of the youth were screened on the day of admission, and another one-third were screened 1 to 7 days after admission. Three-quarters of the facilities that conducted screenings used staff-administered questionnaires, and 55% used self-report by standardized instruments or checklist inventories. Overall, 75% of the facilities used urine-based drug screening; however, one-third of all facilities only tested a subset of admitted youth or only when use was suspected or a request was made by the court or probation officer.

ON-SITE PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

The decision to initiate or change medical treatment of psychiatric disorders in detention is challenging, but acute symptoms may need to be treated with some urgency. Medications should be used to manage symptoms and minimize distress but not to manage behaviors alone. As discussed in the practice parameter from the American Academy of Child and Adolescent Psychiatry, it is ideal to determine the youth's legal disposition and placement before initiating or changing medication regimens. Unlike in longer-term, postadjudication facilities, the length of stay in detention is usually too short for most counseling interventions to treat major psychiatric disorders. However, trained personnel can provide observational data, and short-term counseling interventions can provide support and facilitate the use of problem-solving strategies to prevent problem-escalating interpersonal behaviors. A more extensive evaluation may also be required before making a disposition to residential or community-based mental health treatment. Family involvement is critical at that stage, because it is the key determinant of treatment engagement and success. Whenever the youth is returning to the community, an essential part of the disposition is to include identification of a behavioral health home and care plan.

In 2002, 53% of the facilities that reported mental health evaluation data had in-house mental health professionals who evaluated all admitted youth. Another one-third evaluated some youth. Facilities that provided mental health treatment on-site were more likely to also have a mental health professional evaluate all the youth. Larger facilities were more likely than smaller ones to screen all youth for suicide risk and to evaluate all youth for mental health needs. Privately operated facilities (62%) were more likely to evaluate all youth than were public facilities (41%).

Two-thirds of the facilities that reported substance abuse services provided them on-site; the majority (97%) of them provided drug education, and two-thirds provided individual or group therapy with a substance abuse treatment professional. However, it was also common (60%) for the counseling to be provided by someone not specifically trained in substance abuse treatment. Only 2 of 10 facilities had ongoing specialized treatment for substance abuse, and 1 in 10 had no substance abuse treatment services. Most facilities used in-house services, whereas only 20% relied on off-site services.

HEALTH CARE STANDARDS: THE NCCHC

Standards for care of youth in a juvenile correctional facility have been published by the NCCHC, which also serves as an accreditation organization. The latest version of the standards for youth was published in 2011. These standards are used for facility accreditation but are valuable to help inform facilities about both the minimal and ideal health care for incarcerated youth. The currently published standards do not specifically distinguish between detention centers, which typically involve shorter lengths of stay, and longer-term postadjudication residential facilities. However, at a minimum, the standards state that all youth should be screened immediately on arrival at the intake facility by qualified health care professionals or health-trained staff to identify and meet urgent health needs and to screen for any potentially contagious conditions or dangerous behaviors such as suicidal ideation. The subsequent length of stay would determine further evaluation.

According to the standards, all youth must receive a comprehensive health assessment within 7 days of arrival with hands on assessment by a physician, physician assistant, or nurse practitioner. This assessment includes a complete medical, dental, and mental health history, review and update of immunizations, screening for TB, measurement of vital signs, physical examination, and genitourinary examination, including a gynecologic assessment, as indicated by gender, age, and risk factors. The need for laboratory and/or diagnostic tests for communicable diseases, including STIs, are determined by the responsible physician.

A mental health screening that provides a full assessment by qualified mental health professionals or mental health staff using a structured interview is to be conducted within 14 days of admission and includes past history, suicidal behavior, victimization,
exposure to traumatic events, substance use, violent behavior, cerebral trauma or seizures, and psychotic medication. In addition, an oral health screening is to be performed by a dentist or health care professional trained by the dentist within 7 days of admission, and an oral examination is to be performed by a dentist within 60 days of admission.

Facilities are required to provide an opportunity for the adolescent to request health care on a daily basis, and all requests must be triaged within 24 hours. The facility must provide 24-hour emergency mental health and dental services. Discharge planning must include arrangements for follow-up or referrals to community providers and a supply of current medications to last until that follow-up can occur.

A recently published study that assessed whether juvenile detention facilities follow the standards set out by the NCCHC found significant deficits when comparing reported practices to published standards. Data were analyzed from the Juvenile Residential Facilities Census (2000, 2004) and Census of Juveniles in Residential Placement (2003), which are conducted by the Office of Juvenile Justice and Delinquency Prevention of the US Department of Justice. Most juvenile correctional facilities are not accredited by the NCCHC, and in the absence of mandatory accreditation, it is not clear whether most facilities would fail to meet the standards or just choose not to be accredited. Data from 2004 showed that overall, fewer than half of the facilities were compliant with recommended health screening and assessments. Few detention facilities met even minimal levels of care, although better care was seen as the length of stay increased.

CONTINUITY OF CARE

Continuity of care, both on entering the facility and when transitioning back to the community, is crucial for youth in the juvenile corrections system. However, continuity of care is a challenge. One study found that fewer than half of families showed interest in care deemed important by the on-site medical staff, and a large proportion of families were not successfully contacted. These youth had nonideal medical care before admission, only half of the youth had care in the previous year, and only one-third of them were able to identify a source of regular medical care. The juvenile justice system may be the only place where these youth have received a recent comprehensive medical history or physical examination.

As custodial placement comes to an end, transitions are difficult, particularly for youth who have experienced disruption and failure and who have limited internal resiliency and external support. Transitions of communities, residences, schools, programs, therapists, friends, and family members as well as adjustment to a less restrictive environment can be difficult. Continuity of care starts at the time of admission to the facility. If the youth already has a primary care provider, it is crucial for the medical staff to be able to contact that clinician to verify previous diagnoses and treatment. For cases in which the youth does not have a primary care provider, resources to establish primary care should be provided. Providing summaries of medical care for the primary care provider, appropriate subspecialist, or mental health specialist on discharge back to the community is also extremely important. In some cases, a chronic medical condition may be first diagnosed while the youth is in custody. Facilitating the transition to a provider who can ensure continuity is key, because it is not uncommon for youth to return to the correctional facility with unmet chronic health needs. For some conditions, such as STIs or TB, public health facilities may be able to help with follow-up.

COMMUNITY-BASED INTERVENTIONS FOR INCARCERATED YOUTH

Traditional cognitive behavioral therapy (CBT) is helpful for both internalizing and externalizing behaviors, including anger management, depression, and posttraumatic stress disorder. However, it may not be the best choice for many delinquent youth. There are several promising interventions that have been shown to be effective in treating youth with mental health issues. In some cases, these interventions have been shown to reduce recidivism. Programs that broadly address multiple domains, including the adolescents' family, school, peers, and community, are the most effective. These programs are intensive and highly structured and include social skill development, behavior management, attitude adjustment, and cognitive perceptions. Many of these programs are community-based interventions conducted in the youth's home environment and directly engage the family members. Examples include multidimensional treatment foster care, youth are placed with families trained to provide a structured therapeutic environment as an alternative to incarceration. The biological family is taught the system with the goal of returning the youth home. Multidimensional therapy and functional family therapy have been found to be particularly effective for youth with co-occurring mental health and substance use disorders. Some of the challenges with implementing these
programs are the high initial up-front costs and the labor-intensive nature of the interventions.

When assessing interventions, it is also important to note that the Girls Study Group found that interventions for boys may not directly translate to girls. Protective factors, such as caring adults, school success, school connectedness, and religiosity, may be less effective for girls who have experienced physical and sexual assault, neglect, and neighborhood disadvantage. More research is needed to understand the interaction between risk and protective factors in girls to best design successful intervention programs. Programs for girls need to address victimization, which is commonly found in these youth.

As evidenced by the interventions described above, the approach in the juvenile court system is generally rehabilitative rather than punitive. The Office of Juvenile Justice and Delinquency Prevention advocates a comprehensive strategy that includes supporting the adolescent's family and engaging core institutions, such as schools, businesses, and religious organizations, in helping to develop mature and responsible youth. This strategy utilizes the principle that delinquency prevention is the most effective approach while recognizing that there is a need for graduated sanctions that protect the community. The best prevention involves targeting risk factors for delinquency, such as drugs and firearms in the community, family conflict, abuse and neglect, poor commitment to school, and negative peer influences, while focusing on protective factors such as a resilient individual temperament; close relationships with family, teachers, other adults, and peers; and promoting school success and avoidance of drugs and crime. Reentry plans need to address education, mentoring, prosocial activities, and positive community involvement.

EDUCATIONAL NEEDS

As summarized in the recently published findings of the SYRP, educational difficulties and low commitment to academics are risk factors for delinquency. In this nationally representative survey, one-fifth of the youth reported that they were not enrolled in school at the time they entered custody. This rate is 4 times higher than that for the general population. In addition, 61% had been expelled or suspended, compared with 8% of the general population. Although only 28% of youth in the general population are functioning below grade level, 48% of those in custody reported being below the level expected for their age. Similarly, a higher percentage (25%) of youth in custody reported being held back in school, compared with 11% among peers in the general population. Although the majority (92%) of youth reported attending school while in custody, only half of these youth reported that the school program was of good quality, and most youth did not spend as many hours in school as did the general population.

Learning disabilities are also much more common among youth in custody; rates of 30% have been reported by youth in custody, which is 7 times higher than that of the general population. Despite the requirements of the federal Individuals With Disabilities Education Act, which states that youth in custody must be identified and given special education services, even in short-term facilities, only 46% reportedly receive these services. The SYRP report concluded that there is a need to obtain more information on how custodial facilities address educational needs, including an assessment of the curricula used, the provision of special educational services, and whether individual educational needs are being met for each youth in custody.

JUVENILE TRANSFER LAWS/DEATH PENALTY

In the past decade, an increasing number of states have enacted laws that require that juvenile cases be transferred to adult courts for certain offenses. A parallel increase has been seen in the number of juveniles incarcerated in adult facilities for certain felonies. When convicted in adult court, these juveniles commonly receive longer sentences than those sentenced in juvenile courts. Although these laws were enacted with the thought that they would be a deterrent for juvenile crimes, 6 studies, conducted in 5 different states, with approximately 500 to more than 5000 participants each, showed the opposite effect. Compared with youth retained in the juvenile court system, recidivism rates were higher for juveniles whose cases were transferred to adult criminal court. This was particularly true for violent offenders for whom transfer may actually be promoting rather than deterring further criminal involvement.

Juveniles in adult prisons report learning more about criminal behavior from adult inmates and having fear of victimization; these juveniles were least likely to say they would not reoffend. Juveniles incarcerated in adult prisons compared with juvenile facilities have an eightfold increase in suicide, a fivefold increase in being sexually assaulted, and a twofold increase in likelihood of being attacked with a weapon by other inmates or beaten by staff. Adult facilities have much less emphasis on rehabilitation and family support than do juvenile facilities, and juveniles have expressed both resentment and a feeling of injustice when tried and punished in the adult system.
At the extreme, issues of whether to invoke the death penalty for adolescents have been debated in the past. In 2004, the American Academy of Pediatrics and the Society for Adolescent Health and Medicine issued a joint statement opposing the death penalty for juvenile offenders. In 2005, the Supreme Court ruled that it was unconstitutional to impose capital punishment of individuals who committed crimes as a juvenile. Age 18 was determined to be the age for death-penalty eligibility. This age was based on currently available scientific research that indicates that juveniles do not have the cognitive maturity or sense of responsibility found in adults. This was echoed in the most recent ruling by the Supreme Court in May 2010, in which life without the possibility of parole was not permitted for juveniles who committed nonhomicide crimes.

FINANCING

Financing of health care for incarcerated adolescents presents many challenges. All incarcerated persons are entitled to health care under the US Constitution (see Estelle v Gamble, 429 US 97); however, such a constitutional guarantee does not include access to federally funded health benefits programs such as Medicaid or the Children's Health Insurance Program (CHIP), and it does not apply to private health insurance plans. Section 1905 of the federal Social Security Act specifically prohibits federal money from being used for medical care of inmates in a federal institution and has been applied equally to adolescents.

There is also a federal prohibition on the use of Medicaid benefits for any month during which the individual is a resident of a public institution. Many states have terminated Medicaid benefits rather than suspend them to avoid improper use of federal funds. Because financing for medical care in juvenile justice facilities then largely relies on state and local resources, the extent of medical care provided can be limited. When Medicaid benefits are terminated, there is also commonly a lag in reinstatement when the youth is released back into the community. This occurs even when screening for eligibility is offered before release and application assistance is provided. Although current law allows states to suspend rather than terminate benefits for incarcerated youth, many states do not follow this procedure for administrative or other reasons.

Other states have passed legislation specifically to address this issue and require that Medicaid be suspended and not terminated for at least 6 months while in detention. Ideally, continuation and utilization of active benefits while the youth is incarcerated or detained would ensure that correctional facilities can provide more comprehensive medical care. Continuation of active benefits would also facilitate continuity of care and may prevent some recidivism, especially for those with mental illnesses that require medication. In order for Medicaid benefits to remain active for youth in the juvenile justice system, federal law must be amended to ensure both continuation of benefits and funding for the federal government share of Medicaid. Advocacy is needed at both the federal and state levels to ensure provision of necessary medical services for these youth.

RECOMMENDATIONS

The current and predicted ongoing shortage of child and adolescent psychiatrists, the separation of mental health and drug and alcohol treatment services and personnel, the limited access to health care dollars for youth in detention, and the institutional variability in procedures and human and monetary resources will continue to provide a challenge to meet a reasonable standard of health care for this population. The following recommendations are provided for caring for youth in the juvenile correctional system.

1. Delivery of Medical Care

Youth incarcerated in the juvenile correctional system should receive the same level and standards of medical and mental health care as nonincarcerated youth accessing care in their communities.

a. Health care services should be equivalent to those recommended by guidelines of the American Academy of Pediatrics (Bright Futures [see www.brightfutures.aap.org]). Although the extent of health services provided during the period of incarceration may be mitigated by the length of stay in the facility, shorter-term facilities, at a minimum, should focus on the identification and treatment of immediate medical and psychiatric issues such as injury, infectious diseases (TB, scabies, lice); alcohol, tobacco, and other drug use/addiction, including withdrawal; psychiatric emergencies including suicidal ideation, and identification of chronic medical or mental health problems that require continuation of daily medications.

b. For youth incarcerated for more than 1 week or in longer-term facilities, recommended pediatric and adolescent comprehensive preventive services should be provided. In addition to a comprehensive history and physical examination, youth should receive a dental screening and mental health screening for psychiatric illness and substance use/abuse. Assessments should focus on developmental and psychosocial issues. Immunizations should be provided as recommended by the American...
Completion of the hepatitis B immunization series should be confirmed. Screening for hepatitis C with serologic testing should be considered for high-risk youth, including those who have a history of injection drug use, are HIV-positive, or have signs or symptoms of liver disease, per current CDC recommendations. Juveniles with signs or symptoms of hepatitis should also be tested for serologic markers for acute infection with hepatitis A and hepatitis B. For most youth, the first Papanicolaou test is not indicated until 21 years of age. If clinically indicated per published guidelines, a pelvic examination should be performed for a Papanicolaou test (see pelvic examination and male reproductive health statements).

d. Screening of pubertal girls should include pregnancy testing. Because of the high rates of sexual activity, all pubertal girls should be screened for pregnancy. Nonjudgmental counseling regarding options should be provided for pregnant youth, and accessibility to prenatal services should be provided on-site or in the community. Prenatal vitamins, including iron and folate supplementation, should be provided to all pregnant girls at the time pregnancy is diagnosed and continued throughout the course of the pregnancy. For both female and male youth who are parents, parenting classes should be included in the educational offerings.

e. On-site mental health and substance abuse professionals should be available to provide both evaluation and treatment services. Mental health services can be provided by staff either hired by the facilities or through a contractual arrangement with an outside community provider. Services should include psychiatric services to facilitate continuation of medications from the community mental health provider and ongoing evaluation and treatment. Psychiatrists should have training in child and adolescent psychiatry and preferably be board certified. Tobacco, alcohol, and drug-cessation programs should be available during the period of incarceration. Attention should be paid on an ongoing basis to the medical and mental health status of youth, because new issues can arise during their time in confinement. Correctional staff should receive training in suicide prevention, and specific attention should be paid to youth confined to their rooms in the housing unit. The practice parameter from the American Academy of Child and Adolescent Psychiatry provides specific recommendations on therovision of mental health services within the juvenile correctional system.

f. Regular physical activity and nutritionally balanced meal plans appropriate for adolescents should be provided in all facilities. Given the current national epidemic of obesity, attention to these aspects of a healthy lifestyle is even more critical.

g. Pediatricians should encourage all correctional care facilities to adopt and comply with the NCCHC’s “Standards for Health Services in Juvenile Detention and Confinement Facilities.” Accreditation is encouraged as a means to reach desired levels of health care. Information regarding accreditation can be found at www.ncchc.org.

2. Developmentally Appropriate Confinement Facilities

Children and adolescents should be housed in facilities that are able to ad-
dress their specific developmental needs.

a. Pediatricians, adolescent health care specialists, mental health professionals, and drug and alcohol treatment providers should be consulted about health care policies and procedures governing all correctional care facilities in which children and adolescents are incarcerated.

b. Children and adolescents should be detained or incarcerated only in facilities with developmentally appropriate programs and staff trained to deal with their unique social, educational, recreational, and supervisory needs.

c. If children and adolescents must be housed in adult facilities, they should have routine access to the same developmentally appropriate environment and be separated by sight and sound from the adult population.

3. Integration of Available Systems of Care

a. Coordination between juvenile justice system health care providers and community providers is essential. Health care information elicited in the juvenile corrections setting should, at a minimum, be shared with the adolescent and, as appropriate (when not violating confidentiality), with the parent/legal guardian to allow for continuity of care and prevent unnecessary duplication of services. Pediatricians are a crucial link in the process of ensuring continuity of care between the community and the juvenile correctional system. Information should also be shared between the relevant community providers and correctional health care staff both on admission and at the time of release to ensure continuity of care. If the youth does not have a medical home, correctional staff should make every effort to identify a medical home within the community for that youth. Pediatricians should also coordinate with probation officers who are frequently entrusted with ensuring appropriate follow-up once the youth reenters the community.

b. Electronic medical records available within the community should also be accessible by correctional health care staff. Existing publicly accessed databases, such as state immunization data banks, should be used to document care provided in correctional facilities. With the evolving use of electronic medical records, consideration should be given to the need to share information between correctional institutions and community providers to ensure continuity of care.

c. All youth incarcerated in the juvenile corrections systems should maintain eligibility for their existing health insurance benefits. Uninsured youth should be able to be enrolled in Medicaid while incarcerated. Both Medicaid and private insurance should be available for all youth without suspension or termination during incarceration and without a lag for reinstatement on reentry into the community. Youth without insurance coverage before incarceration should be automatically made eligible for Medicaid at the time of incarceration so that access to appropriate care may be facilitated. Advocacy is needed at both the federal and state levels to amend existing regulations and ensure the provision of necessary medical services for these youth.

4. Treatment and Intervention

a. Evidence-based mental health and substance abuse treatment interventions that have been shown to reduce recidivism should be adopted to improve long-term outcomes for incarcerated youth. Pediatricians should advocate for adequate funding for implementation of programs such as multisystemic therapy and functional family therapy with the recognition that an increased investment in the short-term will lead to cost savings in terms of improved long-term outcomes.

b. Resources should be invested in interventions that address the risk and protective factors involved with juvenile delinquency. There should be emphasis on investing in interventions that address the related family and community factors associated with delinquency. Specific emphasis should be placed on factors that will improve SES such as educational achievement and employment, because these factors are highly correlated with both juvenile delinquency and overall health status.

c. More nationally representative data are needed on the health needs of youth in the juvenile justice system. Funding is needed to collect nationally representative data on youth involved in the correctional system to better inform programming needs and desired outcomes and help guide the choice of appropriate cost-effective interventions.

5. Advocacy

Pediatricians should work with their AAP chapters, the juvenile justice sections of their state judiciary and bar associations, and state and local governmental officials.

a. Pediatricians should advocate to ensure that the appropriate legislation and funding is available to provide for medical, educational, and behavioral health needs of juve-
niles while confined and on reentry into the community.

b. Pediatricians should advocate for adequate health insurance for all medical and behavioral health services for youth both during and after incarceration to ensure that resources are available to provide adequate and continuous care.

c. Pediatricians should support both efforts to decrease the number of youth incarcerated by advocating for interventional programs in the community that address risk and protective factors and legislation that require education of law enforcement officers about at-risk youth and teaches skills to manage interactions with these youth.

LEAD AUTHORS
Paula X. Braverman, MD
Pamela J. Murray, MD, MHP

COMMITTEE ON ADOLESCENCE, 2011–2012
Paula X. Braverman, MD, Chairperson
William P. Adelman, MD
Cora G. Breuner, MD, MHP
David A. Levine, MD
Ark V. Marnell, MD, MHP

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ERRATA


An error occurred in this article by Flick et al, titled: “Cognitive and Behavioral Outcomes After Early Exposure to Anesthesia and Surgery” published in the November 2011 issue of *Pediatrics* (2011; 128[5]: e1053–e1061; originally published online October 3, 2011; doi:10.1542/peds.2011-0351). On page e1054, in the Introduction, paragraph 1, line 5, this reads: “drugs include N-methyl-D-aspartate glutamate receptor agonists and γ-aminobutyric acid antagonists.” This should have read: “drugs include N-methyl-D-aspartate glutamate receptor antagonists and γ-aminobutyric acid agonists.”

doi:10.1542/peds.2011-3305


An error occurred in the American Academy of Pediatrics clinical report “Prevention and Management of Positional Skull Deformities in Infants” published in the December 2011 issue of *Pediatrics* (2011; 128[6]:1236–1241; originally published online November 28, 2011; doi: 10.1542/peds.2011-2220). On page 1237, third column under Prevention, the fourth sentence should read: “Prolonged placement indoors in car safety seats and swings should be discouraged.” We regret the error.

doi:10.1542/peds.2011-3592


An error occurred in the American Academy of Pediatrics policy statement “Health Care for Youth in the Juvenile Justice System” published in the December 2011 issue of *Pediatrics* (2011; 128[6]:1219–1235, originally published online November 28, 2011; doi: 10.1542/peds.2011-1757). On page 1219, the number of arrests cited in the first sentence under the heading “Epidemiology of Juvenile Arrests” was inadvertently printed incorrectly. It should read: “In 2008, approximately 2.11 million juveniles younger than age 18 were arrested.” We regret the error.

doi:10.1542/peds.2011-3723


An error occurred in this article by Chipps B et al, titled “Longitudinal Validation of the Test for Respiratory and Asthma Control in Kids in Pediatric Practices” published in the March 2011 issue of *Pediatrics* (2011; 127[3]: e737–e747; originally published online February 21, 2011; doi:10.1542/peds.2010-1465) on page e738, Fig 1, Questions 3 and 5. This figure shows the Test for Respiratory and Asthma Control in Kids (TRACK) tool. Question 3 states, “During the past 4 weeks, to what extent did your child’s breathing problems, such as wheezing, coughing, or shortness of breath, interfere with his or her ability to play, go to school, or engage in usual activities that a child should be doing at his or her age.” The correct answer choices are “Not at all,” “Slightly,” “Moderately,” “Quite a lot,” and “Extremely.” Question 5 states, “During the past 12 months, how often did your child need to take oral corticosteroids (prednisone, prednisolone, Dexamethasone, Prolone, or Decadron) for breathing problems not controlled by other medications?” The
correct answer choices are “Never,” “Once,” “Twice,” “3 times,” and “4 or more times.” The corrected Fig 1 follows.

In the Acknowledgments, the correct spelling for the writer who provided editorial assistance is Hema Gowda, PharmD.

doi:10.1542/peds.2011-3725

![Figure 1](image)

FIGURE 1
Test for Respiratory and Asthma Control in Kids (TRACK). TRACK is a trademark of the AstraZeneca group of companies. (c)2009 AstraZeneca LP. All rights reserved 278550 5/09


A minor clarification has been made in the American Academy of Pediatrics policy statement “Recommended Childhood and Adolescent Immunization Schedules—United States, 2012” published in the February 2012 issue of Pediatrics (2012;129 [2]:385–386; doi:10.1542/peds.2011-3530). In Fig 3: Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind—United States, 2012, the bullet in footnote 9 that previously read:

Inadvertent doses of DfaP vaccine are counted as part of the Td/Tdap vaccine series.

596 ERRATA
Downloaded from pediatrics.aappublications.org at NYS Dept Of Health on October 2, 2012
now reads:

An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.

and appears as the first bullet rather than the second (i.e., the 2 bullets have switched positions).

The corrected schedule is now posted online at http://pediatrics.aappublications.org/ and Red Book Online. Please note that it will differ from the version that appeared in the print journal.

doi:10.1542/peds.2012-0319