Mental Health Screening in Juvenile Justice Settings

Note: This is a resource which was featured on our previous Collaborative for Change website. The Collaborative for Change website has been retired but we have housed this resource as a PDF document. The document will remain as is and is no longer being updated as of September 2016.

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National Center for Mental Health and Juvenile Justice

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The majority of youth who come into contact with the juvenile justice system have a diagnosable mental or substance use disorder. In fact, many youth are experiencing both. Combinations of mental illness and substance use are often referred to as either behavioral health problems or co-occurring issues.

One of the most important steps in responding to the behavioral health treatment needs of youth in the juvenile justice system is to systematically identify these needs as youth become involved with the system. The development of sound screening and assessment capacity is critical to effectively identify and ultimately respond to mental illness and substance use disorders. With the development over the last 10-15 years of easy-to-use screening tools, many designed to be used by non-clinical staff, the field has taken a major step forward in responding to the behavioral health needs of youth in the system.

An overview of screening, accompanied by a four-phase, ten-step guide generated from input by the juvenile justice field, is presented below. This ten-step guide draws heavily from Dr. Thomas Grisso's work on screening. Each of the steps includes resources for juvenile justice professionals and administrators, behavioral health partners, and other stakeholders seeking to implement screening. The resources are organized – when applicable – into three categories:

- key websites
- examples from the field (best practices and model policies suitable for adaptation or replication)
- critical resources (guides, reports on critical issues, and most recent research)

Overview

Over the last decade, there has been a steady increase in the awareness of the unmet needs surrounding mental illness and substance use disorder among youth in the juvenile justice system. Evidence suggests more than half of all youth in contact with the juvenile justice system have a diagnosable mental or substance use disorder. Many are experiencing both.

- Prevalence studies have consistently found that 60-70 percent of youth in the juvenile justice system meet criteria for mental health disorders (Shufelt & Cocozza, 2006).
- A large, national, multisite study found that 16 percent of youth at juvenile justice intake, 40 percent at pretrial detention, and 47 percent in youth corrections met criteria for a substance use disorder (Wasserman, McReynolds, Schwalbe, Keating, & Jones, 2010).
- The majority of youth with a mental disorder also have a substance use disorder (Shufelt & Cocozza, 2006; Wasserman, McReynolds, Schwalbe, Keating, & Jones, 2010).
- About 27 percent of justice-involved youth have disorders that are serious enough to require immediate and significant treatment (Shufelt & Cocozza, 2006).

SCREENING VERSUS ASSESSMENT

Screening is a relatively brief process often carried out by non-clinical staff to triage and identify youth whose mental or emotional condition suggests that they might have a behavioral health disorder.

Assessments, typically conducted by professionals with specialized training in clinical assessment, are generally more time consuming than screening and often involve discussion with youth's parents, clinical and structured interviews, assessment tools, and review of past records.

Why screen?

One of the most important steps for responding to the behavioral health issues of youth in the juvenile justice system is to systematically identify the needs of youth as they become involved with the juvenile justice system (Skowyra & Cocozza, 2007). In order to do this, behavioral health screening measures and procedures must be in place to identify mental illness and substance use disorder needs among youth at their earliest point of contact with the system.

How has screening evolved?

Only in recent years has reliable evidence about the prevalence of mental illness and substance use disorders among youth in the juvenile justice system become available. Looking back only a decade or two reveals how much things have changed.

In the early 1990s, behavioral 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). Much has changed in the field since the release of that report. Awareness of the needs of these youth has steadily increased, stirring 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 constructed research
- Greater advocacy for behavioral health screening within juvenile justice systems and programs
- Availability of scientifically sound behavioral health screening tools

Behavioral health screening within juvenile justice programs is quickly becoming the rule rather than the exception. Nearly every state in the country is now implementing behavioral health screening measures within some major systems in juvenile justice programs. The issues that have now surfaced are generally more complex – often involving multiple systems and requiring clarification to allow the field to refine its efforts and to continue its progress.

In April 2015, the National Center for Juvenile Justice (NCJJ) released a state-by-state scan on *Mental Health Screening in Juvenile Justice* as part of its Juvenile Justice GPS (Geography, Policy, Practice & Statistics) project. This publication summarizes NCJJ's survey of all 50 states to determine how mental health screening is conducted in juvenile probation, detention, and correctional systems. The survey also looked at whether screening is required by statute or policy and which instruments are used.

What is screening?

Screening is typically a brief procedure conducted by non-clinical staff using one or more standardized tools. Screening is a triage process that is employed with every youth to identify those with mental or emotional conditions that suggest a behavioral health disorder, suicide potential, or risk of harm to others in the immediate future.

What does it mean to be "screened in"?

The term "screened in" is often used to refer to youth who are identified by the screening method as requiring further attention (i.e., might have serious needs). Being "screened in" on a screening tool does not mean that a youth actually has a diagnosable mental disorder, substance use disorder, or significant risk of harming him/herself or someone else. It means only that further follow-up is warranted to determine the presence of a suspected condition. Follow-up steps triggered by being "screened in" may include:

- Managing an urgent risk of harm
- Obtaining a higher level of clinical care
- Referring for further assessment

Failing to be "screened in" usually means that there is relatively low risk that the youth has problems serious enough to require more intense intervention.

What is assessment?

When a youth is "screened in," access to assessment must occur in a timely manner. Assessments are typically conducted by professionals with specialized training in clinical assessment. They are generally more time consuming than screening protocols, often involving discussions with youth's parents, clinical or structured interviews, use of assessment tools, and reviews of past records. The clinician tailors assessment methods to the individual case or the nature of the problem suggested by the screening.

Assessments provide a more detailed description of:

- The youth's history
- Clinical needs
- Functioning across several domains (e.g., family, peers, school)
- Risk and protective factors
- Recommendations for management or treatment

Why use research-based screening instruments?

Screening tools should be backed by research that establishes their measurement dependability (reliability) and whether they actually measure the symptoms or problems they claim to measure (validity). When they are supported in this way, they are referred to as "research-based" tools. Choosing a tool that has been demonstrated by research to be reliable and valid and then using the tool exactly as it was used in the research leads to confidence that the tool is providing reliable results about what it is supposed to measure. If there is no evidence that the screening method dependably measures the psychological conditions or psychiatric symptoms that it is intended to identify, time and resources are likely to be wasted.

Guidance from the Field

The guidelines below are applicable to a wide array of jurisdictions and states seeking to develop or improve screening services for juvenile justice-involved youth who may be experiencing behavioral health disorders.

The four phases and ten steps of Behavioral Health Screening in Juvenile Justice Settings were developed by Dr. Thomas Grisso of the National Youth Screening & Assessment Project (NYSAP) and Dr. Robert Kinscherff of the National Center for Mental Health and Juvenile Justice (NCMHJJ). These guidelines are not meant to imply that the implementation process is always linear, with one step following another; rather, it is to lay out the landscape of activities as comprehensively and clearly as possible.

Additional guidance came from the collaboration of eight states that were competitively selected to participate in the John D. and Catherine T. MacArthur Foundation and the Substance Abuse and Mental Health Services Administration (SAMHSA) initiative entitled Improving Diversion Policies and Programs for Justice-Involved Youth with Co-Occurring Mental and Substance Use Disorders: An Integrated Policy Academy/Action Network Initiative. Six of the eight states (Arkansas, Michigan, Minnesota, Mississippi, South Carolina, and Virginia) committed to improving policies and programs for screening youth with co-occurring disorders.

- Phase I: Setting the Framework
- Phase II: Selecting the Screening Tool
- Phase III: Implementing Screening
- Phase IV: Maintaining and Evaluating Screening

Phase I: Setting the Framework

The first phase of developing screening establishes why, what, and who:

- Why is the screening program necessary?

- What resources will contribute to development and what demands will challenge development?
- Who will be involved in the screening program and its development?

Responding to these questions will provide structure to the development process, as well as establish common expectations for the screening program.

The steps for Phase I are:

- Step One: Review Needs and Options
- Step Two: Review Resources and Demands
- Step Three: Engage Stakeholders

Step One: Review Needs and Options

The first step in establishing screening is twofold: to develop a clear rationale for behavioral health screening and to review options regarding available screening methods.

Identify Reasons for Behavioral Health Screening

Developing a clear, concise view of the program's need for behavioral health screening is valuable for at least two reasons:

- When reasons for screening are explicitly stated and justified, critical stakeholders are more likely to engage in the initiative.
- A statement of needs will guide the selection of screening methods. Tools vary in format and content, so it is important to choose the screening tool that is best suited to address program needs.

Review Behavioral Health Screening Options

While it is premature at this point to actually select a screening tool or method, it is helpful to identify two or three of the most pressing needs for behavioral health screening to help narrow the many screening tool options. As listed below, there are several ways in which screening tools differ. All of these items should be considered during the review and selection process.

1. Format (e.g., paper and pencil; computer-administered/scored)
2. Content (e.g., single-scale versus multiple scales; scales focusing on symptoms versus on social problem areas)
3. Length (e.g., number of items)
4. Time required for administration and scoring
5. Training required to administer (e.g., minimal in-service training; training to become certified)
6. Administration cost (e.g., cost of manual only; fee per case)
7. Evidence base (e.g., quality and extent of research establishing reliability and validity)

Reasons for Behavioral Health Screening

- Identifying youth who may have behavioral health problems before they worsen
- Identifying youth with behavioral health problems that require immediate attention
- Identifying youth who present an imminent risk of suicide or self-injury

KEY WEBSITES

The Global Appraisal of Individual Needs (GAIN) Coordinating Center originated in 1993 as a collaborative effort between clinicians, researchers, and policymakers to create a comprehensive and standardized biopsychosocial assessment tool.

The National Youth Screening & Assessment Project (NYSAP) is a technical assistance and research center dedicated to helping juvenile justice programs identify youths' needs for behavioral health intervention and risk management. NYSAP developed the Massachusetts Youth Screening Instrument (MAYSI), which is currently the most widely used mental health screening tool in juvenile justice programs nationwide.

EXAMPLES FROM THE FIELD

The Louisiana Juvenile Justice System Screening, Assessment & Treatment Services Inventory was designed to provide a local planning board with an inventory of the screening and assessment procedures and existing services and programs available in its parish.

Mental Health Screening and Assessment in the Illinois Juvenile Justice System discusses the identification of mental health problems, how mental health screening and assessment practices are being used in the Illinois juvenile justice system, and what mental health screening and assessment tools are available.

CRITICAL RESOURCES

Grisso, T. (2005). Why we need mental health screening and assessment in juvenile justice programs. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 3–21). New York: Guilford Press.

Substance Abuse and Mental Health Services Administration. (2011). *Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations*. (HHS Publication No. SMA 12-4670). Rockville, MD: Author.

Step Two: Review Resources and Demands

Once reasons for behavioral health screening have been identified and features of different screening tools have been reviewed, the realities of implementation must be considered. Step Two turns to practical matters of screening: 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.

A review of resources and demands should include at least the following topics:

Informant Availability

What information do you need/expect to collect? Screening methods vary regarding the types of information that are necessary for completing them. Some require a review of past records; others require participation by parents or caretakers; and others rely (partly or solely) on information provided by youth.

Staff Expertise

As specified by its design, who administers the tool? What training is required for staff? Who will make decisions based on results of the screening tool? For tools designed to be administered and scored by non-clinical professionals, it is often recommended that staff undergo a brief training process that teaches them how to administer the tool and how to use the results.

Efficiency of Administration

How much time will be allotted for screening? Generally, screening tools range from 10 to 30 minutes in administration and scoring time. The degree of efficiency required by a setting should be carefully reviewed when making screening plans.

Financial Implications

The basic costs associated with screening typically involve (a) manuals, (b) paper forms or computer software, (c) 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. Juvenile justice programs, of course, vary in financial resources that can be devoted to screening, and decisions sometimes require compromises.

When reviewing screening resources remember:

- Why you are using screening
- What information you want to collect
- Who implements the screening tool
- How much time is needed for screening

CRITICAL RESOURCES

Grisso, T., & Vincent, G. (2005). The context for mental health screening and assessment. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), Mental health screening and assessment in juvenile justice (pp. 44–70). New York: Guilford Press.

National Center for Mental Health and Juvenile Justice. (2007, November). Mental health screening within juvenile justice: The next frontier. Chicago, IL: Models for Change

Step Three: Engage Stakeholders

All potential stakeholders associated with the screening of youth for behavioral health disorders must be familiar with the challenges and opportunities associated with this process. Engaging stakeholders involves readying them for the change that must occur at multiple levels.

Administrative Readiness

Persons responsible for establishing policy and providing resources will authorize and direct the implementation of screening procedures. Administrators (such as judges, senior probation officials, commissioners, agency directors) vary widely in their motivation to initiate change. Providing information and eliciting their perspectives on screening can help them:

- Recognize how change might further the goals they value
- Assess what has to occur to implement desired change
- Openly support change and persuade others to do so as well

Should administrators decide to support change, the motivation to succeed must be strong and enduring – especially when securing the cooperation of others, both within and outside of the administrators' work places. Implementing new procedures for youth with behavioral health disorders will have implications for the practices of prosecutors, defense counsel, judges, probation, clinical care providers, and others. In fact, without active support (or at least a willingness to not actively resist change) from each of these, the likelihood of successful implementation is substantially lessened. Much of the "buy-in" will have to be negotiated by administrators who will lead their own organizations while fostering the collaboration of other organizations or systems.

Operational Readiness

Not unlike administrators, directors and supervisors need information that supports their investment in change. Since directors and supervisors oversee daily administration of the screening protocol, they must be prepared to motivate their subordinates – those who will be directly administering the screening tool – to support change.

Two factors contribute to operational readiness. First is the development of a "research-based attitude" that shapes an organizational culture to embrace empirically supported practices. For this to occur, directors and supervisors themselves must appreciate the advantages of using research-based screening tools so that they can persuasively communicate this to staff responsible for integrating change into routine practices.

The second factor of operational readiness is the proactive identification of barriers to implementing screening tools. Staff concerns about changes to daily operations may reveal potential barriers, so directors and supervisors should be alert to these messages and be prepared to address them.

Staff Readiness

The engagement of staff members who administer the screening tool and carry out related procedures is essential, for it is their work that will integrate new screening policies into daily routines. Staff members will likely have questions about:

- The usefulness of the screening tool
- Ease of administration and the time it will take
- Whether it is additional work or will replace some other activity
- The screening tool allowing them to do a better job

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 raise questions about feasibility that administrators might not have anticipated, thus providing 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 behavioral health issues among juvenile justice youth, as well as the role of behavioral health screening in helping staff handle youths' needs in the course of their day-to-day work.

EXAMPLES FROM THE FIELD

The New York State Division of Criminal Justice Services' flyer for its "Diversion of Youth with Co-Occurring Disorders in the Juvenile Justice System" learning collaborative is targeted to local teams consisting of members from probation, mental health, and child welfare systems.

The New York State Division of Criminal Justice Services offered a one-day "Diversion of Youth with Co-Occurring Disorders in the Juvenile Justice System" training to teach local teams about the diversion process.

The New York State Division of Criminal Justice Services created a sample action plan to illustrate what is currently being done in screening, linking youth with treatment services, and what types of evidence-based treatment programs and services are being used.

Ogle County's Juvenile Justice Council is a Models for Change Innovation Brief that details how this county in Illinois improved communication amongst local organizations. The brief discusses how Ogle County opened lines of communication and collaboration with seven different law enforcement agencies and eleven school districts in the county.

CRITICAL RESOURCES

Grisso, T. and Vincent G. (2004, December). *Developing mental health screening in juvenile justice*. Chicago, IL: Models for Change.

Models for Change Research Initiative. (2011, December). *Knowledge brief: Does mental health screening fulfill its promise?* Chicago, IL: Author

National Center for Mental Health and Juvenile Justice. (2007, November). *Mental health screening within juvenile justice: The next frontier*. Chicago, IL: Models for Change.

Vincent G. (2012, January). *Screening and assessment in juvenile justice systems: Identifying mental health needs and risk of reoffending*. Chicago, IL: Models for Change.

Williams, V.; and Grisso T. (2006, October). *Lessons learned: Facilitating mental health screening in juvenile justice programs*. Chicago, IL: Models for Change

Phase II: Selecting the Screening Tool

Once the framework for screening is in place, Phase II of the process can begin: selecting the actual screening method according to quality, content, and format.

The step for Phase II is:

- Step Four: Select the Screening Method and Procedure

Step Four: Select the Screening Method and Procedure

The method for behavioral health screening can now be selected. The three criteria of selection [quality, content, and format] carry equal weight. If, for example, a screening tool addresses the highest priority issues, but requires computer access unavailable to the program, pursuing adoption of that particular tool is imprudent.

Quality

Recent years have seen the development of "research-based" tools, meaning that research supports their validity and reliability in screening behavioral health disorders among juvenile justice populations. These tools tend to be designed for easy administration, scoring, and interpretation, and may offer cut-off scores that can act as screen-in signals to staff that further inquiry or assessment is needed.

However, even research-based tools should be scrutinized for appropriateness to the unique needs of a particular program. The following items should be considered:

- Goals – The purpose of the screening tool should dovetail with the goals of the program. A program seeking to identify youth with co-occurring mental disorders and substance use disorders will not likely be satisfied with a screening tool that classifies youth in terms of recidivism risk.
- Context – The juvenile justice system is multi-faceted, so screening can occur at a variety of points during the judicial process: court or probation intake, detention facilities, and secure treatment/incarceration facilities. A screening tool should be appropriate to when, where, and – as noted in the preceding bullet – why it will be administered.
- Demographics – Research supporting the tool should relate to the gender, age, ethnicity, and language of the program's service recipients.
- Research Base – Currently, no screening tools have been fully field-tested at all potential points of contact within both juvenile justice and behavioral health systems. Some tools have a greater research base within juvenile justice systems, while others have little or no specific research base within juvenile justice, but good research regarding their use in clinical settings.

Content

Programs focusing on youth with behavioral health disorders are seeking a method for detecting both mental illness and substance use disorders. Yet, there are many questions of content that go beyond whether or not the tool measures both types of disorders, such as:

- Does the tool cover symptoms related to the mental and substance use problems of greatest importance for the program? Most programs will want to know about symptoms related to substance use, depression and anxiety, trauma, and suicide risk.
- What is the time frame for symptom reporting? Some tools focus on symptoms within the last few days, while others focus on symptoms during the past month, year, or lifetime.
- Do any of the screening questions require admission or denial of illegal behavior? Defense attorneys often will object to pre-adjudication measures that ask youth to report whether they have engaged in illegal behaviors, whether or not they are related to the present reason the youth has been brought to the system's attention.
- Does the tool offer cut-off scores for decision-making? Tools that offer a particular standardized score above which the case should be considered "high" or "screened in" are generally more user-friendly to persons with no training on mental disorders.

Format

Screening tools differ in how they are administered and scored. They should be regarded within the context of the program and its resources. Considerations include:

- Administration – Screening tools are administered in a variety of ways, such as paper and pencil, computers, and interviewing. Many programs favor computer-based administration, because it is more time efficient, youth prefer it, and it allows automatic creation of data records.
- Information Source – Some screening tools are based on the youth's self-report alone, while others include information from parents, caretakers, or others. Some tools also require information from available records.

- Time Requirements – Consider how much time is required for administration, scoring, and interpretation of results of the screening tool. Ideally, administration and scoring of screening tools should take no longer than 20 minutes.
- Staff Training Needs – Some tools require minimal in-service training that can be accomplished with in-house resources. Others require training through a process of certification, and still others must be administered by professionals with special training on mental and/or substance use disorders.
- Costs – Although some tools require a fee per case, many screening tools require only a one-time cost to purchase the manual and paper-and-pencil forms/software for unlimited use.

CRITICAL RESOURCES

Center for Substance Abuse Treatment. (1999). *Screening and assessing adolescents for substance use disorders*. (Treatment Improvement Protocol (TIP) Series, No. 31). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Dembo, R., & Anderson, A. (2005). Problem-oriented screening instrument for teenagers. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 112-122). New York: Guilford Press.

Grisso, T. (2005). *Evaluating the properties of instruments for screening and assessment*. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 71-96). New York: Guilford Press.

Grisso, T., & Quinlan, J. (2005). Massachusetts youth screening instrument – Version 2. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 99-111). New York: Guilford Press.

Hodges, K. (2005). Child and adolescent functional assessment scale. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 123-136). New York: Guilford Press.

Loney, B, & Counts, C. (2005). Scales for assessing attention-deficit/hyperactivity disorder. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 166-184). New York: Guilford Press.

Miller, F., & Lazowski, L. (2005). Substance abuse subtle screening inventory for adolescents – Second version. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 139-151). New York: Guilford Press.

Substance Abuse and Mental Health Services Administration. (2011). *Identifying mental health and substance use problems of children and adolescents: A guide for child-serving organizations*. (HHS Publication No. SMA 12-4670). Rockville, MD: Author.

Wolpaw, J., Ford, J., Newman, E., Davis, J., & Briere, J. (2005). Trauma symptom checklist for children. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 152-165). New York: Guilford Press.

Phase III: Implementing Screening

Programs that screen for behavioral health disorders must be able to respond to the needs of youth through the capacities of the program or through referrals to service providers. Optimally, service providers will have experience with youth involved in the juvenile justice system and their families, and use evidence-based assessment methods and treatments that are matched to the specific behavioral health needs that are identified. Detailed planning for building and testing this capacity occurs in the four steps of Phase III.

The steps for Phase III are:

- Step Five: Develop Decision Rules and Responses
- Step Six: Assemble Response Resources
- Step Seven: Develop Information-Sharing Policies
- Step Eight: Pilot and Train

Step Five: Develop Decision Rules and Response Policies

Juvenile justice programs must develop policies on how staff will use the screening tool's scores to respond to the apparent behavioral health needs of youth.

Decision Rules

Decision rules define what scores on what scales of the tool will be used to signal that a youth is in need of a staff response. Most screening tools have "high" or "cut-off" scores indicating that a youth has behavioral health needs that warrant some kind of response. It is important to identify and consistently apply "cut-offs" on screening tools to avoid arbitrary decision-making about who is referred for further assessment. Persons administering screening tools should consider the role of professional judgment and strive for consistency in making these judgments. For example, a youth who denies substance abuse on a self-report screening tool and so is not "screened-in" by the tool may nonetheless warrant further assessment if reliable collateral information indicates a concerning pattern of substance abuse. Procedures should be in place to document the reasons for an "override" of screening results. To avoid undermining the integrity of the screening protocol, supervisors should review these override decisions.

Response Policies

Response policies articulate what will be done when a youth "screens-in" for potential behavioral health disorders. These policies must be developed in conjunction with available research-based assessment and behavioral health treatment services. Response policies should not only distinguish screening results that demand immediate staff precautions from those that call for further assessment, but also provide guidelines for following up with youth who do not "screen-in."

EXAMPLES FROM THE FIELD

Mental Health Screening within Juvenile Justice: The Next Frontier is a report developed by the National Center for Mental Health and Juvenile Justice with support from the John D. and Catherine T. MacArthur Foundation. Appendix C provides two examples of protocols:

- Texas MAYSI-2 Protocol (24-26)
- New Jersey MAYSI 2 Protocol (27-34)

CRITICAL RESOURCES

Grisso, T. (2005). Evaluating the properties of instruments for screening and assessment. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), Mental health screening and assessment in juvenile justice (pp. 71-96). New York: Guilford Press.

Step Six: Assemble Response Resources

Once decision rules and response policies are in place, it is time to make the internal and external connections that will support them. As previously noted, administrators and staff providing the screening must be prepared to respond appropriately and to make referrals to qualified behavioral health professionals. Youth who are "screened in" need assessments provided by properly trained clinical professionals within the program or community. If clinical consultation will be a response to particular types of screening results, the program must develop the resources and relationships necessary to make these consultations available.

Identify Partners
When establishing partnerships with providers of clinical services, it is important to determine their expertise in research-based behavioral health assessment and treatment with youth. Many mental health professionals will have experience working with individuals with substance use disorders, but will not have specific training in integrated treatment methods. Similarly, many professionals treating substance use disorders will have experience working with individuals who also have mental disorders, but not actually have specific training in integrated treatment. Others may have had specific training in assessing and treating behavioral health disorders among adults, but not among youth.

Formalize Roles
Roles and responsibilities of all partners should be formalized through contract, collaborative agreements, memoranda of understanding, or other such mechanisms. Typically, agreements specify who the community service provider will accept, details information-sharing procedures, and describes both routine operational protocol and the "emergency response" protocol. Eliminating ambiguity through written agreements can prevent misunderstandings as the program unfolds. Such thoughtful planning often reveals potential barriers to accessing treatment.

Step Seven: Develop Information-Sharing Policies

Information-sharing refers to the degree to which screening results will be shared. A clearly written policy on information-sharing can greatly improve the likelihood that youth and their families will trust the screening program and that stakeholders within and beyond the juvenile justice system will engage in the process.

Informed Consent

Youth and their parents/guardians should be provided with sufficient information to make an informed choice about participating in screening. How informed consent with parents/guardians (and assent with minor youth who cannot give legal consent) is handled can greatly shape the screening process. Research indicates that youth are often remarkably self-disclosing and candid on screening tools that rely on youth self-report. But how youth respond depends on whether they trust the process, feel they fully understand who will receive the specific responses or summary information about the screening, and to what purposes that information will be put.

Particularly since screening for a co-occurring disorders will involve questions about alcohol and drug possession/use, youth need to know if admissions of substance use and related problems will:

- Potentially expose them to greater scrutiny and sanctions for currently charged alleged misconduct
- Potentially expose them to further additional charges for disclosed but previously unknown misconduct
- Provide information for investigation by law enforcement that could result in new charges

Information-Sharing with Stakeholders

As a source of information, screening results can be valuable to anyone seeking to provide the most beneficial services to the youth. However, the youth's right to confidentiality must be upheld. Many judges, prosecutors, and defense attorneys do not use detention intake screening in proceedings on delinquency charges because they understand that:

1. Screening is necessary to identify and respond to youths' needs for the benefit of themselves and the community
2. The screening itself will be invalid if youth must be told that the results can be "used in court against them in their delinquency hearing"

There are other views on information-sharing, however. Some juvenile justice personnel might feel that the screening results should be protected from use in juvenile proceedings only to the extent that the youth successfully completes the program. The defense bar might believe that

screening results—especially if they contain items related to illegal behavior—should not be shared, even with providers of mental illness treatment in the community.

To facilitate trust and understanding of the screening program among youth and stakeholders, a definitive policy on information-sharing will:

- Identify who is allowed access to screening information and for what purpose(s)
- Specify types of information that can be shared (e.g., actual scores on each scale of the screening tool versus general information such as, "The youth was screened-in.")
- Describe potential consequences of sharing information

Once established, this policy should be reinforced by a memorandum of understanding between key stakeholders that clearly spells out the limits for sharing screening information.

KEY WEBSITES

The *Establishing and Maintaining Interagency Information Sharing* bulletin is part of the Juvenile Accountability Incentive Block Grants Best Practices Series produced by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). It details how multi-disciplinary collaboration and information-sharing help at-risk and delinquent juveniles succeed.

OJJDP's Guidelines for Juvenile Information Sharing provides a course of action for key agency and organization stakeholders involved in a state or local effort to implement and sustain juvenile information sharing.

The Illinois Confidentiality Statue (705 ILCS/5-401.5) provides for confidentiality of and protections against self-incrimination in behavioral health assessments. Furthermore, the statue provides that a statement, admission, confession, or incriminating information made by or obtained from a minor related to the offense, as part of any behavioral health screening, assessment, evaluation, or treatment, shall not be admissible as evidence against the minor in the juvenile court proceeding.

The Models for Change Information Sharing Tool Kit provides guidance to jurisdictions seeking to improve their information- and data-sharing practices in the handling of juveniles and reach the ultimate goal of improving the outcomes for those youths. The tool kit was developed by the Child Welfare League of America and the Juvenile Law Center.

This Memorandum of Understanding from Monroe County, New York serves as an example of defining roles and responsibilities between various stakeholders in a juvenile justice program.

CRITICAL RESOURCES

Rosada, L. M., and Shah, R. S. (2007, January). *Protecting youth from self-incrimination when undergoing screening, assessment and treatment within the juvenile justice system*. Philadelphia, PA: Juvenile Law Center.

Step Eight: Pilot and Train

The activities discussed thus far come together in Step Eight. Perhaps the most "hands-on," this step involves staff working directly with the youth for whom the screening program is intended.

Pilot

A brief pilot study with a small number (20-50) of youth can provide useful information about the "on-the-ground" success of the screening process. It often identifies questions or concerns about the scoring tools, their administration, and their interpretation that can be addressed before moving to full implementation. The closer the piloting process approximates the youth, the setting, and the services with whom the program will be working, the more likely that it will yield helpful information. The experience and outcomes of the pilot program should be scrutinized to detect any necessary adjustments to decision rules and response policies. For example, criteria for "screening in" may or may not be deemed well matched to capacities for behavioral health assessment and treatment, resulting in underutilization of the behavioral health capacity or waiting lists that compromise the goal of prompt assessment and initiation of treatment. Situations requiring an immediate response may have arisen, prompting re-examination of the adequacy of the emergency response plan. The pilot program may reveal personnel, situational, resource, and administrative areas for improvement.

Training

Successful implementation of screening procedures for juvenile programs relies on extensive training, which should occur after the pilot study is completed and adjustments are made.

General Training

General training is provided to all who will have access to information gathered through screening procedures. This training helps participants distinguish between screening and assessment, explains the purposes of behavioral health screening, and describes the uses and limitations of screening results. It should also include relevant aspects of information-sharing policies and practices.

Specialized Training

In addition to the general training, anyone who will be administering screening tools and/or supervising screening procedures must receive specialized training to assure correct use, scoring, and interpretation of the tools. Administration instructions found in the manuals accompanying research-based screening tools must be rigidly followed, since research validation of the tools was done under strict adherence to the procedures governing their administration. Deviating from the instructions can invalidate or produce less reliable screening results. Research-based screening tools typically offer Internet-based training or on-site training for a fee.

KEY WEBSITES

The Global Appraisal of Individual Needs (GAIN) Coordinating Center originated in 1993 as a collaborative effort between clinicians, researchers, and policymakers to create a comprehensive and standardized biopsychosocial assessment tool.

The National Youth Screening & Assessment Project (NYSAP) is a technical assistance and research center dedicated to helping juvenile justice programs identify youths' needs for behavioral health intervention and risk management. NYSAP developed the Massachusetts Youth Screening Instrument (MAYSI), which is currently the most widely used mental health screening tool in juvenile justice programs nationwide.

Phase IV: Maintaining and Evaluating the Screening Process

Once the flurry of activity surrounding the launch of the screening initiative has subsided, energies can be diverted to securing the permanency of the service. This involves gathering data that will be instrumental in "selling" the continuing benefits of the program to potential partners and funders, as well as monitoring operations to maintain fidelity to the original screening model.

The steps for Phase IV are:

- Step Nine: Create a Database
- Step Ten: Monitor and Maintain the Screening

Step Nine: Create a Database

One of the great benefits of systematic behavioral health screening is the opportunity to create a database that describes the needs of youths served by a program or agency.

There are two major reasons for including a database as an essential component of the juvenile program:

1. Program management will rely on the database for monitoring the number of youth who are screened in for behavioral health disorders and meet other eligibility requirements. Accurate monitoring is a prerequisite for matching referrals to actual capacity and building capacity to meet actual needs.
2. A database provides the platform for evaluating program success, which is often key to securing funding for long-term operation. Documented results will also help convince potential community-based partners to accept referrals of diverted youth with behavioral health disorders.

Most database software programs allow for generation of basic descriptive statistics. More thorough or complex analysis of data might be provided by policy analysts associated with the courts or the juvenile justice agency. Partners from local colleges and universities, such as faculty or graduate students in criminal justice, public policy, public health, statistics, psychology or other fields, may also be able to conduct database analysis or consult on efforts to analyze data.

The database should consist of a computer-based (rather than paper record) system in which cases are entered as they are identified. Basic information that should be routinely entered includes:

- Demographic information
- Date, time, and source of referral
- Results of screening (scores, "cut-off" scores) for each tool used
- Indications (with dates) if youth was diverted and referred for assessment, began treatment, and completed treatment
- Outcomes
- Youth's insurance status, special case characteristics, and difficulties or obstacles that complicated progress

CRITICAL RESOURCES

Thomas, D. (2006) *How does the juvenile justice system measure up? Applying performance measures in five jurisdictions.* Technical Assistance to the Juvenile Court: Special Project Bulletin. Pittsburgh, PA: National Center for Juvenile Justice.

Step Ten: Monitor and Maintain the Screening Program

Like all functions of a juvenile justice program, screening practices need to be monitored at established intervals for their quality.

Research and experience indicate that programs are vulnerable to "drift" from the original model, policies, and practices over time. This can threaten long-term fidelity of the model and inadvertently compromise program effectiveness. Drift can arise from several sources, including:

- Inattention to policies and practices that emerges as people become comfortable with program operation
- Deviation from established policies and practices in individual cases that are appealing "exceptions" to usual procedures, but which cumulatively create new procedures
- Short-term adjustments or modifications by staff that seem to make sense at the time, but which then become routine
- Staff and administrator turn-over

Staff members responsible for administering the screening process play a key role in preventing this drift. In addition to regular monitoring of staff activities, supervisors of these staff members should periodically elicit feedback from them on how to promote efficiency and effectiveness. New staff orientation should include training on quality assurance, but experienced staff too will benefit from periodic retraining. Providing positive, genuine feedback to all staff will reinforce quality assurance efforts.

Even leadership and key stakeholders are subject to these often subtle, but potentially corrosive, challenges to program effectiveness and fidelity. Therefore, it may be judicious to consult with independent experts as part of a quality assurance plan. This effort should ensure adherence to established decision rules and response policies, as well as identify potential sources of compromise of program effectiveness and fidelity to the program model.

EXAMPLES FROM THE FIELD

Thomas, D. (2006) *How does the juvenile justice system measure up? Applying performance measures in five jurisdictions.* Technical Assistance to the Juvenile Court: Special Project Bulletin. Pittsburgh, PA: National Center for Juvenile Justice.

All Resources: Mental Health Screening in Juvenile Justice Settings

KEY WEBSITES

The *Establishing and Maintaining Interagency Information Sharing* bulletin is part of the Juvenile Accountability Incentive Block Grants Best Practices Series produced by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). It details how multi-disciplinary collaboration and information-sharing help at-risk and delinquent juveniles succeed.

The Global Appraisal of Individual Needs (GAIN) Coordinating Center originated in 1993 as a collaborative effort between clinicians, researchers, and policymakers to create a comprehensive and standardized biopsychosocial assessment tool.

OJJDP's Guidelines for Juvenile Information Sharing provides a course of action for key agency and organization stakeholders involved in a state or local effort to implement and sustain juvenile information sharing.

The Illinois Confidentiality Statue (705 ILCS/5-401.5) provides for confidentiality of and protections against self-incrimination in behavioral health assessments. Furthermore, the statue provides that a statement, admission, confession, or incriminating information made by or obtained from a minor related to the offense, as part of any behavioral health screening, assessment, evaluation, or treatment, shall not be admissible as evidence against the minor in the juvenile court proceeding.

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Youth Screening Instrument (MAYSI), which is currently the most widely used mental health screening tool in juvenile justice programs nationwide.

EXAMPLES FROM THE FIELD

The Louisiana Juvenile Justice System Screening, Assessment & Treatment Services Inventory was designed to provide a local planning board with an inventory of the screening and assessment procedures and existing services and programs available in its parish.

Mental Health Screening and Assessment in the Illinois Juvenile Justice System discusses the identification of mental health problems, how mental health screening and assessment practices are being used in the Illinois juvenile justice system, and what mental health screening and assessment tools are available.

The New York State Division of Criminal Justice Services (NYSDCJS) targeted a flyer for its "Diversion of Youth with Co-Occurring Disorders in the Juvenile Justice System" learning collaborative to local teams consisting of members from probation, mental health, and child welfare systems. This one-day training taught local teams about the diversion process.

The New York State Division of Criminal Justice Services created a sample action plan to illustrate what is currently being done in screening, linking youth with treatment services, and what types of evidence-based treatment programs and services are being used.

Ogle County's Juvenile Justice Council is a Models for Change Innovation Brief that details how this county in Illinois improved communication amongst local organizations. The brief discusses how Ogle County opened lines of communication and collaboration with seven different law enforcement agencies and eleven school districts in the county.

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Assorted Resources on Mental Health and Juvenile Justice

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Adolescent Development

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