Mental Health Screening within Juvenile Justice: The Next Frontier

by the National Center for Mental Health
and Juvenile Justice

ModelsforChange
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

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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 (MAYSI-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 (Grisso & 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 MAYSI-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 MAYSI-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

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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 longer-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 in their lives around them may change. 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).
- **Missouri.** Missouri court rules provide that at any time after a delinquency petition has been field, the court may order that the juvenile be examined by a physician, psychiatrist, or psychologist appointed by the court to aid the court in determining the youth's mental health status. When the examination is made prior to the adjudicatory phase of the hearing, the youth has a right not to incriminate him or herself. After a youth is taken into custody, all admissions, confessions, and statements by the youth to the juvenile officer or court personnel, as well as all reports and records of the juvenile court, are not lawful or proper evidence against the youth and cannot be used for any purpose in any civil or criminal proceeding other than in juvenile court proceedings. In *State vs. Ross*, the Missouri appellate court held that the purpose of excluding statements or confessions made to juvenile officers or court personnel (pursuant to section 211,271) is to allow a youth to discuss his/her problems with juvenile personnel in a relaxed and confidential setting without fear in order to aid youth in their rehabilitation.
- **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

Figure 1. Reasons for Implementing Mental Health Screening
Identifying youth who may have mental health problems requiring attention—to avoid those problems getting worse
Reducing the risk of self-harm by identifying youth who present an imminent risk of suicide or self-injury
Identifying youth with potential substance use problems that require immediate attention
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
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
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
Documenting the level of need for mental health services in your program by developing screening-based data on all youth admitted to the program
Fulfilling Federal, state, or local regulatory obligations to identify and respond to serious mental health needs of youth in juvenile justice custody
Avoiding legal liability associated with youths' injurious behaviors that might have been avoided if mental health screening had been in place

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

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

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 MAYSI-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 MAYSI-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

- Exercising added caution to reduce likelihood of potential aggressive behaviors

- Emergency referral to inpatient or outpatient community mental health services

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 MAYSI-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 MAYSI-2 Reference Card to provide guidance to juvenile probation officers who are responsible for administering the MAYSI-2 to youth entering juvenile probation. The Reference Card includes descriptions of each of the MAYSI-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.

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

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

References

Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners. By T. Grisso & L. Underwood (2004). 88 pages. www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf

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

Mental Health Screening and Assessment in Juvenile Justice. By T. Grisso, G. Vincent, & D. Seagrave, 2005. 395 pages. Guilford Press.

- 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 MAYSI-2 to Youth

Introducing Youths to the MAYSI-2

Instruments like the MAYSI-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 MAYSI-2, we recommend that the person giving the MAYSI-2 take one or two minutes to introduce youths to the MAYSI-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 MAYSI-2 results.

Below we provide a list of guidelines describing the types of information that should be included when introducing youths to the MAYSI-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 MAYSI-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 MAYSI-2

Taking the MAYSI-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 MAYSI-2 is routine (like other health and identity questions) and

intended only for the youth's protection. The information is intended to help staff in the program attend to youths' immediate safety and needs.

5. Check for special needs of youth in completing the procedure

Once the youth is ready to take the MAYSI-2, staff should assist the youth in getting started. If the program uses MAYSIWARE, 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 MAYSI-2 Protocol

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

REFERENCE CARD

MAYSI-2 Scale[1]	Description of Scale/Measurement Components[1]	Questions on Scale[1]
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?

MAYSI-2 REFERENCE CARD *continued*

MAYSI-2 Scale	Description of Scale/Measurement Components[1]	Questions on Scale[1]
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	<u>Girls</u> • 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)? <u>Boys</u> • 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)?

Massachusetts Youth Screening Instrument (MAYSI-2)

Before Administering the Instrument	During Administration[1]	After Administration[1]
• **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."[1] • **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 MAYSI 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."	• 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 MAYSI-2, it is helpful to point to the right side of the MAYSI 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 MAYSI-2, please ensure that you have completed the section entitled "TO BE COMPLETED BY STAFF ONLY" prior to 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 MAYSI-2. • Record the scores and conduct appropriate follow-up actions and procedures.

MAYSI-2 Post-Scoring Recommended Services[1]

SECONDARY SCREENING (by Juvenile Justice Staff)	PRIMARY SERVICES (by Mental Health Professionals)
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**	C. Clinical Consultation. **Staff should seek expertise from clinical professionals/mental health professionals who can intervene to provide brief evaluations or emergency care.**
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 MAYSI-2, as well as outside information that contradicts or is consistent with what the youth reported on the instrument. Complete Follow-Up Questionnaire**	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

Suicide Ideation Scale Only

Warning	Both A and B + Either C or D				
Caution	Either A or B or Both				

Angry-Irritable Scale Only

Warning	Greater attention/vigilance by staff recommended for this juvenile due to greater risk of aggression and impulsive acts.

Any Combination of Scales (Except Suicide Ideation Scale)

Warning	Warning	+			Either C or D or Both
Warning	Caution				Both A + B
Warning					Either A or B or Both
Caution	Caution	Caution	Caution	+	Either C or D or Both
Caution	Caution	Caution			Either A or B or Both
Caution	Caution				Either A or B or Both

[1] Excerpts from Massachusetts Youth Screening Instruments, Version 2-Users's Manual & Technical Report, by Thomas Grisso & Richard Barnum, 2006 Revised Edition

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 MAYSI 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 MAYSI 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 MAYSI~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 MAYSI 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 MAYSI~2, the items the youth endorsed will be listed on the individual report.*

1. If a youth scores the area of warning on any MAYSI 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 provides 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 MAYSI 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 MAYSI~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 MAYSI~2 is not a diagnostic tool and must not be used to make a clinical diagnosis. In New Jersey, the MAYSI 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 MAYSI 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 MAYSI~2 may be used to obtain additional services or assistance; however, the MAYSI~2 itself is not shared with others.
3. MAYSI~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 MAYSI~2 may be documented in the juvenile's folder.
4. MAYSI~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 MAYSI~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 MAYSI data and forms*

1. The "MAYSIData" 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 MAYSI.
3. When the password expiration warning for Windows appears, change the password before the expiration date.

01- **At**lantic	12- **Mi**ddlesex
02- **Be**rgen	13- **Mo**nmouth
03- **Bu**rlington	14- **Mo**rris
04- Cam**de**n	15- **Oc**ean
05- Cape May	16- **Pa**ssaic
06- **Cu**mberland	17- **Sa**lem
07- **Es**sex	18- Somerset
08- **Gl**oucester	19- **Su**ssex
09- **Hu**dson	20- **Un**ion
10- Hunterdon	21- **Wa**rren
11- **Me**rcer	

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 MAYSI.
2. Administer the MAYSI to juvenile. The MAYSI~2 folder icon is on the desktop. Upon completion of the MAYSI the youth's individual report will automatically be saved in a notebook file labeled **MAYSI~2**. The MAYSI~2 folder is found in the **c: drive**.
3. To open a resident's individual screening scores, open the **MAYSI~2** folder, found on the desktop. The individual reports will be named by Juvenile ID Number. Example: s**ca041234**

C. *Sending the data-*

1. In the MAYSI~2 folder there is a notebook file named "**MAYSIData**". Before sending the data, right click the file one time and rename the **MAYSIData** 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.

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