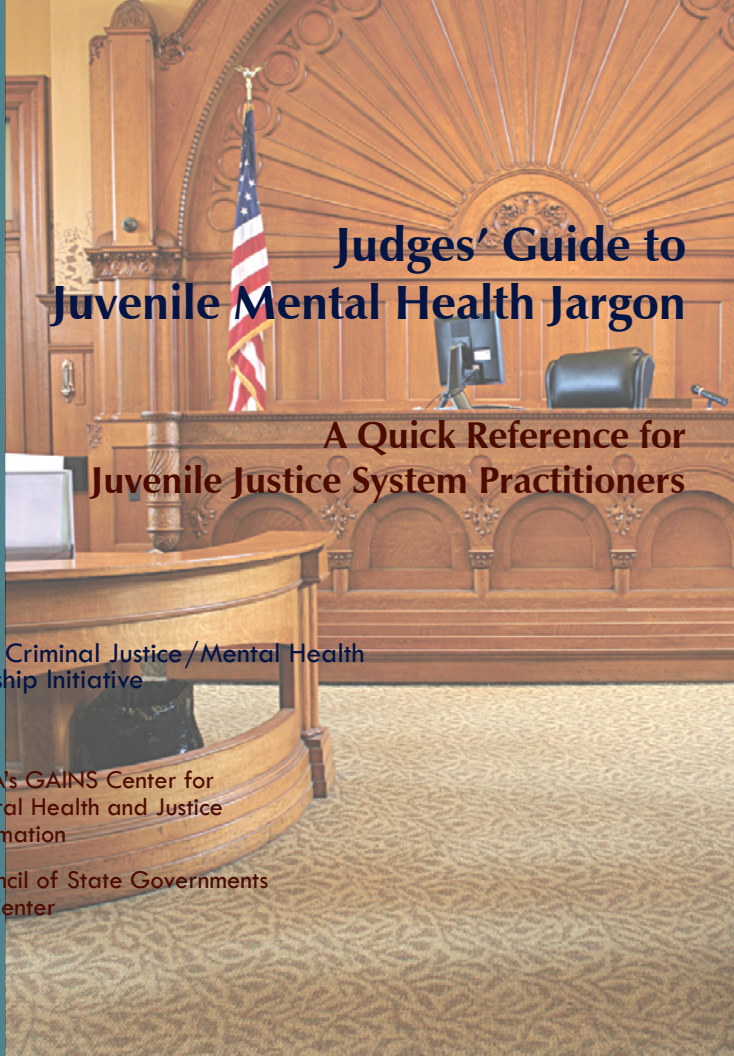

Judges' Guide to Juvenile Mental Health Jargon

A Quick Reference for Juvenile Justice System Practitioners

Judges' Criminal Justice/Mental Health Leadership Initiative

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation

The Council of State Governments Justice Center

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This work was conducted by SAMHSA's GAINS Center, operated by Policy Research Associates, Inc., in collaboration with the CSG Justice Center, and was authored by Thomas Grisso, Ph.D., and Kamlyn Haynes, M.D., of the University of Massachusetts Medical School. Support for this work came from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). The material contained in this publication does not necessarily represent the position of the SAMHSA Center for Mental Health Services, the Council of State Governments, the Justice Center, or the University of Massachusetts Medical School.

Recommended citation: Judges' Criminal Justice/Mental Health Leadership Initiative. (2012). *Judges' guide to juvenile mental health jargon: A quick reference for juvenile justice system practitioners.* Delmar, NY: Policy Research Associates.

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The **Judges' Criminal Justice/Mental Health Leadership Initiative** (JLI) provides support for the expanding leadership role of judges in community and State response strategies to the criminal justice system involvement of people with serious mental illness. The JLI facilitates information sharing and networking opportunities among judges and promotes the growth of judicial leadership. JLI is coordinated by SAMHSA's GAINS Center and the Council of State Governments (CSG) Justice Center's Criminal Justice/Mental Health Consensus Project.◆

Policy Research Associates, Inc. (PRA) has operated SAMHSA's GAINS Center since 1995 as a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system.

The GAINS Center's primary focus is on expanding access to community based services for adults diagnosed with co-occurring mental illness and substance use disorders at all points of contact with the justice system. The Center emphasizes the provision of consultation and technical assistance to help communities achieve integrated systems of mental health and substance abuse services for individuals in contact with the justice system. ◆

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The **Criminal Justice/Mental Health Consensus Project**, coordinated by the Council of State Governments (CSG) Justice Center, is an unprecedented national effort to help local, State, and Federal policymakers and criminal justice and mental health professionals improve the response to people with mental illness who come into contact with the criminal justice system. The landmark *Consensus Project Report* was released in June 2002. Since then, Justice Center staff working on the Consensus Project have supported the implementation of practical, flexible criminal justice/mental health strategies through on-site technical assistance; the dissemination of information about programs, research, and policy developments in the field; continued development of policy recommendations; and educational presentations. ◆

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How to Use This Guide

The *Judges' Guide to Juvenile Mental Health Jargon* is intended to serve as a resource for judges who hear juvenile cases and who are involved in juvenile justice/mental health initiatives in their communities. The guide is divided into nine parts: Acronyms, Screening and Assessment, Treatment and Supports, Diagnoses, Medications, Concepts, Frequently Asked Questions, Resources, and Index. Endnotes are located at the back of the Index tab. Each section consists of entries that provide a concise overview and, when available, suggest where to go within the guide and on the Internet for more information. The *Judges' Guide to Juvenile Mental Health Jargon* is intended for informational use only. Diagnoses, assessments, and treatment recommendations in individual cases can be made only by mental health professionals with direct knowledge of the youth for whom services are being considered.

Acronyms

ADHD **Attention-Deficit/Hyperactivity Disorder**

Go To: Diagnoses, p. 45

ASD **Autism Spectrum Disorder**

Go To: Diagnoses, p. 50

BBBS **Big Brothers/Big Sisters**

Go To: Treatment and Supports, p. 32

CAFAS **Child and Adolescent Functional Assessment Scale**

Go To: Screening and Assessment, p. 21

CANS-MH **Child and Adolescent Needs and Strengths – Mental Health**

Go To: Screening and Assessment, p. 25

CBCL **Child Behavior Checklist**

Go To: Screening and Assessment, p. 22

CBT **Cognitive Behavior Therapy**

Go To: Treatment and Supports, p. 32

CD	**Conduct Disorder**
	Go To: Diagnoses, p. 44
CJCA	**Council of Juvenile Corrections Administrators**
	Go To: Resources, p. 100
DBT	**Dialectical Behavior Therapy**
	Go To: Treatment and Supports, p. 33
DSM	**Diagnostic and Statistical Manual of Mental Disorders**
	Go To: Diagnoses, p, 41
	Go To: Frequently Asked Questions, p. 89
DMC	**Disproportionate Minority Contact**
	Go To: Concepts, p. 79
EBP	**Evidence-Based Practice**
	Go To: Concepts, p. 81
FFT	**Functional Family Therapy**
	Go To: Treatment and Supports, p. 34
GAF	**Global Assessment of Functioning**
	Go To: Screening and Assessment, p. 29

GAIN **Global Appraisal of Individual Needs**

Go To: Screening and Assessment, p. 25

GAIN-SS **Global Appraisal of Individual Needs – Short Screener**

Go To: Screening and Assessment, p. 18

IEP **Individualized Education Program**

Go To: Concepts, p. 82

JAC **Juvenile Assessment Center**

Go To: Screening and Assessment, p. 16

JDAI **Juvenile Detention Alternatives Initiative**

Go To: Resources, p. 101

JUMP **Juvenile Mentoring Program**

Go To: Treatment and Supports, p. 34

JMHC **Juvenile Mental Health Court**

Go To: Concepts, p. 83

MACI **Millon Adolescent Clinical Inventory**

Go To: Screening and Assessment, p. 22

MAYSI-2	**Massachusetts Youth Screening Instrument – Second Version** *Go To: Screening and Assessment, p. 19*
MFC	**Models for Change** *Go To: Resources, p. 101*
MMPI-A	**Minnesota Multiphasic Personality Inventory – Adolescents** *Go To: Screening and Assessment, p. 23*
MSE	**Mental Status Examination** *Go To: Screening and Assessment, p. 30*
MST	**Multisystemic Therapy** *Go To: Treatment and Supports, p. 35*
MTFC	**Multidimensional Treatment Foster Care** *Go To: Treatment and Supports, p. 34*
NCMHJJ	**National Center for Mental Health and Juvenile Justice** *Go To: Resources, p. 99*

ODD **Oppositional Defiant Disorder**

Go To: Diagnoses, p. 44

OJJDP **Office of Juvenile Justice and Delinquency Prevention**

Go To: Resources, p. 98

PCL:YV **Psychopathy Checklist: Youth Version**

Go To: Screening and Assessment, p. 26

PTSD **Posttraumatic Stress Disorder**

Go To: Diagnoses, p. 47

SAMHSA **Substance Abuse and Mental Health Services Administration**

Go To: Resources, p. 98

SASSI-A2 **Substance Abuse Subtle Screeing Inventory – Adolescents 2**

Go To: Screening and Assessment, p. 20

SAVRY **Structured Assessment of Violence Risk in Youth**

Go To: Screening and Assessment, p. 27

SED	**Serious Emotional Disturbance** *Go To: Frequently Asked Questions, p. 88*
SMI	**Serious Mental Illness** *Go To: Frequently Asked Questions, p. 88*
SSDI	**Social Security Disability Insurance** *Go To: Treatment and Supports, p. 38*
SSI	**Supplemental Security Income** *Go To: Treatment, p. 39*
SSRI	**Selective Serotonin Reuptake Inhibitors** *Go To: Medications, p. 58*
TSCC	**Trauma Symptom Checklist for Children** *Go To: Screening and Assessment, p. 20*
TD	**Tardive Dyskinesia** *Go To: Medications, p. 62*
V-DISC	**Voice-Diagnostic Interview Schedule for Children** *Go To: Screening and Assessment, p. 23*

YASI **Youth Assessment and Screening Interview**

Go To: Screening and Assessment, p. 27

YLS/CMI **Youth Level of Services/Case Management Inventory**

Go To: Screening and Assessment, p. 28

Screening and Assessment

Screening and assessment are two different ways to obtain mental health and substance use information about youth. *Screening* is typically a brief procedure, performed by non-mental-health personnel with in-service training, and employed with all youth at some specific point but generally at an early stage in juvenile justice processing. Screening serves to triage, or classify, youth for further processing, but it is not intended to be diagnostic or to determine long-range treatment plans. Based on the results of screening, some youth may be referred for assessment. *Assessment* is a more individualized and comprehensive evaluation, employed selectively with only some youth, and administered by qualified professionals. Assessment assists juvenile justice decision-makers in addressing forensic questions (e.g., competence to stand trial) and deciding on treatment and placement plans. Screening and assessment occur in a number of juvenile justice settings.

Juvenile Assessment Center (JAC)

Some communities have special centers where law enforcement and probation officers (and sometimes parents) can obtain evaluations of youths' mental health needs when they are apprehended and before they are referred to the juvenile court.

Detention Intake

Pretrial detention centers typically administer mental health and substance use screening tools within the first few hours after intake. This helps to identify youth who may be at risk of suicide or who need immediate (emergency) mental health consultation because of an acute condition.

Intake Probation Departments

Intake probation officers often are responsible for collecting initial information about a youth so that they can respond to the court's request for background information on a youth as well as potential placement questions at later adjudication of the case.

They often use screening tools when seeing youth for intake.

Court Clinical Services

Most juvenile courts have a method for obtaining forensic and mental health assessments for use in preliminary or adjudication hearings. Examiners may work in a court clinic as part of the court itself, but more often juvenile courts engage private practitioners or child community mental health professionals for these evaluations. Court clinics can also provide assessments in specialty juvenile courts, such as mental health courts or drug courts.

Corrections Reception/Assessment Centers

Many states maintain reception/assessment centers where youth are received for assessment after they are adjudicated and committed to the state's juvenile corrections agency. Mental health and substance use assessments in these settings focus on identifying appropriate treatment options and level of security required during

treatment. Management of youth focuses on mental health and criminal justice outcomes.

Screening Tools (mental health, substance use)

A number of brief screening tools (5–10 minutes) have been developed for use at first interview or admission to a facility. They aim to identify youth at the moment of intake who might require immediate attention for substance use and mental health conditions (including suicide risk). They do not provide diagnoses and should not be used for long-range treatment planning. They can be given by non-mental-health staff with minimal in-service training. They all rely on youths' own answers to questions about behaviors, thoughts, and feelings.

Global Appraisal of Individual Needs – Short Screener (GAIN-SS)

The GAIN-SS, a paper-and-pencil tool, consists of 20 items asking youth about their behaviors, thoughts, or feelings. Youth are asked to report these matters for the past month, 2–12 months ago, and prior to a year ago. These scores contribute to four scales: Internal Mental Distress, Behavior

Complexity, Substance Problem, and Crime/Violence. *www.chestnut.org/li/gain/*

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

The MAYSI-2 asks youth to report yes/no to 52 items regarding their recent behaviors, thoughts, and feelings. The items contribute to scores on seven scales: Alcohol/Drug Use, Angry-Irritable, Depressed-Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbance, and Traumatic Experiences. Scores above a cut-off on any given scale indicate probable clinical significance in that area. The tool can be administered by paper and pencil or with MAYSIWARE, a computer software program that allows the youth to hear the items by headphone and respond on screen. The MAYSI-2 is used statewide in juvenile detention or corrections intake offices in over two-thirds of states. *www.maysiware.com*

Substance Abuse Subtle Screening Inventory – Adolescent 2 (SASSI-A2)

The SASSI-A2 is a paper-and-pencil tool with 100 questions that ask youth about symptoms, attitudes, and behaviors related to drug and alcohol use. Some of the questions ("subtle") are not obvious in their relation to substance use; reponses to these questions indicate to the examiner when a youth may be avoiding responding honestly to the more obvious drug use items. Scores contribute to several scales that lead to classification of the probability the juveniles have substance use problems. *www.sassi.com/products/*

Trauma Symptom Checklist for Children (TSCC)

The TSCC is a 54-item paper-and-pencil tool that asks youth about emotions, behaviors, and thoughts that may be the result of trauma exposure. Several scales (e.g., Anger, Anxiety, Posttraumatic Stress) assess symptoms, while two scales assess whether

the youth is under-reporting or over-reporting symptoms. *www.johnbriere.com/tscc*

Assessment Tools (mental health, substance use)

A large number of assessment tools have been tested and found to be reliable and are available for comprehensive evaluation of youths' mental health and substance use problems and diagnoses. These tools require special training and are employed primarily by child psychologists and psychiatrists who are qualified to interpret them. The following are a few common tools.

Child and Adolescent Functional Assessment Scale (CAFAS)

The CAFAS guides examiners in organizing information collected on a youth within eight youth problem areas (three of which pertain to mental health or substance use problems) and two parent problem areas. It also provides for ratings of level of impairment in these areas, which may be helpful in assisting examiners to construct meaningful treatment or rehabilitation plans. *www.fasoutcomes.com*

Child Behavior Checklist (CBCL)

The CBCL is a paper-and-pencil tool that has three basic forms for completion by parents, teachers, or youth self-report. It assesses problems of an internalizing type (involving thoughts and feelings) and problems of an externalizing type (behavior problems, especially aggressive behavior). This tool is also known as the Achenbach System of Empirically Based Assessment (ASEBA). *www.aseba.com*

Millon Adolescent Clinical Inventory (MACI)

The MACI is a paper-and-pencil tool with items answered by the youth. It has a number of scales describing two broad classes of characteristics: personality traits (e.g., Introversive; Conforming) and clinical symptoms (e.g., Substance Abuse Proneness; Suicidal Tendencies; Anxiety Feelings). The results must be interpreted by a mental health professional trained to diagnose and

assess children's mental disorders. *www.millon.net/instruments/MACI.htm*

Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)

The MMPI-A consists of ten scales describing clinical disorders as well as a large number of scales useful for identifying specific problem areas. It has 478 items and can be administered to the youth as a paper-and-pencil task or by computer. The results must be interpreted by a mental health professional trained to diagnose and assess child mental disorders. *www.pearsonassessments.com/mmpi_a.aspx*

Voice Diagnostic Interview Schedule for Children (V-DISC)

The V-DISC provides probable diagnoses of adolescents' mental disorders. Its questions are computer administered with headphones and on screen, and are answered by youth on keyboard. The program leads the youth through a series of branching questions that result in a provisional diagnosis. The tool

can be administered by non-clinicians with in-service training, but diagnoses should be confirmed by trained mental health professionals qualified to make diagnostic interpretations. *www.promotementalhealth.org/voicedisc.htm*

Needs, Risk, and Case Management Tools

A number of assessment tools have been developed to identify youths' needs related to their delinquency and risk of aggression or recidivism. Sometimes these are called criminogenic needs, meaning that they are known to play a role in juveniles' illegal behaviors. These tools provide guidance for case management and rehabilitation/treatment planning. They can be administered by trained mental health professionals or by juvenile justice personnel (e.g., probation officers) who receive special in-service training. These are not mental health assessment tools and they do not provide diagnostic information about mental disorders. But most of them include one or two brief scales that can alert users that a youth may need further assessment for mental health and substance use problems.

Child and Adolescent Needs and Strengths – Mental Health (CANS-MH)

The CANS-MH (and the CANS-JJ for juvenile justice) provides child workers an interview process that structures information about adolescents' needs and strengths (47 entries) into six broad psychological or social areas. One of these areas is called Problem Presentation and refers specifically to symptoms of various mental health problems and substance use. The CANS provides information for treatment planning and improves communication among agencies. *www.praedfoundation.org/About%20the%20CANS.html*

Global Appraisal of Individual Needs (GAIN)

The GAIN offers an interview process that helps mental health personnel to structure information about adolescents' needs into eight broad areas. One of these areas is called Mental and Emotional Health. Information is coded for recent needs and for lifetime

needs. It is used to obtain information related to treatment planning and to facilitate communication among child-serving agencies. *www.chestnut.org/li/gain/*

Psychopathy Checklist: Youth Version (PCL:YV)

The PCL:YV assesses certain characteristics associated with psychopathy. Psychopathy refers to a personality type (not listed in the *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition, text revision) that finds satisfaction in antisocial behaviors and lacks feelings of shame, guilt, or remorse. The clinician using the PCL:YV employs past records and sometimes interviews to obtain information to complete a scored checklist of factors that relate to this personality type. The Youth Version has been shown to help assess youths' current risk of re-offending, but research has not determined that the scores can predict whether a youth will develop long-term criminal behavior. *www.hare.org/scales/pclyv.html*

Structured Assessment of Violence Risk in Youth (SAVRY)

The SAVRY assesses the level of risk of violence that a youth poses at the time of the evaluation. Examiners use information from interviews and records to rate youth on 24 items, or factors, known to be associated with risk of future aggression. The items are divided into three categories (one of which includes clinical factors). The SAVRY does not produce a risk score, but assists professionals in making their own clinical judgment about a youth's low, medium, or high risk of future aggression. It also helps to identify areas to target for reduction of risk of future aggression. *www.savryrisk.wordpress.com*

Youth Assessment and Screening Instrument (YASI)

The YASI is an assessment tool (despite "screening" in its title) that provides: (a) level of risk of re-offending, and (b) the youth's needs that can become a focus of treatment/ rehabilitation programming. Caseworkers

use interviews and records to score the youth on items in ten needs domains. Two of these domains are Mental Health and Alcohol/ Drugs. This assists caseworkers in arriving at level of risk of recidivism and a description of the youth's needs that can guide case planning and management. *www.orbispartners.com/index.php/assessment/yasi/*

Youth Level of Services/Case Management Inventory (YLS/CMI

The YLS/CMI provides (a) a level of risk of re-offending, and (b) the youth's needs that can become a focus of treatment/ rehabilitation programming. It allows trained caseworkers to use information from interviews and records to score youth on items in eight needs domains. Two of those domains are Substance Abuse and Personality/Behavior (which includes a few mental health symptoms). The tool offers a level of risk of future recidivism, as well as an assessment of needs that can guide case planning and management. *www.mhs.com/product.aspx?gr=saf&prod=yls-cmi&id=overview*

Clinicians' Diagnostic Aids

Mental health clinicians often use specific clinical methods to assist them in diagnostic evaluations. These methods are not assessment or screening measures. They are structured procedures to improve the quality of information that clinicians gather.

Global Assessment of Functioning (GAF)

The GAF is included in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, text revision (DSM). It is used with both adolescents and adults. It provides clinicians with a way to rate the degree to which a person's disorder impairs functioning. GAF scores range from 1 (most impaired) to 100 (no impairment). DSM provides clinicians with specific examples of degrees of impairment at 10-point intervals across this 100-point range. It is especially useful when clinicians intend to reassess a person at various stages of treatment to identify degree of improvement (or deterioration) in everyday functioning in

relation to changes in symptoms. *www.psyweb.com/DSM_IV/jsp/Axis _V.jsp*

Mental Status Examination (MSE)

The MSE is a technique (not a measure or psychological test) used by psychiatrists and clinical psychologists to improve the reliability of information gathered from patients during interview and observation. Information is collected in 10 domains (some versions vary slightly in the number and type of domains): Appearance, Movement and Behavior, Affect, Mood, Speech, Thought Process, Thought Content, Cognition (e.g., memory), Insight, and Judgment. Obtaining information in a standard set of areas across all cases improves a clinician's thoroughness in exploring a youth's symptoms, improves the diagnostic process, and improves comparisons of a youth's symptoms at different times in the treatment process.

Treatment and Supports

Juvenile justice agencies that offer treatment programs for youth with mental health and substance use problems are encouraged to use evidence-based practices. A treatment method is said to be evidence based when (a) it employs a specific theory and set of procedures described in a manual that allows them to be used uniformly wherever the treatment is provided, and (b) a sufficient body of scientific research has shown that the method has positive effects. (See Concepts section for a more detailed description of evidence-based practices.)

Some youth have acute or persistent mental health problems that require psychiatric hospitalization or out-patient/daycare mental health services. Often these are provided outside the juvenile justice system. Youth with less severe mental health problems often can benefit from programs that incorporate evidence-based practices for delinquency reduction that are sensitive to their mental health needs. Those programs are described below.

Delinquency Reduction Programs Responsive to Mental Health Problems

Big Brothers and Big Sisters of America (BBBS)

This program matches an adult mentor volunteer with a youth. They meet together several times a month for three to five hours at each meeting. The primary purpose is to encourage the development of a caring relationship between mentor and youth. Numerous research studies have demonstrated the effectiveness of this program for delinquency prevention or reduction. *www.bbbs.org*

Cognitive Behavior Therapy (CBT)

Cognitive Behavior Therapy is a general term for a family of specific therapies. This form of therapy presumes that how we think about or interpret events that happen to us influences our feelings and behavior. Therapies based on the principles of Cognitive Behavior Therapy seek to change youths' behavior by giving them more effective ways of thinking

about or interpreting life events. Cognitive Behavior Therapies have demonstrated substantial improvement on average for youth engaged in this type of therapy, which may be individual or in group settings. It is amenable to meeting the needs of youth with mental health problems in juvenile justice programs. *www.nacbt.org*

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy is a form of Cognitive Behavior Therapy that has been adapted for use with delinquent youth who have various mental health problems. Juvenile justice personnel trained in Dialectical Behavior Therapy use exercises with youth to help them interpret events around them in ways that improve their ability to respond adaptively, rather than harmfully. The focus is on reducing emotional dysregulation (reacting to situations emotionally or on impulse). *www.cdcbt.com/problemsadolescents*

Functional Family Therapy (FFT)

Functional Family Therapy is a short-term intervention program that involves working directly with families of youth with conduct, mental health, and substance use problems. It assesses strengths and needs of youth and their families, and employs strategies for improving family functioning. This improvement typically results in better functioning for youth, as well as reduction in offending. *www.fftinc.com*

Juvenile Mentoring Program (JUMP)

Juvenile Mentoring Program refers to a collection of programs associated with the Office of Juvenile Justice and Delinquency Prevention that focus on adult mentoring of youth with conduct, mental health, or substance use problems. *www.ojjdp.gov/pubs/96kit/jump*

Multidimensional Treatment Foster Care (MTFC)

Multidimensional Treatment Foster Care is a systematic program for caretakers of youth

in out-of-home (e.g., temporary foster home) placement. It seeks to decrease problem behaviors and increase prosocial behaviors of youth. Special emphasis is placed on providing fair and consistent limits, setting consistent consequences for rule breaking, establishing supportive relationships with at least one mentoring adult, and improving access to community mental health and educational services. *www.mtfc.com*

Multisystemic Therapy (MST)

Multisystemic Therapy is a family-based treatment program that takes place in the youth's home and involves the whole family. Multisystemic Therapy is not built around therapy sessions. Instead, a practitioner is a daily presence in the family, providing intensive, short-term (typically four months), direct assistance. The objectives are to improve the youth's and family's network to community services and to help them develop coping strategies.*www.mstservices.com*

Multisystemic Therapy with Psychiatric Supports (MST-Psychiatric)

A special form of MST, called MST-Psychiatric, uses the MST family-based concepts but includes access to a team of professionals and caseworkers who are specifically trained in responding to needs of youth with serious or chronic mental health problems.

Substance Use Programs

The above programs generally have been shown to be of value for youth with co-occurring substance use and mental health problems. The programs described below focus specifically on substance abuse reduction in adolescents.

Project SUCCESS

SUCCESS stands for Schools Using Coordinated Community Efforts to Strengthen Students. It is a school-based intervention, operated by counselors placed in the schools. It is designed to prevent and

reduce substance abuse among high-risk youth. The program teaches youth skills to resist peer influences with regard to drug use and increase social competency. *www.promoteprevent.org/publications/ebi.../project-success*

Motivational Enhancement Therapy (MET)

Motivational Enhancement Therapy is built on the principles of Motivational Interviewing (see Concepts). It was developed for use with problem drinkers, but has been adapted for use with youth abusing drugs as well. The objective is to enhance a youth's committment to substance use reduction.

Supports

Medicaid

The Centers for Medicare and Medicaid Services is the Federal agency that administers Medicaid. It provides medical benefits to some people with a low income who have inadequate or no medical insurance. Medicaid often serves as a source

of support for children and adolescents in need of mental health services.

Children's Health Insurance Program (CHIP)

The Centers for Medicare and Medicaid Services administers the Children's Health Insurance Program. Children began receiving insurance through CHIP in 1997, and the program helped States expand health care coverage to over 5 million of the nation's uninsured children. CHIP is jointly financed by the Federal and State governments and is administered by the States. The Federal government establishes general guidelines, but eligibility requirements for Medicaid vary from State to State.

Social Security Disability Insurance (SSDI)

Administered by the Federal Social Security Administration, Social Security Disability Insurance provides wage replacement income

for people with an eligible disability who have paid FICA taxes. When a primary wage earner becomes disabled or dies, the program provides benefits to family members, including unmarried children under age 18, 18–19 if attending primary or secondary school full time, and 18 or older if the adult child meets the definition of disability for adults and the onset of disability was before age 22.

Supplemental Security Income (SSI)

Supplemental Security Income is an income supplement program of the Federal Social Security Administration. It is funded by general tax revenues to help eligible low-income people who are elderly or who have disabilities. The program provides income to meet basic needs.

Diagnoses[1]

Psychiatric diagnoses are more difficult to make with confidence for youth than for adults. Adolescents' developmental progress means that they change more from year to year than do adults. Moreover, some behaviors that are abnormal and would be symptoms of disorder at one age are normal at other ages. The tendency of adolescents to change moods rapidly, and to experiment with various behaviors as they form their identity, also make diagnosis of disorders more difficult.

The system for diagnosing mental disorders in youth is described thoroughly in the *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition, text revision), by the American Psychiatric Association (2000). Each diagnostic category requires the presence of specific behaviors, feelings, thoughts, emotions, and sometimes factors of past history of the youth. The following descriptions are summarized from the above manual.

The diagnoses below are listed in two groups: Axis I disorders and Axis II disorders. (For explanation, see Frequently Asked Questions.) Within these two

broad categories, diagnoses are listed here in order of greatest to least prevalence in juvenile justice populations.

Axis I Disorders

Substance-Related Disorders

Disorders related to substance use are separated into the problematic effects that substances have on a person. Some disorders focus on current effects and others on chronic effects. There are separate diagnoses associated with a wide range of specific substances. There are three main substance-related diagnoses:

Substance Intoxication

Criteria focus on a person's present condition.

Substance Abuse

Describes a pattern of use lasting at least a year that continues despite significant impairment or distress. This must manifest by failure to fulfill obligations at school, placing

self and others at risk by engaging in physically dangerous activities, recurrent legal problems, and/or use despite recurrent interpersonal problems.

Substance Dependence

Diagnostic criteria focus on physical changes in the user's body that create a need for more of a substance to attain the same high (tolerance) — or withdrawal symptoms when the substance is unavailable.

Disruptive Behavior Disorders

Within the section of the DSM called Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence, there is a cluster of diagnoses united under the heading Disruptive Behavior Disorders. These disorders feature recurring patterns of potentially harmful behavior. Each diagnosis is characterized by a pattern of repetitive behavior lasting various lengths of time. The fact that a youth has behaved in a disruptive

way for a short period of time is not sufficient to reach these diagnoses.

Oppositional Defiant Disorder (ODD)

A pattern of behavior that is clearly more intense than is typical for same-aged adolescents and causes impairment in everyday functioning. For at least six months, the youth has been hostile and negativistic; loses his or her temper easily; argues with adults sometimes for the sake of arguing; deliberately annoys others and seems to enjoy it; externalizes blame; appears spiteful and vindictive.

Conduct Disorder (CD)

Diagnosed after at least twelve months during which the youth exhibits repeated violation of basic rights of others or of major age-appropriate societal norms or rules. Specific repeated behaviors

in the criteria for diagnosis include aggression to people and/or animals, destruction of property, deceitfulness or theft, and serious violations of rules.

Attention-Deficit/Hyperactivity Disorder (ADHD)

A persistent pattern of inattention or hyperactive-impulsive behavior, observed from before age 7. There are three subtypes of ADHD: Inattention, Hyperactivity, and Impulsivity.

Anxiety Disorders

The following are a few of the more common anxiety disorders in childhood and adolescence. They have common symptoms associated with excessive worry or fear.

Separation Anxiety Disorder
Involves excessive and age-inappropriate anxiety concerning separation from home or individuals to whom youth is attached.

Obsessive-Compulsive Disorder (OCD)

Involves worries and thoughts that come to youth intrusively (obsessions) and repetitive activities that youth engage in to relieve their anxiety (compulsions). May make result in difficulty following instructions.

Generalized Anxiety Disorder
Characterized by excessive anxiety about many events and/or activities, and has been going on for at least six months.

Panic Disorder

Identified by recurrent discrete episodes of intense fear or discomfort during which multiple physical manifestations of anxiety are present.

Posttraumatic Stress Disorder (PTSD)

Disorder centering on an event the youth witnessed or experienced that involved threatened or actual serious injury to self or threatened or actual serious injury or death to another. Reactions often include re-experiencing the traumatic event, and/or persistent avoidance of stimuli that remind the person of the traumatic event. (Some clinicians believe that another diagnosis, Complex Trauma, better explains youths' traumatic stress reactions than does PTSD.)

Affective Disorders

These disorders involve changes in mood states that lead to functional impairment. They differ in duration and severity of symptoms that describe the diagnosis.

Unipolar Depression

Low (depressed) mood or irritability (touchy, angry mood) for a two-week

period during which either the person or others notice a marked change in typical mood state.

Dysthymia

At least one year of depressed mood or irritability on more days than not, resulting in clinically significant impairment or distress. Associated symptoms include poor appetite or overeating, insomnia or excessive sleeping, low self-esteem.

Bipolar Disorder

Discrete episodes of alternating moods from the lows of a depressive episode (described above) to the highs of mania. Youth with this diagnosis frequently present as having rapid and severe cycling between distinct episodes of high and low mood fluctuation, or they might present in a mixed state that produces chronic irritability. Experts have not yet reached consensus

as to whether youth with chronic irritability and clear mood swings, but without mania, should be classified as having bipolar disorder, yet many youth with chronic anger issues are being diagnosed with bipolar disorder.

Psychotic Disorders

This group of diagnoses describes the experience of not being grounded in reality. Brief psychotic reaction, schizophrenia, schizophreniform disorder, and schizoaffective disorder fall into this category. They differ mostly in how long symptoms have been experienced and what associated symptoms are present. Common symptoms include delusions (fixed false beliefs), hallucinations, and disorganized or incoherent speech. Sometimes youth with non-psychotic disorders (e.g., some cases of bipolar disorder) have symptoms like these, creating difficulty in diagnosis.

Asperger's Syndrome and other Autism Spectrum Disorders (ASD)

These refer to a cluster of disorders that include qualitative impairment in social interactions, best described by marked impairment in the use of nonverbal behaviors (e.g., eye contact, facial expressions, body postures) and repetitive and stereotyped patterns of behavior (e.g., intense preoccupation with restricted interests, performing routines or rituals, preoccupation with parts of objects). Most youth with a diagnosis of Asperger's syndrome have good development of intelligence and language.

Other Axis I Disorders

A number of other Axis I disorders that arise in delinquency cases might not be considered serious mental illness, but may have significant implications for treatment planning.

Adjustment Disorder

After a significant stress event in a youth's life, a distinct change (from

past observations of the youth) in mood, anxiety and/or conduct.

Elimination Disorders

Elimination of waste into inappropriate places past the age when most children are toilet trained.

Enuresis

Involuntary or volitional elimination of urine into bed or clothing after the age of 5 (at least twice a week for three consecutive months).

Encopresis

Involuntary or volitional elimination of feces into bed or clothing after the age of 4 (at least once a month for three consecutive months).

Tic Disorders

A variety of disorders characterized by sudden, rapid, recurrent,

nonrhythmic, stereotyped motor movements or vocalizations. The disorders (e.g., Tourette's disorder, transient tic disorder) differ in length of time tics have occurred and age of onset.

Learning and Communication Disorders

Many kinds, specific to various disabilities that impair a youth's capacity to acquire (receptive) or communicate (expressive) information.

Axis II Disorders – Personality Disorders

Mental Retardation

Many advocacy groups today prefer the terms developmental disability or intellectual disability. Mental retardation involves significant limitations in both intellectual functioning (reasoning, learning, problem solving) and adaptive behavior. Diagnosis requires both an intelligence test score below 70 and evidence of significant deficits in

adaptive functioning. Scores just above 70 may sometimes be referred to as borderline intellectual functioning.

Personality Disorders

Formerly, personality disorders were reserved for adults, but sometimes clinicians find that application to adolescents is warranted (especially in older adolescents). These disorders (e.g., paranoid personality, borderline personality, obsessive compulsive personality) all describe an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the youth's culture. The pattern leads to clinically significant distress and impairment in major areas of life.

Medications

Medications commonly used in child psychiatry can be described in two broad categories: Medications for Mood Disorders and Aggression, and Medications for Attention-Deficit/Hyperactivity Disorder.

Medications Commonly Used for Mood Disorders, Psychotic Disorders, Side Effects, and Aggression Control

The table below provides a list of medications used to help stabilize a youth's mood and help with aggression. They can be grouped broadly as mood stabilizers, antidepressants and anti-anxiety medications, and antipsychotic medications. Sometimes youth are on a combination of agents to help control these symptoms. Most medications offer a good probability that youth will experience a reduction in symptoms, but the medications may also cause adverse side effects. The unpleasant side effects can create difficulties with compliance, with youth going on and off their medications.

Mood Stabilizers

Mood stabilizers are used to treat mood disorders, such as bipolar disorder, but also are often prescribed for anxiety disorders.

Lithium

The oldest mood-stabilizing medication and the gold standard in this category. It requires blood monitoring and may cause an increase in weight, hand tremors, kidney damage, increased thirst and urination, cognitive dulling, worsening acne, and drowsiness.

Anti-Seizure Medications

Valproic acid (e.g., Depakote) and carbamazepine (e.g., Carbatrol, Tegretol) are anti-seizure medications that can help stabilize mood and help youth control aggression. While each has a unique side effect profile, all can potentially change liver functioning and blood counts

or cause drowsiness, gastrointestinal complaints, hand tremor, weight gain, and unsteadiness of gait.

Oxcarbazepine (e.g., Trileptal) is a newer agent much like carbamazapine, with fewer side effects though less proven efficacy for mood stabilization. Lamotrigine (e.g., Lamictal) does not usually cause weight gain but can cause an allergic reaction that starts as a body rash and can lead to death if medical treatment is not provided.

Adrenergic Agents

Medications such as clonidine are used in psychiatry to reduce aggression. They were originally developed for use in the treatment of various cardiac ailments. Side effects include sedation, high or low blood pressure, depression, and irritability.

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Sleep Aides

Sleep aides (e.g., Ambien, Lunesta) are used infrequently but can help a youth regulate sleep cycle, which is frequently the most troubling symptom of a mood disorder. Side effects include bizarre and vivid dreams, potential for addiction, and excessive sedation.

Antidepressants and Anti-Anxiety Medications

Selective Serotonin Reuptake Inhibitors (SSRI)

Generally well-tolerated medications (e.g., Zoloft) for both anxiety and depression. Side effects can include worsening anxiety, insomnia, weight gain or loss, restlessness, nausea, mood flattening. ***There is an increased risk of talking about suicide and self-harm in children and adolescents taking these medications.***

Benzodiazepines

Used for anxiety disorders and can be quite helpful for people with panic disorders, posttraumatic stress disorder, and other anxiety disorders. However, they have a street value and can be addicting for certain individuals. They also can cause sedation, impaired motor function, irritability and paradoxical agitation.

Adrenergic Agents

May be used to treat anxiety and some intrusive symptoms of posttraumatic stress disorder.

Tri-Cyclic Anti-Depressants

Commonly used before SSRIs and other agents were available. They are used now when patients have difficulties taking SSRIs. Side effects are typically more troublesome and can include weight gain, sedation, dry mouth, blurry vision, and constipation. They are potentially

lethal when taken as an overdose and can have serious cardiac complications especially in children and adolescents.

Monoamine Oxidase Inhibitors

Older antidepressants that are almost never used in children and adolescents. Dietary restrictions must be followed; failure to do so can cause a potentially lethal hypertensive crisis.

Other (not SSRI)

A set of anti-depressant and anti-anxiety medications outside of a class. Their side effects are relatively mild, but can be troubling. For example, buproprion (Wellbutrin) lowers seizure threshold more than other anti-depressants; mirtazapine (Remeron) can cause weight gain in some individuals; and venlafaxine (Effexor) can increase blood pressure.

Antipsychotic Medications

Youth sometimes present with psychosis, becoming paranoid, or having fixed false beliefs called delusions. Antipsychotic medications are used for these conditions.

Atypical Antipsychotics

Also referred to as second-generation antipsychotics, these are used with youth much more frequently than the older typical antipsychotics because they have a different side effect profile and most have far fewer muscle-movement side effects. In addition to alleviating the symptoms of psychosis, these medications may calm a youth down, help him or her experience less anger, contain his or her aggression, and feel more in control of his or her moods. Side effects include metabolic side effects that can cause rapid and untenable weight gain, endocrine changes that can lead to the development

of diabetes mellitus, changes in a girl's menstrual cycle, and enlarged breasts in both girls and boys. Some can cause changes in the blood, such as lowering of blood counts to dangerous levels.

Typical Antipsychotics

The older, first-generation antipsychotics are used when either symptoms do not respond to the atypical antipsychotics or side effects prohibit continued use. Typical antipsychotics have some of the side effects listed for the atypical antipsychotics and a number of additional side effects. One of these is tardive dyskinesia, which involves abnormal involuntary movements, slowed muscle movement, or excessive and restless muscle movement. A painful stiffening of the muscles is also possible and can be a symptom of neuroleptic malignant syndrome, which if untreated can lead to death.

Table of Medications Commonly Used for Mood Disorders, Psychotic Disorders, Side Effects, and Aggression Control

The following table is arranged with reference to generic and brand names of medications. Generic names are the general names of the medications, while brand names are the commercial names given to them by pharmaceutical companies. Mental health clinicians will use either the generic or the brand name to refer to a youth's medication; there is no particular convention concerning which type of name they will use. The medications are listed in the following way:

Column 1: All of the names by which medications can be known (generic and brand names) in alphabetical order

Column 2: Whether the name in Column 1 is the brand name or generic name

Column 3: The other name (brand or generic) by which this drug is known.

Column 4: The type of medication

Thus, for the first entry, Abilify is the brand name of a generic medication called aripiprazole, which is an atypical antipsychotic medication.

Medications Commonly Used for Mood Disorders, Psychotic Disorders, Side Effects, and Aggression Control

Name	Brand / Generic	AKA	Type of Medication	Pg.
Abilify	Brand	Aripiprazole	Atypical Antipsychotic	62
Alprazolam	Generic	Xanax, Intensol, Niravam	Benzodiazepine	59
Ambien	Brand	Zolpidem	Sleep Aide	58
Amitriptyline	Generic	Elavil	TCA	
Amoxapine	Generic	Asendin	TCA	
Anafranil	Brand	Clomipramine	TCA	
Aripiprazole	Generic	Abilify	Atypical Antipsychotic	62
Asendin	Brand	Amoxapine	TCA	
Atarax	Brand	Hydroxyzine	Sleep Aide, Allergic reactions, Anxiety	58
Atenolol	Generic	Tenormin	Adrenergic Agent	
Ativan	Brand	Lorazepam	Benzodiazepine	59
Benadryl	Brand	Diphenhydramine	EPS (Extrapyramidal syndromes), Sleep Aide, Allergic reactions, Anxiety	
Benztropine	Generic	Cogentin	EPS	
Budeprion	Brand	Buproprion	Other (not SSRI)	
Buproprion	Generic	Wellbutrin, Budeprion	Other (not SSRI)	
BuSpar	Brand	Buspirone	Other (not SSRI)	
Buspirone	Generic	BuSpar	Other (not SSRI)	
Carbamazepine	Generic	Tegretol, Epitol,Equetro, Carbatrol	Mood Stabilizer	56
Carbatrol	Brand	Carbamazepine	Mood Stabilizer	56

Continued over

Common Medications *continued*

Name	Brand / Generic	AKA	Type of Medication	Pg.
Catapress	Brand	Clonidine	Adrenergic Agent	
Celexa	Brand	Citalopram	SSRI	
Chlorpromazine	Generic	Thorazine, Ormazine	Typical Antipsychotic	64
Citalopram	Generic	Celexa	SSRI	59
Clomipramine	Generic	Anafranil	TCA	
Clonazepam	Generic	Klonopin	Benzodiazepine	59
Clonidine	Generic	Catapress	Adrenergic Agent	
Clozapine	Generic	Clozaril, FazaClo	Atypical Antipsychotic	62
Clozaril	Brand	Clozapine	Atypical Antipsychotic	62
Cogentin	Brand	Benztropine	EPS (Extrapyramidal syndromes)	
Consta	Brand	Risperidone	Atypical Antipsychotic	62
Cymbalta	Brand	Duloxetine	SSRI	59
Cyproheptadine	Generic	Periactin	Sleep Aide, Allergic reactions, Anxiety	58
Dalmane	Brand	Flurazepam	Benzodiazepine	59
Depakene	Brand	Valproic acid	Mood Stabilizer	56
Depakote	Brand	Divalproex sodium	Mood Stabilizer	56
Desipramine	Generic	Norpramin	TCA	
Desmopressin acetate	Generic	DDAVP, Stimate	Bed wetting	
Desyrel	Brand	Trazodone	Other (not SSRI)	
Detrol	Brand	Tolterodine	Bedwetting	
Diazepam	Generic	Valium	Benzodiazepine	59

Continued over

Common Medications *continued*

Name	Brand / Generic	AKA	Type of Medication	Pg.
Diphenhydramine	Generic	Benadryl	EPS, Sleep Aide, Allergic reactions, Anxiety	
Ditropan	Brand	Oxybutynin	Bedwetting	
Divalproex sodium	Generic	Depakote	Mood Stabilizer	56
Duloxetine	Generic	Cymbalta	SSRI	59
Effexor	Brand	Venlafaxine	Other (not SSRI)	62
Elavil	Brand	Amitriptyline	TCA	
Epitol	Brand	Carbamazepine	Mood Stabilizer	56
Equetro	Brand	Carbamazepine	Mood Stabilizer	56
Escitalopram	Generic	Lexapro	SSRI	
Eskalith	Brand	Lithium	Mood Stabilizer	56
Estazolam	Generic	ProSom	Benzodiazepine	
Eszopiclone	Generic	Lunesta	Sleep Aide	58
FazaClo	Brand	Clozapine	Atypical Antipsychotic	62
Fluoxetine	Generic	Prozac	SSRI	
Fluphenazine	Generic	Prolixin, Permitil	Typical Antipsychotic	64
Flurazepam	Generic	Dalmane	Benzodiazepine	59
Fluvoxamine	Generic	Luvox	SSRI	59
Gabapentin	Generic	Neurontin	Mood Stabilizer	56
Geodon	Brand	Ziprasidone	Atypical Antipsychotic	62
Guanfacine	Generic	Tenex, Intuniv	Adrenergic Agent	
Halcion	Brand	Triazolam	Benzodiazepine	59
Haldol	Brand	Haloperidol	Typical Antipsychotic	64
Haloperidol	Generic	Haldol	Typical Antipsychotic	64

Continued over

Common Medications *continued*

Name	Brand / Generic	AKA	Type of Medication	Pg.
Hydroxyzine	Generic	Vistaril, Atarax	Sleep Aide, Allergic reactions, Anxiety	
Imipramine	Generic	Tofranil	TCA	
Inderal	Brand	Propranolol	Adrenergic Agent	58
Intensol	Brand	Alprazolam	Benzodiazepine	59
Intuniv	Brand	Guanfacine	Adrenergic Agent	58
Invega	Brand	Risperidone	Atypical Antipsychotic	62
Lamictal	Brand	Lamotrigine	Mood Stabilizer	56
Lamotrigine	Generic	Lamictal	Mood Stabilizer	56
Lexapro	Brand	Escitalopram	SSRI	59
Lithium	Generic	Eskalith, Lithobid, Lithotab	Mood Stabilizer	56
Lithobid	Brand	Lithium	Mood Stabilizer	56
Lorazepam	Generic	Ativan	Benzodiazepine	59
Loxapine	Generic	Loxitane	Typical Antipsychotic	64
Loxitane	Brand	Loxapine	Typical Antipsychotic	64
Lunesta	Brand	Eszopiclone	Sleep Aide	58
Luvox	Brand	Fluvoxamine	SSRI	59
Mellaril	Brand	Thioridazine	Atypical Antipsychotic	62
Mesoridazine	Generic	Serentil	Atypical Antipsychotic	62
Mirtazapine	Generic	Remeron	Other (not SSRI)	61
Moban	Brand	Molindone	Atypical Antipsychotic	62

Continued over

Common Medications *continued*

Name	Brand / Generic	AKA	Type of Medication	Pg.
Modafinil	Generic	Provigil	Sleep Aide, Narcolepsy and other sleep disorders	58
Molindone	Generic	Moban	Atypical Antipsychotic	62
Naltrexone	Generic	ReVia, Trexane	Substance abuse and to help lessen self injury	
Nardil	Brand	Phenelzine	MAO-I	
Navane	Brand	Thiothixene	Typical Antipsychotic	64
Neurontin	Brand	Gabapentin	Mood Stabilizer	56
Norpramin	Brand	Desipramine	TCA	
Nortriptyline	Generic	Pamelor	TCA	
Olanzapine	Generic	Zyprexa	Atypical Antipsychotic	62
Orap	Brand	Pimozide	Typical Antipsychotic	64
Ormazine	Brand	Chlorpromazine	Typical Antipsychotic	64
Oxcarbazepine	Generic	Trileptal	Mood Stabilizer	56
Oxybutynin	Generic	Ditropan	Bedwetting	
Pamelor	Brand	Nortriptyline	TCA	
Parnate	Brand	Tranylcypromine	MAO-I	
Paroxetine	Generic	Paxil, Pexeva	SSRI	59
Paxil	Brand	Paroxetine	SSRI	59
Periactin	Brand	Cyproheptadine	Sleep Aide, Allergic reactions, Anxiety	

Continued over

Common Medications *continued*

Name	Brand / Generic	AKA	Type of Medication	Pg.
Permitil	Brand	Fluphenazine	Typical Antipsychotic	64
Perphenazine	Generic	Trilafon	Typical Antipsychotic	64
Pexeva	Brand	Paroxetine	SSRI	59
Pindolol	Generic	Visken	Adrenergic Agent	
Prolixin	Brand	Fluphenazine	Typical Antipsychotic	64
Propranolol	Generic	Inderal	Adrenergic Agent	58
ProSom	Brand	Estazolam	Benzodiazepine	59
Provigil	Brand	Modafinil	Sleep Aide, Narcolepsy and other sleep disorders	58
Prozac	Brand	Fluoxetine	SSRI	
Quetiapine	Generic	Seroquel	Atypical Antipsychotic	62
Remeron	Brand	Mirtazapine	Other (not SSRI)	61
Restoril	Brand	Temazepam	Benzodiazepine	59
ReVia	Brand	Naltrexone	Substance abuse and to help lessen self injury	
Risperdal	Brand	Risperidone	Atypical Antipsychotic	62
Risperidone	Generic	Risperdal, Consta, Invega	Atypical Antipsychotic	62
Serentil	Brand	Mesoridazine	Atypical Antipsychotic	62
Seroquel	Brand	Quetiapine	Atypical Antipsychotic	62
Sertraline	Generic	Zoloft	SSRI	59

Continued over

Common Medications *continued*

Name	Brand / Generic	AKA	Type of Medication	Pg.
Sonata	Brand	Zaleplon	Sleep Aide	58
Stelazine	Brand	Trifluoperazine	Typical Antipsychotic	64
Tegretol	Brand	Carbamazepine	Mood Stabilizer	56
Temazepam	Generic	Restoril	Benzodiazepine	59
Tenex	Brand	Guanfacine	Adrenergic Agent	58
Tenormin	Brand	Atenolol	Adrenergic Agent	58
Thioridazine	Generic	Mellaril	Atypical Antipsychotic	62
Thiothixene	Generic	Navane	Typical Antipsychotic	64
Thorazine	Brand	Chlorpromazine	Typical Antipsychotic	64
Tofranil	Brand	Imipramine	TCA	
Tolterodine	Generic	Detrol	Bedwetting	
Topamax	Brand	Topiramate	Mood Stabilizer	56
Topiramate	Generic	Topamax	Mood Stabilizer	56
Tranylcypromine	Generic	Parnate	MAO-I	
Trazodone	Generic	Desyrel	Other (not SSRI)	
Trexane	Brand	Naltrexone	Substance use disorders	
Triazolam	Generic	Halcion	Benzodiazepine	59
Trifluoperazine	Generic	Stelazine	Typical Antipsychotic	64
Trilafon	Brand	Perphenazine	Typical Antipsychotic	64
Trileptal	Brand	Oxcarbazepine	Mood Stabilizer	56
Valium	Brand	Diazepam	Benzodiazepine	59
Valproic acid	Generic	Depakene,	Mood Stabilizer	56
Venlafaxine	Generic	Effexor	Other (not SSRI)	62
Visken	Brand	Pindolol	Adrenergic Agent	58

Continued over

Common Medications *continued*

Name	Brand / Generic	AKA	Type of Medication	Pg.
Vistaril	Brand	Hydroxyzine	Sleep Aide, Allergic reactions, Anxiety	58
Wellbutrin	Brand	Buproprion	Other (not SSRI)	61
Xanax	Brand	Alprazolam	Benzodiazepine	59
Zaleplon	Generic	Sonata	Sleep Aide	58
Ziprasidone	Generic	Geodon	Atypical Antipsychotic	62
Zoloft	Brand	Sertraline	SSRI	59
Zolpidem	Generic	Ambien	Sleep Aide	58
Zyprexa	Brand	Olanzapine	Atypical Antipsychotic	62

Medicines Commonly Used for Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD is one of the more common conditions among youth for which medications are prescribed. The medications for ADHD include stimulant medications and non-stimulant medications. These medications differ in how they are absorbed in the body, how quickly they take effect, and how long they stay active and present in the blood stream.

Medications for ADHD are highly effective (>85% effective for symptom relief in most patients), but they also have a high abuse potential and have street value. Possible side effects of these medications include loss of appetite, increased anger, mood instability, rare but serious cardiac symptoms in youth with preexisting conditions, insomnia, and rebound worsening of symptoms as medication wears off.

The following table is arranged similarly to the preceding medications table, but the fourth column describes how the medication is given and how long a dose lasts.

Stimulant Medications

Medication	Brand / Generic	AKA	Dispensed as / How long does it last	Pg.
Adderall	Brand	Mixed Salts Amphetamine	Tablet/3–5 hours	
Adderall	Brand	Mixed Salts Amphetamine	Capsule with beads /10–12 hours	
Amphetamine	Generic	3 Brands	See Specific Brands	
Daytrana	Brand	Methylphenidate	Transder-mal system (skin patch)	
Dexedrine	Brand	Dextroamphetamine	Tablet/3–5 hours	
Dexedrine Spansule	Brand	Dextroamphetamine	Capsule with par-ticles/6–8 hours	
Dexmethylphenidate	Generic	2 Focalin Brands	See Specific Brands	
Dextroamphetamine	Generic	5 Brands	See Specific Brands	
Dextroamphetamine	Brand	Dextroamphetamine	Capsule/6–8 hours	
DextroStat	Brand	Dextroamphetamine	Tablet/3–5 hours	
Focalin	Brand	Dexmethylphenidate	Tablet/3–4 hours	

Continued over

Stimulant Medications *continued*

Medication	Brand / Generic	AKA	Dispensed as / How long does it last	Pg.
Focalin	Brand	Dexmethylphenidate	Capsule with beads/8–10 hours	
Metadate	Brand	Methylphenidate	Capsule with beads/8 hours	
Metadate	Brand	Methylphenidate	Wax matrix tablet/6–8 hours	
Methylin	Brand	Methylphenidate	Wax matrix tablet/6–8 hours	
Methylphenidate	10 Brands	See Specific Brands		
Methylphenidate	Brand	Methylphenidate	Tablet/3–4 hours	
Ritalin	Brand	Methylphenidate	Tablet/3–4 hours	
Ritalin	Brand	Methylphenidate	Capsule with beads/8–10 hours	
Ritalin SR	Brand	Methylphenidate	Wax matrix tablet/6–8 hours	

Non-Stimulant Medications

Medication	Brand / Generic	AKA	Type	Pg.
Atomoxetine	Generic	Strattera	Other	
Catapress	Brand	Clonidine	Adrenergic	
Clonidine	Generic	Catapress	Adrenergic	58
Guanfacine	Generic	Intuniv	Adrenergic	
Guanfacine	Generic	Tenex	Adrenergic	
Ramelteon	Brand	Melatonin	Sleep Aide	
Rozerem	Generic	Rozerem	Sleep Aide	
Strattera	Brand	Atomoxetine	Other	
Tenex, Intuniv	Brand	Guanfacine	Adrenergic	

Concepts

The following concepts often arise in juvenile justice practice and policy in relation to youth with mental health and substance use problems.

Brain Development

Research in recent decades has demonstrated that certain areas of the brain continue to develop through adolescence into adulthood. These areas are associated with impulse control and executive functions — that is, capacities for delaying one's reaction to situations, foreseeing consequences of behaviors, and planning. Ordinarily, adolescents have not yet developed adult capacities in these areas. These findings have implications for policy in the juvenile justice system's responses to youths' offenses. *www.nimh.nih.gov/health/publications/teenage-brain-a-work-in-progress-fact-sheet/index.shtml*

Community-Based Services

When delinquent youth require mental health and substance use services, many juvenile justice systems promote the use of services based in the community, rather than in secure juvenile justice facilities, whenever this is consistent with public safety concerns. Community-based services include not only mental health services, but also a range of programs (e.g., rehabilitation, education, recreation, and employment) while youth reside at home or in community-based residential settings. *www.guideline.gov/content.aspx?id=10551*

Co-Occurring Disorders (Co-Morbidity)

The term co-occurring disorders (COD) refers to co-occurring substance-related and mental disorders. Youth said to have COD have one or more substance-related disorders as well as one or more mental disorders (e.g., conduct disorder and an anxiety disorder; depression and substance use).

Developmental Immaturity

Children and adolescents undergo rapid physical, intellectual, emotional, and social changes in the course of ordinary development. The term developmental immaturity is sometimes used when adolescents have not yet reached their adult level of maturity in one or more of these areas. It can also be used to identify a youth who has lagged behind same-age peers in some area of development.

Disproportionate Minority Contact (DMC)

Youth of color are over-represented in the juvenile justice system. This is true at every point of contact (arrest, detention, formal processing, and juvenile corrections). Studies have shown that they are more likely to be incarcerated and to serve more time than white youth, even when they are charged with the same offenses. This is called disproportionate minority contact, meaning that a minority group is found in greater proportions in the juvenile justice system

than in the general population. *www.ncjrs.gov/pdffiles1/ojjdp/228306.pdf*

Diversion

Many juvenile justice systems employ strategies for diverting youth from formal processing. Diversion programs can exist at several points in the juvenile justice process. Most commonly, youth are diverted at the point of contact with law enforcement or detention decision, through the discretion by intake probation officers to divert to community services rather than process cases toward adjudication. Diversion programs tend to focus on status offenders, youth who are arrested for the first time and/or for minor delinquencies, and youth for whom mental health services in the community may offer a better response than adjudication. Research evidence suggests that formal processing of youth who are unlikely to re-offend may actually increase their likelihood of re-offending. *www.ncmhjj.com/pdfs/publications/DiversionRPB.pdf*

Evidence-Based Practices (EBP)

This term describes practices that have been shown by research to produce positive outcomes. The term refers to assessment, rehabilitation, or treatment methods. To be considered evidence based, the method must be designed for use in a standardized manner (applied the same way in each case). In addition, there must be ample research evidence that the method increases the likelihood of a desired result. That is, it must produce more accurate assessments, better clinical outcomes, or less recidivism. The term promising is sometimes used for methods that show initial favorable outcomes but for which the empirical evidence is insufficient to call evidence based. Evidence-based practice has become the standard in many juvenile justice systems during the past decade. Prior to this, many treatment methods were used, often based on common sense, that provided little or no benefit for youth. Evidence-based methods offer a better investment of resources because they are

known to advance juvenile justice objectives. See: *Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices* at *www.nami.org*.

Individualized Education Plan (IEP)

When adolescents have a disability that interferes with their educational progress, the Individuals with Disabilities Education Act requires that they receive an individualized education program (IEP). An IEP begins with an assessment of the youth's intellectual and/or social functioning, often focusing on potential learning disabilities. The evaluation is then translated into a plan that will help the youth learn more effectively. IEPs typically are formulated by a youth's school system.

Juvenile Drug Court

A juvenile drug court is a specialized docket within a juvenile court where youth are referred for processing of delinquency charges when their delinquency is related substantially to problems with alcohol and/

or other drugs. The judge of a juvenile drug court typically is also a member of a team that includes specialized defense and prosecuting attorneys, as well as representatives from treatment, social services, education, and law enforcement or probation. Thus a juvenile drug court not only serves a legal function, but also a management and service delivery function. The whole team often maintains close oversight of ongoing cases by way of (sometimes weekly) hearings on the behavioral and treatment status of youth in the court's custody. *www.ncmhjj.com/pdfs/publications/FinalRecommendations.pdf*

Juvenile Mental Health Court (JMHC)

A juvenile mental health court typically is a specialized docket within a juvenile court that processes and manages youth who are adjudicated delinquent and who have mental health problems. Eligibility criteria often focus on youth with more serious and persistent mental health problems that are best treated in the community. These courts typically have a multidisciplinary

team approach to developing treatment plans, monitoring treatment compliance and progress, and making recommendations to the court. Team members often include prosecutors and defense attorneys, mental health professionals, case managers, and probation officers — all with special knowledge of adolescent mental health problems. *www.ncmhjj.com/pdfs/publications/JuvenileMentalHealthCourts.pdf*

Motivational Interviewing

This is a relatively new technique often used by child and family professionals. Motivation is readiness and willingness to change, and Motivational interviewing seeks to create that readiness. As a style and strategy for interviewing, it employs a few relatively simple principles that professionals can readily adapt to their of interactions with clients. Motivational interviewing can be used specifically as a therapeutic method or generally within a wide range of interview

situations by child and family professionals. *www.ncbi.nlm.nih.gov/pmc/articles/PMC1308798/pdf/15239293.pdf*

Wraparound

In recent years, many communities have developed a special youth behavioral health care program that brings together medical, psychiatric, psychological, educational, and social services across agency lines. These systems provide community youth-helping services in a way that "wraps around" the youth and family, meaning they work together to meet a youth's needs in a coordinated and individualized manner. The youth's services may be managed by a wraparound team consisting of representatives from the various provider organizations involved in the youth's service plan. *www.bazelon.org*

Frequently Asked Questions

How prevalent are mental health and substance use problems among youth in juvenile justice?

Upon admission to juvenile detention or corrections programs, about two in three youth (65%) meet diagnostic criteria for one or more mental disorders (as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition).[2, 3, 4] This compares to a prevalence of about 20 percent for adolescents in general in the community.[5] Common disorders are anxiety disorders (e.g., posttraumatic stress disorder), mood disorders (e.g., depression), attention disorder (e.g., attention-deficit hyperactivity disorder), substance use disorders, and disruptive behavior disorders (e.g., conduct disorder). The most prevalent disorders — affecting about 40 percent of youth in juvenile justice settings — are substance use and/or conduct disorders, but most youth with those diagnoses also meet criteria for anxiety, depression, or attention disorders.[6] When a youth has more than one disorder, clinicians often speak of the disorders as co-occurring or co-morbid.

Not all adolescents who meet criteria for a mental disorder are necessarily in need of immediate clinical attention or treatment. Even with the same disorder, they will vary in the severity of their symptoms or in their resilience. However, a subgroup of youth in juvenile justice settings — about 15–20 percent — have long-term, persistent and serious mental illnesses.[7] (This compares to about 8–10 percent in the general community.[8]) These youth are often said to have serious mental illness (SMI) or to be seriously emotionally disturbed (SED). They are most likely to need ongoing care of a kind that often is difficult to provide in juvenile justice facilities.

What is the value of mental health screening in juvenile justice programs?[9]

When youth are admitted to juvenile justice facilities, it is essential to identify whether they have a mental health or substance use need that requires immediate attention. The most common concerns are suicide potential, toxicity related to recent substance use, potential reactions to recent psychological trauma, and active bipolar or psychotic disorders that interfere with interpretation of reality and self-control. Mental

health screening to identify these conditions should be performed with every youth within a few hours after admission to a facility. It is best accomplished with a standardized, validated screening tool that asks youth a set of questions related to their thoughts and feelings. Screening tools do not produce a diagnosis. They simply identify symptoms that suggest the need for an immediate appropriate response, often to be followed up by clinical intervention. Research has shown that routine mental health screening increases staff responses to youth with serious mental health needs at admission.

What is the role of DSM in diagnosis?

Diagnosis of a mental disorder must be established by a trained mental health clinician. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines specific criteria and symptoms that must be found in order to diagnose each type of mental disorder.[10] The DSM includes what is called a multiaxial system for reporting diagnoses. There are five axes, but the two that are most relevant for juvenile justice purposes are Axis I and Axis II diagnoses.

When a youth is described as having an Axis I diagnosis, it means that the youth has been diagnosed with a condition that may require clinical attention. Examples include schizophrenia, bipolar disorder, depression, and anxiety disorders. Any diagnoses under the DSM heading Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence (except mental retardation) are considered Axis I disorders. The more common clinical conditions under this heading that juvenile court judges will encounter are conduct disorder (CD), attention-deficit/hyperactivity disorder (ADHD), and oppositional defiant disorder (ODD).[11]

Axis II is reserved for mental retardation and for various personality disorders (e.g., borderline personality). These conditions are considered more stable for an individual and less amenable to change through treatment. Personality disorders are diagnosed in adolescents only infrequently. The features of these disorders often do not become fixed until early adulthood (youths' personalities often change during their teen years). For example, the DSM criteria for antisocial personality do not even

allow it to be used as a diagnosis for persons under 18 years of age.

What is trauma, and how is it related to delinquency?[12]

As a mental health concept, trauma refers to a serious emotional shock or injury that creates prolonged psychological damage. Many delinquent youth grow up in circumstances that expose them to frightening traumatic events — for example, repeatedly witnessing spousal abuse, being the victim of physical abuse, or living in neighborhoods where violence is common.

Youth react to prolonged trauma in different ways. Some of the more common reactions are recurrent memories of the event (sometimes with frightening dreams), feeling like the experience is happening again, and having angry outbursts and trouble concentrating. Youth who experience repeated trauma may develop an emotional numbing — a decrease in emotional responsiveness — to block the pain of trauma. When symptoms like these are serious and persistent, youth sometimes meet criteria for posttraumatic stress disorder (see Diagnoses).

Trauma-related problems are found much more frequently among delinquent youth than in the general population of youth, and in some studies they have been found in a majority of girls in juvenile justice settings. Trauma-related irritability, fearfulness, and distress increases the risk that youth may react aggressively either toward themselves or toward others, especially when they encounter situations that are reminiscent of the trauma they have experienced.

What is the relation of conduct disorder in adolescence to antisocial personality disorder in adulthood?

Antisocial personality disorder (APD) (applied only to persons 18 or older) refers to a pattern of disregard for rules and rights of others over a long enough time that it can be seen as a stable characteristic of the person. Many adults who habitually get in trouble with the law have an APD diagnosis.

One of the criteria for APD is evidence of conduct disorder (a diagnosis during childhood or adolescence) before age 15. In juvenile court, this sometimes leads to the misunderstanding that a youth with a conduct disorder will develop an APD upon

reaching adulthood. As noted in DSM, however, "In a majority of individuals [with conduct disorder], the disorder remits [disappears] by adulthood."[13] Therefore, while all APD adults have conduct disorder during adolescence, most adolescents with conduct disorder do not develop APD as adults.

Researchers have been attempting to identify which youth with conduct disorder will continue antisocial behavior into adulthood. Current evidence suggests a pathway leading from attention-deficit/hyperactivity disorder in childhood to oppositional defiant disorder in late childhood to conduct disorder in adolescence.[14, 15] But considerably more work is needed in order to offer confident identification of probable adult criminality based on behavior in adolescence.

How is a juvenile's mental health or substance use problems related to their delinquency?

Research is ongoing to determine whether and how youths' mental disorders increase the risk of delinquency. A few things, however, are evident.

- Most delinquency is not due to serious mental disorder (that is, disorders requiring psychiatric treatment).[16]
- When juveniles with serious mental disorders are delinquent, their disorders likely contribute to their delinquency, and treatment of their mental disorders must play a part in efforts to reduce their delinquency.[17]
- Substance abuse increases the risk of delinquent behaviors for several reasons: (a) impairment of judgment; (b) decrease in self-control; and (c) involvement in drug-using social networks that promote illegal behavior.[18]

What are some signs of risk of suicide among youth?

Suicide is the third leading cause of death for 15- to 24-year-olds, and the sixth leading cause of death for 5- to14-year-olds.[19] Thoughts of suicide are common in youth with mood disorders and anxiety disorders. Suicide attempts often are triggered by stressful events that cause youth to feel confused, worthless, hopeless, rejected, or to blame for the stressful event (e.g., parents' divorce). Both youth and adults who

have suicidal thoughts often appear withdrawn from social contacts, have a decreased interest in activities, and report changes in sleeping and eating habits. In adolescence, however, a depressed appearance is not always apparent. Some youth react to stress, depression, and self-doubts with sudden and marked feelings of anger and an increase in rebellious activity.

Resources

Child and Adolescent Mental Health and Substance Use Problems and Treatment

Information Resources

American Association of Child and Adolescent Psychiatry
www.aacap.org

Center for Mental Health Services
www.samhsa.gov/about/cmhs.aspx

Mental Health America (National Mental Health Association)
www.nmha.org

National Alliance on Mental Illness
www.nami.org

National Federation of Families for Children's Mental Health
http://ffcmh.org/

National Institute on Drug Abuse
www.nida.nih.gov

National Institute of Mental Health
www.nimh.nih.gov

National Technical Assistance Center for Children's Mental Health

http://gucchdtacenter.georgetown.edu/index.html

Office of Juvenile Justice and Delinquency Prevention

www.ojjdp.gov

Research and Training Center for Children's Mental Health at the University of South Florida

http://rtckids.fmhi.usf.edu/default.cfm

Substance Abuse and Mental Health Services Administration

http://store.samhsa.gov/home

Technical Assistance Partnership for Child and Family Mental Health

http://www.tapartnership.org/

Evidence-Based Practices

Blueprints for Violence Prevention

Evidence-based rehabilitation and treatment methods in juvenile justice

www.colorado.edu/cspv/blueprints

See also *www.abct.org/sccap/*

National Center for Mental Health and Juvenile Justice

National clearinghouse for mental health and juvenile justice information

www.ncmhjj.com

Reclaiming Futures

A model for improving juvenile justice through community integration. Blog includes publications, webinars and trainings from many other juvenile justice websites.

http://www.reclaimingfutures.org/blog/

Judicial and Corrections Organizations

Center for Juvenile Justice Reform at Georgetown University

http://cjjr.georgetown.edu/index.html

Council of Juvenile Correctional Administrators

http://cjca.net/

Juvenile Law Center

http://www.jlc.org/

National Center for State Courts

Information on juvenile drug courts

www.ncsc.org

National Council of Juvenile and Family Court Judges

Publications on juvenile mental health issues

www.ncjfcj.org

National Judicial College

Online and live courses

www.judges.org

Special Programs

Juvenile Detention Alternatives Initiative (Annie E. Casey Foundation)

Nationwide program promoting appropriate diversion of youth from pretrial detention

www.aecf.org

Models for Change: Systems Reform in Juvenile Justice (MacArthur Foundation)

Nationwide program to promote developmentally appropriate juvenile justice programs

www.modelsforchange.net

Training Aids

National Juvenile Defender Center

Training modules for legal professionals on adolescent development and mental health

www.njdc.info Index

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