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Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System

A Resource Guide for Practitioners

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Policy Research Associates, Inc.

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Foreword

Research indicates that many youth who come into contact with the juvenile justice system may have mental health- and substance use-related disorders. Problems related to these conditions play a continuing role in delinquency and pose risks to the welfare of youth, juvenile justice staff, and others.

Identifying troubled youth is the first step in providing them with appropriate treatment. To take that first step, juvenile justice professionals need reliable screening and assessment instruments and practical guidance in their effective use.

This Resource Guide offers a comprehensive, user-friendly synthesis of current information on instruments that can be used to screen and assess youth for mental health- and substance use-related disorders at various stages of the juvenile justice process. The Guide includes profiles of more than 50 instruments, guidelines for selecting instruments, and best practice recommendations for diverse settings and situations.

Early, accurate identification of youth with mental disorders in the juvenile justice system is a critical need. Once identified, these youth can receive the services required to improve their lives, reduce recidivism rates, and promote community safety. This Resource Guide is intended as a basic tool for juvenile justice professionals working toward this goal.

J. Robert Flores
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Preface and Acknowledgments

This document was produced by the National Center for Mental Health and Juvenile Justice through a grant from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The mission of the Center is to promote awareness of the mental health needs of youth in the juvenile justice system and to assist the field in developing improved policies and programs based on the best available research and practice. The Center has four primary objectives:

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

The National Center for Mental Health and Juvenile Justice is based within Policy Research Associates, Inc., a nationally recognized research and evaluation organization located in Delmar, NY.

The publication of this Resource Guide would not have been possible without the contributions and assistance of a number of individuals and organizations. The Center gratefully acknowledges OJJDP for its support of this project, with special recognition to Dr. Karen Stern, our federal project officer, for her guidance, patience, and invaluable assistance. The Center thanks the authors, Dr. Thomas Grisso and Dr. Lee Underwood, for their tireless efforts and unparalleled expertise. The Center also thanks Deborah Chapin for her editorial and research assistance. Finally, the Center thanks Dr. Nancy Cunningham and Dr. Glenn Thomas of the Ohio Department of Youth Services for their careful review of the document and thoughtful comments.

This Resource Guide is designed to serve as a practical tool for clinicians and practitioners working with youth with mental health disorders who are in contact with the juvenile justice system. Our hope is that the information contained in this Guide will further contribute to the growing knowledge base of best practices and will lead to improved outcomes for children, youth, and families.

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Chapter 1: The Role of Screening and Assessment in Juvenile Justice

Overview

In 2002, law enforcement agencies in the United States made an estimated 2.3 million arrests of juveniles (Snyder, 2004). On any given day, more than 100,000 youth are being held in custody in juvenile justice facilities across the country, either awaiting trial in detention centers or having been placed in residential facilities after being adjudicated delinquent (Snyder and Sickmund, 1999). Many others are supervised by juvenile probation officers after referral to the juvenile court.

A growing body of research suggests that many of these youth meet criteria for at least one mental disorder and that at least one of every five has what is considered to be a serious mental disorder, often coupled with a co-occurring substance use disorder (Cocozza and Skowyra, 2000). Growing awareness of these youth, their needs, and the impact that they have on the juvenile justice and mental health systems has led to increasing concern regarding the need to provide them with appropriate treatment services. Yet the first step—to effectively identify youth who require mental health services—has been largely absent. The situation is changing, however, with the growing awareness in the juvenile justice system of the need to identify these youth by using sound screening and assessment procedures.

There are several reasons why juvenile justice systems throughout the United States are now placing a high priority on identifying and responding to the mental health needs of youth in their custody. These reasons include:

- Ethical, moral, and legal responsibilities require that public and private agencies meet the health and mental health needs of youth who are in state custody.

- Problems associated with mental disorder often play a role in a youth's continuing delinquency and danger to society, so that an appropriate response to these conditions is critical in reducing future delinquency.

- The welfare and safety of youth and staff in juvenile justice facilities are dependent on the identification of any psychological conditions that may pose an immediate risk of aggression or suicide.

Responding to a youth's mental, emotional, and substance use problems requires accurate identification of those problems. Detecting potential mental health and substance use disorders among youth requires reliable and valid screening and assessment tools and instruments, as well as information on how best to use these tools.

This Resource Guide provides clinicians and other professionals working with youth in the juvenile justice system with a range of best practice information that will assist in better identifying youth with mental health disorders, thus ultimately improving their treatment. The Guide reviews and synthesizes information about the most effective instruments for screening and assessing youth for mental health and substance use disorders at various points in the

juvenile justice system. The Guide also provides examples of a variety of models and approaches that have been developed to use available instruments.

Until recently, little attention has been given to the development of instruments designed specifically for identifying mental health and substance use disorders among youth in the juvenile justice system. Moreover, the process of screening and assessment in juvenile justice facilities has often been cursory, without clear purpose, or without an integrated approach (Trupin and Boesky, 1999). Although these circumstances have gradually begun to improve, there are still few standardized and validated tools designed to meet the needs of juvenile justice agencies responsible for screening and assessing the youth in their care. Therefore, the information offered in this Guide will not always provide an ideal solution for the problems facing clinicians and administrators in the juvenile justice system. However, the Guide does provide a benchmark for current progress in this area. It presents information on approaches that may not be ideal but that offer an improvement over current practices in many jurisdictions.

Defining Screening and Assessment

Screening and assessment share the objective of evaluating youth, but they are distinguished by different purposes and often require somewhat different methods.

Screening. Most definitions of screening for mental health and substance use problems (e.g., Trupin and Boesky, 1999; Grisso and Barnum, 2000) describe a relatively brief process designed to identify youth who are at increased risk of having disorders that warrant immediate attention, intervention, or more comprehensive evaluation. Screening, therefore, is a triage process, often employed with all youth entering a particular component of the juvenile justice system.

Screening typically is intended not to provide an accurate psychiatric diagnosis, but rather to distinguish a set of exceptionally troubled youth for whom some special and relatively immediate response is necessary. Examples of responses to "red flags" in juvenile justice screening might include closer monitoring by staff, assignment of a staff member to briefly inquire further about the youth's current feelings, placement on suicide watch, scheduling for a diagnostic interview and consultation with a mental health professional, or, in some cases, immediate transfer to an inpatient psychiatric facility. Identifying the need for further evaluation, however, is a more frequent purpose of screening.

The scope of screening may vary at different points in the juvenile justice process, as will be discussed later. Some screening procedures are very brief (e.g., 10 minutes) and seek the bare minimum of information needed for a specific decision. Other types of screening may take longer (e.g., 30 minutes) and seek a broader range of information, but still in a relatively brief and efficient manner. In any case, screening is standardized, collecting a specific set of readily available information for every youth passing through a particular point in the juvenile justice process.

Assessment. In contrast, assessment (in the present context) is a more comprehensive and individualized examination of the psychosocial needs and problems identified during the initial screening, including the type and extent of mental health and substance abuse disorders, other issues associated with the disorders, and recommendations for treatment intervention.

Assessments typically are more expensive than screening because they require more individualized data collection, often including psychological testing, clinical interviewing, and obtaining past records from other agencies for review by the assessor. Thus, assessment typically requires the expertise of a mental health professional. These facts mean that assessments should be used only for a subset of youth who, through screening or other means, are identified as most likely to be in need of such evaluation.

Stages of Screening and Assessment

At the broadest level, the juvenile justice system consists of a community's juvenile court and a system of services or interventions designed to prevent further misconduct. Juvenile courts gather information and make decisions regarding a youth's needs, make legal decisions about a youth's offending, and, if necessary, make decisions about the type of remedial, rehabilitative, and correctional response that will best meet the needs of the youth and society. Community-based agencies and juvenile correctional facilities then provide the appropriate community services or rehabilitation in secure facilities.

Screening is most likely to be needed at three points in this system:

- At the first interview with a youth after referral to the juvenile court, often conducted by an intake officer.
- Upon admission of a youth to a pretrial detention center to await adjudication.
- Upon admission to a postadjudication community program or correctional facility to begin the rehabilitative process.

Far more youth are processed at the first of these points than at the second, and only a minority of youth referred to juvenile courts reach the third point (i.e., placement in correctional programs). Because of practical concerns associated with these differences in the volume of cases, somewhat different screening procedures are appropriate for different points in the system.

Assessment, the more extensive process of individualized evaluation, may also occur at any of these points and may be focused on a variety of decisional needs. Some assessments address forensic questions—for example, competence to stand trial, risk of future violence, risk of repeated sex offending, and factors associated with the transfer of a juvenile case for trial in criminal court (Grisso, 1998). Far more frequently, however, assessments are used to identify a youth's psychological needs and to recommend treatment and rehabilitative interventions for consideration by the court or correctional programs.

Like screening, assessment serves somewhat different purposes at different stages in the juvenile justice process. At intake, assessment results may be used to divert the youth from moving further into the juvenile justice process, resulting in more appropriate referral to community mental health services. At the second stage, pretrial assessments often provide juvenile court judges with information about the youth's mental health and substance use needs that should be taken into account in deciding what services should be provided for rehabilitation if the youth is

found delinquent. At the third stage, assessments inform rehabilitation staff of community or secure correctional programs about the need for specialized methods of treatment or remediation.

Approaches to Screening and Assessment

Valid and reliable instruments are necessary for creating an effective screening and assessment process. Equally important, however, is knowledge about how best to use these instruments when working with youth within the juvenile justice system. Traditionally, private mental health consultants under contract with a juvenile court or a correctional facility provided screening and evaluation services for some youth involved with the juvenile justice system. Although this arrangement still occurs, various new approaches have been developed to implement screening and assessment strategies for youth at different stages of the juvenile justice system. However, very little is known about the relative effectiveness of these strategies or models and under what circumstances these models work best. Further, there is tremendous variation in how these strategies can be applied or implemented.

Despite the lack of evidence-based knowledge and research regarding effective screening and assessment models, a number of models and approaches are currently in use. These approaches cover a range of community-based and institutional settings and include a variety of partnerships. Examples include the following:

- **Juvenile Intake.** In many communities, juvenile intake is both the initial point of juvenile justice contact for youth and the entity responsible for making decisions about diversion or further referral to detention or juvenile court. Some communities have created probation-based diversion initiatives designed to identify specialized treatment needs and refer youth (and families, if necessary) to appropriate community-based services in lieu of immediate referral to detention or juvenile court. Screening and assessment are performed by juvenile justice staff (or by an outside public or private provider under contract with the juvenile justice agency) to identify a range of service needs, including the need for mental health services or followup. Referrals to community-based services are based on the results of these assessments. New York State's PINS (persons in need of supervision) Diversion Program authorizes probation intake units to temporarily deny direct access to family court by petitioners and uses a designated assessment service to provide comprehensive screening, assessment, and treatment planning services for youth (Cocozza and Skowyra, 2000).

- **Juvenile or Community Assessment Centers.** In some communities, juvenile or community assessment centers provide a centralized point of intake for youth and families who have come into contact or who are at risk of coming into contact with the juvenile justice system. These centers offer a single point of entry for processing and booking youth who have been arrested or picked up by the police. In addition, assessment centers often provide screening, assessment, and evaluation services to youth on a broad range of service issues. The centers typically involve representatives from a range of community-based agencies, including law enforcement, juvenile justice, and human services; often these agencies are colocated at the facility (Dembo and Brown, 1994). Assessment centers have been established in a number of states, including Colorado, Florida, Kansas, and New Mexico.

- **Court Evaluation Clinics.** In some communities, juvenile or family courts operate clinics that provide evaluation information to assist the court in dispositional decisionmaking. These evaluations help the court determine how best to meet the needs of a particular youth. Court clinics often employ psychologists or other mental health professionals who conduct a variety of evaluations of youth and their families to determine specific treatment needs and make service recommendations to the court. One example of such a clinic is the Cook County (IL) Juvenile Court Clinic (CCJCC). CCJCC, which is designed to ensure that clinical information provided to juvenile courts is accurate, culturally sensitive, and timely, employs contracted psychologists who perform clinical assessments of youth for juvenile court judges (Scally et al., 2001).

- **Juvenile Correctional Diagnostic Reception Centers.** In response to the increasing number of youth entering the juvenile justice system with mental health, substance use, and other treatment needs, many states have created centralized diagnostic reception centers. These centers serve as the initial point of referral for youth who are referred by a juvenile court to secure placement within the state's juvenile correctional system. The centers provide comprehensive screening, assessment, and evaluation services to these youth to determine the level and type of rehabilitative treatment needed and the most appropriate facility or program placement within the system. Youth typically spend from 2 to 4 weeks in reception centers, which are often staffed by a combination of mental health professionals and juvenile correctional staff. A number of states, including California, Massachusetts, Ohio, Texas, and Virginia, have created diagnostic reception centers to determine treatment and supervision needs before youth are placed in a facility or program.

- **Mental Health and Juvenile Justice Collaboratives.** The delivery of mental health services to youth in juvenile justice settings can often be complex because multiple agencies or systems provide services. Given the frequent lack of mental health resources within state juvenile justice systems, collaborative arrangements between mental health and juvenile justice agencies can enhance the clinical care provided for youth in juvenile justice settings. One model that illustrates this type of collaboration is New York State's mobile mental health teams—teams of mental health professionals deployed throughout the state to provide onsite assessment, crisis intervention, counseling, and other types of clinical care for youth in state juvenile correctional facilities. This collaboration, which has been in place since 1980, is supported by a memorandum of understanding between the state's Office of Children and Family Services and Office of Mental Health.

Summary

To provide adequate screening and assessment of the mental health- and substance abuse-related needs of youth, mental health professionals and juvenile justice professionals must have access to relevant instruments designed for these purposes. Screening and assessment methods must not only meet various psychometric standards but must also be adaptable to the needs and circumstances of the juvenile justice process. Chapter 2 discusses in more detail the nature of these demands and provides information to assist mental health professionals and juvenile justice personnel in developing appropriate screening and assessment procedures.

Chapter 2: Selecting Screening and Assessment Instruments

This Resource Guide describes more than 50 screening and assessment instruments for consideration by those who are responsible for identifying the mental health and substance abuse service needs of youth (see chapter 3). Choosing among these instruments requires attention to their development, purpose(s), and capacity for meeting the demands associated with use at various stages of the juvenile justice process. Moreover, selection factors differ somewhat for the two categories of instruments. This chapter, therefore, discusses the selection of screening and assessment instruments from three perspectives: the type of information sought, characteristics of the youth involved, and the context in which screening or assessment takes place.

Screening and Assessment for What?

Screening and assessment instruments for identifying mental health- and substance use-related needs of adolescents differ considerably in the kinds of psychological and behavioral characteristics that they evaluate. There is probably no definitive set of characteristics that is essential for all purposes at every stage in the juvenile justice process. However, research on problems among youth in the juvenile justice system suggests several considerations.

Psychiatric Disorders. There is general consensus (e.g., Otto et al., 1992; Kazdin, 2000; Teplin and McClelland, 1998) that certain psychiatric disorders are among the most frequent and troubling in juvenile justice populations. These include the following:

- Conduct disorders.
- Affective disorders (e.g., dysthymia).
- Anxiety disorders (e.g., posttraumatic stress disorder).
- Substance use disorders.
- Attention deficit disorders.
- Developmental disabilities (e.g., mental retardation).

Some instruments attempt to identify youth who meet criteria for these diagnostic conditions, as defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV)* (American Psychiatric Association, 1994). Although this approach has value, it also has shortcomings. It is widely recognized that disorders of adolescence do not fit as easily into homogeneous classes as do disorders of adulthood (Mash and Barkley, 1996). Moreover, use of specific diagnostic instruments runs the risk of settling for a single diagnosis, when in fact comorbidity (co-occurrence) of disorders is the rule rather than the exception among adolescents. In the juvenile justice system, comorbidity of substance use with other disorders is especially common, as is comorbidity of conduct disorder with other disorders (Mash and Barkley, 1996).

Symptoms and Problem Behaviors. Another approach incorporated in some screening and assessment instruments for adolescents is identifying symptoms and behaviors of special relevance for understanding youth and responding to their needs, rather than seeking to establish the presence of formal diagnostic disorders. Many symptoms and problem behaviors are associated with more than one diagnostic condition. Examples include the following:

- Depressed affect.
- Anxiety.
- Suicidal tendencies.
- Alcohol and drug use problems.
- Unusual or bizarre thoughts.
- Anger and aggression.
- Intellectual and neuropsychological deficits.

In this approach, the focus is on identifying mental and emotional disturbances or potential symptoms and behaviors that may be found in any number of mental disorders, without requiring an actual diagnosis. Often, identification of these conditions is sufficient to meet the juvenile justice system's obligation to respond appropriately to a youth's needs.

Family Characteristics. In the context of screening and assessment, a fundamental difference between adults and adolescents is that the latter typically are still dependent on their families and are directly influenced by their caretakers' strengths and weaknesses. Whenever possible, assessments should use instruments that allow the evaluator to obtain relevant information about a youth's family.

Strengths. The process of responding to a youth's problem behaviors and disorders should also include attention to the strengths of the youth (and family) on which treatment and rehabilitation can build. Unfortunately, most screening and assessment instruments designed for use with adolescents focus on deficits and disorders and give little attention to areas of functioning in which the youth shows particular capability. Yet for the clinician, this is an essential part of a complete assessment process, and instruments that do provide such information deserve special consideration.

Not all instruments can be expected to assess the full range of deficits and strengths described here. Moreover, the demands of screening require that these instruments seek only limited, readily available information. Assessment instruments, on the other hand, should be evaluated in terms of all the domains described above. The need for more comprehensive information will often lead clinicians to use more than one instrument for assessments.

Screening and Assessment of Whom?

The characteristics of youth who typically come into contact with the juvenile justice system raise a number of issues that must be taken into account in the selection of appropriate screening and assessment instruments.

Age. Screening and assessment instruments must be designed for the appropriate age range. Typically this range is ages 12–17, although the range for specific settings may be somewhat different, depending on the stage of the juvenile justice process at which the evaluation is being performed or the juvenile jurisdictional age in a particular state. Whether an instrument is appropriate for a particular age group depends on a number of factors, including content, reading level, and norms (scores from the population with whom the instrument was originally developed).

Gender. In 2002, females constituted approximately 29 percent of all juvenile arrests (Snyder, 2004). Despite the steady increase in the number of girls involved with the juvenile justice system, many instruments designed for use in juvenile justice settings traditionally have been developed with and for boys. This tradition is changing but is still in evidence.

Girls differ from boys somewhat in the types of mental, emotional, and substance abuse problems they exhibit and in the prevalence of these problems. Thus, for a particular screening or assessment instrument, clinicians must determine whether the content and norms will be appropriate when girls are among the youth to be screened or assessed.

Ethnicity. The ethnic composition of youth involved in the juvenile justice system varies from one jurisdiction to another and from one stage in the juvenile justice process to the next. Minority ethnic youth make up at least one-half of the youth involved with the juvenile justice system in most communities, far more than that in many urban areas, and nearly all of the youth entering some juvenile corrections facilities (Isaacs, 1992). It is obvious, therefore, that instruments developed and normed primarily or exclusively with non-Hispanic white youth are inadequate for screening and assessment in the juvenile justice system.

When considering the ethnic appropriateness of instruments for juvenile justice samples of diverse ethnicity, it is important to recognize that race is no longer the framework for making these judgments. Second-language skills vary widely within racial groups, as does the level of cultural diversity. African American youth in New York City and Miami, for example, may typically have very different cultural and linguistic backgrounds. An instrument that performed adequately when developed with Hispanic youth in Boston may produce considerably more error in measurement when used with Latino youth in Los Angeles.

These issues have no easy solutions. Test developers probably will never be able to construct screening and assessment instruments that are entirely appropriate for all youth in an increasingly multiracial, multiethnic, multilinguistic, and multicultural society. However, some instruments will come closer to meeting these challenges than others. The selection of screening and assessment instruments must take into account the particular ethnic, linguistic, and cultural composition of the youth in the juvenile justice system where the instruments will be used.

Cognitive and Attentional Deficits. Virtually all large studies of youth in the juvenile justice system find that their average score on standardized intelligence tests is considerably below the average for youth generally in the United States (Frick, 1998). In addition, youth in the juvenile justice system disproportionately have problems in reading, attention, and expressive and receptive language skills. These deficits should, of course, be assessed in determining a youth's cognitive and educational needs. Such deficits also mean that instruments used to screen and assess youth for mental, emotional, and substance abuse problems must be designed to accommodate youth with serious limitations in reading and expressive abilities.

Screening and Assessment in What Context?

The context in which screening or assessment is performed should receive special consideration when selecting instruments. An instrument that requires certain resources might work well at one point in the system but might not be at all feasible for use at another point. Moreover, the importance of identifying a particular type of disorder or problem may vary from one point in the system to the next. A number of factors require consideration when reviewing instruments for use in a particular context.

Time. Typically, the greater the volume of cases that must be screened or assessed, the less time is available for the task. Moreover, some objectives—especially those associated with screening—may simply not require time-consuming methods. Sometimes, shorter is better in all respects. In other situations, however, brevity may compromise the objectives of the screening or assessment.

Screening and assessment instruments vary considerably in the time required to administer and score them, ranging from 10 minutes to several hours. Moreover, some paper-and-pencil instruments may be administered to groups of youth together (e.g., all youth admitted to a facility during the previous 24 hours), whereas other instruments, especially those requiring interviews, must be administered individually. Juvenile justice settings that screen every youth who enters typically cannot afford to spend more than 15–20 minutes per youth. This limitation places some of the better assessment instruments outside the range of feasibility for screening. Because screening instruments that require little time usually sacrifice range or precision in the information they provide, they are inadequate for more thorough assessment unless combined with other measures.

Financial Cost. Instruments vary considerably in their per-case cost. Excluding compensation for staff or clinician time, some instruments may be used without any per-case fees, and others may cost several dollars per case (through purchase of the materials or contracts with commercial, computer-based assessment systems). A direct relationship between cost and quality is not a safe assumption. Each instrument should be considered on its merits and appropriateness for a particular setting.

Expertise of Personnel. Some instruments require professional clinical expertise to administer, score, and/or interpret. Others may be used by line staff or justice-based counselors, either with little training or with some specialized inservice training. Selection of an instrument depends on the nature of the information that is needed. For example, tools designed for indepth evaluation

frequently require professional clinical expertise, whereas brief screening instruments often are designed for use by nonclinicians in juvenile facilities.

Information Sources. Instruments for evaluating the mental health- and substance use-related needs of youth vary considerably in the types of information needed for completion. Some require only the youth's self-report; others require information obtained directly from family members and/or legal, educational, and mental health records. The latter probably would be of little value for screening at admission to pretrial detention facilities, because detention staff usually do not have access to a youth's parents or records until several days after admission (and sometimes longer). On the other hand, in more extensive assessments to arrive at recommendations for longer term treatment, using an instrument that relies solely on a youth's reports of his or her own feelings and behaviors is risky because the information may be distorted, biased, or incomplete.

The Screening and Assessment Relationship. Juvenile justice personnel and mental health professionals who screen or assess youth in the context of adjudication proceedings are expected to act in the best interests of the youth, seeking to identify and meet treatment needs. Yet, the role of an evaluator acting under the authority of the juvenile court is different from that of an evaluator in a children's clinic. For example, the data obtained in a court-ordered evaluation typically are not held to the same standards of confidentiality that apply in strictly clinical settings. The examiner often communicates assessment information to the court, which may use the information to make decisions about long-term incarceration involving significant deprivations of liberty.

Expectations of parents and youth about the potential use of the information they are providing mental health examiners may influence the nature of their responses to the examiner's inquiries. Instruments vary in the degree to which such factors influence results. Moreover, many instruments have been validated only in the context of clinical assessments in which parents and youth expect privacy and confidentiality. Such instruments may not be valid when used in the different context of the examiner-examinee relationship in a juvenile justice setting.

Purpose of Screening and Assessment. As noted earlier, instruments differ in the type of information they provide. Some suggest diagnoses; others focus on symptoms, problem areas, or family characteristics. Different types of information are relevant to varying degrees at different stages in the juvenile justice process, depending on the nature of the decisions to be made. For example, at pretrial detention intake, establishing a psychiatric diagnosis of major depression may be far less important—for purposes of meeting a youth's immediate needs—than learning that the youth recently has been obsessing about self-injurious behaviors and has made a suicide threat within the past few days.

Similarly, some instruments have been designed to bridge the gap between identifying mental health or substance abuse disorders and intervening to address the disorders. For example, an instrument's content may focus on problem areas associated with specific intervention needs (e.g., frequency, recency, social context, and functional consequences of substance use, with high scores indicating a need for a specific type of intervention). Other instruments identify general mental or emotional conditions (e.g., anxiety) that do not automatically suggest a specific

intervention. The selection of a specific instrument depends on the context and the purpose for which the instrument will be used.

How To Judge Psychometric Quality

Choosing an instrument for screening or assessment requires adequate attention to the psychometric properties of the instrument (i.e., the properties related to its use in the quantitative measurement of psychological data), as described in the instrument's manual or in relevant research reports. Instruments vary considerably in the degree to which research has demonstrated their internal consistency, interexaminer reliability, test-retest reliability, and construct and predictive validity.[1] Weighing these factors during instrument selection frequently involves significant compromises, because even the best instruments may not meet stringent and comprehensive tests of both reliability and validity.

Less-than-perfect reliability and validity are not surprising, however, given the heterogeneity of the juvenile justice population. A single instrument is unlikely to meet high standards across all categories of youth (ages, ethnicities, offense histories, cognitive and developmental capacities) for all conditions to be assessed.

Selecting a tool, therefore, involves deciding "how good is good enough" with regard to psychometric properties in light of intended usage. There is no "minimum" requirement set by professional standards. The following guidelines, however, can help juvenile justice administrators and clinicians weigh the psychometric adequacy of instruments for juvenile justice screening and assessment:

- An instrument should not be selected if no research exists on the degree of its reliability or validity when administered to adolescents.

- Instruments that provide evidence of reliability and validity with youth in the juvenile justice system are preferable to those that do not.

- The greater the consequences and import of the decisions to be made (e.g., longer term treatment and/or incarceration), the higher the standard that should be applied in judging whether an instrument has an acceptable degree of reliability and validity.

- Instruments that provide variable norms according to gender, age, and ethnic background are preferable to those that do not.

[1] *Internal consistency* is the degree to which the items on a scale are related to each other. *Interexaminer reliability* is the degree to which an individual's answers on a test are scored similarly by different examiners. *Test-retest reliability* is the degree to which people who take a test twice under the same circumstances have the same scores both times. *Construct validity* is the degree to which an instrument is useful in testing hypotheses about medical or psychological conditions based on a theory about illness or human behavior. *Predictive validity* is the degree to which an instrument identifies individuals who, in the future, do or do not engage in some behavior (or develop some condition) that the instrument is designed to identify.

Administrators who have difficulty evaluating the psychometric properties of assessment instruments may wish to consult with clinical or educational psychologists who are familiar with tests and test development.

Summary: Criteria for Selection of Screening and Assessment Methods

The following checklist describes basic desirable characteristics of instruments for identifying mental health- and substance abuse-related needs among youth in the juvenile justice system.

Both screening and assessment instruments should meet the following criteria:

- Require low levels of reading ability and use relatively simple response formats (for paper-and-pencil instruments that must be completed by youth).
- Assess mental distress and disorder and/or substance use needs along dimensions that are meaningful for the specific context and purpose(s) of the evaluation at a particular point in the juvenile justice process.
- Be amenable to use with youth of diverse ethnic, cultural, and linguistic backgrounds.
- Have some evidence of psychometric reliability and include information regarding the extent and limits of validity with juvenile justice system youth.
- Offer age- and gender-based norms across the age span of youth in a particular juvenile justice setting.

In addition, screening instruments should meet the following criteria:

- Assess psychological or behavioral conditions that may indicate a need for immediate or emergency intervention (e.g., suicide potential, serious depression, anger and aggression, substance abuse).
- Have low per-case costs and low publisher fees (important because of the high volume of cases that typically must be screened).
- Involve brief, simple administration that requires little or no specialized clinical expertise.
- Offer easy scoring that produces uncomplicated results.
- Allow for quick and simple interpretation of scores or application of decision rules in using screening data to determine appropriate responses.

Chapter 3: Menu of Screening and Assessment Instruments

Overview

This chapter provides juvenile justice administrators, probation officers, youth counselors, and mental health professionals with information about a wide range of tools that have been developed for screening and assessing mental health and substance abuse disorders in youth. The information is provided in several forms and will facilitate application of the criteria presented in chapter 2 to the selection of instruments for use in juvenile justice settings.

The instruments described in this chapter were selected on the basis of a thorough search of the literature. Literally hundreds of instruments measure aspects of adolescent mental health, substance abuse, personality, and cognitive abilities. Some have rarely or never been used in clinical or juvenile justice settings. Others have been used even though there is no evidence regarding their psychometric properties. Others have not yet been used but have preliminary manuals because research to establish their value is underway. The authors have selected instruments with at least some known use in juvenile justice or adolescent clinical settings and some evidence of reliability and other psychometric properties.

Having many instruments to choose from is both an advantage and a problem. Although the vast number of instruments means that agencies are more likely to find tools that fit their needs, the sheer volume of both instruments and selection criteria makes choosing among the instruments a daunting task. This Resource Guide has been designed to reduce the complexity of these decisions in several ways.

First, this chapter offers two overview tables: one for screening instruments and another for assessment instruments. These tables summarize basic facts for each instrument and can be used as a threshold for the decision process, to narrow the selection. Next, one-page instrument summaries, arranged alphabetically by instrument title, provide detailed information about each instrument covered in the overview table.

Following this chapter's menu of instruments, chapter 4 presents "best practice" selections recommended by the authors for several hypothetical circumstances. A caution about these selections: What is best for one setting—or in the hypothetical circumstances described—might not be best for other settings. Actual selections should not be based solely on these hypothetical examples.

Overview Tables

The overview tables on pages 16–18 divide the instruments into two classifications: Screening and Assessment. Instruments are classified as suitable for screening if they have all of the following characteristics:

- Require no more than 15 minutes to administer.
- Offer paper-and-pencil or structured interview questions.

- Do not require clinical training for the person administering or scoring the instrument.

Instruments that exceed the time requirement for screening or require a clinically trained examiner are classified as assessment instruments.

Both tables group the instruments into four categories:

- Assess substance use/abuse only.
- Primarily assess symptoms associated with mental or emotional disturbance.
- Focus on psychosocial problems, strengths, or needs.
- Examine cognitive and intellectual abilities.

Overview Table 1: Screening Instruments (15 Minutes or Less, Paper-Pencil or Structured Interview, No Clinician Training)

Category and Instrument	Time To Administer (Minutes)	Age Range	Research (Juvenile Justice)	Tests (X=Yes)			
				Substance Use	Suicide Risk	Symptoms of Disorder	Multiple Scales
Substance Use Only							
Adolescent Substance Abuse Subtle Screening Instrument	15	12–18	X	X			X
Symptoms of Disorder*							
Children's Depression Inventory	10–20	6–17	X			X	X
Massachusetts Youth Screening Instrument-Second Version	10–15	12–17	X	X	X	X	X
Posttraumatic Stress Diagnostic Scale	10–15	17+				X	X
Reynolds Adolescent Depression Scale	5–20	13–18				X	
Suicide Ideation Questionnaire	5–10	12–18	X		X		
Problems/Strengths/Needs**							
Behavioral and Emotional Rating Scale	10–15	5–18	X				X
Personal Experience Screening Questionnaire	15–20	12–18	X	X			X
Resiliency Attitude Scale	10–15	13–17					X
Cognitive Abilities							
Peabody Picture Vocabulary Test	10–15	2+	X				
Wechsler Abbreviated Scales of Intelligence	15–30	6+	X				X

* See also, in assessment table, Child Behavior Checklist–Youth Self-Report, which is appropriate for screening in some settings despite administration time of 20–25 minutes.
** See also, in assessment table, Problem Oriented Screening Instrument for Teenagers, which is appropriate for screening in some settings despite administration time of 20–25 minutes.

Overview Table 2: Assessment Instruments (More Than 15 Minutes, May Require Clinical Experience)

Category and Instrument	Time To Administer (Minutes)	Age Range	Research (Juvenile Justice)	Tests (X=Yes)			
				Substance Use	Suicide Risk	Symptoms of Disorder	Multiple Scales
Substance Use As Primary Focus							
American Drug and Alcohol Survey	20–25	9–18		X		X	X
Comprehensive Addiction Severity Index for Adolescents	45–90	12–18	X	X		X	X
Drug Use Screening Inventory-Revised	20–40	12–17	X	X		X	X
Juvenile Automated Substance Abuse Evaluation	30–45	11–18	X	X		X	X
Symptoms of Disorder							
Adolescent Diagnostic Interview	45–60	12–18	X	X		X	X
Adolescent Psychopathology Scale	45–60	12–19		X		X	X
Brief Psychiatric Rating Scale for Children	20	3–17			X	X	X
Carlson Psychological Survey	15	14+	X	X		X	X
Child and Adolescent Needs and Strengths-Mental Health	20	1–18	X	X	X	X	X
Child Behavior Checklist (Parent Form)	20–25	4–18	X			X	X
Child Behavior Checklist (Teacher Report Form)	20–25	4–18	X			X	X
Child Behavior Checklist (Youth Self-Report)	20–25	4–18	X			X	X
Devereux Scales of Mental Disorders	15	5–18	X			X	X
Diagnostic Interview Schedule for Children-IV (Voice DISC)	60	9–17	X	X	X	X	X
Jesness Inventory	20–30	13–20	X			X	X
Millon Adolescent Clinical Inventory	45–75	13–19	X	X	X	X	X
Minnesota Multiphasic Personality Inventory-Adolescent	60–90	14–18	X			X	X
Practical Adolescent Dual Diagnostic Interview	20–40	13–18	X	X		X	X
Revised Behavior Problem Checklist	30–45	5–18	X			X	X
State-Trait Anger Expression Inventory	15	13+				X	X
Suicide Probability Scale	15–20	13+	X		X	X	X
Symptom Checklist-90-Revised	15–20	13+				X	X
Trauma Symptom Checklist for Children	15–20	8–16	X			X	X

Category and Instrument	Time To Administer (Minutes)	Age Range	Research (Juvenile Justice)	Tests (X=Yes)			
				Substance Use	Suicide Risk	Symptoms of Disorder	Multiple Scales
Problems/Strengths/Needs							
Child and Adolescent Functional Assessment Scale	10–30	4–14	X	X	X		X
Child and Adolescent Needs and Strengths-Juvenile Justice	20	4–21	X	X	X	X	X
Connors' Rating Scales-Revised	15–30	3–17	X				X
Family Adaptability and Cohesion Evaluation Scales-II	30–45	12+					X
Inventory of Suicide Ideation	10–15	13–18	X		X		
Matson Evaluation of Social Skills with Youngsters	20	4–18	X				X
Personality Inventory for Youth	30–60	8–18	X			X	X
Problem Oriented Screening Instrument for Teenagers	20–25	12–19	X	X			X
Relationship With Family of Origin Scale	20–30	15+	X				X
Sixteen Personality Factor Questionnaire	45–60	16+					X
Structured Pediatric Psychosocial Interview	20	5–19	X				X
Vineland Adaptive Behavior Scales	20–90	1–18	X				X
Youth Level of Service-Case Management Inventory	30–40	12–16	X	X			X
Cognitive Abilities							
Kaufman Brief Intelligence Test	15–30	4+	X				X
Peabody Individual Achievement Test-Revised	60	5–18	X				X
Quick Neurological Screening Test II	20–30	5–18	X				X
Stanford-Binet Intelligence Scale	45–90	2–23	X				X
Wechsler Intelligence Scales	60–120	6–16, 16+	X				X
Wide Range Achievement Test-III	15–30	5+	X				X

Instrument Summaries

The instrument summaries are listed alphabetically by title. Each summary includes the information noted below.

Description. A brief review of the instrument, its purpose, and other relevant information. More detailed information is available from the developer/publisher (see below).

Constructs Measured. Each scale and the characteristics (constructs) measured.

Age Range. The specific age range designated for the instrument. All instruments are appropriate for children and/or adolescents.

Administration/Scoring. The form in which the instrument is administered and scored. Forms include paper and pencil, CD–ROM programs in personal computers, and contracts with online assessment services.

Administration Time. Approximately how many minutes are required to complete the instrument. The authors sought instruments that can be completed in 20–30 minutes. However, administration time can vary with the objectives of the instrument. Several instruments that take longer than 20–30 minutes to administer are included because they provide valuable information.

Level of Training Required. Information regarding the level of clinical experience and education needed to administer the instrument. The authors sought assessment instruments that may be administered by practitioners who do not have advanced degrees. The following classifications are used to describe the levels of training required:

- Inservice training with the instrument, no clinical experience.
- Specialized training with the instrument, no clinical experience.
- Master's degree (M.A.), clinical experience.
- Doctoral degree (Ph.D.), clinical experience.

Research in General. Brief indication of the extent of research and development involving the instrument. In the limited space available, even a summary of the research is not possible. Instead, this section attempts to capture the extent to which the instrument has been researched in general, not specifically with youth in juvenile justice programs and facilities. The following categories are used to describe the extent of research:

- Limited research: Minimal or no known research or minimal research has been published.
- Some research: A few studies have been conducted and published.
- Much research: The instrument is the focus of substantial research and development.

There are several ways to obtain more specific information regarding research on reliability, validity, and normative data for most of the instruments: (1) consult the technical manual; (2) ask the publisher for an updated list of research reports; or (3) access computer-based literature search programs through a university library, or with the assistance of a university-affiliated professional (entering the instrument's title or author will produce a complete list of related publications).

Research With Juvenile Justice Youth. Indication (yes or no) of research on reliability, validity, or utility with samples of juvenile justice youth.

Use With Ethnic Minorities. Information on availability in languages other than English and research on possible ethnic/racial differences in scores. This section assigns the instrument to one of three research categories:

- Relevant information is available in the manual.
- Relevant information is available in research reports.
- No known relevant research has been conducted and the manual includes no information pertaining to race/ethnicity.

Test Developer/Publisher. Contact information, including Web and e-mail addresses where available.

Necessary Purchases. Materials that must be obtained to administer and score the instrument. If the instrument may be used without cost, that is indicated. Although the specific costs incurred in implementing an instrument may be an important consideration in selection, that information is not provided here. (Cost information is, however, available from the publishers of the instruments.) The Resource Guide omits cost information for several reasons, which should be considered by potential users of these instruments: (1) Cost information quickly becomes obsolete; (2) some instruments can be administered in various forms at various costs (e.g., pencil and paper, CD–ROM, online testing services with a per-case cost); (3) some instruments will cost less than the list price if a facility can negotiate a reduced purchase price for high-volume purchases; and (4) the true cost of implementation often includes more than the purchase cost of the materials (e.g., computer hardware, staff time, database management).

Adolescent Diagnostic Interview (ADI)

Description	Assesses symptoms found in substance use and mental health disorders as described in the *DSM–IV*. Questions cover all major categories of drug use. The purpose is to assess substance use disorders and problems commonly associated with substance abuse. The ADI also assesses the effect of psychosocial stressors, school and interpersonal functioning, and cognitive impairment. It assists with identifying, referring, and treating adolescents with substance abuse problems.
Constructs Measured	**Psychoactive substance use** Sociodemographic factors Psychosocial stressors Alcohol use symptoms Substance use history Cannabis use symptoms Additional drug use symptoms Level of functioning domains Orientation/memory screen **Psychiatric status** Depression Mania Eating disorders Delusional thinking Hallucinations Attention-deficit disorder Anxiety disorder Conduct disorder
Age Range	12–18 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	45–60 minutes, depending on the number of substances used.
Level of Training Required	Master's degree (with specialized training in drug and alcohol abuse or psychology), clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Western Psychological Services 12031 Wilshire Blvd. Los Angeles, CA 90025 800–648–8857 or 310–478–2061 www.wpspublish.com
Necessary Purchases	Manual and test, administration booklets, scoring templates.

Adolescent Psychopathology Scale (APS)

Description	A 346-item (long-form) self-report instrument that assesses psychopathology, personality, and social-emotional problems. The APS is used to assess psychological problems and behaviors that may interfere with an adolescent's psychological adaptation and personal competence.
Constructs Measured	Conduct disorder Aggression Adjustment disorder Disorientation Sleep disorder Infrequency response Somatization disorder Critical item endorsement Generalized anxiety disorder Panic disorder Obsessive-compulsive personality disorder Borderline personality disorder Psychosocial substance use disorder Schizotypal personality disorder Internalizing disorder factor Paranoid personality disorder Alienation-boredom Posttraumatic stress disorder Major depression Avoidant personality disorder Dysthymic disorder Schizophrenia Self-concept Social phobia Introversion Substance abuse disorder
Age Range	12–19 years.
Administration/Scoring	Paper-and-pencil administration. Scored with a computer program (by publisher).
Administration Time	45–60 minutes (long form), 15–20 minutes (short form).
Level of Training Required	Master's degree, clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	No.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Psychological Assessment Resources 16204 North Florida Avenue Lutz, FL 33549 800–331–8378 (U.S. and Canada) or 813–968–3003 www.parinc.com
Necessary Purchases	Manual and test, surveys.

Adolescent Substance Abuse Subtle Screening Instrument (Adolescent SASSI)

Description	A self-report screening instrument that examines symptoms and other indicators of alcohol and drug dependence (Miller, 1985). The Adolescent SASSI, using a third-grade reading level, examines both obvious and subtle symptoms related to alcohol and drug dependence (Cooper and Robinson, 1987).
Constructs Measured	Substance use frequency, symptoms, and other indicators of alcohol and other drug dependence.
Age Range	12–18 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Scored by hand with a template or with a computer program.
Administration Time	15 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish (under development). Research on ethnic differences: Information available in manual.
Developer/Publisher	The SASSI Institute 201 Camelot Lane Springville, IN 47462 800–726–0526 www.sassi.com
Necessary Purchases	Questionnaire (25 SASSIs, 25 profiles, 25 questionnaires); manual and test; scoring key; user guide. With computerized version, all of the these, plus diskette.

American Drug and Alcohol Survey (ADAS)

Description	A 57-item self-report instrument that covers a broad spectrum of areas, including more than 36 different types of substances, and identifies lifetime use and frequency of use (McLellan and Dembo, 1993).
Constructs Measured	Substance use, frequency of use.
Age Range	9–12 years and 12–18 years.
Administration/Scoring	Paper-and-pencil administration. Scored with a computer program (by publisher).
Administration Time	20–25 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	No.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	RMBS, Inc. 305 West Magnolia Street, #291 Fort Collins, CO 80521 800–447–6354 www.rmbsi.com
Necessary Purchases	Manual and test, surveys.

Behavioral and Emotional Rating Scale (BERS)

Description	A 52-item, strength-based, clinician-rated approach to assessment (Epstein and Sharma, 1998). Using a Likert scale format, BERS includes measures such as a sense of family unity, the ability to ask for help, interests, and other prosocial-related areas.
Constructs Measured	Interpersonal and intrapersonal strengths, involvement with family, school functioning, affective strength.
Age Range	5–18 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	10–15 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Some.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Psychological Assessment Resources 16204 North Florida Avenue Lutz, FL 33549 800–331–8378 (U.S. and Canada) or 813–968–3003 www.parinc.com
Necessary Purchases	Manual and test, summary response forms.

Brief Psychiatric Rating Scale-Children (BPRS–C)

Description	Requires clinician ratings based on a clinical interview. The BPRS–C yields ratings of severity for a variety of psychiatric symptoms and a total symptom severity score (Timmons-Mitchell et al., 1997).
Constructs Measured	Somatic concerns Anxiety Depressive mood Hostility Tension Uncooperativeness Hyperactivity Suicide ideation Distractibility Unproductive speech Speech deviance Manipulativeness Hallucinations Blunted affect Emotional withdrawal Disorientation Feelings of inferiority Peculiar fantasies Delusions Speech and voice pressure Sleep difficulties Stereotypy
Age Range	3–17.
Administration/Scoring	Interview. Scored by hand with a template.
Administration Time	20 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	No.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	WorldMedicus Pty Ltd. 12 Tryon Road Lindfield NSW 2070 Australia +61–2–9416–0406 enquiries@worldmdicus.com.au
Necessary Purchases	Manual and test, parent guide, profile, booklets.

Carlson Psychological Survey (CPS)

Description	A brief self-report of psychological issues (Carlson, 1982). The CPS was normed on a juvenile justice population and is reliable for identifying mental health issues that may need to be further questioned. It provides a very brief measure of psychiatric symptomatology and depression.
Constructs Measured	Chemical abuse, thought disturbance, antisocial tendencies, self-deprecation, validity.
Age Range	14+.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	15 minutes.
Level of Training Required	Master's degree, clinical experience, supervision by psychologist.
Research in General	Some.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English, Spanish, French. Research on ethnic differences: Information available in manual.
Developer/Publisher	Psychological Assessment Resources 16204 North Florida Avenue Lutz, FL 33549 800–331–8378 (U.S. and Canada) or 813–968–3003 www.parinc.com Sigma Assessments 800–265–1285
Necessary Purchases	Manual and test, questionnaire, answer sheet, scoring sheet, profiles.

Child and Adolescent Functional Assessment Scale (CAFAS)

Description	A clinician-rated instrument designed to assess the degree of impairment in children and adolescents with emotional, behavioral, or substance use symptoms or disorders. The CAFAS provides a quick visual profile of problem areas across settings and covers significant life domains, including substance use issues. It can be used in both research and clinical settings to assess progress and outcome (Hodges, 1995). Its purpose is to assess the degree of impairment in a youth's daily functioning, help professionals link clients to resources, and assess changes in clients over time.
Constructs Measured	School/work, home, community, behavior toward others, moods/emotions, self-harmful behavior, substance use, thinking problems.
Age Range	Two versions: 4–7 and 7–14 years.
Administration/Scoring	Paper-and-pencil and computer administration. Scored by hand with a template and with a computer program.
Administration Time	10 minutes, longer if not familiar with youth. A structured option is available that takes 30 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: No known research.
Developer/Publisher	CAFAS 2140 Old Earhart Road Ann Arbor, MI 48105 734–769–9725 hodges@provide.net www.cafas.com
Necessary Purchases	Manual and test, checklist. With computerized version: evaluations, manual and test, data dictionary.

Child and Adolescent Needs and Strengths-Juvenile Justice (CANS–JJ)

Description	An assessment tool that may be administered in the form of an interview, a series of interviews, a child and family planning team meeting, or a record review (Lyons et al., 2000). The CANS–JJ may be used by probation officers, child welfare caseworkers, parent liaisons, and mental health workers.
Constructs Measured	Criminal/delinquent behavior Functioning Substance abuse complications Mental health complications Other risk behaviors Child safety risks Caregiver needs and strengths Youth strengths Organization and intensity of services
Age Range	4–21 years.
Administration Time	20 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English, Spanish (in development). Research on ethnic differences: No known research.
Developer/Publisher	John S. Lyons, Ph.D. Mental Health Services and Policy Program Institute for Health Services Research and Policy Studies Northwestern University 339 East Chicago Avenue, Weibolt Building 717 Chicago, IL 60611 312–503–0425 jsl329@nwu.edu
Necessary Purchases	Manual and test, forms.

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

Description	Assesses children and adolescents prospectively and retrospectively for systems related to the needs and strengths of child and family. The CANS–MH provides a structured assessment of mental health challenges along dimensions relevant to service planning and decisionmaking. It identifies service gaps and is helpful in developing community-based treatment plans (Lyons et al., 2000).
Constructs Measured	**Problem presentation:** Psychosis, attention deficit/impulse control, depression/anxiety, oppositional behavior, antisocial behavior, substance abuse, adjustment to trauma, situational consistency of problems, temporal consistency of problems. **Risk behaviors:** Danger to self, danger to others, elopement, sexually abusive behavior, crime/delinquency. **Functioning:** Intellectual/developmental, physical/medical, family, school/day care. **Care intensity and organization:** Monitoring, treatment, transportation, service permanence. **Caregiver capacity:** Physical, supervision, involvement with care, knowledge, organization, residential stability, resources, safety. **Strengths:** Family, interpersonal, relationship permanence, education, vocational, well-being, spiritual/religious, creative/artistic, inclusion.
Age Range	1–18 years.
Administration/Scoring	Paper-and-pencil and computer administration. Scored by hand with a template and with a computer.
Administration Time	20 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	John S. Lyons, Ph.D. Mental Health Services and Policy Program Institute for Health Services Research and Policy Studies Northwestern University 339 East Chicago Avenue, Weibolt Building 717 Chicago, IL 60611 312–503–0425 jsl329@nwu.edu
Necessary Purchases	Manual and test, forms.

Child Behavior Checklist (CBCL), Parent Report Form

Description	Designed for completion by the parent (caregiver) as a behavioral measure of a youth's overall mental, emotional, and adaptational functioning (Achenbach, 1991). The CBCL is also available in Teacher Report and Youth Self-Report forms.
Constructs Measured	**Competence scales:** Activities, social. **Syndrome scales:** Anxious/depressed, attention problems, delinquent behavior, social problems, somatic complaints, thought problems, withdrawn, aggressive, externalizing, internalizing.
Age Range	4–18 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Computer-automated scoring.
Administration Time	20–25 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: Available in 61 languages. Research on ethnic differences: Information available in the manual and in research reports.
Developer/Publisher	Achenbach System of Empirically Based Assessment (ASEBA) 1 South Prospect St. Burlington, VT 05401 802–264–6432 www.aseba.org/index.html
Necessary Purchases	Manual and test, forms, score sheets.

Child Behavior Checklist (CBCL), Teacher Report Form

Description	Designed for completion by teachers as a behavioral measure of a youth's overall mental, emotional, and adaptational functioning (Achenbach, 1991). The CBCL is also available in Parent Report and Youth Self-Report forms.
Constructs Measured	**Competence scales:** Activities, social. **Syndrome scales:** Anxious/depressed, attention problems, delinquent behavior, social problems, somatic complaints, thought problems, withdrawn, aggressive, externalizing, internalizing.
Age Range	4–18 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Computer-automated scoring.
Administration Time	20–25 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: Available in 61 languages. Research on ethnic differences: Information available in the manual and in research reports.
Developer/Publisher	Achenbach System of Empirically Based Assessment (ASEBA) 1 South Prospect St. Burlington, VT 05401 802–264–6432 www.aseba.org/index.html
Necessary Purchases	Manual and test, forms, score sheets.

Child Behavior Checklist (CBCL), Youth Self-Report Form

Description	Designed for self-report completion by a youth as a behavioral measure of overall mental, emotional, and adaptational functioning (Achenbach, 1991). The CBCL is also available in Parent Report and Teacher Report forms.
Constructs Measured	**Competence scales:** Activities, social. **Syndrome scales:** Anxious/depressed, attention problems, delinquent behavior, social problems, somatic complaints, thought problems, withdrawn, aggressive, externalizing, internalizing.
Age Range	4–18 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Computer-automated scoring.
Administration Time	20–25 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: Available in 61 languages. Research on ethnic differences: Information available in the manual and in research reports.
Developer/Publisher	Achenbach System of Empirically Based Assessment (ASEBA) 1 South Prospect St. Burlington, VT 05401 802–264–6432 www.aseba.org/index.html
Necessary Purchases	Manual and test, forms, score sheets.

Children's Depression Inventory (CDI)

Description	A self-report tool that screens for signs and symptoms related to depression and suicide risk (Kovacs, 1985). The CDI uses principles of the Beck Depression Inventory (Beck, Steer, and Brown, 1996) and is specific for children and adolescents. It is written at a fourth grade reading level.
Constructs Measured	Negative mood, interpersonal problems, ineffectiveness, anhedonia (inability to experience pleasure), negative self-esteem.
Age Range	6–17 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	10–20 minutes.
Level of Training Required	Bachelor's degree (in psychology, education, human relations) or courses in assessment; no clinical experience; inservice training with the instrument.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Pearson Assessments 800–627–7271, ext. 3225 pearsonassessments@pearson.com www.pearsonassessments.com
Necessary Purchases	Manual and test, quick-score rating forms.

Comprehensive Addiction Severity Index for Adolescents (CASI–A)

Description	An interview-based screening instrument designed to measure the severity of addiction and problems in other life areas (McLellan and Dembo, 1993). The CASI–A assesses concomitant symptomatology and consequences of adolescent alcohol/drug use within multidimensional functional domains, so that problems are not hidden. It guides treatment planning and assessment of outcomes, determines when problem symptoms started, and assesses a youth's awareness of a problem and the level of discomfort the problem is causing.
Constructs Measured	Education Alcohol/drugs Family relationships Legal Use of free time General information Peer relationships Psychiatric
Age Range	12–18 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Computer-automated scoring.
Administration Time	Approximately 45–90 minutes, depending on the extent of alcohol/drug use.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: Information available in manual.
Developer/Publisher	Kathleen Meyers System Measures, Inc. P.O. Box 506 Spring Mount, PA 19478 610–287–4426
Necessary Purchases	Manual and test, scoring sheets.

Connors' Rating Scales-Revised (CRS–R)

Description	An interviewer-rated and a caretaker-rated questionnaire designed to measure a wide range of problem behaviors (Connors, 1997). The CRS–R measures dimensions rather than categories of symptoms. It obtains data from multiple sources for use in diagnosis.
Constructs Measured	School/employment Medical Psychosomatic problems Social relations Family and relationships
Age Range	3–17 years.
Administration/Scoring	Pencil-and-paper and computer-automated administration. Scored with a computer program.
Administration Time	15–30 minutes, depending on the form used.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English, Spanish, and French. Research on ethnic differences: Information available in manual.
Developer/Publisher	MHS, Inc. P.O. Box 950 North Tonawanda, NY 14120 800–456–3003 www.mhs.com
Necessary Purchases	Manual and test, score sheets.

Devereux Scales of Mental Disorders (DSMD)

Description	A 110-item, clinician-rated behavior-rating scale designed to measure behaviors associated with psychopathology in children and adolescents (Naglieri, LeBuffe, and Pfeiffer, 1994). Item content of the DSMD is based on *DSM–IV* categories.
Constructs Measured	Conduct Delinquency Externalizing Anxiety Depression Internalizing Autism Acute problems Critical pathology
Age Range	5–18 years.
Administration/Scoring	Paper-and-pencil administration. Scored with a computer program.
Administration Time	15 minutes.
Level of Training Required	Master's degree, clinical experience, supervision by psychologist.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Howard Savin, Ph.D. Institute of Clinical Training and Research 610–520–3000 www.devereux.org
Necessary Purchases	User's guide, disks, child record forms, adolescent forms.

Diagnostic Interview Schedule for Children-IV (Voice DISC)

Description	A structured youth self-report interview, administered on the computer, that provides provisional DSM–IV diagnoses (Shaffer et al., 2000). Voiced version for parent report currently being bench-tested.
Constructs Measured	Assesses past-month DSM–IV diagnoses and conditions: anxiety disorders, mood disorders (and suicidality), disruptive disorders, substance use disorders, and miscellaneous disorders (e.g., eating disorders).
Age Range	9–17 years.
Administration/Scoring	Requires no clinical expertise to administer and is readily scored by computer. The Voice DISC presents prerecorded questions via headphones, while the same questions appear on the computer screen. Scoring algorithms generate a provisional diagnosis. Results can immediately be reviewed on the computer screen, saved to a diskette, and/or printed for later review. The computer-generated "Clinical Report" lists youths' positive, sub-threshold, and negative diagnoses, "impairment" and "symptom" scores by diagnosis, and a preset list of "clinically significant symptoms" (e.g. suicide risk). Allows for aggregation of data across individuals.
Administration Time	Approximately 1 hour for conventional 21 disorders. Administration time can be shortened by reconfiguring computer software to skip certain disorders if other scientifically sound instruments are in use.
Level of Training Required	Inservice training with instrument, no clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: Voiced format only available in English. However computerized (but nonvoiced) versions of the DISC are available in English and Spanish. Research on ethnic differences: information available in published and non-published research reports
Developer/Publisher	David Shaffer, FRCP (Lond), FRC Psych (Lond) Prudence Fisher, PhD Columbia University/New York State Psychiatric Institute Division of Child Psychiatry www.c-disc.com Institutional contact for use of Voice DISC in juvenile justice settings: Gail A. Wasserman, PhD Center for the Promotion of Mental Health in Juvenile Justice Columbia University/New York State Psychiatric Institute 1051 Riverside Drive, Unit 78 New York, NY 10032 646–443–8197 www.promotementalhealth.org
Necessary Purchases	Computer program is available without charge for collaborating research sites, or can be purchased for noncollaborative use. Training on how to use and best incorporate the DISC into existing assessment protocols is available.

Drug Use Screening Inventory-Revised (DUSI–R)

Description	A 159-item, self-report instrument that addresses the health, behavior, and psychosocial adjustment of adolescents. The DUSI–R is helpful for adolescents with alcohol and drug problems, along with psychosocial issues. It reports the severity of problems across 10 domains in a practical manner and attempts to determine the type and intensity of resources needed to maximize the success of interventions (McLellan and Dembo, 1993).
Constructs Measured	Substance abuse Psychiatric disorder Behavior problems School adjustment Health status Work adjustment Peer relations Social competency Family adjustment Leisure/recreation
Age Range	12–17 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Hand scoring with a template
Administration Time	20–40 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Weak to moderate psychometric properties.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English, Spanish, French, Norwegian, Finnish. Research on ethnic differences: No known research.
Developer/Publisher	David Gorney Gordian Group P.O. Box 1587 Hartsville, SC 29550 843–383–2201 www.dusi.com
Necessary Purchases	Manual and test (audiotape available).

Family Adaptability and Cohesion Evaluation Scales-II (FACES–II)

Description	A self-report tool that assesses family relations by measuring the dimensions of cohesion and family adaptability and the occurrence of patterns of enmeshment or chaos (Olson et al., 1982). (Cohesion refers to the emotional bonding and individual autonomy of family members, adaptability to the capacity of the family unit to adjust in response to ongoing or situational stress.)
Constructs Measured	Family cohesion, family adaptability.
Age Range	12–65 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	30–45 minutes.
Level of Training Required	Inservice training, no clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	No.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: No known research.
Developer/Publisher	Life Innovations, Inc. 2660 Arthur Street Roseville, MN 55113 FIP@lifeinnovation.com www.prepare-enrich.com/studies/fip.html#family
Necessary Purchases	Manual and test, forms.

Inventory of Suicide Orientation-30 (ISO–30)

Description	A self-report inventory designed to help identify adolescents at risk for suicide. Gives an overall suicide risk classification.
Constructs Measured	Hopelessness, suicide ideation.
Age Range	13–18 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	10–15 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: No known research.
Developer/Publisher	MHS, Inc. P.O. Box 950 North Tonawanda, NY 14120 800–456–3003 www.mhs.com
Necessary Purchases	Manual and test, answer sheets.

Jesness Inventory (JI)

Description	A 155-item, self-report inventory designed to describe and measure certain personality characteristics of delinquent youth (Jesness, 1988). The JI provides information on level of social adjustment and deviant behavior. It has been widely used for many years in juvenile justice programs.
Constructs Measured	Social maladjustment Value orientation Immaturity Autism Alienation Manifest aggression Withdrawal-depression Social anxiety Repression Denial Asocial index
Age Range	13–20 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Scored by hand with a template and with a computer program.
Administration Time	20–30 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: Information available in manual.
Developer/Publisher	MHS, Inc. P.O. Box 950 North Tonawanda, NY 14120 800–456–3003 www.mhs.com
Necessary Purchases	Behavior checklist manual and test, observer item booklets, observer QuikScore™ forms, self-appraisal item booklets, self-appraisal QuikScore™ forms.

Juvenile Automated Substance Abuse Evaluation (JASAE)

Description	A 107-item, self-administered questionnaire that evaluates adolescent alcohol and drug use experiences as well as attitudes and life stress (ADE Incorporated, 1997). The JASAE can be used to identify substance dependence and to provide critical information on other life problems.
Constructs Measured	Test-taking attitude Life circumstance evaluation Drinking evaluation Alcohol addiction evaluation Drug use evaluation Possible areas of concern Drug use symptoms Low or unusual life circumstance ratings
Age Range	11–18 years.
Administration/Scoring	Computer-automated administration. Scored with a computer program.
Administration Time	30–45 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: Information available in manual.
Developer/Publisher	ADE Incorporated P.O. Box 660 Clarkston, MI 48347 800–334–1918 www.adeincorp.com
Necessary Purchases	Manual and test, test-items evaluations, key used with a computer program.

Kaufman Brief Intelligence Test (K–BIT)

Description	A brief measure of intelligence, with scales similar to those used in full-battery intelligence testing (Kaufman and Kaufman, 1990). The K–BIT provides a composite I.Q. score that allows the professional to draw conclusions about a youth's level of cognitive functioning. It provides an estimate of intellectual ability but does not provide sufficient detail to identify specific strengths and weaknesses in thinking and reasoning ability. Therefore, it is not suitable for assessing possible learning disabilities.
Constructs Measured	Verbal, nonverbal, full I.Q.
Age Range	4–90 years.
Administration/Scoring	Interview. Scored by hand with a template.
Administration Time	15 minutes for children ages 4–7, up to 30 minutes for persons older than 7.
Level of Training Required	Master's degree, clinical experience, supervision by psychologist.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: Information available in manual.
Developer/Publisher	American Guidance Services, Inc. 4201 Woodland Road Circle Pines, MN 55014 800–328–2560 www.agsnet.com
Necessary Purchases	Easel, manual and test, individual test records (25).

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

Description	A 52-item, self-report instrument that identifies potential mental health and substance use needs of youth at any entry or transitional placement point in the juvenile justice system (Grisso et al., 2001). The MAYSI–2 can be administered to juveniles in probation intake interviews or within 24 to 48 hours after admission into juvenile justice facilities.
Constructs Measured	Alcohol/drug use Somatic complaints Thought disturbance Depressed-anxious Suicide ideation Traumatic experiences Angry-irritable
Age Range	12–17 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Scored by hand with a template and with a computer program.
Administration Time	10–15 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English, Spanish (under development). Research on ethnic differences: Information available in manual.
Developer/Publisher	National Youth Screening Assistance Project (MAYSI) Department of Psychiatry, WSH–8B University of Massachusetts Medical School Worcester, MA 01655 508–856–8564 www.umassmed.edu/nysap
Necessary Purchases	Answer forms, scoring forms, and computer programs are available without charge. However, use is authorized only for programs that register with the National Youth Screening Assistance Project.

Matson Evaluation of Social Skills With Youngsters (MESSY)

Description	A 62-item, self-rating scale that assesses how a child engages in a range of appropriate and inappropriate social behaviors (Matson, Rotatori, and Helsel, 1983). The MESSY focuses on the interpersonal world of the youth, a factor that is considered essential in the appraisal of functioning.
Constructs Measured	Appropriate social skills Inappropriate assertiveness Impulsive-recalcitrant traits Overconfident Jealousy-withdrawal
Age Range	4–18 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	20 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	International Diagnostic Systems P.O. Box 389 Worthington, OH 43085
Necessary Purchases	Manual and test, score sheets.

Millon Adolescent Clinical Inventory (MACI)

Description	An instrument comprising 160 true-and-false items in 31 subscales (Millon, 1993). The MACI measures clinical syndromes and is useful in identifying personality dysfunctions.
Constructs Measured	**Personality patterns:** Introversive, inhibited, doleful, submissive, dramatizing, egotistic, unruly, forceful, conforming, oppositional, self-demeaning, borderline tendency. **Modifying indices:** Disclosure, desirability, debasement. **Clinical syndromes:** Eating dysfunctions, substance abuse proneness, delinquent predisposition, impulsive propensity, anxious feelings, depressive affect, suicidal tendency. **Expressed concerns:** Identity diffusion, self-devaluation, body disapproval, sexual discomfort, peer insecurity, social insensitivity, family discord, childhood abuse. **Other:** Reliability.
Age Range	13–19 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Computer scoring available at extra cost.
Administration Time	45–75 minutes.
Level of Training Required	Master's degree, clinical experience, supervision by psychologist.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: Information available in manual.
Developer/Publisher	Pearson Assessments 800–627–7271, ext. 3225 pearsonassessments@pearson.com www.pearsonassessments.com
Necessary Purchases	Test booklets, manual and test, user's guide, answer sheets, worksheets, profile forms, answer key.

Minnesota Multiphasic Personality Inventory-Adolescent (MMPI–A)

Description	An extensive self-report, true-and-false inventory that is used to broadly assess clinical symptomatology and personality characteristics (Butcher et al., 1994). The MMPI–A uses familiar categories in describing personality and behavioral characteristics that are most associated with degrees of psychopathology.
Constructs Measured	**Clinical scales:** Hypochondriasis, depression, hysteria, psychopathic deviate, masculinity-femininity, paranoia, psychasthenia, schizophrenia, hypomania, social introversion. Other subscales are available.
Age Range	14–18 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Hand scoring with a template and with a computer program.
Administration Time	60–90 minutes.
Level of Training Required	Master's degree, clinical experience, supervision by psychologist.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: Information available in manual.
Developer/Publisher	Pearson Assessments 800–627–7271, ext. 3225 pearsonassessments@pearson.com www.pearsonassessments.com
Necessary Purchases	Manual and test, answer sheets, booklets (audiotape available).

Peabody Individual Achievement Test-Revised (PIAT–R)

Description	A 100-item test designed to measure academic achievement. The PIAT–R instrument was normed on a sample that was comparable to the U.S. population in terms of ethnicity, gender, and parental education.
Constructs Measured	General information Reading recognition Reading comprehension Total reading Mathematics Spelling Total test Written expression Written language
Age Range	5–18 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Scored by hand with a template or with a computer program.
Administration Time	60 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: Information available in manual.
Developer/Publisher	American Guidance Services, Inc. 4201 Woodland Road Circle Pines, MN 55014 800–328–2560 www.agsnet.com
Necessary Purchases	Manual and test, test record, response booklets, software package.

Peabody Picture Vocabulary Test-Third Edition (PPVT–III)

Description	Designed as a screening test of verbal ability and receptive (hearing) vocabulary. The PPVT–III has two 240-item forms: IIIA and IIIB. Each item has simple black-and-white illustrations on a page; the youth selects a response from multiple choices. Youth can select a response by pointing; no verbalization is required.
Constructs Measured	Verbal ability.
Age Range	2–90 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template and with a computer program.
Administration Time	10–15 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: Information available in manual.
Developer/Publisher	American Guidance Services, Inc. 4201 Woodland Road Circle Pines, MN 55014 800–328–2560 www.agsnet.com
Necessary Purchases	Manual and test, forms IIIA and IIIB, norms booklet, performance records.

Personal Experience Screening Questionnaire (PESQ)

Description	A 40-item, self-report instrument that measures a number of problem areas. The PESQ is formatted in an easy-to-read fashion and has a fourth grade readability level. It is often used as a screening instrument for determining drug treatment needs among adolescents (Winters, Weller, and Meland, 1993).
Constructs Measured	Problem severity, psychosocial problems, drug use history, defensiveness, and other behaviors and attitudes most consistent with alcohol and drug use.
Age Range	12–18 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Score by hand with a template and with a computer program.
Administration Time	15–20 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Western Psychological Services 12031 Wilshire Blvd. Los Angeles, CA 90025 310-478-2061 800–648–8857 or 310–478–2061 www.wpspublish.com
Necessary Purchases	Manual and test, autoscore forms.

Personality Inventory for Youth (PIY)

Description	A 270-item, self-report inventory designed to assess personality, behavioral, and emotional issues. The PIY can be administered in a group setting.
Constructs Measured	Validity Inconsistency Dissimulation Defensiveness Cognitive impairment Marital discord Family dysfunction Impulsivity and distractability Parent maladjustment Reality distortion Somatic concern Psychological discomfort Social withdrawal Social skill deficits
Age Range	8–18 years.
Administration/Scoring	Paper-and-pencil administration (audiotape available). Scored by hand with a template and with a computer program.
Administration Time	30–60 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: Information available in manual.
Developer/Publisher	Western Psychological Services 12031 Wilshire Blvd. Los Angeles, CA 90025 800–648–8857 or 310–478–2061 www.wpspublish.com
Necessary Purchases	Manual and test, interpretation guide, technical guide, answer sheets, scoring templates, profile forms, critical item summary sheets, mail-in answer sheets for computer scoring, administration booklets, audiotape, disk for onsite computer scoring and interpretation.

Posttraumatic Stress Diagnostic Scale (PDS)

Description	A brief self-report instrument that measures stressful and traumatic events that youth have either experienced or witnessed. The results can be useful in measuring current social and psychological functioning (Foa et al., 1993).
Constructs Measured	Symptom onset Symptom severity Number of symptoms Symptom duration Level of impairment in functioning
Age Range	17–65 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	10–15 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Limited.
Research With Juvenile Justice Youth	No.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Pearson Assessments 800–627–7271, ext. 3225 pearsonassessments@pearson.com www.pearsonassessments.com
Necessary Purchases	Manual and test, answer sheets, worksheets, scoring sheet.

Practical Adolescent Dual Diagnostic Interview (PADDI)

Description	Used to assist in determining whether a youth has symptoms and behaviors consistent with *DSM–IV* diagnostic criteria (Hoffmann and Estroff, 2001). The PADDI uses a standardized structured interview to gather information.
Constructs Measured	Major depressive episode Manic episode Anxiety/phobias Conduct disorder Oppositional defiant disorder Substance dependence Substance abuse
Age Range	13–18 years.
Administration/Scoring	Paper-and-pencil administration. Hand scoring with a template.
Administration Time	20–40 minutes.
Level of Training Required	Master's degree, clinical experience, supervision by psychologist.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: Information available in manual.
Developer/Publisher	Evince Clinical Assessments P.O. Box 17305 Smithfield, RI 02917 800–755–6299 evinceassessment@aol.com www.evinceassessment.com/product_paddi.html
Necessary Purchases	Manual and test, scoring sheets.

Problem Oriented Screening Instrument for Teenagers (POSIT)

Description	A 139-item, yes-no, self-administered instrument that measures 10 problem areas, including mental health and substance abuse. The POSIT includes information on the history of juvenile justice and mental health contacts, health care utilization, and current stressors. It is designed to quickly identify problems in areas requiring further assessment (McLellan and Dembo, 1993).
Constructs Measured	Substance use/abuse Physical health Mental health Family relationships Peer relationships Educational status Vocational status Social skills Leisure and recreation Aggressive behavior/delinquency
Age Range	12–19 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Scored by hand with a template and with a computer program.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: In research reports.
Administration Time	20–25 minutes.
Developer/Publisher	National Clearinghouse for Alcohol and Drug Information P.O. Box 2345 Rockville, MD 20847 800–729–6686 Dr. Elizabeth Rahdert 301–443–0107 For information: www.niaaa.nih.gov/publications/posit-text.htm To view online: www.niaaa.nih.gov/publications/insposit.htm
Necessary Purchases	Manual and test, scoring templates.

Quick Neurological Screening Test II (QNST)

Description	An untimed, self-report screen of neurological deficits. The QNST is adapted from standard pediatric neurological exams. Scoring patterns suggest possible avenues for further diagnostic assessment (Mutti et al., 1998).
Constructs Measured	Early identification of learning disabilities Manual and test dexterity Spatial orientation Fine and gross motor movements Visual tracking and tactile perceptual activities
Age Range	5–18 years.
Administration/Scoring	Paper-and-pencil administration (although teachers and parents might be involved in observation and explanation of implications). Scored by hand with a template.
Administration Time	20–30 minutes.
Level of Training Required	Doctoral degree, clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Academic Therapy Publications 20 Commercial Boulevard Novato, CA 94949 800–422–7249 sales@academictherapy.com www.academictherapy.com
Necessary Purchases	Manual and test, scoring forms, geometric form reproductive sheets, remedial guideline forms and cue cards.

Relationship With Family of Origin Scale (REFAMOS)

Description	A standardized clinician-rated interview (Hill et al., 1999). The REFAMOS provides assessment information on relationships between young people (i.e., ages 15–35) and their parents.
Constructs Measured	Work/education Love relationships Social relationships Appearance Leisure Day-to-day coping
Age Range	15–35 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	20–30 minutes.
Level of Training Required	Doctoral degree, clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Jonathan Hill University of Liverpool 0151–252–5509 0151–252–5285 (fax) jonathan.hill@liverpool.ac.uk
Necessary Purchases	Manual and test, scoring forms.

Resiliency Attitude Scale (RAS)

Description	Provides a brief self-report of resiliency in various domains. The RAS measures persistence in working through difficulties (Biscoe and Harris, 1994).
Constructs Measured	Insight, independence, relationships, initiative, creativity, humor, morality.
Age Range	13–17 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	10–15 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Limited.
Research With Juvenile Justice Youth	No.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Belinda Biscoe bbiscoe123@aol.com psyche@okcforum.org
Necessary Purchases	Manual and test, questionnaires.

Revised Behavior Problem Checklist (RBPC)

Description	An 89-item, self-report instrument designed to assess the dimensions of behavioral problems. Teachers, parents, and childcare staff complete ratings for an overall score.
Constructs Measured	Conduct disorder-socialized Attention problem-immaturity Anxiety-withdrawal Aggression Psychotic behavior Motor-tension access
Age Range	5–18 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	30–45 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: Information available in manual.
Developer/Publisher	Psychological Assessment Resources 16204 North Florida Avenue Lutz, FL 33549 800–331–8378 (U.S. and Canada) or 813–968–3003 www.parinc.com
Necessary Purchases	Manual and test, scoring sheets, templates, checklists.

Reynolds Adolescent Depression Scale (RADS)

Description	A self-report instrument that can be administered individually and in groups (Reynolds, 1987). The RADS consists of 30 items rated on a four-point scale. Well suited for individual or group assessment in clinical or school situations, the RADS is highly effective for large-scale administration.
Constructs Measured	Depressive symptoms.
Age Range	13–18 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	5–20 minutes.
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	No.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: Information available in manual.
Developer/Publisher	Sigma Assessment Systems, Inc. P.O. Box 610984 Port Huron, MI 48061 800–265–1285 inforeq@sigmaassessmentsystems.com www.sigmaassessmentsystems.com
Necessary Purchases	Manual and test, answer sheets, score sheet

Sixteen Personality Factor Questionnaire (16PF), Fifth Edition

Description	A self-report measure of personality traits that are relevant in treatment planning.
Constructs Measured	Warmth (cool vs. warm) Intelligence (concrete vs. abstract thinking) Emotional stability (easily upset vs. calm) Dominance (not assertive vs. dominant) Impulsiveness (sober vs. enthusiastic) Conformity (expedient vs. conscientious) Boldness (shy vs. venturesome) Sensitivity (tough-minded vs. sensitive) Suspiciousness (trusting vs. suspicious) Imagination (practical vs. imaginative) Shrewdness (forthright vs. shrewd) Insecurity (self-assured vs. self-doubting) Radicalism (conservative vs. experimenting) Self-sufficiency (group-oriented vs. self-sufficient) Self-discipline (undisciplined vs. self-disciplined) Tension (relaxed vs. tense)
Age Range	16 and older.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template (mail-in scoring).
Administration Time	45–60 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	No.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: Information available in manual.
Developer/Publisher	Developer: Institute for Personality and Ability Testing (IPAT) Publisher: Pearson Assessments 800–627–7271, ext. 3225 pearsonassessments@pearson.com www.pearsonassessments.com
Necessary Purchases	Manual and test booklets.

Stanford-Binet Intelligence Scale, Fourth Edition

Description	A standardized test that assesses intelligence and cognitive abilities in children and young adults.
Constructs Measured	Verbal reasoning Quantitative reasoning Abstract/visual reasoning Short-term memory
Age Range	2–23 years.
Administration/Scoring	Interview and paper-and-pencil administration. Scored by hand with a template.
Administration Time	45–90 minutes, depending on subject's age and number of subtests given.
Level of Training Required	Doctoral degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Research on ethnic differences: Information available in manual.
Developer/Publisher	Riverside Publishing 425 Spring Lake Drive Itasca, IL 60143 800–323–9540 www.riverpub.com
Necessary Purchases	Stanford-Binet examiner's kit. Items sold separately: Guide for administering and scoring Technical manual Record booklets Inferred abilities and influences charts Examiner's handbook: expanded guide

State-Trait Anger Expression Inventory (STAXI)

Description	A 44-item, self-administered inventory that measures several facets of anger. The STAXI assesses anger and associated behavioral expressions (e.g., suppressed, directed against self, directed outward).
Constructs Measured	Anger.
Age Range	13 and older.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template. Computer interpreter report.
Administration Time	15 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	No.
Use With Ethnic Minorities	Languages: English. Research on ethnic differences: Information available in manual and research articles.
Developer/Publisher	Psychological Assessment Resources 16204 North Florida Avenue Lutz, FL 33549 800–331–8378 (U.S. and Canada) or 813–968–3003 www.parinc.com
Necessary Purchases	Manual and test, answer sheets, computer program.

Structured Pediatric Psychosocial Interview (SPPI)

Description	Uses an interview format to determine how a youth views his or her experience (Webb and Van Devere, 1985) and provide measures of interpersonal functioning. The SPPI is intended for use in arriving at a subjective estimate of a youth's latent psychological processes or traits that are thought to underlie his or her current emotional state.
Constructs Measured	Fretfulness Impetuosity Adherence Emulation Doubtfulness Obdurateness Composure Unhappiness Resentfulness
Age Range	5–19 years.
Administration/Scoring	Interview and computer-automated administration. Scored by hand with a template and with a computer program.
Administration Time	20 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Limited.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: In research reports.
Developer/Publisher	Fourier, Inc. P.O. Box 125 Akron, OH 44308
Necessary Purchases	Interview booklets, computer program.

Suicide Ideation Questionnaire (SIQ)

Description	A 25-item, self-report instrument designed to measure suicide ideation. The SIQ can be administered individually or in a group setting.
Constructs Measured	Suicide ideation.
Age Range	12–18 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Scored by hand with a template and with a computer program.
Administration Time	5–10 minutes
Level of Training Required	Master's degree, clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: Information available in manual.
Developer/Publisher	Psychological Assessment Resources 16204 North Florida Avenue Lutz, FL 33549 800–331–8378 (U.S. and Canada) or 813–968–3003 www.parinc.com
Necessary Purchases	Manual and test, answer sheets, scoring sheets.

Suicide Probability Scale (SPS)

Description	A self-report suicide-risk measure consisting of 36 items based on a larger item pool (Cull and Gill, 1988) that differentiates adults who have attempted suicide from those who have not. The SPS measures four significant risk areas and has been empirically studied among adolescents in residential facilities (Larzelere et al., 1996).
Constructs Measured	Hopelessness Suicide ideation Negative self-evaluation Hostility
Age Range	13 and older.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	15–20 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Western Psychological Services 12031 Wilshire Blvd. Los Angeles, CA 90025 800–648–8857 or 310–478–2061 www.wpspublish.com
Necessary Purchases	Manual and test, test forms, profile forms.

Symptom Checklist-90, Revised (SCL–90–R)

Description	A 90-item, self-report measure used to assess current psychological symptom patterns of youth (Derogatis, 1994) and levels of symptomatology. Each item is rated on a five-point scale of distress. The SCL–90–R covers nine primary symptom dimensions.
Constructs Measured	Somatization Obsessive-compulsive Interpersonal sensitivity Depression Anxiety Hostility Phobic anxiety Paranoid ideation Psychoticism
Age Range	13 and older.
Administration/Scoring	Paper-and-pencil administration. Hand scored with a template.
Administration Time	15–20 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research with Juvenile Justice Sample	No.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: No known research.
Developer/Publisher	Pearson Assessments 800–627–7271, ext. 3225 pearsonassessments@pearson.com www.pearsonassessments.com
Necessary Purchases	Answer sheets, manual and test, answer key.

Trauma Symptom Checklist for Children (TSC–C)

Description	A 54-item, self-report instrument designed to evaluate acute and chronic posttraumatic symptoms (Briere, 1996).
Constructs Measured	Anxiety Depression Anger Posttraumatic stress Dissociation Sexual concerns
Age Range	8–16 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	15–20 minutes
Level of Training Required	Inservice training with the instrument, no clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: No known research.
Developer/Publisher	Psychological Assessment Resources 16204 North Florida Avenue Lutz, FL 33549 800–331–8378 (U.S. and Canada) or 813–968–3003 www.parinc.com
Necessary Purchases	Manual and test, test booklets, male profiles, female profiles.

Vineland Adaptive Behavior Scales

Description	Designed to assess life skills and interpersonal competence in daily situations. The Vineland's comprehensive content makes it useful in determining mental retardation. This instrument comes in an interview edition survey (297 items), interview edition expanded form (577 items), and classroom edition (244 items).
Constructs Measured	Communication Daily living Socialization Motor skills Adaptive behavior composite Maladaptive behavior
Age Range	1–18 years and low-functioning adults.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	Survey edition: 20–60 minutes. Expanded form: 60–90 minutes. Classroom edition: 20 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English and Spanish. Research on ethnic differences: Information in manual.
Developer/Publisher	American Guidance Services, Inc. 4201 Woodland Road Circle Pines, MN 55014 800–328–2560 www.agsnet.com
Necessary Purchases	Manual and test, test booklets, score summary and profile reports.

Wechsler Abbreviated Scales of Intelligence (WASI)

Description	A brief measure of intelligence, with verbal and nonverbal subscales. The WASI provides a composite I.Q. score that makes it possible to draw conclusions about the level of cognitive functioning.
Constructs Measured	Vocabulary, matrix, and full I.Q. score.
Age Range	6–89 years.
Administration/Scoring	Interview and paper-and-pencil administration. Scored by hand with a template.
Administration Time	15 minutes for children ages 4–7; up to 30 minutes for persons older than 7.
Level of Training Required	Master's degree, clinical experience, supervision by psychologist.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English. Research on ethnic differences: Information available in manual.
Developer/Publisher	Harcourt Assessment 19500 Bulverde Road San Antonio, TX 78259 800–872–1726 www.psychcorp.com
Necessary Purchases	Manual and test.

Wechsler Adult Intelligence Scale, Third Edition (WAIS–III)
Wechsler Intelligence Scale for Children, Third Edition (WISC–III)

Description	Designed to measure a full range of indices associated with cognitive functioning (Wechsler, 1991) in persons ages 16 and older (WAIS–III) and 6–16 (WISC–III). Both the WAIS–III and the WISC–III have been revised and updated to reflect current societal and cultural norms (Wechsler, 1997).
Constructs Measured	Verbal, performance, full-scale I.Q.
Age Range	6–16 years (WISC–III), 16+ years (WAIS–III)
Administration/Scoring	Interview and paper-and-pencil administration. Scored by hand with a template.
Administration Time	Approximately 60–120 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Research on ethnic differences: Information in manual.
Developer/Publisher	Harcourt Assessment 19500 Bulverde Road San Antonio, TX 78259 800–872–1726 www.psychcorp.com
Necessary Purchases	Manual and test.

Wide Range Achievement Test-3 (WRAT–3)

Description	A clinician-rated screening instrument designed to measure current functioning in areas associated with academic achievement.
Constructs Measured	Reading Arithmetic Spelling
Age Range	5–75 years.
Administration/Scoring	Paper-and-pencil administration. Scored by hand with a template.
Administration Time	15–30 minutes.
Level of Training Required	Master's degree, clinical experience.
Research in General	Much research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Language: English.
Developer/Publisher	Wide Range, Inc. 15 Ashley Place, Suite 1A, Wilmington, DE 19804 800–221–9728 302–652–1644 (fax) wr@widerange.com www.widerange.com
Necessary Purchases	Manual and test, profile/analysis forms, plastic cards for reading/spelling.

Youth Level of Service—Case Management Inventory (YLS/CMI)

Description	Designed to survey attributes of offenders and their situations relevant to selecting an appropriate level of supervision and making treatment decisions. Probation officers, parole officers, and/or correctional workers interview youth and review file data and test scores, etc. These ratings provide a comprehensive risk/needs assessment important for offender treatment planning.
Constructs Measured	Prior and current offenses/dispositions Family circumstances/parenting Education/employment Peer relations Substance abuse Leisure/recreation Personality/behavior Attitudes/orientation
Age Range	12–16 years.
Administration/Scoring	Paper-and-pencil and computer-automated administration. Scored by hand with a template and with a computer program.
Administration Time	30–40 minutes.
Level of Training Required	Inservice training with instrument, no clinical experience.
Research in General	Some research.
Research With Juvenile Justice Youth	Yes.
Use With Ethnic Minorities	Languages: English, Spanish, French-Canadian. Research on ethnic minorities: Information in manual.
Developer/Publisher	MHS, Inc. P.O. Box 950 North Tonawanda, NY 14120 800–456–3003 www.mhs.com
Necessary Purchases	Manual and test, interview guides, score forms.

Chapter 4: "Best Practice" Selections

The previous chapter reviews a large number of screening and assessment instruments. Selecting instruments is a formidable task for those attempting to develop mental health and substance abuse screening and assessment procedures for juvenile justice programs. Are there any "best practice" selections that can be recommended? Yes, but only with a word of caution.

The circumstances in which screening and assessment occur in the juvenile justice system vary considerably among entry points within the system, among different states, and even among different facilities within a single jurisdiction. Screening and assessment often are more extensive in centers that receive adjudicated youth for long-term custody and placement, while resources and time typically are more limited in pretrial detention centers. Some detention centers may have better resources or greater access to clinical assistance than others. Therefore, it is unlikely that a single instrument or combination of instruments will be the best selection for all juvenile justice contexts. Each program or facility must base its selections on its own particular circumstances and objectives.

With these caveats in mind, it is possible to provide some examples of "best practice" selections within the context of hypothetical programs. This chapter briefly describes some "typical" facilities or programs and then offers suggestions for selecting instruments that might best meet their specific needs. It takes into account the principles of screening and assessment discussed in chapters 1 and 2 and the information on individual instruments presented in chapter 3.

Intake Assessment Center

A community is establishing a center where all youth arrested by local law enforcement officers can be assessed to provide a relatively rapid evaluation of their potential danger to themselves and others, family and social resources, mental health needs, and potential substance abuse needs. The assessment center is expected to route the youth to community services or, where necessary, refer the youth to the juvenile court for formal adjudication. The assessment must be completed in only a few days, so it must use highly efficient methods but at a level of specificity not usually accomplished with quick screening instruments. The center will be staffed by master's degree social workers and psychologists with excellent preparation for identifying youth mental health and rehabilitation needs.

The assessment center will probably have time to obtain some records on youth (e.g., offense records from the court, mental health records from community agencies) and to conduct very focused interviews with youth and their parents or guardians. Several instruments not reviewed in this manual are becoming available for assessing the risk of future harmful aggression among youth (e.g., Augimeri et al., 2001; Borum, Bartel, and Forth, 2002). A battery of assessment instruments that could help the center achieve its other objectives, offering a range of important and not overly redundant information, might include the following:

- The Child Behavior Checklist (Parent Report Form) and/or the CBCL Youth Self-Report (the parallel measure based on the youth's own responses to questions about feelings, thoughts, and behaviors related to delinquency and mental health symptoms).

- Either the Youth Level of Service-Case Management Inventory (YLS/CMI) or the Problem Oriented Screening Instrument for Teenagers (POSIT), both of which identify problem areas and resources that can be used to create a community-based plan of service for the youth and family. (The YLS/CMI also provides an index of risk of harm to others.)

- A single-scale measure for substance abuse and another single-scale measure for suicide risk (see overview table in chapter 3 for choices). These measures are intended to provide information not offered by the YLS/CMI or the POSIT, both of which have basic indicators for substance abuse but are not comprehensive and do not provide an indicator for suicide risk. Alternatively, the Massachusetts Youth Screening Instrument (MAYSI–2) offers both a substance use problem scale and a suicide ideation scale. However, the MAYSI–2 should be used only when screening is the objective; it does not provide a detailed view of a youth's substance abuse or suicide risk.

Juvenile Detention Center

The Bigtown Juvenile Detention Center (BJDC) admits 150–200 youth each month. Most youth are there for less than 3 weeks, but some (youth who are harder to place elsewhere, or youth who face more serious charges) stay longer. BJDC has no psychiatrists or psychologists on staff, but it has several social workers who manage youth with special needs. The center believes that it needs a screening tool to help identify youth who (1) pose an immediate suicide risk, (2) may need emergency psychiatric services, and/or (3) may have serious substance abuse problems that will require further assessment and possible intervention when the youth leaves the center. BJDC is a well-run facility, but it is crowded and somewhat understaffed. The screening method must be highly efficient. Moreover, it must collect only the data needed to address the three questions: to do more might interfere with procedures at the nearby juvenile court clinic, where some youth undergo more thorough assessment before trials or disposition hearings.

The Massachusetts Youth Screening Instrument (MAYSI–2) best meets this combination of needs. It takes less than 15 minutes to administer and score, requires no clinical training, and was designed specifically for use with youth admitted to juvenile detention centers. It includes scales for problematic substance use, suicide ideation, and symptoms (e.g., depressed-anxious) that are common to several mental disorders of adolescence. Moreover, it provides cutoff scores that identify youth whose problems and symptoms may be in the clinically significant range. Paper-and-pencil administration and scoring are available, but BJDC might wish to administer and score the MAYSI–2 by computer to maximize efficiency and minimize staff time. Facility administrators (in consultation with clinicians) will have to determine which MAYSI–2 criteria to use to translate scores into policies regarding appropriate staff response (e.g., cutoff scores on specific scales).

Pretrial Emergency Mental Health Consultation

The juvenile court in Bigtown has contracted with a private group of psychiatrists and psychologists to provide emergency consultations to the Bigtown Juvenile Detention Center. BJDC will contact these clinicians when the MAYSI–2 and brief followup interviews by BJDC social workers identify youth who appear to have mental or emotional problems that may require immediate attention. The consultants are expected to provide relatively clear diagnoses and, when necessary, arrange for psychiatric inpatient referral or prescriptions for psychoactive medication to be administered by the BJDC nurse. A university hospital adolescent psychiatric unit has agreed to maintain a limited number of beds for inpatient referral from BJDC's consultants, provided that they establish diagnoses and demonstrate a clear need for inpatient care by means that include not only a psychiatric interview but also an objective assessment of psychiatric disorder.

The consultants might consider augmenting their clinical interviews with at least two instruments designed to identify psychiatric disorders among youth. The Diagnostic Interview Schedule for Children (DISC–IV) offers computerized administration and produces diagnoses consistent with the *DSM–IV*. In addition, the consultants could choose between two paper-and-pencil instruments designed specifically for diagnostic assessments with adolescents: the Minnesota Multiphasic Personality Inventory-Adolescent Version or the Millon Adolescent Clinical Inventory.

Court Clinic Evaluations

For some youth adjudicated delinquent in the Middletown Juvenile Court (especially for the first time), judges may request that the court clinic (consisting of a full-time Ph.D. clinical psychologist and full-time master's degree social worker) perform evaluations to assist the court in case disposition. The purpose of these evaluations is to help the court determine whether the youth's rehabilitation needs can be met in the community or whether the youth will require placement in the secure facilities of the state's Department of Youth Correction (DYC). If community services are appropriate, a service plan will be built on this evaluation. However, a detailed plan is not necessary if the youth requires the more secure programs of DYC, which performs its own assessment for rehabilitation planning (see next example).

The following battery would supplement a clinical interview, assessment of risk of harm to others (e.g., Augimeri et al., 2001; Borum, Bartel, and Forth, 2002), and information from school and mental health records:

- A comprehensive instrument for assessing mental and emotional disorder (such as the Child Behavior Checklist Youth Self-Report Form, the Minnesota Multiphasic Personality Inventory-Adolescent, or the Millon Adolescent Clinical Inventory), to assist in decisionmaking about the need for community mental health services.

- A tool, such as the Family Adaptability and Cohesion Evaluation Scales-II, that will augment the clinician's family interviews in assessing the strengths and weaknesses of the family as a resource in community placement.

- Either the Youth Level of Service-Case Management Inventory or the Problem Oriented Screening Instrument for Teenagers, both of which offer practical information about problem areas to be addressed in a community-based treatment plan. These instruments should be augmented with a single-scale method for evaluating substance abuse (see overview table in chapter 2).

- The Wechsler Intelligence Scale for Children-III and the Wide Range Achievement Test-3, to help evaluate the youth's academic needs.

Juvenile Correctional Reception Center

When dispositional hearings in Middletown Juvenile Court result in commitment to the state's Department of Youth Correction (DYC), youth are sent for 2–4 weeks to a DYC reception center for evaluation. The reception center performs evaluations that determine the level and type of rehabilitation services that seem best suited for the youth, given the level of security needed (e.g., semisecure residential programs located in places where treatment resources can be accessed in the community versus more secure facilities where educational and rehabilitation services must be provided inhouse).

The DYC reception center could administer the Massachusetts Youth Screening Instrument upon admission, for triage and to alert staff to any special needs (e.g., suicide risk) that might arise during the brief time that the youth is at the center. The center's formal assessment should include rather complete evaluations of a youth's educational needs, vocational aptitudes, and risk of harm to others—none of which are featured in the assessment instruments reviewed in this manual. In addition, the center should be prepared to perform specialized assessments related to particular offenses, such as assessments focused on treatment planning for juvenile sex offenders.

Beyond those assessments, the center should consider the following instruments (if not previously administered by the court clinic) to focus on mental health and substance abuse needs:

- Either the Minnesota Multiphasic Personality Inventory-Adolescent or the Millon Adolescent Clinical Inventory, to identify the presence of serious mental disorders requiring treatment.

- One of the single-scale assessment instruments for assessing substance use problems.

- A personality measure designed for classifying youth according to patterns of delinquent behavior, personality, and/or interpersonal style. Both the Jesness Inventory and the Revised Behavior Problem Checklist, for example, provide information that is helpful in classifying youthful offenders for assignment to particular types of rehabilitation programs.

Chapter 5: Final Comments and Recommendations

Screening and assessment are essential steps in appropriately identifying and responding to the mental health- and substance use-related needs of youth in the juvenile justice system. It is critical that clinicians and other professionals working with these youth understand the importance of screening and assessment and how the information collected from these processes should be used to inform treatment and placement decisions.

Providing screening and assessment for youth in the juvenile justice system involves challenges, and only limited empirical knowledge about how best to provide these services is available. Nevertheless, clear recommendations are emerging that can offer guidance to juvenile justice administrators, practitioners, and mental health professionals. These recommendations include the following:

- **Screening should be performed for all youth at the earliest point of contact with the juvenile justice system.** All youth should be screened to identify the possibility of mental health and substance use disorders. The screening should be brief and should be used to identify youth who require further evaluation and assessment. Although screening is most critical at a youth's earliest point of contact with the system, it should also be used to monitor mental health status at all stages of involvement with the system, particularly at transitions from one setting to another (e.g., from detention to secure corrections).

- **Assessments should be performed for youth who require further evaluation.** More detailed assessments should be performed for youth whose initial screening indicates a need for further examination of psychosocial needs and problems. Although often more expensive than screening, assessment can yield more detailed diagnostic information about a youth's mental health and substance use status and can form the basis of treatment recommendations.

- **Care should be taken to identify the most appropriate instruments.** The screening and assessment instruments selected by a juvenile justice agency or facility should be suitable and appropriate for use with the population being assessed and, ideally, should meet standards for reliability and validity. Important considerations, such as the age, gender, ethnicity, linguistic background, and cognitive skills of the youth being assessed, should be taken into account. Other considerations include the following:

  - **Contextual factors.** It is important to consider "situational" factors when selecting instruments. These include the amount of time it takes to administer an instrument, the financial cost involved, and the level of education and expertise required to administer, score, and interpret an instrument.

  - **Psychometric properties and adequacies.** Available research suggests that instruments that evaluate psychiatric disorders, problem behaviors, family characteristics, and strengths are most appropriate for the juvenile justice population. Instruments that provide evidence of reliability and validity when used with juvenile justice populations should be considered. Tools that can demonstrate normative performance according to gender, age, and ethnic background are preferable.

- **Need and risk levels should be appropriately balanced.** Juvenile justice agencies and facilities often conduct risk assessments to evaluate a youth's risk of future delinquency or to determine the most appropriate level of security for the youth. Risk assessment results should be combined with needs assessment results to develop treatment plans that reflect both the level of risk a youth presents and the youth's need for services and treatment.

- **There is no one best way to provide mental health screening and assessment for youth in the juvenile justice system.** Implementation of a particular screening and assessment approach depends on a variety of factors: the point within the juvenile justice system where screening and assessment occur, the resources available to support the effort, the amount of time available to conduct the evaluations, and the extent to which other systems (e.g., mental health and child welfare) can serve as collaborators or partners in the effort.

This Resource Guide has been written to provide practical assistance to individuals working in the juvenile justice system who are committed to improving their ability to identify youth with mental health disorders. The importance of their work cannot be overstated. It reflects the growing awareness that many youth in the juvenile justice system require mental health care and that effective identification and treatment of these youth are essential not only for achieving positive outcomes for individual youth and their families but also for reducing recidivism rates and ensuring community safety.

At the same time that commitment to improving the juvenile justice system has intensified, there is growing concern over what has come to be known as the "criminalization of mental illness." Evident within the adult system for some time, this practice involves incarcerating individuals with mental and addiction disorders for relatively minor offenses because community-based mental health services and alternatives to incarceration are unavailable. It is widely recognized that the increasing reliance on the criminal justice system to care for individuals with mental health disorders exists within the juvenile justice system as well (Butterfield, 2000).

This Resource Guide is not designed to exacerbate this situation. Some youth, because of their behavior, will come in contact with the juvenile justice system. For these youth, early identification of mental health treatment needs and the provision of quality care are critical. The authors hope that this Resource Guide will improve the delivery of services to these youth, perhaps even preventing their further involvement with the justice system.

Whenever public safety considerations allow, however, youth with identified mental health disorders should be diverted from further involvement with the juvenile justice system and into appropriate community-based services and programming. Many youth with mental health disorders experience seriously exacerbated symptoms as they penetrate further into the system. Appropriate diversion can decrease the growing number of youth with mental health disorders in the juvenile justice system and increase the likelihood that they will receive the treatment they need.

About the Authors

Thomas Grisso, Ph.D., a clinical psychologist, is Professor of Psychiatry at the University of Massachusetts Medical School, where he is Coordinator of the Law and Psychiatry Program. He received his Ph.D. in psychology at the University of Arizona in 1969. He is the author of more than 100 journal articles in clinical, applied developmental, and forensic psychology, as well as books, including *Evaluating Competencies* (1986), *Juveniles' Waiver of Rights* (1981), *Competency to Stand Trial Evaluations* (1988), *Understanding Aggressive Behavior in Children* (1996, edited with C. Ferris), *Assessing Competence to Consent to Treatment* (1998, with Paul Appelbaum), *Forensic Evaluation of Juveniles* (1998), and *Youth on Trial* (2000, edited with Robert Schwartz). Dr. Grisso has received several research grants from the National Institute of Mental Health, the National Science Foundation, and private foundations. He is currently a member of the MacArthur Foundation's Research Network on Adolescent Development and Juvenile Justice. His research and clinical practice have focused on legal competencies in civil, criminal, and juvenile law; methods for improving forensic clinical assessments; and mental health needs and service delivery systems for adults and juveniles in justice and corrections settings.

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