Mental Health Assessments in Juvenile Justice: Report on the Consensus Conference

GAIL A. WASSERMAN, PH.D., PETER S. JENSEN, M.D., SUSAN J. KO, PH.D., JOSEPH COCOZZA, PH.D., ERIC TRUPIN, PH.D., ADRIAN ANGOLD, M.R.C.PSYCH., ELIZABETH CAUFFMAN, PH.D., AND THOMAS GRISSO, PH.D.

ABSTRACT

Objective: At national, state, and local levels, there is increasing recognition of the importance of identifying and responding to the mental health needs of youths in the juvenile justice system, as policymakers and practitioners struggle to find ways to address causes and correlates of juvenile crime and delinquency. The proposed guidelines for mental health assessment provide explicit information about how, why, and when to obtain mental health information on justice youths at each important juncture in processing. **Method:** A national group of expert researchers and practitioners convened in April 2002. Experts derived six recommendations, following the expert consensus method, for conducting mental health assessments in juvenile justice settings. Experts had broad experience creating collaborations between juvenile justice, mental health, and child welfare systems and understood the policy and health implications of conducting such assessments in juvenile justice settings. **Results:** Consensus Conference recommendations regarding screening for emergent risk, screening and assessment of mental health service needs, comprehensive mental health assessment components, assessment before community re-entry, need for periodic reassessment, and staff training are presented. **Conclusion:** Deriving specific recommendations that can be implemented systematically is a necessary first step toward policy changes that will optimize the standard of care for this vulnerable population. *J. Am. Acad. Child Adolesc. Psychiatry*, 2003, 42(7):752–761. **Key Words:** juvenile justice, consensus conference, assessment, screening, best practices.

Recent scientific studies using well-standardized procedures concur that as many as 65% of youths in the juvenile justice system have diagnosable disorders (Garland et al., 2001; Teplin et al., 2002; Wasserman et al., 2002;). However, many youths with mental health problems enter the justice system without having been either identified or treated in their communities. In one study of juvenile detainees, only 40% of those with a diagnosed substance use disorder and only 34% of those with anxiety, mood, or disruptive behavior disorders had received earlier services (Novins et al., 1999).

Little systematic information is available concerning best practices for the clinical management of justice system youths with mental health concerns. In the past decade, several organizations have developed broad standards for managing youths in detention and correctional facilities (i.e., American Association for Correctional Psychology [AACP], 2000; American Correctional Association, 1991; Council of Juvenile Correctional Administrators, 2001; National Commission on Correctional Health Care [NCCHC], 1999; Office of Juvenile Justice and Delinquency Prevention [OJJDP], 1994), which include recommendations regarding how and when to assess for both emergent risk and more long-ranging mental health service needs among youths in secure care. Similar adult standards appear in the Criminal Justice/Mental Health Consensus (CJMHC) Project (Council of State Governments, 2002).

Accepted January 30, 2003.

Drs. Wasserman and Ko are with the Center for the Promotion of Mental Health in Juvenile Justice, Department of Child Psychiatry, Columbia University, New York; Dr. Jensen is with the Center for the Advancement of Children's Mental Health, Department of Child Psychiatry, Columbia University; Dr. Cocozza is with the National Center for Mental Health and Juvenile Justice, Delmar, NY; Dr. Trupin is with the Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, Seattle; Dr. Angold is with Duke University School of Medicine, Durham, NC; Dr. Cauffman is with the Division of Law and Psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh; and Dr. Grisso is with the Department of Psychiatry, University of Massachusetts Medical School, Boston.

The authors gratefully acknowledge the input of the participants in the conference; they are listed at the end of the text.

Reprint requests to Dr. Wasserman, Director, Center for the Promotion of Mental Health in Juvenile Justice, Columbia University/New York State Psychiatric Institute, 1051 Riverside Drive, Unit 74, New York, NY 10032; e-mail: wassermg@childpsych.columbia.edu.

0890-8567/03/4207–0752©2003 by the American Academy of Child and Adolescent Psychiatry.
DOI: 10.1097/01.CHI.0000046873.56865.4B

To focus such standards more clearly on assessment of justice system youths, a national group of expert researchers and practitioners convened in April 2002 to draft practice recommendations.

A youth's "progress" through the juvenile justice system takes him or her through various settings, administered by different agencies (Fig. 1). Youths may await trial ("adjudication") in either a secure detention or community setting; after determination of guilt/innocence, a plan ("disposition") is developed to be implemented in either a secure or community setting; after completing required time in a secure postadjudicatory setting, youths' community reintegration ("aftercare") is often also supervised. The Consensus Conference began with recommendations relating to entry into secure care (whether pre- or postadjudication) and continued through to community release. Alternative processing points (e.g., community-based probation intake), specific dispositions (e.g., mental health court), or treatment recommendations were not examined. We identified two primary purposes for gathering mental health information on justice youths, and a number of points when such information should aid in decision-making.

METHOD

We followed the RAND Corporation expert consensus guidelines approach (Brook et al., 1986). We first developed a survey, administered in paper and Internet formats, in which juvenile justice staff (clinical and nonclinical) nationwide reported on assessment practices in their work settings and then expressed their opinions on best practices for such assessments (Evans et al., 2003). We then held a Consensus Conference on "Mental Health Assessments in Juvenile Justice Settings," sponsored by the Center for the Promotion of Mental Health in Juvenile Justice, the Center for the Advancement of Children's Mental Health (both at Columbia University), and the National Center for Mental Health and Juvenile Justice, on April 17, 2002. The conference was attended by a nationally recognized group of more than 20 expert mental health assessment researchers and expert juvenile justice practitioners. Attendees were experienced in creating collaborations across mental health, juvenile justice, and child welfare service systems and were well aware of the policy and health implications of conducting mental health assessments in juvenile justice settings. The conference included a series of scientific presentations. Review of the practitioner survey results provided a springboard for developing consensus on concrete recommendations.

RESULTS

SCREENING AND ASSESSMENT

Mental health information should inform identification of both emergent risk and mental health service needs. Screening can be an efficient mechanism for gathering either type of information, at several points in the youth's contact with the system. Screening is the identification of unrecognized problems in apparently well persons via procedures that can be applied rapidly and inexpensively. Screening is not intended to be definitive; persons who screen positive should receive further assessment to establish whether the problem truly is present (Valanis, 1999, p. 313). Compared with comprehensive assessment, screening should be low in cost, should have

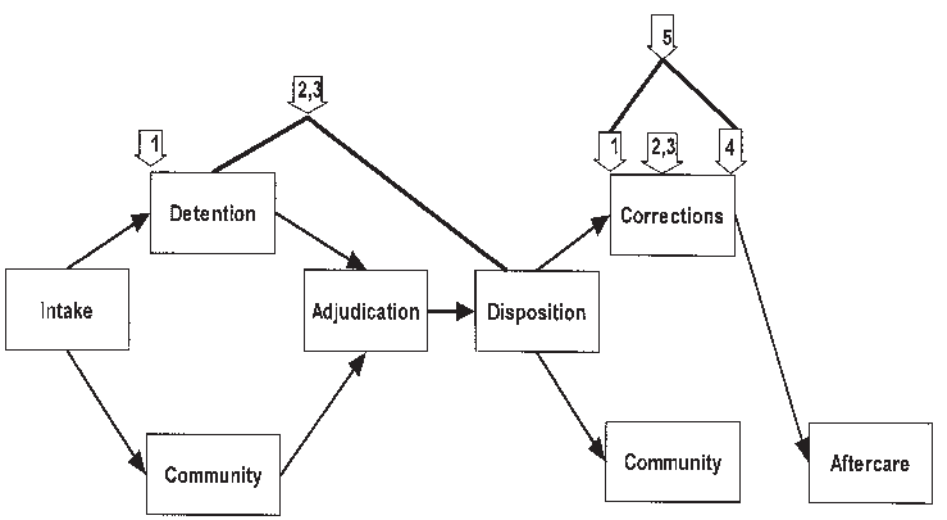

Fig. 1 Timing of mental health screening and assessment recommendations. Recommendation 1: Emergent Risk; Recommendation 2: Mental Health Service Needs; Recommendation 3: Mental Health Assessment Components; Recommendation 4: Community Re-entry; Recommendation 5: Reassessment; Recommendation 6: Staff Training.

at least low to moderate accuracy, and should be simple, safe, and acceptable.

Issues of accuracy and safety relate to concepts from public health and epidemiology of "sensitivity" and "specificity." Sensitivity reflects the screen's ability to identify truly positive "cases," minimizing the likelihood of false negatives (individuals who *have* a problem missed by screening); specificity reflects the degree to which the screen minimizes false positives (problem-free individuals incorrectly identified as "cases"). An ideally accurate screen would show high sensitivity and high specificity, although there is generally a trade-off between these two. A tolerable degree of safety in a screening procedure relates to the likelihood and danger of missing a "case" (false negative). For a high-risk behavior such as a suicide attempt, for example, only a very low proportion of false negatives would be tolerable.

The experts agreed upon the following recommendations, targeted for use by administrators and directors of juvenile justice facilities and their clinical staff.

RECOMMENDATION 1: EMERGENT RISK

Provide an evidence-based, scientifically sound mental health screen within the first 24 hours of a youth's arrival at a facility.

An evidence-based, scientifically sound mental health screening should be included in the general health screen. While addressing legal protections for the youth, screening should attend to current use of any medications, service/treatment history, current substance use, and risk of suicidal, self-injurious, and assaultive behavior.

Rationale

What we have termed "emergent risk screening" has elsewhere been called "reception" (AACP, 2000) or "intake" screening (Council of State Governments, 2002); below, we distinguish screening for emergent risk from procedures intended to identify mental health service needs. Reception screening in a juvenile justice population includes use of a short procedure on every youth arriving at a secure facility to ascertain emergency and triage information for safety concerns (Grisso, 2002). Because they should be simple and administered by nonclinical staff, minimal training is generally necessary and decision rules regarding selection of youths for further scrutiny are usually based on agency policy.

To counteract difficulties in using nonstandardized screens, we recommend using *evidence-based, scientifically sound* screens that are well-validated and reliable. Systematic screening helps alleviate biases that influence staff recommendations (Niarhos and Routh, 1992) and allows for comparisons across settings. The American Psychiatric Association (APA) Guidelines on Psychiatric Services in Jails and Prisons (APA, 2002) recommends standardizing mental health screening procedures and instruments so that responses can be documented systematically and, presumably, aggregated across settings.

Purpose. Because the primary purpose of emergent risk screening is identifying potential risk for harm to self and others and mental health crises, it should occur as soon as a youth enters a facility (within the first few hours), just as youths are assessed for emergency medical conditions (e.g., asthma).

Several attendees felt that screening should occur within the first hour after admission; understanding that facilities may not have screening staff available 24 hours a day, 7 days a week, we have extended this period to 24 hours. Youths who must wait for screening, however, should be kept on close watch until their status can be determined. Although youths may be particularly non-forthcoming at entry, it is difficult to know who is answering accurately and who is not. Youths who appear to be denying problems during screening should be rescreened at a later opportunity. It should be noted, however, that the accuracy of currently evidence-based screens is based on samples that have included some proportion of likely inaccurate respondents (i.e., deniers and exaggerators) so that such inaccuracy has been addressed, in aggregate, in determining the screen's validity.

Lengthy assessment is likely to be impractical at this juncture, given the realities of staffing and context. Youths whose mental or physical status (e.g., head injury) interferes with ability for accurate self-report should be triaged to an emergency room or supervised closely.

Existing Practices. While 90% or more of the juveniles in the detention, reception, and training school facilities examined in the OJJDP study (1994) received such screening at *some* point during their stay, only 80% of juveniles in detention and reception facilities, and fewer than half of those in training schools, were screened within their first hour. This difference may reflect the fact that training schools are more likely to receive juveniles previously evaluated at reception centers and may rely on that earlier screening. While 90% of the juveniles in detention and reception facilities were screened for emergency medical conditions and drug/alcohol use (with correspond-

ingly lower rates in training schools), other components were less consistently inquired about. Across settings, fewer than 75% of the juveniles were asked about mental health problems and fewer than 60% were asked about prior mental health treatment or hospitalization.

Despite the suggestion that initial admission to a facility is a period of particularly high risk for suicide attempts (Hayes, 1999), almost 90% of juvenile detainees, but fewer than 70% of those in reception centers or training schools, are screened in any way for suicide at admission (OJJDP, 1994).

Components. Many conditions impact initial adjustment to secure care and may call for immediate attention and/or triage. Institutions receiving youths into custody need to provide for continuity of mental health services by identifying those currently using psychotropic medications or with a mental health service/treatment history. Abrupt termination of medication may pose a health emergency. Similarly, current intoxication or history of recent substance use confers added risk, as youths may require detoxification. Additional conditions (e.g., self-injurious behavior, suicidality, physical assaults on other youths or staff, and potential for sexual misconduct) elevate risk for youths in institutional care, for other youths held with them, and for the staff who supervise them.

Instruments. A number of scientifically sound instruments developed as *general* screening tools, such as the Youth Self-Report (Achenbach, 1991), the Symptom Checklist-90-Revised (Derogatis, 1977), and the Brief Symptom Inventory (Derogatis, 1993), have been used in juvenile justice populations. The Massachusetts Youth Screening Instrument-2 (MAYSI-2), in particular, was developed as an intake screen for potential mental, emotional, or behavioral problems for justice youths (Grisso et al., 2001). The Problem Oriented Screening Inventory (Rahdert, 1991) and the Child and Adolescent Functional Assessment Scale (Hodges and Wong, 1996) assess global functioning and general problems.

Other instruments tap one or more components of emergent risk (i.e., suicide risk, substance use, self-injurious behavior, service history). The American Academy of Child and Adolescent Psychiatry (AACAP) has published a series of practice parameters that provide guidelines and descriptions of instruments and procedures helpful in assessing various conditions. Those addressing assessment of sexually abusive behavior (AACAP, 1999) and the management and prevention of suicide (AACAP, 2001a) also note a number of resources for locating additional information. Instruments that assess mental health service history generally are too complex (in their wording and descriptions of type of services) to be self-administered by youths (e.g., Stiffman et al., 2000). As a result, complete information about mental health service history is often not obtained.

To our knowledge, no instrument inquires about all components for which emergent risk screening should be used. Thus, not only do justice sites need to work toward more systematic use of evidence-based screens, but mental health researchers need to develop instruments covering all important aspects of screening for emergent risk for justice youths.

Legal Protections. Facilities charged with processing juveniles prior to adjudication must balance the need to provide mental health care with the responsibility to protect youths from self-incrimination. Information disclosed to detention staff may not be confidential. During screening for emergent risk a youth may admit illegal behavior (e.g., substance use) that was not the focus of detention (e.g., shoplifting). Thus justice facilities must have protections in place so that either information provided in an intake screen cannot be used in support of current or future charges, or facilities do not ask questions by which youths may self-incriminate.

RECOMMENDATION 2: MENTAL HEALTH SERVICE NEEDS

Provide an evidence-based, scientifically sound mental health screening and/or assessment for all youths as early as possible in order to determine need for mental health services.

This comprehensive mental health assessment should occur prior to disposition to inform judicial and probation planning. Because mental health conditions may contribute to misbehavior, treatment may help prevent recontact with the justice system. Because of the potential overlap between mental health conditions and criminal activity, screening and assessment must incorporate legal protections for youths. Youths screening positive should receive comprehensive mental health assessments.

Rationale

Definitions. Independent from measurement of emergent risk at intake, information regarding need for mental health services should be gathered for *all* justice youths who will remain in care or supervision. This can be accomplished with or without screening. As noted earlier, a safe and accurate screen may make information-gathering more efficient.

Purpose. Since the purposes of emergent risk screening are different from mental health service need screening, the same instruments and assessment protocols may not suffice for both. Youths demonstrating emergent risk should receive a mental health service need screening/assessment more quickly. Youths positive on the mental health service need screening should then be followed up with a comprehensive mental health assessment. The service need screening may uncover further needs not detected during emergent risk screening.

Comprehensive mental health assessments should occur before disposition to inform judicial and probation planning. Availability of assessment results prior to disposition may decrease referrals to inappropriate programs and allows mental health services to be included in disposition plans. Comprehensive assessments undertaken prior to adjudication should incorporate procedures for legal protections against self-incrimination. Once youths have entered long-term care, the State has the responsibility to provide appropriate care (including mental health care).

Importance of Obtaining a Diagnosis. Providing appropriate care begins with an assessment that accurately identifies mental health service needs. Although not the only component in the assessment process, obtaining a diagnosis is central to that process (AACAP, 1997), since treatment recommendations necessarily vary depending on diagnosis. In recent years the fields of psychology and psychiatry have moved dramatically to establish treatment guidelines based on empirical evidence (e.g., Chambless et al., 1996; Weisz and Hawley, 1998). Most evidence-based treatments map onto specific disorders; efficacy has been demonstrated *only* for those disorders.

Instruments. Since comprehensive mental health assessment should provide a diagnosis for service planning, instruments used should include those that generate probable diagnoses. Although not formally a screen, the self-administered voice version of the Diagnostic Interview Schedule for Children Version IV (Shaffer et al., 2000) lends itself to use as a mental health service needs screen. Youths meeting criteria for certain disorders can be selected for more comprehensive evaluation (see Recommendation 3, below). Another example of a structured self-administered mental health assessment is the Diagnostic Interview for Children and Adolescents (Reich, 2000).

Existing Practices. In practice, many justice youths are not assessed for mental health service needs. The OJJDP study (1994) reported that overall, 80% of juveniles received such an appraisal within a week of admission, but only 61% of detainees, 86% of juveniles in reception centers, and 67% of those in training schools received health appraisals that included any type of mental health component.

RECOMMENDATION 3: MENTAL HEALTH ASSESSMENT COMPONENTS

A comprehensive mental health assessment must be based on careful review of information from multiple sources and must measure a range of mental health concerns.

Most Axis I disorders and suicidality are important to measure, as well as the youth's functioning and impairment in such contexts as home and school. Assessment should consist of direct observation and face-to-face interview with the youth; mental status examination; chart review; interview with parents/other adults, if available; and family history.

Rationale

Components. The clinical assessment process by which a diagnosis and treatment plan are derived for children and adolescents proceeds in multiple steps and targets a number of components (AACAP, 1997; Sattler, 1998). Youth interviews should also include a mental status examination by a properly trained clinician (Casat and Pearson, 2001). History of head trauma with loss of consciousness or seizures would also be important information to obtain.

Continuity of Care. Mental health assessment for youths entering justice facilities should include review of community and/or justice charts to determine prior or current mental health service use and should incorporate existing evaluations and school reports.

Using Multiple Sources. Family history should move beyond diagnosis to consider psychosocial and mental health history for the youth and family members (e.g., Andrews et al., 1993), thereby highlighting risk both for disorders with a genetic component and for environmental and social stressors affecting current functioning. Youths in the justice system, with expectably limited insight, judgment, and remorse, may not be accurate reporters of their own impairment (Wasserman et al., 2002). Children and adolescents usually report significantly fewer hyperactive/inattentive and oppositional behaviors than parents or teachers (Jensen et al., 1999), and parents' reports of externalizing problems map better onto justice indicators than do youths' reports (Loeber et al., 1991). Pooling diagnostic information for disruptive disorders from both parents and youths results in increased prevalence rates (Bird et al., 1992).

Measure a Range of Mental Health Concerns. The youth interview should measure a range of disorders and conditions (e.g., suicidality) that have relatively high prevalence among adolescents, that are most likely to interfere with adjustment to justice programs, and for which evidence-based treatments are available. Recent prevalence studies based on standardized assessments report comparably high rates of both expectable and unexpected disorders in justice system youths (Garland et al., 2001; Teplin et al., 2002; Wasserman et al., 2002). Expectable disorders include conduct and substance use disorders, as justice youths' high levels of disruptive and substance-related behaviors are often directly related to their offense. Because prevalence studies also document high levels of mood and anxiety disorders (e.g., Wasserman et al., 2002), a comprehensive assessment should measure a full range of disorders and conditions to ensure that both expectable and unexpected diagnoses are evaluated. Internalizing disorders (e.g., depression) are easily overlooked because symptoms may be less readily observed (LeCroy et al., 2001).

Existing Practices. In the juvenile justice system, conducting a comprehensive mental health assessment is challenging because of unavailability of charts and parents/other adults. The Conditions of Confinement report (OJJDP, 1994) noted that, across all types of facilities, only 60% of interviewed juveniles had been visited by parents during their stay, regardless of length of stay. The average facility was almost 60 miles away from juveniles' homes, and, for 25% of facilities, there was no public or provided transportation to encourage parental contact. Thus many facilities may only be able to complete one component of a mental health assessment: the youth interview.

RECOMMENDATION 4: COMMUNITY RE-ENTRY

Provide an evidence-based and scientifically sound screening or assessment for all youths preparing to leave a postadjudicatory secure facility and return to their communities.

To facilitate linkage to community mental health services, high-risk youths should receive a comprehensive assessment, and low-risk youths should receive a screen to identify any mental health concerns before release. Youths who screen positive should receive a full mental health assessment.

Rationale

Continuity of Care. Just as charts and previous mental health service history should be reviewed when youths enter the system, they should be reviewed again before return to their communities (Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities, AACAP, in preparation). This can provide important information about services received, youth's response to those services, availability of family/caretaker, family history of mental illness or substance abuse, and family service needs. Altschuler and Armstrong (1994a,b) emphasize the critical need for case management to ensure a seamless transition from a highly regimented institutional environment to a more unstructured life in the community. This includes arranging postinstitutional referrals and placements for mental health services *before* institutional release. Youths in secure care identified with continuing mental health needs should be able to continue that treatment in their communities. Referrals and placement decisions should be based on information from a comprehensive mental health assessment (described under Recommendation 3). In addition, this assessment should include an evaluation of the youth's family characteristics and needs and community resources.

Need for Reassessment. None of the existing guidelines we reviewed stressed the value of mental health evaluation of juveniles prior to community release. Although attenuated by either treatment or the structure provided by incarceration, some disorders are likely to reappear when treatment is terminated or if the youth is free to engage in behavior that has been curtailed in confinement. Thus youths who may have been substance-free during incarceration will face obvious challenges when returning to an environment in which illicit drugs are available. Even if symptom-free, substance-using youths, as well as those whose disorders abated or remitted during incarceration, should undertake an assessment that considers their full symptom and treatment history before discharge.

RECOMMENDATION 5: REASSESSMENT

Provide evidence-based, scientifically sound screening/assessment on a regular basis for all youths.

Certain components of mental health status are likely to change over time in response to internal and external events. While the exact timing and interval for mental health screening and assessment may vary, at a minimum it should be a part of any routine medical screening and/or assessment. Youths who screen positive should receive a full mental health assessment.

Rationale

Chronicity and Developmental Course of Disorder. Even youths with chronic disorders require regular reassessment

because stressors may exacerbate symptoms or may increase risk for developing other disorders. The developmental course of certain disorders also impacts importantly on the likelihood of onset during adolescence/early adulthood. For example, schizophrenia usually emerges in early adulthood, with onset prior to adolescence rare, while some symptoms of attention-deficit/hyperactivity disorder (ADHD) usually appear before age 7. Youths not identified during adolescence as having schizophrenia might still develop the disorder later, while those found earlier to have ADHD are likely to still have it at a later time point.

Role of External Events in Precipitating Disorder. The onset of a disorder is often precipitated by an identifiable stressor. For example, separation anxiety disorder usually develops after some life stress (e.g., change of school, move to a new neighborhood; APA, 1994). Thus it is not surprising that many justice youths, perhaps in an unfamiliar environment or separated from families for the first time, exhibit symptoms of separation anxiety disorder. Manic episodes, major depressive disorder, and social phobia are also often precipitated by psychosocial stressors (APA, 1994). Transitions in justice system processing, transfer to a new facility, or peer suicide could easily qualify as psychosocial stressors or stressful life events and thus may contribute to the onset or worsening of a disorder.

Existing Practices. A report that constitutes part of the Performance-Based Standards Resource Guide (Hayes, 1999) notes that risk for suicide attempts in confined youths may increase in the postadjudication period when the youth is returned to confinement from court; following receipt of bad news, humiliation, or rejection; when confined in isolation or segregation; or after a prolonged stay at the facility. All of these are useful points for systematic rescreening.

RECOMMENDATION 6: STAFF TRAINING

Ensure that mental health staff are professionally credentialed or are directly supervised by credentialed staff. Provide training for staff appropriate to their role for assessment in evidence-based, scientifically sound mental health screening/assessment procedures.

Staff at a variety of levels need to be able to assist with assessing a youth's risk to self and others, so that they will be able to inform treatment and service planning/disposition for the youth.

Rationale

Current Training Levels. In a recent national mental health practices survey (Evans et al., 2003), 10% of justice staff reported that mental health assessments in their settings were conducted by nonclinical staff. Furthermore, even designated mental health staff in juvenile justice facilities often are not professionally trained, licensed, and/or supervised by someone who is licensed. According to the practices survey, 15% of mental health staff in juvenile justice facilities had a bachelor's degree or less. In addition, 72% of respondents desired more training in mental health issues (e.g., workshops, conferences).

Importance of Licensure for Mental Health Providers and/or Their Supervisors. In most states, obtaining licensure as a psychologist or psychiatrist or social worker is rigorous, requiring an advanced degree at minimum. In addition, most licenses require documentation of continuing education to demonstrate knowledge of innovations in one's field. Provision of care by licensed mental health professionals, or their direct supervision of noncredentialed staff, would likely result in a higher standard of care for justice system youths.

Cross-Training. Nonclinical staff are often called upon to provide information regarding youths' observed behavior and social interactions. Their skills would be enhanced by a better understanding of the interplay between mental disorders and everyday management. Similarly, mental health staff need to learn the policies and procedures of the juvenile justice agency or facility in which they work (Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities, AACAP, in preparation). Besides encouraging dialog in case conferences, event review meetings, or in-house workshops, formal cross-training curricula are available. The National GAINS Center has developed a cross-training curriculum for justice staff, mental health practitioners, and substance use practitioners (Trupin and Boesky, 2001), consisting of a Web-based component and 2-day training, focusing on narrowing service provision gaps for youths or adults with treatment needs who are involved with the justice system.

Existing Practices. Many justice agencies do not require credentialing for mental health staff. OJJDP's Conditions of Confinement report (1994) found that 33% of juveniles in detention centers were screened for health (including mental health) concerns by staff who were neither licensed health care staff nor trained by medical personnel.

DISCUSSION

As noted, several groups have developed guidelines and standards for management of youths in detention and

corrections facilities. More recent publications, and those whose focus is mental health, have addressed the present recommendations more explicitly. Of the groups providing guidelines, none provides explicit information for all six recommendations, although the CJMHC Project (Council of State Governments, 2002), pertaining only to adults, comes closest. Currently, practitioners seeking mental health practice guidance would need to consult several publications that include that information along with recommendations for security and for youth privileges. Mental health standards available in more general documents rarely provide specifics about implementation practices. We hope that the current recommendations expand on a growing trend toward setting clear standards for mental health care for justice youths.

Future Directions

Training/Development of Curricula. There are currently about 6,300 child and adolescent psychiatrists practicing in the United States (AACAP, 2001b); in 1997, approximately 2.8 million juveniles were arrested, and in 1996, 1.8 million delinquency cases were processed by juvenile courts (Snyder and Sickmund, 1999). Disproportionality is comparable for psychologists, although obtaining exact numbers of clinical child psychologists is more difficult. The limited number of mental health professionals cannot themselves address *all* components of direct assessment and treatment for *all* justice youths at *all* points in processing. To the contrary, mental health staff in justice settings are not always professionally trained or supervised; some settings have no designated mental health staff. Thus judges, probation officers, and detention workers often function as gatekeepers for youths' entry into mental health treatment. It is essential that both mental health staff and other gatekeepers be provided with appropriate training and clear mental health assessment protocols. Going beyond these recommendations, the CJMHC Project (Council of State Governments, 2002) also recommends training for court officials (defense attorneys and prosecutors) regarding defendants with mental illness. Mental health professionals need to open dialog with justice professionals to exchange information regarding research and practices. Mental health professionals also need to take the lead in developing instruments and procedures for the fair and accurate mental health assessment of justice youths.

Standardization and Implementation of Procedures. Current practices for obtaining mental health information vary enormously across settings (detention, court, corrections, diversion) and jurisdictions (even within the same state) and often do not reflect the highest standard of care (Wiebush et al., 1995). Moreover, staff representing various organizations, including public agency staff (with and without formal clinical training) and private individual and group care contractors, have mental health assessment responsibilities. While mental health professionals may be able to provide important information relevant to dispositional planning and recidivism risk, existing guidelines do not establish how that information should be obtained, how it should be used, and when and to whom it should be disclosed (Niarhos and Routh, 1992). While there has been a recent movement toward standardization of other types of forensic assessments (e.g., competency to stand trial, child custody proceedings; Nicholson and Norwood, 2000), and despite the juvenile justice system's presumed responsibility for rehabilitation, there has been no comparable movement toward standardization of mental health assessment procedures for justice youths.

These recommendations address important points in case processing (Fig. 1). They have been developed to be comprehensive in scope and to help justice settings implement system changes in a fair and accurate manner. The next step for the field of juvenile justice is to standardize these recommendations and make them part of their procedures. As an example, procedures for exchange between mental health staff and parents need to be developed and supported. Parents can provide vital insight regarding youths' level of impairment and medical and family history that are essential components of a complete evaluation.

Instrument Development. There is a need to develop a comprehensive instrument that screens for all of the conditions described under Recommendation 1. Such an emergent risk screen would be valuable for juvenile justice sites, many of which currently gather this information unsystematically. For example, there are currently no evidence-based measures that assess sexual misconduct (AACAP, 1999). However, this type of information would greatly enhance the ability of justice settings to aid and protect staff and youths in their care.

There is broad consensus in the fields of psychology and psychiatry that the components listed under Recommendation 3 are essential aspects of comprehensive mental health assessment (e.g., parent interview, family history, service history). Although we have evidence-based instruments that address the youth interview component, there

are fewer instruments that systematically obtain information about family medical and psychiatric history, service history, and mental status. That being the case, we need to work on developing instruments for each component in Recommendation 3.

Legal Protections. There is considerable controversy at present regarding how to balance protections regarding youth self-incrimination and confidentiality with need to address mental health needs. The AACP Standards (2000) include a documented policy ensuring confidentiality of all psychological files, records, and test protocols, with access to this material only on a "need-to-know" basis. The NCCHC (1999) report underscores the inappropriateness of health services staff collecting forensic information. Although some states have formal and informal procedures for protecting such information, they are rare. Dialog among legal advocates, mental health advocates, and justice practitioners on these issues should be encouraged.

Deriving specific and detailed recommendations that can be implemented systematically is a necessary first step toward affecting policy changes that will optimize the standard of care for this vulnerable population. The recommendations derived from the Consensus Conference will generate guidelines for a higher real-world standard of care.

Participants: Gregory L. Fricchione, M.D., is with the Division of Psychiatry and Medicine, Massachusetts General Hospital; Ralph E. Kelly, Ed.D., is former Commissioner of the Kentucky Department of Juvenile Justice; Chris Koyanagi is with the Bazelon Center for Mental Health Law; Edward J. Loughran is with the Council of Juvenile Correctional Administrators; Howard Snyder, Ph.D., is with the National Center for Juvenile Justice; Tom Stokes is with the National Juvenile Detention Association; Ray Wahl is with the American Probation and Parole Association; Prudence Fisher, Ph.D., Laurence Greenhill, M.D., Kimberly Hoagwood, Ph.D., Laura Mufson, Ph.D., Bruce Waslick, M.D., and Larkin S. McReynolds, M.P.H., are all with the Department of Child Psychiatry, Columbia University; William Arroyo, M.D., is with Children's Services, Los Angeles County Department of Mental Health; Michael Bigley, M.S.S., C.S.W., and Lois Shapiro, Ph.D., are with the New York State Office of Mental Health; Joyce Burrell is with the American Institutes for Research; Larry Faison, Ph.D., is with Mobile County Juvenile Court; Kathi Grasso is with the Office of Juvenile Justice and Delinquency Prevention; William Haxton, Ph.D., is with Clinical Services, South Carolina Department of Juvenile Justice; Diana Quintana, Ph.D., is with the Texas Juvenile Probation Commission; Lee Underwood, Psy.D., is with the National Center for Mental Health and Juvenile Justice.

REFERENCES

Achenbach TM (1991), *Manual of the Youth Self Report and 1991 Scoring Profile.* Burlington: University of Vermont Department of Psychiatry

Altschuler DM, Armstrong TL (1994a), *Intensive Aftercare for High-Risk Juveniles: A Community Care Model; Program Summary.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention

Altschuler DM, Armstrong TL (1994b), *Intensive Aftercare for High-Risk Juveniles: Policies and Procedures.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention

American Academy of Child and Adolescent Psychiatry (1997), Practice parameters for the psychiatric assessment of children and adolescents. *J Am Acad Child Adolesc Psychiatry* 36:4S–20S

American Academy of Child and Adolescent Psychiatry (1999), Practice parameters for the assessment and treatment of children and adolescents who are sexually abusive of others. *J Am Acad Child Adolesc Psychiatry* 38:55S–76S

American Academy of Child and Adolescent Psychiatry (2001a), Practice parameters for the assessment and treatment of children and adolescents with suicidal behavior. *J Am Acad Child Adolesc Psychiatry* 40:24S–51S

American Academy of Child and Adolescent Psychiatry (2001b), *Report of the AACAP Task Force on Work Force Needs: Meeting the Mental Health Needs of Children and Adolescents: Addressing the Problems of Access to Care*. Washington, DC: American Academy of Child and Adolescent Psychiatry

American Association for Correctional Psychology (2000), Standards for psychology services in jails, prisons, correctional facilities, and agencies. *Crim Justice Behav* 27:433–494

American Correctional Association (1991), *Standards for Juvenile Detention Facilities*. Lanham, MD: American Correctional Association (available from 4380 Forbes Blvd, Lanham, MD 20706-4322)

American Psychiatric Association (1994), *Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).* Washington, DC: American Psychiatric Association

American Psychiatric Association (2002), *Psychiatric Services in Jails and Prisons: A Report of the Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons*. Washington, DC: American Psychiatric Association

Andrews VC, Garrison CZ, Jackson KL, Addy CL, McKeown RE (1993), Mother–adolescent agreement on the symptoms and diagnoses of adolescent depression and conduct disorders. *J Am Acad Child Adolesc Psychiatry* 32:731–738

Bird HR, Gould M, Staghezza-Jaramillo B (1992), Aggregating data from multiple informants in child psychiatry epidemiological research. *J Am Acad Child Adolesc Psychiatry* 31:78–85

Brook RH, Chassin MR, Fink A, Solomon DH, Kosecoff J, Park RE (1986), A method for the detailed assessment of the appropriateness of medical technologies. *Int J Technol Assess Health Care* 2:53–63

Casat CD, Pearson DA (2001), The Mental Status Exam in child and adolescent evaluation. In: *Clinical Assessment of Child and Adolescent Behavior,* Vance HB, Pumariega AJ, eds. New York: Wiley, pp 86–97

Chambless DL, Shoham V, Sanderson WC et al. (1996), An update on empirically validated therapies. *Clin Psychol* 49:5–18

Council of Juvenile Correctional Administrators (2001), Performance-based standards for juvenile correction and detention facilities; *www.performance.standards.org* (accessed June 26, 2002)

Council of State Governments (2002), *Criminal Justice/Mental Health Consensus Project*. Washington, DC: Council of State Governments (available from 2760 Research Park Drive, Box 11910, Lexington, KY 40578)

Derogatis L (1977), *The SCL-90 Manual I: Scoring, Administration, and Procedures for the SCL-90.* Baltimore: Johns Hopkins University School of Medicine, Clinical Psychometrics Unit (available at *http://assessments.ncspearson.com*)

Derogatis LR (1993), *Administration, Scoring, and Procedures Manual.* Minneapolis: National Computer Systems

Evans AC, Wasserman GA, McReynolds LS, Ko SJ, Katz LM (2003), Practices around mental health assessments in juvenile justice. Paper presented at the NIMH conference "Beyond the Clinic Walls: Expanding Mental Health, Drug and Alcohol Services Research Outside the Specialty Care System," Washington, DC, March 11

Garland AF, Hough RL, McCabe KM, Yeh M, Wood PA, Aarons GA (2001), Prevalence of psychiatric disorders in youths across five sectors of care. *J Am Acad Child Adolesc Psychiatry* 40:409–418

Grisso T (2002), Mental health screening: responsibilities, resources, and responses. Paper presented at Columbia University Consensus Conference, "Mental Health Assessments in Juvenile Justice Settings," April 17

Grisso T, Barnum R, Fletcher KE, Cauffman E, Peuschold D (2001), Massachusetts Youth Screening Instrument for mental health needs of juvenile justice youths. *J Am Acad Child Adolesc Psychiatry* 40:541–548

Hayes LM (1999), *Suicide Prevention in Juvenile Correction and Detention Facilities: A Resource Guide for Performance-Based Standards for Juvenile Correction And Detention Facilities.* Washington, DC: Council of Juvenile Correctional Administrators

Hodges K, Wong MM (1996), Psychometric characteristics of a multidimensional measure to assess impairment: the Child and Adolescent Functional Assessment Scale. *J Child Fam Stud* 5:445–467

Jensen PS, Rubio-Stipec M, Canino GJ et al. (1999), Parent and child contributions to diagnosis of mental disorder: are both informants always necessary? *J Am Acad Child Adolesc Psychiatry* 38:1569–1579

LeCroy CW, Stevenson P, MacNeil G (2001), Systems considerations in treating juvenile offenders with mental disorders. In: *Treating Adult and Juvenile Offenders With Special Needs,* Ashford JB, Sales BD, Reid WH, eds. Washington, DC: American Psychological Association, pp 403–417

Loeber R, Green S, Lahey BB, Stouthamer-Loeber M (1991), Differences and similarities between children, mothers, and teachers as informants on disruptive child behavior. *J Abnorm Psychol* 19:75–95

National Commission on Correctional Health Care (1999), *Standards for Health Services in Juvenile Detention and Confinement Facilities*. Chicago: National Commission on Correctional Health Care

Niarhos F, Routh DK (1992), The role of clinical assessment in the juvenile court: predictors of juvenile dispositions and recidivism. *J Clin Child Psychol* 21:151-159

Nicholson RA, Norwood S (2000), The quality of forensic psychological assessments, reports, and testimony: acknowledging the gap between promise and practice. *Law Hum Behav* 24:9–38

Novins DK, Duclos CW, Martin C, Jewett CS, Manson SM (1999), Utilization of alcohol, drug, and mental health treatment services among American Indian adolescent detainees. *J Am Acad Child Adolesc Psychiatry* 38:1102–1108

Office of Juvenile Justice and Delinquency Prevention (1994), *Conditions of Confinement: Juvenile Detention and Corrections Facilities* (Report 145793). Washington, DC: Office of Juvenile Justice and Delinquency Prevention

Rahdert E (1991), *Adolescent Assessment Referral System Manual.* Rockville, MD: National Institute on Alcohol Abuse and Alcoholism

Reich W (2000), Diagnostic Interview for Children and Adolescents (DICA). In: *Handbook of Psychiatric Measures,* Rush AJ, Pincus HA, First MB et al., eds. Washington, DC: American Psychiatric Association, pp 314–318

Sattler JM (1998), *Clinical and Forensic Interviewing of Children and Families: Guidelines for the Mental Health, Education, Pediatric, and Child Maltreatment Fields.* San Diego, CA: Jerome M Sattler (available from the author at Box 151677, San Diego, CA 92175)

Shaffer DM, Fisher PW, Lucas C, Dulcan MK, Schwab-Stone ME (2000), NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): description, differences from previous versions, and reliability of some common diagnoses. *J Am Acad Child Adolesc Psychiatry* 39:28-38

Snyder H, Sickmund M (1999), *Juvenile Offenders and Victims: 1999 National Report.* Washington, DC: US Department of Justice, Office of Juvenile Justice and Delinquency Prevention

Stiffman AR, Horwitz SM, Hoagwood K et al. (2000), The Service Assessment for Children and Adolescents (SACA): adult and child reports. *J Am Acad Child Adolesc Psychiatry* 39:1032–1039

Teplin LA, Abram KM, McClelland GM, Dulcan MK, Mericle AA (2002), Psychiatric disorders in youth in juvenile detention. *Arch Gen Psychiatry* 59:1133–1143

Trupin E, Boesky LM (2001), Working together for change: co-occurring mental health and substance abuse disorders among youth/adults in contact with the justice system. The National GAINS Center for People With Co-occurring Disorders in the Justice System and University of Washington; *www.gainsctr.com/curriculum/juvenile/index.htm* (accessed June 26, 2002)

Valanis B (1999), Screening. In: *Epidemiology in Healthcare.* Stamford, CT: Appleton & Lange, pp 313–333

Wasserman GA, McReynolds L, Lucas C, Fisher PW, Santos L (2002), The Voice DISC-IV with incarcerated male youth: prevalence of disorder. *J Am Acad Child Adolesc Psychiatry* 41:314–321

Wiebush RG, Baird C, Krisberg B, Onek D (1995), Risk assessment and classification for serious, violent, and chronic offenders. In: *Serious, Violent, and Chronic Juvenile Offenders: A Sourcebook,* Howell JC, Krisberg B, Hawkins JD, Wilson JJ, eds. Thousand Oaks, CA: Sage, pp 171–212

Weisz JR, Hawley KM (1998), Finding, evaluating, and applying empirically supported treatments for children and adolescents. *J Clin Child Psychol* 27:206–216