CHAPTER 1

Why We Need Mental Health Screening and Assessment in Juvenile Justice Programs

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At a recent meeting of the states' administrators of juvenile correctional programs, the host asked one of them, "In your opinion, what are the three most pressing issues in juvenile justice facilities today?" The administrator answered without hesitation, "Mental health, mental health, and mental health."

He would probably have given a different answer if he had been asked the question 15 years ago. In the early 1990s, when the nation was facing a wave of juvenile homicides (Blumstein, 1995; Zimring, 1998), the most important issue on everyone's minds—the public's and juvenile justice administrators' as well—was "public safety, public safety, and public safety." That issue is still pressing. Yet only a decade or so later, the juvenile crime rate has subsided (Blumstein, Rivara, & Rosenfeld, 2000) while the issue of young offenders' mental disorders has grown, stirring enormous public attention and governmental efforts to respond to what is widely identified as a crisis.

This crisis is represented by the very high prevalence of mental disorders among youths in the juvenile justice system, verified only recently by adequate research studies (e.g., Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). Responses to this news by policymakers, legislators, administrators, and clinical professionals have been wide-ranging, calling for changes on four major fronts.

1. Youth advocates have stressed the need for more effective diversion of youths to mental health programs, in lieu of juvenile justice processing (e.g., Cocozza & Skowyra, 2000). Some youths with mental disorders who are arrested on minor or first-time offenses are likely to be better served by receiving mental health services in the community than by entering the juvenile justice process.
2. For youths who do enter the juvenile justice system, emergency mental health services need to be improved. This will facilitate immediate response to crisis conditions such as suicide risk, prevent the escalation of symptoms before they reach critical levels, and address high-risk consequences of alcohol or drug dependence (Wasserman, Jensen, & Ko, 2003).
3. The increasing proportion of youths with mental disorders in juvenile justice programs requires the development of rehabilitation plans that do more than seek "correctional" adjustments or general rehabilitation. When youths with mental disorders are delinquent, their delinquencies themselves are often related in some way to their disorders. Thus juvenile justice programming must include better resources and clearer plans for addressing youths' mental disorders as part of their rehabilitation, aimed at reducing recidivism.
4. Finally, juvenile advocates call for better treatment planning and more focused follow-up for delinquent youths with mental disorders as they reenter the community after incarceration (Burns & Hoagwood, 2002).

Moving toward these objectives is a complex process that requires diverse knowledge and resources. But one thing is clear. All of these proposed responses begin with a single, important requirement: *The juvenile justice system must be able to identify youths with mental health needs as they enter and reenter the system*. Diversion, emergency responses, and long-range treatment planning can occur only if we have reliable ways to identify which youths have serious mental health needs, what those needs really are, and how they can be described in ways that promote rational responses to the youths' clinical conditions.

Identification and description of youths' mental health needs are the objectives of mental health screening and assessment. The purpose of this book is therefore to provide juvenile justice personnel with critical, up-to-date information on mental health screening and assessment methods, in order to improve the juvenile justice system's identification of youths with mental health needs, and ultimately to improve its response through therapeutic interventions.

This chapter provides an overview of (1) the prevalence of mental disorders among youths in the juvenile justice system, (2) the nature of the system's obligation to respond to their disorders, (3) an introduction to mental health screening and assessment, and (4) a review of the contexts in which mental health screening and assessment are needed in juvenile justice programs.

The remainder of Part I (Chapters 2, 3, and 4) focuses on three types of information essential for understanding and selecting tools for mental health

screening and assessment in juvenile justice settings. Chapter 2 describes features of adolescent personality and psychopathology from a developmental perspective; it focuses especially on the nature of mental disorders in adolescence and the challenges faced by those who develop tools to identify them. Chapter 3 discusses the practical demands of juvenile settings (the juvenile justice context), which must be considered when one is selecting tools to meet mental health screening and assessment objectives. Chapter 4 explains the specific properties of instruments that one needs to understand in order to evaluate them and select certain instruments for use in juvenile justice facilities and programs. With all this information as a background, Parts II through VI review individual tools that offer the field's current best efforts to assist the juvenile justice system to fulfill its objective to identify youths with special mental health needs.

WHAT DO WE KNOW ABOUT THE PROBLEM?

Only in recent years have we had reliable evidence regarding the prevalence of mental disorders among youths in juvenile justice custody. Studies before the 1990s were often performed in a single facility, using small samples, vague definitions of youths' disorders, and measures with questionable reliability (Otto, Greenstein, Johnson, & Friedman, 1992). They reported widely varying prevalence rates for mental disorders, and thus offered little guidance for national or local policymaking. The more recent studies discussed below have used larger samples across several jurisdictions, with clearer definitions of mental disorders and better measures of adolescent psychopathology than were available formerly. Some of these studies have employed psychiatric diagnoses as their focus, while others have examined alternative definitions of youths' clinical conditions.

Common Diagnoses in Juvenile Justice Programs

Studies of the prevalence of psychiatric diagnoses in juvenile justice programs begin with definitions of the domain of mental disorders that appear to be relevant for juvenile justice populations and objectives. This in itself is an important contribution, because it provides a common language with which juvenile justice policy makers and practitioners can address the issue. A recent comprehensive review (Grisso, 2004) indicates that the following are the most common disorders assessed in major studies of youths' mental disorders in juvenile justice programs:

- *Mood disorders*, such as major depression, dysthymia, bipolar disorder, and other depressive or bipolar disorders.
- *Anxiety disorders*, such as obsessive–compulsive disorder and posttraumatic stress disorder.

- *Substance-related disorders*, including disorders (i.e., abuse and dependence) related to chronic and serious drug or alcohol use.
- *Disruptive behavior disorders*, such as oppositional defiant disorder and conduct disorder.
- *Thought disorders*, such as schizophrenia or adolescent precursors of psychotic conditions.

Literature on child disorders and policy in juvenile justice often reveals skepticism about the inclusion of the disruptive behavior disorders as psychiatric diagnoses. These disorders are largely defined and identified by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV; American Psychiatric Association, 1994) and its text revision (DSM-IV-TR; American Psychiatric Association, 2000) on the basis of the presence of a number of illegal and/or aggressive behaviors. Some argue that these categories are different from the rest of the disorders in that they identify youths simply as "troublesome," without any underlying psychological theory to suggest that they are "troubled" in the way that is implied in other categories of disorder (Lambert, Wahler, Andrade, & Bickman, 2001; Richters, 1996). Some evidence in Chapter 2 will challenge that view. But as shown in later discussions in this chapter, recent studies estimating the proportion of juvenile justice youths with mental disorders render this a moot issue, because almost all delinquent youths diagnosed with disruptive behavior disorders *also* manifest disorders in one or more of the other categories in the list above. Setting aside the disruptive behavior disorders as "not really mental disorders" would barely change the picture of mental health needs in the juvenile justice system, because only a small proportion of youths manifest disruptive behavior disorders alone.

Prevalence of Psychiatric Diagnoses

To date, the three best studies of the prevalence of mental disorders among youths in the juvenile justice system were performed in juvenile detention and corrections facilities by three groups of researchers: Teplin and colleagues (2002; Abram, Teplin, & McClelland, 2003), Atkins, Pumariega, and Rogers (1999), and Wasserman and colleagues (2002). All studies used the Diagnostic Interview Schedule for Children (DISC; Shaffer et al., 1996; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) (although not all employed the same version), which identifies youths meeting various diagnostic conditions according to DSM-IV criteria (American Psychiatric Association, 1994). All studies also employed large samples, including both boys and girls, with adequate proportions of black, Hispanic, and white non-Hispanic youths.

These studies did not all find the same prevalence for specific types of disorders, probably because they sampled youths in different juvenile justice contexts (e.g., pretrial detention vs. postadjudication correctional programs). But all were in agreement at the broadest level of analysis, in that the prevalence

of mental disorders among youths in their studies was between 60% and 70%. That is, *about two-thirds of youths in pretrial detention or juvenile corrections programs in these studies met criteria for one or more of the psychiatric disorders* within the mood, anxiety, substance use, disruptive behavior, and thought disorders categories. This prevalence is about two to three times higher than the prevalence of the same disorders among U.S. youths in general (Costello et al., 1996; Kazdin, 2000; Roberts, Attkinson, & Rosenblatt, 1998).

In addition to the overall prevalence of psychiatric diagnoses among youths in juvenile justice facilities, these studies provide three findings of primary importance. First, they report very high rates of youths with "comorbidity" (i.e., youths who met criteria for more than one mental disorder). (See Chapter 2 for a discussion of the importance and frequency of comorbidity of disorders during adolescence.) Abram and colleagues (2003), for example, found that about one-half of youths in pretrial detention met criteria for two or more mental disorders. Second, the studies report fairly consistent ethnic differences, with general prevalence of mental disorders being highest for white non-Hispanic youths and lowest (although still well over 50%) for black youths in juvenile justice settings. Finally, in almost all studies that included both boys and girls, the prevalence of mental disorders among girls in juvenile justice facilities was higher than for boys. (See Grisso, 2004, for a more detailed analysis of these studies.)

Three Caveats

These recent studies are of enormous benefit in defining the scope of the problem. Applying this information to decisions about policy and practice, however, requires certain cautions.

First, none of these primary studies of youths in juvenile justice programs included mental retardation or attention-deficit/hyperactivity disorder, both of which are found with significant frequency among delinquent youths (Mash & Barkley, 2003). Addition of these disorders would probably increase the proportion with psychiatric disorders reported in this population, although perhaps not substantially (since they are often comorbid with other disorders that have already been included in the studies).

Second, the fact that youths qualify for a psychiatric diagnosis does not necessarily define the proportion of youths in juvenile justice programs who need psychiatric care (Grisso, 2004). Youths who meet criteria for a particular mental disorder are not all alike. Some will be functioning fairly well in every day life despite their disorder, while others may be extremely impaired. Among the latter, many jurisdictions identify a class of youths—sometimes called "seriously emotionally disturbed" or "seriously mentally ill"—who have chronic, persistent, and multiple disorders (Davis & Vander Stoep, 1997). They constitute a small proportion of youths who meet psychiatric diagnostic criteria (about 9% to 13% of youths in the community: Fried-

man, Katz-Levy, Manderscheid, & Sondheimer, 1996), but their prevalence in juvenile justice programs is about twice as high as in the general community (Cocozza & Skowyra, 2000). They share some diagnoses with other youths who are less seriously or chronically disturbed. A psychiatric diagnosis alone does not allow us to distinguish the degree of need across youths who are given that particular diagnosis. Thus, in addition to diagnosis, some index of severity of disorder is needed when one is defining the meaning of diagnostic prevalence rates for the juvenile justice system's task of responding to youths' disorders.

Finally, psychiatric diagnoses are not the only way to describe the mental health needs of youths in juvenile justice programs. There are at least three other approaches (Chapter 2 describes these in more detail). Some studies examine symptom conditions (e.g., feeling depressed or anxious, experiencing suicidal ideation) and symptom severity, without identifying specific psychiatric diagnoses. Others have developed alternative dimensions of psychopathology that do not parallel DSM psychiatric diagnoses. Still others use a "problem-oriented" perspective, focusing less on diagnosis and more on youths' actual problem behaviors in school, family, or other social contexts. All of these approaches have a helpful role to play, along with psychiatric diagnosis, in addressing various policy questions and case-by-case decisions relevant for the juvenile justice system's response to youths' mental health needs. All of them have formed the basis for various instruments described later in this volume.

WHY IS THE JUVENILE JUSTICE SYSTEM OBLIGATED TO IDENTIFY YOUTHS' MENTAL DISORDERS?

Knowing that the majority of youths in juvenile justice programs have various mental disorders does not lead automatically to any particular conclusion about the system's obligations to respond to their needs. Few would doubt that there is such an obligation, but there is less agreement regarding its nature and extent. Juvenile justice settings were not designed as sites for comprehensive psychological and psychiatric treatment of adolescents' mental disorders. On the other hand, some level and some type of "essential" services seem necessary. What is the scope of the juvenile justice system's obligation to respond to youths' mental health needs?

To determine this requires considering the juvenile justice system's purposes as defined by its social and legal mandates. Such an analysis (Grisso, 2004) reveals three primary reasons why the juvenile justice system is obligated to respond to the mental health needs of youths in its custody: (1) a *custodial* obligation, (2) a *due process* obligation, and (3) a *public safety* obligation. Those response obligations provide the foundation for the general obligation to identify youths' mental health needs through screening and assessment.

Custodial Obligation

The first obligation to respond to youths' mental health needs resides in the condition of custody itself. Juvenile justice custody often restricts youths' access to public health services for which they have a pressing need and that they would otherwise be eligible to receive. Adolescents typically depend upon adults for access to most mental health services. While youths are in juvenile justice custody, those adults are the youths' juvenile justice custodians. Therefore, especially in circumstances of incarceration (e.g., pretrial detention, secure juvenile corrections), the juvenile justice system is obligated to provide access to emergency or other essential mental health services when youths are in significant distress or have acute disabilities that require immediate attention.

This obligation begins with awareness. Parents or other caregivers may be charged with abuse or neglect not only because of harmful acts, but also because they have failed to recognize physical and psychological conditions that are detrimental to their children. Similarly, ignorance of a youth's suicidal potential does not absolve a juvenile justice facility from its responsibility as custodian when a youth commits suicide. The facility must show that it took reasonable steps to identify whether the youth might have been at risk of suicide.

Identification of youths' mental conditions is therefore an obligation of the juvenile justice system as a part of its custodial role. Note that the custodial argument for the system's obligation to identify youths' mental health needs increases under two conditions: (1) when youths are incarcerated, which decreases their access to community services; and (2) with regard to acute mental conditions, which create the need for emergency services to avoid imminent distress, psychological deterioration, and harm to the youth.

Due Process Obligation

For youths who are charged with delinquencies, the juvenile justice system has a mandate to assure that the legal process judges their responsibility for their alleged delinquencies fairly, and that the system does not abuse its discretion in deciding on penalties and rehabilitative measures when youths are found delinquent. All states have identified due process requirements in the adjudication of youths; these follow from a series of important federal constitutional protections for youths charged with crimes or delinquencies that can result in loss of liberty (e.g., *Kent v. United States*, 1966; *In re Gault*, 1967; *Fare v. Michael C.*, 1979).

Among the due process rights of youths in juvenile court adjudication are the right to avoid self-incrimination, the right to waive or obtain representation by an attorney, and various rights associated with the process by which courts hear evidence and make determinations of guilt and disposition (sentencing). In addition, most states' legislatures or courts have determined in

recent years that youths must be competent to stand trial in delinquency cases (Bonnie & Grisso, 2000; Redding & Frost, 2002). That is, they must be able to understand the trial process, assist counsel in developing a defense, and make important decisions about the waiver of their constitutional rights.

All of these legal protections are designed to assure fairness in police questioning of youths, youths' interactions with their attorneys, and youths' participation in their trials. In addition, they focus on the capacities of youths themselves to make decisions during the juvenile justice process that may have far-reaching implications for their lives. Youths with mental disorders and developmental disabilities are especially at risk of incapacities in the process of their trials that might jeopardize their fair defense (Grisso, 1997, 2000; Grisso et al., 2003). Thus the system's obligation to protect youths' due process rights includes identification of mental conditions that might impair their ability to make decisions during their adjudication.

This obligation has implications at several levels of juvenile justice protection: (1) promoting laws that recognize the relevance of mental disorders for youths' participation in their trials; (2) providing methods to identify youths with mental disorders for whom the question of mental incompetence should be raised, and to determine when this question should be raised; and (3) assuring the availability of adequate assessment services to determine whether a youth's mental disorder actually impairs the youth's functioning in a way that threatens due process in the youth's adjudication.

Public Safety Obligation

The juvenile justice system is charged with exercising reasonable efforts to protect the public from harm. This mandate drives two primary functions of the juvenile justice system. One function is to protect the public from the immediate risk of harm by youths who are imminently dangerous to others. This sometimes requires placement of youths in secure facilities at the pretrial stage of their adjudication and/or after they are found delinquent. The second way in which the mandate is expressed is in the juvenile justice system's responsibility to reduce recidivism by providing rehabilitative services intended to decrease the likelihood that youths will reoffend in the long run or pose a longer-term risk of harm to others.

Youths in the juvenile justice system who have mental disorders are not known to present a substantially greater risk of violence or harm to others than other youths in the juvenile justice system do (for a review, see Grisso, 2004). But when youths have mental disorders, their disorders do play a role in their aggression (Connor, 2002). Their mental disorders influence whether, how, and under what circumstances their aggression is likely to be expressed. Therefore, reducing their aggression requires a response to their mental disorders, which begins with the ability to identify these disorders and the level of risk that they present (Borum, 2000).

The mandate has implications for two kinds of identification: (1) assessing youths' level of risk of violence; and (2) if that risk is high, assessing youths' mental disorders as factors that may be related to that risk and therefore require intervention. Moreover, identification must focus on at least two kinds of risk of harm and their relation to mental disorders: (1) imminent risks requiring an immediate response to protect others; and (2) longer-range risks requiring appropriate treatment of youths' mental disorders as part of general rehabilitation efforts to reduce aggressive recidivism.

WHAT ARE MENTAL HEALTH SCREENING AND ASSESSMENT?

Given the evidence for high prevalence of youths with mental disorders, and in light of clear mandates to identify youths' mental disorders, juvenile justice programs throughout the nation are employing two broad ways to fulfill those mandates, typically called "screening" and "assessment." The field's choice of these terms is potentially confusing, because the term "assessment" is often used in the behavioral sciences to refer to *any* type of measurement of psychological characteristics. So the following discussions use the term "identification" or "measurement" for the broader concept, while referring to "screening" and "assessment" as two ways to measure and identify youths' mental health needs and behaviors.

A second source of potential confusion is the lack of consensual definitions of "screening" and "assessment" in the current juvenile justice literature (e.g., Grisso & Underwood, in press; Wasserman et al., 2003). Although there is considerable overlap, in specific instances one writer's "screening" may be another writer's "assessment." The definitions provided later in this section strive to incorporate what does seem to be consistent across earlier descriptions, with commentary where there may be divergence.

A final source of confusion is in authors' labeling of instruments as "screening tools" or "assessment tools." As will become evident, the present discussion does not use the terms to refer to names or types of instruments, but to two different identification processes. Some tools may work better for one process or the other. But the mere fact that an instrument's author has called it a "screening tool" does not guarantee that it will serve all juvenile justice programs' needs for a screening process. "Screening" and "assessment" provide the context within which we can decide what types of instruments can best accomplish the objectives of these two broad types of identification.

Defining Screening and Assessment

If you were developing a process to identify youths' mental health needs as they enter the juvenile justice system, what would it look like? In one ideal

image of that process, all youths entering a detention center or an intake probation office would receive an extensive interview by a psychiatrist or clinical psychologist, several psychological tests to describe their personalities and diagnose their mental disorders, a detailed assessment of their risk of aggression and suicide, and an analysis of problem areas in their everyday lives. This information would be used to produce an individualized view of their immediate, emergency mental health needs, as well as longer-range plans for rehabilitation.

This objective is, of course, impossible. In a given year in the United States, about 1.7 million youths are arrested on delinquency charges, and about 320,000 youths are admitted to pretrial detention facilities (Snyder & Sickmund, 1999). Performing such comprehensive mental health inquiries with every youth referred to intake probation or pretrial detention would be far outside even the most generous definition of juvenile justice systems' resources, not to mention the availability of doctoral-level professionals to perform such services. Even if this ideal were possible, it would not be "ideal" at all. It would be wasteful of our resources for caring for youths, because for many youths we simply do not need this degree or depth of clinical scrutiny in order to meet their needs adequately. Providing it to all would inevitably mean that there would be fewer resources left for treatment services to those who genuinely need them. Moreover, there are good reasons to avoid any greater level of intrusion in youths' and families' lives than is clearly justified by the benefits to youths and society (Grisso, 2004).

The notions of "screening" and "assessment" are ways to deal with this problem. They are conceptualized as two levels of identification of youths' mental health needs. Screening provides a type of economical identification applied to all youths, whereas assessment, following after screening, provides more extensive and individualized identification of mental health needs to those youths whose screening results suggest that it is warranted.

Screening has two defining characteristics. First, it is applied with *every youth* at entry into some part of the juvenile justice system—for example, with every youth within the first day after his or her entrance to a pretrial detention center, or at the first interview contact by an intake probation department after every referral to the juvenile court. Second, screening tends to focus on identifying conditions that signal the potential need for some sort of *immediate response*—for example, the need to consider placing a youth on suicide watch, the need to consider transfer to an alcohol/drug detoxification unit, or the potential need to obtain additional clinical information on the youth's immediate need for psychoactive medication,

In contrast, assessment is performed *selectively* with some youths and not others, often in response to signals (e.g., indications during screening) that suggest the need for a more individualized and thorough identification of mental health needs than can be provided by screening. The timing of assessment methods is more variable. Assessment may occur soon after first contact in response to screening information, in which case it may be aimed at deter-

mining whether an emergency situation truly exists, what the specific nature of the emergency is in this particular youth's case, and how best to deal with it. Or it may be delayed if screening does not suggest an emergency situation, focusing instead on comprehensive collection of data aimed at developing longer-range treatment planning or meeting judicial needs for information related to a forensic question.

It is worth noting that screening and assessment do not necessarily differ in the mental health conditions they attempt to identify. Both may seek to learn about the presence and severity of symptoms often associated with mental disorders (e.g., depressed mood, anxiety), the potential for problem behaviors (e.g., suicide, aggression), specific psychiatric diagnoses (e.g., major depressive disorder), or problem areas in a youth's life (e.g., school difficulties, family problems). Yet, as explained later, screening typically identifies these conditions far more tentatively than assessment; its results are valid for a shorter period of time; and it provides a less individualized perspective on the nature of a youth's mental health needs. The reasons for this will become clear as we examine screening and assessment practices more closely.

The Nature of Screening

Screening involves every youth at high-volume points in juvenile justice processing. Its purpose is to do an initial "sorting" of youths into at least two groups: one group that is very unlikely to have the characteristics one wishes to identify (e.g., mental health needs, risk of harm to others), and another that is at least somewhat more likely to have those characteristics. The screening process is similar to triage in medical settings, where incoming patients are initially classified (in triage, into three categories) according to their level of urgency. Like triage, screening is useful in systems that have limited resources and therefore cannot respond comprehensively or immediately to every individual's particular needs. In these circumstances, identifying those who may be most greatly and most urgently in need is not just a defensible position, but the best one.

For reasons described in Chapter 3, tools that are likely to be favored for screening processes require no more than 10–30 minutes of administration time by persons who do not have advanced training in the provision of mental health evaluations or treatment. Those that work best for these purposes are standardized and highly structured, providing the same process (e.g., interview questions) for every youth. But as we will see in Parts II and III, they vary considerably in their specifics. Some focus on symptoms, others on social problem areas, still others on one dimension or several dimensions of psychopathology, and yet others on the risk of suicidal or aggressive behaviors.

The brevity of screening methods requires a tradeoff. Most screening methods sort youths into categories, but are not intended to provide sufficient detail about a youth's condition to allow for an individualized decision about the youth's need for specific services. For example, a brief 10-minute screen

that focuses on symptoms of mental or emotional distress (e.g., the Massachusetts Youth Screening Instrument) will sort youths into those with no remarkable symptoms and those with significant symptoms, but it will not provide diagnoses for youths in the latter group. A lengthier, 1-hour screen that focuses on psychiatric diagnoses (e.g., the DISC) will sort youths into diagnostic categories and indicate degree of impairment, providing a better basis for deciding on certain types of responses (such as hospitalization). The cost, however, is greater in time and resources than many screening situations can afford.

The value of a screening method is its identification of a group of youths who are more greatly at risk of mental health problems than those in the group that is "screened out." Although only some of the "screened-in" youths may have the acute disorders that the screening targets, the proportion in that group will be much greater than the proportion among all youths admitted to a facility. Screening therefore allows a juvenile justice system to focus its efforts and its scarce resources on a group containing a higher proportion of higher-need youths.

The Nature of Assessment

In contrast to screening, assessment strives for a more comprehensive or individualized picture of a youth. The assessment tools described in Parts IV and V are chosen to verify the presence or absence of mental health needs among "screened-in" youths, determine how disorders are manifested in these specific youths, and focus on recommendations for some specific intervention. The instruments used in assessment often involve longer administration times (e.g., more than 30 minutes), and they are often supplemented with clinical interviews and with past records from other agencies. They may or may not be performed by mental health professionals (child-specialized psychiatrists, psychologists, or psychiatric social workers), depending on their nature and scope, but they all require considerable training and expertise. All of the costs of assessment are compensated for by greater depth, breadth, and clarity than usually can be offered by tools more suited for screening.

The comparative advantages and costs of screening and assessment methods have resulted in their symbiotic use in many juvenile justice programs. Screening is often used to determine which subset of youths is most likely to need the more comprehensive yet costly assessment methods.

A Note about Short-Range and Long-Range Objectives

Screening and assessment tend to address different types of questions about youths' mental health needs. In general, screening is more appropriate for addressing short-range questions about youths' needs and behaviors, while assessment, with its more comprehensive and individualized focus, is better for longer-range questions. There are several reasons why this is so.

Screening focuses to a large extent on the condition of youths as they are entering the system, often within a day or two after their arrest and at the very beginning of the adjudicative process. In addition, a significant part of the reason for screening is to identify conditions that may need a response within the very near future—that is, within hours or days. Because of both these factors, screening at intake may provide information that reflects not only a youth's enduring traits and characteristics, but also the youth's thoughts and feelings that are stimulated by immediate events—the offenses he or she has just committed, stresses at home that may have contributed to the delinquent behavior, or emotions (such as fear or anger) associated with arrest and placement in a secure facility. Were the youth to be given the instrument in a few weeks, after those circumstances had passed, it would not be surprising to find somewhat different results.

In contrast, assessment often occurs later in a youth's stay in a particular juvenile justice setting, after the youth has had some time to become accustomed to the setting and circumstances. In addition, the more comprehensive methods used in assessment allow a clinician to focus on the youth's general behavior in everyday life and on his or her psychological history. This allows the clinician to begin to identify which of the youth's thoughts, feelings, and problems are typical of him or her across time and which are primarily reactions to the current situation.

As a consequence, screening can be expected to reflect the youth's current condition and an estimate of the youth's circumstances for the immediate future. Will the youth need suicide precautions tonight? Should we expect a high risk of aggression during the next week or two while the youth is in detention? But screening results are typically less reliable for making longer-range judgments about a youth's treatment needs. In contrast, assessments are typically better suited to guide us in making disposition recommendations, long-term placements among various secure treatment programs, and plans for implementing various community resources to maximize rehabilitation efforts.

VARIATIONS IN SCREENING AND ASSESSMENT AT "DOORWAYS" IN THE JUVENILE JUSTICE SYSTEM

We have described screening as occurring at entry points in the juvenile justice process. By "entry points" we do not mean merely the point of arrest and the beginning of custody, but the many "doorways" through which youths pass as they move through the juvenile justice process. In addition, screening at these doorways may lead to assessment at several different points in juvenile justice processing. Although there are variations across jurisdictions, it is convenient and fairly common to identify at least five of these doorways as potential points for screening and/or assessment: (1) probation intake, (2) pretrial detention, (3) preadjudication and disposition, (4) juvenile corrections recep-

tion, and (5) community reentry. These five doorways are briefly described here, and the differing demands they place on tools used for screening and assessment are discussed in more detail in Chapter 3.

Probation Intake

Most youths referred to juvenile courts on delinquency charges have their first contact with the system at their first meeting with a probation intake officer (who may be part of either the community's probation department or the juvenile court itself). Some probation intake programs use a mental health screening instrument with every youth at the first intake interview. The volume of youths at this point is very high, so that individualized clinical assessments of every youth by mental health professionals are typically not possible.

The most common purpose of screening at this doorway is the identification of those youths who are most likely to have special mental health needs, requiring more detailed clinical assessment or emergency referral for community mental health services. Sometimes mental health screening (or assessment) at this point results in diversion from the juvenile justice process, with probation intake officers using their discretion to arrange for appropriate community services for youths instead of filing the cases for delinquency adjudication.

Pretrial Detention

Some youths referred to the juvenile court are immediately admitted to pretrial detention centers, which may be either secure or nonsecure. This admission (especially to a secure facility) is based on a judgment that they present a significant danger to themselves or to others if they are not detained, or that they themselves may be in danger if they are not in protective temporary custody. Mental health screening at the front door of a detention center—often between 1 and 12 hours after admission—has become routine in many jurisdictions nationwide. Detention centers typically have a high volume of admissions and high turnover of residents, calling for relatively inexpensive screening devices. Their purpose is to identify youths who need emergency services (e.g., referral to inpatient psychiatric facilities, suicide watches, referral for substance use detoxification), a more complex assessment, or consultation with a mental health professional. Some of the most frequent mental health concerns at this point include the immediate toxic effects of heavy substance use just prior to admission, suicide potential, significant depression or anxiety, and anger that might increase the risk of harm to staff or other residents.

Preadjudication and Disposition

Either through intake or detention screening, or by other means, some youths may be identified as having significant mental disorders that could impair

their ability to participate in their defense (i.e., their competence to stand trial) (Barnum, 2000; Grisso, 1998). In other cases, a youth may be petitioned for a juvenile court hearing to determine whether he or she should be transferred (waived) to criminal court for trial as an adult—a decision that often requires consideration of the youth's mental status, treatment potential, and risk of harm to others (Fagan & Zimring, 2000). These forensic questions often require evaluations by mental health professionals. They are called "forensic" questions because answering them requires courts' decisions based on the application of legal criteria. Forensic evaluations typically do not involve screening methods, but rather full assessments by specially trained forensic mental health professionals. These examiners often use tools designed to provide comprehensive information about a youth's personality and psychopathology (Part IV), but in addition they may employ specialized tools to assess risk for violence (Part V) or to examine characteristics relevant for specific forensic questions (Part VI).

When youths are adjudicated delinquent, courts must then determine the proper disposition for each case. Most courts have a wide range of dispositions, which can be classified broadly as including community placements or out-of-community secure and nonsecure placements. Community placements can range from a youth's own home to staff-secure residential group homes, and community placement conditions often include referral to community mental health services or special treatment programs for delinquent youths with mental disorders. Out-of-community placements range from low-security to high-security juvenile facilities or programs, usually administered by a state's juvenile corrections department. States vary widely in the availability of mental health treatment for youths in juvenile corrections facilities.

Most large juvenile courts have the resources to order clinical assessments for youths with mental disorders, and the need for such assessments must be taken into account by the judges deciding on these youths' proper dispositions. The focus of these assessments is on necessary treatment for the mental disorders—for the youths' welfare and the reduction of delinquency recidivism—as well as on the degree of security required in each youth's immediate placement, in order to protect the public and the youth.

Juvenile Corrections Reception

When youths' dispositions include placement with the state's department of youth corrections, this is another doorway that often requires screening and assessment. Many juvenile corrections programs operate reception centers, where youths reside for a few weeks in order to ascertain their appropriate placement within corrections programs. Entrance to such a reception center frequently includes a mental health screen. The purpose is less often to determine the need for further assessment, since the purpose of reception centers is typically to provide assessment for all youths to determine their individual needs and appropriate placement. Therefore, screening in these settings serves

as a "first look" to determine whether there are needs that require immediate attention, while the youth embarks on an assessment process that often will take several weeks. Screening is often needed as well when the youth finally arrives at the juvenile corrections placement that has been recommended, in order to determine the youth's immediate emotional response to incarceration.

Community Reentry

Youths who have been placed in secure corrections programs are eventually returned to their communities—either to their homes or to community-based residential programs. Assessment is sometimes necessary to identify a youth's readiness for community reentry, and to develop plans for obtaining necessary mental health services as part of the reentry plan. Arrival at a community residential program is often an appropriate point for screening to assess the youth's immediate emotional reactions to returning to the community, especially if he or she is returning to stressful circumstances.

CONCLUSION: PREPARING TO DESIGN SCREENING AND ASSESSMENT PROGRAMS

Parts II through VI of this book review a wide range of tools that are currently used in juvenile justice settings for screening and assessment of mental health needs and aggression risk. These tools are not interchangeable. Instruments in one category have very different purposes from those in another category, and even instruments within a category have their own unique features that may make them more or less suitable for specific settings and purposes.

Selecting among these instruments therefore requires an understanding of the reasons for wanting to evaluate youths' mental health needs. In addition, administrators and clinicians need to take into account a variety of factors with which to weigh the quality and feasibility of the available instruments. The three chapters in the remainder of Part I provide information to assist in the process of evaluating, choosing, and implementing tools for use in juvenile justice settings for screening and assessment of mental health needs and aggression risk.

Chapter 2 provides basic concepts in developmental psychopathology that are important to consider in weighing the value of screening and assessment. What makes a "child" screening or assessment tool different from an "adult" tool, and why are instruments designed for adults usually inappropriate in juvenile justice settings? What does one need to know about types of adolescent psychopathology in order to assure that an instrument is measuring the mental health concepts one wants to measure? What are the limits of screening and assessment, in light of the complex nature of adolescent psycho-

pathology? And what (if anything) is different about adolescent psychopathology in delinquent populations, including its relation to aggression?

Chapter 3 focuses on the context for screening and assessment, especially the legal, policy, and practical demands encountered in developing screening and assessment methods and selecting appropriate instruments. From an administrator's perspective, any strategies for evaluating youths' mental health needs must be guided by law, policy, and agency objectives; constraints associated with staffing and budget resources; the specific population of youths within the facility or facilities; and the potential uses of information about youths' mental disorders. Screening and assessment occur in the context of a complex, practical set of circumstances, and this context places particular demands on instruments—demands that are somewhat different from those in other settings where psychological and psychiatric evaluations are performed. Some tools meet these pragmatic and legal demands better than others, and these matters play a significant role in one's decisions about their use.

Chapter 4 reviews the technical properties of screening and assessment tools, as well as important decisions about the screening and assessment process that must guide one's choice of instruments. In selecting methods, what does one need to know about how screening and assessment tools are developed? What are the important indicators of a method's dependability and accuracy, and how dependable and accurate does an instrument have to be in order to be useful for various specific purposes? Given that there are no perfect screening or assessment tools, how does one weigh the balance of their strengths and limitations when deciding among them?

The importance of being careful to choose the right tools and procedures for the job cannot be overemphasized. In these days when juvenile justice programs are urgently seeking assistance in dealing with the system's three most pressing issues—"mental health, mental health, and mental health"—there may be a tendency to reach for the first option that gets one's attention. Yet one can argue that ineffective measures can be worse than no measures at all, given the waste of resources that could be used to meet other important needs of youths. Proper identification of youths' mental health needs and risk of harm requires taking the time to make careful selections and to position the right tools within an effective screening and assessment process.

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