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Illinois Juvenile Justice Commission

Mental health screening and assessment in the Illinois juvenile justice system

Prepared for
The Illinois Juvenile Justice Commission

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Introduction

Meeting the mental health needs of youthful offenders is one of the most important issues facing juvenile justice systems across the nation. Many model programs are addressing and mitigating mental health issues among youth in the juvenile justice system. In 2000, Illinois piloted the Mental Health Juvenile Justice Initiative (MH-JJ) which links youth in detention facilities to mental health services. The program serves all Illinois counties and any youth who have had any contact with the juvenile justice system. Programs such as Models for Change and the Illinois Children's Mental Health Partnership also are working diligently to address the issue of youth with mental illnesses in the Illinois juvenile justice system.

As Illinois is attempting to create a solid network of mental health services for juvenile justice system-involved youth, information is lacking about practices currently used by the system to identify youth with mental health needs. The Illinois Criminal Justice Information Authority (Authority) surveyed practitioners in various components of the juvenile justice system between November 2008 and March 2009 to determine mental health screening and assessment practices.

Survey results indicated a lack of standardized mental health screening and assessment across the juvenile justice system. This report provides information on the screening and assessment tools used by respondents, and other tools that can be adopted to identify mental health needs, including reliability and validity studies and construct measurement. Finally, the report also discusses the concerns voiced by practitioners on mental health in the Illinois juvenile justice system.

Mental illness in the justice system

Mental health issues can be a barrier to success for any individual, regardless of social and demographic characteristics. Juveniles who are dealing with mental health problems while being involved in the juvenile justice system are more likely to continue to experience justice system involvement.[1] Properly identifying youth in need and linking them with appropriate services will help facilitate their rehabilitation and likely reduce subsequent law violating behavior.[2]

Offenders with mental illness often have more difficulty complying with rules and regulations while in secure confinement as well as with release conditions of probation and parole, especially when mental health treatment compliance is a condition of their release.[3] One study found that specialized mental health probation officers had more contacts with their probationers with mental illness than standard probation officers, which can lead to more opportunities for technical violation; however, they were less likely than traditional probation officers to use punitive sanctions on these clients.[4] Research also found that jail inmates with untreated mental illness were perceived to exhibit more problematic behaviors and were more likely to be victimized by other inmates.[5] Furthermore, offenders with mental illness often have substance abuse problems, which can exacerbate the mental illness and lead to increasing difficulty in obtaining comprehensive and cohesive treatment.[6]

Introduction

Emerging research has indicated that a large number of youth in our nation's juvenile justice system experience mental health problems. Some studies have estimated the number of youth in the juvenile justice system with mental health issues as high as 70 percent.[7] Additionally, research has shown that 20 percent of youth in the juvenile justice system have serious mental health problems.[8]

While research has not been done on the overall prevalence of mental illness among youth in the Illinois juvenile justice system, studies have examined this issue at different points in the system. For instance, in a well-known study by Linda Teplin and her colleagues of 1,829 randomly sampled youth at the Cook County Juvenile Temporary Detention Center, it was revealed that about 60 percent of male detainees and about 66 percent of female detainees met the diagnostic criteria for one or more psychiatric disorders.[9] Among the most common were disruptive behavior disorders, anxiety disorders, affective (mood) disorders, and substance use disorders.[10]

The high proportion of youth in the juvenile justice system with mental health issues indicates a need for policies that address this issue. Many studies have shown mental health services and treatment programs are scarce and fragmented in communities, and often offenders turn to the criminal and juvenile justice systems for mental health care. These systems are ill-equipped to provide mental health services.[11] Some researchers and advocates argue that the criminal and juvenile justice systems have become "part of the de facto mental health care system."[12] Other studies argue that without access to mental health services in communities, police and other first responders must take on the role of removing offenders from the public and placing them into custodial care, a task for which they lack training and resources.[13]

Whatever role the criminal justice system has in mental health care, most experts in the field recognize it is increasing and the system is largely under-resourced to adequately address the need.[14] Furthermore, cost-benefit analysis indicates it is more beneficial to treat mentally ill offenders than bringing them into the justice system.[15] Further exacerbating the obstacles of mental health services is the great variation in how youth with mental illness are identified. This issue is examined in the next section.

Mental illness and juveniles

Recent research has shown that three-fourths of mental illness symptoms are present by age 24, indicating that many mental illness symptoms will be present in adolescence, particularly those of anxiety and behavior disorders.[16] Typically, mental illness is classified using the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the most recent of which is the *Fourth Edition, Text Revision (DSM-IV-TR)*. The *DSM-IV-TR* identifies sets of symptoms and signs reflecting a specific mental disorder that has no physical or medical impetus. These disorders are then placed into Axis I and Axis II categories. Additional dimensions are available in Axis III through Axis V that examine other factors influencing diagnosis and prognosis, such as life events, physical problems, and level of functioning.

Axis I disorders are referred to as clinical syndromes and are typically further grouped into the following categories:

- **Adjustment disorders**—characterized by a significant or abnormal difficulty adjusting to a life circumstance, such as a death of a loved one.
- **Anxiety disorders**—characterized by abnormal or inappropriate anxiety. Includes disorders such as generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, and obsessive-compulsive disorder.
- **Attention deficit and disruptive behavior disorders**—characterized by inability to focus, impulsivity, aggressive behavior, repeated engagement in antisocial behavior (such as lying). Includes attention-deficit hyperactivity disorder, conduct disorder, and oppositional defiant disorder.
- **Dissociative disorders**—characterized by disruptions in perception, consciousness, memory or identity. Includes dissociative amnesia, dissociative identify disorder (multiple personality disorder), and depersonalization disorders.
- **Eating disorders**—characterized by abnormal eating behaviors. Includes anorexia and bulimia.
- **Impulse-control disorders**—characterized by inability or extreme difficulty in controlling impulse behaviors, regardless of consequences. Includes intermittent-explosive disorder, pyromania, and kleptomania.
- **Mood (affective) disorders**—characterized by disturbances (inappropriate, limited, or exaggerated) or extreme fluctuations in mood. Includes depression, bipolar disorder, cyclothmia, and dysthymia.
- **Psychotic disorders**—characterized by psychosis (loss of contact with reality), delusions, and hallucinations. Includes schizophrenia, psychotic disorder, schizoaffective disorder, and delusional disorder.
- **Sexual disorders and paraphilias**—disorders are characterized by impairments in normal sexual functioning that lack a physical or medical cause. Paraphilias are characterized by distressing, unusual, and repetitive desires, urges, behaviors, or fantasies. Includes pedophilia, fetishism, voyeurism, and exhibitionism.
- **Sleep disorders**—characterized by impairments or disturbances in sleep. Includes insomnia, narcolepsy, sleep terror disorder, and sleep walking.

Mental illness and juveniles, continued

- **Somatoform disorders**—characterized by the manifestation of physical conditions that mimic a medical condition when none is present. Include body dysmorphic disorder, conversion disorder, hypochondria, and pain disorders.
- **Substance abuse related disorders**—characterized by impairment of daily functioning, addiction or dependence, or distress as a result of legal or illegal substance use.

Axis II disorders include mental retardation and personality disorders. Personality disorders are characterized by a pattern of thoughts or behaviors that deviate markedly from what is culturally accepted. These typically manifest themselves in severe disturbances in the behaviors or personalities of an individual and are grouped into clusters:

- **Cluster A**—odd or eccentric disorders
  - Paranoid personality disorder
  - Schizoid personality disorder
  - Schizotypal personality disorder
- **Cluster B**—dramatic, emotional, or erratic disorders
  - Antisocial personality disorder
  - Borderline personality disorder
  - Histrionic personality disorder
  - Narcissistic personality disorder
- **Cluster C**—anxious or fearful disorders
  - Avoidant personality disorder
  - Dependent personality disorder
  - Obsessive-compulsive personality disorder

The most common mental disorder diagnoses seen among youth are attention deficit and disruptive behavior disorders and anxiety disorders. It is estimated that about 13 percent of youth ages 9 to 17 have an anxiety disorder, and 10 percent have a disruptive behavior disorder.[17] While affective (mood) disorders and substance abuse disorders are frequently present among adolescents, symptoms are more likely to present in early adulthood with a median age of onset at 30 and 20, respectively, compared to age 11 for anxiety and behavior disorders.[18] Symptoms of psychotic disorders, such as schizophrenia, most commonly manifest in young adulthood as well. Many argue that it is difficult to identify personality disorders in youth due to the nature of adolescent development.

According the U.S. Centers for Disease Control and Prevention, suicide is the third leading cause of death among youth 15 to 24 years old. In 2009, 15 percent of high school students said they have seriously considered committing suicide while 7 percent have attempted it. Suicidal thoughts are often symptoms, but not mutually inclusive, of underlying mental disorders (especially depression or anxiety). Identifying youth with suicidal thoughts does not necessarily indicate the presence of a mental disorder in all circumstances.

Identification of mental health problems

Identifying mental health issues in youth in the juvenile justice system is difficult. Historically, assessments of risk for future criminality and mental health issues were based on clinician interviews and professional judgment. However, following the publication of numerous studies indicating the lack of reliability and validity of clinical assessment methods, criminal and juvenile justice practitioners and mental health professionals recognized the limitations to this method, and the use of standardized screening and assessment instruments became more common.[19]

Over the last decade, many standardized mental health screening and assessment tools have been developed and rigorously evaluated. However, few tools are specifically intended for youth and even fewer are intended for youth involved in the juvenile justice system. The University of Massachusetts implemented the National Youth Screening and Assessment Project (NYSAP) in 2000 to provide assistance to juvenile justice practitioners implementing mental health screening and assessment.[20]

First, it is important to understand and distinguish mental health *screens* from mental health *assessments* as they are conceptualized as two different levels of identifying a youth's mental health problems and/or needs.[21] Leading experts in the field of mental health screening and assessment point out that there is often legitimate confusion between the two, stemming from the nomenclature used in behavioral sciences, the usage of terms in instrument titles, and the lack of consistent definitions utilized by researchers and practitioners.[22] Operational definitions, established by Dr. Thomas Grisso, a leading expert in the field, will be used throughout this report.

Mental health screening

Grisso defines screening as having two main characteristics in the context of the juvenile justice system. First, screening is usually done with "every youth at entry into some part of the juvenile justice system."[23] Second, a screen identifies the need for an immediate response.[24] Mental health screenings attempt to identify youth who have immediate risks or needs so that they can be addressed promptly. Screening instruments tend to be brief and often require little to no training to be administered. This benefits resource-strapped agencies that lack trained mental health professionals.[25] While screening instruments work to identify immediate need, typically through short questionnaires with 'Yes' or 'No' responses, they are usually unable to indicate the specific levels of need and do not "provide sufficient detail about a youth's condition to allow for an individualized decision about the youth's need for specific services." [26]

Mental health assessment

While mental health screens are brief and given to all youth entering a particular point of the juvenile justice system, mental health assessments are used on a smaller group of individuals. Typically, an assessment will be used to obtain more detailed information about a youth's mental health status and needs after a screen indicates potential issues.[27] Mental health assessments are

more comprehensive than a screen and are typically administered by trained clinicians; however some assessments may be conducted by untrained professionals. Assessments allow practitioners to determine the severity and scope of a youth's mental health problems, sometimes providing mental illness diagnoses. Assessments often are used to recommend specific interventions or case plans.[28]

Standardized and unstandardized tools

This report makes the distinction between standardized and unstandardized screening and assessment instruments. Standardized tools are those that have been developed and evaluated systematically. For instance, the questions on a standardized tool are created and tested to be theoretically, practically, and statistically sound. Standardized tools go through numerous stages of development and use scale validity and reliability analyses to determine which questions to include, determine how to phrase or ask questions and in what order, and measure and determine appropriate classifications (such as diagnoses) based on scores.

Changing the wording or removing questions on a standardized instrument threatens the validity of the instrument. Tools may be developed by a facility or practitioner to include questions from multiple standardized tools, but the tool will remain unstandardized if it is not systematically validated or evaluated.

Mental health screening and assessment practices in the Illinois juvenile justice system

In Illinois, mental health problems among youth in the juvenile justice system is identified in a variety of ways. In many situations, mental health issues may become apparent without the use of standardized instruments and non-mental health professionals are sometimes able to identify the need for further mental health care. However, studies have shown such subjective methods are often inaccurate, so standardized mental health screening and assessment tools are used.[29]

Research is limited on mental health screening and assessment practices of agencies and facilities serving youth in the Illinois juvenile justice system. Each county controls its own detention center and court services, and standardized practices do not exist across facilities and jurisdictions. The Authority, on behalf of the Illinois Juvenile Justice Commission, conducted a survey of juvenile justice agencies across the state on mental health screening and assessment practices between November 2008 and March 2009.

Methodology

Survey

The Authority designed a survey consisting of 33 forced-answer and open-ended questions grouped into six sections. In the first section were questions about general mental health issues in the respondent's facility. Questions in the second section were about what screening tools the respondent used, when they administered the tool, why they chose that instrument, and who administered the instrument. The third section listed questions about what occurs in the respondent's facility post-screening. In the fourth section were questions about what assessment tools the respondents used, when they administered the tool, why they chose that instrument, and who administered the instrument. In the fifth section, questions were asked on what occurs in the respondent's facility post-assessment. The sixth section solicited opinions of the respondents on mental health issues in their facility and the juvenile justice system as a whole.

Surveys were mailed in November 2008 with self-addressed stamped envelopes for their return. A total of 99 surveys were sent. Respondents also were given the option of completing the survey online via the Authority website. Follow-up emails to non-respondents were sent to elicit a higher response rate.

A copy of the full survey is available in *Appendix D*.

Study participants

In order to ascertain the practices of the different stages of the juvenile justice system, participants were chosen from the main contact points: arrest/diversion/initial contact, probation and court intake, detention, and corrections.

Arrest, diversion, and initial contact

Information on screening or assessment at the arrest, diversion, or initial contact stage was not obtained due to lack of participation by necessary police agencies. Collecting information on screening and assessment at initial contact should be re-visited in future study.

Probation and court intake

Probation and court services are operated by county or judicial circuits and overseen by the Administrative Office of the Illinois Courts. Formal probation occurs post-adjudication. However, probation departments may also monitor youth on informal probation (a method of pre-trial diversion), petitions continued under supervision, and court-supervised youth. Court services departments—combined with probation departments in most counties—provide intake screening and other court services. Surveys were sent to the 70 probation and court services departments serving the 102 counties in Illinois.

Juvenile detention

In Illinois, temporary juvenile detention centers are operated in 17 counties. Most detention centers will house youth from any county, however some detention centers, such as the Cook County Juvenile Temporary Detention Center, only serves youth from a specific county. Detention centers house youth awaiting a hearing and youth sentenced to short terms in secure confinement. Youth are first screened to determine the need for detainment and, when warranted, are admitted to a detention center with space to accommodate them. A survey was sent to the superintendent of each temporary juvenile detention facility (n=17).

Juvenile corrections

The Illinois Department of Juvenile Justice (IDJJ) operates the state's eight juvenile correctional facilities, referred to as Illinois Youth Centers. The facility in which the youth will be placed to serve his or her sentence is determined by IDJJ based on special medical or mental health needs, security level, estimated length of stay, type of offense, and other factors. A survey was sent to the superintendent of each facility (n=8).

Response

Of the 99 mailed surveys, 64 were returned between November 2008 and March 2009. Three surveys were from social service agencies serving juvenile justice populations and since the focus of this study was on the screening and assessment practices of the juvenile justice system, these responses were excluded. One survey did not contain identifying information and two

surveys were duplicates, therefore these were excluded. Without these surveys, there were 58 survey responses, for a response rate of 59 percent.

The Authority was unable to determine the screening and assessment practices at initial point of contact for the juvenile justice system due to a lack of survey responses.

Forty-five of the 70 probation and court services departments completed the survey (64 percent). These departments served 62 counties or 61 percent of all Illinois counties.

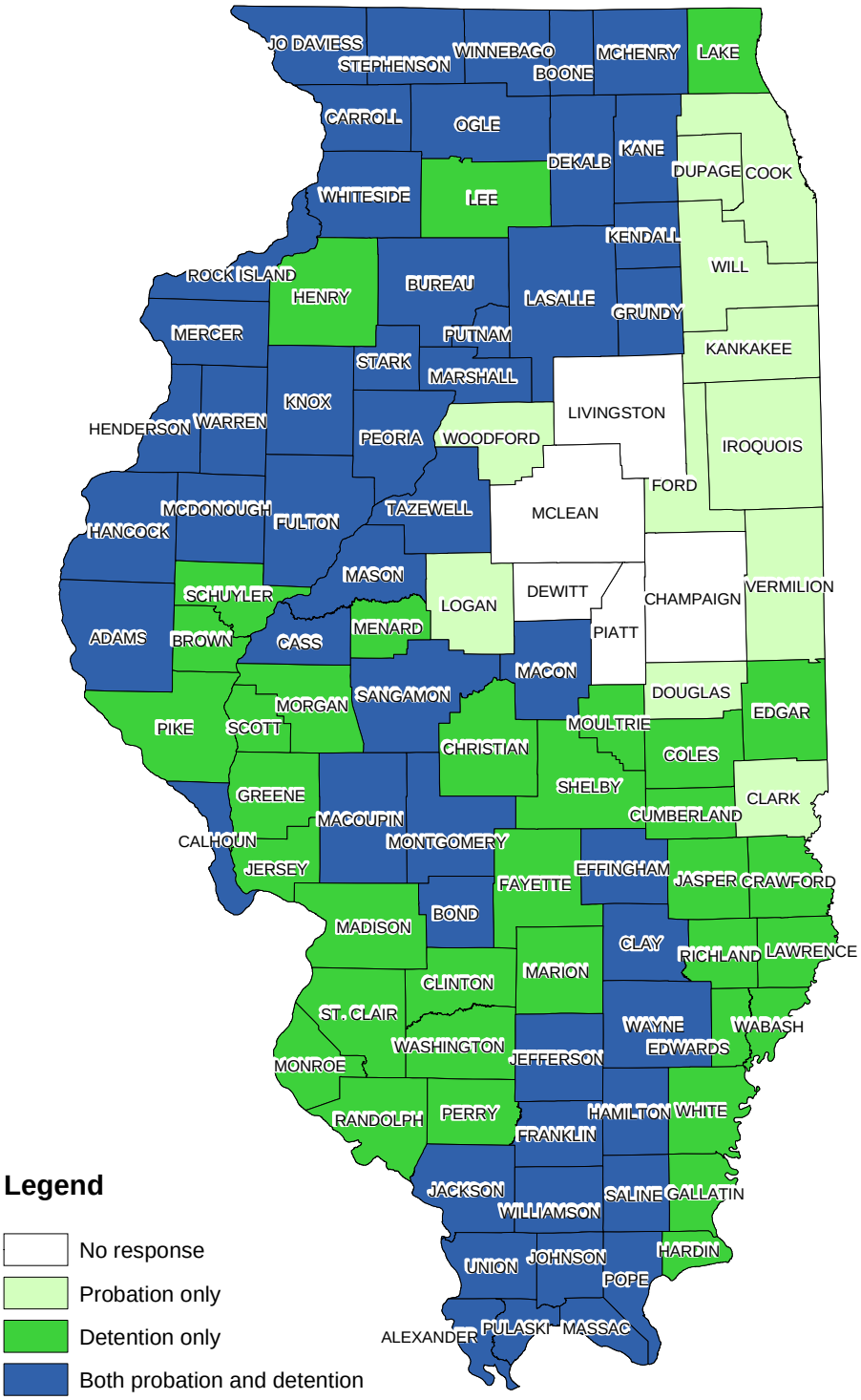
Eleven of the 17 detention centers in Illinois completed the survey (65 percent). These centers served 84 percent of Illinois counties (86 counties total).

One of the eight Illinois Youth Centers responded to the survey (12 percent). These facilities serve the state as a whole, and do not serve specific counties.

Combined, 94 percent of counties in Illinois provided responses for at least one stage in the juvenile justice system (either detention or probation). In 49 percent of counties, the surveys were completed for both detention and probation.

Map 1 shows survey responses by county.

Map 1
Illinois survey responses by type



Results

Identification of youth with mental health issues

Twenty-two probation and court services departments serving 32 counties in Illinois (31 percent) indicated they had some method of identifying youth with mental health problems, either formally or informally. Probation and court services departments serving 10 counties indicated they routinely screened all youth. Probation departments serving 18 counties reported they made referrals for screening to outside agencies, but they did not specify how those referrals were made. Probation departments serving seven counties said they used a standard period of observation to identify youth with possible mental health problems. Three counties were served by probation departments that reported using some other method of identification.

All responding detention centers (n=11) indicated they had formal or informal methods of identifying mentally ill youth. Eighty-one counties (79 percent) were served by detention centers that indicated they routinely screened all youth entering their facilities. Sixty-two counties (61 percent) were served by detention centers that made referrals to agencies for mental health identification in addition to screening all youth.

Reported screening methods used by respondents include: Adolescent Substance Abuse Subtle Screening Instrument; Childhood Severity of Psychiatric Illness; Jesness Inventory-Revised; Kaufman Brief Intelligence Test; Massachusetts Youth Screening Instrument, second version; Personality Inventory for Youth; Wechsler Intelligence Scales for Children; and Youth Assessment and Screening Instrument.

Reported assessment methods used by respondents include: Adolescent Suicide/Homicide Risk Assessment; Childhood Adolescent Functional Assessment Scale; Child and Adolescent Needs and Strengths; CRAFFT; Diagnostic Interview Schedule for Children, 4th edition; Millon Adolescent Clinical Inventory; Minnesota Multiphasic Personality Inventory-Adolescent; Personality Inventory for Youth; and Ohio Youth Problems , Functioning, and Satisfaction Scales. These instruments are discussed in depth in the *Mental health screening and assessment* section of this report.

Results of this report may be skewed by apparent confusion over how *screening* and *assessment* should be defined and confusion between risks and needs assessment instruments and mental health screening and assessment tools. Many agencies indicated their method of screening and assessing youth for mental health problems was the Youth Assessment and Screening Instrument (YASI), a general risk and needs assessment tool. While the YASI does flag immediate mental health problems, such as suicide risk, use of psychotropic medication, or aggressive behavior, it is not intended to identify general clinical mental health symptoms.

Probation screening and assessment practices

Screening

Probation departments serving 15 counties reported conducting mental health screens of their youth using tools other than the YASI. Forty-seven counties reported using only the YASI. Probation departments serving three counties gave no indication of screening practices. Confusion as to what constitutes a mental health screen again may have skewed the results.

Use of the YASI is required by the Administrative Office of the Illinois Courts for all probation and court services departments, and most responding departments reported the YASI was their primary screening tool (covering 46 percent of all Illinois counties). *Map 2* depicts the findings of probation screening practices in Illinois based on survey responses.

Five counties utilize a standardized mental health screening tool: Cook, DeKalb, DuPage, Kane, and Kendall. Cook and DuPage counties use the Massachusetts Youth Screening Instrument, Second version (MAYSI-2).

The Kane County Probation and Court Services Department, serving DeKalb, Kane, and Kendall counties, utilize the Jesness Inventory-Revised (JI-R) as a primary mental health screening tool. These counties reported also using other instruments that are not specific to mental health: the Wechsler Intelligence Scale for Children (WISC), Substance Abuse Subtle Screening Inventory (SASSI), and the Kaufman Brief Intelligence Test (KBIT).

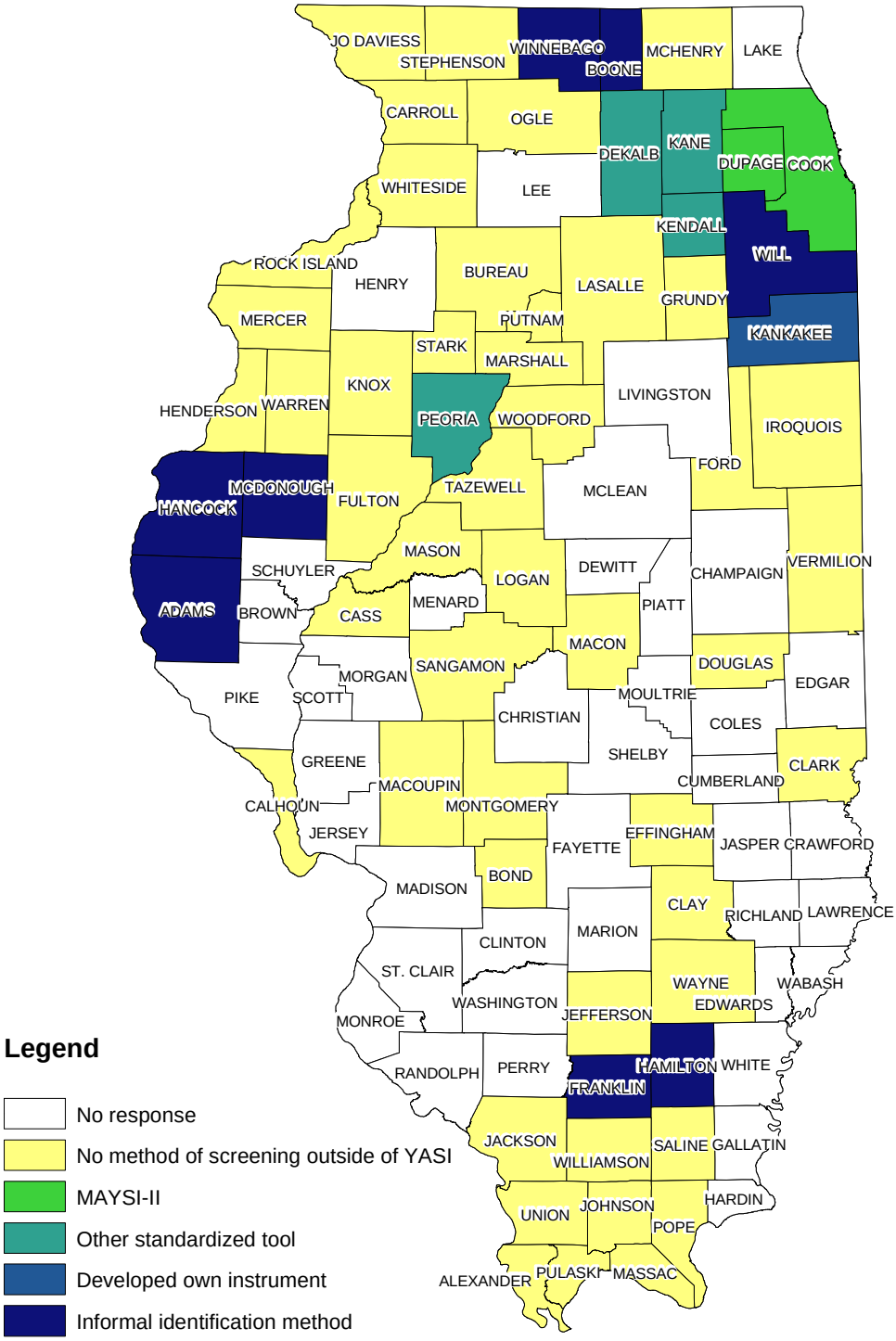
Kankakee County developed its own screening tool—the Problem Behavioral Health Screening Instrument—consisting of several behavioral and mental health questions asked at intake.

Peoria County utilizes the Personality Inventory for Youth (PIY), a screening and assessment tool that measures emotional and behavioral adjustment, family interaction, and academic functioning.

Probation and court services departments of Adams, Boone, Franklin, Hamilton, Hancock, McDonough, Will, and Winnebago counties indicated that they used observation and professional judgment to identify youth with potential mental health problems.

Appendix A summarizes mental health screening practices in probation and court services by county.

Map 2
Mental health screening practices in Illinois probation



Assessment

Map 3 depicts the probation assessment practices in Illinois based on the survey results. Cook, DeKalb, DuPage, Kankakee, Kane, Kendall, and Peoria counties reported conducting mental health assessments within their departments. Seventeen counties reported referring youth to outside mental health agencies for assessments.

Fifty-seven counties were served by probation departments that reported they did not conduct mental health assessments. This may include some agencies that referred probationers to mental health agencies for further evaluation but did not specify that process in the survey response.

Cook, DeKalb, DuPage, Kane, Kendall, and Peoria counties reported using a standardized assessment tool. Kankakee County developed its own assessment process, and departments serving 17 percent of counties made referrals to outside agencies to complete assessments (n=17).

Probation departments serving 17 counties make referrals to mental health agencies for assessments when screening reveals mental health risk. Three of those counties used informal screening methods, mainly questions asked during intake about the youth's mental health. The remaining 14 counties utilized the YASI.

Cook County reported using the Child and Adolescent Needs and Strengths (CANS) as their mental health assessment tool if the MAYSI-2 screen they use indicates need for further assessment.

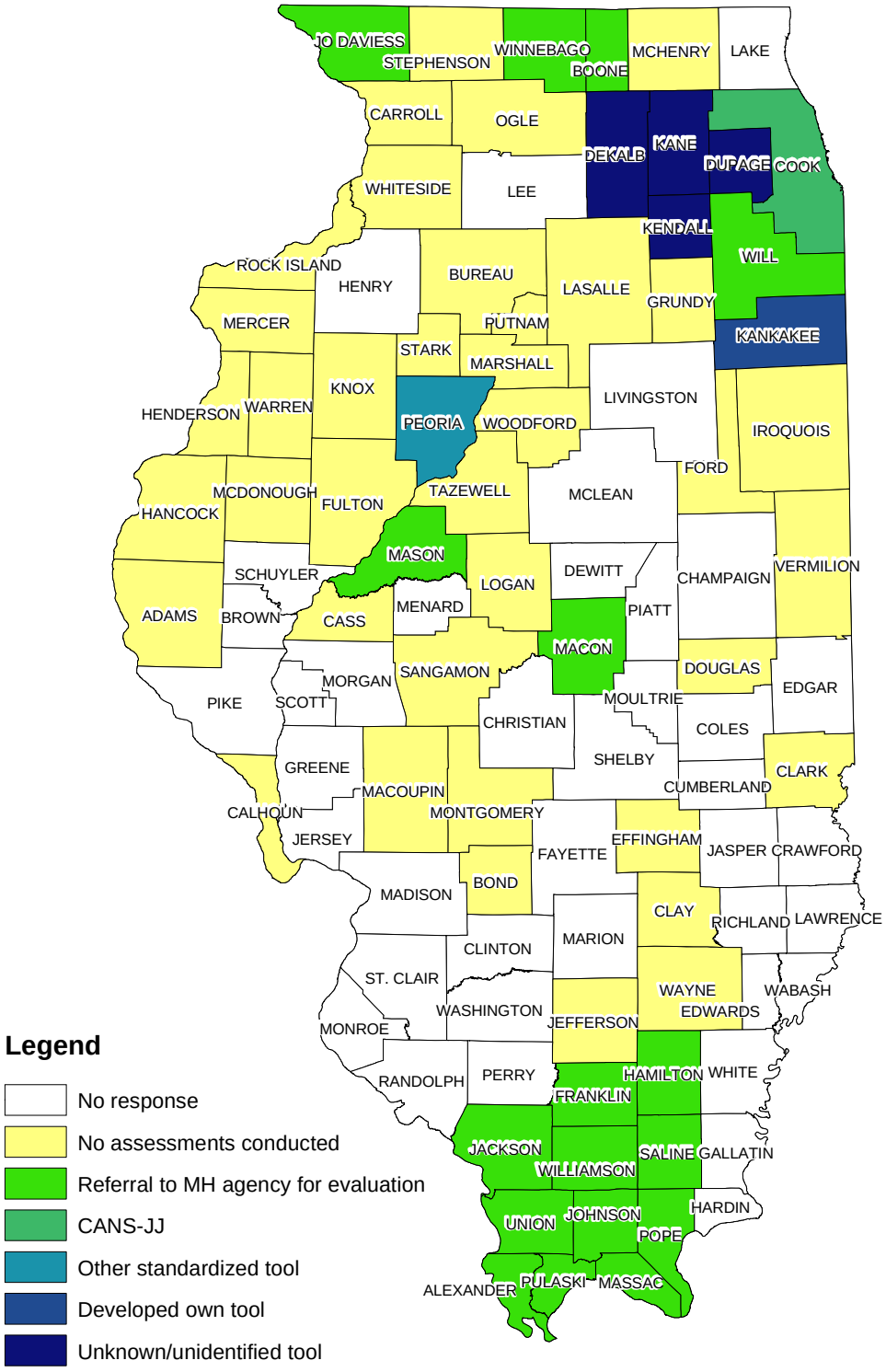
The Kane County Probation and Court Services Department, serving DeKalb, Kendall, and Kane counties, indicated use of an assessment tool, but did not specify which one.

DuPage County indicated they use an informal assessment process consisting of questioning by a case manager.

Kankakee County performs both screening and assessment with the Problem Behavioral Health Screening Instrument, which they developed.

Peoria County uses the Personality Inventory for Youth (PIY) full assessment to identify youth with mental health issues should screening indicate the need for further assessment. *Appendix A* provides a summary of the mental health assessment practices in Illinois by county.

Map 3
Mental health assessment practices in Illinois probation



Detention center screening and assessment practices

Screening

Map 4 depicts the mental health screening processes used by responding detention centers in Illinois. All 11 detention centers that responded, serving 86 counties, indicated they routinely screened all youth at intake.

Nine counties in Illinois are served by detention centers that use only the Mental Health Juvenile Justice (MH-JJ) Initiative referral screening tool. The MH-JJ Initiative works with detention centers to provide comprehensive mental health services to detained and juvenile justice system-involved youth. Each detention center uses a quick referral screen to determine whether to refer the youth to the MH-JJ Initiative. If a referral is made, the MH-JJ Initiative uses the Childhood Severity of Psychiatric Illness (CSPI) tool.

The Knox County Detention Center, serving 19 counties in northern and western Illinois, uses a set of informal mental health screening questions in addition to the MH-JJ tool. The Knox County Detention Center is working with the developers of the MAYSI-2 and the National Youth Screening Assistance Project, sponsored by the University of Massachusetts Medical School, to upgrade its mental health screening and assessment practices.

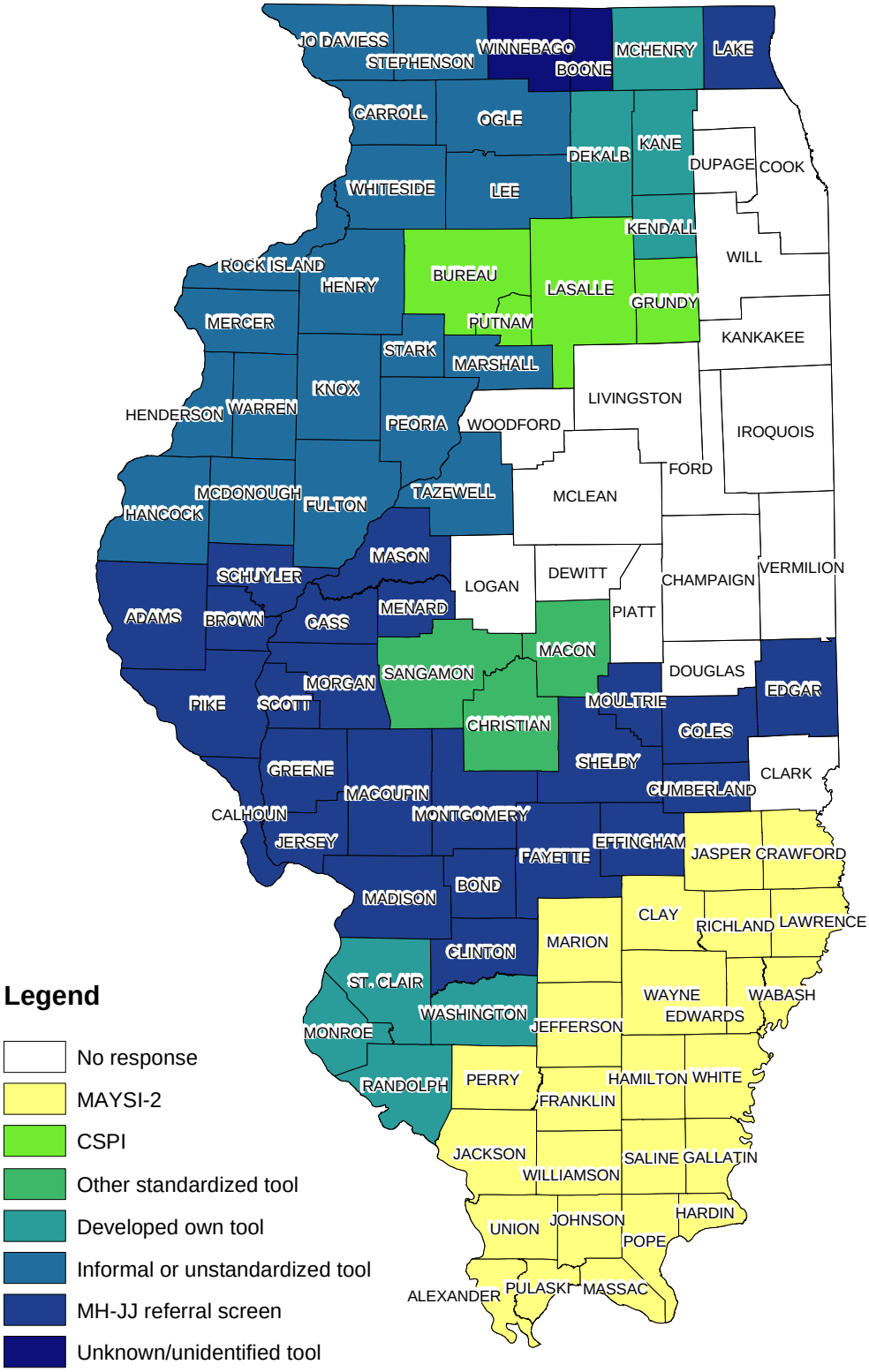
The Peoria County Detention Center, serving Peoria, Tazewell, and Marshall counties, developed its own screening and assessment tools.

The LaSalle County Detention Center, serving Bureau, LaSalle, Grundy, and Putnam counties, uses the CSPI to screen youth.

The Sangamon County Detention Center, serving Sangamon, Christian, and Macon counties, uses the MH-JJ tool and the CRAFFT to screen for substance use issues, and the Adolescent Suicide/Homicide Risk Assessment (ASHRA) to determine the risk of harm to oneself and others.

The Franklin County Detention Center, serving approximately 25 counties in the First and Second Judicial Circuits, uses the MAYSI-2 screen in addition to the MH-JJ referral screen. *Appendix B* provides a summary of the mental health screening practices used by detention centers by county in Illinois.

Map 4
Mental health screening practices in Illinois detention centers



Assessment

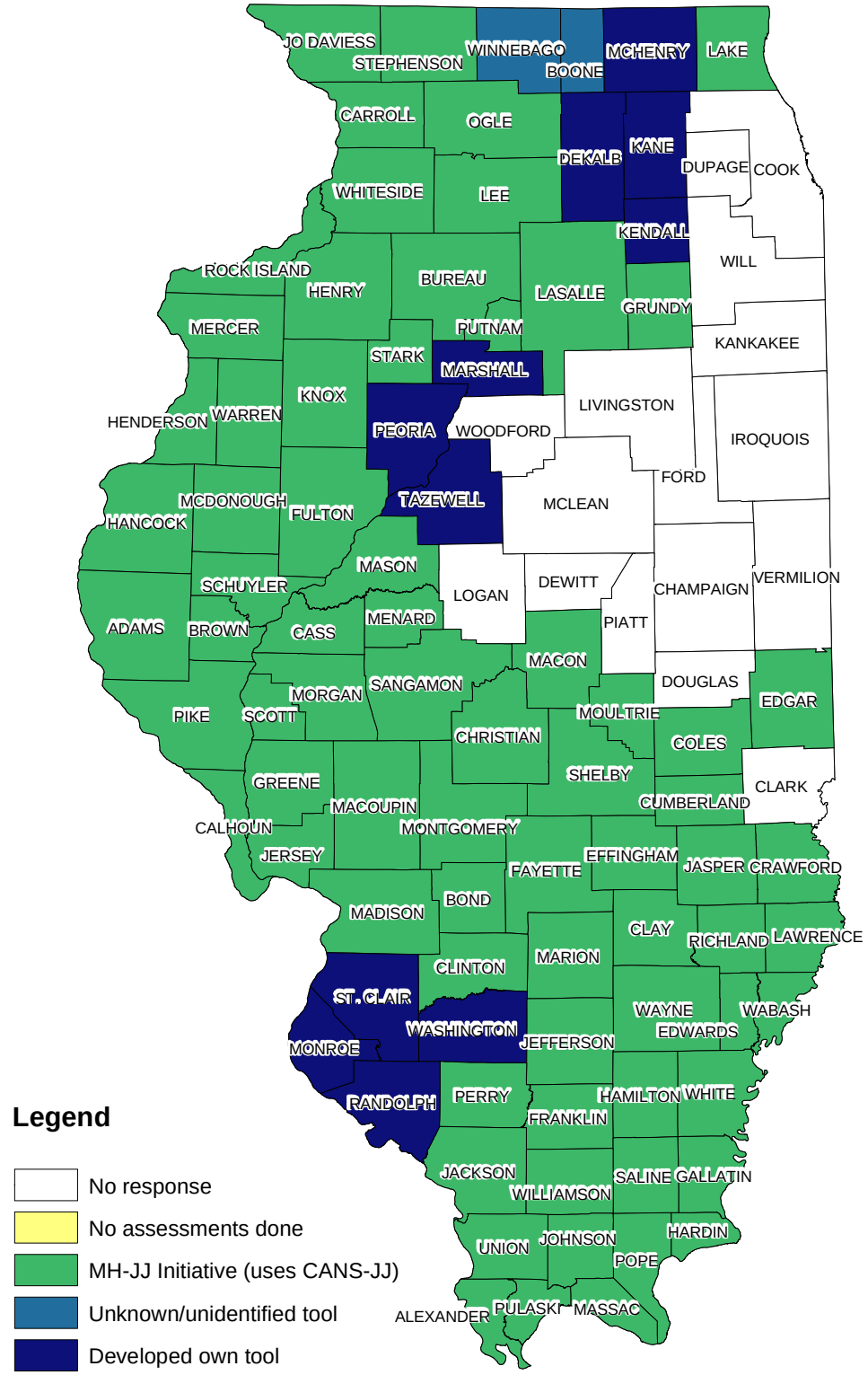
Map 5 depicts the mental health assessment practices of detention centers in Illinois. Eighty-four percent of counties are served by detention centers that use the MH-JJ Initiative for assessments (n=72). The MH-JJ Initiative utilizes the Child and Adolescent Needs and Strengths for Juvenile Justice System Involved Youth (CANS-JJ) as their assessment tool.

In addition to the counties using the MH-JJ Initiative, DeKalb, Kane, Kendall, McHenry, Marshall, Monroe, Peoria, Randolph, St. Clair, Tazewell, and Washington counties are served by detention centers that developed their own assessment tools.

The Winnebago County Detention Center, serving Winnebago and Boone counties, did not specify what tools they used.

Appendix B provides a summary of the mental health assessment practices of detention centers by county in Illinois.

Map 5
Mental health assessment practices in Illinois detention centers



Illinois Youth Center screening and assessment practices

Only IYC-Warrenville returned a completed survey. IYC-Warrenville reported routinely screening all youth entering the facility within one hour of admission. They use the Sad Person Scale (SPS), a semi-structured interview tool intended to screen for suicide risk. In addition to the SPS, they use the Juvenile Assessment and Intervention System (JAIS), a risk assessment instrument developed by the National Council on Crime and Delinquency. The JAIS is a gender-responsive risk, strengths, and needs assessment and is not specific to mental health. Additionally, IYC-Warrenville conducts mental health assessments on youth determined to be in need. IYC-Warrenville uses the DISC-IV, CANS-JJ, and Childhood Adolescent Functional Assessment Scale (CAFAS) for their general mental health assessments

Juvenile justice system mental health issues and needs

The survey also asked for opinions on mental health issues facing the Illinois juvenile justice system. More than half of the respondents said one of the greatest challenges the juvenile justice system faced was access to mental health services, funding for mental health services, and access to mental health evaluations.

A large proportion of respondents said provision of mental health services upon identification of need also was a challenge. Many respondents indicated there were not enough mental health services or child psychologists and psychiatrists available within a reasonable distance in their counties. A number of respondents also indicated one of the biggest barriers for their clients was finding transportation to and from available mental health services. Some respondents were concerned about over-medicating youth without providing any other form of treatment.

Some respondents said it often took several months to get a youth into treatment or to undergo a mental health assessment. Wait times were exacerbated by disputes and issues with insurance companies, and difficulty in finding appropriate mental health services that accepted Medicaid.

Another common response was the expressed desire for standardized and consistent practices across all jurisdictions and points in the system for identifying youth with mental health needs and linking youth to appropriate services. Some respondents indicated that having mental health issues identified prior to sentencing would greatly assist the courts and probation officers.

Family issues were often raised by respondents. Many stated that parents often had untreated mental health issues of their own, which hindered the organizations' attempts to appropriately treat and manage the offender's plan for mental health services.

Lack of familial involvement was another common family issue raised. While this issue is prominent even among youth without mental health issues, lack of parental involvement exacerbates difficulties faced by agencies in working with mentally ill youth. Other respondents said that while some families expressed a willingness to be involved in the youth's treatment, there were often few meaningful opportunities to do so.

Finally, many respondents reported seeing an increase of mentally ill youth offenders and expressed concerns about the lack of funding for evaluations and services, especially when the youth is no longer under the jurisdiction of the agency. Many respondents stated that comprehensive mental health services should be available for service continuity for youth after leaving detention centers or completing probation. Wrap-around services will help reduce fragmentation in service delivery and increase effectiveness of the services.

A few respondents indicated that, overall, they are content with the process through which they screen, assess, and provide services for youth with mental health problems. A few probation departments reported having specialized probation officers for youth with mental health and behavioral issues which, they found, increased their effectiveness in dealing with youth with mental health issues.

Discussion

Table 1 provides a summary of mental health screening practices at the different stages of the juvenile justice system in Illinois. Because only IYC-Warrenville responded to the survey, its practices appear as a check mark in the table.

Table 1
Summary of screening practices in Illinois, by stage

Stage	Number of counties (%)				
	No response	MH-JJ referral screen only	Unstandardized screening instrument/ unknown	YASI only (immediate risk)	Standardized screening instrument
Probation	40 (39.2%)	0 (0.0%)	9 (8.8%)	47 (46.1%)	6 (5.9%)
Detention	16 (15.7%)	25 (24.5%)	29 (28.4%)	0 (0.0%)	32 (31.4%)
Corrections (Girls IYC Warrenville)	—	—	✓	—	—

Survey results revealed that few probation and court service departments screen youth systematically for mental health issues beyond the few mental health questions contained in the YASI. Forty-five of the 70 probation and court services departments, serving 62 counties in Illinois, returned completed surveys. Of those, only six counties were served by probation and court services departments that used standardized mental health screening instruments (10 percent of responding counties and 6 percent of all Illinois counties).

Eleven of the 17 detention centers in Illinois, serving 86 counties, returned surveys. Twenty-nine counties employed a standardized mental health screen for youth (34 percent of responding counties and 28 percent of all Illinois counties)—25 use the MAYSI-2 and four use the CSPI. Nine counties are served by detention centers that use the MH-JJ referral screen (10 percent of

responding counties and 9 percent of all counties). If a referral is made to the MH-JJ initiative, the youth are screened with the CSPI. Three counties use detention centers that use the MH-JJ referral screen in addition to the SASSI, CRAFFT, and ASHRA. Finally, 3 counties are served by a detention center using a non-standardized screening instrument.

Table 2 provides a summary of mental health assessment practices at the different stages of the juvenile justice system in Illinois. Because only IYC-Warrenville responded to the survey, its practices appear as a check mark in the table.

Table 2
Summary of assessment practices in Illinois, by stage

Stage	Number of counties (%)				
	No response	No assessments completed	Referral to outside agency for assessments (includes MH-JJ)	Unstandardized or informal instrument	Standardized assessment instrument
Probation	40 (39.2%)	38 (37.3%)	17 (16.7%)	5 (4.9%)	2 (2.0%)
Detention	16 (15.7%)	1 (1.0%)	72 (70.6%)	13 (12.7%)	0 (0.0%)
Corrections (Girls IYC Warrenville)	—	—	—	—	✓

Cook and Peoria counties indicated they used a standardized mental health assessment tool (3 percent of responding counties and 2 percent of all Illinois counties). Three counties reported using a standardized assessment tool in the probation and court services department but did not indicate which instrument they used. Seventeen counties indicated they make referrals to outside mental health agencies for further assessments (27 percent of responding counties and 17 percent of all Illinois counties). The majority of these agencies made referrals for mental health assessments based on YASI screen findings (n=14, 23 percent of responding counties and 14 percent of all Illinois counties).

The MH-JJ Initiative, which provides screening and assessment to referred youth, is open to all counties and most participate. Of the 86 responding counties, 72 indicated they used the MH-JJ tool to provide assessments for referred youth (84 percent of responding counties and 71 percent of all counties).

Mental health initiatives in Illinois—the Mental Health and Juvenile Justice Initiative

In January 2000, the Illinois Department of Human Services (IDHS) began the Mental Health and Juvenile Justice (MH-JJ) Initiative to aid counties in referring mentally ill youth in detention to community-based mental health services. IDHS contracts with mental health providers for

case monitoring of detained youth identified as having a mental health problem. The program operates in all counties housing youth detention centers in Illinois.

Eligibility for MH-JJ services is based on the presence of a psychotic disorder (disorders characterized by hallucinations and delusions) or affective disorder (disorders characterized by mood disturbances or extreme fluctuations in mood). Youth with behavioral disorders, such as conduct disorder or oppositional defiant disorder, are excluded from the program unless they occur with a psychotic or affective disorder. Also excluded are youth with personality disorders or developmental disabilities. Wards of the Illinois Department of Children and Family Services are ineligible.

Court staff may refer youth to MH-JJ, but the CSPI screening tool determines who receives services. An MH-JJ program liaison conducts the initial eligibility screening upon referral from a juvenile justice professional. The liaison then develops a treatment plan and connects the youth to appropriate treatment.

In 2006, the initiative removed detention as a requirement for eligibility. Referrals may come from any juvenile justice contact, including probation officers, court officials, and court services, within six months of a youth's initial contact.

An evaluation of the initiative revealed that participants have lower rates of recidivism compared to detained youth who do not receive mental health treatment. Recidivism was defined by the rate at which youth who had been detained are re-arrested. The study showed 27 percent of participants were rearrested in state fiscal year 2005 (FY05), and 28 percent were rearrested in FY06, while non-participants had a 72 percent recidivism rate.[30]

Mental health screening and assessment tools

The survey results indicate that few agencies are using standardized mental health screening and assessment instruments. Further, there is considerable confusion as to which tools constitute screens or assessments. Other respondents indicated that the adoption of a standardized tool for use across all jurisdictions would be beneficial.

This section presents information regarding screening and assessment tools being used in Illinois and others being used nationally to assist agencies selecting a mental health screening and/or assessment instrument.

Many mental health screening and assessment tools have been tested for reliability and validity. Many of these tools examine a variety of issues in addition to mental health. Some are specific to juveniles in the juvenile justice system and others are for the general youth population. For simplicity, the tools discussed forthwith are some of the more commonly employed youth screening and assessment tools used in Illinois and nationally are discussed in this section.

Psychometric properties of instruments

Instrument reliability

Reliability typically refers to the internal consistency of a tool. Internal consistency is measured by how well different questions measuring the same construct yield similar results. For example, the MAYSI-2 mental health screen has a subscale on depression. A youth's answers to all the questions on the MAYSI-2 that are intended to measure depression should be similar. Another common type of reliability is test-retest reliability, or the ability of an instrument to get similar or the same results when administered more than once. Inter-rater reliability is the ability of an instrument to get the same or similar results when the test is completed and scored by multiple raters.

Instrument validity

The validity of an instrument refers to the tool's ability to measure what it is intended to measure. The validity of a tool used to diagnose mental illness would be contingent upon its ability to accurately diagnose mental disorders. There are different measures of instrument validity.

Internal validity is when the outcome of a screening or assessment is the result of true measurement, and not outside influences. For example, the internal validity of a mental health screening would depend upon high scores reflective of increased risk for mental health problems and not the increased stress a youth feels during the intake process of a detention center.

External validity refers to the ability of an instrument to be used across various groups. For instance, the external validity of an assessment instrument is threatened when it does not accurately diagnose mental illness for youth of a specific age group or gender.

Construct validity measures how well the tool is constructed to capture the information it is intended to capture. In order to establish construct validity for clinical survey instruments, researchers pilot the tool with multiple recipients with differing psychological symptoms to determine the tool's strength. Convergent and divergent validity, subgroups of construct validity, compare the results of one instrument to another validated instrument.

Sensitivity and *specificity* also are common measurements of a tool's validity. Sensitivity of a mental health tool measures the instrument's ability to correctly identify youth with mental health issues (true positives). The specificity of a mental health tool measures the instrument's ability to correctly identify youth without mental health issues (true negatives). For most tools, there will be a trade-off between sensitivity and specificity which is most commonly analyzed and represented by receiver operating characteristics (ROC) analysis. While there are other measures of reliability and validity, these are the most common.

Mental health screening instruments

This section provides information on mental health screening instruments that counties in the study indicated they use. Many screening instruments are abbreviated versions of assessment tools. Shortened versions of assessment tools are often developed and validated to create screening instruments. This method can provide agencies with screening and assessment tools that have similar questions to the full assessment, requiring less training and reducing the cost to obtain and implement both screening and assessment tools.

Information on how to obtain the tools described in this section and the training required to use them is available in *Appendix C*.

Child and Adolescent Functional Assessment Scale Screener

The Child and Adolescent Functional Assessment Scale (CAFAS) is an assessment tool that can measure a youth's impairment in daily functioning due to behavioral, emotional, psychological, psychiatric, or substance abuse problems.[31] The CAFAS Screener is a shortened version based on concrete behaviors that determines the need for a referral to services or a full assessment and is completed in approximately 15 to 20 minutes by a trained CAFAS rater.[32] Youth are "rated on the CAFAS based on the trained rater's observations and the youth's, caregiver's, and other informant's reports about a youth's behavior."[33] Information about the youth's strengths and positive behaviors or characteristics also are taken into account.

Reliability and validity of the CAFAS Screener

The author of this report was unable to locate any reliability or validation studies specific to the CAFAS Screener. However, numerous validation and reliability studies on the full CAFAS

assessment instrument have been conducted, with most identifying the instrument to be both reliable and valid. The CAFAS is discussed further in the next section of this report.

Childhood Severity of Psychiatric Illness

The Childhood Severity of Psychiatric Illness (CSPI) is a shortened version of the Child and Adolescent Needs and Strengths (CANS) assessment instrument and can be used as a mental health screen. The CSPI can identify possible mental health service needs along five dimensions.[34] They include:

- Symptoms—Explores the possibility of symptoms relating to schizophrenia, autism, psychotic disorders, affective disorders, anxiety disorders, conduct disorder, behavior disorders, and ADHD.
- Risk factors—Explores suicide risk, runaway risk, crime or delinquency risk, and sexual aggression.
- Functioning—Explores dysfunction in schools, families, and peers.
- Co-morbidity—Looks at post-traumatic stress disorder, medical problems, substance abuse problems, child abuse and neglect, sexual development, and learning disability or developmental delay.
- Systems factors—Examines the caregiver's ability to provide supervision, caregiver's motivation for change, caregiver's knowledge of child, safety of current living arrangements, community capacity for wraparound services, and multi-system needs of the child.[35]

The CSPI is completed by individuals directly involved with the youth and is used to identify a number of mental health and social factors that are child-specific. A juvenile's involvement in the juvenile justice system is part of the screen, but the tool is not specific to the needs of juveniles in the justice system. In Illinois, the CSPI is used by the Department of Children and Family Services (DCFS) to "establish decision support guidelines for placement decision makers…[providing a] framework in which decision makers consider the mental health needs of a particular case…"[36] The CSPI is an open source screening tool, meaning it is free to use, but practitioners must be trained prior to using the instrument.

Reliability and validity of the CSPI

Studies have found the reliability of the CSPI to be good to excellent. After training, the inter-rater reliability is high.[37] However, additional research is needed as few studies assessing the reliability and validity of the CSPI were available.

Massachusetts Youth Screening Instrument, 2nd Version

The MAYSI-2 mental health screening instrument was designed for use in juvenile justice facilities, particularly detention centers, to "identify youths experiencing thoughts, feelings, or behaviors that may be indicative of mental disorders and/or acute emotional crises requiring immediate attention."[38] However, the MAYSI-2 is not intended to diagnose mental disorders.

The MAYSI-2 is a 52-item, self-administered questionnaire, available in both English and Spanish, and written at a fifth grade reading level.[39] The questionnaire requires youth to circle 'yes' or 'no' answers to questions concerning mental health needs in recent months. While the MAYSI-2 is typically filled out by the youth being screened, it may be read by a facility practitioner. Youth may also complete the questionnaire using computer-based software.

Answers to the MAYSI-2 are mapped on seven sub-scales:

- Alcohol and Drug Use—Identifies youth who are using drugs or alcohol to a significant degree and are at risk for substance dependence.
- Angry-Irritable—Identifies feelings of anger and a general tendency towards irritability, frustration, and tension.
- Depressed-Anxious—Identifies youth with feelings of depression and anxiety.
- Somatic complaints—Asks about physical manifestations of anxiety which may take the form of bodily aches and pains.
- Suicide Ideation—Identifies youths' thoughts and intentions of self-harm.
- Thought Disturbances—Only applies to males and indicates the possibility of serious mental disorders and problems with reality orientation.
- Traumatic Experiences—Identifies whether a youth has had greater exposure to traumatic events compared to other youths. The Traumatic Experiences scale is gender-specific.[40]

Scores for each subscale are compared to cutoff scores. Scores above cutoff points are grouped into "Caution" and "Warning" categories, and practices for responding to these scores are suggested in the MAYSI-2 manual.[41]

Reliability and validity of the MAYSI-2

The MAYSI-2 is one of the most researched tools currently available for mental health screening among juvenile justice-involved youth. It is one of the most commonly used screening tools in the U.S. due to its ease of use and the extensive research establishing it as valid and reliable.[42]

The initial validation and reliability study of the MAYSI-2 was conducted on a sample of 5,283 youth from two states at probation intake, in secure detention facilities, held for observation and evaluation at assessment centers, and in custody following adjudication. The initial study found most scales to be moderately to highly reliable for both boys and girls of most races.[43] However, tests of reliability among certain scales was lower—the Somatic Complaints scale for both girls and boys, the Angry-Irritable scale for girls, and the Thought-Disturbance scale for boys were only marginally acceptable.[44]

Further analysis into the sensitivity and specificity of the tool using ROC analysis determined appropriate cutoff scores that reduced false positives and maximized true positives. Using the findings from the ROC analysis, the authors of the tool set their cutoff points to correctly capture between 60 to 90 percent of youth, varying on the scale and sometimes by race and ethnicity.[45]

Further research into the reliability and validity of the MAYSI-2 generally replicated the tool's scales using principal components (a factor-analytic method loading responses on certain constructs). However, one study was unable to replicate the Depressed-Anxious scale and the

Thought Disturbance scale, which had the weakest validity of the scales in the study.[46] While this study suggested re-examining these scales, overall the tool was shown to be reliable and valid, a result supported by other studies.[47]

Mental health assessment instruments

This section provides information on mental health assessment instruments that counties in the study indicated they use. Assessment tools are more prolific than screening instruments in the field of juvenile justice. While a screen is often used to identify immediate risks or the need for additional information, assessments provide a more comprehensive overview of a youth's issues. Some assessments can diagnose specific mental illnesses. Many commonly utilized mental health assessment tools were specifically developed or modified for use with juvenile justice system-involved youth.

Child and Adolescent Functional Assessment Scale

The Child and Adolescent Functional Assessment Scale (CAFAS) is intended to assess the degree of impairment a youth experiences in their daily life as a result of emotional, behavioral, psychological, and substance abuse problems.[48] The assessment is not a test that is given to youth to complete, but a rating scale used by a clinician. During an interview at intake, a trained professional may rate the youth based on different domains of functioning: school/work, home, community, moods, self-harm behavior, substance use, and abnormal thinking. The CAFAS has 315 items and takes about 30 minutes to complete.[49] The CAFAS provides scores on the specific behavioral problems the youth may be experiencing, the level of impairment for each subscale, and a "summary score reflecting overall impairment."[50]

Reliability and validity of the CAFAS

Research has shown that the internal consistency of the CAFAS is moderate and inter-rater reliability is moderate to excellent.[51] Other findings have shown solid evidence for the validity of the CAFAS and it has successfully predicted juvenile recidivism and contact with law enforcement.[52] However, additional studies on the reliability and validity of the CAFAS are warranted due to small number of studies on the tool and the smaller sample sizes in said studies.

Child and Adolescent Needs and Strengths

The Child and Adolescent Needs and Strengths (CANS) assessment tool is an expansion of the CSPI. The CANS includes a broader range of needs, and a dimension on the youth's strengths. The CANS assessment offers a number of variations designed for youth with specific needs or experiences, including versions for developmental disabilities (CANS-DD), juvenile justice (CANS-JJ), child welfare (CANS-CW), and mental health (CANS-MH).

The CANS-JJ is most commonly used for youth in the juvenile justice system and includes information pertinent to the needs and issues of juvenile justice system-involved youth, such as compliance with legal mandates.[53] The CANS is completed by individuals who receive training on the instrument. The CANS, like the CSPI, is an open source assessment tool and is free to

obtain and use. Costs may be incurred for training. However, many trainers offer free instruction on the tool.[54]

The CANS is used for treatment planning and outcome measurement.[55] More specifically, the CANS "is a tool developed to assist in the management and planning of services to children and adolescents and their families with the primary objectives of permanency, safety, and improved quality in of life."[56] The CANS provides a profile of the youth and can be used to plan treatment and/or services and can also be used to assess the status of the youth currently receiving services, including measuring outcomes and goal achievement. The CANS-JJ assesses a number of dimensions: [57]

- Criminal and Delinquent Behavior—Examines the youth's history and seriousness of criminal behavior, violent activity, sexually abusive behavior, peer involvement, and parental involvement.
- Mental Health Complications—Examines evidence of psychosis, ADD or other impulse control issues, depression and anxiety, oppositional behavior, antisocial behavior, substance abuse, and consistency of mental health issues.
- Care Intensity & Organization—Assesses the monitoring, treatment, transportation, and service permanence of a youth's services.
- Functioning, Strengths—Examines intellectual and developmental capacities of the youth, along with physical and medical issues, family functioning, and school/day care
- Other Risk Behaviors—explores other risk behaviors including social behavior, danger to self, and risk of running away.
- Caregiver Capacity—Assesses the caregiver's capacity in terms of their physical ability, ability to provide supervision, level of involvement with care, their knowledge and organization, as well as their resources and safety.
- Strengths—Examines family, peers, relationship permanency, education, vocation, well-being, spirituality/religiosity, talents and interests, and inclusion strengths.

Each item is scored from zero to three. A zero indicates either no evidence of the item, no need for action, or a strength on which to build. A score of one indicates a mild degree of the category, the need for watchful waiting to see if action is warranted, or an opportunity for strength development. A score of two indicates a moderate degree of the category, a need for action, or a need for development of the strength. A score of three indicates a severe degree of the item, a need for immediate or intensive action, or a need for significant strength identification or creation.[58]

Reliability and validity of the CANS

CANS inter-rater reliability has been found to be moderate to very good and appears to be highly correlated with other measures of psychopathology. Further studies have indicated that it accurately predicts service utilization, hospitalization, and level of care, and that it is capable of differentiating offender populations.[59] Further validation of the CANS for juvenile justice populations is warranted, however due to fewer validation studies and the lack of such studies in peer-reviewed journals.

Diagnostic Interview Schedule for Children, 4th Edition

The Diagnostic Interview Schedule for Children (DISC-IV) is a diagnostic assessment instrument that assesses youth on 36 mental health disorders. The DISC-IV uses diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. The DISC-IV provides provisional diagnoses of disorders present based on responses to six sets of questions.[60] The most recent version, the Voice-DISC-IV, is a computerized version of the tool that is self-administered using pre-recorded questions heard through headphones, and takes approximately 60 minutes to complete.[61] The instrument is scored and assesses more than 30 *DSM-IV* diagnoses using specific criteria on symptoms, onset, frequency, duration, and degree of impairment.[62]

The Voice-DISC-IV provides practitioners with four possible reports:[63]

- Diagnostic Report—Lists the diagnoses, diagnostic criteria met, and symptoms identified.
- Clinical Report—Compiles positive sub-thresholds, and negative diagnoses, impairment and symptom scores by diagnosis, and a list of clinically significant symptoms.
- Reconstruction Report—Provides questions asked and corresponding answers.
- Symptom Report—Reports all symptoms identified.

Reliability and validity of the DISC-IV

The Voice-DISC-IV is a commonly used assessment and diagnostic tool in the juvenile justice system. However, fewer studies are available on the current version's reliability and validity. Studies of the Voice-DISC-IV have shown acceptable levels of validity shored by the removal of potential biases present in clinical interviews.[64] Research on previous versions revealed overall test-retest reliability to be acceptable and comparable to other similar instruments.[65] Furthermore, every symptom scale has shown as least good reliability, with most considered excellent.[66] Test-retest reliability and diagnostic strength had similar results.[67] Initial results of a validation study undertaken by the instrument's developers indicated moderate to good validity, and analysis of the sensitivity of the tool was shown as good to excellent.[68] However, further validation on juvenile justice populations is warranted due to few follow-up validation studies on the current version.

Jesness Inventory – Revised

The Jesness Inventory is a personality inventory for delinquent youth ages 8 to 18.[69] Restandardized in 2003 to revise existing scales and include new ones, the JI-R is a 160-item, self-reported, true-false questionnaire that takes about 45 minutes to complete. The JI-R includes:[70]

- Personality scales (11)—Measure social maladjustment, immaturity, alienation, manifest aggression, and withdrawal and depression, among others.
- Subtype scales (9)—Measure immaturity, conformity, passivity, aggression, pragmatism and manipulation, inhibition, and other concepts.
- *DSM-IV-TR* subscales (2)—Assess presence of conduct disorder and oppositional defiant disorder.

- Validity scales (2)—Determine whether the respondent is randomly responding or lying in his or her responses.

Reliability and validity of the JI-R

Initial studies of the Jesness Inventory indicated moderate to high levels of reliability, sensitivity, and validity.[71] The JI-R also shows promising validity, especially with regard to the sensitivity of the tool, but further study is needed as few validation studies on the JI-R beyond the initial sample have been conducted.[72]

Millon Adolescent Clinical Inventory

The Millon Adolescent Clinical Inventory (MACI) assesses adolescent personality and clinical mental health symptoms using a questionnaire completed by the youth. The MACI contains 27 content scales that are categorized on three subscales. They include: [73]

- Personality patterns—Maps onto the *DSM-IV-TR* Axis II personality disorders such as depressive, antisocial, obsessive-compulsive, borderline, and schizoid tendencies.
- Expressed concerns—Assesses identity diffusion, self-devaluation, body disapproval, sexual discomfort, peer insecurity, social insensitivity, family discord, and childhood abuse. [74]
- Clinical symptoms—Assesses eating dysfunction, substance abuse, delinquency, impulse control issues, anxious feelings, depressive feelings, and suicidal thoughts.[75]

The MACI also has four response scales that measure the respondent's test-taking attitudes.[76] They include:

- Disclosure—Determines honesty of the respondent.
- Desirability—Assesses the respondent's desire to favorably present himself or herself.
- Debasement—Determines whether and how much the respondent devalues himself or herself.
- Reliability—Determines whether the respondent is truly reading the questions and/or answering randomly.

The MACI consists of 160 true or false questions and takes about 30 minutes to complete. It requires a sixth grade reading level and is intended for youth ages 13 to 19 years. It is recommended that the MACI be completed on a computer with software for complex scoring.

Reliability and validity of MACI

Internal consistency of the MACI appears to be good, although test-retest reliability studies have had mixed results, with reliability falling in the moderate to excellent range.[77] The validity of the MACI is moderate to strong, although the samples in these studies have been small. Reliability and validity studies with larger samples should be conducted. [78]

Minnesota Multiphasic Personality Inventory - Adolescent

One of the most widely used psychological assessment instruments today is the Minnesota Multiphasic Personality Inventory (MMPI). The MMPI was restandardized in 1982 to become the MMPI-2 and an adolescent version for youth ages 14 to 18 was developed in the 1990s (MMPI-A). The MMPI-A is a self-report instrument that assesses characteristics using 478 true or false questions. It is closely related to the MMPI-2, and many of the scales and subscales overlap between instruments. The MMPI-A contains the following scales:[79]

- Validity scales (7)—Assess the test-taking attitudes of the respondent. These scales measure response consistency and can identify respondents who are faking answers, defensively answering, and randomly answering.[80]
- Clinical scales (10)—Include assessments for a number of psychological disturbances including depression, hypochondria, psychopathic deviance, and social introversion.[81]
- Content scales (15)—Assess what particular content area is influencing outcomes on the clinical scales. These content scales include assessments of depression, anxiety, obsessiveness, fears, anger, familial discord, low self-esteem, and other issues.
- Supplementary scales (6)—Assist in identification of substance abusers, post-traumatic stress disorder, school problems, family relationships, school problems, peer relationships, and conduct problems.[82]
- Harris-Lingoes (supplementary content) subscales (28)—Supplement and refine findings from the previous clinical and content scales.[83]

The MMPI-A takes 60 to 90 minutes to complete and is available electronically via computer or on paper. The instrument requires a seventh to eighth grade reading level and assumes respondents can understand the questions being asked.

Reliability and validity of the MMPI-A

Internal consistency results of the MMPI-A were moderate to excellent.[84] Test-retest reliability results were moderate to good. These results were less strong when youth were re-tested one year or more later but this was expected as adolescents' circumstances change frequently.[85] Results of validation studies have been mixed, with findings of studies examining correlations between the MMPI-A and other tools to be weak to excellent. Studies examining the correlations between the MMPI-A and future behavior were found to be slightly higher, although still inconsistent. These mixed results have led many researchers to call for additional validation of the MMPI-A.[86]

Personality Inventory for Youth (PIY)

The Personality Inventory for Youth (PIY) is a 270-question, self-report instrument that assesses youth on numerous clinical scales and subscales. Nine clinical scales measure:[87]

- Cognitive impairment.
- Impulsivity and distractability.
- Delinquency.
- Family dysfunction.

- Reality distortion.
- Somatic concern.
- Psychological discomfort.
- Social withdrawal.
- Social skill deficits.

Most of the PIY questions were translated from the Personality Inventory for Children (PIC) completed by parents into questions youth answer on their own. The PIY also contains four validity scales to determine whether the respondent is answering truthfully, responding defensively, and comprehending the questions.[88]

Additionally, a 32-item screening scale is available for screening purposes. The PIY requires a high third grade to a low fourth grade reading level and takes about 45 minutes to complete.[89]

Reliability and validity of the PIY

The PIY has shown moderate to high levels of internal consistency, test-retest reliability, and inter-rate reliability.[90] The PIY also correlates well with other similar instruments and measures, such as the MMPI, leading credence to its validity.[91] Furthermore, the PIY shows consistent reliability and validity for youth in the juvenile justice system.[92]

Other screening and assessment instruments

Many facilities and agencies use screening instruments that are not specific to mental health. In addition, some screening tools are intended for only one mental disorder, such as depression or post-traumatic stress. Other instruments focus on substance abuse problems, which are highly co-morbid with mental illness.[93] Moreover, some instruments focus on cognitive, intelligence, and behavioral development. Finally, some instruments are general risk and needs screenings, which may include a suicide risk or mental health component but are not specifically mental health screenings. This section provides information on other instruments that counties in the study indicated they use.

Adolescent Substance Abuse Subtle Screening Instrument

The Adolescent Substance Abuse Subtle Screening Instrument (SASSI) is a brief screening tool intended to identify youth who need further assessment for substance use and abuse problems. It is intended for youth ages 12 to 18 and consists of 72 true or false questions.[94] The questions cover symptom related issues, family and social environment risks, attitudes toward drugs and alcohol, and a subtle scale with items that can be used to identify youth with alcohol and drug problems that do not acknowledge any misuse.[95] An additional 28 questions help determine how often the respondents experience certain problems related to substance use.[96] The results of the test indicate high probability or low probability of substance use problems and also measures the extent to which the youth responses were similar to those involved with the juvenile justice system.[97]

Reliability and validity of the SASSI

The test-retest reliability for the SASSI is very good and the validity has shown to be acceptable.[98] A review of reliability and validity studies of the SASSI showed mixed results. Internal consistency of the SASSI for adolescents was low, however, some studies showed a moderate level of internal consistency for the items that were not included on the "subtle" scale.[99] The same review of studies revealed moderate convergent validity and acceptable validity for respondents in the justice system.[100]

CRAFFT

The CRAFFT is a short screening instrument for high risk drug and alcohol use and abuse disorders developed by the Children's Hospital Boston and maintained by The Center for Adolescent Substance Abuse Research (CeASAR). The CRAFFT* consists of six questions:

(1) Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
(2) Do you ever use drugs or alcohol to relax, feel better about yourself, or fit in?
(3) Do you ever use alcohol/drugs while you are by yourself, alone?
(4) Do you ever forget things you did while using alcohol or drugs?
(5) Do your family or friends ever tell you that you should cut down on your drinking or drug use?
(6) Have you gotten into trouble while you were using alcohol or drugs?[101]

Prior to asking those questions, a youth is asked three opening questions: during the past 12 months did you (1) Drink any alcohol (more than a few sips)? (2) Smoke any marijuana or hashish? (3) Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things you sniff or "huff"). If a youth answers yes to one or more of these opening questions, all six CRAFFT questions are asked. If a youth answers no to all three opening questions, only the first question is asked.[102] The CRAFFT is available in paper format and answering yes to two or more of the CRAFFT questions indicates the need for further evaluation.

The CRAFFT is free, accessible via the CeASAR website. The organization also will provide CRAFFT cards free of charge.

Reliability and validity of the CRAFFT

Studies on the reliability of the CRAFFT found the internal consistency of the instrument to be acceptable. Further, results from ROC analyses used to determine appropriate cut-off points considering sensitivity and specificity of the CRAFFT indicate the CRAFFT is a valid substance abuse screen, a finding supported by other studies.[103]

*

Kaufman Brief Intelligence Test

The Kaufman Brief Intelligence Test (KBIT) is an intelligence test that consists of a core and an expanded battery of questions. The KBIT measures verbal and non-verbal intelligence from age four through adulthood. The KBIT consists of two subtests:

- Vocabulary—Assesses the respondent's expressive vocabulary (identification of an object presented visually) and ability to provide a word based on two clues including a phrase and partial spelling of the word (82 questions).[104]
- Matrices—Nonverbal subtest in which the respondent is asked to answer questions about relationships between visual stimuli.[105]

Non-psychologists are able to administer the KBIT, which takes approximately 20 minutes to complete.

Reliability and validity of the KBIT

The KBIT has shown moderate to very good reliability with very good to excellent findings for test-retest reliability.[106] Validity studies were acceptable, with convergent validity being weak to moderate.[107]

Ohio Youth Problems, Functioning, and Satisfaction Scales

The Ohio Youth Problems, Functioning, and Satisfaction Scale (Ohio Scales), is intended to measure clinical outcomes for youth receiving mental health and psychiatric services. The Ohio Scales use information gathered from the youth, the parent, and case manager or professional involved with the youth and consists of four scales:[108]

- Problem severity scale—Covers typical problems experienced by youth receiving mental health services, such as aggressive behavior or depressed feelings (44 questions).
- Functioning scale—Rates the youth's level of daily functioning (20 questions).
- Hopefulness scale—Covers how prepared the parent feels or how optimistic the youth is about future outcomes (four questions).
- Satisfaction scale—Assesses parent and youth overall satisfaction with the mental health services they are receiving (four questions).

Reliability and validity of the Ohio Scales

The internal consistency of the Ohio Scales is moderate to excellent.[109] Initial studies also indicated the test-retest reliability to be adequate, although the tool is intended to be sensitive to change. Validity studies have shown the construct and convergent validity to be good, although some studies have indicated caution in using the results for youth younger than age nine.[110] Furthermore, small effect sizes have been found for validity studies, so further studies are needed.[111]

Wechsler Intelligence Scales for Children (WISC)

The Wechsler Intelligence Scales for Children (WISC) is an intelligence test and does not measure for mental health disorders. However, it is often used in conjunction with other screening and assessment testing as it provides valuable information about the general intelligence, nonverbal intelligence, and verbal intelligence of the youth. The WISC assesses the cognitive abilities of youth ages six to 16 and its most recent (WISC-IV) version contains 10 subtests that produce four composite scores: verbal comprehension index (VCI), perceptual reasoning index (PRI), working memory index (WMI), and processing speed index (PSI). The entire battery of tests requires about 60 to 90 minutes to complete.

Reliability and validity of the WISC

The reliability of the WISC-IV and previous WISC versions has consistently been found to be very strong, particularly its test-retest reliability.[112] Additionally, the construct validity of the WISC-IV is considered very high.[113]

Youth Assessment and Screening Instrument

The Youth Assessment and Screening Instrument (YASI) is an interactive risk screening and assessment tool that offers both a quick screen (pre-screen) option, as well as a more in-depth assessment option. The pre-screen option offers an initial determination of risk and consists of 32 questions about a youth's legal history, family, school, community and peers, substance use and abuse, mental health, and general attitudes. Youth who score 'moderate' to 'high' risk on the pre-screen should receive the full assessment. [114]

The YASI assists in case planning for youth in the juvenile justice system and assesses the youth's risks, needs, and protective factors (strengths).[115] The YASI does not screen or assess for clinical mental health issues, but does ask questions about existing or previously diagnosed mental health issues, abuse, aggressive behavior, and flags the need for immediate mental health attention, suicide risk, and homicide risk.[116] The YASI is largely intended for use in case planning. The YASI software allows for a graphic display of ratings of both risk and protective factors and allows case managers to monitor case plans and track progress.[117]

Training is required and consists of a two-day curriculum on the YASI and a two-day training on case planning using the results.[118]

Reliability and validity of the YASI

While the YASI is often cited as highly valid and reliable, the author of this report was unable to substantiate such claims and could not locate any peer-reviewed articles in which these properties were assessed. However, the YASI is based on the Washington State Juvenile Court Assessment (WCJA) model. While no studies have been conducted on the reliability of the WCJA, a few studies have examined the validity of the pre-screen YASI, showing acceptable validity.[119] Further studies establishing the validity and reliability of this tool are necessary.

Table 3 provides a summary of the screening and assessment tools discussed.

Table 3
Summary of screening and assessment tools

Tool	Training required	Time to complete	Reliability and validity	Other information
Mental health screening tools				
Child and Adolescent Functional Assessment Scale Screener (CAFAS)	Yes	15-20 minutes	None on screener	Shortened version of full CAFAS assessment
Childhood Severity of Psychiatric Illness (CSPI)	Yes	15-20 minutes	Good to excellent. More studies needed	Shortened version of CANS. Free to obtain. Training required for use.
Massachusetts Youth Screening Instrument, 2nd Version (MAYSI-2)	Yes	10-18 minutes	Good to excellent	
Mental Health assessment tools				
Child and Adolescent Functional Assessment Scale (CAFAS)	Yes	30 minutes	Moderate to excellent. More studies needed	
Child and Adolescent Needs and Strengths (CANS)	Yes	10-15 minutes	Moderate to very good. More studies needed	Free to obtain. Training required for use.
Diagnostic Interview Schedule for Children, 4th Edition (DISC-IV)	No	60 minutes	Moderate to excellent. More studies needed.	
Jesness Inventory – Revised (JI-R)	Training in use of psychological tests	45 minutes	Moderate to excellent.	
Millon Adolescent Clinical Inventory (MACI)	Degree or training in use of psychological tests	30 minutes	Moderate to excellent. More studies with larger samples needed.	
Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)	Degree or training in use of psychological tests	60-90 minutes	Moderate to excellent.	
Personality Inventory for Youth (PIY)	Degree or training in use of psychological tests	45 minutes	Good to excellent. Consistently high.	

Table 3
Summary of screening and assessment tools

Other screening and assessment instruments				
Adolescent Substance Abuse Subtle Screening Instrument (SASSI)	No	10-15 minutes	Moderate to very good.	Substance abuse screen.
CRAFFT	No	5-10 minutes	Good to excellent.	Substance abuse screen.
Kaufman Brief Intelligence Test (KBIT)	Degree or training in use of psychological and intelligence tests	20 minutes	Very good to excellent.	Intelligence test.
Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales)	Yes	20-30 minutes	Moderate to excellent. More studies needed.	Risks, needs, strengths assessment.
Wechsler Intelligence Scales for Children, 4th Edition (WISC-IV)	Degree or training in use of psychological and intelligence tests.	60-90 minutes	Very good to excellent.	Intelligence test.
Youth Assessment and Screening Instrument (YASI)	Yes	15-20 minutes	Good. More studies needed	Risk, needs, strengths assessment.

Conclusion

Overall, less than 6 percent of counties in Illinois are served by probation and court services departments that use standardized mental health screening instruments, and even fewer departments used standardized mental health assessments (3 percent). While many probation and court services departments refer youth to outside agencies for mental health screening and assessment, referral decision criteria is unclear. Often the YASI is the primary decisive factor, despite that it is not intended to identify mental health needs beyond immediate danger or risk.

Detention centers were more likely than probation and court services to conduct mental health screening and assessments. Overall, about one-third of Illinois counties are served by detention centers that employ standardized mental health screening instruments. An additional 10 percent of counties are served by detention centers that use the MH-JJ referral screen. The MH-JJ initiative only screens for psychotic or affective disorders.

Most survey respondents indicated that mental health is increasingly becoming an issue facing their agencies and the juvenile justice system in Illinois as a whole. Most respondents indicated a need for more standardized practices of screening and assessment, more comprehensive services that continue after a youth is no longer involved with the juvenile justice system, and better quality services. Not surprisingly, most respondents indicated a need for additional resources and funding to provide comprehensive mental health identification and services for juvenile justice system involved youth. Difficulties with family involvement, medication management, transportation, and the lack of quality services were often discussed as areas of concern for respondents.

As most recognize the importance of appropriately identifying youth with mental health issues, there is a disturbing dearth of quality evaluation and validation of the tools used as mental health screening and assessment instruments. Many of the instruments discussed in this report lacked rigorous study into their reliability and validity, particularly lacking in the number of peer-reviewed study results and evaluations beyond the initial sample on which the instrument was developed. As a result, caution must be used when jurisdictions adopt a new instrument for use.

Further, many of the tools have not been studied for their appropriateness for juvenile justice involved youth. Risk assessment tools, such as the YASI, are frequently employed in case planning. However, the YASI should not be used as a mental health screen or assessment.

Also, based on responses, there appears to be considerable, and understandable, confusion on difference between a screen and assessment, and the difference between a general mental health tool and other instruments, such as intelligence testing and substance use and abuse testing. In addition, some scholars and practitioners argue that substance abuse comprises a separate area of concern and should be assessed separately from general mental health, while others argue substance abuse is a component of overall mental health. Understandably, some general mental health screening and assessment tools include substance abuse, or that some agencies will use a general mental health tool in combination with a substance abuse tool.

Recommendations

The results of the survey indicate a number of possible recommendations. First, as suggested by respondents, standardized and consistent practices and procedures should be adopted for identifying and responding to mental health issues across all jurisdictions and points in the Illinois juvenile justice system. Adoption of such practices, will reduce confusion as to the needs of youth moving through the system, and create fewer opportunities for conflicting case or treatment plans, and fewer gaps in services.

Each agency should proceed with caution when adopting an instrument. More rigorous evaluation should be conducted on the tools discussed in this report. Further, tools should be validated on the unique populations for which it is used. When adopting a new mental health identification instrument, evaluation plans by the agency should be in place to determine its effectiveness before implementing the new tool. To support efforts to validate and evaluate their selected tools, many agencies may need training on how to undertake such evaluation endeavors.

Finally, to adequately address the needs of mentally ill youth offenders, resources and funding need to be available. If youth are effectively identified as in need of services, it is important that there are resources in place to meet them. The infrastructure for properly identifying and providing comprehensive treatment for mentally ill youth in the juvenile justice system must be developed to adequately and effectively address this growing issue. As many respondents stated, while identification is the first step, it accomplishes little without reasonable options and follow-up opportunities.

Appendix A: Mental health screening and assessment in Illinois juvenile probation

County	Served by probation department covering	Screening practices	Screening tool	Assessment practices	Assessment tool
Adams	Adams	Informal method	YASI Informal	No assessments conducted	None
Alexander	1st Judicial Circuit	Does not screen	YASI only	Referral to mental health agency	None
Bond	Bond	Does not screen	None	No assessments conducted	None
Boone	Boone	Informal method	Informal method	Referral to mental health agency	None
Brown	Survey not returned				
Bureau	13th Judicial Circuit	Does not screen	None	No assessments conducted	None
Calhoun	Calhoun	Does not screen	None	No assessments conducted	None
Carroll	Carroll, Stephenson	Does not screen	None	No assessments conducted	None
Cass	Cass	Does not screen	Non	No assessments conducted	None
Champaign	Survey not returned				
Christian	Survey not returned				
Clark	Clark	Does not screen	None	No assessments conducted	None
Clay	Clay	Does not screen	YASI only	No assessments conducted	None
Clinton	Survey not returned				
Coles	Survey not returned				
Cook	Cook	Routine screen	MAYSI-2	Assessments conducted	CANS-JJ
Crawford	Survey not returned				
Cumberland	Survey not returned				
DeKalb	DeKalb, Kendall, Kane	Routine screen	WISC, SASSI, KBIT, Jesness (JI-R)	Assessments conducted	Unknown
DeWitt	Survey not returned				
Douglas	Douglas	Does not screen	None	No assessments conducted	None
DuPage	DuPage	Routine screen	MAYSI-2 YASI	Assessments conducted	Informal
Edgar	Survey not returned				
Edwards	Survey not returned				

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County	Served by probation department covering	Screening practices	Screening tool	Assessment practices	Assessment tool
Effingham	Effingham	Does not screen	YASI only	No assessment conducted	None
Fayette	Survey not returned				
Ford	Ford	Does not screen	YASI only	No assessments conducted	None
Franklin	Franklin, Hamilton	Informal method	None	Referral to mental health agency	None
Fulton	Fulton	Does not screen	None	No assessments conducted	None
Gallatin	Survey not returned				
Grundy	13th Judicial Circuit	Does not screen	None	No assessments conducted	None
Hamilton	Franklin, Hamilton	Informal method	None	Referral to mental health agency	None
Hancock	Hancock	Informal method	None	No assessments conducted	None
Hardin	Survey not returned				
Henderson	Henderson	Does not screen	None	No assessments conducted	None
Henry	Survey not returned				
Iroquois	Iroquois	Does not screen	None	No assessments conducted	None
Jackson	1st Judicial Circuit	Does not screen	YASI only	Referral to mental health agency	None
Jasper	Survey not returned				
Jefferson	Jefferson, Wayne	Does not screen	YASI only	No assessments conducted	None
Jersey	Survey not returned				
JoDaviess	JoDaviess	Does not screen	YASI only	Referral to mental health agency	None
Johnson	1st Judicial Circuit	Does not screen	YASI only	Referral to mental health agency	None
Kane	DeKalb, Kendall, Kane	Yes	WISC, SASSI, KBIT, Jesness (JI-R)	Assessments conducted	Unknown
Kankakee	Kankakee	Routine screen	Developed own tool	Assessments conducted	Developed own tool
Kendall	DeKalb, Kendall, Kane	Yes	WISC, SASSI, KBIT, Jesness (JI-R)	Assessments conducted	Unknown
Knox	Knox	Does not screen	None	No assessments conducted	None
Lake	Survey not returned				
LaSalle	13th Judicial Circuit	Does not screen	None	No assessments conducted	None
Lawrence	Survey not returned				
Lee	Survey not returned				

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County	Served by probation department covering	Screening practices	Screening tool	Assessment practices	Assessment tool
Livingston	Survey not returned				
Logan	Logan	Does not screen	None	No assessments conducted	None
McDonough	McDonough	Informal method	None	No assessments conducted	None
McHenry	McHenry	Does not screen	None	No assessments conducted	None
McLean	Survey not returned				
Macon	Macon	Does not screen	YASI only	Referral to mental health agency	None
Macoupin	Macoupin	Does not screen	None	No assessments conducted	None
Madison	Survey not returned				
Marion	Survey not returned				
Marshall	Marshall, Putnam, Stark	Does not screen	None	No assessments conducted	None
Mason	Mason	Does not screen	YASI only	Referral to mental health agency	None
Massac	1st Judicial Circuit	Does not screen	YASI only	Referral to mental health agency	None
Menard	Survey not returned				
Mercer	Mercer	Does not screen	None	No assessments conducted	None
Monroe	Survey not returned				
Montgomery	Montgomery	Does not screen	YASI only	No assessments conducted	None
Morgan	Survey not returned				
Moultrie	Survey not returned				
Ogle	Ogle	Does not screen	None	No assessments conducted	None
Peoria	Peoria	Routine screen	PIY Screen	Assessments conducted	PIY
Perry	Survey not returned				
Piatt	Survey not returned				
Pike	Survey not returned				
Pope	1st Judicial Circuit	Does not screen	YASI only	Referral to mental health agency	None
Pulaski	1st Judicial Circuit	Does not screen	YASI only	Referral to mental health agency	None
Putnam	Marshall, Putnam, Stark	Does not screen	None	No assessments conducted	None
Randolph	Survey not returned				
Richland	Survey not returned				
Rock Island	Rock Island	Does not screen	None	No assessments conducted	None

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County	Served by probation department covering	Screening practices	Screening tool	Assessment practices	Assessment tool
St. Clair	Survey not returned				
Saline	1st Judicial Circuit	Does not screen	YASI only	Referral to mental health agency	None
Sangamon	Sangamon	Does not screen	None	No assessments conducted	None
Schuyler	Survey not returned				
Scott	Survey not returned				
Shelby	Survey not returned				
Stark	Marshall, Putnam, Stark	Does not screen	None	No assessments conducted	None
Stephenson	Carroll, Stephenson	Does not screen	None	No assessments conducted	None
Tazewell	Tazewell	Does not screen	YASI only	No assessments conducted	None
Union	1st Judicial Circuit	Does not screen	YASI only	Referral to mental health agency	None
Vermilion	Vermilion	Does not screen	None	No assessments conducted	None
Wabash	Survey not returned				
Warren	Warren	Does not screen	None	No assessments conducted	None
Washington	Survey not returned				
Wayne	Wayne	Does not screen	YASI only	No assessments conducted	None
White	Survey not returned				
Whiteside	Whiteside	Does not screen	YASI only	No assessments conducted	None
Will	Will	Informal method	YASI only	Referral to mental health agency	None
Williamson	1st Judicial Circuit	Does not screen	YASI only	Referral to mental health agency	None
Winnebago	Winnebago	Informal method	YASI only	Referral to mental health agency	None
Woodford	Woodford	Does not screen	None	No assessments conducted	None

Appendix B: Mental health screening and assessment in Illinois juvenile detention centers

County	Detention center served by	Screening practices	Screening tool	Assessment practices	Assessment tool
Adams	Adams	Routine screen	MH-JJ Referral screen	MH-JJ	CANS-JJ
Alexander	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Bond	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Boone	Winnebago	Routine screen	Unidentified	Routine assessment	Unidentified
Brown	Adams	Routine screen	MH-JJ Referral screen	MH-JJ	CANS-JJ
Bureau	LaSalle	Routine screen	CSPI Ohio Scales MH-JJ Referral	MH-JJ	CANS-JJ
Calhoun	Adams	Routine screen	MH-JJ Referral screen	MH-JJ	CANS-JJ
Carroll	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Cass	Adams	Routine screen	MH-JJ Referral screen	MH-JJ	CANS-JJ
Champaign	County served by detention center that did not return survey				
Christian	Sangamon	Routine screen	MH-JJ Referral screen, CRAFFT, ASHRA	MH-JJ	CANS-JJ
Clark	County served by detention center that did not return survey				
Clay	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Clinton	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Coles	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Cook	County served by detention center that did not return survey				
Crawford	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ

County	Detention center served by	Screening practices	Screening tool	Assessment practices	Assessment tool
Cumberland	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
DeKalb	Kane	Routine screen	Developed own tool	Routine assessment	Developed own tool
Douglas	County served by detention center that did not return survey				
DuPage	County served by detention center that did not return survey				
Edgar	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Edwards	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Effingham	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Fayette	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Ford	County served by detention center that did not return survey				
Franklin	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Fulton	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Gallatin	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Greene	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Grundy	LaSalle	Routine screen	CSPI Ohio Scales MH-JJ Referral	MH-JJ	CANS-JJ
Hamilton	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Hancock	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Hardin	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Henderson	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Henry	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ

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County	Detention center served by	Screening practices	Screening tool	Assessment practices	Assessment tool
Iroquois	County served by detention center that did not return survey				
Jackson	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Jasper	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Jefferson	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Jersey	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
JoDaviess	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Johnson	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Kane	Kane	Routine screen	Developed own tool	Routine assessment	Developed own tool
Kankakee	County served by detention center that did not return survey				
Kendall	Kane	Routine screen	Developed own tool	Routine assessment	Developed own tool
Knox	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Lake	Lake	Routine screen	MH-JJ Referral screen, Tracker	MH-JJ	CANS-JJ
LaSalle	LaSalle	Routine screen	CSPI Ohio Scales MH-JJ Referral	MH-JJ	CANS-JJ
Lawrence	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Lee	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Livingston	County served by detention center that did not return survey				
Logan	County served by detention center that did not return survey				
McDonough	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
McHenry	Kane	Routine screen	Developed own tool	Routine assessment	Developed own tool
McLean	County served by detention center that did not return survey				
Macon	Sangamon	Routine screen	MH-JJ Referral screen, CRAFFT, ASHRA	MH-JJ	CANS-JJ

County	Detention center served by	Screening practices	Screening tool	Assessment practices	Assessment tool
Macoupin	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Madison	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Marion	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Marshall	Peoria	Routine screen	Developed own tool	Routine assessment	Developed own tool
Mason	Adams	Routine screen	MH-JJ Referral screen	MH-JJ	CANS-JJ
Massac	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Menard	Adams	Routine screen	MH-JJ Referral screen	MH-JJ	CANS-JJ
Mercer	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Monroe	St. Clair	Routine screen	Developed own tool	Routine assessment	Developed own tool
Montgomery	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Morgan	Adams	Routine screen	MH-JJ Referral screen	MH-JJ	CANS-JJ
Moultrie	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Ogle	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Peoria	Peoria	Routine screen	Developed own tool	Routine assessment	Developed own tool
Perry	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Piatt	County served by detention center that did not return survey				
Pike	Adams	Routine screen	MH-JJ Referral screen	MH-JJ	CANS-JJ
Pope	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Pulaski	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Putnam	LaSalle	Routine screen	CSPI Ohio Scales MH-JJ Referral	MH-JJ	CANS-JJ

County	Detention center served by	Screening practices	Screening tool	Assessment practices	Assessment tool
Randolph	St. Clair	Routine screen	Developed own tool	Routine assessment	Developed own tool
Richland	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Rock Island	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
St. Clair	St. Clair	Routine screen	Developed own tool	Routine assessment	Developed own tool
Saline	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Sangamon	Sangamon	Routine screen	MH-JJ Referral screen, CRAFFT, ASHRA	MH-JJ	CANS-JJ
Schuyler	Adams	Routine screen	MH-JJ Referral screen	MH-JJ	CANS-JJ
Scott	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Shelby	Madison	Routine screen	MH-JJ Referral screen, SASSI, Informal	MH-JJ	CANS-JJ
Stark	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Stephenson	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Tazewell	Peoria	Routine screen	Developed own tool	Routine assessment	Developed own tool
Union	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Vermilion	County served by detention center that did not return survey				
Wabash	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Warren	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Washington	St. Clair	Routine screen	Developed own tool	Routine assessment	Developed own tool
Wayne	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
White	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ

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County	Detention center served by	Screening practices	Screening tool	Assessment practices	Assessment tool
Whiteside	Knox	Routine screen	MH-JJ Referral screen Tracker	MH-JJ	CANS-JJ
Will	County served by detention center that did not return survey				
Williamson	Franklin	Routine screen	MAYSI-2 MH-JJ Referral screen	MH-JJ	CANS-JJ
Winnebago	Winnebago	Routine screen	Unidentified	Routine assessment	Unidentified
Woodford	County served by detention center that did not return survey				

Appendix C: Mental health screening and assessment tool information

The following includes information on how to obtain the screening and assessment tools discussed in this report.

Mental health screening instruments

Massachusetts Youth Screening Instrument, 2nd Version (MAYSI-2)

Authors	Thomas Grisso, Ph.D. & Richard Barnum, M.D.
Publisher	Professional Resource Press P.O. Box 15560 Sarasota, Florida 34277 800-443-3364
Cost	Full kit: $194.95
Training	National Youth Screening Assistance Project nysap@umassmed.edu
Website	www.prpress.com
More information	www.maysiware.com

Child and Adolescent Functional Assessment Scale (CAFAS) Screener

Authors	Kay Hodges, Ph.D.
Publisher	Functional Assessment Systems 3600 Green Court, Suite 110 Ann Arbor, Michigan 48105 734-769-9725
Cost	Unknown
Training	Unknown
Website	www.cafas.com
More information	www.cafas.com

Childhood Severity of Psychiatric Illness (CSPI)

Authors	John S. Lyons, Ph.D.
Publisher	Buddin Praed Foundation praedfoundation@yahoo.com
Cost	Free
Training	Training required Mental Health Services and Policy Program Northwestern University
Website	N/A
More information	John S. Lyons Mental Health Services and Policy Program Northwestern University 710 N. Lake Shore Drive, Abbot 1205 Chicago, Illinois 60611 312-908-8972 JSL329@northwestern.edu Susan Furrer, Psy.D. UMDNJ- University Behavioral HealthCare Behavioral Research and Training Institute 151 Centennial Avenue, Room 1150 Piscataway, New Jersey 08854 732-235-9298 sfurer@umdnj.edu Lynn Steiner, MSW Mental Health Services and Policy Program Northwestern University 710 N. Lake Shore Drive, Abbot 1205 Chicago, Illinois 60611 312-503-1259 Lynn-steiner@northwestern.edu

Mental health assessment instruments

Child and Adolescent Needs and Strengths (CANS)

Authors	John S. Lyons, Ph.D.
Publisher	Buddin Praed Foundation praedfoundation@yahoo.com
Cost	Free
Training	Training required Mental Health Services and Policy Program Northwestern University
Website	N/A
More information	John S. Lyons Mental Health Services and Policy Program Northwestern University 710 N. Lake Shore Drive, Abbot 1205 Chicago, Illinois 60611 312-908-8972 JSL329@northwestern.edu Susan Furrer, Psy.D. UMDNJ- University Behavioral HealthCare Behavioral Research and Training Institute 151 Centennial Avenue, Room 1150 Piscataway, New Jersey 08854 732-235-9298 sfurer@umdnj.edu Lynn Steiner, MSW Mental Health Services and Policy Program Northwestern University 710 N. Lake Shore Drive, Abbot 1205 Chicago, Illinois 60611 312-503-1259 Lynn-steiner@northwestern.edu

Diagnostic Interview Schedule for Children, 4th Edition Voice (Voice-DISC-IV)

Authors	N/A
Publisher	NIMH-DISC Training Center at Columbia University Columbia University/New York State Psychiatric Institute Division of Child and Adolescent Psychiatry 722 W. 168th Street, Unit 78 New York, New York 10032 212-543-5357
Cost	$2,000 (computerized version)
Training	No training necessary
Website	N/A
More information	Prudence Fisher, M.S. nimhdisc@child.cpmc.columbia.edu

Child and Adolescent Functional Assessment Scale (CAFAS)

Authors	Kay Hodges, Ph.D.
Publisher	Functional Assessment Systems 3600 Green Court, Suite 110 Ann Arbor, Michigan 48105 734-769-9725
Cost	Unknown
Training	Unknown
Website	www.cafas.com
More information	www.cafas.com

Millon Adolescent Clinical Inventory (MACI)

Authors	Theodore Millon, Ph.D. with Carrie Millon, Ph.D., Roger Davis, Ph.D., and Seth Grossman, Ph.D.
Publisher	Pearson Assessments 19500 Bulverde Road San Antonio, Texas 78259 800-627-7271
Cost	Varies ($117.00 - $377.50)
Training	Workshops available
Website	www.pearsonassessments.com
More information	www.millon.net

Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)

Authors	Starke R. Hathaway, Ph.D. & J.C. McKinley, Ph.D.
Publisher	University of Minnesota Press Pearson Assessments 19500 Bulverde Road San Antonio, Texas 78259 800-627-7271
Cost	Varies
Training	Workshops available
Website	www.pearsonassessments.com
More information	N/A

Personality Inventory for Youth (PIY)

Authors	David Lachar, Ph.D. & Christian P. Gruber, Ph.D.
Publisher	Western Psychological Services 12031 Wilshire Blvd Los Angeles, California 90025 800-648-8857
Cost	Varies ($247.50 - $450.00)
Training	Training necessary
Website	www.wpspublish.com
More information	N/A

Jesness Inventory- Revised (JI-R)

Authors	Carl F. Jesness, Ph.D.
Publisher	Multi-Health Systems, Inc 800-456-3003
Cost	Varies ($199.00)
Training	Training necessary
Website	www.mhs.com
More information	N/A

Other screening and assessment instruments

Wechsler Intelligence Scales for Children, 4th Edition (WISC-IV)

Authors	David Wechsler, Ph.D.
Publisher	Pearson Assessments 19500 Bulverde Road San Antonio, Texas 78259 800-627-7271
Cost	Varies ($989.00 – $1,049.00)
Training	Training necessary
Website	www.pearsonassessments.com
More information	N/A

Adolescent Substance Abuse Subtle Screening Instrument (SASSI)

Authors	Franklin G. Miller, Ph.D., James Robertson, Marlene K. Brooks, & Linda E. Lazowski
Publisher	The SASSI Institute 201 Camelot Lane Springville, Indiana 47462 812-275-7013
Cost	Varies ($125.00 – $260.00)
Training	Training necessary TASSI, Inc. 800-697-2774 sassi@sassi.com
Website	www.sassi.com
More information	N/A

Kaufman Brief Intelligence Test (KBIT)

Authors	Alan S. Kaufman & Nadeen L. Kaufman
Publisher	Western Psychological Services 12031 Wilshire Boulevard Los Angeles, California 90025 800-648-8857
Cost	Varies ($255.00)
Training	Unknown
Website	www.wpspublish.com
More information	N/A

CRAFFT

Authors	Children's Hospital Boston
Publisher	The Center for Adolescent Substance Abuse Research 300 Longwood Avenue Boston, Massachusetts 02115 617-355-5433
Cost	Free
Training	None required
Website	www.ceasar.com
More information	http://www.ceasar-boston.org/clinicians/crafft.php

Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales)

Authors	Benjamin M. Ogles, Ph. D., Gregorio Melendez, M. S., Diane C. Davis, M.S., & Kirk M. Lunnen, Ph. D.
Publisher	Ben Ogles & Southern Consortium for Children Ohio University Porter Hall 241 Athens, Ohio 45701 ogles@Ohio.edu
Cost	Free
Training	None required
Website	N/A
More information	N/A

Youth Assessment and Screening instrument (YASI)

Authors	N/A
Publisher	Orbis Partners, Inc. Box 520 1143 Clapp Lane Ottawa, Ontario K4M 1A5 888-682-7720
Cost	Varies
Training	Training required Orbis Partners, Inc.
Website	www.orbispartners.com
More information	http://www.orbispartners.com/index.php/assessment/yasi/

Appendix D: Mental health screening and assessment practices survey

The following pages consist of the original survey that was sent to probation and court services and detention centers.

Illinois Criminal Justice Information Authority Survey:
Mental Health Screening and Assessment in the Juvenile Justice System

Name _____ **Organization** _____

Position / Title _____ **County** _____

Address _____ **Phone** _____

E-Mail _____ **Counties served** _____

_____

MENTAL HEALTH IN THE JUVENILE JUSTICE SYSTEM

1 Does your organization or facility have specific practices in place for identifying youth who may have mental health issues?

☐ **YES** See below ☐ **NO** ☐ **Other**

If you do have specific practices (formal or informal), please specify what they are.

☐ **Routine screening of all youth** ☐ **Standard period of observation** ☐ **Referral** ☐ **Other** Please specify below

If you checked "Other," please specify. _____

_____

SCREENING

Mental health screening is a brief process intended to identify youth who have or are at risk of having mental health disorders that warrant attention, often used with all youth entering a particular part of the juvenile justice system and most often used to identify need for further evaluation.

For example, a mental health screening tool may include the following question:
Have you felt like hurting yourself? Yes NO

2 Do you screen youth for mental health problems in your organization or facility?

☐ **YES** ☐ **NO** ☐ **Unsure**

3 If yes, at what point do you screen your youth?

Or

If probation, at what point in the court process do you screen?

☐ **Immediately upon admission or first contact** ☐ **Within a specified time period** See below ☐ **Other** Please specify below

If you screen within a specified time period or at a specific point, what is it? _____

If you checked "Other," please indicate when youth are screened by your agency or facility.

_____

_____

_____

_____

4 Do you use a standardized mental health screening tool in your organization or facility or have you developed your own?

☐ **Standardized tool** ☐ **Developed own**** ☐ **Unsure**

*****If you have developed your own, please attach it to this survey.***

5 If you do use a standardized tool(s), which of the following do you use

☐ **MAYSI-II**
Massachusetts Youth Screening Instrument-2nd Version

☐ **SASSI**
Adolescent Substance Abuse Subtle Screening Instrument

☐ **CSPI**
Childhood Severity of Psychiatric Illness

☐ **Other**
Please specify below

If you checked "Other," please indicate what screening tool or instrument you use.

_____

_____

_____

_____

Please continue on next page

Which standardized tool do you use?	Why did your organization / facility decide to use this instrument? What factors were considered in selecting this instrument?	Did you use the tool as is or modify it? If modified, why?	Who is responsible for administering the screening tool?	What training did this person receive? Who provided the training?
MAYSI-II		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____	
SASSI		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____	
CSPI		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____	
Other_____		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____	
Other_____		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____	

* If you use a modified instrument, please attach a copy of the instrument with this survey.

10 If you use more than one tool, how do you use these tools together and why do you use both?

11 Are any of the tools ever re-administered? ☐ YES ☐ NO ☐ Unsure

If yes, please indicate: which ones; how frequently; and under what circumstances (every month, after a behavioral episode, etc) they are re-administered.

POST-SCREENING

13 If the screening instrument identifies a youth as having mental health needs, what is the next step?

14 Does your organization have specific protocols for how to respond to mental health screening results? ☐ YES ☐ NO ☐ Unsure

Please specify what these protocols are. If possible, please attach them to this survey.

ASSESSMENT

Mental health assessment is a more comprehensive examination of needs and problems identified during the initial screening; they indicate the type and extent of mental health disorders, issues associated with disorders, and recommendations for treatment intervention.

An assessment is often a follow-up to a "positive" finding on a screening. An assessment is often performed by a licensed professional.

15 Are mental health assessments done in your organization or facility? ☐ YES ☐ NO ☐ Unsure

16 If yes, at what point are mental health assessments completed?

Or

If probation, at what point in the court process are these assessments completed?

If completed within a specified time period, what is it? _____

☐ **Immediately after initial screening**

☐ **Within a specified time period** See Below

☐ **Other**

17 Do you use a standardized mental health assessment tool in your organization or facility or have you developed your own?

☐ **Standardized tool**

☐ **Developed own****

☐ **Unsure**

*****If you have developed your own, please attach it to this survey.***

18 If you do use a tool(s), which of the following tools do you use?

☐ **DISC-IV** Diagnostic Interview Schedule for Children-Version IV

☐ **CANS-MH** Child And Adolescent Needs and Strengths-Mental Health

☐ **CAFAS** Child and Adolescent Functional Assessment Scale

☐ **Other** Please specify below

If you checked "Other," please indicate what assessment tool you use.

_____

_____

_____

_____

Please continue on next page.

Which standardized tool do you use?	Why did your organization / facility decide to use this instrument? What factors were considered in selecting this instrument?	Did you use the tool as is or modify it? If modified, why?	Who is responsible for administering the assessment tool?	What training did this person receive? Who provided the training?
DISC-IV		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____	
CANS-MH		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____	
CAFAS		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____	
Other_____		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____	
Other_____		o Use as is o Modified* _____ _____ _____ o Unsure	o Social Worker o Counselor o Psychologist o Psychiatrist o Prob. Officer o Facility Staff o Other_____ __	

* If you use a modified instrument, please attach a copy of the instrument with this survey.

22 **If you use more than one tool, how do you use these tools together and why do you use both?**

23 **Is the tool ever re-administered?** ☐ YES ☐ NO ☐ Unsure

If yes, please indicate: which ones; how frequently; and under what circumstances (every month, after a behavioral episode, etc) they are re-administered.

POST-ASSESSMENT

25 **After the assessment is completed, how is that information used?**

26 **Does your organization have specific protocols for how to respond to mental health assessment results?** ☐ YES ☐ NO ☐ Unsure

Please specify what these protocols are. If possible, please attach them to this survey.

Please continue on next page.

RECOMMENDATIONS AND IMPROVEMENTS

30 In your opinion, how would you improve the current state of mental health screening and assessment for youth in the juvenile justice system?

31 In your opinion, what are the most pressing mental health issues in *your* area of the juvenile justice system (arrest, corrections, detention, probation, etc.)?

32 In your opinion, what are the most pressing mental health issues in the *other* areas of the juvenile justice system (arrest, corrections, detention, probation, etc.)?

33 Any additional comments or suggestions?

Thank you for your time. Please return this survey in the self-addressed stamped envelope provided to:

Illinois Criminal Justice Information Authority
300 West Adams Street, Suite 700
Chicago, Illinois 60606
ATTN: Lindsay Bostwick

Notes

[1] Louden, Jennifer Eno, Jennifer L. Skeem, Jacqueline Camp, and Elizabeth Christiansen, "Supervising Probationers with Mental Disorders: How do agencies respond to violations?," *Criminal Justice and Behavior* 35(7) (July 2008): 839 -841.
[2] Wasserman, Gail A., Susan J. Ko, and Larkin S. McReynolds, "Assessing the Mental health Status of Youth in Juvenile Justice Settings," Juvenile Justice Bulletin, Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, August 2004, NCJ 202713.
[3] Solomon, Phyllis, Jeffrey Draine, and Steven C. Marcus, "Predicting Incarceration of Clients of a Psychiatric Probation and Parole Service," *Psychiatric Services* 53(1) (January 2002): 54;
[4] Louden, Skeem, Camp, and Christiansen, "Supervising Probationers with Mental Disorders: How do agencies respond to violations?," 839 -841.
[5] Ruddell, Rick, "Jail Interventions for Inmates with Mental Illness," *Journal of Correctional Health Care* 12 (2) (April 2006): 124.
[6] Lurigio, Arthur J., "Persons with Serious Mental Illness in the Criminal Justice System: Background, prevalence, and principles of care," *Criminal Justice Policy Review* 11(4) (December 2000): 320.
[7] Cocozza, Joseph J., and Kathleen R. Skowyra, "Youth with Mental Health Disorders: Issues and emerging responses," *Juvenile Justice* 7(1) (April 2000): 6.
[8] Ibid., 6..
[9] Teplin, Linda A., Karen M. Abram, Gary M. McClelland, Mina K. Dulcan, and Amy A. Mericle, "Psychiatric Disorders in Youth in Juvenile Detention," *Archives of General Psychiatry* 59 (December 2002): 1137.
[10] Ibid., 1138.
[11] Lamb, Richard H., and Linda E. Weinberger, "Persons with Severe Mental Illness in Jails and Prisons: A review," *Psychiatric Services* 49(4) (April 1998): 488-491; Lamb, Richard H., Linda E. Weinberger, Jeffrey S. Marsh, and Bruce H. Gross, "Treatment Prospects for Persons with Severe Mental Illness in an Urban County Jail," *Psychiatric Services* 58(6) (June 2007): 786.
[12] Skeem, Jennifer L., Paul Emke-Francis, and Jennifer Eno Louden, "Probation, Mental Health, and Mandated Treatment: A national survey," *Criminal Justice and Behavior* 33(2) (April 2006): 160.
[13] Lurigio, "Persons with Serious Mental Illness in the Criminal Justice System: Background, prevalence, and principles of care," 313.
[14] Clark, Pam, "Juvenile Justice Faces Mental Health Issues," *Corrections Today* (February 2008): 8-13; Kennedy, Patrick J., "Mental Health Issues Burden the Juvenile Justice System," *Corrections Today* (December 2007): 24; See Skeem, Emke-Francis, and Louden, "Probation, Mental Health, and Mandated Treatment: A national survey," 159; and Ruddell, "Jail Interventions for Inmates with Mental Illness," 119.
[15] Caldwell, Michael F., Michael Vitacco, and Gregory J. Van Rybroek, "Are Violent Delinquents Worth Treating?: A cost-benefit analysis," *Journal of Research in Crime and Delinquency* 43(2) (May 2006): 162.
[16] Kessler, Ronald C., Patricia Berglund, Olga Demler, Robert Jin, and Ellen E. Walters, "Lifetime Prevalence and Age-of-Onset Distributions of *DSM-IV* Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry* 62(6) (June 2005): 595.
[17] Shaffer, David, Prudence Fisher, Mina K. Dulcan, Mark Davies, John Piacentini, Mary E. Schwab-Stone, Benjamin B. Lahey, Karen Bourdon, Peter S. Jensen, Hector R. Bird, Glorissa Canino, and Darrell A. Reiger, "The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC 2.3): Description, acceptability, prevalence rates, and performance in the MECA study," *Journal of the American Academy of Child and Adolescent Psychiatry* 35(7) (July 1996): 872-873.
[18] Kessler, Berglund, Demler, Jin, and Walters, "Lifetime Prevalence and Age-of-Onset Distributions of *DSM-IV* Disorders in the National Comorbidity Survey Replication," 595.
[19] Grove, William M., David H. Zald, Boyd S. Lebow, Beth E. Snitz, and Chad Nelson, "Clinical Versus Mechanical Prediction: A meta-analysis," *Psychological Assessment* 12(1) (2000): 25.
[20] For more information see: http://www.umassmed.edu/nysap/index.aspx.
[21] Grisso, Thomas, "Why We Need Screening/Assessment in Juvenile Justice," in *Mental Health Screening and Assessment in Juvenile Justice*, ed. Thomas Grisso, Gina Vincent, and Daniel Seagrave, New York: The Guilford Press, 2005: 12.
[22] Ibid., 11.
[23] Ibid., 12.

[24] Ibid., 12.
[25] Ibid., 13.
[26] Ibid., 13.
[27] Ibid., 12.
[28] Ibid., 15.
[29] Grove, Zald, Lebow, Snitz, and Nelson, "Clinical versus Mechanical Prediction: A meta-analysis," 24; Sartorius, Norman, Charles T. Kaelber, John E. Cooper, Margaret T. Roper, Donald S. Rae, Walter Gulbinat, Dipl Math, T. Bedirhan Ustun, and Darrel A. Regier, "Progress Toward Achieving a Common Language in Psychiatry: Results from the field trial of the clinical guidelines accompanying the WHO classification of mental and behavioral disorders in ICD-10," *Archives of General Psychiatry 50(2)* (February 1993): 118.
[30] Lyons, John S., et al., "Clinical and Forensic Outcomes from the Illinois Mental Health Juvenile Justice Initiative," 1632.
[31] http://www.cafas.com
[32] Hodges, Kay, "Child and Adolescent Functional Assessment Scale," in *Mental Health Screening and Assessment in Juvenile Justice*, ed. Thomas Grisso, Gina Vincent, and Daniel Seagrave, New York: The Guilford Press, 2005: 126.
[33] Ibid., 126.
[34] *Childhood Severity of Psychiatric Illness: Manual*, Mental Health Services and Policy Program, Chicago, Illinois: Department of Psychiatry and Behavioral Science, Northwestern Medical School and the Department of Adolescent Psychiatry, Children's Memorial Hospital, 1997: 2.
[35] Ibid., 17-20.
[36] Lyons, John S., Kenneth I. Howard, Michael T. O'Mahoney, and Jennifer D. Lish, *The Measurement and Management of Clinical Outcomes in Mental Health*, Hoboken, New Jersey: John Wiley & Sons, Inc., 1997: 226.
[37] Ibid., 217, 220, & 226.
[38] Grisso, "Why We Need Screening/Assessment in Juvenile Justice," 99.
[39] http://www.maysiware.com
[40] http://www.maysiware.com/MAYSI2Info.htm
[41] Grisso, "Why We Need Screening/Assessment in Juvenile Justice," 102.
[42] Williams, Valerie, Thomas Grisso, Melissa Valentine, and Nicole Remsburg, "Mental Health Screening: Pennsylvania's experience in juvenile detention," *Corrections Today* (February 2008): 24.
[43] Grisso, Thomas, Richard Barnum, Kenneth E. Fletcher, Elizabeth Cauffman, and Dawn Peuschold, "Massachusetts Youth Screening Instrument for Mental Health Needs of Juvenile Justice Youths," *Journal of the American Academy of Child and Adolescent Psychology* 40(5) (May 2001): 544.
[44] Ibid., 545.
[45] Ibid., 547.
[46] Ford, Julian D., John F. Chapman, Geraldine Pearson, Randy Borum, and Jennifer Meltzer Wolpaw, "Psychometric Status and Clinical Utility of the MAYSI-2 with Girls and Boys in Juvenile Detention," *Journal of Psychopathology and Behavioral Assessment* 30(2) (June 2008): 93-95.
[47] Archer, Robert P., Rebecca Vauter Stredny, John A. Mason, and Randolph C. Arnau, "An Examination and Replication of the Psychometric Properties of the Massachusetts Youth Screening Instrument- Second Edition (MAYSI-2) Among Adolescents in Detention Settings," *Assessment* 11(4) (December 2004): 294; Cauffman, Elizabeth, "A Statewide Screening of Mental Health Symptoms Among Juvenile Offenders in Detention," *Journal of the American Academy of Child and Adolescent Psychology* 43(4) (April 2004): 435; Wasserman, Gail A., Jennice S. Vilhauer, Larkin McReynolds, Rebecca Shoai, and Reni John, "Mental Health Screening in the Juvenile Justice System: A comparison between the Voice-DISC-IV and the MAYSI-2," *Journal for Juvenile Justice and Detention Services* 19(1) (2004): 10-12.
[48] http://www.cafas.com/
[49] Winters, Nancy C., Brent R. Collett, and Kathleen M. Myers, "Ten-Year Review of Rating Scales, VII: Scales assessing functional impairment," *Journal of the American Academy of Child and Adolescent Psychiatry* 44(4) (April 2005):328.
[50] Ibid., 328.
[51] Ibid., 328
[52] Ibid., 328
[53] Lyons, John. S., personal communication, September 4, 2009.

[54] Lyons, John S., personal communication, September 4, 2009.
[55] Lyons, John S., personal communication, September 4, 2009.
[56] Buddin Praed Foundation, *Child & Adolescent Needs and Strengths (CANS) Methodology*, Winnetka, IL: Buddin Praed Foundation, 1999: 2.
[57] Ibid.,2.
[58] Ibid., 4.
[59] Winters, Collett, and Myers, "Ten-Year Review of Rating Scales, VII: Scales assessing functional impairment," 331.
[60] Wasserman, Gail A., Susan J. Ko, and Larkin S. McReynolds, "Assessing the Mental health Status of Youth in Juvenile Justice Settings," *Juvenile Justice Bulletin*, Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, August 2004, NCJ 202713: 2.
[61] Wasserman, Gail A., Larkin S. McReynolds, Prudence Fisher, and Christopher P. Lucas, "Diagnostic Interview for Children: Present state voice version," in *Mental Health Screening and Assessment in Juvenile Justice*, ed. Thomas Grisso, Gina Vincent, and Daniel Seagrave, New York: The Guilford Press, 2005: 227.
[62] Ibid., 225.
[63] Ibid., 228.
[64] Lucas, Christopher P., "Use of Structured Diagnostic Interviews in Clinical Child Psychiatric Practice," in *Standardized Evaluation in Clinical Practice*, ed. Michael B. First, Arlington, Virginia: American Psychiatric Publishing, Inc., 2003: 89-90.
[65] Shaffer, et. al., "The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC 2.3)," 872-873.
[66] Shaffer, Davis, Prudence Fisher, and Christopher Lucas, "The Diagnostic Interview Schedule for Children (DISC)," in *Comprehensive Handbook of Psychological Assessment: Volume 2 – Personality Assessment*, ed. Mark J. Hilsenroth, Daniel L. Segal, and Michael Hersen, Hoboken, New Jersey: John Wiley & Sons, Inc., 2004: 264.
[67] Ibid., 265.
[68] Ibid., 265-266.
[69] Pinsoneult, Terry B., "Updating the Jesness Inventory Randomness Validity Scales for the Jesness Inventory Revised," *Journal of Personality Assessment* 86(2) (April 2006): 190.
[70] Multi-Health Systems, *Jesness Inventory-Revised* (2003): 3.
[71] Cowden, James E., William M. Peterson, and Asher R. Pacht, "The MCI vs. the Jesness Inventory as a Screening and Classification Instrument at a Juvenile Correctional Institution," *Journal of Clinical Psychology* 25(1) (January 1969): 59; Kunce, Joseph T., and Hoyet Hemphill, "Delinquency and Jesness Inventory Scores," *Journal of Personality Assessment* 47(6) (December 1983): 633.
[72] Pinsoneault, Terry B., "Updating the Jesness Inventory Randomness Validity Scales for the Jesness Inventory-Revised," *Journal of Personality Assessment* 86(2) (April 2006): 193.
[73] Gumbiner, Jann, *Adolescent Assessment*, Hoboken, New Jersey: John Wiley & Sons, Inc., 2003: 165.
[74] Ibid., 165.
[75] Ibid., 166.
[76] Ibid., 166.
[77] Ibid., 171.
[78] Ibid., 173.
[79] Baer, Ruth A., and Jason C. Rinaldo, "The Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)," in *Comprehensive Handbook of Psychological Assessment: Volume 2 – Personality Assessment*, ed. Mark J. Hilsenroth, Daniel L. Segal, and Michael Hersen, Hoboken, New Jersey: John Wiley & Sons, Inc., 2004: 213.
[80] Ibid., 214.
[81] Ibid., 214.
[82] Ibid., 214.
[83] Archer, Robert P., *MMPI-A: Assessing adolescent psychopathology* (2nd Ed.), Mahwah, New Jersey: Lawrence Erlbaum Associates, Inc, 1997: 253-258.
[84] Baer, and Rinaldo, "The Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)," 216.
[85] Ibid., 216.
[86] Ibid., 217.
[87] Lachar, David, "The Personality Inventory for Children, Second Edition (PIC-2), Personality Inventory for Youth (PIY), and Student Behavior Survey (SBS)," in *Comprehensive Handbook of Psychological Assessment: Volume 2 – Personality Assessment*, ed. Mark J. Hilsenroth, Daniel L. Segal, and Michael Hersen, Hoboken, New Jersey: John Wiley & Sons, Inc., 2004: 194.

[88] Ibid., 194.
[89] Ibid., 197.
[90] Ibid., 199.
[91] Lachar, David, and Jenine Boyd, "Personality Inventory for Children, Second Edition; Personality Inventory for Youth; and Student Behavior Survey," in *Mental Health Screening and Assessment in Juvenile Justice*, ed. Thomas Grisso, Gina Vincent, and Daniel Seagrave, New York: The Guilford Press, 2005: 217.
[92] Negy, Charles, David Lachar, Christian P. Gruber, and Neil D. Garza, "The Personality Inventory for Youth: Validity and comparability of English and Spanish versions for regular education and juvenile justice samples," *Journal of Personality Assessment* 76(2) (April 2001): 258.
[93] Siegfried, Nandi, "A Review of Comorbidity: Major mental illness and problematic substance use," *Australian and New Zealand Journal of Psychiatry* 32 (1998): 708.
[94] Miller, Franklin G., and Linda E. Lazowski, "Substance Abuse Subtle Screening Inventory for Adolescents-Second Version," in *Mental Health Screening and Assessment in Juvenile Justice*, ed. Thomas Grisso, Gina Vincent, and Daniel Seagrave, New York: The Guilford Press, 2005: 141.
[95] Ibid., 141.
[96] Ibid., 141.
[97] Ibid., 143.
[98] Ibid., 146.
[99] Feldstein, Sarah W., and William R. Miller, "Does Subtle Screening for Substance Abuse Work?: A review of the Substance Abuse Subtle Screening Inventory (SASSI)," *Addiction* 102(1) (January 2007): 44.
[100] Ibid., 44-46.
[101] Children's Hospital Boston, *CRAFFT*, Center for Adolescent Substance Abuse Research, 2009, Boston, Massachusetts, www.ceasar.org
[102] Ibid.
[103] Knight, John R., Lon Sherritt, Lydia A. Shriver, Sion Kim Harris, and Grace Chang, "Validity of the CRAFFT Substance Abuse Screening Test Among Adolescent Clinic Patients," *Archives of Pediatrics & Adolescent Medicine* 156(6) (June 2002): 611-612; Knight, John R., Lon Sherritt, Sion Kim Harris, Elizabeth C. Gates, and Grace Chang, "Validity of Brief Alcohol Screening Tests Among Adolescents: A comparison of the AUDIT, POSIT, CAGE, and CRAFFT," *Alcoholism: Clinical and Experimental Research* 27(1) (January 2003): 70-71.
[104] Carman, Carol A., "A Review and Critique of the Kaufman Brief Intelligence Test," paper presented at the Annual Meeting of the Southwest Educational Research Association, Texas, January 28, 2000, 2-3.
[105] Ibid., 3.
[106] Ibid., 6.
[107] Ibid., 6.
[108] Ogles, Benjamin M., Gregorio Melendez, Diane C. Davis, and Kirk M. Lunnen, "The Ohio Scales: practical outcome assessment," *Journal of Child and Family Studies* 10(2) (June 2001): 200.
[109] Ibid., 206.
[110] Dowell, Kathy A, and Benjamin M. Ogles, "The Ohio Scales Youth Form: Expansion and validation of a self-report outcome measure for young children," *Journal of Child and Family Studies* 17(3) (June 2008): 303.
[111] Turchik, Jessica A., Veronika Karpenko, and Benjamin M. Ogles, "Further Evidence of the Utility and Validity of a Measure of Outcome for Children and Adolescents," *Journal of Emotional and Behavioral Disorders* 15(2) (Summer 2007): 126.
[112] Grumbiner, *Adolescent Assessment*, 200.
[113] Groth-Marnat, Gary, *Handbook of Psychological Assessment* (5th ed.), Hoboken, New Jersey: John Wiley & Sons, Inc., 2009: 128-129.
[114] Orbis Partners, Inc., *Youth Assessment and Screening Instrument*, Ottawa, Ontario: Orbis Partners, Inc., 2007:5.
[115] Orbis Partners, Inc., *Long-Term Validation of the Youth Assessment and Screening Instrument (YASI) in New York State Juvenile Probation*, Ottawa, Ontario: Orbis Partners, Inc, 2007: 11.
[116] Orbis Partners, Inc., *Youth Assessment and Screening Instrument*,3.
[117] Ibid., 6.
[118] Ibid., 7.
[119] Barnoski, Robert, and Steven Markussen, "Washington State Juvenile Court Assessment," in *Mental Health Screening and Assessment in Juvenile Justice*, ed. Thomas Grisso, Gina Vincent, and Daniel Seagrave, New York: The Guilford Press, 2005: 275-277.