NOT JUST CHILD'S PLAY

The Role of Behavioral Health Screening and Assessment

in the Connecticut Juvenile Justice System

Prepared by:
Connecticut Center for Effective Practice of the
Child Health and Development Institute of Connecticut, Inc.

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The Connecticut Center For Effective Practice of the Child Health and Development Institute of Connecticut, Inc.

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Executive Summary

Behavioral health screening and assessment can provide vital information about the emotional and behavioral problems, needs, and strengths of children in the juvenile justice system. This report describes how behavioral health screening and assessment can help those children and their families to overcome problems such as depression, substance abuse, and trauma so that they have a better chance at building healthy lives and safe communities. The report addresses the following key issues:

- WHY screening and assessment are needed in order to improve children's lives and reduce recidivism.
- HOW screening and assessment are done by behavioral health specialists in the juvenile justice system.
- WHAT the scientific evidence indicates is necessary for behavioral health screening and assessment to be accurate and helpful for judges; probation, parole, and detention staff; rehabilitation and counseling staff; teachers, parents, and the children themselves.
- WHERE changes in polices, procedures and practices concerning behavioral health screening and assessment could make a positive difference for children in the juvenile justice system, their families, and adults working with them.


Children in the juvenile justice system are four times more likely than children in the community to have serious behavioral health problems. In this report, "behavioral health problems" means a wide range of emotional, psychological, and substance use problems, as well as related problems with learning, getting along with other people, and healthy development. The children in the juvenile justice system typically are children who range in age (and developmental phase) from elementary school age (10 years old) to middle adolescence (16 years old), and in some cases as old as late adolescence (18 years old). We know that in Connecticut, more than 10,000 children were arrested last year. While children of color are 26% of the state population, they were 75% of the children placed in detention. As many as three out of four children in the juvenile justice system in the United States have one or more psychiatric disorders, such as depression, anxiety, attention deficit hyper-activity disorder, conduct disorder, and post-traumatic stress disorder (PTSD) — all of which can contribute to or exacerbate problems with delinquency, substance abuse, school failure, peer and family conflict, and dangerousness to self or others. These problems interfere with a child's emotional, social, and educational/vocational development, compromising the child's ability to become (and continue in adulthood as) a contributing member of the community.

Timely behavioral health screening and assessment are crucial first steps to providing effective treatments that can help break the cycle of repeated and escalating problems with the law. However, nationwide, many children in juvenile justice systems who have behavioral health problems are neither identified by screening nor provided with a thorough behavioral health assessment. As a result, these children either do not receive behavioral health services or receive services that are not targeted to their specific needs.

While some states recently have begun to recognize the need for identifying and responding to the behavioral health needs of children in their juvenile justice systems, the behavioral health assessments and services provided in those states vary greatly in type, quality and methods. In many jurisdictions, neither screening nor assessment is done. In most, few standards define the process, instruments or procedures for experts conducting screenings and assessments (Soler, 2002). Often, what is called a behavioral health "assessment" is, instead, a brief screening that points out a need for services but does not identify a child's specific needs or the most appropriate services to meet those needs.

Behavioral health screening identifies issues that require urgent attention or further investigation, while behavioral health assessment provides a more comprehensive or in-depth picture of the child's specific needs and strengths. Screening is a first step which, if done upon a child's entry to a facility or juvenile justice setting, can prevent crises by identifying problems such as suicidality. When behavioral health needs are identified by screening, a more detailed assessment can then determine the best plan for services to address specific behavioral health issues, including:

- **Adversities (problems):** violence and other forms of trauma; poverty; homelessness; stigma and discrimination; genetic risk factors; personal or family mental or medical health problems; personal or family substance abuse; difficulties or delays in healthy mental, social, and physical development.

- **Resiliency (strengths):** knowledge; education; creativity; talents; supportive relationships; positive role models and values; involvement in cultural, faith, recreational, or community activities and groups; genetic inheritance; family resources.

Connecticut is a leader in this area, as the result of having instituted systematic screening and assessment processes for some — but not all — children involved in juvenile justice programs. This report describes those promising efforts in the context of the workings of juvenile justice systems historically, and the limitations of current behavioral health screening and assessment programs in Connecticut's juvenile justice system. We also define the standards and methods necessary for a truly "evidence-based" approach to behavioral health screening and assessment. The report concludes with the following policy and practice recommendations to help ensure that every child with behavioral health needs in Connecticut's juvenile justice system can receive timely screening, accurate assessment, and effective behavioral health services.

Decisions about children in the juvenile justice system are assisted when behavioral health information acquired is current and relevant and when assessors are experienced in forensic issues and in child development.

When behavioral health needs are identified in screening, detailed assessment can then determine the best plan for services and supports to help each child and family.

Practice and Policy Recommendations

1. Screening services should be provided for all children upon their entry to the juvenile justice system to identify those in crisis and those who have behavioral health needs warranting further assessment.

2. Every child with screening results suggesting serious behavioral health problems should receive further assessment.

3. Those children with serious behavioral health problems who remain in the juvenile justice system for an extended time should receive periodic re-screening, re-assessment, and appropriate adjustments to behavioral health services.

4. Coordinating mechanisms in juvenile justice for early surveillance, screening, assessment and treatment of children's behavioral health problems is imperative.

5. Mechanisms for early behavioral health identification and intervention should be expanded in public service gateways like schools, primary health settings and the child welfare system to prevent children from entering the juvenile justice system with undetected, serious behavioral health disorders.

6. A quality assurance and continuous-improvement system is needed to guide screening procedures, to credential and monitor the work of assessors, and ultimately to ensure that all behavioral health screenings and assessments adhere to best-practice standards.

7. Screening and assessment must produce findings and recommendations that directly and accurately address the main questions posed by the judges and justice personnel.

8. Behavioral health professionals who supervise screenings or conduct court-ordered assessments should have professional credentials necessary to provide services (such as a license for independent practice and training and supervised experience in children's behavioral health assessment) and also specialized training and supervised experience to ensure that they are competent to deliver these services in the juvenile justice system.

9. A credentialing and quality assurance model such as that developed by the Cook County (Illinois) courts ensures that all behavioral health screening and assessment procedures, recommendations, and reports are conducted by qualified professionals and meet standards of best practice.

10. Statutory protection is needed to prevent the results of behavioral health screening or assessment from being used against any child or family in either a current or future legal proceeding. Concerns about stigmatization and self-incrimination currently prevent many children with behavioral health problems from being appropriately identified to receive timely services. Some states, such as Texas, provide universal behavioral health screening for delinquents as a result of legislation introduced to protect clinical information.

11. An advisory group of legal, behavioral health, and child advocacy professionals should review the statutory and ethical issues concerning behavioral health screening and assessment within the juvenile justice system, and recommend reforms. The group should review state statutes, policies, regulations, practice guidelines, and practice patterns relevant to improving screening and assessment services in the juvenile justice system for Connecticut children with serious behavioral health needs.

Introduction:

Children's Behavioral Health: *A National and State Concern*

Over the past decade, the incidence of children with behavioral health (mental health and substance abuse) problems has been recognized as a public health crisis, resulting in an increase of resources aimed at reducing the high rates of child and adolescent mental illness, substance abuse and serious childhood psychosocial and functional impairment. A 1999 U.S. Surgeon General's report estimates that 11% of all children and adolescents have at least one diagnosable psychiatric illness that contributes to serious impairment in psychosocial development, physical health, family and peer relationships, or school performance (report of the Surgeon General's Conference on Children's Mental Health, 2001). Moreover, a recent report from the President's Freedom Commission on Mental Health states that 20% of all children are affected by emotional disorders that can be serious or long-lasting and that can lead to significant consequences such as dropping out of school, delinquency, violence, or suicide (President's New Freedom Commission on Mental Health, Sub-Committee on Children and Families, 2003). Meanwhile, only 30% of all children with mental, substance use and emotional disorders in the U.S. receive any kind of behavioral health treatment (Leaf, 1996).

Growing National Support for Children's Behavioral Health Assessment

Historically, the failure of states to address children's behavioral health needs led to reforms such as the federal Child and Adolescent Service System Program (CASSP) which, in turn, laid the groundwork for the development of state and local "systems of care" (SOCs). Systems of care are models for improved behavioral health treatment coordination and delivery to children and their families (Center for Mental Health Services, 1998; Stroul & Friedman, 1986). More recently, there has been increased attention to the cornerstone of any system of care — the assessment of children's behavioral health needs (Kelleher et al., 1998; Young & Ferrari, 1998). Thorough screening and accurate assessment are essential to the identification of children suffering from behavioral health disorders and for subsequent planning, selection and delivery of treatments geared to management or recovery from acute and chronic illness (Lewczyk, 2003).

Children's behavioral health screening and assessment has been strongly supported by many national organizations such as the Children's Defense Fund, Child Welfare League of America and the National Center for Mental Health and Juvenile Justice. In the past 25 years, numerous initiatives for public and professional education and for research and services funding have been launched. Public and private managed care providers now widely authorize or even require mental health and substance abuse assessments for children who have or are at risk for behavioral health problems.

note to advocates and policy-makers

We know that children involved with the juvenile justice system have substantially higher rates of behavioral health disorders compared with children in the general population and comparable rates to those who are treated in behavioral health systems. While the prevalence (*the percentage of people*) of behavioral health disorders among children in the general population is estimated at 20%, the prevalence rate for children in the juvenile justice system is as high as 60%, (National Center for Mental Health and Juvenile Justice, 2004). We are also learning much more about the prevalence of particular behavioral health problems common to children in the justice system. Fewer than one in ten adolescents in the general population has a mood disorder (including depression and manic-depressive disorder), but at least twice that number (and possibly as many as three out of four) children in the juvenile justice population have mood disorders (Ryan and Redding, 2004).

note to advocates and policy-makers

Research also suggests that mood disorders play a significant role in leading to and/or worsening delinquent behaviors (Ryan & Redding, 2004). Symptoms of depression can approximate behaviors seen in delinquency including hopelessness and negative thoughts, boredom, low self-esteem, social withdrawal, sleep disturbance, low energy, school problems, irritability and aggression. Depression is also the single most common behavioral disorder associated with suicide among adolescents. A new and comprehensive review (Ryan and Redding, 2004) of research studies over the past two decades concludes that standardized assessment methods are essential to accurately identify depression and related disorders among children in the juvenile justice system. These authors argue that thorough and accurate behavioral health screening and assessment are essential to providing "more comprehensive behavioral health services" for children who may suffer from mood disorders or other common problems.

Addressing Behavioral Health Needs for Children in Connecticut

The past decade in Connecticut has seen increased attention to children's behavioral health needs and services. Reports have recommended that the state address "service gridlock," inadequate funding and neglect of its public behavioral health service system (Govenor's Blue Ribbon Report, 2000), and in addition, develop a complementary statewide network of behavioral health services combining community and residential-based services using the systems of care model. Such a network would address both prevention and treatment of emotional disturbance in all Connecticut children — something especially important in the youngest children, those from birth through 5 years old (Ford & Sanders, 2001).

An analysis of children's behavioral health financing led by the Department of Children and Families (DCF) and the Department of Social Services (DSS) resulted in legislation creating Connecticut Community KidCare, a state-wide integrated system of children's behavioral health services and supports (Child Health and Development Institute, 2001). Earlier assessment and treatment of children's behavioral health needs, particularly for those reliant on publicly funded service systems, is a priority for Connecticut leaders and policy-makers (Connecticut Commission on Children, 1997; Geballe, 2000; The Mental Health Policy Council's Sub-Committee Report, 2002).

State partnerships designed to improve behavioral health practices like the Connecticut Center for Effective Practice, planning efforts like Connecticut's State Prevention Council, and court actions like the *Emily J v. Rowland, Juan F v. Rowland* consent judgments have helped turn Connecticut's collective attention to the improvement of children's behavioral health services. This has led not only to initiatives such as Connecticut Community KidCare, but also to the increasing awareness of a need for more implementation of evidence-based treatments within child and adult behavioral health care.

Nearly 60% of the children admitted to detention in Connecticut have behavioral health problems and are in need of treatment.

Evidenced-based treatments are behavioral health treatments (such as psychosocial, pharmacologic or comprehensive community practices) that have been well researched and show proof of clinical improvements. These treatments are identified as "evidence-based" if rigorous research studies, when repeated by different researchers, can continue to demonstrate treatment success.

Children in Connecticut's Juvenile Justice System

Connecticut is one of only three states that considers children as young as 16 to be legal adults in the justice system. The vast majority of children constituting the state's juvenile justice population are between 12 and 15 years old. Also, increasing numbers of children are entering the juvenile justice system despite the overall decrease in crime rates. Between 1994 and 2000, the arrest rate for children in the U.S. for violent criminal offenses decreased by 41%. The arrest rate for children in Hartford County, Connecticut has fallen 35% since 1994 while violent crimes by children have fallen by over 60%. Still, even though serious juvenile crime has been decreasing locally and nationally, child referrals to Connecticut courts have risen 79% since 1989. In addition to populations of younger children accused of non-violent crimes, a disproportionate number of children in Connecticut's system are cultural and ethnic minorities.

Children of color are 26% of the state population but account for more than 75% of detention placements and 83% of commitments to public facilities.

The above statistics suggest that children entering the system at increasing rates for non-violent crimes are young ethnic minorities, many with unidentified but serious behavioral impairments. Nearly 60% of the children admitted to detention in Connecticut have behavioral health problems and are in need of treatment, according to a state report (Chapman, 2000). This figure is consistent with national reports indicating that children in juvenile justice systems have a high prevalence of behavioral disorders (Teplin, 2002) and frequently enter juvenile justice facilities because of the lack of community behavioral health treatments (U.S. House of Representatives, 2004).

In light of this data, state agencies have begun to use comprehensive, evidence-based models of behavioral health treatment. The Connecticut Department of Children and Families (DCF) and the judicial branch Court Support Services Division (CSSD) have become sensitive to the behavioral problems and treatment needs of children entering the juvenile justice system. Concerns were raised by a civil lawsuit that alleged inadequate behavioral health services in the juvenile justice system (*Emily J. vs. State of Connecticut*) and also by negative reviews of juvenile justice program outcomes (Dougherty, Thomalla, Larsons, 2002).

...the essential precursor to effective behavioral health services for children in the juvenile justice system is access to thorough assessment of behavioral health status.

The Connecticut Center for Effective Practice (CCEP) of the Child Health and Development Institute of Connecticut is a partnership of public and private institutions committed to increasing the number of evidence-based practices and improving the quality of all behavioral health practices for children. An earlier report, funded by the Connecticut Health Foundation and the Tow Foundation, documents the need for behavioral health services for children in the juvenile justice system (Ford, Williams, McKay, 2003). It also examines existing services in Connecticut, and identifies national models for evidence-based treatments for these children and their families. One of the principal findings is that the essential precursor to effective behavioral health services for children in the juvenile justice system, regardless of the specific treatment model, is access to screening and accurate and thorough assessment of behavioral health status. The report recommends state-wide behavioral health screening and assessment of children upon entry and at critical juvenile justice decision points.

The importance of creating a comprehensive and strategic juvenile justice plan for the state has been reiterated by a number of Connecticut experts. The MacArthur Foundation sponsored the Comprehensive System Change Initiative (CSCI) in Connecticut, a three-year technical assistance project. CSCI, a multidisciplinary group dedicated to improving policies and practices affecting children with behavioral health needs in the juvenile justice system, also recommends improved screening and assessment.

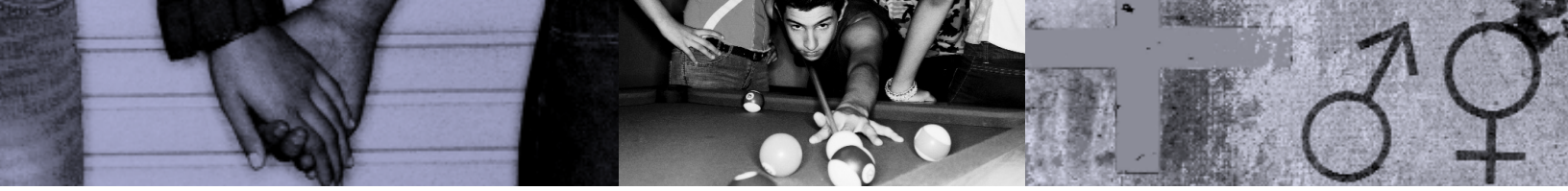
CSCI supported the development of a Connecticut strategic plan integrating children's behavioral health services into the justice system and used the technical assistance of the National Center for Mental Health and Juvenile Justice and the Council of Juvenile Correctional Administrators as well as the Child Welfare League of America.

This CCEP report, *Not Just Child's Play*, is intended to:

- address concerns about behavioral health screening and assessment identified by several Connecticut groups.
- develop recommendations for statewide adoption of approaches to screening and assessment that will result in children receiving the most appropriate services.

The findings are intended to help children, families, their legal representatives, judges and court staff, detention and probation personnel, and behavioral health professionals.

In 2004, the Office of Juvenile Justice and Delinquency Programs released a report entitled *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System* (Grisso & Underwood, 2004; http://www.ncjrs.org/pdffiles1/ojjdp/ 204956.pdf). We highly recommend this document to all professionals concerned with the behavioral health of children in the juvenile justice system.



The report describes specific evidence-based screening and assessment procedures and tools, and also offers a clear introduction to the topic, current background information on assessment instruments and descriptions of strength-focused, gender-appropriate and ethno-culturally sensitive approaches. It is an excellent companion to this report and particularly helpful for clinical practitioners. Another timely report by the National Mental Health Association about the most effective and empirically supported treatments currently available is *Mental Health Treatment for Youth in the Juvenile Justice System: A Compendium of Promising Practices* (NMHA, 2004; http:// www.nmha.org/children/JJCompendiumofBestPractices.pdf). This document emphasizes screening and assessment, provides information about behavioral health practices that achieve good results for justice-involved children, and criticizes those treatments shown not to work. The report's recommendations include:

- early problem identification;
- access to a comprehensive array of individualized formal and informal services;
- families and caregivers as active participants in all aspects of service planning and delivery; and
- care coordination ensuring that multiple services are linked and clinically indicated.

The National Mental Health Association report and the Grisso and Underwood report offer excellent overviews of promising practices geared to the needs of general and special populations of justice-involved children.

In contrast, *Not Just Child's Play* focuses on specific issues relevant to Connecticut and is aimed particularly at policymakers, juvenile justice program planners, court officers and service providers. Our goal is a clear description of how screening and assessment for behavioral health issues are being done in the Connecticut juvenile justice system. We describe current practices, analyze system barriers to comprehensive behavioral health assessment and review the relevant scientific literature and expert consensus. We conclude with policy and practice recommendations for improving both assessment practice and Connecticut's response to the behavioral health needs of children in the juvenile justice system. We ask the following questions:

WHY assessment is needed in order to improve children's lives and reduce recidivism.

HOW assessment is done by behavioral health specialists in the juvenile justice system.

WHAT the scientific evidence indicates is necessary for behavioral health screening and assessment to be accurate and most helpful for judges, probation officers, rehabilitation and counseling staff, teachers, parents, and the youths themselves.

WHERE changes in policy, procedures, and practices concerning behavioral health screening and assessment in the juvenile justice system could make a positive difference for children, their families, and the adults who work with them.

Below are basic definitions of some terms central to this report. Additional terminology is explained in the glossary.

- **Screening** is a brief process — the first step to identify children at risk for behavioral health problems and to determine which problems require further investigation.

- **Assessment** refers to a more complex process, involving in-depth, targeted or comprehensive, multidisciplinary examination of psychological needs, problems, strengths, and resources (Grisso & Underwood, 2004).

- We define **children** as all young people up to 18 years of age, covering both early childhood and the adolescent developmental period, recognizing that the justice system defines those from 0 to15 years old as children and from 16-18 years old as youth.

- **Behavioral health** encompasses the wide range of emotional and behavioral problems, including all mental health and substance abuse disorders, behavioral, psychosocial and developmental problems experienced by children.

SOME NOTABLE STATISTICS:

- An estimated 2.4 million children are involved in the US juvenile justice system as a result of arrests each year, accounting for 17% of all arrests and 16% of all violent crimes.

- A recent federal report states that 20% of all children are affected by emotional disorders that can be serious or long-lasting and that can lead to significant consequences such as dropping out of school, delinquency, violence, or suicide, At the same time, only 30% of all children with mental, substance use and emotional disorders receive any kind of intervention.

- Nearly 60% of the children admitted to detention in Connecticut have behavioral health problems and are in need of treatment. This figure is consistent with national reports indicating that children in juvenile justice systems have a high prevalence of such disorders and frequently enter juvenile justice facilities because of the lack of community behavioral health treatments.

- Juvenile substance abuse is implicated in 69% of violent offenses, 72% of property crimes and 81% of all other crimes.

- The vast majority (over 90%) of boys and girls entering the juvenile justice system have histories of victimization or trauma — including witnessing violence in their homes or communities.

Section 1:

The Intersection of Behavioral Health and Juvenile Justice

The major public child-serving systems — including juvenile justice, child welfare, education, and primary health care — traditionally have not been designed or funded to address children's serious behavioral health needs. However, these systems are potential gateways to the behavioral health service system for large numbers of children with serious but unidentified emotional and behavioral problems. With adequate funding and effective procedures for screening and assessment in these systems, many behavioral health problems that currently are not detected or addressed could be identified and treated.


note to advocates and policy-makers

An estimated 2.4 million children are involved in the U.S. juvenile justice system as a result of arrests each year. This number accounts for 17% of all arrests (Snyder, 2002; Abram, Teplin, Charles, Longworth, McClelland & Dulcan, 2003) and 16% of all violent crimes (Snyder, 2002). Juvenile courts, detention centers, and community programs face ongoing pressure to safely place, monitor, and rehabilitate the growing numbers of children in their charge. For some children, this process can mean separation from family, peers, and community, and placement in institutional settings such as juvenile training schools or reformatories, where they experience increased contact with negative peer cultures. Stresses on children who are arrested are amplified because of changes in the law and the national lowering of the age at which a child can be tried as an adult. Not only are more children than ever before incarcerated, but more of them are serving sentences in adult prisons (Teplin, Abram, McClelland, Dulcan & Mericle, 2002). Stress on the family and the child is compounded by the fact that children and adolescents often lack the maturity to understand complex legal proceedings, weigh the risks and consequences of their decisions, or evaluate the dangers of doing time in jail or prison (Grisso, 2000).

For many children, especially those with prior psychological or emotional problems, juvenile justice involvement is not only stressful but also can result in the start of or the worsening of a behavioral health disorder (such as depression, sleep disorder, or conduct disorder; Cocozza & Skowyra, 2000). Teplin and colleagues (2002) recently conducted a large study of mental disorders among child detainees in Cook County, Illinois. Using the Diagnostic Interview Schedule for Children (see Appendix for description), they found that 66 percent of boys and 74 percent of girls had at least one mental disorder. Conduct disorders were understandably common among these children, but most of them also had other mental disorders. Many children who do not "act out" with anger or aggression may be overlooked because they instead withdraw or become severely isolated or self destructive as a result of depression, anxiety, or related disorders. In Teplin's study, half of the males and almost half the females had substance use disorders. Another one in three of the children had either mood (depression or bipolar disorder) or anxiety disorders. Almost half the boys (46 percent) and 57 percent of the girls had two or more mental disorders (Abram, Teplin, McClelland, & Dulcan, 2003). Young people entering juvenile justice detention are more likely than not to have serious and complex behavioral health problems, which may complicate their apparent "bad behavior" (such as impulsivity, aggression, delinquency) and their problems with peers, adults, and "authority" (such as isolation or hostility).

PTSD symptoms also are often misinterpreted by adults and peers as "bad" behavior, making traumatized children vulnerable to rejection and compounded legal troubles.

Nationally, children in the juvenile justice system are just as likely to have psychiatric disorders as children who are receiving specialized behavioral health treatment in psychiatric hospitals or residential treatment centers, or those who are in the child welfare system due to suspected abuse or neglect. A 2004 report by the Special Investigation Division of the U.S. House of Representatives concluded that, based on information from 47 states, two-thirds of all U.S. juvenile detention facilities hold children who need community behavioral health treatment (U.S. House of Representatives Committee on Reform, 2004). Garland and colleagues (2001) found that 52% of juvenile justice children met criteria for a psychiatric diagnosis, comparable to the 54% rate for these other groups of high risk or impaired children. Many children in the juvenile justice system end up in the legal system after having been identified in prior contacts with the child welfare, behavioral health, or education systems, as at-risk for or seriously impaired by substance use or emotional problems. Effective behavioral health services in the children's mental health or child welfare systems can identify and treat delinquency, but unfortunately many children will still "fall through the cracks" and end up with unidentified or untreated behavioral health problems.

Both boys and girls often enter the juvenile justice system with histories of victimization. In the Cook County study, almost all children (93%) reported having experienced at least one trauma—and on average 15 separate incidents (Abram, Teplin, Charles, Longworth, McClelland, & Dulcan, 2004). Although more males (93%) than females (84%) reported at least one traumatic experience, about the same proportion (one in nine, or 11%) of girls and boys had post-traumatic stress disorder (PTSD) in the prior year. Witnessing violence was the most common cause of PTSD, reported by more than half of the children with PTSD.

Recent Connecticut juvenile justice screening data

49% boys **76% girls**	**Entering detention:** Reported past or recent exposure to traumatic events. (MAYSI-2; see Appendix)
66% boys **65% girls**	**In probation:** Acknowledged past trauma exposure.
80% of boys and girls	**Detailed trauma screen:** Indicate past trauma, consistent with Abram's Cook County results.

Problems with post-traumatic stress and grief also were screened, and were reported by most of the girls and boys who had experienced traumatic events in their lives. Thus, trauma, PTSD, and traumatic grief are likely to be an additional source of behavioral health needs for both girls and boys in the juvenile justice system (Cauffman et al., 1998; Steiner et al., 1997). For these children, anxiety, sleeplessness, haunting memories, emotional detachment, and suspicious watchfulness are a way of life. PTSD symptoms also are often misinterpreted by adults and peers as "bad" behavior, making traumatized children vulnerable to rejection and compounded legal troubles.

A growing body of scientific research shows that delinquency and antisocial behavior often occur as a result of behavioral health problems affecting the child and family.

Behavioral Health and Juvenile Justice:

An Historical Partnership

The first U.S. juvenile court was established in Cook County, Illinois in 1899. It was designed to meet the clinical and developmental needs of "wayward children and adolescents," who were thought to be in need of "benevolent justice" to redirect their growth and development (Grisso, 1998). The Juvenile Psychiatric Institute, organized in 1909 to support the Cook County Juvenile Court, was directed by William Healy, a neurologist. Healy led a multidisciplinary team, composed of a psychiatrist, psychologist and social worker, in conducting comprehensive child evaluations that included thorough medical reviews, social histories and psychological examinations.

By 1920, all but two states had laws establishing similar juvenile court models and child evaluation mechanisms. According to a prominent expert at that time, the most enlightened courts attached themselves with "child study departments" where every child, before a hearing, was given a thorough "psycho-physical" evaluation (J. Mack, Harvard Law Review, 1909). Also, the doctrine of "parens patriae" was developed in which a judge strived to understand the total child and to respond as a "merciful father." Jurists, with the help of medical and social service professionals, saw understanding each child's psychosocial needs as a part of creating a collaborative rehabilitation plan.

Juvenile courts flourished in the U.S. in the first half of the 20th century, but by the 1960s these courts were criticized as being "overly ambitious, failing to rehabilitate delinquent children, unable to prevent institutionalization and lacking the means to stem the rising tide of juvenile crime" (President's Crime Commission Task Force Report, 1967). At the same time, a series of Supreme Court cases succeeded in granting children in delinquency proceedings the same legal rights — "due process" — afforded adults. Juvenile courts that had been viewed as "benevolent" in addressing psychological and physical health as well as behavior problems now were seen as intruding on children's constitutional rights. A juvenile rights movement was applauded for protecting the rights of children by moving away from the "child guidance" model in which children were provided with not only legal representation but also "psycho-physical" evaluations and treatment if behavioral health problems were identified.

Juvenile court proceedings became split into two parts, operating much like adult courts by having the judge first make a legal decision (called "adjudication") if a child was considered "delinquent," and then ordering a plan of rehabilitation (called "sentencing" or "disposition"). Further reforms came in the 1980s as the pendulum swung further toward "law and order," in the wake of rising national rates of violent youth crime. State legislatures passed more punitive laws, such as the practice of trying serious juvenile offenses in adult courts in which harsh (and often fixed) sentences were common.

Since the early 1970s, Connecticut has enacted laws making it easier to transfer a child offender to the adult criminal justice system (formerly law PA 95-225, now CT Statute 46b-127). "This law also expanded sentencing options to include harsher punishments and reduced children's rights to have personal information kept private (confidential)." In the early 1970s, the Coles Commission recommended lowering the age at which children could be prosecuted as adults and Statute PA 71-72, enacted in 1971, now requires all children aged 16 or older to be prosecuted in adult criminal court.

With the pendulum swinging toward harsher penalties for juvenile crime, advocates have urged that the juvenile justice system incorporate best practices and proven strategies of rehabilitation. A growing body of scientific research shows that delinquency and anti-social behavior often occur as a result of behavioral health problems affecting the child and family (Lahey, 2000). Different states' juvenile justice systems now are shaped by very different philosophies. Some focus mainly on protecting community safety, while others emphasize behavioral health rehabilitation and support for children and their families. Connecticut attempts to balance the needs of children in the juvenile justice system with concerns for public safety (Connecticut Statute 46b-120). Most states have incorporated standards from the 1974 federal Juvenile Justice and Delinquency Prevention Act which required community-based services as an alternative to incarceration ("deinstitutionalization") for less serious offenders and separate custody facilities for adults and child offenders.

While behavioral health and medical professionals typically play a secondary role in today's juvenile court proceedings, juvenile courts would benefit from specialized consultation because they increasingly encounter children with complex psychosocial, emotional and physical health problems (Scally, Kavanaugh, & Biehl, 2002). Parental mental illness and substance abuse, child neglect, physical and sexual abuse, family and community violence, poor nutrition and inadequate health care, racism and poverty affect development and contribute to placing children at risk of involvement in crime and delinquency (Lahey, 2000). These complex factors contribute to children's initial entry and subsequent return to services within the juvenile justice system (Minor, Wells, & Sims, 2003; Scott, Snowden, & Libby, 2002), requiring new collaborations of juvenile justice and legal decision-makers with behavioral health and medical professionals. Effective and economically feasible services for children in the juvenile justice system who have behavioral health needs can best be achieved if these children are quickly and accurately identified and provided with prevention or treatment services. These services should be based on the best available scientific evidence so that they can enhance each child's right to a full and fair trial and to rehabilitation that promotes both health and good citizenship.

Section 2:

Evidence-Based Approaches to Behavioral Health Screening and Assessment in Connecticut's Juvenile Justice System

Early Detection of Behavioral Health Problems and Needs

Early and accurate identification of behavioral health difficulties may make the difference between a legal disposition that allows for positive community readjustment versus costly, prolonged legal proceedings and increasingly chronic behavioral problems. In Connecticut, juvenile detention centers have screened for behavioral health problems since 1992. Increasingly, efforts are being made to use evidence-based tools at points of entry and other critical juvenile justice decision-points (Connecticut's juvenile justice system is described further in Section 3).

Case Study 1: Problems in School May Lead to Juvenile Justice Involvement

Juanita had been truant from school frequently, and teachers reported that she had become increasingly disruptive when she did attend. While her mother reported that Juanita was "out of control," she had not previously had a behavioral health assessment. Juanita was brought to detention after she was caught spraying graffiti on a highway overpass. Intake staff immediately conducted a 45-minute behavioral health screening with Juanita, as they do with all children entering the center, that included brief standardized (see below) questionnaires and interviews with her and her parents. Juanita described experiencing symptoms of depression, including thoughts of suicide and feeling irritable, especially when she couldn't get enough sleep because of waking up early in the morning. The worker who administered the screening discussed the results with a staff psychiatric social worker, who recommended a comprehensive behavioral health assessment and referral for a family-based treatment to involve her mother in her care.

A juvenile forensic psychologist interviewed Juanita privately and with her parents, conducted several standardized psychiatric and psychological tests, and obtained input from her teachers and school records. In a second private interview with Juanita, the psychologist asked her about stressful past and current experiences, and she tearfully described having been the victim of a sexual assault when she was ten years old (which she had never told anyone before), as well as having witnessed several incidents of gang violence (including a knife fight where a friend was killed). Juanita's disruptive behavior now could be understood as her way of trying to cope with feelings of depression that had started not long after the assault and increased every time she witnessed further violence.

A psychiatrist met with Juanita and prescribed antidepressant medication, which helped her feel more hopeful and more able to get along with people, as well as to concentrate at school. Juanita and her family met with a family therapist who helped her parents both encourage and set limits with her, and helped Juanita talk with her parents about her feelings and the stressful experiences she had kept secret. Juanita met privately with the social worker to learn ways to express and cope with both positive and negative feelings without "shutting down" or reacting aggressively. The social worker also helped her enroll in a martial arts program for young women who had experienced trauma; this program provided positive peer support and a sense of physical and social empowerment.

Juanita continued to have periodic difficulties with anger and impulsive behavior, but she was able to work out conflicts without further serious incidents or legal problems. At her high school graduation she spoke about how she had learned that she could deal with terrible events without giving up on herself, and about how she now believed that she didn't have to fight the entire world anymore. The brief screening and careful assessment proved to be a turning point: not a simple or easy solution, but a chance to help Juanita learn alternative ways to deal with emotional distress that she previously felt she had to hide behind a wall of secrecy and anger.

screening

A review of behavioral health services in the juvenile justice system nationwide concluded that most treatment and rehabilitation decisions are based on inadequate screening, assessment, and planning/ monitoring procedures (MacKinnon-Lewis, Kaufman, & Frabutt, 2002). In many jurisdictions, neither screening nor assessment is done. In most others, where screenings or assessments are conducted, few standards define the process, instruments or procedures for experts conducting screenings or assessments (Soler, 2002).

note to advocates and policy-makers

In addition, juvenile justice behavioral health services tend to be fragmented and most often based on what is "wrong" with the child or family (a "deficit-model") as opposed to positive abilities and resources that can serve as the basis for a healthier adjustment (a "strengths-based model," Cocozza & Skowyra, 2000). "Deficits" are problems or limitations such as behavioral health disorders like depression, PTSD, substance abuse, or a tendency to act impulsively or aggressively. "Strengths" are positive attributes (such as the ability to get along with friends who do not use drugs and who engage in creative, school, or athletic activities). Behavioral health screening and assessment will be most complete and helpful if strengths are a focus of a child's legal disposition and rehabilitation.

Distinguishing Between "Screening" and "Assessment"

Behavioral health screening and assessment are two ways of gathering information that, while similar, differ in form and function and are not interchangeable.

note to advocates and policy-makers

Screening refers to a brief process in which problems and strengths are identified (Grisso & Underwood, 2003). Screening identifies behavioral health issues requiring urgent attention or further investigation while assessment provides a more comprehensive or in-depth picture of the child's behavioral health needs. Screening is a first step in the process of gathering information; screening results help determine whether behavioral health symptoms are sufficient to warrant further assessment or care. Screening upon entry to a facility or any other juvenile justice setting is essential for identifying the potential of harm to self and others or the development of behavioral health crises, whereas an assessment is a more complex clinical examination of a child. Behavioral health screening is important for every child entering the juvenile justice system, ideally within the first 24 hours after entry into the system (Wasserman, 2003; also see Case Study 2).

An effective screening should be broad enough to identify most children with emotional, behavioral or substance use problems that are severe enough to warrant further assessment and treatment. It also should examine a wide range of potential problems, as well as resources that can be used to build on the strengths of the child and family.

Behavioral health screening and assessment will be most complete and helpful if strengths are a focus and deficits are addressed from the perspective of a "strengths-based" approach.

Case Study 2: Probation Violation for Minor Offenses Can Lead to Juvenile Confinement

Johnny, a 15-year-old Caucasian boy from a single-parent, working-class family, was on probation due to his defiant and rebellious behavior at home. He was taken to detention by a probation officer after he repeatedly violated the terms of probation by cutting school. He had never received any behavioral health services until he entered detention. On intake, a detention screening process included the Massachusetts Youth Screening Instrument (MAYSI-2), which detects behavioral health and substance problem areas. Johnny's answers on the MAYSI-2 screen suggested that he was depressed, had thoughts of suicide and experienced hallucinations (hearing voices). Further assessment by a psychologist revealed that Johnny had been hearing voices for several months. He had been defiant with his mom and refused to attend school because the "voices" were worse at school compared to when he was home and in his room alone. Communicating with his mom or other students appeared to make the voices worse.

Detention staff met with Johnny's mother and grandmother. The conversation with Johnny's relatives revealed that similar psychiatric problems ran in the family. A psychiatrist met with Johnny and prescribed a medication that made the voices go away most of the time, helped him feel calmer around other children and enabled him to think more clearly to complete his schoolwork and follow directions. After returning home from the detention facility, Johnny met with a mental health agency counselor and attended a depression group with other adolescents. He was able to return to school, attend classes and complete his probation with no further detention.

The goal of doing an assessment is to create a plan for providing behavioral health, family and educational services to help a child make a healthy adjustment and avoid legal problems.

Behavioral health assessment is a more complex process that involves a thorough examination of psychological needs, problems, strengths, and resources (Grisso & Underwood, 2003; see table 1 below). Assessment takes more time and costs more than screening. The goal of doing an assessment is to create a plan for providing children's behavioral health, family and educational services. Behavioral health assessment is designed to follow up screening in order to provide an understanding of and plan for addressing behavioral health needs.

A complete assessment uses several methods of gathering information:

- asking the child questions in an interview or with questionnaires;
- talking with adults knowledgeable about the child (such as parents, teachers, or probation officers);
- getting records from programs with which the child has been involved (such as DCF, schools, hospitals, or counseling centers); and
- observations by staff who currently spend time with the child (such as detention staff).

A complete assessment will gather information to answer questions such as the following:

- Is the child showing symptoms of behavioral health disorders or other behavioral or emotional problems (such as thoughts of suicide, substance use, feeling alone, withdrawing from family or peers, fearfulness, aggression, or impulsive risk-taking)?
- Does the child have difficulty getting along with or being able to trust and depend upon family, adults or peers, or in school, work, or recreational activities?
- What are the child's strengths (for example: positive coping behaviors, social, academic, athletic, or other skills); positive accomplishments (for example: attending school, involvement in activities); and social resources (for example: friends, adult role models, access to activities)? Screening and assessment will use these and other methods of information gathering.

Age, gender, ethnicity, and cognitive (mental) ability are considered when choosing screening or assessment instruments.

Table 1: Comparison between behavioral health screening and assessment

	SCREENING	ASSESSMENT
How long does it take?	Brief (5 to 30 minutes).	Lengthy (2 to 10+ hours).
Who should receive service?	All children in the juvenile justice system.	Only those identified by initial screen as needing assessment.
What is the main purpose?	Identify children with possible behavioral health needs, and connect them to appropriate services (including assessment).	Determine type and severity of behavioral health and substance use problems and recommend services tailored to the individual.
When in a child's encounter with the juvenile justice system should the process occur?	As soon as possible (for example, in the first interview with probation officer) but ideally within the first 24 hours of contact.	Soon enough after screening, if indicated, to preserve strengths and prevent problems from occurring or worsening and to help juvenile justice staff provide needed services.

Key Considerations in Behavioral Health Screening and Assessment

Age, gender, ethnicity, and cognitive (mental) ability are considered when choosing screening or assessment instruments. The Child Behavior Checklist (CBCL) and the Trauma Symptom Checklist for Children (TSCC) are two examples of assessment measures that use different normative scales for children based on age (see Appendix for description of these instruments). In addition, practical issues specific to the juvenile justice system must be taken into account when screenings or assessments are performed.

...the forms problems take are often different for children of different ages and developmental stages.

Adapting Behavioral Health Screening and Assessment for Different Ages and Developmental Stages

While the same general types of behavioral health problems can occur at almost any time in childhood, the forms these problems take are often different for children of different ages and developmental stages. Doing screening and assessment therefore requires knowledge of child development. For example, in early childhood, anxiety and depression primarily appear as problems with eating, sleep, physical discomfort, specific fears (such as of dogs), "fussiness," and difficulty in tolerating change or separation from familiar people. It is not until the school years that children with these problems tend to report feeling worried, sad or "blue." Severe problems with anxiety (such as being unable to leave home to go to school or activities) or depression (such as wanting to die or thinking of killing oneself) usually do not emerge until the later elementary school or early middle/junior high school years. These age breakdowns are not absolute, so screening and assessment always should be attentive to serious problems even at the youngest age, but the focus needs to be on the types of problems most likely to occur.

Age and developmental state also are important in choosing the activities used to collect screening or assessment information. With infants and preschool-age children, activities usually include parent(s) or adult caregivers as well as the child, both for the child's sense of security and because the child's relationship with caregivers is a key aspect of behavioral health at this stage. Screening or assessment with school-age children may involve brief questionnaires (written in child-friendly language and often read out-loud to ensure comprehension) or interview questions, but also may include observing the child playing games or in natural interactions with peers or family. With all but the youngest children, drawing and other creative forms of self-expression provide a means to gathering information. Screening and assessment with adolescents can rely more on questionnaires or interviews (answered either by the child or knowledgeable adults or both), but observing actual behavior in pre-planned or spontaneous activities and in creative forms of self-expression (such as doing a collage or writing a poem or lyrics for a rap song) also can be valuable.

Adapting Behavioral Health Screening and Assessment to Address Gender Differences

As noted earlier, while girls and boys in the juvenile justice system are equally likely to experience behavioral health problems, the specific types and natures of these problems often differ. Girls are more likely than boys to report problems with anxiety, depression, eating (too much or too little), personal relationships, focus and attention in school, and bodily discomfort with no clear medical cause.

The focus of screening or assessment should differ in several ways that reflect basic differences in how girls and boys tend to have been raised to believe a female or male should act.

Boys are more likely to report or be observed to have problems with aggression, impulse control, and having too much energy (hyperactivity).

While any of these problems can occur for either girls or boys, the focus of screening or assessment should differ in several ways that reflect basic differences in how girls and boys tend to have been raised to believe a female or male should act ("sex role socialization") and how they differ in their basic biology and in their social, emotional, and mental development.

First, the specific questions used to draw conclusions about behavioral health problems will differ. A larger number of questions may be needed to assess thoroughly the problems that are more common for girls when a girl is screened or assessed than when a boy is screened or assessed for the same general type of problem. The same is true for boys when a boy is screened or assessed for problems more common among boys. For example, numerous questions about symptoms of anxiety and depression may be needed to cover all the possible ways these problems can occur for girls, while a smaller set of questions may suffice when assessing boys regarding anxiety. This is not a hard-and-fast rule; however, screening and assessment measures are scientifically developed ("standardized" — see below for a full explanation) to ensure that the right type and number of gender-specific questions are used.

Secondly, problems or behavioral health symptoms which generally are uncommon for one gender should receive particularly careful attention with children of that gender in order not to miss a rare but crucial problem. If a problem is less frequent (such as a girl's use of violence in intimate relationships or severe eating problems in boys), it is easy to overlook, and a child with this problem may experience distress not only because of the problem but also because peers or adults may view that child as particularly "odd" or "bad." Children often are reluctant to disclose these problems for fear of being socially rejected or viewed as particularly "sick" by adults.

Thirdly, when standardized tests are developed they frequently generate very different results based on gender (assessment instrument norms are discussed later). These gender differences are important in interpreting results. For example, the seriousness of the same score on the MAYSI-2 screening questionnaire is different for boys compared to girls — sometimes a lower score for one gender reflects just as serious a problem as a higher score for the other gender. Therefore, professional behavioral health assessors need to be knowledgeable about how results of screening or assessment tests apply to boys and to girls so that their recommendations will be accurate for each gender.

People of different cultural, national, linguistic, spiritual, and ethnic backgrounds define behavioral health, mental illness, trauma, treatment, and recovery in different ways.

Ethnocultural Fairness and Sensitivity in Behavioral Health Screening and Assessment

Because psychological problems and strengths are defined and described differently by different ethnocultural groups, screening or assessment instruments must be meaningful and understandable in relation to ethnocultural background and language(s). Ethnocultural background includes race or ethnicity, nationality (currently and in the past), languages, cultural traditions, practices, values, roles, norms, public and private rituals, and expectations and definitions of child development and parenting. Many studies show that ethnocultural factors affect the presence, persistence and severity of behavioral health problems and the ways in which people deal with and recover from behavioral health problems (Armstrong et al., 2002; Dollinger et al., 1996; Feiring et al., 2001; Galea et al., 2002; Garbarino & Kostelny, 1996; Hill et al., 1996; Locke et al., 1996; Munczek & Tuber, 1998; Thabet et al., 2002; Widom, 2000). Ethnocultural factors also influence the "strengths" and "resilience" of communities, families, and individuals (Almqvist & Broberg, 1999; Barbarin et al., 2001; K. Miller, 1996; Punamaki et al., 2001; Westermeyer & Wahmanholm, 1996; Widom, 2000). Ethnocultural sensitivity and staff competency in designing and administering juvenile justice screening and assessments are essential for addressing problems of disproportional minority treatment and confinement occurring locally and nationally within juvenile justice systems.

People of different cultural, national, linguistic, spiritual, and ethnic backgrounds define behavioral health, mental illness, trauma, treatment, and recovery in different ways (Loo et al., 2002; Manson, 1996; Perilla et al., 2002; Stamm & Friedman, 2000). Clinical assessment should always be respectful of the child's and family's cultural norms and traditions (Manson, 1996). When and how a behavioral health issue is considered to be a problem warranting prevention or treatment differs not only across national and cultural groups but within sub-groups (for example, geographic regions of a country with different subcultures; different religious communities within the same geographic area).

Standardized behavioral health screening or assessment therefore always must be done with an awareness that the questions being asked or the activities used to collect information may be considered unacceptable (for example, including peyote as an illicit drug); irrelevant (for example, distinguishing blood family from close friends, in a group that considers all community members as family); incomplete (for example, limiting health care to Western medical or therapeutic services, to the exclusion of traditional forms of healing and healers); or simply confusing (Hollifield et al., 2002; Manson, 1996; Phan & Silove, 1997) by children and adults of some ethnocultural backgrounds. Fortunately, culturally sensitive approaches to behavioral health screening and assessment have been developed for adults (for example, Loo et al., 2002) and children (Cohen et al., 2001).

There is no "one-size-fits-all" way to achieve "cultural competence" in behavioral health screening and assessment. Questionnaires and interviews must be reviewed by knowledgeable professionals and persons with different ethnocultural backgrounds to ensure that the questions and answers are appropriate. Staff who conduct screenings and assessments must have ongoing training and supervision in cultural competency.

Behavioral Health Screening and Assessment for Varying Cognitive Capacities

"Cognitive (or mental) capacity" refers to the ability to learn, recall, and use information. It is related to but not exactly the same as "intelligence." Highly intelligent persons may — due to injuries, illnesses, genetic problems, lack of education, or exposure to stress — have temporary or lasting limitations in memory or in ability to use information. Limitations in cognitive capacity may include or be due to problems in learning (for example dyslexia or poor short-term memory); limited intellectual capacity (such as low IQ due to mental retardation); social skills (such as not knowing how to listen carefully when another person is speaking); or educational or work skills (such as not having learned how to do arithmetic or to memorize the steps required by a new activity).

These problems may be worsened by stressors in juvenile justice settings (for example: crowded detention centers; separation from family, peers and environment; forced contact with intimidating or potentially dangerous peers; and harsh disciplinary practices).

Limited cognitive capacity, whether permanent or temporary, can prevent a child from understanding and participating in screening and assessment activities unless those activities are designed to reduce stress and prevent confusion. Identifying such limitations in cognitive capacity also is a key goal in screening and assessment, so that counseling or rehabilitation services can be designed to help the child with these limitations. For instance, consider a child who has a chronic problem with cognitive capacity (for example, difficulty staying focused due to ADHD) or an temporary problem (for example, trouble thinking due to anxiety about being in detention) who is being screened when entering a detention center. The assessor could adjust the length of the test to help the child stay focused. Additionally, specialized testing methods and service planning (such as counseling, mentoring, and medication evaluations) can be designed to help the child develop improved mental capacity.

As a child goes through the steps involved in the legal system, different kinds of screenings or assessments may be done for different reasons.

Behavioral Health Screening and Assessment in a Legal Context

Practical issues related to the workings of the juvenile justice system must also be taken into account. These include:

- the often limited time available for behavioral health screening or assessment;
- limits on the system's ability to afford the personnel qualified to perform screening and assessment procedures and prepare summary reports;
- the need for behavioral health screeners or assessors to have either specialized training and knowledge or supervision by professionals with the relevant training and knowledge;
- the legal and constitutional impediments that arise when interpreting or introducing the results from screening and assessments.

As a child goes through the steps involved in the legal system, different kinds of screenings or assessments may be done for different reasons. Soler (2002) notes that children's assessment needs may change at various stages of juvenile justice involvement. At the initial arrest phase, for example, assessment may be required to determine whether children understand certain rights and whether they can competently agree to waive these rights.

In court, the judge may require knowing whether a child is legally competent to stand trial — that is whether the child both knows what crimes they are accused of and understands what happens in a courtroom. In detention, assessment occurs immediately to determine whether a child is safe or might potentially be a danger to themselves or others. Assessments also may assist judges by determining the treatment needs to consider when constructing a disposition. Each phase of legal proceedings requires different information.

For reasons of convenience and cost, screenings often are administered by staff members who are not trained behavioral health professionals. The results of such screenings are helpful only when they are properly scored and interpreted by qualified behavioral health professionals or by staff who have training and consultation from such experts. For example, in Connecticut, screening instruments for identifying traumatic stress and also social and school functioning are being administered by officers in Connecticut's Court Support Services Division (CSSD) probation and detention center programs.

Constitutional protections for children in the juvenile justice system can affect when and how assessments are conducted and how the results are used.

These personnel are trained by behavioral health professionals on test administration and score evaluation and then have ongoing consultation with licensed clinical professionals to ensure that results are used appropriately in matching children with programs.

Constitutional protections for children in the juvenile justice system can affect when and how assessments are conducted and how the results are used. Information obtained may be used in highly sensitive ways that are different from methods of handling the clinical information of children who are treated in community behavioral health settings (Grisso & Underwood, 2003). In Connecticut, the right to avoid self-incrimination overrides many children's access to necessary behavioral health assessments. The Connecticut Practice Book (a manual containing the Code of Judicial Conduct and Rules of the Superior Court) says that, with two exceptions, any child who denies the charges against him/herself cannot be examined by a physician, psychiatrist, psychologist, or social worker. The first exception is if the child's parent or guardian and attorney agree to a screening or assessment. The second is that, when a child first is placed in detention state Statute 46b-121 allows the Judicial Branch to "develop and use intake and assessment procedures for the evaluation of juveniles."

Some children, parents, or attorneys may be concerned that admitting to behavioral health problems will lead to harsher sentences due to stigmatization or teasing and victimization by peers encountered in justice programs. Other children may simply be unaware of or used to minimizing the interference caused by behavioral health difficulties as a way of coping with stressful or dangerous life circumstances. If children are given the opportunity to disclose potential problems in a matter-of-fact manner that is responsive and followed by confidential professional help, problems can be identified and addressed.

Assessors must be experienced in forensic issues and the courts should balance children's confidentiality and protection from self-incrimination with the need to address pressing behavioral health concerns.

Case Study 3: Relationship Between Traumatic Experiences and Criminal Behaviors in Adolescents

TJ, a 16-year-old African-American boy, was arrested for the third time in six months, most recently for stealing a car from a municipal lot. After that arrest, a detention counselor had TJ complete a brief behavioral health screening questionnaire. TJ answered that he was not bothered by most of the symptoms, but he indicated that he had experienced several types of traumatic experiences, including gang and family violence, and that he had bad memories of some of those experiences.

Given this potential trauma history and the potential traumatic stress symptoms, as well as the number of arrests in such a short period of time, the judge ordered that a behavioral health assessment be completed before recommendations were made in TJ's case. For this assessment, a structured interview was conducted by a behavioral health professional trained to do this type of assessment with adolescents. In addition, questionnaires were administered which more thoroughly assessed alcohol and drug use, and subtle problems with anger, anxiety, and depression. Parent versions of several measures were also included in the assessment.

Though TJ continued to minimize the obvious types of emotional distress, he and his parents noted that he had been troubled by worries, irritability, poor sleep and appetite and risk-taking behavior since several traumatic experiences in the past year. TJ had witnessed the death of his closest friend in a car accident in which both children were involved. Though TJ suffered only minor injuries, his friend had died at the scene. TJ's mother reported that ever since the accident her son was "just not the same." The comprehensive assessment, which included a third party report of TJ's symptoms, was crucial in figuring out how to best help him. In addition to the penalties required for the crimes, he was required to join a bereavement group for adolescents, and he and his parents began family therapy to help them deal together with the anger, anxiety, and sleep problems related to trauma.

Use of standardized assessment instruments leads to more effective decision-making in the juvenile justice setting.

Uses of "Standardized" Behavioral Health Assessment: Benefits and Limitations

Use of standardized assessment instruments leads to more effective decision-making in the juvenile justice setting (Hoge, 1999). "Standardized tests" are instruments that ask the same set of questions in the same way to everyone who is assessed. Standardized tests also are "normed." That is, the tests have been administered to clearly defined groups of subjects (the "normative group") and each person's score is calculated both as a number (a "raw" score based on answers to the test) and a ranking within the normative group (that is, how high or low the individual's score is, compared to scores of others taking the test).

For example, the normative groups for a standardized questionnaire measuring problems with anger in children might include: (a) typical children ages 6 to 12 years old in inner city schools in several cities; and (b) children of the same age who have been arrested for a crime. When the anger test is scored for a child who is being newly assessed, that score is compared to the scores for the children in each normative group. The result is a "standard score" that tells how much this child's score is above or below the average score for each normative group (Sattler, 1992). A high standard score compared to the first normative group means that the child has more problems with anger than the typical same-age child. A high standard score compared to the second norm group means that the child has more problems with anger than the typical same-age child in a juvenile justice normative group.

Standardized screening and assessment instruments may take several forms, most often either:

- questionnaires (written questions read and answered independently by the child or caregiver, or, if necessary, read out loud by an assessor and answered orally);

or

- structured interviews (pre-set questions asked to the child or caregiver[s] by a trained interviewer). Both are conducted in a consistent manner with every interviewee and scored based on pre-set answer categories.

Non-standardized screenings or assessments involve questions or observations that are not formally tested in advance, that may be asked in an open-ended way with wording and order varying from interview to interview, and that are not scored based on pre-determined categories.

Non-standardized assessments may involve different ways of asking questions, and they either do not result in scaled scores or their scores are not based on any norm group. For example, a non-standardized interview for depression might ask different questions of different children in order to uncover each child's symptoms. While non-standardized assessments may offer certain benefits (for example the ability to test an individual for whom standardized scores would be inapplicable; flexibility to ask different questions in different ways to different persons being tested), they do not allow the clinician to gain an understanding of how an individual compares with peers or with other norm groups.

For example, a child's performance in school could be used as a non-standardized way to assess intelligence. However, if his performance has been poor, this approach could misclassify the child as below average if the assessment does not take into account other reasons that grades may be poor (such as depression, hyperactivity, or test anxiety). IQ can be measured using a standardized test (such as the WISC-III), thus providing information on how a child processes verbal and nonverbal information as compared to other children of the same age and gender from several normative groups (such as schoolchildren in general, or children with specific health or behavioral health or legal problems). The results of non-standardized tests also tend not to be as accurate as those of standardized tests in assessing a child's progress over time, because what appears to be a positive or negative change may be the result of changes in the questions or the manner of asking questions in subsequent testing.

Using only non-standardized techniques creates a greater risk for unfairness in how treatment decisions are made. Since standardized testing includes the requirement that each person receive the same careful administration, scoring, and interpretation of each assessment test or interview, the chance of unfairness in decision-making is reduced. For example, if two children from different backgrounds receive a standardized screening instrument (for example, the MAYSI-2 [Massachusetts Youth Screening Inventory]), the questions will be the same, the method of scoring the same, and the results can be translated into comparable decisions about services for each child. While conducting an assessment in a standardized manner cannot entirely prevent bias or even discrimination from entering into how the findings are translated, standardized assessment methods can help personnel monitor the process and detect inequities directly and objectively.

On the other hand, standardization can lead to an "assembly line" or "cookie cutter" approach to screening and assessment that can result in overlooking potentially vital information.

Age, gender, ethnocultural background, nationality and language, family economic status, and geographic residence are the factors considered most important in creating norms....

Some flexibility and inclusion of standardized and non-standardized information gathering methods make behavioral health services better individualized for every child. The screening or assessment procedure may be similar for each child, but the specific tests, discussions with key people such as teachers or family members, and service recommendations are adapted to best suit the needs of each child and family.

When any test results are used, care must be taken to do so fairly and without discrimination based on age, gender, or ethnocultural background. For example, both adults and children of color (such as African American or Latino/Hispanic youths) receive behavioral health services less often than white persons, even for similar problems (Bloche, 2004). The risk of inequity based upon ethnocultural differences is especially important to monitor in light of national and local statistics indicating continuing disproportionate minority confinement. To yield the relevant information, assessment measures must be in a language and at a comprehension level appropriate for both the child and any other participants in the assessment.

Standardized measures produce scores that are meaningful only in comparison. Therefore, such measures cannot validly be used unless the "norms" — the formulas for comparison — have been created with children or adults who truly are similar.

For example, if an instrument's normative scores are based on the scores of only Caucasian adolescent males, it would be inappropriate to draw conclusions based on testing scores of an African-American girl. As we have discussed — so that scores can be fairly compared — many standardized behavioral health assessments include norms that are reported separately for boys and girls, for children of different ages, and for children of different economic and ethnocultural backgrounds. Age, gender, ethnocultural background, nationality and language, family economic status, and geographic residence are the factors considered most important in creating norms that fairly account for differences. While creating norms to account for every difference is not feasible, the best and fairest procedures attempt to account for as many of these differences as possible.

Careful standardization with options for thoughtful individualization is especially important in cases in which direct decision-making is used in immediate treatment planning for delinquent children (Hoge, 1999). Reviews of the way juvenile justice systems frequently use assessment tools suggest that there is often "considerable discretion" allotted to decision-makers when non-standardized assessment instruments are used (Hoge, 1999). Use of standardized assessment tools in the juvenile justice system can lead to "more valid inferences about the client and, ultimately, more appropriate and equitable decisions" (Hoge, 1999).

The less visible "internalizing" psychiatric problems (for example, depression, anxiety) should be identified, as well as more obvious "externalizing" problems....

Case Study 4: Status Offenses Can Lead to More Restrictive Juvenile Justice System Involvement

Tanya, a fifteen-year-old African-American girl, was held in detention after being picked up by police in an abandoned building with a knife and a small bag of marijuana in her possession. Tanya reported that she had run away from her mother's home after a violent argument had erupted between her mother and her mother's boyfriend. Tanya reported that physical violence between her mother and this man was frequent.

Tanya had been placed in foster care several times over the past few years when Department of Children and Families removed her from her mother's custody. Fearing she would be removed from her home once again, Tanya had decided to run away. This was Tanya's first encounter with the juvenile justice system. She was charged with illegal possession of a weapon and illegal drug possession. The probation officer who met with Tanya was concerned about the history of violence in the home and whether Tanya had been a victim of abuse. In talking to Tanya, the probation officer realized that she was somewhat delayed in her cognitive abilities. He wanted to have thorough screening to determine what further testing would be needed to make an appropriate treatment plan.

The detention staff overseeing Tanya as she completed the computer administered MAYSI-2 found that she had great difficulty reading the items required. Tanya's resulting scores on the MAYSI-2 reflected problems with substance use, anger, and traumatic experiences. The staff referred Tanya for an assessment that included: standardized tests of intelligence and academic achievement; interests and abilities; structured interviews and questionnaires; screening for substance use, traumatic stress symptoms, depression, anxiety, and eating problems; and a home observation. The data from the assessment revealed that Tanya was struggling with depression and using drugs (particularly marijuana) as an "escape" from her family situation. In addition, the scores were elevated on several scales including the one that assesses for post traumatic stress disorder (PTSD). Tanya disclosed to the clinician that her mother's boyfriend had physically abused her over the past few years. Tanya had never discussed her situation with anyone for fear that her mother would be harmed if Tanya disclosed the boyfriend's behavior.

The cognitive testing revealed that Tanya was in the high average range of overall intelligence but the achievement testing showed that her academic skills were two to three grades below grade level. The clinician concluded that Tanya's behavioral problems were not due to low intelligence but instead were the result of a combination of an undiagnosed learning disability along with the chaos and violence in the home. The clinician recommended that Tanya be placed in a group home to protect her from further violence. In the meantime, an Individualized Education Plan (IEP) meeting was scheduled for her at school to develop a plan for helpful educational programs. In addition, family-based therapy was recommended to help Tanya and her mother with the traumatic experiences they each had endured and to work towards building a new life for them without the boyfriend.

"Best practices" is the term used for the most effective behavioral health practices, supported both by empirical research and treatment outcomes.

Best Practices in Behavioral Health Screening and Assessment

Wasserman and colleagues (2002) make a strong argument for reform in the way that behavioral health screening and assessment are done in the juvenile justice system. They propose creating best practices in behavioral health screening and assessment.

"Best practices" is the term used for the most effective behavioral health practices, supported both by empirical research and treatment outcomes. "Best practices" for behavioral health screening and assessment in the juvenile justice system means following the guidelines that we have discussed, based upon scientific research about how behavioral health screening and assessment should be done. Briefly, recommended best practices are:

- **Reliable and valid** standardized screening and assessment instruments should be used in a manner that is individualized for every child and family.
- Screening and assessment measures and procedures should be sensitive to **individual** differences such as age, gender, ethnocultural background and cognitive ability.
- Assessors should be well **trained and experienced** in children's behavioral health and in forensic issues.
- When deciding whether behavioral health screening or assessment should be done, courts should consider both children's rights to confidentiality and protection from self-incrimination and the **potential value** to the child's well-being and rehabilitation of providing services that address pressing behavioral health concerns.
- Behavioral health screening and assessment should focus on **recent** rather than past symptoms, and periodic re-assessments should occur for children who continue to be involved in the juvenile justice system.
- Screening and assessment should identify two key groups: (1) **psychologically impaired** children who need immediate treatment; and (2) **high-risk** children who should be provided with education, skills, and supervision in order to prevent future serious problems, functional impairments, and costly treatments.
- The less visible **"internalizing"** behavioral health problems (for example, depression and anxiety) should be identified, as well as the more obvious "externalizing" problems (for example, drug and alcohol disorders, aggression, and impulsivity).
- Screening and assessment should be **strength-based**, focused on adaptive abilities and resources as well as on symptoms and adjustment or behavior problems.
- Screening and assessment should use input from multiple sources that include **parents and other caregivers**, both to get the caregivers involved in a positive way and because children often under report behavioral health problems.

Reliable and Valid Screening and Assessment Instruments

The **reliability** of a standardized screening or assessment instrument is a measure of the consistency of the scores obtained. Ideally, consistency means that the same answers and scores should be obtained no matter who the assessor is and no matter when the child or parent(s) are asked the questions. There are three ways of checking on the reliability of a behavioral health screening or assessment instrument.

- An interview is reliable if the results are consistent when the same questions are asked independently to the person(s) by two different interviewers ("interviewer agreement") or the answers are scored independently by two assessors reviewing the results of the interview ("inter-rater agreement").
- An interview or questionnaire is reliable if the results are consistent if it is used two separate times with the same child or parent(s) ("test-retest reliability").
- An interview or questionnaire is reliable if a child or parent's answers to similar questions are consistent even though the questions are not exactly identical ("internal consistency reliability").

Validity is defined as the extent to which a test measures what it is designed to measure and therefore the appropriateness of interpretations based on the instrument (Sattler, 1992). A structured interview or questionnaire designed to measure depression, for example, is valid if it accurately tells if a child is or is not experiencing depression. Like reliability, validity can take several forms, because there is more than one way to check on the accuracy of a screening or assessment instrument (Sattler, 1992).

Because of the impracticality of testing the reliability and validity of a screening or assessment instrument every time it is used, studies are done to test reliability and validity. If the assessor uses the instrument in the manner in which it was tested in the research study, the results are likely to be reliable (consistent) and valid (accurate) for each newly screened or assessed person. This means that research on screening and assessment instruments must be done with children whose personal characteristics — such as age, gender, ethnocultural background, language, community environment, and type of juvenile justice problems — are similar to those of the children with whom a future assessor uses the instrument. For example, a questionnaire researched only with white male teenagers could not be assumed to be reliable or valid with younger

Consistency means that the same answers and scores should be obtained no matter who the assessor is and no matter when the child or parent(s) are asked the questions.

children, girls, or children of other ethnocultural backgrounds. An instrument that has not been researched with children in juvenile justice settings may offer some useful information, but it cannot be assumed to provide consistent or accurate information until it is tested in those settings.

Dozens of behavioral health screening and assessment instruments have been developed and researched, but relatively few have been researched and shown to be reliable and valid with children in juvenile justice settings. Research is ongoing (Grisso, 2001), but at present the list of instruments with evidence of reliability and validity in this population is short (see the Appendix for example profiles of the MAYSI-2, the CBCL, and the DISC structured interview). A thorough and comparative menu of screening and assessment instruments used in juvenile justice settings can be found in a new resource guide prepared for the National Center for Mental Health and Juvenile Justice (Grisso and Underwood, 2004). Fortunately, the researched instruments cover the reliable and validated instruments for identifying children in the juvenile justice system with behavioral health needs.

The Importance of Focusing on Recent Behavioral Health Issues

Although problems can persist for months or years, sometimes getting worse and other times better, the key issue for behavioral health screening and assessment in juvenile justice settings is the child's current behavioral health situation. While learning about the child's past experiences is definitely helpful, an understanding of current circumstances will assist in planning interventions that address present behavioral and legal problems, integrating screening and assessment results into treatment.

Because some problems and disorders are lasting or change frequently over time, some children (such as those confined over extended periods) should be re-assessed periodically (see Appendix B on page 76).

Because some problems and disorders are lasting or change frequently over time, some children (such as those confined over extended periods) should be re-assessed periodically.

Triage: Identifying Children with Immediate Treatment Needs

The prevalence of behavioral health problems in juvenile justice populations does not mean that every child needs immediate treatment. The critical factor in determining need is the extent to which the problems are impairing the child's ability to function. Some symptoms are more disruptive or dangerous than others, to the child, to others, or to important activities. For example, psychotic hallucinations or post-traumatic flashbacks may lead to extreme problems with communication, learning, and adhering to basic social or institutional rules and routines. On the other hand, mild or moderate levels of frustration, worry, or sadness are not unusual for children, and even more so for adolescents, and therefore warrant attention (in case they become worse) but not immediate professional assessment or treatment.

Some symptoms may not cause immediate functional impairment but still place the child at high risk for future impairment or danger. For example, a child may entertain suicidal thoughts without having any intention to act on those thoughts. In this situation, while there may be no imminent risk, thoughts of suicide or self-harm still require intervention to prevent future impulsive or unintended acts of harm.

Similarly, aggressiveness, argumentativeness, anger, impulsive behavior (acting without sufficient planning and consideration of the consequences), risky sexual behavior, and substance use are examples of "externalizing" problems that may be a source of harm to the child or others or cause serious disruption to relationships, school, work, and other activities. However, these problems do not necessarily require immediate behavioral health services unless they mean that the child cannot get along with peers, family, or others. Feeling worried, discouraged, sad, nervous, guilty, or pessimistic are examples of "internalizing" reactions that are typical for children dealing with legal problems. Behavioral health screening and assessment can play an important role by distinguishing between instances where a child is feeling mildly distressed and needs support and structure, and where the child is severely distressed or unable to cope adequately.

Identifying "Invisible" Internalizing Problems

Emotional problems such as severe anxiety or depression are often overlooked because they are less overtly a problem for parents, teachers, or juvenile justice personnel than the more "in your face" externalizing problems such as aggressive, impulsive, or law-breaking behavior.

...four out of five children ages 10-17 years in juvenile justice systems were under the influence of alcohol or drugs while committing crimes....

Studies with children in (or at risk for involvement in) the juvenile justice system suggest that serious problems with anxiety and depression can be early warning signals preceding delinquency and behavior problems, especially when compounded by experiences of violence, abuse, or neglect (Ford, 2002). In addition, many children of both genders in the juvenile justice system are not violent or aggressive, but are instead withdrawn and socially isolated. They may end up in legal trouble because they isolate or use substances to cope with undiagnosed depression, anxiety, or other emotional distress.

Substance Abuse

An analysis by the National Center on Addiction and Substance Abuse at Columbia University estimates that 78.4% of the 2.4 million juvenile arrests in 2000 were substance involved (that is under the influence of alcohol or drugs while committing their crimes). Of the 1.9 million arrests of children with substance abuse and addiction problems, only about 3.6% receive formal screening, assessment and referral to substance abuse treatment. Juvenile substance abuse is implicated in 69.3% of violent offenses, 72% of property crimes and 81.2 of all other crimes (NCASA, 2004). Internalizing problems often occur before and lead to substance abuse, and substance abuse can lead to legal problems (Clark, et. al., 1996; Compton et. al., 2002; Rao et. al., 1999), so it is imperative to identify children suffering from internalizing problems as early as possible.

Specialized screening and assessment for substance use disorders should be incorporated into a comprehensive approach identifying behavioral health problems.

Strength-Based Assessment

When children (those in the justice system, in particular) are referred for specialized assessments, the focus is on finding a problem.

While there is an understandable tendency to want to find out "what's wrong," the solution(s) needed to rehabilitate children who have broken the law are not likely to be found by focusing only on what's wrong. Rather, there is a need to identify personal strengths and social resources that can be used to achieve social, academic and vocational success without further legal infractions.

Strength-based assessment is defined as "the measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one's ability to deal with adversity and stress; and promote one's personal, social, and academic development" (Epstein & Sharma, 1998, p. 3).

Strength-based assessment is based on the notion that every child has strengths, plus the following core beliefs:

- The child's motivation is increased when supportive adults point out the child's strengths.
- The child's failure in a certain area should not be viewed as a deficit but rather a lack of experience or an attempt to cope with stress in that area.
- Goals and services for children should be based on the child's strengths and the resources of his/her family (Epstein, Rudolph & Epstein, 2000).

Few screening and assessment instruments exist to identify children's strengths, but one of the best validated measures of this type — the BERS (Behavioral and Emotional Rating Scale) — has been both researched and widely used with children in juvenile justice systems (see profile of the BERS in the Appendix). In Connecticut, 918 children entering detention were rated on another widely used instrument, the Structured Assessment of Violence Risk in Youth (Borum, 2003) and found to have the following strengths suggestive of positive rehabilitation: 30% showed pro-social interests; 48% reported strong social support; 63% reported strong attachments or bonds to a pro-social adult; 28% had a positive attitude towards treatment staff or authority figures; 28% reported having academic interests; and 54% had resilient personality traits.

Parents/Caregivers: Key Participants in Screening and Assessment

The involvement of parents or caregivers is key to the success of an assessment. During the screening and assessment phases, a child needs to know that caregivers will be discussing concerns with the interviewer. Often, when a child might not know or is unwilling to disclose relevant information, the caregiver can assist in providing essential background and insight — for instance, into early childhood experiences, developmental and medical concerns or trauma. While adolescents know many things about themselves that no one else knows, they may not be objective about their own emotional distresses, behavioral difficulties or family and legal circumstances. Aside from the practical need for caregivers' involvement, the adolescent should also understand that the needs to ensure safety and to address behavioral health problems warrant input from close family members.

In addition, because information from different sources may vary, multiple informants are critical to a comprehensive understanding of a child (Ferdinand, van der Ende & Verhulst, 2004). Achenbach, McConaughy, and Howell (1987) found that different persons (such as children, parents and teachers) more often disagreed than agreed when rating children's psychological problems and needs. Input from several sources helps to provide a comprehensive understanding of behavioral health problems and needs.


The findings that high family stress and high family conflict seem to be associated with poorer parent-child agreement (Grills & Ollendick, 2003; Kolko & Kazdin, 1993) are particularly relevant in light of the complex and frequently conflicted family situations often seen in the juvenile justice setting.

The importance of parental involvement at each step of the screening and assessment process cannot be overstated.

Model of Evidence-Based Behavioral Health Assessment

In addition to selecting best practices, it is important to train professionals, coordinate activities and include quality assurance mechanisms within a comprehensive and integrated assessment system. Connecticut has studied a state system (Cook County, Illinois) to learn from their successes and to incorporate innovative changes within the Connecticut system.

The Cook County Clinical Evaluation and Services Initiative (CESI)

In order to both meet the behavioral health needs of children involved in (or at risk for involvement in) the juvenile justice system and to protect the needs of the community by ensuring its safety, the Juvenile Justice Department of Cook County, Illinois, designed a practical and comprehensive approach to behavioral health assessments (Scally, Kavanaugh, Budd, Baerger, Kahn, & Biehl, 2001/2). The program, called the "Clinical Evaluation and Services Initiative" (CESI), was created in 1995 at the request of the chief judge of the Circuit Court of Cook County and included professionals from a wide range of both public and private sector disciplines (i.e. law, psychology, psychiatry, social work and economics).

In June 2003, the experimental CESI model became permanent when the Cook County Juvenile Court Clinic (CCJCC) was established by the Office of the Chief Judge of the Circuit Court of Cook County. The CCJCC, the court-wide embodiment of CESI's research, design, and modifications resulting from the lessons learned during the pilot, now serves the entire Cook County Juvenile Court.

The CESI was created because of a shared concern by legal and behavioral health professionals and families that behavioral health assessments were not serving the needs of troubled and vulnerable children in the juvenile justice system. Although assessment often was lengthy and costly, the resulting recommendations were not consistently helpful to the children or the courts. Standardized approaches to assessment rarely were used, so conclusions about a child's problems and needs were not clearly reliable or valid. Assessments were done by behavioral health professionals who generally were not trained in addressing legal (also called "forensic") issues, so questions of importance to judges or probation/detention staff or attorneys often were not addressed. For example, how a child's behavioral health problems might contribute to problems in detention, or how helping the child with behavioral health problems could reduce the risk of recidivism (the chance that the juvenile will have another offense) were not dealt with in a surprising number of assessments. At other times, behavioral health assessors overstepped their bounds and made recommendations about the child's legal disposition — the responsibility of judges and other juvenile justice staff and professionals and not an appropriate role for behavioral health professionals.

The CESI identified three areas in which change was needed:

- methods of obtaining behavioral health information needed to be more logical and efficient;
- the information and recommendations in behavioral health reports and treatment plans needed to be of higher quality and greater relevance to the questions asked by courts, probation officers, detention staff, or attorneys; and
- the behavioral health assessment process needed to be practical, given the limitations on funding and the regulations that are facts of life in the juvenile justice system (Scally, et. al., 2001/2).

Following is a summary describing how the CESI attempted to build on the strengths of the existing system in order to address these serious problems. The CESI model might require alterations in order to work in locations such as Connecticut, where the juvenile justice system is spread out over a larger geographic area than the single centralized court system in a city such as Chicago (Cook County); however, the process of change developed by the CESI can be adapted to enhance the approach to behavioral health assessment.

The CESI team created "clinical coordinator" positions located in the courts, probation offices, and detention centers rather than in separate behavioral health settings. Clinical coordinators are behavioral health professionals with forensic expertise, familiar with the real-world legal, political, and economic issues facing children, attorneys, judges, probation officers and detention staff. Clinical coordinators also help with the development of individualized plans for behavioral health assessment and treatment plans and provide regular reports to judges regarding the behavioral

Judges or staff who do not have behavioral health expertise were no longer forced to make recommendations about behavioral health issues "by the seat of their pants,"....

health issues and the progress in obtaining appropriate treatment for children whose cases are in court.

When the Court requests clinical information, the clinical coordinator documents this request with a standardized form called a request for clinical information (RCI). The coordinator files the RCI and provides a copy to all necessary parties. The RCI contains information about the date clinical information is needed by the court, demographic information about the juvenile and his/her family, the legal decision pending in the case, and clinical questions for which the court needs answers prior to making recommendations. The RCI and subsequent evaluation is a fluid and efficient system. The average time between court order and initial intake in the Cook County Juvenile Court Clinic (CCJCC) is 1 day. The majority of evaluations are initiated within the same day as the RCI.

Completed evaluations are returned to the court between 27 and 41 calendar days after the referral has been made. The CESI clarifies roles and increases the efficiency of the assessment process. Judges or staff with no behavioral health expertise do not have to make recommendations about behavioral health issues "by the seat of their pants," but instead are able to rely on the expertise of the clinical coordinators. Rather than being the "default" recommendation for all children with possible behavioral health needs, extensive behavioral health assessments are recommended only when necessary and for specific rather than general questions.

If assessments are unhelpful, inaccurate, or incomplete, the clinical coordinator can work with the assessor to improve methods and to revise their reports.

The CESI also proposed that every behavioral health assessor or treatment provider would have to earn a credential (a certificate confirming that they have expertise) in "forensics" (professional work with people in the criminal justice system) in order to:

- be selected to receive referrals from courts, attorneys, or juvenile justice probation or detention staff, and
- to provide assessments and reports of sufficient quality to warrant continuing to receive future referrals.

Cook County has implemented a comprehensive and practical program that is informing the development of Connecticut improvements.The Cook County system standardizes the approach to screening and assessment, employs best practices that ensure reliable and valid reports, coordinates credentialed professionals who serve the court system and oversees a quality management system in children's behavioral health screening and assessment. The system is monitored to ensure judicial satisfaction while carefully managing clinical information to serve the best interests of children before the courts.

Section 3:

Providing Behavioral Health Assessment within the Connecticut Juvenile Justice System

Organization of Connecticut's Juvenile Justice System

The Connecticut juvenile justice service system is overseen by the Superior Courts and the Court Support Services Division (CSSD) within the judicial branch of state government, and the Department of Children and Families (DCF) agency within the executive branch of state government. Together, they provide a juvenile justice system whose purpose, as described in Connecticut Statute (46b-121h) reads: It is the intent of the General Assembly that the juvenile justice system provides individualized supervision, care, accountability and treatment in a manner consistent with public safety to those juveniles who violate the law. The juvenile justice system shall also promote prevention efforts through the support of programs and services designed to meet the needs of juveniles charged with the commission of a delinquent act (General Statutes of Connecticut, http://www.cga.ct.gov/2003/pub/Chap815t.htm#Sec46b-121h.htm).

CSSD CJTS DCF

note to advocates and policy-makers

In Connecticut, a "child" is any person under 16 and a "youth" is any person 16 or 17. The system serves children referred for serious crimes or delinquent acts committed prior to their 16th birthdays as well as those referred for less serious crimes or "status offenses" prior to their 18th birthdays. "Delinquent crimes" include those acts committed by a child, such as robbery, burglary, or assault, which would result in an arrest in the adult system. "Status offenses" are less serious acts of rebellion and defiance, such as truancy or running away from home. The judicial branch is charged with upholding the laws through a state court system. The Superior Court for Juvenile Matters is where judges hear legal matters involving children. Connecticut has 13 juvenile courts that serve the state's 169 towns. The Court Support Services Division (CSSD) operates secure detention facilities, probation services, and community programs. The services provided by CSSD programs include monitoring (keeping track of children, the legal charges against them, and the services they receive) and rehabilitation activities for children who either have charges pending before a juvenile court or have been determined by a court to have violated the law by "committing delinquent acts." The goal of CSSD programs and services is to reduce the likelihood that children who have broken the law will continue to do so and to increase the likelihood that they will be safe and successful in their homes, schools and communities. DCF and CSSD jointly administer a program to assist children when status offenses are committed and families need help. Families with Service Needs (FWSN petitions for children up to their 16th birthdays) and Youth in Crisis (YIC petitions for youth ages 16 and 17) are referrals to the court requested by parents, guardians or school personnel. They occur when a child commits "status offenses" such as being truant, incorrigible, runaway or defiant of school rules. Petitions for FWSN and YIC status may allow children and their families access to a range of therapeutic counseling services, probation supervision, and judicial review.

DCF also operates a Bureau of Juvenile Services that includes parole professionals who monitor children who are adjudicated (found guilty) of delinquent acts. These children are removed from the community by a judge and committed to the Department of Children and Families for out-of-home placements. The Bureau operates the Connecticut Juvenile Training School (CJTS), a maximum security facility for boys alleged to have engaged in the most dangerous or persistent delinquent acts. CJTS houses fewer than 50 children in a facility designed for 240. The Governor is calling for its closing and placement of these children in alternative facilities or smaller and less prison-like facilities closer to their homes. Most children committed to DCF supervision are either placed in CJTS or other residential treatment centers for supervision, specialized treatment and rehabilitative services.

The goal of CSSD is to reduce the likelihood that children who have broken the law will continue to do so and to increase the likelihood that they will be safe and successful.

Local police departments, review boards, local diversion programs, family service agencies and schools also are community partners of the juvenile justice system. The police are often first responders who bring children into the system when their behavior presents a danger to others or requires external control. Juvenile review boards and local diversion programs are run by towns and municipalities to deal with less serious delinquency cases by helping children and families to receive services that can prevent further problems. Family service agencies help families in need of assistance with parenting, child care, money, housing or other concerns. These agencies often work with families whose children have behavioral problems that may lead to delinquency. Schools often are confronted with problem behaviors — such as aggression or truancy — and have developed programs and services either to prevent these problems from becoming delinquency or to get help from the juvenile justice system. While some of these programs and professionals may screen to identify children with serious behavioral health symptoms, most do not use standardized screening or assessment procedures for this purpose.

Two other state agencies partner with the juvenile justice system. Although the Department of Corrections (DOC) handles mainly adults charged with crimes, 14 and 15 year old children charged with serious and violent crimes may be sent to the adult court system and confined to adult jails or prisons. Children age 14 or 15 charged with Class A or B felonies (such as murder or drug sales) are automatically transferred to the adult criminal court. Additionally, children age 14 or 15 charged with a Class C or D felony (such as consuming alcohol or destroying property) or with an unclassified felony may be transferred to the adult criminal court upon a motion by the juvenile prosecutor and order of a Juvenile Matters Judge (discretionary transfers). Children charged with a Class B felony and the "discretionary transfers" can be returned to the Superior Court for Juvenile Matters upon order of a judge in the adult court. Children who are confined in a detention center and subsequently transferred to adult court may be placed in the custody of the Department of Corrections and held in an adult correctional facility both pretrial and following conviction.

Similarly, although the Department of Mental Health and Addiction Services (DMHAS) treats mainly adults with mental health and substance abuse problems, DMHAS works closely with DCF and CSSD to provide services to children with special needs in juvenile justice custody who are becoming young adults (approaching 18 years old) and who are likely to need continuing services.

Table V.

PROCESSING OF A JUVENILE DELINQUENCY CASE

Courtesy of Fran Carino, Juvenile Prosecutor, Office of the Chief State's Attorney

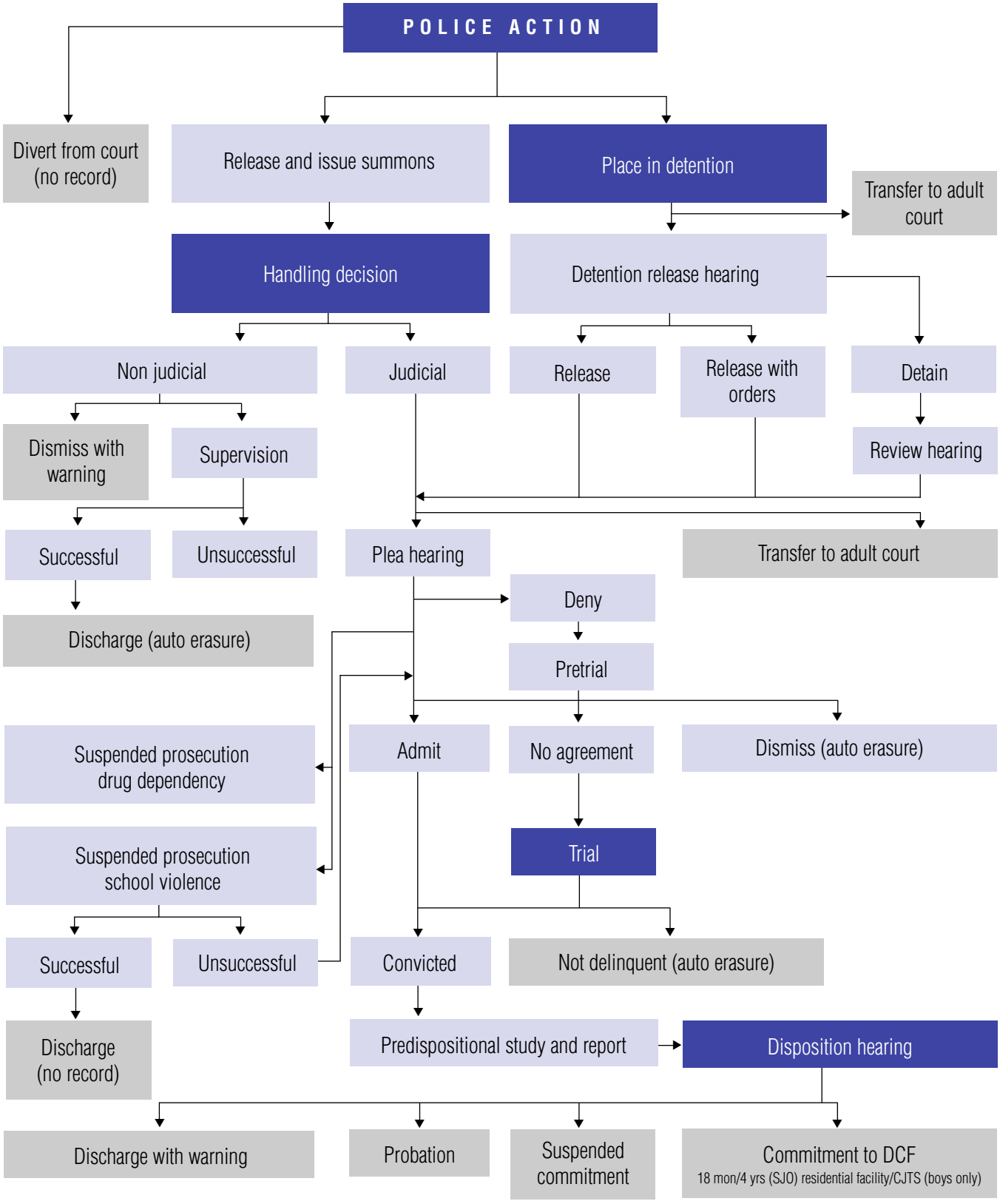
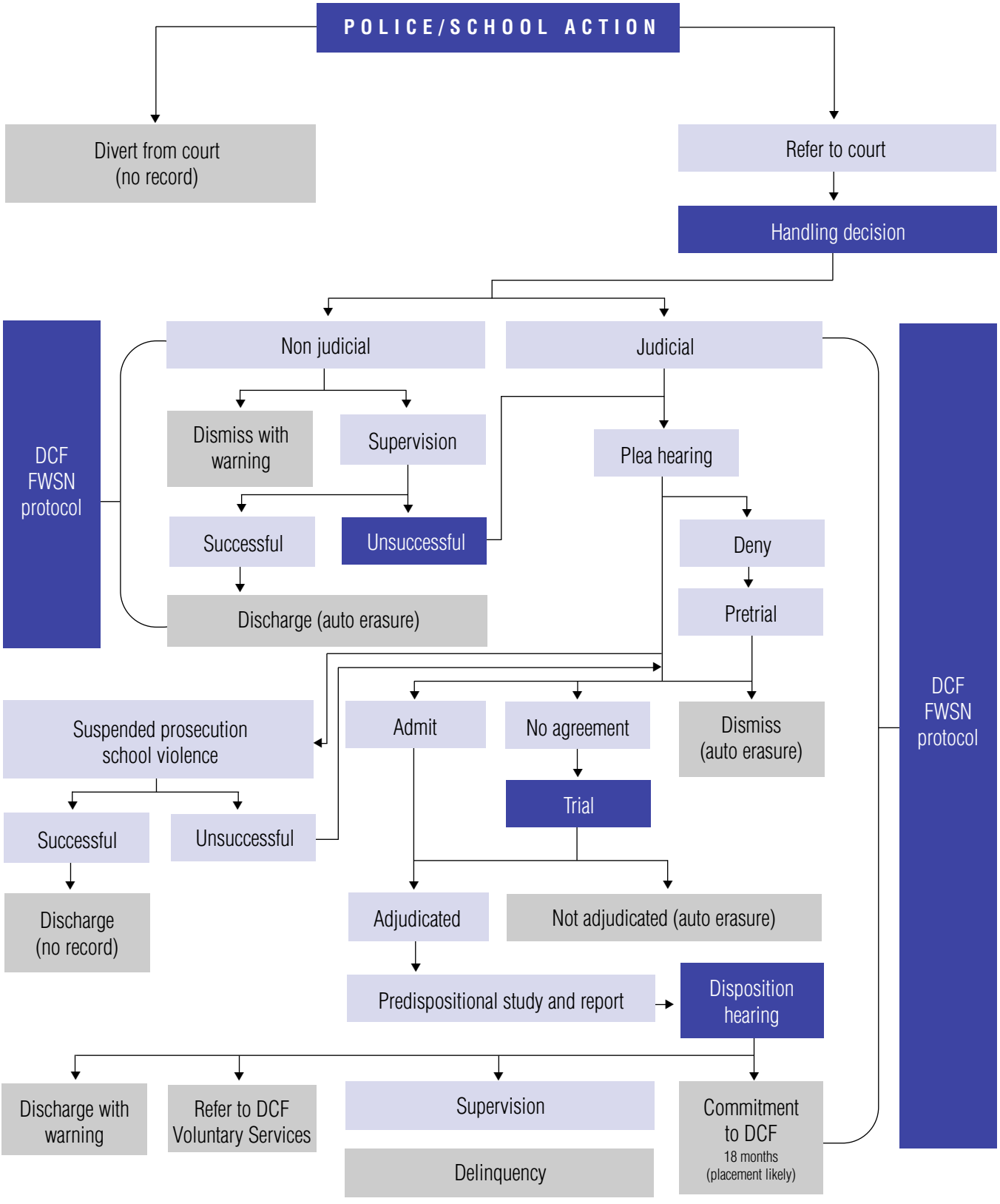


Table VI.

PROCESSING OF A FAMILY WITH SERVICE NEEDS CASE

Courtesy of Fran Carino, Juvenile Prosecutor, Office of the Chief State's Attorney



Connecticut children can enter the juvenile justice system as young as 9 years old, and up to their 16th birthdays.

Contact Points for Behavioral Health Screening and Assessment in Connecticut's Juvenile Justice System

Connecticut children can enter the juvenile justice system as young as 9 years old, and up to their 16th birthdays. An exception may be made for children with serious mental or developmental disabilities, who may remain in the juvenile justice system, if placed in the custody of ("committed to") DCF, until their 21st birthdays. For a better understanding of Connecticut's juvenile justice system, see the tables, glossary and appendices within this report as well as to the *Close to Home* report (available at www.chdi.org) or websites for the Court Support Services Division and the Office of Policy and Management Juvenile Justice Advisory Committee. (http://www.jud.state.ct.us/; http://www.opm.state.ct.us/pdpd1/grants/jjac/AboutJJAC.htm.)

A review of procedures for juvenile courts in other areas of the country shows that behavioral health assessment generally is not conducted during the time between the child's initial arrest and the adjudication (determination of guilt or innocence). As in the adult criminal system, this delay in behavioral health assessment is intended to guard against the child's revealing information that might make a guilty verdict more likely or cause a judge to impose a harsher penalty.

We, however, do not actually know whether, how often, or under what circumstances behavioral health assessment actually does lead to negative legal consequences for children.

There are exceptions permitting the behavioral health screening and assessment of a juvenile defendant before adjudication. Certain state and federal laws enable judges to order that assessment be done to determine if a defendant is mentally competent to stand trial or to give up ("waive") certain legal rights. However, in Connecticut this is true only for adults, not for children. On the other hand, Connecticut laws give juvenile court judges the option of requesting behavioral health screenings or assessments when the judge believes that information about a child's situation is needed to assist legal decision-making.

Later, we describe problems that arise in using important but sensitive information prior to adjudication. Although consideration of behavioral health information is allowed in Connecticut juvenile courts, the procedures used to ensure protection and uniform treatment of children's clinical information is not well defined and therefore this vital information is often excluded from juvenile court hearings.

While withholding from judges information about children's emotional illnesses, behavioral impairments, education or treatment histories may provide legal protection, doing so also prevents decision-makers from understanding children's needs and the potential benefits of behavioral health services.

Police can best help a child with behavioral health problems if they are knowledgeable about child development and have basic information about child behavioral health.

In order to focus on the implementation of behavioral health screening and assessment, it is important to understand how children enter and move through the juvenile court system, the locations where behavioral health problems are identified and some of the system-level barriers to effective screening and assessment. Behavioral health screening or assessment can play a vital role at each legal decision point. We describe below the role of behavioral health screening and assessment in Connecticut at points of:

1. INTAKE AND PROCESSING
2. DETENTION
3. ADJUDICATION
4. DISPOSITION
5. AFTERCARE

INTAKE: Contact with Police and Probation Processing

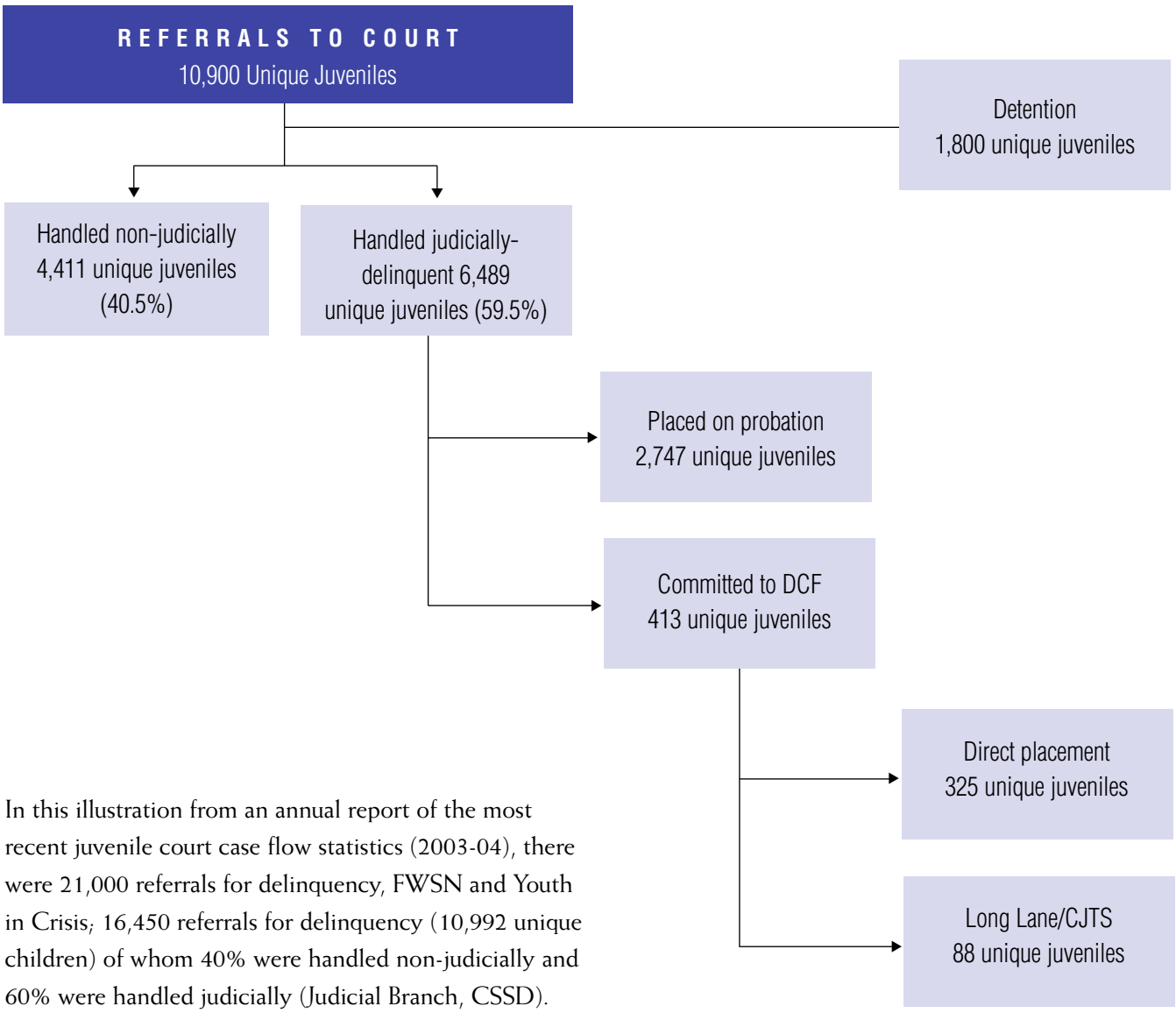
Police are typically the first points of contact for children encountering the juvenile justice system. A child's entry into the juvenile system typically begins with an arrest and a charge by police that the child has broken the law or violated the requirements of probation or a judge's orders. When an arrest is made, the police issue a juvenile summons and prepare an arrest report that describes the incident, lists the charges, specifies a court appearance date, and includes a promise to appear signed by the parents or guardians. For certain offenses, such as cases where public safety concerns exist, police may apprehend and place a child in detention, after making a sworn statement (affidavit). For lesser offenses, police may exercise a number of alternatives to arrest. They may warn a child, or hold a conference with their legal guardians before releasing a child to go home. Police can refer a child to the local youth review board or recommend a diversion program or community-based services.

Children whose behavior ultimately leads to contact with the police may have serious behavioral health problems. Police are authorized to make important decisions for impaired children, such as referral to community behavioral health services; if necessary they may force an emergency assessment in hospital emergency rooms. Police in this situation can best help a child with behavioral health problems if they are knowledgeable about child development and have at their disposal basic information about child behavioral health. For example, the Yale Child Development-Community Policing Program (CD-CP) educates police officers and provides them with hands-on support in assisting children (Marans, 1998).

When an arrest is made, police notify probation supervisors located in one of Connecticut's 13 juvenile courts. Probation supervisors decide whether cases are sufficiently serious to warrant formal court hearings before a judge — "judicial processing" — or whether a case can be handled "informally" by probation staff (for example, giving the child and family a warning and instructions to prevent further delinquent behavior) — "non-judicial processing."

Children whose behavior...leads to contact with the police may have serious behavioral health problems.

Table II. CONNECTICUT JUVENILE MATTERS CASE FLOW
CALENDAR YEAR 2003-04



In this illustration from an annual report of the most recent juvenile court case flow statistics (2003-04), there were 21,000 referrals for delinquency, FWSN and Youth in Crisis; 16,450 referrals for delinquency (10,992 unique children) of whom 40% were handled non-judicially and 60% were handled judicially (Judicial Branch, CSSD).

Presently, probation officers are expected to inform families and guardians about screening and assessment outcomes....

Table III. Connecticut Juvenile Court Referrals

	Delinquency Cases	FWSN Cases	Detention Admissions	Total Cases
2002-03	15,625	4,608	3,079	20,233
2003-04	16,459	4,161	3,100	20,620

Non-judicial cases, typically involving non-violent and minor offenses, are usually settled when children, along with their guardians and attorneys, agree to make a statement of responsibility for the crime, thus avoiding a more formal court process. In cases where the child denies responsibility, commits another crime or refuses to comply with probation conditions, the child is referred back to court for formal judicial handling. When charges warrant non-judicial oversight, the child is required to adhere to detailed conditions of probation. These agreements specify changes in offending behaviors — like resuming school attendance or getting home before a curfew. The child also may be required to participate in community programs, to attend counseling sessions or to cooperate with recommended services.

In non-judicial cases, children automatically receive behavioral health screening after signing a statement admitting responsibility for the crime. While "screening" is automatic in these cases, behavioral health "assessment" is not, even when shown to be necessary by a prior screening. Only after obtaining the consent of a parent or guardian and the child's attorney can behavioral health screening or assessment be requested by non-judicial probation staff. Probation officers recommend behavioral health screening or assessment according to guidelines found in the Connecticut Practice Book (see Table IV). Presently, probation officers are expected to inform families and guardians about screening and assessment outcomes, particularly when there is a need for further assessment or treatment services.

Table IV.

Behavioral health assessments may be requested by probation officers only after obtaining consent from a child's guardian and attorney and showing that assessment is needed because of one or more of the following reasons:

1) no behavioral health assessment has been done recently;

2) prior behavioral health assessments indicate that the child has behavioral health problems or recommended behavioral health services for the child;

3) the child's delinquent behavior involved a high degree of emotional instability or aggression;

4) there is evidence that they child may attempt self-harm;

5) there is evidence that they child may be dangerous to others;

6) the child may be sufficiently psychological unstable or unsafe to require residential treatment;

7) consulting professionals have recommended a behavioral health assessment for this child. An eighth reason, which is not now included in the state guidelines, would be that serious behavioral health concerns have been identified in the course of standardized behavioral health screening.

Since 1992, children entering Connecticut detention facilities have received extensive intake screening that exceeds national standards.

In non-judicial cases, where a child has signed a statement of responsibility, screening is conducted to identify behavioral health needs. However, the majority of children do not receive further behavioral health assessment for identified problems.

Detention and Alternative Detention Centers

In accordance with the settlement of a Connecticut civil lawsuit in 2002, *Emily J. vs. John Rowland*, detention centers in Connecticut provide a thorough behavioral health screening upon intake for all detained children. Children can be detained by court order following an arrest if the judge decides they are likely to commit further crimes, run away before a hearing, or not be safe in their homes or communities.

Since 1992, children entering Connecticut detention facilities have received extensive intake screening that exceeds national standards and uses validated instruments. In 2002, responding to research and best practice recommendations, CSSD introduced the Massachusetts Youth Screening Instrument, Second Edition (MAYSI-2; [Grisso et al., 2001] see Appendix for description). The MAYSI was added to a protocol that also includes the Adolescent Alcohol Involvement Scale (AAIS), the Suicidal Ideations Questionnaire (SIQ), the Drug Abuse Screening Test for Adolescents (DAST-A) and a semi-structured child and parent interview. In December 2004, standardized screening for past traumatic experiences (Traumatic Events Screening Instrument, TESI-SC) and for Post Traumatic Stress Disorder (UCLA-PTSD-RI) and traumatic grief (Traumatic Grief Inventory, TGI) were added to the detention intake procedure.

Children are screened within 24 hours of entering detention and cases are discussed with a psychologist or licensed clinical social worker. If results identify behavioral health needs that may make the child dangerous to self or others, a licensed professional will conduct further assessment within seven days. Trained detention officers assist children in completing questionnaires and work with licensed behavioral health consultants to determine when and how to address needs. Although the process is well-defined and organized, there is not yet a procedure for tracking and analyzing data to determine whether the information is being used effectively to address behavioral health needs of detained children.

The purpose of detention screening and assessment is to identify and manage behavioral health problems so the child and other children are safe during detention placement. Detention officers do not request information from the child regarding current legal charges or about their guilt or innocence. Detailed information revealed in detention assessments is not provided during court hearings. The terms of the *Emily J* consent agreement provide that judges may receive summarized screening results at the initial detention hearing, occurring within 24 hours of the child's arrest, to determine whether services are best provided in detention or in the community.

...without laws that clearly prevent the use of behavioral health information against a child in court, children, families and attorneys will be reluctant to agree to screening or assessment.

Due to the objections of some attorneys for detained children, juvenile court judges often do not consider screening results at initial detention hearings. Still, the *Emily J* detention screening and assessment process may serve as a model for the timely identification of behavioral health needs in a manner that improves the services while not compromising legal rights or causing unintended negative results.

Detention screening results that recommend further behavioral health assessment are contested by attorneys for a number of reasons. The introduction of behavioral health information about children at pre-adjudicatory court hearings has raised concerns by attorneys about the potential for prejudice toward children based upon incriminating disclosures made at the time or in future court cases. In Connecticut, the *Emily J* consent decree has resulted in making resources available for performing behavioral health assessments with children in detention centers and subsequently upon their return to the community. However, without laws that clearly prevent the use of behavioral health information against a child in court, children and their families and attorneys will be understandably reluctant to agree to screening or assessment.

An example: If during an adjudication hearing, a prosecuting attorney makes a motion to introduce at the detention hearing MAYSI-2 screening results indicating that a child is chronically suicidal because of past trauma, the child's attorney is likely to object because she is rightly concerned with protecting her client's freedom from being detained. Screening results identifying behavioral health concerns may present the child as too dangerous to reside at home while awaiting trial. A child's attorney is also concerned that decisions leading to unfair restriction for the child can occur if community services are unavailable. With objection from a child's attorney, a judge may refuse to introduce screening results or to consider them in decision-making regardless of the need for behavioral health service.

Two of the newest juvenile justice programs, working in concert with probation and detention centers, are intended to promote the coordinated use of behavioral health screening and assessments. DCF established "court liaisons" to work with probation officers and judicial officials. These are positions in which social work or behavioral health professionals work closely with judges and judicial staff to ensure that they have sufficient information about the availability of behavioral health services and help in coordinating care that is ordered.

Another service is the "Home Care Program" for detained children and those at risk of detention. This program provides behavioral health consultation and medication management to children leaving detention, ensuring smooth transitions for children who have serious behavioral health problems and are being released back to homes and communities. Behavioral health screening and assessment is done with each child during their contact with Home Care psychiatry and psychiatric nursing professionals, in order to determine the best approach to medication and other therapeutic services and to evaluate the child's progress towards a positive readjustment.

Guilty or Not: Judicial Contact and the Adjudication Process

"Judicial processing" requires a child to meet with a judge in formal hearings; the judge ultimately decides whether the child is or is not guilty of a crime. The judge's "finding" (decision) of guilt or innocence, after a formal hearing, is referred to as "adjudication." Attorneys operate as adversaries in the hearings — one working on behalf of the state and against the child, and another representing the child. Children on trial may be held in a detention facility (described earlier) or they may live at home under the supervision of adult guardians. Slightly more than half of all referred court cases are judicially handled. In cases that formally go to trial, behavioral health screening and assessment can occur, but only after probation officers have completed all of the following:

- recommended assessment in accordance with procedural guidelines;
- obtained parent or guardian consents;
- obtained agreement from the child's attorney; and
- obtained a court order for assessment from the judge (Connecticut Practice Book).

At present, there has been no systematic evaluation to determine:

- how many children receive screenings in judicially handled cases;
- how often screening leads to recommendation for further behavioral health assessment;
- how often recommended assessments actually occur;
- what percentage of screenings or assessment reports are admitted into court hearings; and
- how behavioral health screening and assessment results affects judicial decision-making.

Penalty Phase: Judicial Study and Case Disposition

If the judge finds a child guilty of a delinquent act, the child comes before the judge for another hearing on "disposition" in a penalty phase. The disposition occurs after adjudication and is the judge's decision about what should happen to the child. Options include:

- dismissal with a warning;
- conditional discharge;
- placement on probation;
- placement in the home of a relative or in a private school; or
- commitment to the Department of Children and Families (for example, placed in a public or private residential treatment center).

The majority of convicted delinquents are placed on probation. The probation supervision plan includes a combination of conditions and treatment services.

Juvenile courts provide more flexibility than adult courts; however, they also implement tougher consequences and sanctions similar to the adult system.

Conditions can include: random drug testing; restitution (making restoration, such as payments or community service, to compensate the victims of crime); community service; electronic monitoring; curfews; monitored school attendance; and employment. Treatment options can include: referral to individual and family services; day reporting programs that include educational, recreational, life skills, drug treatment and other services; specialized services for females, sex offenders and abused juveniles; intensive behavioral health or short-term residential services. If placement is deemed appropriate by the court, the statutes provide for commitments to DCF for a period of up to 18 months in most cases and a maximum commitment of up to four years in serious offenses.

Behavioral health screening and assessment is crucial in this "disposition" phase because the judge's orders now can affect the child's life for months or years. Once a case has been adjudicated, behavioral health screening and assessment can be ordered at any time by the court. In Connecticut, all children at disposition receive the MAYSI-2, which is reviewed along with all assessments that may have occurred.

Disposition is an opportunity to address behavioral health needs. Before the disposition hearing, a probation officer prepares for the judge a report called a PDS — pre-dispositional study (Connecticut Practice Book, Sec. 35a-9). The PDS is a comprehensive psychosocial history based on family, school, and community information and may include a psychological assessment.

The probation officer determines whether behavioral health information is needed based upon PDS guidelines described in earlier sections. After a judge orders a disposition, the probation officer still has the option of doing behavioral health screening. Although the MAYSI is used to screen children at the penalty phase, there is as yet no systematic process for collecting and analyzing behavioral health information informing the selection of different types of services. Behavioral health training and professional clinical expertise is important for court staff that provide judges with clinical information and recommendations in dispositional service planning.

Aftercare: Community Re-entry

After a period of confinement or secure residential treatment, children are introduced to the community needing services and supports to achieve educational goals, assist family reintegration and stabilize behavioral health following a transition. Children released from confinement are especially vulnerable and at greater risk for suicide and other high risk behavior. Screening and assessment interventions prior to returning to the community ensure continuity of care and prevent juvenile recidivism. While not typically requested by probation or parole officers, pre-release screening and assessments are important components of an effective and intensive juvenile justice aftercare plan (Altschuler & Armstrong, 1994).

In disposition hearings, behavioral health information is less likely to lead to negative consequences and more likely to help judges decide about specific conditions and services.

General Issues in Using Behavioral Health Information in Juvenile Justice Settings

The juvenile justice system has changed dramatically, since the beginning of the 20th century with the inception of the juvenile courts. Today, juvenile courts provide more flexibility than adult courts; however they also implement tougher consequences for children and sanctions similar to the adult criminal justice system (National Council on Disability, 2003). Behavioral health screening and assessment can be done under certain conditions at any of the decision points in the juvenile justice process. However, they are frequently not allowed because of concerns, noted above, about the potentially prejudicial impact of behavioral health information upon the legal case. Some states (such as Texas) are addressing these issues with laws that prevent the results of screenings and assessments from being admissible in court proceedings.

During each phase of a child's involvement in the Connecticut juvenile justice system, key personnel must bring behavioral health issues to the court's attention. However, the majority of these personnel have no behavioral health training. Justice personnel such as police officers, probation officers, DCF workers, and detention staff handle information about children and their families that determines access to resources and services for behavioral health rehabilitation.

Children with serious problems may require drug and alcohol counseling, family therapy or intensive in-home behavioral services to reduce risks for recidivism. Unlike the adjudication phase, in disposition hearings, behavioral health information is less likely to lead to negative consequences and more likely to help judges decide about specific conditions (such as curfews, employment, tutoring attendance) and services (such as day-treatment programs, in-home therapies, medication management) that will help the child.

In addition to the police and court probation staff, behavioral health professionals conducting court-based screenings and assessments require specialized training so that they can offer assessments that address the court's needs for information, as well as for clearly articulated and practical recommendations. Behavioral health assessors should be licensed professionals and experienced in using evidence-based methods in behavioral health assessments. Proper training and court-based experience ensure that behavioral health professionals clearly understand the roles and responsibilities of all juvenile justice system participants, are familiar with relevant case law and court procedures, and are able to abide by constitutional "due process" rights and legal safeguards. Specialized training also enables behavioral health assessors to understand and follow the unspoken court "etiquette" (for example, knowing when and how to communicate with attorneys or judges), to know how to present reports and to provide expert testimony.

Few forensic professionals (with specialized training in law and behavioral health) work with juvenile courts or state juvenile justice systems.

Unfortunately, with few exceptions, states do not set professional standards, monitor training or credential behavioral health professionals who provide assessments for juvenile court settings. Additionally, few forensic professionals (with specialized training in law and behavioral health) work with juvenile courts or state juvenile justice systems. Cook County, Illinois is highlighted based upon its work to improve training and quality standards related to using behavioral health information in juvenile courts. Dedicated clinicians working in the Cook County, Illinois justice system coordinate clinical information and provide objective clinical perspectives. Clinical coordination and collaboration with court staff offer an efficient service model to inform legal decision-makers using standardized methods for obtaining accurate and timely behavioral health information (Scally & Kavanaugh, 2002). Methods for behavioral health screening and assessment must meet high standards of quality and also must adapt to the needs and circumstances of the juvenile justice court process (Grisso and Underwood, 2004).

Connecticut Options for Behavioral Health Assessment in the Juvenile Justice System

The Judicial Branch, Court Support Services Division (CSSD) contracts for approximately $30 million in services for children each year. Many service decisions made by probation officers for adults and children are guided by a risk/needs assessment instrument (Juvenile Assessment Generic) developed by CSSD. Court-ordered behavioral health assessments in the Connecticut juvenile justice system, conducted in ways described on the following pages, are different from the Juvenile Assessment Generic (JAG), which is primarily designed to determine if a person is at risk for being dangerous or for recidivism.

This report sought to provide up-to-date information about those behavioral health screening and assessment resources used by the Connecticut juvenile justice system. Policy-makers, state agency administrators, clinical service contractors and non-contracting behavioral health professionals were interviewed about their experiences. Services evaluated were: a) community child guidance clinics and family service agencies; b) juvenile court clinic assessments for CSSD; c) juvenile justice intermediate evaluations (JJIE) assessments; and d) hospital emergency and inpatient departments.

Without systematic benchmarks or quality standards for contractors, behavioral health assessments are likely to use inconsistent approaches....

Community Child Guidance and Family Service Agencies

Frequently, community agency records are requested to obtain assessments and treatment histories by probation staff if children have a history of receiving behavioral health treatment. Assessments by community agencies are typically diagnostic evaluations. Formats routinely include the presenting problem, developmental and family history, mental status examination and a formulation with psychiatric diagnoses. In some cases, when specially requested, intellectual, achievement, and personality tests may be included. According to one clinic administrator, "assessment is not an isolated activity in a community agency, but a starting point to determine and respond to a child's behavioral health service needs." A range of intensive services, psychosocial therapies, case management services and school-based interventions are often available through community child guidance and family service agencies.

A focus group discussion on issues and practices for conducting behavioral health assessments with children in the juvenile justice system was held with clinical directors representing the Connecticut Community Providers Association (CCPA). Following the large group discussion, telephone interviews were conducted with clinical administrators of child guidance clinics in Enfield, New London, Plainville and Stamford. Agencies without competitive state contracts reported that juvenile courts seldom made direct referrals for behavioral health assessment.

Most participating agencies did not typically identify and track data on clients' involvement in the juvenile justice system, unless required in monitoring for particular state contracts. Without systematic data collection and tracking, it is difficult to determine accurately the number of juvenile justice involved children who are receiving or have received assessments or other treatment services in community behavioral health agencies and clinics. Data from the juvenile justice system, specifically for a cohort of children admitted to Connecticut detention centers, highlight the importance of tracking children's involvement in both behavioral health and the juvenile justice services. Although these children entered detention because of legal problems, 16% had been previously treated in a psychiatric hospital, 14% had been in residential treatment programs, and 58% had received prior outpatient treatment (CSSD internal communication, 2004). One child guidance clinic interviewed for this report collects and analyzes data on children receiving court-ordered clinical assessment, but generally data collection and analysis for this population was rare.

The potential value of coordinating services across child behavioral health clinics and juvenile justice systems is illustrated by a report by Lyons and colleagues in Illinois describing an initiative where detained children with behavioral health needs were linked to community services and monitored for improvements on follow-up. Results showed that linkages between juvenile justice and behavioral health services have a positive effect on both behavioral health and delinquency (Lyons, 2003).


Court Behavioral Health Clinics

CSSD contracts with five private, non-profit, clinical agencies to conduct court-based assessments of children referred by judicial court order. A CSSD evaluation report of those services was reviewed for this study (A Study of the Current Court-based Assessment Services Service Delivery Model, Cathy Foley Geib: February 23, 2002). Contracted assessments are available for children living in all regions covered by the thirteen Connecticut juvenile matters courts. Most court clinic assessors conduct psychological, psychiatric, substance abuse and sexual offender assessments. However, one of the contracting agencies conducts only sexual offender assessments.

In most cases, court-based assessments are requested by judges to assist in understanding a child's diagnosis, treatment needs and service recommendations. We were unable to obtain information about the background, credentials, specialized training, relevant experience or quality assurance mechanisms used by selected contractors and subcontractors performing court-based assessments. Without providing systematic benchmarks or quality standards for contractors, behavioral health assessments are likely to use inconsistent approaches and demonstrate uneven quality in reports and recommendations. While most contracted assessments are conducted by individual licensed psychologists, reports can vary in format and organization, quality and scope, use of standardized assessment instruments, and the ultimate usefulness of their recommendations. While Connecticut courts currently do not have quality standards or professional guidelines for assessors or their contracted products, CSSD is working to reorganize and improve this system.

Contracted providers do not routinely conduct family assessments, neuropsychological, educational assessments nor answer forensic questions such as those about the child's competency to stand trial. The court accesses competency to stand trial assessments through the adult Office of Court Evaluations provided by the Department of Mental Health and Addiction Services (DMHAS). Court clinic assessments have a two-week turn around time. Sometimes reports are delayed due to problems with transportation or child care, work obligations and parental fears; assessors can also have difficulty obtaining consent to procure pertinent information from sources such as schools, child protective services, and health care providers.

Children in detention receive behavioral health assessments or treatment from behavioral health professionals and consultants working specifically for the detention centers. However, the same children may additionally be required to undergo court-ordered assessments by contracted assessors. Judicial policies prohibit introduction in court of most medical and behavioral health information gathered in detention settings. Therefore, detention-based clinicians focus on information gathering needed to provide clinical support and behavior management to children in detention centers. In contrast, court clinic assessors focus on information specifically requested to assist the court in planning and legal decision-making.

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Juvenile Justice Intensive Assessment Services

The Juvenile Justice Intermediate Evaluation (JJIE) program grew out of the 2002 *Emily J* consent agreements mandating improvements in the services provided to detained children with behavioral health needs. Under the auspices of DCF, the JJIE program contracts with three separate non-profit agencies located in northeast, central and southern Connecticut. Each agency conducts comprehensive, multidisciplinary behavioral health assessments for children who do not require acute hospitalization but who have serious behavioral health problems and are in detention or at risk of being detained. Court-based clinics generally provide a larger number of assessments and less often use standardized assessment tools, compared to those done by JJIE programs.

The JJIE assessments are different from other court ordered behavioral health assessments because they are designed to be more comprehensive in several ways. For example, JJIE assessments routinely involve multiple professional disciplines, such as psychiatry, clinical psychology, neuropsychology, educational testing, social work, occupational or recreational therapy, and nursing. JJIE assessments are typically conducted in the family's home or community as well as in behavioral health or child guidance clinics. A two-week turnaround is required for reported recommendations, but delays can be frequent, for the same reasons as indicated with court-based assessments.

At the time of this report, JJIE programs are not required to use exactly the same approaches or report formats, nor are all reports held to specific standards for report content, organization or quality. JJIE assessments may typically include:

- non-structured psychiatric interviews;
- standardized interviews and structured questionnaires;
- tests assessing intellectual and neuropsychological functioning (i.e., mental attention, memory, and learning skill problems), psychological, educational achievement and personality; and
- family interviews and home observations.

JJIE teams include a range of professionals such as psychiatrists, psychologists, social workers, childcare workers, education specialists, nurses, probation officers and (if the child is involved with DCF) DCF caseworkers. Each has designated responsibilities on the teams; for example, a childcare worker might provide transportation, while a social worker conducts the home assessment and the psychologist conducts intellectual, emotional and educational assessments in a clinical setting. Key personnel at JJIE programs were interviewed at their sites and also were observed in cross-site monthly meetings convened by DCF and CSSD. The administrators and professional staff at the three JJIE programs reported conducting approximately 20 evaluations each month, with most children being referred by juvenile court judges.

Since the implementation of JJIE assessments, the need for court ordered stays for obtaining intensive assessments has substantially decreased....

All programs use multiple sources in the assessment process to obtain information, attempting to include the child, parents, other family members, school officials, teachers, juvenile justice staff, and previous treatment providers.

Following a 10-day testing period, JJIE programs have an additional 5 days to complete and submit a comprehensive report including specific recommendations. Recommendations are tracked by monthly reports submitted to a DCF JJIE coordinator. The majority of the recommendations are for community-based services such as:

- in-home family treatments;
- intensive psychiatric case management;
- medication management;
- outpatient services (individual therapy, family therapy, or substance abuse treatment); or
- community readjustment programs such as therapeutic mentoring, vocational training, or structured recreation.

A small number of recommendations are made each month for residential placement or hospitalizations. Partial hospitalization programs (PHP) and intensive outpatient programs (IOP) may also be recommended. During the 10-day testing period, some sites engage the child in their own partial hospital program, groups, vocational and recreational activities.

All JJIE providers interviewed expressed concerns about the ability to access community services or suitable programs where children live. Even when appropriate programs are found, there have been long waiting lists for counseling or transportation services to the programs and denial for program entry unless children are committed to DCF.

To date, JJIE assessment services have demonstrated that many children formerly confined in hospitals or costly placements can benefit from less restrictive community-based services. Intensive family in-home therapies and community stabilization services are achieving better outcomes, as identified and described in the CCEP Close to Home report (Ford, 2003).

Children who cannot safely return to the community or juvenile justice placements may be provided with extended treatment for several months at Riverview Hospital....

Hospital Emergency and Inpatient Services

If a child requires acute hospitalization, inpatient psychiatric facilities have the capacity to conduct thorough behavioral health assessments. Actual services obtained may range from brief screenings in emergency departments to intensive multidisciplinary assessments similar to those conducted by the JJIE programs. Before JJIE assessments were available, thorough assessments were limited and based only upon the availability of in-patient hospital beds. Since the implementation of JJIE assessments, the need for court ordered stays for obtaining intensive assessments has substantially decreased, while numbers of acute hospitalizations required for behavioral stabilization have remained the same.

While court orders for hospital assessment are made only to Riverview (the only state-run child psychiatric hospital), courts routinely consent to acute, crisis-oriented admissions to community hospitals when facilitated by a physician's emergency certificate (PEC). The most intensive inpatient behavioral health care (assessment and treatment) for children committed to DCF occurs at Riverview Hospital, the state psychiatric hospital for children.

A child can be required by court order to reside at Riverview for up to 30 days for a comprehensive inter-disciplinary behavioral health assessment. At Riverview, each child receives a comprehensive assessment including examination of individual, family, psychological and educational factors which are used in treatment planning and disposition by an interdisciplinary team.

Children who cannot safely return to the community or to juvenile justice placements may be provided with extended treatment and further assessment for several months at Riverview or at other DCF-run intensive residential children's mental health facilities such as Connecticut Children's Place or High Meadows.

These placements permit the behavioral health professionals at these facilities to conduct more comprehensive assessments than are possible when children in the juvenile justice system are treated (usually briefly, to manage immediate crises) in other psychiatric hospitals. Like JJIE assessments, those at the DCF-run inpatient/residential facilities include a review of psychiatric history and current problems, using unstructured interviews and standardized test instruments for the purpose of determining psychiatric diagnoses, educational, medical and social needs and recommendations for further services.

Section 4:

Conclusion and Recommendations

The research from national studies of juvenile justice systems suggests that many children in Connecticut's juvenile justice system may have unidentified psychiatric, substance abuse or developmental problems — problems that compound their difficulties with delinquency and also compromise their safety. In order to determine the nature and extent of these behavioral health problems, thorough and accurate behavioral health screening and assessment are needed in the juvenile justice system. Particularly important is the capacity to screen children in the early phases of involvement in the system before problems become chronic and debilitating, and also in the later phases when children are directed toward various rehabilitation activities.

Historically, the founders of the juvenile justice system in the United States emphasized child development, behavioral health and rehabilitation. However, over the past two decades, the emphasis has moved away from treatment and rehabilitation to a focus on holding juvenile offenders accountable and protecting the public. This national shift towards punishment and accountability leaves juvenile justice systems unprepared, ill-equipped and under-funded to handle the increasing influx of children with serious and complex behavioral health problems.



Nationally, the number of children referred to state juvenile justice systems continues to increase, while at the same time the number of violent or serious offenses committed by juveniles is steadily decreasing. In Connecticut, the typical child entering the juvenile justice system is younger than 16 and charged with a non-violent offense (such as stealing, running away or refusing to obey adults). Many of these "unmanageable" behaviors are caused or compounded by children's unmet behavioral health needs, such as mood, anxiety, traumatic stress, attention, or developmental disorders. As a result, the Connecticut juvenile justice system is often the place of last resort for children with serious behavioral health problems.

In Connecticut and other states, the demand for behavioral health services for children exceeds available resources. Even when community behavioral health treatments are available, many families endure long waits for service (MHPC Report, 2003).

A crucial first step toward building a comprehensive structure of behavioral health services for children in the juvenile justice system is the accurate and timely screening to identify children who need services.

Identification and service access for children with behavioral health needs can also be a challenge in all child-serving public systems such as schools, primary health care and child welfare systems. The President's New Freedom Commission on Mental Health (a multidisciplinary workgroup convened in 2002), reported that public service systems overlook many adults and children with unidentified and unmet behavioral health needs. Of the 72 million children in the United States reported in the 2000 Census Report, as many as 6.5 million (5-9%) live with mental illness, substance abuse and other behavioral health problems. A report by the U.S. House of Representatives also confirmed the large numbers of children needing behavioral health service who are found in state juvenile detention facilities while awaiting treatment. Empirical research also now confirms that behavioral health problems are much more likely to occur for children in the juvenile justice system than for other young people.

In light of these concerns, Connecticut has recognized the importance of coordinating efforts to respond to the behavioral health needs of children involved in the juvenile justice system. Connecticut has demonstrated leadership by implementing evidence-based screening and treatment services and adopting behavioral health best practices within the juvenile justice system. During the past decade, the state has increased all behavioral health services and disseminated new family-based treatment models that reduce institutionalization. Connecticut has also coordinated behavioral health care approaches among state agencies.

The benefit for children and families is a genuine second chance to succeed in relationships, school, work, and life.

This report identifies both strengths and weaknesses in Connecticut's ability to perform behavioral health screenings and assessments for children in the juvenile justice system.

STRENGTHS

- Standardized screening to identify behavioral health problems for children entering the juvenile system as illustrated by the intake process for children entering a detention facility.
- A number of children with behavioral health problems are identified through screening and then receive intensive behavioral health assessments in court clinics or Juvenile Justice Intermediate Evaluation (JJIE) programs.
- JJIE assessments use a comprehensive multidisciplinary approach that can also include administration of standardized assessment tools by qualified clinicians
- Court-based clinics provide the larger number of assessments compared with the JJIE program, and in some cases also use standardized testing instruments.

WEAKNESSES

- Standardized screening and assessment procedures with multidisciplinary and family/community input are not used in most court-based or community behavioral health assessment of juvenile justice involved children, or are used only sporadically for specific questions (such as testing for intellectual functioning).
- There is an absence of coordination among the JJIE, court-based, hospital/residential, and community behavioral health assessment providers; as a result, there is no consistent approach to selecting or using screening or assessment instruments, procedures, or quality control guidelines to ensure that every juvenile justice-involved child and family receives a comparable behavioral health evaluation.
- Family history, community, developmental, and school-based data are not routine components of juvenile justice behavioral health assessment reports.
- Children's strengths and assets are not systematically identified in behavioral health assessment reports to juvenile courts.
- Several important psychological domains are not routinely included in the screening or assessment of children in the juvenile justice system, including: emotion regulation; traumatic stress; anxiety management; attachment /relational style; and family and community resources.
- Parents, teachers and other significant adult figures involved with children in the home, school and community are often not involved in juvenile justice assessments, recommendations, or service plans.
- Quality standards have not been established to guide the process of behavioral health assessment, or to train and credential clinical assessors, or to ensure that findings and recommendations are accurate and helpful to judicial decision-making.
- Defense attorneys often object to introducing information from behavioral health screenings or assessments because there is no clear protection preventing the results from being used against the child in court.
- The demand for intensive community-based behavioral health services is greater than the supply of these services.

Evidence-based practices are methods of behavioral health screening and assessment that follow guidelines based upon scientific research.

Everyone benefits when children with serious behavioral health problems are identified and provided with appropriate services as early as possible. The benefit for children and families is a genuine second chance to succeed in relationships, school, work, and life. The benefit to the legal system is an additional set of options for rehabilitating delinquent children and reducing the burden on the system caused by further delinquency. The benefit to schools and health care systems is having fewer children with severe and chronic problems requiring costly specialized treatments. The benefit to communities is a healthier citizenry, stronger economy, greater public safety and decreased likelihood of repeated criminal behavior by children.

Early behavioral health screening is vital for every child entering the juvenile justice system. Equally important is that screening be done earlier in schools, primary health clinics and child welfare programs. Screening and assessment occurring within local schools, for instance, can lead to improved behavioral health but also can improve attendance, learning, grades, and relationships with peers and educators. Screenings and assessments provided systematically at juvenile justice entryways and major transition points within Connecticut's juvenile justice service system could identify treatable problems (such as undiagnosed learning disorders, substance abuse, hyperactivity) that otherwise continue to contribute to delinquent behavior.

Connecticut Practices

At each decision point in the juvenile justice system, behavioral health information can assist judges and other key personnel in making important decisions, including at:

1. POLICE INTAKE
2. DETENTION
3. INITIAL COURT PROCESSING
4. ADJUDICATION
5. DISPOSITION
6. AFTERCARE

Police Intake

Police have the earliest contact with children who have broken the law. They have a great deal of discretion. Their options include: giving warnings; contacting parents; seeking placement resources; requiring that a child be sent to a hospital for assessment; arresting children; or requesting their placement in detention. Behavioral health training is often not available to police, even though they make important decisions for impaired children with obvious behavioral health needs. Police would benefit from routine training in child development, behavioral health, crisis management and family welfare as well as professional opportunities for consultation and behavioral health collaboration. The Yale Child Development-Community Policing Program is an excellent example of an international model for training and providing the very earliest behavioral health screening, hands on

assistance to police on actual calls so that they use knowledge of child development, behavioral health issues and services, crisis intervention, and related topics to assist and manage the behavior of troubled children and families (Marans et al., 2003).

Detention

Detention is the one place where behavioral health screening occurs routinely. An extensive screening process is now used in detention centers; this process incorporates several nationally recognized brief screening instruments with strong empirical support and measures for suicide risk, substance use problems, and traumatic stress problems. The results of these screenings are available within 24 hours to judges, but the judge cannot legally use this information if the child's attorney objects because of concern that the information will have a negative effect on the judge's decision. A careful review is needed of the current practices and limitations in using behavioral health information prior to adjudication in juvenile hearings.

Initial Court Processing

Once children are arrested and sent to court, probation supervisors decide whether to handle the charges informally (without involving a judge) or formally (with a judge). Most cases are handled informally. Behavioral health screening can occur only for children who sign statements admitting criminal responsibility and also obtain parental and attorney consent. Those children with serious but unidentified behavioral health disorders are at risk for repeat encounters with the law, behavioral problems that interfere with successfully meeting the conditions of probation, and consequences that preclude treatment but send them deeper into the juvenile justice system. Identification of behavioral health needs at the earliest stages of processing is necessary for assisting probation supervisors in making rehabilitation and supervision plans. Decisions made when children first enter the juvenile justice system are crucial for deterring further unlawful behavior and also for helping children deal with behavioral health problems — such as depression, grief or addiction — that fuel further delinquency.

Adjudication (trial phase)

Formal delinquency cases are adjudicated, that is, handled by a judge making decisions about the child's punishment, supervision, and rehabilitation. Currently, probation officers can request behavioral health assessments for children in formal judicial handling only after obtaining the agreement of parents/guardians and attorneys and a judicial court order. Probation policies recommend that staff consider several factors when deciding whether children should receive behavioral health assessment: availability of other recent assessments; prior assessments or diagnoses; potential risks for self harm or need for residential placement. However, the potential benefits of a current behavioral health screening do not weigh heavily as a factor in this decision.

Identification of behavioral health needs at the earliest stages of processing is necessary for assisting probation supervisors in making rehabilitation and supervision plans.

If a child is screened or otherwise observed to have possibly severe behavioral health problems, a behavioral health assessment may be ordered by the judge and done either by a court-based clinic or the juvenile justice intermediate evaluation (JJIE) program. Most such assessments are done on the basis of non-standardized screening, and often the issues or questions that the assessment should address are not clearly stated. JJIE behavioral health assessments tend more to use multiple sources of information and standardized tests than do court-based clinic assessments. Court-based clinics provide a larger number of court ordered assessments and generally do not use a comprehensive or multi-disciplinary assessment approach.

JJIE and court-based assessments are both important resources that would benefit from the development of clear protocols that determine the selection criteria and quality assurance standards for court-based versus JJIE assessments. A systematic procedure should specify:

- how children's screening results inform the selections for a particular type of assessment;
- how assessment questions are formulated and communicated to assessors; and
- how assessment results and written reports are coordinated for timely and efficient use by the courts.

Connecticut is considering adopting models such as the Cook County (Illinois) approach, which provide better guidance, coordination and standardization in the assessment process. One possibility is an expert behavioral health professional within the courts to train, consult and oversee the selection ("credentialing") of assessors, the quality of assessments and reports done when judges order a court-based behavioral health assessment.

A careful review of the current Connecticut practices in using behavioral health information prior to adjudication will be important for development of a systematic screening and assessment procedure that establishes clear boundaries and fair practices.

Disposition (penalty phase)

More children receive screening and assessment at the point of disposition than at any earlier point in the juvenile justice process. Probation staff, which are responsible at disposition for collecting relevant social and behavioral data and coordinating it for judicial review, would benefit from more guidance regarding the acquisition and use of clinical information as well as the availability and accessibility of community "best practice" services. A better collaboration between probation and behavioral health professionals during this phase would improve mechanisms for determining what behavioral health information is needed, how best to get it, and how to use it to best advantage in making service recommendations. The Cook County model could provide this type of support to probation staff.



Aftercare: Community Re-entry

Transitioning from out of home services back to the community can be a stressful transition for children and their families. Attention to the behavioral health and treatment planning during this time is critical to ensuring a safe transition, providing continuity of care and preventing juvenile recidivism. This stressful and high risk period in the juvenile justice system requires attention to the behavioral health status and impending needs of young people in transition. Strong collaboration is necessary between secure treatment and confinement professionals and community providers planning aftercare services. There are effective models of intensive aftercare available to assist juvenile offender reintegration in the community. These best practices highlight the importance of re-entry screening and behavioral health assessment.

Recommendations

We offer recommendations for policy and practice to improve the screening and assessment of behavioral health needs for children in the juvenile justice system. Children with unrecognized and untreated behavioral health needs are at risk for persistent and escalating delinquency and behavior problems — problems which are damaging to these children, their families, and their communities. As evidence mounts about the high proportion of children in the juvenile justice system with socio-emotional, developmental, and behavioral disorders, it is incumbent upon Connecticut to identify these behavioral health needs through screening and assessment and to respond with appropriate and timely services.

Toward Best Practices

Behavioral health screening and assessment should be evidence-based — supported by scientific research indicating effectiveness. This means using reliable, valid, and standardized screening and assessment instruments whenever possible. Evidence-based practices are methods of behavioral health screening and assessment with children and families that follow guidelines based upon scientific research.

- Reliable and valid standardized screening and assessment instruments should be used in a manner that is individualized for every child and family.
- Screening and assessment measures and procedures should be sensitive to differences such as age, gender, ethnocultural background and cognitive ability.
- Assessors should be experienced with and knowledgeable about state statutes and experienced in child development and general forensic issues.
- When deciding whether behavioral health screening or assessment should be done, courts should consider both children's rights to confidentiality and protection from self-incrimination and the potential value of providing services that address pressing behavioral health concerns.

- Behavioral health screening and assessment should focus on recent rather than past symptoms and periodic re-assessments should occur for children who continue to be involved in the juvenile justice system.
- Screening and assessment should identify two key groups; (1) psychologically impaired children who need immediate treatment; and (2) high risk children who should be provided with education, skills, and supervision in order to prevent future problems, functional impairments and costly treatments.
- The less visible "internalizing" problems (for example, depression, anxiety) should be identified, as well as more obvious "externalizing" problems (for example, drug and alcohol disorders, aggression, and impulsivity).
- Assessment and screening should focus on adaptive abilities, strengths and resources as well as on symptoms and behavior problems.
- Assessment and screening should use input from multiple sources such as parents and other caregivers, both to get the caregivers involved and because children often under-report behavioral health problems.

Toward Improved Policies

- Screening services should be provided for all children upon their entry to the juvenile justice system to identify those in crisis and those who have behavioral health needs warranting further assessment.
- Every child with screening results suggesting serious behavioral health problems should receive further assessment.
- Those children with serious behavioral health problems who remain in the juvenile justice system for an extended time should receive periodic re-screening, re-assessment, and appropriate adjustments to behavioral health services.
- Coordinating mechanisms in juvenile justice for early surveillance, screening, assessment and treatment of children's behavioral health problems is imperative.
- Mechanisms for early behavioral health identification and intervention should be expanded in public service gateways like schools, primary health settings and the child welfare system to prevent children from entering the juvenile justice system with undetected, serious behavioral health disorders.
- A quality assurance and continuous-improvement system is needed to guide screening procedures, to credential and monitor the work of assessors, and ultimately to ensure that all behavioral health screenings and assessments adhere to best-practice standards.

- Screening and assessment must produce findings and recommendations that directly and accurately address the main questions posed by the judges and justice personnel.
- Behavioral health professionals who supervise screenings or conduct court-ordered assessments should have professional credentials necessary to provide services (such as a license for independent practice and training and supervised experience in children's behavioral health assessment) and also specialized training and supervised experience to ensure that they are competent to deliver these services in the juvenile justice system.
- A credentialing and quality assurance model such as that developed by the Cook County (Illinois) courts ensures that all behavioral health screening and assessment procedures, recommendations, and reports are conducted by qualified professionals and meet standards of best practice.
- Statutory protection is needed to prevent the results of behavioral health screening or assessment from being used against any child or family in either a current or future legal proceeding. Concerns about stigmatization and self-incrimination currently prevent many children with behavioral health problems from being appropriately identified to receive timely services. Some states, such as Texas, provide universal behavioral health screening for delinquents as a result of legislation introduced to protect clinical information.
- An advisory group of legal, behavioral health, and child advocacy professionals should review the statutory and ethical issues concerning behavioral health screening and assessment within the juvenile justice system, and recommend reforms. The group should review state statutes, policies, regulations, practice guidelines, and practice patterns relevant to improving screening and assessment services in the juvenile justice system for Connecticut children with serious behavioral health needs.

The recommendations of this report are designed to encourage careful reflection and meaningful action by leaders and advocates who work within or are concerned about the juvenile justice system, the broader network of state agencies responsible for children's and families' health, education, and welfare, and the behavioral health professions. Consistent with the findings of the President's New Freedom Commission, we envision a future when all children with behavioral health needs will be identified early and provided with timely and non-stigmatizing access to the services and supports that will enable them to participate successfully in learning, in work and in the lives of their families and communities.

Appendix A: Instrument Profile

Instrument Profile: Behavioral and Emotional Rating Scale (BERS)

The Behavioral and Emotional Rating Scale (BERS; Epstein and Sharma, 1998) was developed to address the need for a more standardized assessment tool for measuring strengths of children and adolescents. This 52-item scale assesses five areas of strength:

- Interpersonal strength refers to the ability to regulate emotions in a social context.
- Family involvement assesses the quality of the child's relationships with his/her family members.
- Intrapersonal functioning refers to the child's self-perceptions of competence and success.
- School competence examines the child's level of academic functioning.
- Affective strength measures the child's ability to express feelings.

The BERS is considered to be a highly reliable and valid method (Rudolph and Epstein, 2000) and can be administered by any adult who knows about the child's behaviors. The items on the BERS are on a Likert-type scale with 4-point responses (0= not at all like the child and 3= very much like the child). In addition to the above items, there are eight open-ended questions about the child's interests and resources. The goals of administering the BERS are: to identify emotional and behavioral strengths of a child; identify children at risk of problems because of less well-developed strengths; identify goals for treatment planning; assess improvements in strength areas as a result of treatment; and serve as an outcome measure in research and evaluation projects (Epstein, et. al., 2000).

Instrument Profile: Diagnostic Interview Schedule for Children (DISC)

Designed for youths between ages 9 and 17, the Diagnostic Interview Schedule for Children (DISC; Shaffer et. al., 1992) is a widely used structured interview that assesses psychiatric disorders in children and adolescents. There is also a parent version for children ages 6-17. A computerized version of the DISC presents questions through headphones (voice-DISC); this version was used in a prevalence study examining the rate of psychiatric disorders in incarcerated male adolescent juveniles (Wasserman, et. al., 2002). The DISC allows the interviewer to learn about many psychiatric problems and diagnoses and has specific modules for areas of concern (e.g. PTSD module). Though thorough training is needed to administer the interview, its language is relatively easy to understand. There is extensive validation data for the DISC.
A major limitation on its use in the juvenile justice system is that it is a lengthy interview.

Instrument Profile: MAYSI-2

The MAYSI-2 is a 52-item self-report instrument that identifies potential mental health and substance abuse needs (Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001). It was designed to screen youth within 24-48 hours of entry into the juvenile justice system for immediate intervention, as in the case of suicidality, as well as for indicators for further, more comprehensive assessment. It is written on a fifth grade level and takes approximately 10 minutes to administer (Grisso et al., 2001). Youths answer "yes" or "no" to each item, depending on whether it is true for them "within the past few months" (Cauffman, 2004).

Scores on the MAYSI-2 are added up based on the total number of endorsed responses to the 52 items. Using factor analysis, seven distinct scales were derived: alcohol/drug use; angry-irritable; depressed-anxious; somatic complaints; suicide ideation; thought disturbance; and traumatic experiences. Internal consistency and test-retest reliability are adequate for the MAYSI-2.

A study in the state of Washington further validated the MAYSI-2 through its use at intake for adjudicated adolescents. The study found that youths with prior mental health problems were more likely to score in the clinical range on the MAYSI scales than were those with no prior mental health history (Stewart and Trupin, 2003). In addition, those who had high scores on the MAYSI were more likely to receive severe sentences and less likely to be recommended for community-based treatment programs.

The MAYSI-2 was developed to address the need for a brief, low cost, easily administered, yet psychometrically sound screening tool that could be widely used at multiple processing points in the juvenile justice system (Grisso & Underwood, 2003). It is not intended as a diagnostic instrument corresponding to DSM-IV criteria (Cauffman, 2004); rather, it identifies both emergent risk and mental health service needs consistent with recommendations of the Consensus Conference on mental health assessments in juvenile justice (Wasserman, Jensen, Ko, Cocozza, Trupin, Angold, Cauffman, & Grisso, 2003). Its purpose, according to one of its developers, is "to assist non-clinical personnel in collecting information quickly, efficiently, and cheaply, for use in making decisions about emergency intervention or professional consultation" (Grisso, 1999, p. 148).

Instrument Profile: Trauma Symptom Checklist for Children (TSCC)

The Trauma Symptom Checklist for Children (TSCC) is a self-report instrument that measures the emotional, behavioral, and cognitive effects of trauma exposure (Briere, 1996; Wolpaw, Ford, Newman, Davis, & Briere, in press). The six scales measured are as follows:

- anxiety
- depression
- post-traumatic stress
- dissociation (disruption in thinking and perceptions of the world around oneself)
- anger
- sexual concerns (both distress about sex and an over-interest or preoccupation with sex)

In addition, two validity scales are used to determine the child's tendency to say "no" to symptoms or say "yes" to a lot of symptom items.

The TSCC lists 54 feelings, thoughts and behaviors and asks respondents to rate each on a 4-point scale from never (score=0) to almost all the time (score=3). Administration usually takes 15-20 minutes. Scoring and interpreting require another 5-10 minutes (Briere, 1996). The TSCC does not address specific trauma events, so it is advised to administer the instrument with a trauma history assessment as well (Wolpaw, et. al., in press).

The TSCC is probably the most widely used trauma instrument by mental health professionals since it provides an efficient and standardized measure of both post-traumatic stress and associated symptomatology (Wolpaw, et. al., in press). This is particularly important in juvenile justice settings, where there is limited time to assess a wide array of problems and needs. The TSCC was designed to assess a wide range of youth and symptoms, and was standardized on large clinical and non-clinical groups (Briere, 1996). Its use in forensic settings has increased following research evidence suggesting that traumatic stress symptoms may be related to juvenile offending and responsiveness to rehabilitation (e.g., Newman, 2002). (Structure of that sentence is a bit unclear.)

The 75 initial items developed for the TSCC by clinicians were reduced to the current 54 items. A non-clinical standardization sample of 3,008 children from a wide range of racial groups, geographical areas, and socioeconomic groups was then obtained (Briere, 1996). This sample included 2,399 school children in Illinois and Colorado (Singer, Anglin, Song, & Lunghofer, 1995), 387 Colorado school children (Evans, Briere, Boggiano & Barrett, 1994); and 222 children at the Mayo Clinic in Minnesota who were relatives of patients or undergoing minor or routine medical care (Friedrich, 1995).

While the TSCC assesses post-traumatic stress and associated symptoms, it does not evaluate trauma exposure and does not give way to a diagnosis of PTSD. However, TSCC scores do appear to be associated with histories of violence exposure, childhood abuse, violent conduct, anger, dissociation, and psychosocial impairment (Briere, 1996; Wolpaw, et. al., in press).

CBCL Profile

The Child Behavior Checklist (CBCL) is a widely used, reliable, and well-validated behavior checklist. There are two versions of the CBCL: one for children ages 2-3 and one for children ages 4-16. The latter version has norms for children ages 4-5, 6-11, and 12-16, with separate gender norms for each subgroup. The CBCL is a list of 100 items (younger version) and 113 items (older version) that covers a wide array of behavioral problems and strengths (Achenbach and Edelbrock, 1986a; Sattler, 1992). Standard scores are derived based on a mean of 50 (SD=10). Profiles are computed with either eight or nine (based on which age form is used) subscales for behavior problems (for example, "Depressed", "Somatic Complaints", "Aggressive", etc.) and three scales for strengths. These subscales are then transformed into two main scales or "broad-band factors": Internalizing and Externalizing (Sattler, 1992; see Section II of this report for clarification on Internalizing/Externalizing problems).

The CBCL takes between 30 and 40 minutes to administer. A parent or caregiver completes the instrument. There are also forms available for teachers (the Teacher's Report Form; Achenbach and Edelbrock, 1986b) and a similar version (the Youth Self Report; YSR, Achenbach and Edelbrock, 1986a) for youths to complete to compare to the parent report on the CBCL (Sattler, 1992). The CBCL can be scored by hand but there is a user-friendly computerized scoring system that can be purchased for scoring and interpretation.

Appendix B: Terms of Psychometric Quality

- **Content validity** refers to whether the specific items on a test are representative of the area that the test is designed to measure. For example, questions on a measure of depression should include the most common symptoms experienced by persons diagnosed with depression (such as feeling "blue," worthless, and hopeless, or having thoughts of suicide).

- **Face validity** is how much a test appears to measure what it is supposed to measure. For example, an instrument that measures depression would have high face validity if one could tell from the kind of questions (for example, about sadness, suicidal thoughts) what the measure was designed to assess.

- **Criterion validity** looks at the relationship between an instrument's scoring and a specific outcome or criterion. An example of criterion validity would be if scores on an instrument designed to measure a child's readiness in school correlated with the teacher's assessment of each child's readiness based on observations of the child (Sattler, 1992).

- **Convergent and discriminant validity**, respectively, refer to the extent to which a test correlates with other variables with which it should correlate and does not correlate with different variables (Anastasi & Urbina, 1997). A high correlation between a math ability test score and math class grades is an example of convergent validity. A low correlation between a math test score and grades in a class unrelated to math (such as reading or history) is an example of discriminant validity.

- **Incremental validity** refers to whether a measure adds information that helps improve the results obtained with other assessment measures (Hunsley & Meyer, 2003). Assessment should be as efficient as possible and avoid redundancy; each interview or questionnaire should provide added value (Johnston & Murray, 2003). If an instrument's incremental validity is high, it is worth the time and effort needed to administer, score and interpret. However, if the incremental validity is low, time spent giving the assessment may not be justified. This factor is important in the juvenile justice setting, where time and resources are limited.

- **Ecological validity and the "real world."** There is another type of validity — "ecological validity" — which means that a screening or assessment produces meaningful and helpful outcomes in the "real world."

Appendix C: Glossary of terms and acronyms

List of Acronyms

AAIS	Adolescent Alcohol Involvement Scale
ACF	Administration for Children and Families
BERS	Behavioral and Emotional Rating Scale
CAASP	Child and Adolescent Service System Program
CBCL	Child Behavior Checklist
CCEP	Connecticut Center for Effective Practice
CCJCC	Cook County Juvenile Court Clinic
CCPA	Connecticut Community Providers Association
CESI	Clinical Evaluation and Services Initiative
CHDI	Child Health and Development Institute of Connecticut
CJTS	Connecticut Juvenile Training School
CSCI	Comprehensive System Change Initiative
CSSD	Court Support Services Division
CWLA	Child Welfare League of America
DAST-A	Drug Abuse Screening Test for Adolescents
DCF	Department of Children and Families
DISC	Diagnostic Interview Schedule for Children
DMHAS	Department of Mental Health and Addiction Services
DOC	Department of Corrections
DSS	Department of Social Services
FWSN	Family With Service Needs
IOP	Intensive Outpatient Program
JAG	Juvenile Assessment Generic
JJIE	Juvenile Justice Intermediate Evaluation
MAYSI-2	Massachusetts Youth Screening Instrument
NAMI	National Alliance for the Mentally Ill
NICHD	National Institute of Child Health and Development
NIMH	National Institute of Mental Health
NMHA	National Mental Health Association
OJJDP	Office of Juvenile Justice and Delinquency Programs
OPM	Office of Policy and Management
PDS	Pre-dispositional Study
PEC	Physician's Emergency Certificate
PHP	Partial Hospital Program
PTSD	Post Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SIQ	Suicidal Ideations Questionnaire
SOC	System of Care
TESI-SC	Traumatic Events Screening Instrument
TGI	Traumatic Grief Inventory
TSCC	Trauma Symptom Checklist for Children
UCLA-PTSD-RI	Post Traumatic Stress Disorder Rating Instrument
WISC	Wechsler Intelligence Scale for Children
YIC	Youth in Crisis

Glossary of terms

Adjudication: A finding by the court indicating that a child is guilty of committing offense(s) alleged in a petition. Similar to a conviction in adult criminal court.

Alternative sanctions: Mechanism for informal diversion and immediate sanctioning, usually to first or second time status or misdemeanant offenders.

Adjudication hearing: Hearing at which the juvenile delinquency court judge or judicial officer determines that a juvenile is responsible for the offense that has been filed.

Affidavit: Document that describes the circumstances of the alleged offense. Also referred to as the police report, the case summary, and the probable cause statement.

Alternative to detention: A privately-run facility contracted by the CSSD to provide an environment made secure by staff. This type of facility is for children from detention who are assessed to be appropriate for this less restrictive environments.

Arrest: When a person with legal authority, usually law enforcement, takes someone into involuntary custody for questioning or detainment.

Assessment tools: In-depth information gathering and diagnostic tools, used by trained professionals to determine needs, diagnoses, and strengths.

Competency to stand trial: Whether a person has the ability to understand the nature of the court proceedings and to assist attorneys with his or her defense. Based on an assessment of capacity, the judge decides whether a person is competent to stand trial.

Court order: Document that records the decisions made by the court at delinquency hearings and which is distributed to legal parties and key participants at the end of the court hearing.

DCF commitment: Placement of a child/youth in the custody (for delinquent and FWSN children) or guardianship (for neglected, dependent or uncared for children/youth) of the Department of Children and Families by an order of the court.

Delinquent: A child found to have violated any federal or state law, municipal or local ordinance (other than one regulating behavior of a child in a FWSN), or order of the Superior Court.

Delinquency hearing: Proceedings presided over by a juvenile delinquency court judge or judicial officer to respond to a petition alleging a juvenile law violation.

Detention: State-operated or state-designated facility providing temporary care for children alleged to be delinquent and who require a physically-restricted secure environment.

Detention hearing: The first juvenile delinquency court hearing regarding an alleged delinquent child who is placed in detention at the time the child is being arrested on a warrant.

Dismissal: A judge's decision to end court proceedings.

Disposition: Orders of the court following adjudication that assign the most appropriate type of care and treatment for a child/youth (similar to sentencing in criminal court).

Disposition hearing: Hearing at which the juvenile delinquency court makes orders regarding the consequences to an adjudicated child as a result of the law violation.

Diversionary programs: Community-based programs that allow convicted offenders who are eligible to remain out of prison.

Evidence-based treatments: Theoretically-based, scientifically researched interventions that have clear evaluation procedures, have been replicated successfully, and are shown to have measurable and sustained positive outcomes.

Externalizing disorders: Behavioral health disturbances characterized by physically demonstrated symptoms such as hyperactivity, impulsiveness, or fighting.

Extra-familial supports: Activities, resources, or people, outside of one's immediate family, that are available to provide help and support.

Family with service needs (FWSN): A family which includes a child who: a) runs away without just cause; b) is beyond the control of his/her parents or guardian; c) has engaged in indecent or immoral conduct; and/or d) is truant, habitually truant or continuously and overtly defiant of school rules and regulations.

Felony: Offense for which a person may be sentenced to a term of imprisonment in excess of one year.

Gender-specific (female focus): A program that adheres to the principles of effective programming for girls as delineated by the Office of Juvenile Justice and Delinquency. Prevention (see Guiding Principles for Promising Female Programming, OJJDP, 1998). Founded in research about female development, the program design emphasizes relational and strength-based approaches delivered within female-only environments.

Internalizing disorder: Behavioral health disturbances characterized by non-physically demonstrated symptoms such as fear, anxiety, or depression.

Judicial handling: Cases, handled by a judge, where a person is not willing to admit responsibility, or which require issuing of a judicial order. A delinquency petition is filed with the court stating the allegations and the state's attorney becomes involved.

Legal guardian: Adult who is not the biological parent, or a licensed child caring agency, who has been given legal authority by a court to provide care for and custody of a child.

Misdemeanor: A broad category of offenses for which a person may be sentenced to a term of imprisonment of not more than one year.

Non-judicial handling: Minor delinquent or FWSN cases handled in an informal manner by a probation officer when the child admits responsibility. The probation officer can dismiss the case, place the child in a program with supervision or treatment for up to six months, or recommend a hearing before a judge.

Parole: Placement of an adjudicated and committed delinquent under the supervision of a DCF-employed parole officer following a period of residential treatment or incarceration.

Probation: Placement of an adjudicated delinquent under the supervision of a CSSD-employed probation officer and the rules set forth by the court.

Recidivism: Relapse into a previous condition of (criminal) behavior. Usually refers to re-arrest and adjudication.

Residential treatment programs: Programs that provide extensive behavioral, psychiatric or substance abuse treatment while the individual is attending school and living at the program.

Status offender: Juvenile who has committed an offense that would not be considered an offense if committed by an adult (i.e. truancy, running away).

Supervision: A status used in FWSN or delinquency cases, similar to probation, where it is understood that the court can take further action if a child or parent/guardian does not follow court recommended plans.

Treatment planning: Process of developing a written plan of service containing problem formulations and recommended interventions that have measurable outcomes.

Truancy: Four unexcused absences from school in any single month or ten unexcused absences in any school year as defined by Connecticut statute.

Youth in crisis: Youth between the ages of 16 and 17 who, within the last two years: a) have run away from home without just cause; b) are beyond the control of parents/guardian/custodian; or c) are truant from school.

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