

Miami-Dade Juvenile Assessment Center

**Procedural Guidelines for Conducting
Need/Risk Screening & Assessment**

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PROCEDURAL GUIDELINES FOR CONDUCTING
NEED/RISK
SCREENING AND ASSESSMENT

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I. OVERVIEW OF THE PROCEDURAL GUIDELINES

A. Goals

These procedural guidelines for administering mental health and substance use need and delinquency risk screening and assessment instruments are designed to ensure that all youth are evaluated so that they may receive needed services. They were developed to advise screening and assessment staff in the following ways:

1. Provide procedures for administering, scoring, and interpreting mental health and substance use need and delinquency risk screening and assessment instruments;
2. Provide a uniform screening protocol that is clearly linked to the assessment process to ensure that assessments are completed on youth who score highest on the screen;
3. Reinforce the link between the screening, assessment, treatment and contract planning, and referral, treatment and contract implementation functions to ensure that recommended services match the specific needs and level of risk of the youth; and
4. Assist with the development of treatment plans for youth.

The procedural guidelines detail a comprehensive screening and assessment model for youth. They serve as a single-source of information on how to screen, assess and develop treatment and contract plans for youth. Additionally, these guidelines were developed to ensure public safety by providing a framework for making decisions on how best to link youth to services and interventions that provide them with skills and competencies needed to live crime free lives.

B. Purpose and Review of Process

Under the guidelines, each youth will be administered a standardized screening instrument to assist in the determination of mental health, substance use, and other critical needs. Youth who score high on the screening measure will receive targeted assessments to measure areas in need of further examination. Appendix B, page 24, provides an overview of the instruments to be used in the needs screening and assessment process. Assessment staff will assess the level of continued delinquency risk using a screening instrument. Those youth who score within the predetermined risk range will then be assessed with the delinquency risk assessment measure. The results of the screening and assessment instruments are clinically evaluated by the case planning team. This team should include assessment staff, the clinical supervisor, the youth, family members and others familiar with the youth. Once the results have been evaluated, the case planning team meets for a case planning conference. Discussion among this group leads to the development of a treatment plan and referrals for necessary services.

C. Considerations in the Screening and Assessment Process

The screening and assessment process should be used to answer the following questions:

1. Does the youth have a problem(s) behaviorally, emotionally, in relationships that are of sufficient severity and duration to cause distress, disability or disadvantage?
2. If there is a problem(s), is the clinical profile consistent with a recognizable pattern?
3. What is the etiology and sustaining forces that maintain the problem(s)?
4. What are the strengths, resiliencies and competencies of the youth and family?
5. What, if any, clinical services have successfully benefited the youth in the past?
6. Untreated, what is the likelihood of further delinquent behavior?
7. What types of interventions are most likely to be effective?
8. What is the nature of the offense and how is it related to future needs?

D. Overview of Screening and Assessment Procedural Guidelines

The gathering of information and creation of the recommendations were initially intended to encompass the entirety of the JAC. It became clear, however, that while the information noted here could apply to JAC operations, the PAD program had more control over any changes that could be made in operations. Thus, the processes and procedures within this document have been tailored to meet the screening and assessment needs of the PAD program.

In the following document are suggested steps for screening and assessment activity. Step One, on page 6, is a description of the needs screening protocol. Step Two describes the needs assessment protocol for youth with high elevations on the MAYSI-2 and can be found on page 8. Step Three in the process, page 10, involves the collection of collateral and family information. Step Four is the risk screening and assessment process and Step Five is the interpretation of the screening and assessment instruments as well as the determination of need and risk. These can be found on pages 13 and 14, respectively. Step Six, page 16, is the participant contract planning conference and Step Seven, page 17, is the development of the contract. Each step in the screening and assessment continuum is illustrated in the flowchart on page 5.

References to research literature used to formulate the Procedural Guidelines are listed on page 19. The last section of this document is a set of appendices that supplement the information provided in the Procedural Guidelines and are meant to assist with the reader's understanding of the screening and assessment process.

II. STEP ONE: NEEDS SCREENING PROTOCOL FOR ALL YOUTH

A. Prevalence of Disorders among the Juvenile Justice Population

More than one million youths come in contact with the juvenile justice system each year. Approximately 100,000 of these youth are placed in correctional facilities, including juvenile detention. Although researchers (Cocozza, 1992; Cocozza & Skowrya, 2000; Otto Greenstein, Johnson, and Friedman, 1992; Wierson, Forehand, & Frame, 1992) have noted that there is scant research and literature on the prevalence of mental health and substance abuse disorders among youth involved with the juvenile justice system, available information suggests that these disorders do exist within this population.

Researchers (Kazdin, 2000) have found that youth involved with the juvenile justice system have diagnosable mental health disorders or serious emotional disturbances at rates greater than their non-justice-involved counterparts. Cocozza & Skowrya (2000) reported at least one in five justice-involved youth has serious mental health problems and that nearly 50 to 75 percent of these youth also have a co-occurring substance use disorder. Teplin, Abram, and McClelland (1998), in a study of 1500 Cook County Juvenile Detention Center youth, reported similar results. Twenty percent of these youth met the DSM-III-R criteria for some affective disorder, twenty percent for an anxiety disorder, approximately fifty percent for a substance abuse disorder, and almost fifty percent for a disruptive behavior disorder.

B. Definition of Screening

Screening is generally the first in a sequence of different intervention strategies. The purpose of the screen 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). It is usually conducted to identify youth who may require additional attention, monitoring, immediate treatment, facility programming, or more comprehensive assessments. Screening provides opportunities for the treatment provider to better understand the social and emotional functioning of the youth. Screening generally does not provide psychiatric diagnoses, yet it provides information on the mental state of youth. Screening can generally be done by professionals with appropriate training.

Screening can also be effective in identifying transient and reactive mental and emotional responses these youth have to recent events in their lives (Grisso & Barnum, 2000). These can be issues of safety for the youth and others in the care of the juvenile justice facility, as well as indications of possible future mental health problems. Substance use issues are important to identify as a possible need for treatment and for the more immediate concerns of physical and psychological detoxification. Suicide risk and the tendency of aggression towards others should also be identified early in the justice process to provide safety to the youth and others. In fact, many states now have regulations requiring that every youth entering a juvenile justice facility be screened (Grisso & Barnum, 2000).

C. Introduction to the MAYSI-2

In 1992, a national collaboration of organizations involved in mental health and juvenile justice published a monograph focused on the need for improved mental health services for this population (Cocozza, 1992). However, the first step to providing these services was to identify youth who were experiencing mental health problems. The development of *The Massachusetts Youth Screening Instrument* (MAYSI), a screening instrument for use with justice-involved youth, began in 1994 with a pilot grant from the *Center for Mental Health Services Research* (University of Massachusetts Medical School) (Grisso & Barnum, 2000). Funding from the *William T. Grant Foundation* (1996-98) was used to examine the instrument's reliability and validity in a large sample of youth in contact with the juvenile justice system. Subsequent development and refinement produced the revised MAYSI-2 in 2000 (Grisso & Barnum, 2000). The MAYSI-2 is now being used in 25 states and internationally.

The Massachusetts Youth Screening Inventory-Two (MAYSI-2) is a 52-item self-report instrument that identifies potential mental health and substance abuse needs of youth at any entry or placement point in the juvenile justice system. It takes approximately 10-15 minutes to administer and is a public domain instrument.

The MAYSI-2 provides a standardized score on identified symptomatology. For youth who score low on the screen, additional follow-up testing may not be required. However, for youth who score highest on the screen (MAYSI-2 warning range), an examination of the scope and severity of those clinical elevations will ensue. While there may be documented reasons for clinical elevations and variations, the use of standardized assessment instruments are used to capture relevant information. Furthermore, the use of a primary instrument is a method of bringing additional standardization to the screening and assessment process.

D. Proposed Protocol

All youth will undergo a comprehensive screen using the MAYSI-2. In preparing to administer the MAYSI-2, the assessment staff will prepare youth for the questionnaire. Part of this preparation will assist in developing rapport and informing each youth of the purpose of the screen and how the results will be used.

III. STEP TWO: NEEDS ASSESSMENT PROTOCOL FOR YOUTH WITH HIGH ELEVATIONS ON MAYSI-2

A. Definition of Assessment

Whereas the screening process highlights areas for additional investigation, the assessment process assists in determining the severity of mental health and substance use disorders, conditions associated with the disorders, individual motivation, readiness for treatment, and other deficit or strength based issues. Assessment is a more comprehensive and individualized examination of the psychosocial needs and problems identified during the initial screen, including the type and extent of mental health and substance use disorders, other issues associated with the disorders and recommendations for treatment intervention. Generally, assessments can be administered by professionals with some specialized training. This training can include: clinical interviews, training on the use of specialized instruments, and collecting biological data, including alcohol and drug tests.

B. Proposed Protocol

For those youth whose score on a MAYSI-2 subscale is within the Warning Cutoff, a more targeted assessment should be conducted. The chosen assessment instrument depends in part on the clinical symptom elevation (**See Appendix C-Clinical Assessment Decision Tree Chart, page 25. More information on screening and assessment process may also be found in the Needs Assessment Determination Breakdown, found in Appendix D, page 26**). *NOTE: If the thought disturbance item # 26 is the sole item marked, additional testing may not be warranted. The clinical supervisor will need to follow-up with the youth to determine mitigating factors (i.e. reading level, substance use, cultural factors, etc.) pertaining to the youth's response to this item.*

The MAYSI-2 identifies 7 subscales of elevated symptomatology including:

- Thought disturbance,
- Depressed/anxious,
- Alcohol/drug use,
- Suicide ideation,
- Traumatic experience,
- Angry/irritable and
- Somatic complaints.

The following section describes these elevated symptoms and lists the instrument(s) to be used for targeted assessment.

C. Objective Assessment Instruments & Elevation Scales:

Elevated MAYSI-2 Thought Disturbance and/or Depressed/Anxious Scales:

Use: Comprehensive Addiction Severity Index for Adolescents (CASI-A) and Brief Psychiatric Rating Scale-Children (BPRS-C)

The Comprehensive Addiction Severity Index for Adolescents (CASI-A) is an interview based instrument designed to measure the severity of addiction and problems in other life areas. The CASI-A takes approximately 45 minutes to administer and is a public domain instrument.

The Brief Psychiatric Rating Scales (BPRS) requires clinician ratings based on a clinical interview. It yields ratings on severity of a variety of psychiatric symptoms and provides a total symptom severity index. The BPRS takes approximately 20 minutes to administer and is a public domain instrument.

Elevated MAYSI-2 Alcohol/Drug Use, Angry/Irritable, Traumatic Experiences and/or Somatic Complaints Scales:

Use: Comprehensive Addiction Severity Index for Adolescents (CASI-A)

The Comprehensive Addiction Severity Index for Adolescents (CASI-A) is an interview based instrument designed to measure the severity of addiction and problems in other life areas. The CASI-A takes approximately 45 minutes to administer and is a public domain instrument.

Elevated MAYSI-2 Suicide Ideation Scale:

Use: Comprehensive Addiction Severity Index (CASI-A) and Suicide Clinical Interview

The Suicide Clinical Interview is the primary targeted measure used to obtain diagnostic clarity for youth whose MAYSI-2 Suicide Ideation screening scale is elevated. Use of the Suicide Clinical Interview is also triggered whenever youth have made recent suicidal attempts and for youth with an in-patient psychiatric hospitalizations within the past year. This interview coupled with the CASI-A provides a comprehensive analysis of suicide risk factors. The Suicide Clinical Interview takes approximately 30-60 minutes to administer.

Behavioral and Emotional Rating Scale (BERS):

The Behavioral and Emotional Rating Scale (BERS) is a 52-item strengths-based approach to assessment that is clinician rated. Using a Likert scale format, the BERS measures behaviors associated with family unity, ability to ask for help, interests and other pro-social related areas. It takes approximately 10 –15 minutes to administer. It is not a public domain instrument and associated costs include manual, test, and summary response forms. The BERS is useful as it provides information on youth strengths and resiliencies. Balancing this tool with the other tools that generally provide information on deficits, allows the case planning team to develop treatment plans. Additionally, the BERS provides valuable information on the family, including consideration of cultural factors and other available resources. (More information on these instruments may be found in Appendices E, pages 27 through 34.)

IV. STEP THREE: COLLECTION OF COLLATERAL AND FAMILY INFORMATION

The collection of collateral and family information adds further dimension to the screening and assessment process. Collateral information generally includes a review of previous psychosocial, psychological, and psychiatric information; medical and court data; and consultation with family members and previous treatment providers. The collection of collateral information specifically assists assessment staff in gathering pertinent information regarding family strengths, considering cultural factors and other resources. Ideally, collateral information should be gathered during the screening period; however, it may be more feasible and practical to collect this information during the assessment. Collateral information assists in the development of comprehensive treatment plans.

V. SPECIAL CONSIDERATIONS

In cases where youth assessments are not completed within the determined time parameters, the assessment staff will be responsible to communicate the reasons to other appropriate staff members. Under these circumstances, the assessment staff will complete as much of the screening and assessment as possible. For youth needing additional time for testing, the assessment staff will ensure that those youth are assessed by requesting additional time to complete this process. The clinical supervisor will provide additional support to the assessment staff to facilitate the assessment of youth whose mental health or security needs preclude their assignment to a correctional or community treatment program.

Please note:

1. Youth who are currently prescribed psychotropic medication shall be seen by the clinical supervisor for a targeted clinical interview, regardless of his/her score on the MAYSI-2.
2. Youth who have been admitted to an inpatient psychiatric hospital within the past year should undergo both the mental health screen and assessment regardless of their MAYSI score.
3. Youth who have been administered a psychological evaluation within a year of referral, using the recommended assessment instruments, may have certain portions of mental health assessment waived.

Among a small fraction of youth who may require other referral information for specialized mental health and substance use needs, highly specified instruments may assist in determining the issues needing to be addressed. The next section provides information on other referrals for specialized assessments.

Specialized Referrals for Assessment

While a battery of comprehensive assessment instruments have been identified, there may be instances where a more specialized assessment instrument is necessary. Youth presenting the following types of behaviors or disorders may require further assessment:

Neurological Problems

- Hyperactivity, restlessness and impulsivity;
- Attention deficits, distractibility and poor organization;
- Neurological, minimal brain damage and organicity;
- Motor proficiency, stereotypic movements;
- Sensory impairment, perceptual difficulties; and
- Visual-motor perception, auditory perception.

Developmental Problems

- Pervasive developmental, autistic, mutism;
- Developmental delays and milestone misses;
- Memory deficits, short, intermediate and long-term;

- Tic, tourette's, chronic motor or vocal;
- Elimination, encopresis and enuresis;
- Achievement, learning disabilities and disorders; and
- Eating disturbance, bingeing and purging, pica.

Whenever these issues are present, a coordinated and collaborative process must guide information gathering and recommendations. Additional consultation from subject matter experts may be needed. Many of the aforementioned specialized areas will most likely be further assessed once a youth is transferred to the appropriate treatment provider.

VI. STEP FOUR: RISK SCREENING AND ASSESSMENT

A. Introduction to the Youth Level of Service/Case Management Inventory (YLS/CMI)

YLS/CMI Screening Instrument

The YLS/CMI screening instrument, created by Robert D. Hoge, Ph.D., is an 8-item short form that will be used on all youth. The screening instrument is currently in pilot test form and is designed to provide an initial screening of risk and need levels in youth for purposes of determining whether a more thorough assessment is appropriate. Completion of the screen should be based on the information gathered from the mental health and substance abuse needs screening and assessment process and from all available collateral information. For more information on how to obtain the YLS/CMI, please contact Multi-Health Systems at (800) 456-3003 or www.mhs.com.

YLS/CMI Full Risk Assessment

The YLS/CMI originated from the Level of Service Inventory (LSI) (Andrews & Bonta, 1995), a risk and needs assessment instrument for use with adult offenders. The YLS/CMI is designed to aid juvenile justice assessment staff in assessing the level of risk of continued delinquency in youthful offenders. The YLS/CMI is a 42-item checklist that identifies risk factors most predictive of continued delinquent activity. Many of the items are identified as criminogenic needs factors that are amenable to change, and if changed, will reduce the chances of continued antisocial behavior.

The YLS/CMI is composed of six sections that yield a detailed survey of risk and need factors exhibited by the youth and provides linkages between these factors and the formation of a case plan. A fundamental assumption of the instrument is that decisions about youth must be based on valid and relevant assessment instruments known to assist in the determination of the risk and need characteristics of youth (Hoge, 1999).

B. Proposed Protocol

After the mental health and substance abuse needs screening and assessment process has been completed and collateral information has been gathered, the YLS/CMI screening instrument is completed on the youth. Youth scoring low on the risk screen will not need further assessment. However, should youth score in the moderate or high range on the screen, assessment staff will be required to complete the full YLS/CMI assessment instrument.

VII. STEP FIVE: INTERPRETATION OF INSTRUMENTS AND DETERMINATION OF NEED/RISK

Assignment of Mental Health Level of Need

After the screening and assessment and information-gathering process is completed, assessment staff will interpret the screening and assessment instruments and assign the youth a Mental Health Need Level using the Youth Mental Health Profile Rating Scale (See Appendix I, page 41). The Youth Mental Health Profile Rating Scale is designed to assist assessment staff in the determination of the youth's level of need from the screening and assessment instrument scores. If a youth has a High score on ANY one or all of the needs assessment instruments (BPRS, CASI-A, and the Suicide Clinical Interview), that youth has a profile of High Need. Should a youth score in the mid-level range on one or more of the instruments, with no high scores on any, the youth's profile would be one of Moderate Need. If a youth scores low on all three of the needs assessment instruments, his or her profile of need would fall into the Low Need category. Youth who do not have any elevated scores on the MAYSI-2 will fall into the No Need category.

Assignment of Level of Risk

After completion of the YLS/CMI screen and full risk assessment, assessment staff will assign youth with a level of risk using the score from the YLS/CMI screening instrument or from the worksheet from Part IV of the YLS/CMI full assessment form.

Composite Mental Health Index

Current research literature indicates that the most intensive services should be expended on youth who demonstrate highest need, while little or no services be assigned to youth who demonstrate lower levels or no need. Appendix J, page 42, is a diagram illustrating these findings.

Once level of need and level of risk has been determined and assigned to youth, assessment staff may use the Composite Mental Health Index, Appendix K, page 43, to refer youth to appropriate level of services and other interventions. The Index consists of 16 need/risk categories and is intended to create an objective decision-making system that matches mental health and substance abuse need and delinquency risk to services and interventions and intensity of PAD supervision. For example, the Index ranks the most intensive levels of psychiatric services with the highest levels of need and risk would receive the highest levels of services and other interventions, as well as the most intensive levels of supervision. Conversely, youth with low or no need/risk scores should receive the little or no services or interventions or supervision. Youth with moderate risk scores fall into moderate levels of services and interventions, as well as moderately intensive levels of supervision. (Please see Appendix G, page 39, for a chart of current contact by level of risk.)

It should be noted that this Composite Mental Health Index is a chart of suggested treatment and sanctions characterized by level of need and risk and that sound clinical judgment always takes precedence over the decision tree process.

PAD Processing Continuum

The PAD Processing Continuum, found on page 5, is a pictorial representation of PAD youth processing operations from initial intake to referral. The Continuum depicts the initial separation of youth at intake after the administration of the MAYSI-2. Youth scoring highest on the

MAYSI-2 go on to assessment staff to be further tested for mental health and substance abuse needs. Both groups of youth are screened for criminogenic risk factors with the use of the YLS/CMI. Youth are then assigned a level of mental health need and a level of risk. A contract plan is developed based on the Composite Need/Risk Index, the BERS, and all other information gathered on the youth. The participant contract planning conference discussed in the next section then leads to referral to services and other interventions.

VIII. STEP SIX: PARTICIPANT CONTRACT PLANNING CONFERENCE

After completing the screening and assessment battery and the assignment of need/risk, the contract planning team is convened. As previously noted, the team should consist of assessment staff, the clinical supervisor, the youth, family members and other persons familiar with the youth. If a youth is currently involved with any other child-serving systems, an appropriate agency official should be invited to participate in the Contract Planning Conference. The clinical supervisor shall oversee this process, including the referral, to ensure its completion. The goal of the Participant Contract Planning Conference is to make final recommendations regarding all treatment and criminogenic needs of the youth. Additionally, these conferences provide opportunities for family, youth and staff to collaborate on significant issues and to plan accordingly. The conference, through utilization of motivational interviewing techniques and principles of brief therapy, will encourage youth to participate in the contract planning and subsequent treatment and other interventions. Additionally, the conference will allow input from family members and other available sources for contract planning purposes.

A report needs to be prepared prior to the contract planning conference. This report should serve as the basis of the Contract Planning Conference and should include:

- identifying information,
- reason for referral,
- current situation,
- pertinent background history,
- mental status/behavioral observations,
- screening and assessment results, and
- clinical and diagnostic impressions.

During the Contract Planning Conference, the following areas should be reviewed:

1. Explain the purpose of Contract Planning Conferences;
2. Parent/Guardian's perception of youth;
3. Obtain youth's self-perception of strengths/weaknesses;
4. Review medication, if warranted;
5. Review of special needs (social, family, environment, etc.);
6. Review of the mental health diagnosis & necessary treatments;
7. Do youth and family understand mental health & special needs? and
8. Do youth and family agree with the assessment?

At the end of the conference, a contract should be developed with specific treatment recommendations, goals and objectives.

IX. STEP SEVEN: THE CONTRACT

A. Contract Planning

The purpose of the Contract is to combine the information from the Contract Planning Conference with specific recommendations for treatment and other services. The following should be considered when writing the Contract:

- The Contract should communicate the clinical and juvenile justice profile of the youth.
- The Contract should integrate the scores from each instrument with observations of the youth's behavior, attitude, cultural factors, temperament, case history information and personality variables.
- When constructing the Contract, consideration should be given to the setting and location of test administration. Situational factors such as the youth's difficulty or ease in adjustment to the JAC must be considered.
- The document should contain specific examples of the youth's behavior that exemplify his or her overall demeanor and response to the screening and assessment process. It is crucial that assessment staff preface their conclusions concerning this matter, with culturally relevant information gathered during the process.
- Information gathered from family members and other collateral sources should be reflected in the Contract.
- The Contract should include specific goals and objectives, and ways in which progress or attainment of goals may be measured.
- Periodic re-evaluations should be built in to gauge progress and to reconsider intervention strategies.

Recommendations, based on the youth's strengths and treatment and criminogenic needs, should be made with a thorough understanding of the youth, his or her family, culture, school and community. Efforts should be made to ensure that the referral source(s) implement the recommendations as soon as possible and to ensure that applicable information is shared across all care systems.

Based on the contract, youth are referred to the most appropriate juvenile justice and community treatment programs.

1. Review with youth and family services to be rendered and the frequency of services;
2. Review of goals and objectives to meet treatment needs;
3. Review timetable for goal accomplishment;
4. Review organization that will provide specified services;
5. Review who is responsible for overall coordination of services; and
6. Youth signs Contract. (If youth refuses to sign Contract, it should be noted by the signature line.)

B. Referral

Information from the Contract Planning Conference is used to help assure youth are matched and assigned to interventions that best address his/her individualized needs.

The contract planning team works closely with parents, guardians, referral agents and court staff members in placing youth in the most appropriate placement. All relevant information is shared with juvenile justice and community treatment programs and providers so that a successful transition is accomplished. Each program receives youth based on their initial needs, degree of risk and level of maturity. These programs shall also take into account individualized issues such as intellectual functioning and special management issues secondary to suicide risk or potential for violence, sexual aggression and vulnerability to being victimized by others.

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XI. APPENDICES

Appendix A – Overview of Appendices

An overview of the appendix information is provided to further illustrate the aforementioned guidelines.

This information is categorized as follows:

Appendix B: Screening & Assessment Battery

The Screening and Assessment Battery provides an illustration of the screening and assessment instruments. It provides information on who administers the instruments, total staff time to administer the instruments, total youth time and the percentage of youth who receive screening and assessment instruments. Additionally, the Screening and Assessment Battery provides information on what objective assessment tools and collateral measures to be used based on the MAYSI-2 subscale elevations.

Appendix C: Clinical Assessment Decision Tree Chart

The Clinical Assessment Decision Tree Chart is designed to assist assessment staff in identifying the screening and assessment tools to be implemented at various points in the screening and assessment protocol. Use of these tools is based on previous information and MAYSI-2 cutoff scales. Any elevation on the MAYSI-2 subscales, current use of psychotropic medications, current mental health issues, prior history of suicidal behavior and prior admission to an inpatient psychiatric hospital within a year will prompt the assessment staff to implement targeted testing. Based on the level of acuity, youth are referred to an appropriate correctional or community-based program for on-going care. Additionally, the Clinical Assessment Decision Tree Chart provides information on contingencies to consider when screening and assessing youth.

Appendix D: Assessment Determination Breakdown

Building on the Clinical Assessment Decision Tree Chart, the Assessment Determination Breakdown provides an illustration of the screening and assessment process.

Appendix E: Instrument Summary Sheets

The Instrument Summary Sheets are designed to inform readers of the essential elements of screening and assessment instruments. This emphasis allows readers to adjust to the needs of youth while individually addressing their needs. It allows for an ethical, moral, and legal approach to identify the most appropriate instruments. It further assists in streamlining relevant information categories in determining the treatment needs of youth involved in the juvenile justice system. The categories included serve as a review and synthesis of the most effective screening and assessment instruments to determine the mental health and substance use needs. Although instruments can be categorized in many ways, description of relevant characteristics most useful for practitioners is provided.

Appendix F: Suicide Clinical Interview

The Suicide Clinical Interview is the primary targeted measure used to obtain diagnostic clarity for youth whose Suicide Ideation screening scale is elevated along with youth with recent suicidal attempts and with more than two in-patient psychiatric hospitalizations within the past year. The interview measures frequency, duration and intensity of suicide ideation, gestures, attempts and self-mutilative behaviors.

Appendix G: Current PAD Contact by Level of Risk

The Current PAD Contact by Level of Risk is a chart that describes the intensity of PAD supervision of youth at each level of risk currently assigned by PAD. This chart was designed as part of the decision tree model to demonstrate current PAD risk assignment processes.

Appendix H: Youth Level of Service/Case Management Inventory (YLS/CMI) Screening Version

The Youth Level of Service/Case Management Inventory (YLS/CMI) Screening Version is the short version of the YLS/CMI full risk assessment. It is currently in pilot test form and is to be used on all youth in the PAD program. Higher risk/need scores obtained from this instrument indicate the need for a more thorough risk assessment.

Appendix I: Youth Mental Health Profile Rating Scale

The Youth Mental Health Profile Rating Scale is designed for assessment staff to easily determine a youth's level of mental health need using scores from the mental health and substance abuse screening and assessment battery of instruments. This Profile was created as part of the decision tree model to assist in the objective linkage of screening and assessment to services referral.

Appendix J: Diagram of Need/Risk for Level of Services

The Diagram of the Need/Risk for Level of Services is a diagrammatic view of assigning services at prescribed need/risk levels. The Diagram was designed to demonstrate findings from research literature that indicates providing the most intensive level of services to high need youth and lesser or no services to low need youth.

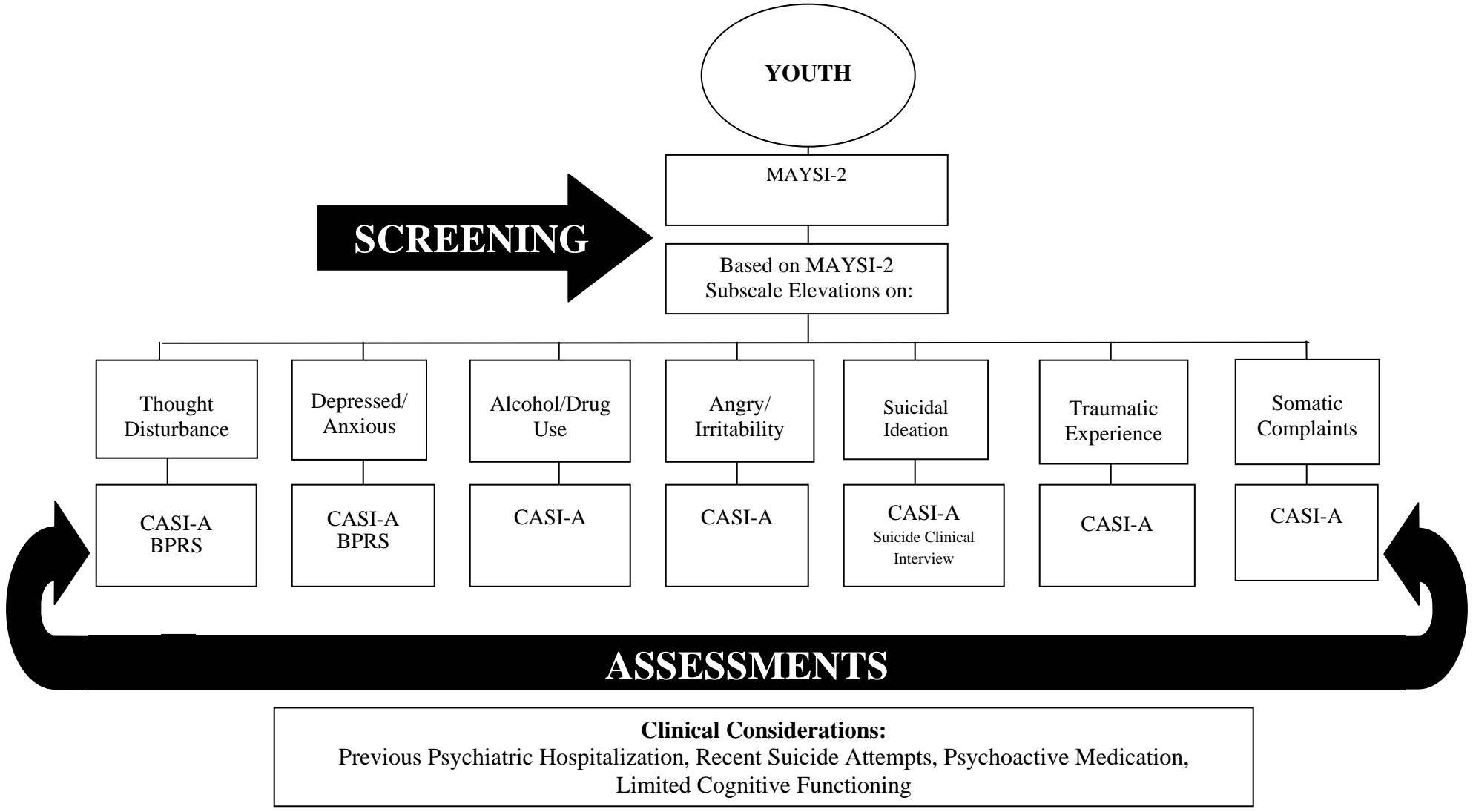
Appendix K: Composite Need/Risk Index

The Composite Need/Risk Index is constructed as a primary decision-making tool for assignment of services and supervision during contract planning after the screening and assessment and information gathering process is completed. . The Index indicates 4 levels of mental health and substance abuse need and 4 levels of delinquency risk and is designed to provide suggestions for contract planning and services referral and intensity of supervision.

Appendix B – Screening and Assessment Battery

INSTRUMENTS/MEASURES	STAFF	TOTAL STAFF TIME	TOTAL YOUTH TIME	PERCENT YOUTH
SCREENING				
Massachusetts Youth Screening Instrument – Two (MAYSI-2)	Intake Staff	15 mins.	15 mins.	100%
ASSESSMENT				
Elevated Thought Disturbance/Depressed-Anxious Scales – <ul style="list-style-type: none"> • Comprehensive Addiction Severity Index for Adolescents (CASI-A) and • Brief Psychiatric Rating Scales (BPRS) 	Assessment Staff	20 mins.	20 mins.	50%
Elevated Alcohol/Drug Use, Traumatic Experiences, Angry/Irritability, & Somatic Complaints Scales – <ul style="list-style-type: none"> • Comprehensive Addiction Severity Index for Adolescents (CASI-A) 	Assessment Staff	45 mins.	45 mins.	50%
Elevated Suicidal Ideation – <ul style="list-style-type: none"> • Comprehensive Addiction Severity Index for Adolescents (CASI-A) and • Structured Suicide Clinical Interview 	Assessment Staff	25 mins.	25 mins.	50%
Strengths –based Assessment - <ul style="list-style-type: none"> • Behavioral Emotional Rating Scale (BERS) 	Assessment Staff	15 mins.	15 mins.	100%

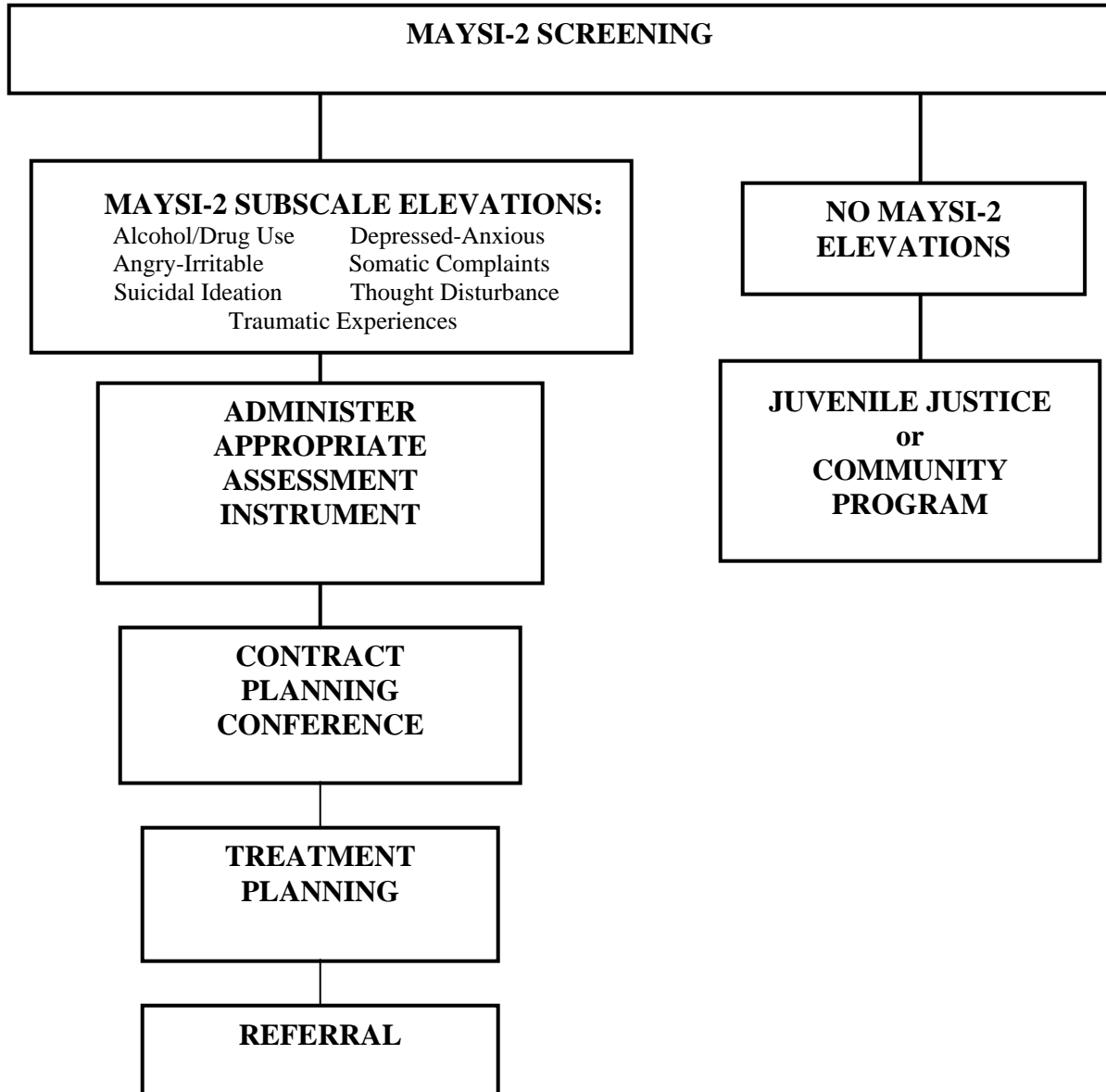
CLINICAL NEEDS ASSESSMENT DECISION TREE CHART



ASSESSMENTS

Clinical Considerations:
Previous Psychiatric Hospitalization, Recent Suicide Attempts, Psychoactive Medication,
Limited Cognitive Functioning

Appendix D – Needs Assessment Determination Breakdown



Appendix-E – Instrument Summary Sheets

This section contains Instrument Summary Sheets to inform the reader of the essential elements of the screening and assessment instruments discussed in this manual. These sheets summarize by category the relevant information for each instrument. The categories are defined and listed below.

Description

This category provides readers with a cursory review of the instrument, its purpose and other relevant information. More detailed information may be obtained by contacting each instrument's respective "Developer/Publisher".

Constructs Measured

This category provides readers with a list of multi-life domains measured by each instrument. Special attention is given to the instrument's relevancy in the juvenile justice system. Areas may include the actual clinical indices measured (resiliencies, depressed affect, anger and aggression, intellectual and neuropsychological deficits, anxiety, confusion, etc.) or the broad category of information obtained (medical, employment, social relations, etc.).

Age Range

This category provides the specific age range designated for the various instruments. All instruments included in this monograph are applicable for children and adolescents.

Administration/Scoring

Various forms of administration are practical and valuable for planning. This category indicates the following methods of administration:

- Paper-and-pencil
- Interview
- Computer-automated

Additionally, this category uses the following terminology for scoring:

- Scored by hand with a template
- Scored with a computer program
- Scored online by the test publisher only.

Administration Time

This category provides readers with allocated times for the completion of each instrument. An attempt was made to locate instruments with an administration time of approximately 20-30 minutes. However, depending on the objectives of various instruments, the length of administration times vary accordingly.

Level of Training Required

This category provides information regarding the level of clinical experience and education needed to administer each instrument. Special attention has been given to provide assessment instruments that may be administered by non-advanced degreed practitioners. The following language has been utilized to capture this information:

- In-service training with the instrument, no clinical experience required
- Specialized training with the instrument, no clinical experience required
- Clinical experience required, Master's level degree
- Clinical experience required, Doctoral degree level

Research Background

This category provides information on the research background of each instrument. Special attention is given to providing instruments that are considered most relevant to clinicians and other professions working with youth in the juvenile justice system. At the time of this publication, very few instruments have been validated with juveniles with co-occurring disorders and studies may be currently underway in the identification of psychometric properties. This section attempts to capture the degree to which the instrument has been researched in general. The following categories are utilized:

- Limited research
- Some research
- Much research

“Limited research” is used to communicate that minimal to no known research has been published regarding these particular instruments. “Some research” indicates a few studies with these instruments have been conducted and published. “Much research” asserts that many published studies with these instruments have been conducted.

Research with Juvenile Justice Samples

This category provides information on instruments that have had reliability and/or validity studies done with juvenile justice samples and provides information on whether the instrument is being used in juvenile justice settings.

Use with Ethnic Minorities

This category provides information on the languages in which the instrument is available and the research on the instrument that has examined possible ethnic/racial differences in scores. The following categories are used:

- Information available in the manual
- Information available in research reports
- No known research and no information available in the manual.

Developer/Publisher

This category provides contact information for each instrument's developer/publisher. When available, web and email addresses have been included. The readers may also contact developer/publisher for cost information.

Necessary Purchases

This category provides a list of necessary items to purchase in order to implement the instrument.

Instrument Summary Sheets

1. Massachusetts Youth Screening Instrument-Two (MAYSI-2)

Description	The Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) is a 52-item self-report instrument that identifies potential mental health and substance use needs of youth at any entry or transitional placement point in the juvenile justice system (Grisso & Barnum, 2000). The MAYSI-2 can be administered to juveniles in probation intake interviews or within 24 to 48 hours after their admission into juvenile justice facilities.
Constructs Measured	Alcohol/Drug Use Depressed-Anxious Angry-Irritable Somatic Complaints Suicidal Ideation Thought Disturbance Traumatic Experiences
Age Range	12-17 years
Administration/Scoring	Paper and pencil & computer-automated administration Scored by hand with a template & with a computer program
Administration Time	10 to 15 minutes
Level of Training Required	In-service training with the instrument, no clinical experience needed
Research Background	Some research
Research with Juvenile Justice Samples	Yes
Use with Ethnic Minorities	Available Languages: English & Spanish (under development) Research On Ethnic Differences: Information available in Manual & Test
Developer/Publisher	National Youth Screening Assistance Project (MAYSI) Department of Psychiatry – WSH-8B University of Massachusetts Medical School Worcester, MA 01655 508-856-8727 For more information: www.unmassmed.edu/nysap
Necessary Purchases	Answer forms, scoring forms, and computer programs available without charge, but use is authorized only for programs that register with the National Youth Screening Assistance Project.

2. The Behavioral and Emotional Rating Scale (BERS)

Description	The Behavioral and Emotional Rating Scale (BERS) is a 52-item strengths-based approach to assessment that is clinician rated. Using a Likert scale format, the BERS measures behaviors associated with family unity, ability to ask for help, interests and other pro-social related areas.
Constructs Measured	Interpersonal Strength, Involvement with Family, Intrapersonal Strength, School Functioning, Affective Strength
Age Range	5 – 18 years
Administration/Scoring	Paper-and-pencil Scored by hand with a template
Administration Time	10 to 15 minutes
Level of Training Required	Clinical experience required, Master's level degree
Research Background	Some
Research with Juvenile Justice Samples	Yes
Use with Ethnic Minorities	Available Languages: English Research On Ethnic Differences: No known research
Developer/Publisher	Psychological Assessment Resources P.O. Box 998 Odessa, FL 33556 1-800-331-8378 (U.S. & Canada) or 813-968-3003 For more information: http://www.parinc.com/forensic/CPS52a.html
Necessary Purchases	Manual & Test Summary Response Forms

3. Brief Psychiatric Rating Scale for Children (BPRS-C)

Description	The Brief Psychiatric Rating Scale for Children (BPRS-C) provides a description of emotional and behavioral disorders. This 21-item clinician-rated interview is designed to characterize youth and evaluate treatment responses, for a variety of different diagnostic classifications.
Constructs Measured	Behavioral Problems Uncooperativeness Hostility Manipulativeness Depression Depressive Mood Feelings of Inferiority Suicidal Ideation Thinking Disturbance Peculiar Fantasies Delusions Hallucinations Psychomotor Excitation Hyperactivity Distractibility Speech or Voice Pressure Withdrawal Retardation Underproductive Speech Emotional Withdrawal Blunted Affect Anxiety Tension Anxiety Sleep Difficulties Organicity Disorientation Speech Deviance Stereotyping
Age Range	3-17 years
Administration/Scoring	Interview Scored by hand with a template
Administration Time	20 minutes
Level of Training Required	In-service training with the instrument, no clinical experience needed. Some Research
Research Background	
Research with Juvenile Justice Samples	Yes
Use with Ethnic Minorities	Available Languages: English Research On Ethnic Differences: No known research
Developer/Publisher	Dr. John E. Overall Department of Psychiatry and Behavioral Sciences University of Texas Medical School P.O. Box 20708 Houston, TX 77025
Necessary Purchases	Manual & Test Parent Guide Profile

4. Comprehensive Addiction Severity Index for Adolescents (CASI-A)

Description	The Comprehensive Addiction Severity Index for Adolescents (CASI-A) is an interview-based screening instrument designed to measure the severity of addiction and problems in other life areas (McLellan & Dembo, 1993). Assesses concomitant symptomatology and consequences of adolescent alcohol/drug use within the multidimensional functional domains listed below so that problems do not remain hidden. Guides treatment planning and assessment of outcomes. Determines when the problem symptoms began to occur. Assesses adolescent's knowledge of presence of the problem and the amount of discomfort the problem is causing.	
Constructs Measured	Education Alcohol/Drugs Family Relationships Legal	Use of Free Time General Information Peer Relationships Psychiatric
Age Range	12-18 years	
Administration/Scoring	Paper/pencil, Interview & Computer-automated administration. Scored with a computer program.	
Administration Time	Approximately 45-90 minutes depending on the amount of alcohol/drugs used.	
Level of Training Required	In-service training with the instrument, no clinical experience needed.	
Research Background	Some research	
Research with Juvenile Justice Samples	Yes	
Use with Ethnic Minorities	Available Languages: English Research On Ethnic Differences: Information available in Manual & Test.	
Developer/Publisher	Kathleen Meyers System Measures, Inc. P.O. Box 506 Spring Mount, PA 19478 1-610-287-4426	
Necessary Purchases	Manual & Test Scoring sheets	

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

Description	The Youth Level of Service Inventory (YLS/CMI) is designed to survey attributes of offenders and their situations relevant to level of supervision and treatment decisions. Probation officers, parole officers, and /or correctional workers interview youth and review file data and test scores, etc. These ratings provide a comprehensive risk/needs assessment important to offender treatment planning.
Constructs Measured	Prior and Current Offenses/Dispositions Family Circumstances/Parenting Education/Employment Peer Relations Substance Abuse Leisure/Recreation Personality/Behavior Attitudes/Orientation
Age Range	12 - 16 years
Administration/Scoring	Paper and pencil & Computer-automated administration Scored by hand with a template & with a computer program
Administration Time	30 – 40 minutes
Level of Training Required	In-service training with instrument, no clinical experience required
Research Background	Some research
Research with Juvenile Justice Samples	Yes
Use with Ethnic Minorities	Available Languages: English, Spanish, French-Canadian Research On Ethnic Minorities: Information available in manual
Developer/Publisher	Multi-Health Systems, Inc. 908 Niagara Falls Blvd. North Tonawanda, NY 14120-2060 1-800- 456-3003 For more information: http://www.mhs.com/
Necessary Purchases	Manual & Test Interview Guides Score Forms Interview Guides ColorPlot Profiles

Appendix F – Suicide Clinical Interview

SIGNIFICANCE		GENERAL CATEGORY AND SPECIFIC RISK FACTORS	QUESTIONS & AREAS TO BE EXPLORED
Social-Relational			
Yes	No	<i>Social Supports</i>	Family relationships? Last contact by phone, letter, visit? Recent or expected significant change?
Yes	No	<i>Recent Losses</i>	Recent death of loved one? Imminent loss anticipated due to illness, etc.? Unusual factors in losses (e.g., murder, etc.)?
Yes	No	<i>Status Issues</i>	Significant alteration of circumstances? Unusual high risk group (newsworthy crime, etc.)?
Situational			
Yes	No	<i>Juvenile Justice</i>	Time in institution (first incarceration, etc.)? Length of incarceration? Status with Court? Release date and plans?
Yes	No	<i>Institutional Issues</i>	Adjustment crisis (disciplinary issues)? Problems with other Youth/security?
Yes	No	<i>Safety Issues</i>	View of institution environment (dangerous)? Level of fear and perception of ability to cope?
Medical			
Yes	No	<i>Distressing Illness</i>	Medical illness? Life-threatening condition?
Yes	No	<i>Pain (physical)</i>	Intensity/duration/frequency? Ability to tolerate?
Yes	No	<i>Chemical Abuse/Use</i>	History of drug/alcohol abuse? Use? Current problem status (withdrawal, intoxication, etc.)?
Psychiatric			
Yes	No	<i>Treatment History</i>	Type of treatment? Diagnoses? Recent discharge from inpatient status? Medications (dosages, side effects, problems, compliance, history of use in self-destructive actions)?
Yes	No	<i>Current Status</i>	Diagnosis? Medication regime? Specific suicide risk features (command hallucinations, etc.)?
Psychological			
Yes	No	<i>General Mental Health</i>	Current mental status exam (mood, affect, thought content, reality perception, judgment, insight, intellectual function, etc.)? Diagnostic impressions? Anxiety, emotional instability, etc.? Acute perturbation?
Yes	No	<i>Hopelessness/helplessness</i>	Absence of strong positive reasons to live? Dependency issues? Personal internal resources? Views factors in situation as uncontrollable or unchangeable?
Yes	No	<i>Depression</i>	Obvious and subtle signs? Irritability? Feelings of worthlessness? Rating of level of severity? Loss of pleasure or interest?

			Clinical depression?
Yes	No	<i>Pain (emotional)</i>	Heightened level emotionality in relation to pain?
			Low frustration tolerance expressed?
			Self-assessment of pain as intolerable?
Yes	No	<i>Negative cognitions</i>	Evidence for shame, self-loathing, and/or perceived humiliation?
			Evidence of pessimistic world view?
			Exaggeration of symptoms?
			Inability to articulate positive alternatives?
Yes	No	<i>Coping Resources</i>	Inability to articulate cogent reasons for living?
			History of deficits in coping?
			Major deficits in basic living skills?
			Presence of constriction?
Historical			
Yes	No	<i>Self-destructive</i>	Past suicide attempts?
			Past suicide gestures?
			Past suicide ideations?
			Methods used?
			Lethality assessment?
			Intentions?
			How discovered?

Yes	No	<i>Impulsivity</i>	History of impulsive acting out?
			Level of self-control?
			Frustration tolerance level?
			History of unpredictable actions?
			History of violent acts? Assaultive?
Yes	No	<i>Personal awareness</i>	Family members with completed suicide?
			Family members with history of depression/substance abuse?
			Personal contact with suicidal individual(s) (completed or attempted)?
			Unusual factors—fascination with suicide?
Behavioral			
Yes	No	<i>Self-destructive</i>	Self-inflicted injury?
			Current attempt?
			Type of attempt?
			Lethality of attempt?
Yes	No	<i>Withdrawal</i>	Personal hygiene?
			Change in isolation or socialization?
			Eating? Sleeping?
			Changes in interactions with others?
Yes	No	<i>Related Actions</i>	Hoarding/stealing medications?
			Collecting materials?
			Writing a letter with death references? Suicide note?
			Making final arrangements? Putting affairs “in order?”
Motivational			
Yes	No	<i>Intentionality</i>	Desire to die, escape, effect change, solve problem?
			Malingering, feigning, or factitious features?
			Communicated intent? To whom?
			Ambivalence?
Yes	No	<i>Plan</i>	Specific plan?
			Lethality of plan?
			Means available?
Yes	No	<i>Goals</i>	Sees death as way out of terrible psychological or other pain?
			Absence of short or long range goals?
			Unwillingness to work with clinician?
			Unwillingness and/or inability to convincingly state will ask for help?

*Adapted from Kelly Ray, Ph.D., Louisiana State University

Suicide Clinical Interview Summary

Yes	No	Key Points
		Does person have a specific plan on how they will take their life?
		Has person had a plan and/or did they ever actually attempt to take their life in the past?
		Are person's intentions to end their life at this time?
		<i>Does person believe that ending their life at this time will be rewarding or remove from emotional/physical pain?</i>
		Has there been a recent significant life tragedy or loss for person?
		<i>Is person depressed to the point that they are thinking about ending their life? Degree of depression?</i>
		Does person have current significant physical health problems?
		Does person currently see life as basically hopeless?

Italics/bold print warrants immediate precautions

Appendix G - Current PAD Contact by Level of Risk

Miami-Dade Juvenile Assessment Center PAD Program

RISK LEVEL	LOW	MODERATE	HIGH
Staff Assigned	Monitoring Unit	Field Unit	Field Unit
Face to Face Contact with Youth and Family	Letter sent within 3 to 4 days after release from JAC. Appointment scheduled at JAC within 7 to 12 Days to review contract.	Appointment scheduled at Field Office within 7 to 14 days to review contract.	Appointment scheduled at Field Office within 7 to 14 days to review contract.
Home Visits	No	By end of first month	By end of first month
School Visit	No	By end of second month	By end of second month
Community Work Service Contact	Youth provides documentation by fax or in person.	Youth provides documentation by fax or in person.	Youth provides documentation by fax or in person.
Phone Contacts with Youth	Monthly	Youth calls bi-weekly (usually Friday or Monday); Staff to follow up, if not.	Youth calls bi-weekly (usually Friday or Monday); Staff to follow up, if not.
Contacts with Community-Based Organizations	Not Applicable.	At least once a month. Organization provides monthly written reports.	At least once a month. Organization provides monthly written reports.
Final Contact to Close Case	Phone call to youth once all documentation is provided. Staff to follow-up, if not. Letter sent noting completion of program	Phone call to youth once all documentation is provided. Staff to follow-up, if not. Letter sent noting completion of program	Phone call to youth once all documentation is provided. Follow-up home visit by staff, if not. Letter sent noting completion of program

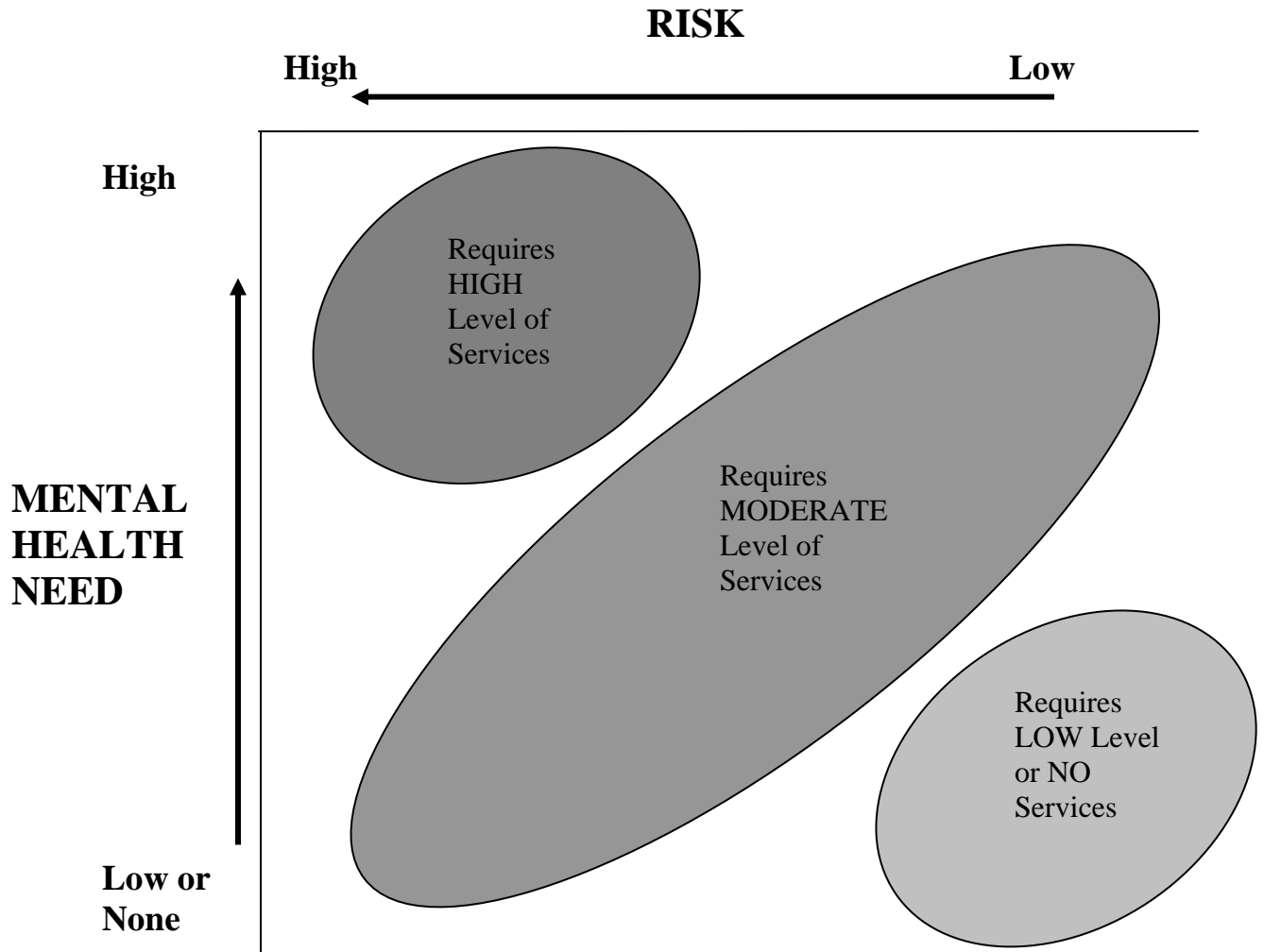
Appendix H - Youth Mental Health Profile Rating Scale

Prepared by the National Center for Mental Health and Juvenile Justice
Policy Research Associates, Delmar, New York

<u>SCORES OBTAINED FROM NEEDS ASSESSMENT(S) (BPRS, CASI-A, AND THE SUICIDE CLINICAL INTERVIEW)</u>	<u>SCORE GIVEN TO YOUTH ON COMPOSITE NEED/RISK INDEX</u>
If youth has HIGH scores on ANY one (or all) of the Needs assessment instruments	High Need
If youth scores in the MID-LEVEL range on ANY one instrument, but NO high scores	Moderate Need
If youth scores LOW on all three of the needs, with NO mid-level or high scores	Low Need
If youth does NOT have ANY elevated scores on the MAYSI-2	No Need

Appendix I – Diagram of Need/Risk for Level of Services

**Prepared by the National Center for Mental Health and Juvenile Justice,
Policy Research Associates, Delmar, New York**



Appendix J - Composite Need/Risk Index for Assignment of Services and Supervision

Prepared by National Center for Mental Health and Juvenile Justice
Policy Research Associates, Delmar, New York

Mental Health Need/ Delinquency Risk	Very High Risk Scores 35-42	High Risk Scores 23-34	Moderate Risk Scores 9-22	Low Risk Scores 0-8
High Need Scores <i>Services/ Interventions</i>	<u>Most Intensive Services</u> , such as Childrens Psychiatric Center/ Functional Family Therapy/Follow up Psychiatric Services/ Substance Abuse Services, Turn Around Police Academy (TAPA)	<u>Most Intensive Services</u> , such as Childrens Psychiatric Center/ Functional Family Therapy/Follow up Psychiatric Services/ Substance Abuse Services, Turn Around Police Academy (TAPA)	<u>Moderate Intensity of Services</u> , such as Follow up Psychiatric Services/ Substance Abuse Services, Turn Around Police Academy (TAPA)	
<i>PAD Supervision/ Sanctions</i>	<u>Most Intensive Supervision</u> , such as High Frequency of Home & School Visits, & Weekly Phone Contact/ Community Work Service	<u>Most Intensive Supervision</u> , such as High Frequency of Home & School Visits, & Weekly Phone Contact/ Community Work Service	<u>Moderate Intensity of Supervision</u> , such as Bi-Weekly Phone Contact/Community Work Service	
Moderate Need Scores <i>Services/ Interventions</i>	<u>Moderate Intensity of Services</u> , such as Supportive Individual, Family, and/or Group Counseling up to Therapeutic Foster Care/ Substance Abuse Services	<u>Moderate Intensity of Services</u> , such as Supportive Individual, Family, and/or Group Counseling up to Therapeutic Foster Care/ Substance Abuse Services	<u>Moderate Intensity of Services</u> , such as Supportive Individual, Family, and/or Group Counseling up to Therapeutic Foster Care/ Substance Abuse Services	<u>Least Intensive Services</u> , such as Substance Abuse Education
<i>PAD Supervision/ Sanctions</i>	<u>Most Intensive Supervision</u> , such as High Frequency of Home & School Visits, & Weekly Phone Contact/ Community Work Service	<u>Most Intensive Supervision</u> , such as High Frequency of Home & School Visits, & Weekly Phone Contact/ Community Work Service	<u>Moderate Intensity of Supervision</u> , such as Bi-Weekly Phone Contact/Community Work Service	<u>Least Intensive Supervision</u> , such as Monthly Phone Contact/Community Work Service
Low Need Scores <i>Services/ Interventions</i>	<u>Moderate Intensity of Services</u> , such as Supportive Individual, Family, Group Counseling/Substance Abuse Services	<u>Moderate Intensity of Services</u> , such as Supportive Individual, Family, and/or Group Counseling/ Substance Abuse Services	<u>Moderate Intensity of Services</u> , such as Supportive Individual, Family, and/or Group Counseling/ Substance Abuse Services	<u>Least Intensive Services</u> , such as Substance Abuse Education
<i>PAD Supervision/ Sanctions</i>	<u>Most Intensive Supervision</u> , such as High Frequency of Home & School Visits, & Weekly Phone Contact/ Community Work Service	<u>Most Intensive Supervision</u> , such as High Frequency of Home & School Visits, & Weekly Phone Contact/ Community Work Service	<u>Moderate Intensity of Supervision</u> , such as Bi-Weekly Phone Contact/Community Work Service	<u>Least Intensive Supervision</u> , such as Monthly Phone Contact/Community Work Service
No Need PAD Supervision/ Sanctions		<u>Most Intensive Supervision</u> , such as High Frequency of Home & School Visits, & Weekly Phone Contact/ Community Work Service	<u>Moderate Intensity of Supervision</u> , such as Teen Court, Bi-Weekly Phone Contact/Community Work Service	<u>Least Intensive Supervision</u> , such as Teen Court, Monthly Phone Contact/Community Work Service

Empty Cells Indicate That Youth Are Unlikely to Fall Into These Categories