

C010949 ABSTRACT: Out of necessity, most juvenile justice systems offering screening and assessment services to African-American youth with co-occurring mental health and substance use needs have relied on inappropriate instruments and methodologies. This has led to the inconclusive and unreliable analysis of the actual needs of African-American youth with co-occurring disorders. There is an urgent need for proper guidelines, testing and interview materials and acceptable procedures for African-Americans' treatment upon entering the juvenile justice system. This paper discusses topics such as minority overrepresentation, cultural competency, selection of instruments, and recognizing key clinical signs and symptoms. It offers recommendations on future research.

Title Screening and Assessing African-American Youth Involved in the Juvenile Justice System: Practical Considerations.

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California Youth Authority (CYA) Sued Over General Conditions: Mental Health Care Attacked

On January 24, 2002 a complaint was filed in the federal district court in Sacramento generally alleging wholesale failure on the part of the CYA. The complaint's specific allegations range from the imposition of excessive force and a concomitant failure to protect vulnerable wards; excessive use of lockup; inadequate physical facilities; lack of due process; inadequate programs and exercise; interference with counsel; and, inadequate dental, medical, and mental health care.

The allegations in a complaint, of course, are just that — allegations. However, as reported in the *New York Times*, p. A-8 (Jan. 26, 2002), the CYA apparently conceded, over two years ago, that something in the system was quite wrong. With about 6300 youths, the 11 prisons and four camps in the system had become known for brutality and abuse.

State Inspector General Steven White concluded that "it would be impossible to overstate the problem." The California Board of Corrections then ordered an experts' report that was completed in November of 2000 and which included scores of recommendations for reform. Nonetheless, the Prison Law Office in San Quentin, led by the formidable Donald Specter filed the law suit under discussion: *Stevens v. Harper*, No. Civ. S-01-0675DFL-PAN-P (E.D. Cal.).

Plaintiffs are seeking injunctive relief.
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Screening and Assessing the Mental Health and Substance Use Needs of African-American Youth

By Lee A. Underwood

Introduction

Out of necessity, most juvenile justice systems offering screening and assessment services to African-American youth with co-occurring mental health and substance use needs have relied on inappropriate instruments and methodologies. This has led to the inconclusive and unreliable analysis of the actual needs of African-American youth with co-occurring disorders. There is an urgent need for proper guidelines, testing, and interview materials, and for acceptable procedures for African-Americans' treatment upon entering the juvenile justice system.

The current state of affairs results in a population of juvenile offenders which has slipped through the cracks, unable to receive effective treatment for their specific disorders. The general area of screening and assessing co-occurring disorders has consumed enormous amounts of energy on the part of juvenile justice professionals in the reformulation of their ideas and notions. Now that such professionals have acquired expertise and experience in the area of screening and assessment, it is time to address the specific needs of African-American youth with co-occurring disorders.

Available research has noted ma-

major discrepancies in the screening, assessment, and treatment involvement of minority youth, particularly African-American youth as compared with Caucasian youth in the juvenile justice system (Isaacs, 1992; Rubin, 2001). The overrepresentation of minorities in the juvenile justice system, and the underutilization of mental health and substance use services for African-American youth, ultimately raises serious concerns about the treatment of these youth. What happens to African-American youth when they are not appropriately screened and assessed for co-occurring mental health and substance use problems?

General prevalence statistics indicate that African-Americans increasingly are coming into contact with the juvenile justice system for all types of offenses. These youth represent 15% of the American youth population; yet they continue to comprise the majority of adolescents involved in the juvenile justice system. Data from 1997, demonstrates that African-Americans constitute 26% of juvenile arrests, 32% of referrals to juvenile courts, 41% of persons held for secure pretrial detention, 52% of individuals transferred to criminal courts, and 46% of those sentenced

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to correctional facilities (Rubin, 2001). They have more contact with law enforcement, are more likely to be held in detention and training schools, and have more referrals for felony offenses with more restrictive dispositions.

There is, then, minority overrepresentation and disproportionate minority confinement. The former refers to the harsher treatment of minorities in comparison to their Caucasian counterparts by the juvenile justice system at every stage. The latter is a subset involving only the harsher treatment of minorities detained at secure facilities during pre-trial and post-dispositional stages.

The culmination of these phenomena strongly argues that many of the African-American youth involved with the juvenile justice system have co-occurring mental health and substance use issues. Consequently, juvenile justice, mental health, and substance use practitioners across the nation increasingly face the arduous task of screening, assessing, and treating youth with co-occurring disorders, particularly African-American youth.

The following sections discuss opportunities to incorporate key issues into the screening and assessment of African-American youth in contact with the juvenile justice system. First, information on minority overrepresentation and disproportionate minority confinement in the juvenile justice system and its association with under detection and under treatment is presented. Second, an overview of co-occurring disorders and its difficult problem in screening and assessment is offered. Third, principles of cultural competency guide readers to ensure accuracy in the process of screening and assessing youth. Fourth, principles of screening and assessment are provided. This fourth section focuses on the four major principles of screening and assessment: selection of instruments, administration and interpretation of instruments, key clinical signs and symptoms, and reporting the results. Fifth, a review and synthesis of commonly used instruments are presented. This section includes the name of the instrument, its validation with a juvenile justice population, information on training required for administration,

scoring and interpretation, and research on ethnic differences. Sixth, recommendations are provided to assist the field in focusing on areas of future research.

Minority Overrepresentation and Disproportionate Confinement

Minority overrepresentation and disproportionate minority confinement is a predictor of arrest, incarceration, and release, and of juvenile justice involvement rather than involvement with the mental health system (Issacs, 1992). This phenomenon coupled with the implementation of improper screening and assessment methodologies relate to negative characterization of African-American youth. These characterizations often add barriers that prevent the identification of mental health problems experienced by African-Americans, including rage. Their behaviors are de-contextualized and diagnosed as symptoms of "anti-social acting out," "manipulative and willful," and "aggressive." Such labels not only perpetuate low self-esteem and self-

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fulfilling prophecies, but also compound difficulties in addressing the underlying etiology of emotional and high-risk behaviors leading to delinquency. With limited access to treatment and resources to meet their needs, many African-American youth express their distress by engaging in high-risk behavior, school truancy, gang-related activities, abusing substances, and minimizing mental health symptoms. These youth are consequently labeled delinquent.

Despite the increasing numbers of African-American youth coming in contact with the juvenile justice system, little information is available regarding their characteristics as they traverse various correctional, educational, health, child welfare, mental health, and substance abuse systems. This is pronounced in the lack of evidence-based and psychometrically sound instruments derived from this population. The dearth of epidemiological studies on the prevalence of mental health and substance abuse concerns impacting the lives of African-American youth further pronounces this concern. The next section provides an overview of co-occurring disorders and its associated outcomes.

Overview of Co-Occurring Disorders

Co-occurring disorders are varied and complex by virtue of simultaneously having multiple clinical syndromes. The term is consistently used to describe the existence of two or more disorders; one as substance use and the second referring to a clinical syndrome or mental health disorder. Mental health disorders consist of those that meet the criteria for some of the disorders listed in the Diagnostic Statistical Manual, Fourth Edition, Text Revision (American Psychiatric Association, 2000). References in this document to mental health disorders generally refer to disorders that substantially impair judgment, mood, or thought when accompanied by functional impairment. Individuals with co-occurring disorders are heterogeneous in terms of psychiatric diagnoses, use of substances, and degree of dysfunction or impairment (Osher and Drake,

1996). Indeed, there is no typically dually diagnosed youth. Further, there is a great deal of heterogeneity within diagnoses and types of substances abused. For example, the alcohol abuser can be classified into subgroups on the basis of etiology, family history, course, prognosis, and treatment response (Bukstein et al., 1989).

The number of all juvenile offenders presenting with mental disorders continues to increase. Studies demonstrate that 20% to 30% of all juveniles who enter the justice system have serious mental disorders while 50% to 75% have other service needs (Davis, Bean, Schmacher & Stringer, 1991; Timmons-Mitchell, 1997). Results from the Office of Juvenile Justice Delinquency Program's (OJJDP) Program of Research on the Causes and Correlates of Delinquency indicates that 50% of drug-using males and 20% of drug-using females were persistent serious delinquents (Huizinga, Loeber, Thornberry & Cothorn, 2000).

The presence of co-occurring disorders in youth enhances the risk for all youth to behave more impulsively and aggressively (Underwood et al., 1997). These youth are at great risk for negative outcomes in several dimensions of their lives (Greenbaum et al., 1996; Kaminer and Frances, 1991; Osher and Drake, 1996). These dimensions are reflected in behaviors that complicate matters in treatment and rehabilitation; they negatively impact not only the youth's present ability to adjust, but also his or her transition through society and psychosocial development into adulthood. When compared with youth having one or no disorders, the youth under discussion are at elevated risk for the following: depression (Capaldi, 1992; Zoccolillo, 1992), with adolescent girls displaying relatively higher rates of depressive disorders (Angold and Rutter, 1992; Robins and Reiger, 1991; Timmons-Mitchell et al., 1997); suicidal behavior (Timmons-Mitchell et al., 1997); deviant sexual behavior (Kraemer, Spielman, and Salisbury, 1995); impulse, aggression, and perhaps violence (Underwood, Walter and Walter, 1997; Villani, 1999); and, rapid progression from initial use to drug dependence.

Those with co-occurring disorders

have poorer prognoses for involvement in treatment than those with singular disorders. Individuals with co-occurring disorders in the community have been found to experience the following: poor medication compliance, decreased likelihood for successful completion of treatment, more rapid recurrence of symptoms following release from treatment, admittance to psychiatric hospital beds at high rates, and high service utilization (Cuffel and Chase, 1994; Davis et al., 1991; Timmons-Mitchell, 1997).

Other studies of adult offenders with co-occurring disorders in treatment have shown that they are more likely than those in the general population to experience pronounced difficulties in employment, family and social relationships, and physical health, including vulnerability to HIV and other medical problems (Peters and Hills, 1997). There is no reason to expect that juvenile offenders would not similarly experience psychosocial and adjustment problems. The inadequacy of services currently in place will have serious consequences for youth as they move into adulthood (Cocozza, 1997).

The assessment and treatment of youth with co-occurring disorders necessitates the collaborative systems of care: juvenile justice, substance abuse, mental health, child welfare, and education. Each of these systems has distinct philosophies of treatment and rehabilitation by which they measure and achieve success. Blending their concerns and resources would help ensure proper and efficient care for these individuals.

In order to successfully blend the concerns of collaborative systems, an understanding of cultural competency is needed. The next section provides a rationale for this phenomenon to be present at all stages of the screening and assessment process.

Cultural Competency

Juvenile justice, mental health, and substance abuse practitioners also face another challenging responsibility. They must address the needs of African-American juvenile offenders with co-occurring disorders while practicing

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the principles of cultural competency.

Cultural competence includes an awareness of how language, class, and ethnic factors; worldview and communication styles innate to minorities; and, one's own biases influence the different facets of the screening and assessment process (Sue, Carter, Casa, Fouad, Ivey, Jensen, LaFromboise, Manese, Ponterotto & Vasquez-Nuttall, 1998).

When regarding African-American juveniles with co-occurring disorders, screenings and assessments must be culturally competent to ensure accuracy in the process. Practitioners who do not adhere to principles of cultural competence during the screening and assessment of African-American youth may produce results that are culturally biased. Subsequently, misdiagnoses as well as poor and ineffective treatment and rehabilitation plans may result.

The requirement of cultural competence demands that practitioners at various points in the juvenile system observe certain guidelines that require special preparation in test administration. The preparation necessary for such development consists of educating oneself on the general worldview and customs of the African-American population; recognizing fears, taboos, and acceptable subjects of discussion among minority youth; consulting with practitioners of similar cultural background and developing a knowledge of minority youths' general perceptions (levels of acceptance or rejection) concerning screening and assessment procedures; and, implementing engagement strategies with family members to facilitate therapeutic alliance. Achieving this level of preparation may require ongoing training by attending workshops, in-services, or small group discussions on the topic.

Practicing culturally competent principles in the screening and assessment process is the first step in improving the reliability and conclusions made about African-American youth. However, the next section focuses on some basic principles of screening and assessment in the over-

all analysis of youth.

Principles of Screening and Assessment

As noted earlier, the pivotal component to overcoming the challenges of effectively treating African-American youth with co-occurring mental health and substance use disorders lies in appropriate screening and assessment practice. Screening and assessment help juvenile justice, mental health, and substance abuse practitioners to identify co-occurring diagnosed youth before further penetration into the juvenile justice system. This enables the implementation of the most beneficial treatment for such offenders. In many cases, identified youth may be diverted from the juvenile justice system altogether.

Although appropriate screening and assessment practice is critical, practitioners should be aware of the practical procedures that may hinder or enhance the process. The following section provides information on the four major procedures: selection of instruments, administration and interpretation of instruments, recognizing key clinical signs and symptoms, and reporting the results.

Selection of Instruments. A comprehensive screening and assessment process provides information about the emotional, substance use, behavioral, and juvenile justice information concerning the youth. No single instrument can provide all of this information. Therefore, a battery of instruments is recommended. The basis for selecting the appropriate instruments for screening and assessment relies on the combined influence of several factors.

First, the reason that the juvenile was referred for screening and assessment should be examined before selecting combinations of instruments. The combination of instruments used should ultimately respond to the needs of the referring system or agency.

The second factor includes the specific areas to be screened and assessed. Screening is the initial method of detecting juveniles with possible mental health and substance use disorders. During the screening phase of the process, only a few areas are routinely evaluated. They include intellectual

functioning, mental health, substance use, co-occurring disorders, and risk for further delinquent behavior. Assessment involves a more in-depth evaluation. The specific areas of interest in assessment normally include intellectual functioning, mental health, substance use, co-occurring disorders, family dynamics, educational status, juvenile justice risk, and other critical domains that may affect a youth's level of functioning.

Third, the psychometric properties of the instruments must be considered. Only instruments with the strongest research support, reliability, and validity should be selected. Instruments should be chosen that ensure linguistic comparability, clinically relevant cultural characteristics, assessment of acculturation and bi-culturation, and assessment of culture-specific dimensions of family functioning.

Fourth, budget constraints, cost efficiency, and general availability of instruments require continual consideration. An attempt should be made to select instruments that are either public domain or offered at low cost. Also, they should be readily accessible from various resources.

Fifth, the gender of the youth must be considered. Females' patterns of offending, which are often different in scope and motivation, require additional approaches to traditional screening and assessment methodologies. These include understanding the unique needs of females, valuing the female perspective, honoring her experience, celebrating the contributions of girls and women, and respecting female development (Prescott, 1997). Slight adaptations in the content and structure of screening and assessments may be needed. Although the manifestation of these symptoms may vary in intensity, frequency, and duration, it is important that instruments and other diagnostic protocol consider the differences.

In a study investigating the varying mental health needs of female and male incarcerated juvenile delinquents, it was found that prevalence of mental health disorders among females was 84% in comparison to 27% among males (Timmons-Mitchell, Brown,

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Schulz, Webster, Underwood & Semple, 1997). Research on female juveniles' diagnoses using the Diagnostic Interview for Children and Adolescents found the following frequency of mental health disorders among the sample: 100% conduct disorder, 87% substance abuse, 80% mood disorder, 47% anxiety disorder, 20% Attention Deficit Hyperactivity Disorder, and 20% enuresis (Myers, Burkett, Lyles, Stone & Kempf, 1990; Timmons-Mitchell et.al., 1997). In order to effectively determine the individual needs of female juveniles in the justice system, practitioners must carefully consider gender differences throughout the screening and assessment phase. Just as gender differences require different approaches, so should cultural differences.

Numerous instruments could be included in a battery for screening and assessment. However, many have been designed separately for measuring mental health, substance use, behavioral, and juvenile justice information. Therefore, for co-occurring issues, one must try to synthesize theoretical, research, and clinical issues from the literature into a common set of instruments for effective and comprehensive service planning. The next step involves the administration and interpretation of the instruments.

Administration and Interpretation of Instruments. The administration and interpretation of screening and assessment instruments consist of administering procedures, scoring, gathering the facts, and interpreting the results. Ideally, the administration should occur in a quiet and safe place. This practice controls for any distractions that may negatively influence the youth's performance on various instruments.

The practitioner's perception of African-American youth with co-occurring disorders is very important. A biased perception of these youth may contribute to a misinterpretation of the facts. It is crucial that the practitioner does not view the youth as helpless, disabled, impaired, victimized, poor, needy, and/or wounded (Isaacs, 1992). The youth is in need of screening and

assessment services from a practitioner who seeks to fully understand the dynamics of the youth's culture (Boyd-Franklin, 1991; Isaacs, 1992). A negative bias disregards the inherent strengths of African-American youth and their culture. Consideration of the youth's strengths may be used during treatment planning to assist the youth in achieving stability, wholeness, and, ultimately, rehabilitation. Therefore, practitioners should ensure that their face-to-face clinical interviews are culturally competent and that they exercise appropriate clinical overrides. Sound clinical judgment based in the best practices literature should be utilized whenever notable discrepancies occur among the results of instruments; it helps prevent erroneous conclusions.

A clinical override refers to the process of recognizing and exercising sensitivity to cultural nuances of minority populations by a practitioner. It enables him or her to investigate and/or resolve any discrepancies due to cultural biases of instruments by obtaining more accurate information regarding the areas under assessment. Appropriate clinical overrides include the practitioner's interpretation of instrument results in light of the youth's degree of acculturation, an understanding of the youth's worldview, idiosyncrasies of slang language, and the motivation behind certain behaviors. Clinical overrides serve as a safeguard against cultural bias and inaccurate evaluations.

A culturally competent clinical interview is the standard method of investigating an African-American youth's level of acculturation. Concerning the four areas of investigation, it is often found that African-American youth differ in comparison to their Caucasian counterparts in several areas. African-American youth generally have a present time orientation as opposed to futuristic perspective, a collateral sense of relationships versus individualistic, and a harmony with nature perspective contrary to a mastery over nature perspective. Only in the area of human activity do African-Americans and Caucasians tend to agree. Each normally prefers a "doing" mode of activity. Unlike many Caucasian youth, African-American youth often

find themselves negotiating a number of double binds particular to their minority status. For instance, the same decisions encouraged as healthy information sharing for Caucasians (disclosing family dynamics) can constitute "disloyalty" in African-American youth resulting in colliding desires and seen as resistance to the treatment process. Many African-American youth and their families are unable to separate themselves from environments and the values of those environments that place them at risk for fully accessing services in their community.

While the aforementioned procedures are necessary in the total appraisal of youth, practitioners must also recognize key clinical signs and symptoms of youth.

Recognizing Key Clinical Signs and Symptoms. African-American youth in contact with the juvenile justice system who have complicated mental health and substance abuse needs do not fare well in juvenile justice settings. Anecdotal and current research suggest there are significant differences in the manifest signs and symptoms of mental health and substance abuse, patterns of aggression, socialization, environmental stressors, and development. Screening and assessing co-occurring disorders in the juvenile justice system should examine relevant information on co-occurring, mental health, substance abuse, criminal history, and current criminal justice status. This may reveal the secondary and tertiary gains behind the actual criminal behavior.

While some of this information may be obtained from the objective instruments, the culturally competent clinical interview allows for an individualized approach to obtaining information on critical symptoms that need to be addressed. These symptoms include those manifestations of co-occurring disorders, mental illness, substance abuse disorders, and juvenile justice issues. The following section provides specific information on signs and symptoms most commonly seen in youth with co-occurring, mental health, substance abuse and juvenile justice issues.

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*(PRINCIPLES, from page 58)***Signs and Symptoms of Co-Occurring Disorders**

- Unpredictable deterioration of current mental health functioning
- Episodic rageful behavior
- Unusual affect, appearance, thoughts, or speech
- Mental confusion and disorientation
- Compartmentalized and fragmented thinking
- Excessive clingy and attention-seeking behavior
- Drug-seeking behavior
- Hypervigilance and paranoia
- Excessive curfew violation
- Negative peer association
- Intense parental conflict
- Elevated or lowered vital signs
- Excessive risk taking

Signs and Symptoms of Mental Illness

- Acute mental health symptoms
- Chronic mental health symptoms
- Suicidal behavior
- Homicidal behavior
- Onset of mental health issues
- Degree of past and current trauma
- Family history of mental illness
- Prior mental health counseling
- Out of home placement
- Presence of personality dysfunction
- Degree of agitation and explosiveness
- Degree of impulsivity and sexual perversity

Signs and Symptoms of Substance Abuse

- Signs of acute drug or alcohol intoxication
- Drug tolerance or withdrawal
- Physical impairment due to use and abuse
- Cognitive deficits
- Other addictive patterns
- Drug-seeking behavior
- Family history
- Prior treatment involvement

**Juvenile Justice Information
What Types of Juvenile Justice Information Should be Assessed?**

- Juvenile justice history
- Family history of criminal involvement
- Substance related offenses
- Disciplinary incidents while incarcerated
- Use of seclusions and restraints while incarcerated
- Validation of aggressive behaviors

Current Juvenile Justice Status

- Police reports
- Victim statements
- School records
- Social treatment
- Medical records
- Process of victim selection
- Use of force, weapons, and violence
- Ritualistic processes
- Self-destructive behaviors
- Denial and minimization
- Impulse control and compulsivity

Recognition of the aforementioned issues forms the framework for the reporting the results. The next section provides additional information to be shared with the youth, his/her family, and treatment providers.

Reporting the Results. The screening and assessment process is complete only after the results have been shared with the referral source and family members. The report is the summation of the results from the screening and assessment procedures. It should be written immediately after the completion of the battery of instruments, because the preparation of the document is integral to information sharing. The findings and organization of the report are partially dependent on the chosen instrument battery. If cultural competence was achieved during the selection and administration of instruments, the content of the report should reflect it.

All youth and their families deserve a well-written report; it is likely to follow the youth for many years. Consequently, it should communicate succinctly the co-occurring phenomenon of mental and substance abuse disorders and critical juvenile justice information. The report should reflect the

individuality of the youth. It should not be simply a collection of scores and interpretative remarks, but should integrate the scores from each instrument with behavioral observations, attitudes, cultural factors, temperament, case history information, and personality variables.

When constructing the report, 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 correctional facility must be considered. The document should contain specific examples of the juvenile's behavior, which exemplify his or her overall demeanor and response to the screening and assessment process. It is crucial for African-American youth that clinicians preface their conclusions concerning this matter with culturally relevant information gathered during the process. Additionally, information gathered from family members and other collateral sources should be reflected in the report.

Recommendations should be made with an understanding of the needs of the youth, his or her family, school, and the community. Inattentiveness to factors within the African-American culture that influence each of these areas may result in inappropriate recommendations. The referral source should implement the recommendations as soon as possible and ensure that applicable information is shared across all care systems. A typical report should provide the following information: identifying information, reason for referral, current situation, pertinent background history, mental status/behavioral observations, screening and assessment results, clinical and diagnostic impressions, summary, and recommendations.

How does one go about choosing the actual screening and assessment instrument? The next section provides information most relevant to practitioners in choosing the instruments.

Review and Synthesis of Instruments

The following section of this document is included to inform readers of the most effective screening and

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assessment instruments to determine the mental health and substance use needs among youth at various points in the juvenile justice system. Although there are numerous screening and assessment instruments, the following description of relevant characteristics most useful for practitioners helped guide the inclusion of these instruments: validation for juvenile justice population, cost factors, training required for administration, scoring and interpretation, research on ethnic differences, and domains measured. (Please refer to Tables 1, 2, 3 for a review and synthesis of commonly used instruments.) Those instruments with the associated mark of "X" indicate its association with that particular category. For a detailed analysis of these and other instruments and information on how to obtain them, please refer to the emerging study on screening and assessing juveniles with co-occurring disorders in the juvenile justice system (Underwood and Grisso-expected publication date spring, 2002).

Conclusion and Recommendations

Despite the heightened interest in co-occurring disorders, the screening and assessment of youth experiencing this phenomenon remains a complex clinical and practical process. This process is even more complex when it involves African-American youth. Yet, this does not justify the occurrence of poor, ill-advised screening and assessment procedures for this population. Instead it should motivate every clinician to be particularly conscious of this matter and recognize that principles of cultural competency must be exercised throughout the screening and assessment process.

Co-occurring screening and assessment instruments should measure emotional, behavioral, chemical risk, and, criminal characteristics that create problems in youths' performance or their families' performance. It involves specialized and skillful implementation of procedures across a wide range of service systems and providers. The practical recommendations present in this discourse are the result of research, a review of the literature, and clinical experience.

There is a dearth of normative data on African-American juveniles with co-occurring mental and substance abuse disorders. As research is conducted and such data becomes readily available, it will enhance practitioners' decision-making in this area. The results should offer practical guidelines for the effective screening and assessment of African-American youth with co-occurring mental and substance abuse disorders.

Future studies should focus on developing and integrating strength-based screening and assessment methodologies rather than solely relying on deficit-based methodologies for use with African-American youth. This method acknowledges and supports the abilities of youth and their families. Focusing on skills and resiliencies African-American youth have developed in order to negotiate their

communities reframes much of their behavior as adaptive responses and mitigates the negative effects of labeling. Additionally, these instruments could be the basis for developing culturally specific and developmentally appropriate protocol for African-American youth.

Research should focus on the multiple decision-making points in the juvenile justice system. Focus on the multiple stages may assist in understanding how small biases may effect African-American youth at later points. Continued research in the areas of organizational policy and practice in arrests, adjudication, and confinement rates is needed. Research around police contact with youth, human relations, and cultural diversity should inform researchers of innovative and challenging ways to overcome existing barriers and limitations.

Table 1: Selected Instruments

Instrument	Validation For Juvenile Justice Population	Cost	Training Required for Administering Scoring and Interpreting	Research on Ethnic Differences	Domains Measured
The Adolescent Diagnostic Interview	X	X	X	-	MH, SA,
Adolescent Substance Abuse Subtle Screening Instrument	X	X	X	X	SA
The Behavioral and Emotional Rating Scale	X	X	X	-	BH, EM
Brief Psychiatric Rating Scale	-	X	-	-	MH
Carlson Psychological Survey	X	X	X	X	MH, SA, JU
Child and Adolescent Needs and Strengths-Juvenile Justice	X	X	-	-	JU, MH, SA
Child and Adolescent Needs Strengths-Mental Health	X	X	-	-	BH, MH
Child Behavior Checklist: Parent, Teacher & Self-Report	X	X	X	X	BH, EM, JU
Children's Depression Inventory	X	X	X	-	EM
Comprehensive Addiction Severity Index for Adolescents	X	X	-	X	JU, MH, SA
Connors' Rating Scales-Revised	X	X	-	X	BH, EM

Key: AD-Academic, BH-Behavioral Problems, EM-Emotional Difficulties, IN-Intelligence, JU-Juvenile Justice, MH-Mental Health, SU-Substance Abuse, SP-Special Domain

Table 2: Selected Instruments

Instrument	Validation For Juvenile Justice Population	Cost	Training Required for Administering Scoring and Interpreting	Research on Ethnic Differences	Domains Measured
Diagnostic Interview Schedule for Children	X	X	X	-	MH
The Family Adaptability and Cohesion Evaluation Scales-II	-	X	-	-	FM
Jesness Inventory	X	X	X	X	BH, EM, MH, JU
Kaufman Brief Intelligence Test	X	X	X	X	IN
Massachusetts Youth Screening Instrument-Two	X	-	-	X	EM, MH, SA
Millon Adolescent Clinical Inventory	X	X	X	X	MH
Minnesota Multiphasic Personality Inventory-Adolescents	X	X	X	X	MH
The Personality Inventory for Youth	X	X	X	X	BH, MH

Table 3: Instruments

Instrument	Validation For Juvenile Justice Population	Cost	Training Required for Administering Scoring and Interpreting	Research on Ethnic Differences	Domains Measured
The Personal Experience Screening Questionnaire	X	X	-	-	BH, EM, SA
Posttraumatic Stress Diagnostic Scale	-	X	-	-	MH
The Problem Oriented Screening Instrument for Teenagers	X	X	-	X	JU, MH, SA
State-Trait Anger Expression Inventory	-	X	X	X	BH
Suicide Probability Scale	X	X	X	-	EM
Trauma Symptom Checklist for Children	X	X	-	-	BH, EM, MH
Wechsler Abbreviated Scales of Intelligence	X	X	X	X	IN
Wide Range Achievement Test-3	X	X	-	X	AD
Young Offender-Level of Service Inventory	X	X	X	-	JU

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(See PRINCIPLES, next page)

*In Passing***Termination of Parental Rights**

The involuntary termination of parental rights, the legal and physical severance of a child from a parent, surely is one of the gravest powers exercised by government. One reads some of the decisions on point and an initial sympathy for the parent gives way to the gravest concern for the child. The younger and more innocent the child, the graver the concern.

In *State in the Interest of S.F.*, 802 So.2d 791 (La. App. 2001), there is an all too common litany of an unknown father; drug abuse and dependence; leaving an infant unattended, found with marijuana neatly tucked into the diaper; a mother going in and out of jail, prison, treatment; and an unparented child.

It is too easy, and too depressing, to predict S.F.'s future. The mother's grief and guilt when faced

with the termination of parental rights should be balanced against trying to salvage a toddler's future; a toddler we are all too likely to read about again as a struggling juvenile.

Like corrective surgery, termination is painful but the surgery on the patient here just might save an innocent. •

AND THEN

After an agonizing review of legislative history accompanied by excruciating analysis the Court of Appeals for Wisconsin concludes:

that Wis. Stat. § 48.415(9) is ambiguous as to the extent of its applicability. After examining the statute and its legislative history, we hold that § 48.415(9) was in-

tended to be used to terminate the parental rights of fathers whose sexual assault results in the birth of a child but not the parental rights of a mother of a child who is either the victim or the perpetrator of a sexual assault.

In *re Quianna M.M. v. Stacey A.M.*, 2001 WL 1046974, (Wis. App.), the adult mother apparently had repeated sexual contact with a twelve-year old boy with the result of a pregnancy carried to term. The mother is doing twenty-two years in prison but manages to retain parental rights.

So, one parent loses and another retains parental rights and both decisions may well be right. •

(PRINCIPLES, from page 61)

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