

## Juvenile Justice Resource Series

# Screening and Assessment in Juvenile Justice Systems: Identifying Mental Health Needs and Risk of Reoffending





***Screening and Assessment in Juvenile Justice  
Systems: Identifying Mental Health Needs  
and Risk of Reoffending***

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### **About the Technical Assistance Partnership for Child and Family Mental Health**

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) provides technical assistance to system of care communities that are currently funded to operate the Comprehensive Community Mental Health Services for Children and Their Families Program. The mission of the TA Partnership is "helping communities build systems of care to meet the mental health needs of children, youth, and families."

This technical assistance center operates under contract from the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The TA Partnership is a collaboration between two mission-driven organizations:

- The American Institutes for Research—committed to improving the lives of families and communities through the translation of research into best practice and policy, and
- The National Federation of Families for Children's Mental Health—dedicated to effective family leadership and advocacy to improve the quality of life of children with mental health needs and their families.

The TA Partnership includes family members and professionals with extensive practice experience employed by either the American Institutes for Research or the National Federation of Families for Children's Mental Health. Through this partnership, we model the family-professional relationships that are essential to our work. For more information on the TA Partnership, visit the Web site at <http://www.tapartnership.org>.

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## **Forward**

Each year, more than 2 million children, youth, and young adults formally come into contact with the juvenile justice system, while millions more are at risk of involvement with the system for myriad reasons (Puzzanchera, 2009; Puzzanchera & Kang, 2010). Of those children, youth, and young adults, a large number (65–70 percent) have at least one diagnosable mental health need, and 20–25 percent have serious emotional issues (Shufelt & Coccozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). System of care communities focusing on meeting the mental health and related needs of this population through comprehensive community-based services and supports have the opportunity to not only develop an understanding around the unique challenges this population presents, but also to decide how best to overcome those challenges through planned and thoughtful programs, strong interagency collaboration, and sustained funding.

The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) recognizes the many challenges system of care communities face in working to better meet the needs of all of the children, youth, and young adults they serve. In an effort to help these communities meet the unique needs of young people involved or at risk of involvement with the juvenile justice system, the TA Partnership is releasing a resource series focused on this population. The TA Partnership has contracted with the National Center for Mental Health and Juvenile Justice (NCMHJJ) and other experts in the field to produce this resource series. Each brief examines a unique aspect of serving this population, from policy to practice, within system of care communities.

We hope that this resource series will support the planning and implementation of effective services, policies, and practices that improve outcomes for children, youth, and young adults involved or at risk of involvement with the juvenile justice system as well as their families.

## Screening and Assessment in Juvenile Justice Systems: Identifying Mental Health Needs and Risk of Reoffending

When agencies are responsible for protecting both the welfare of youth and public safety, two broad issues become important to address among the youth they serve: mental health and risk of reoffending. With respect to *mental health*, juvenile justice facilities have a legal and societal responsibility to respond to the needs of youth in their custody if those needs place the youth at risk of harm to themselves (Grisso, 2004). With respect to *risk*, in juvenile justice, this concept refers to the potential for serious reoffending and/or continued delinquent activity and potential for harming others. Juvenile court decisionmakers are often faced with the task of determining whether such behaviors might occur in the future and whether the “risk” is sufficiently great that some sort of intervention is necessary. This brief will explain why screening and assessment for risk and mental health are best used together by child-serving agencies when planning the most effective course of action for individual youth.

Addressing risk and mental health needs starts with appropriate and accurate identification. One method for identifying youth with mental health needs or youth at high risk of reoffending involves having psychologists on staff at all points of entry into a system (e.g., juvenile probation offices, detention facilities, and child welfare agencies) to conduct extensive interviews and testing with every youth. This would result in a detailed assessment of the youth’s risk of aggression, further offending, suicide, and potential psychiatric diagnoses. The problem with this approach is that it would be extremely costly given that approximately 2 million youth are arrested each year, of which more than 600,000 are processed through juvenile detention centers (Snyder & Sickmund, 2006). Many of these youth have significant mental health needs—approximately 70 percent have a diagnosable mental health disorder or symptoms of a mental disorder, and 27 percent experience disorders that impair their ability to function (Shufelt & Coccozza, 2006; Teplin et al., 2002; Vincent, Grisso, Terry, & Banks, 2008). Instead, a more efficient way of handling identification and subsequent response is to implement a two-tiered process that involves both screening and assessment.

### ***How Do Screening and Assessment Differ?***

The terms “screening” and “assessment” are often used interchangeably, but they are really not the same thing. Screening can serve as a cost-effective method for identifying potential mental health problems that can be applied to all youth entering a system or facility. Assessment, on the other hand, can provide more extensive and individualized identification of mental health needs for only those individuals whose screening results suggest it is warranted (Grisso, 2005; Vincent, Grisso, & Terry, 2007). The confusion about these concepts has stemmed from multiple sources, such as (1) the use of the term “assessment” to refer to *any* type of measurement of psychological characteristics, (2) a lack of consensual definitions of screening and assessment in the current juvenile justice literature, and (3) test authors’ labeling of instruments as screening or assessment tools without attention to the definition described here (Grisso, 2005).

Screening has two main purposes (Grisso, 2005). The first purpose is to identify youth at the point of initial system contact who might require an *immediate* response—for example, those with an immediate need for medication or placement on suicide watch. Second, screening is intended to “sift” through the total number of youth in order to identify those with the *higher likelihood* of having a problem requiring special attention. It should sort youth into at least two groups: those very unlikely to have the characteristics in question (“screened out”) and those more likely to have the characteristics in question (“screened in”). This is similar to a triage process in medical settings, which helps conserve resources in systems that cannot respond comprehensively to every youth’s needs (Grisso, 2005). Due to the nature of screening, a proportion of youth who are screened in will not actually have the problem in question (i.e., false positives), but this proportion will vary depending on the quality of the tool. For this reason, results on a screening tool are used to signal the need for a more thorough assessment of the problem.

It is also important to remember what screening does not do. Specifically, with regard to mental health, screening is not designed to provide clinically valid diagnoses of mental disorders. Screening does not provide clinicians or staff with the causes of mental health problems; it only identifies current symptoms. Mental health screening is not appropriate for long-range treatment or rehabilitation planning. Scores or ratings on mental health screening tools are expected to fluctuate because they target acute problem areas. Put simply, screenings have a short shelf life: 2–4 weeks is a good rule of thumb. Finally, given the inconsistency with which some tools have been titled by the authors, agencies should be reminded that the simple fact that an instrument is called a screening tool does not guarantee that it will serve all juvenile justice programs’ needs for a screening process.

The purpose of assessment, on the other hand, is to gather a more comprehensive and individualized profile of a youth. Thus, assessment is performed selectively with those youth screened in as requiring a more thorough identification. With regard to mental health, the intent of assessment is to verify the presence or absence of mental health needs, possibly make psychiatric diagnoses, determine how disorders manifest in an individual, and provide recommendations for longer range interventions.

Assessment practices differ in several ways from screening procedures. First, the timing of assessment methods is more variable than it is for screening. Assessment may occur soon after first contact in response to screening information to determine whether an emergency situation truly exists, the specific nature of the emergency, and how best to handle it. Or it can occur several weeks later in cases in which no crisis condition is immediately apparent. Second, assessment generally involves specialized staff or clinicians and longer administration times (more than 30 minutes) to include comprehensive testing, interviewing, and obtaining collateral information. Finally, the conclusions generated from assessment procedures are intended to be more stable (i.e., have a longer shelf life) than findings from screening tools, because they can afford to examine a youth’s conditions in more detail, including the duration and severity of



symptoms, as well as the degree to which they are actually impairing the youth's functioning.

### ***How Do These Concepts Differ for Risk Assessment Tools?***

The concepts of “screening” and “assessment” do not apply as well to risk assessments as they do to mental health tools. Rarely does one see a risk tool with the term “screen” in the name. Part of the reason for this is that, unlike mental health screening tools, most risk-related tools, whether long or short, were designed to be used in final decisions (e.g., whether to hold youth in detention or release them to the community while they await trial). Nonetheless, there is variation among risk tools in that some are brief and others are more comprehensive. Brief risk assessment tools help to answer only one question: What is the youth's likelihood of reoffending? These tools have value as a mechanism for sorting youth into categories of high and low risk, but like mental health screens, these tools generally do not have much value with respect to treatment or intervention planning. Further, many such tools will have a relatively high false positive rate (i.e., many youth who score high turn out to not reoffend).

A comprehensive risk assessment tool, on the other hand, generally will answer two questions: (1) Is this youth at relatively low or relatively high risk of reoffending? and (2) What factors in this youth's life or characteristics of the youth are likely contributing to the youth's offending or delinquent behavior? Comprehensive risk assessment tools are generally more accurate than brief tools, and they include an assessment of dynamic risk factors that can be used to guide intervention planning for the purpose of reducing risk of reoffending. As will be described in more detail later, “dynamic risk factors” are characteristics that elevate one's likelihood of offending in the future but are changeable and conceivably treatable.

### ***How Does an Agency Select a Valid Tool That Is Appropriate for Its Purposes?***

Because risk and mental health problems are two distinct concepts, valid identification of these issues requires implementing more than one tool. There is no “one size fits all” tool that will identify both problems with any reasonable degree of accuracy. Even if such a tool did exist, it is highly unlikely that it would be valid for youth from a range of populations spanning child welfare to secure correctional settings. There are a few important considerations when deciding which tool to use: (1) the “decision point” and the agency's purpose for using the tool, (2) the relevance of the tool, and (3) whether the tool is evidence based.

The “decision point” refers to a particular point in the juvenile justice or mental health agency's decisionmaking process (Grisso, 2005; Mulvey, 2005). It has a large impact on the type of screening and/or assessment process that is needed because it dictates the questions the agency needs answered and the resources available to answer them. Screening and assessment tools should be selected that are both *relevant* to the questions and *feasible* for use at these decision points (e.g., level of staff training



required to administer the tool, the time and amount of information required to administer the tool). Examples of key decision points in juvenile justice include (1) juvenile court intake, (2) pretrial detention, (3) disposition or sentencing, (4) probation, (5) placement in a juvenile corrections assessment center, and (6) community reentry. At intake, for example, the question may be whether the youth is appropriate for diversion from formal processing and/or in need of specialized mental health programming. At pretrial detention, the primary questions are (1) whether the youth needs secure detention to prevent reoffending or failure to appear in court and (2) whether mental health problems exist that warrant immediate attention for the safety of the youth.

To select a mental health screening tool that is relevant, agencies should be aware that there are considerable differences across instruments in terms of the mental health concerns and behaviors that they are designed to identify. As summarized by Grisso and Vincent (2005), screening tools that fulfill legal obligations are those that include at a minimum (1) one or more scales aimed at current mood and anxiety symptoms, (2) some indication of the short-term likelihood of aggression, (3) some indicator of risk of suicide or self-harm, and (4) an indicator of alcohol and drug abuse.

Agencies should only adopt tools that have evidence of scientific rigor or are “evidence based” so the agency can trust the information the tool provides. Tools should have an instructional manual that makes the administration standardized and structured so it is used with every youth in the same way. There should be research evidence of the tool’s reliability and validity specifically with the population of interest (e.g., arrested youth, adjudicated youth). The question of reliability asks whether the tool will produce consistent results across each administration. With respect to validity, the question is whether the tool actually measures what it purports to measure. In other words, for a risk tool, is there evidence that it accurately predicts reoffending? Some of the documented research evidence of reliability and validity should come from independent parties that do not have an investment in the particular instrument.

### ***What Are Some Examples of Tools Used In Juvenile Justice Facilities and Community-based Services?***

The following are examples of *mental health screening* tools currently used by juvenile justice personnel, mainly in probation intake or detention. The instruments generally take less than 20 minutes to administer by nonprofessional staff and have some research evidence for their value:

- [\*Massachusetts Youth Screening Instrument—Version 2\*](#) (MAYSI-2; Grisso & Barnum, 2006): a 52-question self-report screening instrument that measures symptoms on seven scales pertaining to areas of emotional, behavioral, or psychological disturbance, including suicide ideation. This tool has been examined in more than 50 research studies, and it is possibly the only tool with national norms.

- [\*Suicidal Ideation Questionnaire\*](#) (SIQ; Reynolds, 1988): a 25-item self-report screening instrument used to assess suicidal ideation in adolescents. It can be administered individually or in a group setting.
- [\*Global Appraisal of Individual Needs—Short Screener\*](#) (GAIN-SS; Dennis, Scott, Funk, & Foss, 2005): a 20-item behavioral health screening tool designed to identify adolescents in need of more detailed assessment for substance use or mental disorders. Many studies have been conducted to demonstrate that this tool accurately identifies drug and alcohol problems.
- [\*Voice-Diagnostic Interview Schedule for Children\*](#) (Voice-DISC; Wasserman, McReynolds, Fisher, & Lucas, 2005): a self-report, computerized tool based on the *DSM-IV* that produces computer-assisted suggested diagnoses. This instrument can take up to 1 hour to complete, yet it is often classified as a screen because a follow-up assessment is recommended to confirm any diagnosis.

The following are examples of *mental health assessment* tools that are used in many youth systems and have research evidence to varying degrees:

- [\*Child and Adolescent Functional Assessment Scale\*](#) (CAFAS; Hodges, 2000): a functional assessment that rates youth on the basis of the adequacy and deficits in functioning within life domains such as home and school and with regard to potential problem areas such as substance use or self-harmful behavior. It was developed to assist in identifying those individuals with “serious emotional disturbances” for the purpose of determining service eligibility. A screening version of this assessment—the *Juvenile Inventory for Functioning*—has been created and is currently undergoing validation.
- [\*Child and Adolescent Needs and Strengths—Comprehensive\*](#) (CANS-C; Lyons, Griffin, Fazio, & Lyons, 1999): the CANS has several versions. Although the content of this tool includes information about a youth’s mental health problems and risk, it does not measure these characteristics, but rather provides a mechanism to support consistent communication about a youth’s service needs and level of functioning. It is considered a needs assessment tool that documents functioning in several domains, including substance abuse, mental health, other risk behaviors, and caregiver needs. It has some reliability evidence.
- [\*Achenbach System of Empirically Based Assessment\*](#) (ASEBA; Achenbach & Rescorla, 2001)—formerly known as the *Child Behavior Checklist*: a widely studied and used 118-item self-report form focusing on eight behavioral and problem dimensions that can be grouped into two broader types of pathology: “externalizing” (outward expression) and “internalizing” (inward feelings and thoughts). It is completed by the youth, parents, or teachers.
- [\*Behavioral Assessment System for Children\*](#) (BASC-2; Reynolds & Kamphaus, 2004): a self-report tool that has different versions for the adolescent, parent/guardians, and teacher. The BASC-2 has different age-appropriate versions ranging from childhood to young adulthood. It provides norm-based information

about problem areas including aggression, anxiety, attention problems, conduct problems, and depression.

- [Practical Adolescent Dual Diagnosis Interview](#) (PADDI; Estroff & Hoffmann, 2001): a guided interview procedure that identifies suggested diagnoses related to substance abuse and mental disorders. It can be useful in mental health clinics, private practices, courts, and juvenile justice facilities.

The following are examples of *risk assessment* tools that have evidence of predictive validity in more than one jurisdiction:

- [Washington State Juvenile Court Assessment](#) [PDF] (WSJCA; Barnowski, 2004): the WSJCA has also been modified into the *Youth Assessment and Screening Instrument* (YASI). Both are computerized assessment tools that measure risk of reoffending and consist of three parts: prescreen, full assessment, and reassessment. They are administered by trained probation officers and other staff. Youth rating moderate or high risk on the prescreen complete the full assessment, whereas those rating low risk do not get a full assessment. The WSJCA/YASI prescreen currently is the only brief risk assessment tool with published evidence of validity in more than one jurisdiction.
- [Youth Level of Service/Case Management Inventory](#) (YLS/CMI; Hoge & Andrews, 2006): a well-validated, comprehensive, standardized inventory for assessing risk among youth ages 12–17 involved with the juvenile court. It includes measures of static and dynamic risks that can assist with postadjudication case planning. Created specifically for administration by probation officers, it is probably the most widely used tool by probation offices in the United States.
- [Structured Assessment of Violence Risk in Youth](#) (SAVRY; Borum, Bartel, & Forth, 2006): a comprehensive risk assessment for adolescents. It contains measures of structured static and dynamic risk factors and protective factors to be combined with professional judgment in deriving the youth's level of risk. Although the SAVRY originally was intended to assess violence risk, research indicates that it also has high accuracy for predicting general delinquent reoffending.
- [Risk & Resiliency Checkup](#) (RRC; Justice System Assessment and Training [J-SAT], 1998): a comprehensive risk assessment with semi-structured interview designed to assess behaviors that place a youth at risk of reoffending. It contains both risk and protective factors. J-SAT allows juvenile justice agencies to add items to the existing validated instrument in order to meet the needs of the agency. Both San Diego (SDRRC) and Los Angeles (LARRC) have versions of the RRC.

### ***What Are the Benefits of Screening and Assessment Tools for Mental Health Problems and Risk for Re-offending?***

The benefits of a sound screening and assessment system are wide reaching. First, they help agencies to assign youth to *proper levels of treatment intensity and/or degrees of security*. Such decisions are important for conserving scarce resources and are also better for youth. For example, when decisionmakers face choices about placement of

youth in an inpatient mental health facility, they should reserve such settings for the more severe mental health cases. Likewise, in juvenile justice, the most intensive interventions and placements should be reserved for the highest risk offenders, who need them in order to reduce their likelihood of continued offending. Conversely, low-risk youth have a much lower chance of reoffending, even in the absence of intervention, and therefore could do well with minimal attention (Andrews & Dowden, 2006). In this context, the term *interventions* can refer to a range of activities from intensive supervision and behavioral health services to incarceration for extreme cases. There is no good evidence that placement in juvenile justice settings is rehabilitative, and research has demonstrated that in fact it can make youth worse (Gatti, Tremblay, & Vitaro, 2009; Lipsey, 2009). Indeed, the deeper youth penetrate the juvenile justice system, the more time they spend with more deviant peers, making them more likely to offend as an adult and less likely to be rehabilitated (Gatti et al., 2009). Youth identified as low risk should be seen as eligible for diversion or should receive minimal levels of intervention whenever possible.

Second, assessment permits us to provide the *proper types of services*. A “one size fits all” approach to service utilization and treatment does not work. For example, youth who do not have a major substance abuse problem do not belong in substance abuse treatment. In juvenile justice, aside from mental health concerns that can jeopardize a youth’s safety and affect their response to treatment, interventions should target only those factors associated with increasing the youth’s likelihood of reoffending. These are known as “dynamic risk factors” (often referred to as “criminogenic needs”) and include issues like ineffective parental monitoring, antisocial attitudes, and poor school achievement. Youth who receive services that have nothing to do with their specific dynamic risk factors are more likely to reoffend than youth who receive only targeted services commensurate with their dynamic risk (Vieira et al., 2009).

Finally, identification of the dynamic risk factors and mental health needs present among the youth served by a particular agency is a benefit because it provides a means to document *the need for services in a youth’s community*. Awareness of the extent of mental health concerns, well-being needs, and dynamic risk areas is critical for jurisdictions and communities to allocate resources and develop appropriate policy and management plans.

### ***The Importance of Sound Implementation***

Without quality implementation and buy-in from essential stakeholders, the benefits of adopting screening and assessment tools will not be realized. Too often agencies adopt screening or assessment tools and train their staff to complete them but the results of the screening or assessment are never used. Agencies should consider that they are not merely adopting a tool, but instead a screening and assessment *system* (Bonta, Bogue, Crowley, & Mottuk, 2001; Grisso & Vincent, 2005). This means deciding exactly how information about a youth’s mental health concerns, risk level, and/or dynamic risk factors will be used in decisions. For example, dynamic risk factors are crucial to address in a youth’s case plan or management plan. The case plan should target

dynamic risk factors for services; the service referrals should be completed by probation officers or staff, with continuous input from parents/family and youth; and then the youth's progress in the service should be documented. Thus, it is important to train staff in exactly how the assessment is used to set up the case plan. It is also crucial that agencies and staff recognize that the label "high risk" does not warrant automatic placement. Many high-risk youth can be managed safely in the community with intensive services. Similarly, if a mental health need is identified in a screening tool, it is crucial that staff members know how to respond. To accomplish this, the agency can adopt decision rules about how to respond and when.

Agencies can increase the likelihood of positive outcomes if screening and assessment procedures are memorialized by documenting policies and procedures, providing staff training and retraining about how to use tools in their daily decisions, and having quality assurance mechanisms to ensure the process is happening as intended. The implementation procedures must be sound. For example, if an agency adopts a screening tool, it should be administered to every youth on entry into a part of the juvenile justice system (e.g., the first day after entrance to a pretrial detention center).

## Conclusion

This brief highlights the benefits of adopting screening and assessment tools for both mental health problems and risk of reoffending among many youth populations. The selection of tools depends on a variety of factors. The following are some key points that agencies should consider when engaging in this process.

- Agencies should choose their screening and assessment tools and plan the identification process wisely to ensure they receive the information they need about the youth they serve in the most accurate, timely, and feasible manner possible.
- Agencies must be aware that there are considerable differences across instruments in terms of the mental health concerns and behaviors they are designed to identify.
- There is no "one size fits all" tool that will identify both mental health needs and risk of reoffending or dynamic risk factors with any reasonable degree of accuracy. Further, risk assessment or mental health screening tools that were designed and validated to be used with youth located in multiple systems do not exist currently. However, some mental health assessment tools have been validated with multiple populations.
- Important considerations when deciding which tool or tools to use include the decision point, the purpose of implementation, and whether the tool or tools are evidence based. Other considerations include the costs of the tools (including the per-administration costs, manual purchase, software when applicable, and costs of training) and whether the agency has the staff resources to implement a specific tool well.
- Agencies should adopt a screening and assessment *system*, not merely screening or assessment tools, in order to ensure positive outcomes. This means thorough

implementation, involving staff training and appropriate, thoughtful policies and procedures.

- All risk and mental health assessments should be seen as dynamic when dealing with youth populations. This means adopting tools that can measure changes in risk and/or mental health status, or viewing these tools as having a limited shelf life.
- Staff need to be educated on the meaning of what mental health and risk tools provide, rather than believing that scores automatically translate into specific decisions. The mere fact that a youth scores “high” on a mental health screening tool or “high risk” on a risk tool should not automatically translate into intensive treatment or a high-security placement.



## References

- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age Forms and Profiles*. Burlington: University of Vermont, Research Center for Children, Youth, and Families.
- Andrews, D. A., & Dowden, C. (2006). Risk principle of case classification in correctional treatment: A meta-analytic investigation. *International Journal of Offender Therapy and Comparative Criminology*, 50, 88–100.
- Barnoski, R. (2004). *Washington State Juvenile Court Assessment manual, Version 2.1* (Report No. 04-03-1203). Olympia: Washington State Institute for Public Policy.
- Bonta, J., Bogue, B., Crowley, M., & Mottuk, L. (2001). Implementing offender classification systems: Lessons learned. In G. A. Bernfeld, D. P. Farrington, & A. Leschied (Eds.), *Offender rehabilitation in practice* (pp. 227–245). Chichester, England: Wiley.
- Borum, R., Bartel, P., & Forth, A. (2006). *Structured Assessment of Violence Risk in Youth (SAVRY)*. Odessa, FL: Psychological Assessment Resources.
- Dennis, M. L., Scott, C. K., Funk, R. R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment. *Journal of Substance Abuse Treatment*, 28(Supp. 1), S51–S62.
- Estroff, T. W. & Hoffmann, N. G. (2001). *PADDI: Practical Adolescent Dual Diagnosis Interview*. Smithfield, RI: Evinco Clinical Assessments.
- Gatti, U., Tremblay, R. E. & Vitaro, F. (2009). Iatrogenic effect of juvenile justice. *Journal of Child Psychology & Psychiatry*, 50, 991–998.
- Grisso, T. (2004). *Double jeopardy: Adolescent offenders with mental disorders*. Chicago: University of Chicago Press.
- Grisso, T. (2005). Why we need mental health screening and assessment in juvenile justice programs. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 3–21). New York: Guilford Press.
- Grisso, T., & Barnum, R. (2006). *Massachusetts Youth Screening Instrument—Version 2: User’s manual and technical report*. Sarasota, FL: Professional Resource Press.
- Grisso, T., & Vincent, G. (2005). The context for mental health screening and assessment. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 44–70). New York: Guilford Press.
- Grisso, T., Vincent, G., & Seagrave, D. (Eds.). (2005). *Mental health screening and assessment in juvenile justice*. New York: Guilford Press.



- Hodges, K. (2000). *Child and Adolescent Functional Assessment Scale* (3rd ed.). Ypsilanti: Eastern Michigan University.
- Hodges, K. (2011). *Juvenile Inventory of Functioning*. Ypsilanti, MI: Functional Assessment Systems.
- Hoge, R. D., & Andrews, D. A. (2006). *Youth Level of Service/Case Management Inventory: User's manual*. North Tonawanda, NY: Multi-Health Systems.
- Justice System Assessment and Training [J-SAT]. (1998). *Risk & Resiliency Checkup manual*. Boulder, CO: Author.
- Lipsey, M. W. (2009). The primary factors that characterize effective interventions with juvenile offenders: A meta-analytic overview. *Victims & Offenders, 4*, 124–147.
- Lyons, J., Griffin, E., Fazio, M., & Lyons, B. (1999). *Child and Adolescent Needs and Strengths: An Information Integration Tool for Children and Adolescents with Mental Health Challenges (CANS-MH)—Manual*. Chicago: Buddin Praed Foundation.
- Mulvey, E. P. (2005). Risk assessment in juvenile justice policy and practice. In K. Heilbrun, N. E. Sevin Goldstein, & R. E. Redding (Eds.), *Juvenile delinquency: Prevention, assessment, and intervention* (pp. 209–231). New York: Oxford University Press.
- Reynolds, C. R., & Kamphaus, R. W. (2004). *Behavior Assessment System for Children—Second Edition manual*. Circle Pines, MN: American Guidance Service Publishing.
- Reynolds, W. (1988). *Manual for the Suicidal Ideation Questionnaire*. Odessa, FL: Psychological Assessment Resources.
- Shufelt, J. L., & Coccozza, J. J. (2006). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study*. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- Snyder, H. N., & Sickmund, M. (2006). *Juvenile offenders and victims: 2006 national report*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*, 1133–1143.
- Vieira, T. A., Skilling, T. A., & Peterson-Badali, M. (2009). Matching court-ordered services with treatment needs. *Criminal Justice and Behavior, 36*(4), 385–401.

Vincent, G. M., Grisso, T., & Terry, A. (2007). Mental health screening and assessment in juvenile justice. In C. L. Kessler & L. Kraus (Eds.), *Mental health needs of young offenders: Forging paths toward reintegration and rehabilitation* (pp. 270–287). Cambridge, England: Cambridge University Press.

Vincent, G. M., Grisso, T., Terry, A., & Banks, S. (2008). Gender and race differences in mental health symptoms in juvenile justice. *Journal of American Academy of Child and Adolescent Psychiatry*, 47, 282–290.

Wasserman, G. A., McReynolds, L. S., Fisher, P., & Lucas, C. P. (2005). Diagnostic Interview Schedule for Children: Present state voice version. In T. Grisso, G. Vincent, & D. Seagrave (Eds.), *Mental health screening and assessment in juvenile justice* (pp. 224–239). New York: Guilford Press.