

**Screening For Mental Health Problems among Incarcerated Youth in Nevada:  
Practice and Policy**

Michelle Chino PhD, Jennifer Personius-Zipoy MA, Denise Tanata JD  
Nevada Institute for Children's Research and Policy  
University of Nevada Las Vegas, School of Public Health

**ABSTRACT**

Incarcerated youth in Nevada with serious mental health problems are not being effectively identified. The current study examined the utility of simple screening instruments as a mechanism for identifying incarcerated youth who may have a mental health disorder. Adjudicated youth, incarcerated at each of Nevada's 12 juvenile detention facilities, participated in the study by completing a demographic questionnaire and a standardized mental health screening instrument: the *Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2)*. Findings indicate a high prevalence of mental health disorders among incarcerated juveniles in Nevada. Identifying youth with mental health problems is complicated by the lack of a systematic screening or assessment process within detention facilities, and limited enabling legislation at the State level. Based on the research findings, policy recommendations were made and subsequently adopted by the State Legislative Counsel Bureau.

**KEYWORDS:** mental health assessment; incarcerated juveniles; MAYSI-2

**INTRODUCTION**

Youth who enter the juvenile justice system are at high risk for problems that not only contribute to their criminal behavior but that may also interfere with rehabilitation and reintegration (Loeber et al., 1998; Lynam, 1996; Wasserman, 2004). Recent studies estimate that one in five juvenile offenders has serious mental health problems, substantially higher than the rate for children in the general population (Cocozza & Skowrya, 2000; Otto et al., 1992). However, there is a lack of definitive information regarding the prevalence of serious mental health problems among incarcerated juveniles. Current, tentative estimates of specific disorders prevalent among incarcerated youth include 50-90% with conduct disorder, up to 46% with attention deficit disorder, 6-41% with anxiety disorders, 25-50% with substance abuse or dependence, 32-78% with affective (emotional) disorders, and 1-6% with psychotic disorders (Goldstrom, 2000). Many of these youth require mental health services both during and after their time in custody. Without early identification and the availability of treatment services, these disorders not only go untreated, but may escalate to increasingly severe and debilitating conditions requiring emergency services (Grisso et al., 2004).

While most experts agree that screening should occur at intake, it is a rare occurrence. Many systems rely primarily on a child's history of receiving mental health services to identify an existing disorder. However, it is estimated that only about one in three juvenile detainees ever received services for a documented mood or behavior disorder prior to entry into the system (Novins et al., 1999). Further, despite considerable advances in mental health assessments for youth (Jensen et al., 1995; Schaffer et al., 1996), assessments in juvenile justice settings are still highly

variable and often do not rely on instrumentation designed specifically for detention settings (Cocozza & Skowrya, 2000; LeBlanc, 1998; Nicol et al., 2000; Towberman, 1992; Wiebush et al., 1995). The lack of routine standardized screening and assessments results in inadequate and fragmented services for mental health problems that are often not recognized until the child is in crisis.

In Nevada, and most other states, there is currently no systematic screening process for either detainees or incarcerated youth, and policies and procedures regarding the identification of mental health issues for youth in the juvenile justice system are vague. Although the states' are ultimately responsible for the juveniles in their care and custody, specific policies and procedures regarding the provision of mental health assessments and resulting services to incarcerated juveniles are rarely present in state legislation. Few states have enacted legislation specifically addressing the mental health needs of youth in juvenile detention facilities.

The current study examined the utility of simple screening instruments as a mechanism for identifying incarcerated youth who may have a mental health disorder. One of these instruments, the MAYSI-2, has demonstrated success in juvenile detention settings in other states, and could be a cost-effective screening tool that could become part of the regular intake process for all youth entering juvenile detention facilities in Nevada. Even with the challenges of less than adequate funding and staffing, a simple screening process would help practitioners identify problems early and better assess both overall and specific mental health issues for their offender populations. Appropriate and timely diagnosis and treatment of a mental disorder will improve a juvenile's chances for successful rehabilitation and reintegration as well as reduce the chances for further

delinquent and/or violent behavior related to the mental illness.

## **METHODS**

Adjudicated youth, incarcerated at each of Nevada's 12 juvenile detention facilities, participated in the study by completing an anonymous demographic questionnaire and two standardized mental health screening instruments. The data were collected at one point in time for each facility during the spring of 2003. It is estimated that less than 10% of youth were not included in the data collection activity. Thus, the sample provided a reasonable estimate of the prevalence of each factor being examined at that point in time.

Initial contact with the detention centers was made in January 2003. Contact information for the Chief Juvenile Probation Officers was received from the State Juvenile Justice Commission. A letter introducing the project was faxed to each Officer by the research team. A follow-up phone call was made to schedule time in the facility to administer the questionnaires. Researchers traveled to each facility between March and June to administer the questionnaires.

The juveniles who had received parent/guardian permission to participate were brought to the facility's classroom in groups of 15-20. One facility staff person remained in the room throughout the process to monitor the behavior of the participant. When the juveniles were seated in the room, the researcher handed out the packet of questionnaires to each youth. The researcher introduced the survey and discussed the process of informed consent/assent with the group. Each youth was asked to read the consent form while the researcher read the form aloud. Those who chose to participate were asked to sign the assent form attached to the front of the packet. After the youth assent form was signed, the form was torn off the packet and placed in a separate envelope to maintain anonymity. Youth who chose not to participate were escorted out of the room by facility staff. The survey process took about one hour. All completed forms were collected by the researchers and placed in a sealed envelope. None of the information was given to the facility staff.

The demographic questionnaire included questions regarding participant age, sex, ethnicity, and current grade in school. In addition, youth were asked several open-ended questions regarding their home life, the reason they were in detention, and about risk factors associated with mental health problems such as substance use, suicide ideation, and violence in the home. Two screening instruments were also administered, the Massachusetts Youth Screening Instrument-Version 2 - MAYSI-2 (Grisso

et al., 2001), and the Manifestation of Symptomatology Scale - MOSS (Mogge, 1999). The focus of this paper is the MAYSI-2.

The MAYSI-2 is a self-report inventory, designed for children and adolescents that contains 52 questions with a "yes/no" response format and can be completed in 10 to 15 minutes. Questions include "Have you had a lot of problems concentrating or paying attention?" and "Have you felt like life was not worth living?" The response scores for the questions create six scales that assess: Alcohol/Drug Use, Anger/Irritability, Depression/Anxiety, Somatic Complaints, Suicidality, and Thought Disturbance (normed for boys only). Further, the instrument assesses the youth's experiences with traumatic incidents.

All MAYSI-2 scores have a cut-off point for "acceptable" and for at-risk scores coded as "caution" or "warning". All scores at or below the cut-off point, i.e., in the "acceptable" range were assigned a zero (0). All scores above the cut-off point, i.e., in the "at risk" range were assigned a one (1). A summary score of all 0's and 1's was calculated for each individual. Summary scores ranged from 0 to 6 depending on the test. A score of 0 means the individual scored in the acceptable range on all test components. Scores between 1 and 3 indicate the individual scored in the at-risk range in one, two, or three areas and probably should be evaluated further. Scores between 4 and 6 indicated the individual scored in the at-risk range in four, five or all six areas and may have serious mental health issues. In order to create an estimate of the overall scope of mental health problems among Nevada's juvenile delinquents, the scales were combined for each individual.

The study also included an electronic survey of State detention facility staff and an analysis of relevant state and federal policy. Survey participants included members of the juvenile justice system in Nevada such as Chief Juvenile Probation Officers, facility administrators, and mental health service providers. The survey included questions about ways mental health problems are identified, access to mental health care, training and development opportunities for staff, and policy issues. No identifying information was collected. A review and analysis of federal laws, recent court cases, and federal and state efforts to improve screening and treatment efforts was included in the study to provide a framework for policy recommendations for Nevada.

## **Limitations of the Data**

The data collected in this assessment process have several limitations that must be considered when interpreting the results. First, the data are self-report.

The responses may be intentionally false, or inaccurate due to difficulties remembering events or behaviors, even when the youth is trying hard to be accurate. Further, youth may respond randomly or inconsistently due to deliberate lack of caring or inattention. The data are not validated in any way to check for accuracy. Although the data represent almost the complete population of incarcerated youth at the time the study was conducted, the data should not be used to extrapolate to the general population.

**RESULTS**

The data set included responses and test scores from 660 adjudicated youth (547 male and 113 female) incarcerated in 12 public detention facilities in Nevada. The 660 youth include both males and females ranging in age from 11 to 18 years old with a mean age of 15.85. About 14% of the youth were less than 15 years of age and 35% were older than 16. Males outnumber females by about four to one with males representing 83% of the youth and females representing 17% of the youth. When asked to

identify their race/ethnicity, 40% indicated White, 28% indicated Hispanic, 20% indicated Black, 8% indicated Native American, and 4% indicated Asian. Some of these percentages include youth who identified more than one category (i.e., mixed race).

The youth were asked several questions about their own and their family’s mental health. Many indicated a family history of drug and/or alcohol abuse (63%), violent behavior (54%), and mental disorders (30%). More than half of the youth (58%) reported having had some prior treatment for emotional or behavioral problems, higher than the national estimate of 30% (Novins et al., 1999). More than half (53%) reported they had been violent towards someone they cared about and 44% had themselves been a victim of violence by someone they cared about. One in five youth (18%) had attempted suicide. Almost half (40%) had a close friend or family member attempt suicide and one-fourth (24%) had a close friend or family member who died as a result of suicide.

**Table 1. Study population % scores on the MAYSI-2 scales by gender**

Scale	Males			Females		
	%Low Risk	%Moderate Risk	%High Risk	%Low Risk	%Moderate Risk	%High Risk
Angry/Irritable	42%	32%	26%	33%	36%	31%
Thought Disturbance	40%	44%	16%	N/A	N/A	N/A
Depressed/Anxious	49%	37%	14%	31%	39%	30%
Somatic Complaints	40%	49%	11%	20%	51%	29%
Alcohol/Drug Use	33%	42%	25%	33%	35%	32%
Suicide Ideation	73%	8%	19%	55%	11%	34%
Traumatic Experiences	22%	40%	38%	12%	29%	59%

**Table 2. Study population % scores on the MAYSI-2 scales by age group**

	Angry/Irritable	Thought Disturbance*	Depressed/Anxious	Somatic Complaints	Alcohol/Drug Use	Suicide Ideation	Traumatic Experiences
<b>Risk</b>	<b>Youth ages 11 to 14</b>						
Low	42%	67%	57%	48%	64%	67%	29%
Moderate	40%	33%	25%	41%	18%	7%	39%
High	18%	0	18%	11%	18%	26%	32%
	<b>Youth ages 15 to 16</b>						
Low	40%	39%	46%	38%	33%	71%	22%
Moderate	33%	43%	38%	47%	42%	7%	40%
High	27%	18%	16%	15%	25%	22%	38%
	<b>Youth ages 17 to 18</b>						
Low	41%	39%	45%	32%	28%	68%	15%
Moderate	30%	46%	37%	53%	40%	11%	35%
High	29%	15%	18%	15%	32%	21%	50%

\*The thought disturbance scale is normed only for boys.

### **Mental Health Screening**

The MAYSI-2 includes six summary scales and an indicator of the level of psychological trauma an individual has experienced. Three scales measure emotion and thought disturbance – Angry/Irritable, Thought Disturbance, and the Depressed/Anxious scale. One average, 60% of the study population showed an elevated risk for emotional and psychological problems on these three scales. Of these youth, almost half were at very high risk with scores indicating the possibility of severe problems. Table 1 presents scores for the study population by gender. Table 2 presents scores for the study population by age group.

The Angry/Irritable scale assesses feelings of anger, vengefulness and a tendency toward related irritability, frustration and tension. Scores higher than four indicate that anger may be expressed impulsively through physical aggression when the individual is experiencing annoyance or frustration. The average score for all youth in this study was 5.101 with 59% of youth scoring five or higher. Almost one-third (27%) were at very high risk with a score of eight or higher.

The Thought Disturbance scale indicates the possibility of serious mental disorder involving problems with reality orientation. This score has been normed only for boys. Girls were not included in either the scoring or the analysis. A score of one or higher may indicate abnormal perception and consciousness and a score of three or higher may indicate a psychotic illness or major depression with psychotic features. The average score for boys in this study was 1.135 with 60% reporting a score of one or higher. A score of three or higher was reported by 16% of boys.

The Depressed/Anxious scale indicates symptoms of depression and anxiety. Lower scores (3, 4, or 5) may indicate an emotional reaction to immediate events such as detention. Higher scores (6 or higher) may indicate an enduring problem. The average score for the study population was 3.089 with 54% reporting a score of three or higher. Scores higher than five were reported by 17% of the youth. There were significant differences between males and females on this scale (Chi Square;  $P \leq .0001$ ).

The Somatic Complaints scale measures bodily expressions of anxiety including shortness of breath, upset stomach, and shakiness. Elevated scales not found in association with other elevated scales may be an indicator of physical illness. When found in combination with other elevated scales, a high score (3 or higher) may reflect significant emotional problems. The average score for the study population was 3.148 with 63% of youth scoring three or higher. Half of the youth (49%) had scores of three, four, or

five. Scores of six or higher were reported by 14% of youth. There were significant differences between scores for males and for females on this scale (Chi Square;  $P \leq .0001$ ).

The Alcohol/Drug Use scale identifies youth for whom alcohol or drug use is a significant problem and who may be at risk for dependence and/or abuse. High scores (4 or higher) indicate an individual has or is developing significant substance abuse problems. Juvenile offenders usually score higher than other adolescents on this scale. The average score for the study population is 4.454 with 67% of youth scoring four or higher. One in four youth (26%) scored seven or higher indicating significant problems.

The Suicide Ideation scale addresses thought and intentions about self-harm. These scores reflect recent and current subjective states. The developers of the MAYSI-2 note that there is currently no research to determine whether youth with high Suicide Ideation scores are actually more likely to attempt suicide. Elevated scores (2 or higher), however, are likely to reflect potential suicidal intent and very high scores (3 or higher) may reflect a high risk for a suicide attempt. The average score for the study population is 1.159 with 30% of youth reporting a score of two or higher. Of these youth, 70% had a score of three or higher indicating a high level of suicide ideation. There were significant differences between scores for males and for females on this scale (Chi Square;  $P = .0005$ ).

The final score on the MAYSI-2 assessment is the Traumatic Experiences scale. This scale reflects whether an individual has had greater lifetime exposure to traumatic events compared to other youth. Although the specific questions are different for boys and for girls the scores are comparable. High scores reflect exposure to specific traumatic events such as rape or beatings and also the possible presence of Post Traumatic Stress Disorder. There should be individual follow-up with youth who respond positively to any of the questions which was not possible within the scope of this study. The average score for the study population was 2.986 on a scale of 0 to 5 with 65% of youth scoring three or higher. There were significant differences between males and females in the number of traumatic experiences (Chi Square;  $P \leq .0004$ ).

### **Current screening and assessment efforts in Nevada**

The study also included an assessment of current juvenile detention facilities to establish a baseline for they type of mental health problems identified among the populations, methods for identifying youth at risk, available services, and priority areas of need. Since

Nevada's twelve public juvenile detention facilities in the state are operated by different entities rather than one overarching agency, it was hypothesized that there would be a lack of consistency between the facilities.

Facility staff were asked to identify the two most serious mental health problems encountered in their facility, followed by the most common problem. The most serious problems were depression, anger and suicide ideation, closely followed by substance abuse. Other responses included conduct disorder and behavior problems, as well as one or two specific psychotic disorders. The most common problems identified were behavior problems/conduct disorder, major depression, and substance abuse.

Most facility staff stated that mental health problems among youth are usually identified by staff psychologists. Problems are also commonly identified by probation officers, through family reports and from observations by other facility staff. When a mental health problem is identified it is usually reported directly to the facility's mental health staff and other staff such as court personnel and detention staff. The facility's nurse also gets a report, as does the facility administrator. Social workers and probation officers are also usually notified.

Facility staff also identified priority mental health needs of their facilities, as well as specific changes that would help facility staff better address the mental health needs of the population. Priority needs were more mental health staff, more training for front-line staff, and more treatment programs. Specific changes mentioned included a mental health screening at intake, standard assessment and testing protocols, more mental health and substance abuse programs, and easier access to medication.

### Policy Analysis

Courts across the country have been addressing the disparate treatment of incarcerated juveniles since the early 1970s. More recently, the federal government and some states have begun to address the need for adequate mental health services in juvenile detention facilities. There are generally three sources of law that are applicable in addressing the rights of incarcerated juveniles with respect to their mental health needs. These include the Constitution (particularly the 8<sup>th</sup> and 14<sup>th</sup> Amendments), the Americans with Disabilities Act, and the Individuals with Disabilities Education Act. Under these legal standards, juveniles are entitled to reasonable safety and adequate medical and mental health care. Furthermore, as noted by the United States Supreme Court in "In re Gault", the purpose of the juvenile justice system is to determine "what is he, how has he

become what he is, and what had best be done in his interest and in the interest of the state to save him from a downward career...the child was to be 'treated' and 'rehabilitated' and the procedures...were to be 'clinical' rather than punitive."

Nevada law does not specifically address the issue of provision of mental health services for incarcerated juveniles. A juvenile judge, at her discretion, may order a juvenile to be assessed if the juvenile is showing outward indications of mental illness. Additionally, the law provides that the superintendent of a facility must designate staff to "determine which program of education, employment, training, treatment, care and custody is appropriate for the child" within 30 days of entrance into the facility. The law is ambiguous, however, as to what type of "treatment and/or care" is to be addressed.

### Discussion

Juvenile offenders often suffer from a multitude of problems culminating in their entrance into the juvenile justice system. They exhibit multiple symptoms and often have multiple diagnoses. This means that there must be a wide variety of treatments, services and programs available to these youth to address these multiple problems. Delinquent behavior may overshadow the emotional problems and therefore the emotional disorder may be unrecognized and underreported (Davis et al., 1991).

By identifying possible mental illness, through a simple screening process at the juvenile's entrance into the detention center, the staff has the opportunity to get the offender the care he or she needs and begin the rehabilitation process. It is critical that youth with mental health disorders who are placed in juvenile correctional facilities receive appropriate treatment (Cocozza & Skowyra, 2000). Lack of appropriate mental health treatment in adolescence may lead to further delinquency, adult criminality and adult mental illness (Lexcen & Redding, 2000) as well as school failure, substance abuse, violence or suicide. Early identification and treatment of adolescent mental illness before an adolescent enters the juvenile justice system reduces a child's risk for these difficulties.

The screening tools administered for this study revealed that a high number of youth in Nevada juvenile detention facilities showed indications of a mental health disorder, half of whom were identified as needing immediate mental health services. Although further assessment is necessary to determine the extent and degree of mental illness and needed services, it is clear that the vast majority of

youth in Nevada's juvenile detention facilities are in need of mental health services.

In order to receive the care, treatment and rehabilitation necessary to effectuate the goals of the state's juvenile justice system, it may be best to implement a standardized screening process. As Grisso & Underwood (2003) stated, the screening process is a short "triage" process designed to identify a youth's needs and assist staff in referring for further treatment where needed. The screening should be undertaken at the youth's earliest contact with the detention center, ideally at intake.

In order to facilitate the implementation process, the MAYSI-2 is recommended as a viable tool for detention screening. It is simple to administer, taking approximately 15-20 minutes for the youth to complete on his or her own, simple to score, and the results can be interpreted without specialized training, which means there is less burden on the facility staff. This tool is recommended for screening youth for mental health problems at intake. It must be stated that this research does not substitute for a comprehensive assessment and diagnosis by a mental health professional. The tools used in the research are screening tools designed to identify signs of mental health problems and to assist facility staff in determining which juveniles need further assessments and treatment.

#### **Policy Recommendations for Nevada**

The following are recommendations to improve state legislation in regard to providing the appropriate level of mental health services for youth who are in the care of custody of the state:

1. The state legislature should require the establishment of a statewide committee to address the mental health needs of incarcerated juveniles. The primary purpose of the committee should be to exhaustively identify available mental health services for this population and to examine the specific types of mental health services that are needed to fully address the mental health problems of incarcerated juveniles. The committee should also explore costs and means of financing a full-spectrum system of mental health services in juvenile detention facilities.
2. The state should require mental health screenings for all juveniles who enter a juvenile detention facility, regardless of the existence of outward signs of mental health problems. Further, in depth, assessments should be provided as deemed necessary by the screenings.

3. The state should require juvenile detention facilities to provide intensive, appropriate mental health services by qualified mental health personnel. Although the state requires facilities to provide "treatment" to the juveniles, the law should specifically identify the need for quality, intensive mental health services.

Since these policy recommendations were first made to the Nevada Juvenile Justice Commission, recommendation #2 has been put forward by the State Legislative Counsel Bureau's Juvenile Justice Interim Study Committee.

**Acknowledgments:** This study was funded by a grant from the State of Nevada Department of Human Resources, Health Division, Trust Fund for Public Health. The authors would like to thank the Chief Juvenile Probation Officers and Facility Administrators for their support of this research.

**Protection of Human Subjects:** The Human Subjects Protocol for this study was approved on February 13, 2003 by the UNLV Institutional Review Board (OPRS #113F0103-010). Youth who participated in the study provided both their assent and permission from a parent or guardian.

#### **About the Authors**

Michelle Chino, Ph.D., is an Associate Professor and Director of the Nevada Institute for Children's Research and Policy at the University of Nevada Las Vegas, School of Public Health.

Jennifer Personius-Zipoy, MA, is the Director of Research at the Nevada Institute for Children's Research and Policy at the University of Nevada Las Vegas, School of Public Health.

Denise Tanata, JD, is the Policy Analyst and Associate Director of the Nevada Institute for Children's Research and Policy at the University of Nevada Las Vegas, School of Public Health.

**REFERENCES**

Americans with Disabilities Act of 1990, 20 U.S.C. §12101 et seq.

Cocozza, J., & Skowrya, K. (2000). Youth with mental health disorders: issues & emerging responses. *Juvenile Justice*. 7 (1).

Davis, D., Bean, G. Jr., Schumacher, J.E., & Stringer, T.L. (1991) Prevalence of emotional disorders in a juvenile justice institutional population. *American Journal of Forensic Psychology* 9(1), 5-17.

Goldstrom, I. (2000) The availability of mental health services to young people in juvenile justice facilities: a national survey. Chapter 18 of *Mental Health, United States, 2000*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services

Grisso, T., Barnum, K., Fletcher, E., Cauffman, B., & Peuschold D. (2001). Massachusetts youth screening instrument for mental health needs of juvenile justice youth. *Journal of the American Academy of Child and Adolescent Psychiatry*. 40(5), 541-548

Grisso, T., & Underwood, L. (2003). Screening and assessing mental health and substance use disorders among youth in the juvenile justice system. Research and Program Brief National Center for Mental Health and Juvenile Justice. <http://www.ncmhjj.com> Retrieved August 2003

Grisso, T., Davis, M., & Vincent, G. (2004). Mental health and juvenile justice systems: responding to the needs of youth with mental health conditions and delinquency. CMHSR Issue Brief. U Mass Medical School Dept of Psychiatry.

Individuals with Disabilities Education Act, 20 U.S.C. §§1400-1485.

In re Gault, 387 U.S. 1 (1967).

Jensen P, Roper, M., Fisher, P., Piacentini, J., Canino, G., Richters, J., Rubio-Stipac, M., Dulcan, M., Goodman, S., Davies, M., Rae, D., Shaffer, D., Bird, H., Lahey, B., & Schwab-Stone, M., (1995). Test-retest reliability of the diagnostic interview schedule for children: parent, child, and combined algorithms. *Archives of General Psychiatry*. 52, 61-71.

LeBlanc, M. (1998). Screening of serious and violent juvenile offenders: identification, classification, and prediction. In: R. Loeber and D. Farrington, Eds., *Serious and Violent Juvenile Offenders: Risk factors and Successful Interventions*, pp. 167-193. Thousand Oaks CA: Sage Publications.

Lexcen, F. & Redding, R. E. (2000) Mental health needs of juvenile offenders. *Juvenile Justice Fact Sheet*. Charlottesville, VA: Institute of Law, Psychiatry & Public Policy, University of Virginia.

Loeber, R., Farrington D., Stouthamer-Loeber, M. & Van Kammen W., (1998). *Antisocial behavior and mental health problems: explanatory factors in childhood and adolescence*. Mahwah, NJ: Lawrence Erlbaum.

Lynam, DR. (1996). Early identification of chronic offenders: who is the fledgling psychopath? *Psychological Bulletin*. 120, 209-234.

Mogge, N. (1999). *Manifestation of Symptomatology Scale*. Western Psychological Services. Los Angeles, CA

Nicol, R., Stretch, D., Whitney, I., Jones, K., Garfield, P., Turner, K., & Stanton, B. (2000). Mental health affects needs and services for severely troubled and troubling young people including young offenders in an NSW region. *Journal of Adolescence* 23, 243-261.

Novins, D, Duclos, C, Martin C., Jewett, C., and Manson, S. (1999). Utilization of alcohol, drug, and mental health treatment services among American Indian adolescent detainees. *Journal of the American Academy of Child and Adolescent Psychiatry*. 38, 1102-1108.

Otto, R., Greenstein J., Johnson M., & Friedman, R. (1992). Prevalence of mental disorders among youth in the juvenile justice system. In: J. Cocozza Ed., *Responding to the mental health needs among youth in the juvenile justice system*. (pp 7-48). Seattle WA: The National Coalition for the Mentally Ill in the Criminal Justice System.

Shaffer, D., Fisher, P., Dulcan, M., Davies, M., Piacentini, J., Schwab-Stone, M., Lahey, B., Bourdin, K., Jensen, P., Bird, H., Canino, G., & Reiger, D. (1996). The NIMH diagnostic interview schedule for children: description, acceptability, prevalence, and performance in the MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry*. 35, 865-877

Shaffer, J., & Ruback, R. (2002). Violent victimization as a risk factor for violent offending among juveniles. *Juvenile Justice Bulletin* Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, Department of Justice. NCJ 195737.

Towberman, D. (1992). National survey of juvenile needs assessment. *Crime and Delinquency* 38, 230-238.

Wasserman, G. S. Ko & L. McReynolds (2004) Assessing the mental health status of youth in

juvenile justice settings. *Juvenile Justice Bulletin*. US Department of Justice, Office of Juvenile Justice and Delinquency Prevention. August 2004.

Wiebush, R., Baird, C., Krisberg, B., & Onek, D. (1995). Risk assessment and classification for serious, violent, and chronic juvenile offenders. In: J. Howell, G. Krisberg, J. Hawkins, and J. Wilson, Eds., *Serious, Violent, and Chronic Juvenile Offenders: A sourcebook*, (pp. 171-212). Thousand Oaks, CA: Sage Publications.