

# **REPORT**

## **PREVALENCE OF MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDERS AMONG INCARCERATED JUVENILE OFFENDERS**

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## **Disclaimer**

Points of view in this document are those of the authors and do not necessarily represent the position or policies of the U.S. Department of Justice or the Mississippi Division of Public Safety Planning.

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## Executive Summary

This study examines the co-occurrence of mental health and substance abuse disorders among incarcerated juveniles held in Mississippi detention centers and training schools. In addition, the study examines, by gender, the types and severity of disorders prevalent in Mississippi incarcerated juveniles.

A total of 482 juveniles in nine out of 15 detention centers and two state training schools participated in the study. The sample was composed of 317 juveniles detained in detention centers and 165 incarcerated in the two state training schools. Approximately two-thirds of the incarcerated juveniles studied were male and African American.

Prevalence of mental health and substance abuse disorders among juveniles in the detention centers and training schools was assessed in three ways. First, all juveniles were administered the Adolescent Psychopathology Scale (APS), a 346-item questionnaire designed to indicate the severity of mental health symptoms and problems according to *DSM-IV* criteria. Secondly, juveniles held in detention were interviewed by mental health clinicians, who gave their diagnostic impressions and recommendations for treatment. Third, training school juveniles were administered the Problem Oriented Screening Instrument for Teens (POSIT), which identifies risk for problems and potential need for services in ten functional areas including mental health, physical health, family and peer relationships, and substance abuse.

### Key findings:

- Between 66% to 85% of the juvenile offenders assessed met *DSM-IV* diagnostic criteria for a mental disorder.
- Multiple, co-occurring mental health and substance abuse diagnoses were evident. Half with two or more disorders have a Conduct Disorder and 38% have a co-occurring substance abuse disorder.
- Males were twice as likely to have a conduct or substance use disorder as females. Girls were five to seven times more likely than boys have a mood disorder and were two to five times more likely than boys to meet the criteria for an anxiety disorder.
- 9% of incarcerated juveniles reported suicidal thoughts and plans.

### Recommendations:

- Implementation of routine mental health screening of all juveniles placed in detention using of a structured youth and family problem history interview and a mental health status examination.
- Collaboration between community mental health centers and county youth courts to increase mental health and substance abuse treatment of juvenile offenders.

A comprehensive and coordinated system of care in which services are integrated and resources are shared across child serving agencies is the best approach to addressing service needs of children and youth with behavioral and emotional problems that are manifested at home, in school and in the community.

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## Introduction

Between 14% and 20% of youth in the general population have a diagnosable mental disorder at any given time (Cocozza, 1992) and the estimated rate of serious emotional disturbance among youth is 9% to 13% (Friedman et al., 1996). Also of concern is that 56% of all persons with a mental or addictive disorder have at least one other co-occurring disorder (Kessler et al., 1994). Substance use disorders and disruptive behavior disorders tend to co-occur in adolescents (Cohen et al., 1993; Greenbaum, Foster-Johnson, & Petrilia, 1996) particularly in the delinquent population (Cocozza, 1992). Juvenile offender studies suggest that there is substantial overlap of serious delinquency with drug use, problems in school, and mental health problems (see Huizinga & Jakob-Chien, 1998) and that juvenile offenders experience significantly higher rates of mental health disorders than youth in the general population (Otto et al., 1992).

Using the (national) Center for Mental Health Services (CMHS) estimates of the prevalence of serious emotional disturbance among children and adolescents, the Mississippi Department of Mental Health has estimated that there are from 27,489 to 35,342 youth ages 9 to 17 years with severe mental health problems in this state. Using very conservative estimation procedures, Howell et al., (1998) has estimated that over 7,000 Mississippi public school students in grades 6 to 12 are in need of substance abuse treatment and that 2,234 Mississippi school dropouts under the age of 18 years need substance abuse treatment. In 1998 Mississippi Youth Courts handled 21,706 cases involving 17,032 juveniles. Most of the cases (83.5%) were referred for a delinquent offense, that is, 16,144 juveniles in 1998 committed an illegal offense which could possibly result in confinement. Also in 1998, 4,710 Mississippi youth were placed in detention centers pending case disposition and there were 1,762 commitments to one of the state's two training schools. If CMHS estimates of 9% to 13% prevalence of serious emotional disturbance among youth are applied to the 1998 Mississippi delinquent population (16,144), then it is likely that between 1,453 to 2,099 juvenile offenders may require mental health services. The actual prevalence of mental health and substance abuse disorders among Mississippi juvenile offenders is unknown.

There is insufficient research on the prevalence of mental health and substance abuse disorders among youth in the juvenile justice system (Cocozza & Skowrya, 2000). The purpose of this study is to determine the point prevalence of mental health (MH), substance abuse (SA) and co-occurring MH and SA disorders of juveniles held in Mississippi detention centers and training schools. A secondary goal is to determine the types and severity of problems by gender. The objectives required to accomplish these goals are, as follows:

1. Obtain the cooperation and assistance of nine youth detention centers in Mississippi with a capacity of at least 25 beds and of the nine Youth Courts in the counties where these detention centers are located.
2. Recruit mental health clinicians from community mental health centers or other community-based organizations providing children's mental health services and train them to administer a standardized instrument, the Adolescent Psychopathy Scale, and conduct semi-structured diagnostic interviews to a sample of youth incarcerated in participating detention centers.

3. Collect the Adolescent Psychopathy Scale and the Problem Oriented Screening Instrument for Teens (POSIT) from a sample of juveniles committed to the two state training schools.

This project will impact two state agencies: the Department of Human Services-Division of Youth Services, and the Department of Mental Health- Division of Children and Youth Services. The information obtained as a result of this study will aid state administrators in planning and providing mental health and substance abuse treatment services for juvenile offenders.

### **Definitions of Mental Illness**

Epidemiological studies of childhood psychiatric disorders is relatively new as standardized assessment instruments and formal diagnostic criteria for children have recently been developed (Costello & Angold, 1995; Poznanski & Mokros, 1994). The scant prevalence research on addictive and mental disorders among juvenile offenders has also been hampered by inconsistent definitions and measurement of mental illness (Cocozza & Skowyra, 2000). A youth may meet formal diagnostic criteria for a disorder listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (American Psychiatric Association, 1994), but not be considered to have a serious emotional disturbance (SED) unless there is evidence of functional impairment which substantially interferes with family, school, or community activities. While this may appear pedantic, access to publically funded children's mental health services, particularly specialized residential or inpatient services, in many localities is based on being labeled SED. In Mississippi, there is a barrier to obtaining a mental health assessment. There are limited numbers of appropriately credentialed professionals available to make a psychiatric diagnosis, especially in rural areas. Furthermore, access to children's mental health services is restricted by the geographic location of services. There are 14 children's outpatient programs certified by the Mississippi Department of Mental Health. All located in cities and half of those are located in the Greater Jackson Metropolitan area.

The Mississippi Department of Mental Health (MDMH) defines children and adolescents with a serious emotional disorder as individuals, from birth to age eighteen who meet *DSM-IV* diagnostic criteria. Furthermore, the identified disorder must result in serious functional impairment and must require mental health services and other special/support services at a more intense rate and for a longer period of time than children or youth with less severe emotional disorders/disturbances.

The MDMH, Division of Children and Youth Services characterize children and youth with serious emotional disorders as often lacking in an awareness and understanding of self and the environment. This decreased awareness and/or understanding may result in an inability to exercise self control or an inability to appropriately express feelings. Consequently, school, home, and play experiences are often impaired.

Satisfactory interpersonal relationships are another indicator of emotional health; children who have difficulty establishing or maintaining relationships with others are often readily identified by peers and teachers. Satisfactory interpersonal relationships are defined as the “ability to establish and maintain close relationships, work and play cooperatively with others, the ability to demonstrate sympathy, warmth, and sharing with others, as well as the skills to make appropriate choices and to interact in an assertively constructive manner (MDMH, Division of Children and Youth Services Directory, April 2000).

According to MDMH, children at high risk for serious emotional disorders may exhibit one or more the following factors: failure to thrive in infancy; failure to develop at the appropriate stage(s) or in normal time ranges in infancy and early childhood; environmental stressors such as divorce or death of a family member. Other stressors may include living in a home where one or both parents are unemployed, family deprivation due to poverty, or in a single parent home. Factors known to contribute to severe emotional disorders include living in a family context characterized by alcohol/drug addiction and/or mental illness. Children and adolescents who have been subject to child abuse, neglect, sexual abuse, or those with chronic physical illness or handicaps are at higher risk to develop serious emotional disorders. In addition, children who have a parent currently or previously incarcerated are at higher risk for emotional disturbances (MDMH, Division of Children and Youth Services Directory, April 2000).

### **Literature Review**

The prevalence of mental disorders among incarcerated juveniles has been assessed in four states: Maryland (Shelton, 1998), Virginia (Virginia Policy Design Team, 1994), Georgia (Marsteller et al., 1997) and South Carolina (Atkins et al., 1999). Different methods have been utilized, but the findings are similar. There are high rates of mental disorder, including substance abuse disorders and multiple co-occurring disorders among youth in secure confinement.

In 1993, Virginia conducted an assessment of the mental health needs of youth in all 17 secure detention homes. The Virginia Team used a combination of individual psychological interviews and the Derogatis Symptom Checklist-90 to determine if youth had a diagnosable mental disorder and to determine the degree of functional impairment. Based on this approach, 605 youth were assigned to five levels of mental health problems ranging from “none”, that is, those demonstrating no need for mental health treatment to “urgent” meaning the juvenile needs immediate psychiatric hospitalization. Only 23.2% of the males and 13.7% of the females had no mental illness at the time of the census (Virginia Policy Design Team, 1994). The study found that 8.8% of detained juveniles required immediate treatment, and an additional 39% in the “moderate” category “will require mental health services in association with their continuing involvement with the juvenile justice system or as part of the larger continuum of community services” (Virginia Policy Design Team, 1994, p. 5).

The Georgia Departments of Human Services and of Children and Youth Services collaborated in a 1995 survey designed to estimate the prevalence of substance use and other DSM-III-R psychiatric disorders among juvenile offenders placed in youth detention centers. The Diagnostic Interview Schedule for Children (DISC), Version 2.3 was employed and very

conservative criteria was set. The Georgia team assigned a diagnosis if all symptom and duration criteria were met. Based on a random sample of 693 youth, 8% of the population admitted to 20 regional detention centers during a seven month period, 61% of the youth had of at least one psychiatric disorder (Marsteller et al., 1997).

The DISC was also used in a South Carolina study that compared 75 incarcerated youth with 60 youth served by a local Community Mental Health Center (CMHC) and 50 youth in a state adolescent inpatient program (Atkins et al., 1999). Incarcerated youth had significantly higher mean numbers of diagnoses than CMHC youth, but lower numbers than hospitalized youth. 72% of the random sample of youth in South Carolina juvenile justice facilities met criteria for at least one psychiatric diagnosis.

Conduct disorder is the most prevalent diagnosis for juvenile offenders, with rates ranging from 50% to 90% (Otto et al., 1992; Virginia Policy Design Team, 1994; Wierson, Forehand, & Frame, 1992). Given the *DSM-IV* criteria for conduct disorder, which includes aggression, destruction of property and deceitfulness or theft, such high rates of the disorder among juvenile offenders are to be expected. However, assuming that all offenders will meet conduct disorder or antisocial personality disorder criteria may preclude a comprehensive assessment. Disruptive behavior could be the result of attention-deficit/hyperactivity disorder or a mood disorder.

The Virginia report stated that a number of their clinicians were less likely to pursue specific diagnostic criteria for conduct or substance use disorders because “the clinicians were focusing their attention on those disorders which often translate into a need for mental health treatment (e.g., Mood Disorder)” (Virginia Policy Design Team, 1994, p 15). In Mississippi, Medicaid reimbursement for a substance abuse disability is not available through the statewide system of community mental health centers. And in a study of youth receiving public mental health services in Sonoma County, California, youth with recent arrest records were significantly more likely to receive primary diagnoses of conduct/oppositional defiant disorder and less likely to receive diagnoses of anxiety disorder than youth participating in treatment without recent arrest records (Rosenblatt, Rosenblatt, & Biggs, 2000).

The youngest age group, 15-24 years, of the National Comorbidity Study had the highest prevalence within the last year of any disorder, any substance use disorder, and three or more disorders when compared to the other age groups (Kessler, et al., 1994). One half of youth having at least one substance use disorder also had a disruptive disorder (Cohen et al., 1993). Prevalence studies and program evaluations have shown that juveniles with arrest records do meet criteria for a variety of mental disorders and tend to have multiple disorders. Disruptive behavior disorders, i.e., conduct disorder, attention-deficit/hyperactivity disorder (ADHD), and oppositional defiant disorder, frequently co-occur with alcohol and other drug disorders in the general adolescent population. Findings in the Georgia study indicate that the prevalence of substance abuse disorders among youth in detention are nearly 8 times that of the general youth population and 73% of juvenile offenders studied in Georgia endorsed both symptoms for psychiatric comorbidity and substance abuse disorders (Marsteller et al., 1997). Longitudinal studies on the causes and correlates of delinquency in Denver, Pittsburgh and Rochester all found a statistically significant relationship between persistent drug use and serious delinquent behavior for both females and males (Huizinga, Loeber, Thornberry, & Cothorn, 2000).

The prevalence of ADHD in school-aged children is 3% to 5% (American Psychiatric Association, 1994). Studies of juvenile delinquents found the rate of ADHD to range from 19% to 46% (Otto et al., 1992). Virginia and South Carolina did not differentiate between types of disruptive disorders, reporting 52% and 43% respectively. In the Georgia study 7% were diagnosed with ADHD and 35% with any disruptive behavior disorder. A treatment program in Milwaukee that targets youth in the child welfare and juvenile justice systems reported 44% of the caseload meet *DSM-IV* criteria for ADHD (Kamradt, 2000). Just over 60% of the youth in the Milwaukee program were adjudicated delinquents.

Anxiety and depression may also be prevalent among juvenile offenders. Over one-third (37.2%) of children and adolescent mental health services users with arrest records were diagnosed with mood disorders (Rosenblatt, Rosenblatt, & Biggs, 2000). Five percent of children and between 10% to 20% of adolescents from the general population have experienced a depressive disorder (Reynolds, 1992; 1994), while prevalence rates of such disorders among incarcerated youth range from 38% to 50% (Wierson, Forehand, & Frame, 1992). The prevalence of depression and other mood disorders ranged from 17% in the Virginia sample, to 19% in Georgia, and 24% in South Carolina. In Maryland, 19% of incarcerated youth reported suicidal thoughts (Shelton, 1998), and 13% of the youth in Virginia's secure detention homes were on suicide watch.

Anxiety disorders include panic disorder, social phobia, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), and generalized anxiety disorder. Anxiety disorders range from 5.7% to 17.7% in the 6 to 17 age group (Costello & Angold, 1995). Only 5.6% of juveniles in Virginia secure detention homes were diagnosed with an anxiety disorder (Virginia Policy Design Team, 1994). But in other studies estimates of the prevalence of anxiety disorders among youth in the juvenile justice system was much higher: 30% in Georgia, 33% in South Carolina, and 58% in Maryland.

PTSD is a stress response syndrome to trauma such as criminal victimization, or sexual assault. The issue of rape, battering, child sexual abuse, and other forms of victimization has been raised as potential pathways to substance abuse and crime (Chesney-Lind, 1997; Chesney-Lind & Sheldon, 1998; Richie, 1996; Richie & Johnson, 1996). Abuse is common for girls involved in the juvenile justice system: 81 percent reported physical abuse and 56 percent reported sexual abuse (Acoca & Dedel, 1998). Dembo et al. (1992) found similar victimization rates among Florida juveniles in secure detention: 65 percent of the females and 24 percent of males were sexually victimized and over half reported some form of physical abuse with 17 percent requiring medical treatment for physical abuse.

The lifetime prevalence of PTSD was found to be 7.5% in a national representative sample of adults (Kessler, Sonnega et al., 1995). Given that juvenile offenders are at high risk for victimization, prevalence of PTSD is expected to be much higher in a juvenile offender sample. For example, in studies of incarcerated youth in California 65% of girls experienced PTSD at some point in their lives with 49% currently experiencing signs of PTSD and 32% of boys met criteria for PTSD (Caufman et al., 1998; Steiner, Garcia, & Matthews, 1997). 50% of the boys endorsing symptoms of PTSD had witnessed an interpersonal violent act, such as the killing of a family member or friend. Similarly, girls reported both witnessing and experiencing violence with 60% reported being raped

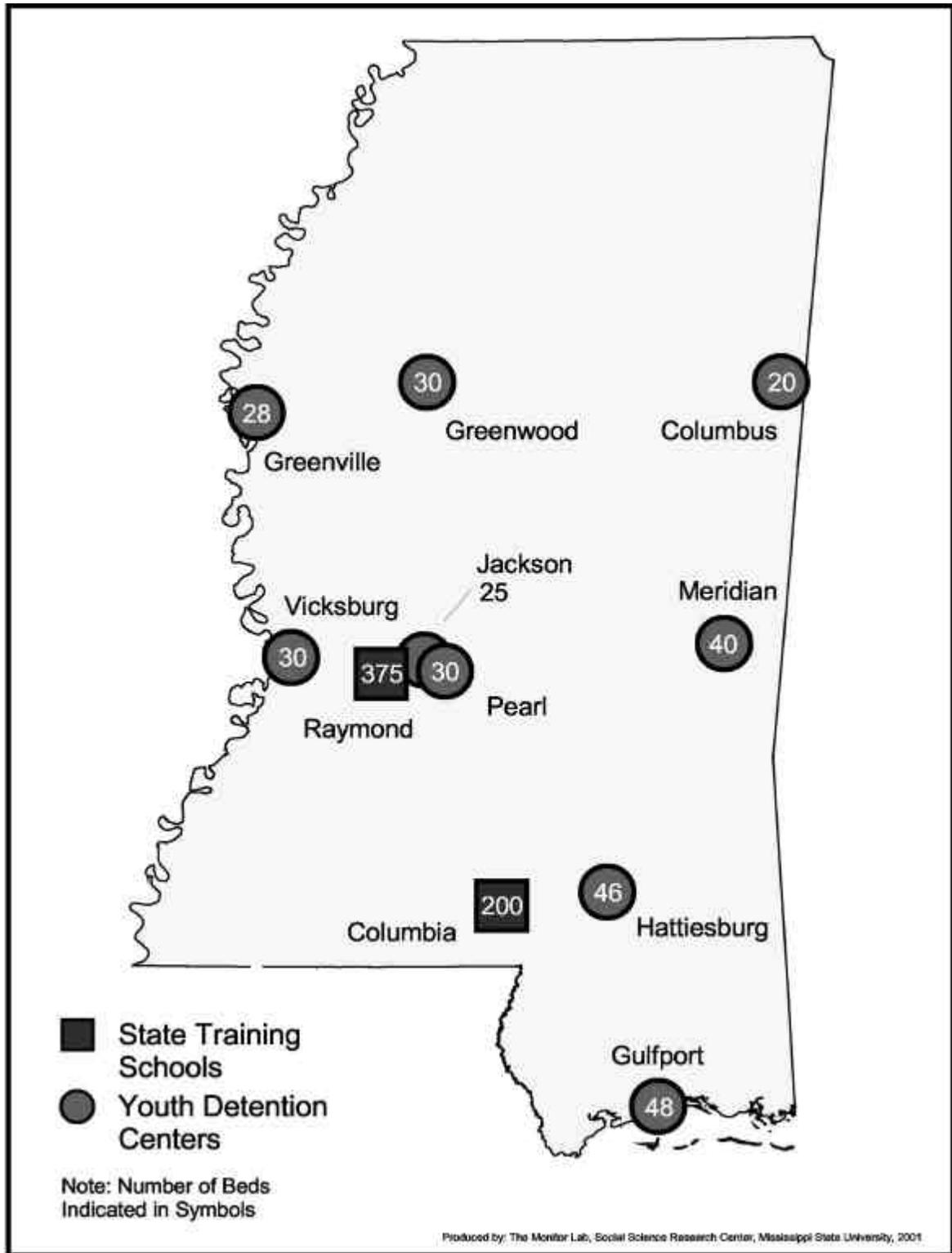
or in danger of being raped. In cases of both males and females, witnessing violence or experiencing traumatic events is correlated with the development mental health disorders, substance abuse and delinquency (Foy et al, 1996; Widom, 1989, 1995).

## **Methods**

### Accessing Juveniles in Secure Confinement

Figure 1 shows the locations of the participating juvenile detention centers and the two state training schools where juveniles were assessed for mental health and substance abuse problems. Mississippi has 15 juvenile detention centers with a total bed capacity of 406. Nine youth detention centers with a capacity of at least 25 beds were identified in the following counties: Forrest, Harrison, Hinds, Lauderdale, Leflore, Rankin, Warren, Washington, and Yazoo. Beginning in June, 2000, Youth Court Judges were contacted by letter, follow-up telephone contacts, and in one case, a personal visit. The objectives of the study were fully explained and permission to interview juvenile detainees under their jurisdiction was requested. All but the Judge in Yazoo county signed agreements or court orders giving access to juveniles in detention; therefore, Lowndes county was substituted for Yazoo county. Once the Youth Court Judge authorized access to juveniles, we still had to negotiate the data collection procedures with detention center administrators or in some cases, the Sheriff, who managed both county jail and the juvenile detention facility. Due to issues regarding security and scheduling of assessments, each detention center administrator imposed different restrictions on accessing juveniles in their custody. Data collection from juveniles in detention began in some facilities by July, 2000 and was completed by the end of the year.

Figure 1: Data Collection Sites and Bed Capacity of Juvenile Secure Confinement Facilities



Mississippi has two training schools with the capacity to house 575 juveniles. Columbia training school, which houses females and younger males age 10 to 14, is located in the town of Columbia. Males, ages 15 to 18, are housed at the other training school. Oakley is located in Raymond, MS which is near the state capital city of Jackson. In 2000, 1253 juveniles were sent to the two state training schools from 41 out of 82 Mississippi counties.

Accessing youth at the state training schools was difficult. The Department of Human Services-Division of Youth Services (DYS), the state juvenile justice agency, imposed stringent requirements on access to juveniles. DYS required individual court orders on each juvenile be obtained. This was accomplished through the compilation of a list of all juveniles incarcerated at the Oakley and Columbia training schools, then contacting County Youth Court Judges to request court orders. Counties who commit large numbers of juveniles to the state training schools were thereby burdened with producing an equal number of court orders. This process was time consuming. Unfortunately, by the time court orders were returned some juveniles had been released from training schools.

In August and again in September, 2000, researchers tested groups of 20 to 25 training school juveniles. The project was explained in detail to the participants. Juveniles who refused to participate were excused and returned to their scheduled activities. Group testing lasted approximately one and one half to two hours. When finished, youth placed the measures inside an 8 ½ x 11 inch manila envelope, sealed the flap, and wrote their names on the outside of the envelope. The sealed envelopes were placed in the custody of the respective training center administrator who transported them to the DYS in Jackson. All measures remained in the custody of DYS until court orders were received. Approximately two months later, the measures were released to the researchers for scoring, coding, and analysis.

The average census of the training schools at the times of data collection was 531. Of that number, 222 juveniles were approached to participate 193 agreed to complete measures, but data were released for only 165 juveniles. The process proved cumbersome and inefficient.

Figure 2 shows the counties of residence for all study participants. As can be seen some juvenile offenders from every region of the state were assessed.

### Description of Juvenile Confinement Facilities

The imposing presence of security is evident at detention centers and medium security units of training schools. The focus on security is evident in the physical layout of detention centers, which are characterized by fencing topped with razor wire, one or two person cells arranged for continuous visual monitoring by guards, electronic locking doors, minimal metal furniture that is bolted to the floor, no external windows, and an absence of decoration and reading materials to provide mental stimulation. Detention centers are jails for kids. Inside the facility, adolescents wear generic jumpsuits, are often cuffed and shackled when escorted from one area of the facility to the next, and live in cells designed to exclude him/her from communal interactions with others. Very few detention centers provide academic instruction, but all have small cells and a day room where meals may be served and where some juveniles are permitted to watch television or socialize.

In comparison, Columbia and Oakley training schools have dormitories, academic, administrative and various other program facilities. Although not technically boot camps, Mississippi training schools have military programs with a large portion of the daily schedule devoted to physical exercise and military instruction. All students dress in army fatigues and march in a military fashion. The Columbia campus is “open” and considered minimum security, that is, students live in cottages or dorms and move in platoons escorted by security officers from one activity or facility to another. Oakley campus has minimum to maximum security. The medium and maximum security facilities are equivalent to jails with juveniles locked in cells and continuously monitored electronically. Juveniles are placed in a medium security facility for the length of their commitment based upon the severity of the offense and if they were convicted of multiple charges. Juveniles are placed in maximum security for assaultive behavior while at the training school. No mental health assessments were conducted in the medium or maximum security units.

### Data Collection Procedures

An important aspect of the this study was the recruitment of interviewers to collect information and to assess the mental health of juveniles detained in detention centers across the state of Mississippi. Regional community mental health center directors were initially sent a letter in which the objectives of the study were outlined and recommendations of qualified personnel were solicited. Two weeks after the initial letter was mailed, follow up contact by telephone was made to each Regional director. During these telephone calls, the project was explained in further detail, questions were addressed, and names of potential data collectors secured.

Once the Regional directors provided us with a list of potential names, we contacted each person by telephone, provided a brief overview of the project, and asked if the person was interested in working on the project. The criteria established for recruiting interviewers included a minimum of a bachelor’s degree with experience in children’s mental health. In addition, we targeted interviewers adept in establishing rapport and effectively communicating with juveniles. Twelve master’s level and three bachelor’s level interviewers, currently working in some type of counseling capacity and experienced in providing services to adolescents, participated in the project. Interviewers received one full day of training on protection of human subjects, informed consent, and administration of measures and data collection procedures.

The primary obstacle faced by interviewers regarding access to juveniles in detention centered around the rigid scheduling of activities. In many instances, interviewers were afforded a limited window of opportunity to interview newly detained adolescents. Therefore, they were only able to approach a fraction of those incarcerated juveniles. Unlike the training schools where juveniles were approached in groups, adolescents held in detention centers were assessed individually. Interviewers provided an overview of the project, sought consent from the juvenile to participate, and solicited signature on the informed consent document.



Interviewers administered the Adolescent Psychopathology Scale (APS), a 346-item questionnaire designed to indicate the severity of mental health symptoms and problems, and conducted semi-structured interviews using the modified Juvenile Detention Center Screening form (CSAT,1995). At the conclusion of the assessment, interviewers completed a form giving their diagnostic impression and making recommendations for appropriate treatment, if any. Interviewers were instructed to immediately notify the Detention Center Administrator of adolescents in need of emergency services. For example, adolescents reporting suicidal thoughts and plans were to be promptly brought to the attention of detention center staff or the youth's Youth Services Counselor.

Training school juveniles were administered the APS and the Problem Oriented Screening Instrument for Teens (POSIT) since both can be administered to groups of adolescents. Data collection at Oakley was conducted in the school library. Oval tables seating four were situated in one half of the library. Groups of approximately twenty-five boys were escorted into and seated at the available tables. Conversely, juveniles at Columbia Training School were tested in classrooms where the juveniles sat at individual desks. One researcher testing girls was assigned to a classroom while another was provided a separate room to test the younger boys. Both researchers were assigned a staff member to help maintain order and discipline in the classroom. Both at Oakley and Columbia, researchers provided each new group of juveniles with an overview of the study, solicited willing participants (and excused those who were unwilling), and completed a basic demographic form that focused on current grade placement in school, last grade completed, home county, birth date, race, and age. In addition, height and weight were measured and duly recorded.

Adolescents requiring assistance with reading were helped individually. In cases where several juveniles appeared to be reading slowly or with difficulty, the researcher (or the assistant) read the questions aloud. In other situations where several juveniles required simultaneous help, reading aloud took place in an area away from the majority. This strategy decreased the distraction to those working individually. While juveniles completed each instrument at their own pace, testing consumed approximately one and one half to two hours per group, taking reading difficulties into consideration. In negotiating the institutional schedule at Oakley, four groups of juveniles completed the measures, with 92 boys completing the assessment instruments. In contrast, the Columbia Training School assessments were completed during two visits, approximately one month apart. Five groups, or 101 juveniles (74 females and 27 boys) completed the assessment measures at Columbia.

### Measures

A prevalence rate for a particular disorder is defined as the number of cases of a disease present in a population at a specific time divided by the number of persons in the population at that time (number of cases/number of persons in the population). Point prevalence is a mixture of old and new cases because it focuses on current disease at a particular point in time. In this case, the population of interest is youths involved in the Mississippi juvenile justice system and held in secure confinement. Our stated goal is to determine the number of juveniles with mental health and substance abuse problems that could potentially meet *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (American Psychiatric Association, 1994) (*DSM-IV*) diagnostic criteria.

All incarcerated juveniles participating in the study completed the Adolescent Psychopathy Scale (APS). The APS is a 346 item self-report measure of adolescent psychopathy, that directly evaluates the severity of symptoms associated with specific *DSM-IV* clinical and personality disorders. In addition, the APS assesses behaviors (such as suicidal behavior and aggression) that interfere with successful psychosocial adaptation and personal competence. The instrument is designed to be administered to youth 12 to 19 years of age individually or in groups. It is written at a third grade reading level. Information on test development, psychometric properties, and descriptions of the standardization and clinical samples is available in the *APS Psychometric and Technical Manual* (Reynolds, 1998).

Although the APS does not provide a formal diagnosis, it does provide an indication of the severity of symptoms and problems. Scale scores are reported as T scores, i.e., standard scores with a mean of 50 and a standard deviation of 10, that are based on a standardization sample of 1,827 adolescents. T scores below 60 are in the normal range, 60 to 64 indicate subclinical level and are only relevant for disorders with relatively high base rates in the general population, such as Substance Abuse, Conduct and Anxiety disorders. Scores 65 to 69 are in the mild clinical range, 70 to 79 are in the moderate range, and scores 80 or above are in the severe clinical range. “An adolescent’s score at or above a cutoff score is interpreted as a clinically significant problem within the domain measured by the particular scale. However, this cutoff score method is *not equivalent* to providing a formal *DSM-IV* diagnosis.” (Reynolds, 1998, p. 5). Unless otherwise stated, we report the percentage of juveniles who score in the moderate or higher range for specific disorders as higher APS subscale scores increases our confidence that the juvenile is experiencing mental, behavioral, and/or emotional problems likely to result in a formal *DSM-IV* diagnosis.

The APS is composed of 20 Clinical Disorder, 5 Personality Disorder, 11 Psychosocial Problem Content, and 4 Response Style Indicator scales. The Clinical Disorder scales correspond to 20 *DSM-IV* Axis I disorders that are common among adolescents. The Clinical Disorder scales assess the presence or frequency of occurrence of symptoms during the past six months for the following disorders:

#### Disruptive Behavior Disorders

Attention-Deficit/Hyperactivity - 10 items

Conduct Disorder - 19 items

Oppositional Defiant disorder - 11 items

#### Other Externalizing Disorders

Adjustment Disorder - 15 items

Substance Abuse Disorder - 12 items

#### Eating Disorders

Anorexia Nervosa - 9 items

Bulimia Nervosa - 8 items

Sleep Disorders - 12 items

Somatoform Disorders: Somatization Disorder - 12 items

## Anxiety Disorders

- Panic Disorder - 17 items
- Obsessive-Compulsive Disorders - 6 items
- Generalized Anxiety Disorder - 19 items
- Social Phobia - 12 items
- Separation Anxiety Disorder - 8 items
- Posttraumatic Stress Disorder - 12 items

## Mood Disorders

- Major Depression - 29 items
- Dysthymic Disorder - 16 items
- Mania - 13 items

Dissociative Disorders: Depersonalization Disorder - 5 items

Psychotic Disorders: Schizophrenia - 27 items

Personality disorders represent relatively stable, enduring, and maladaptive personality traits that deviate significantly from normal characteristics of adolescents. The Personality Disorder scales gauge *DSM-IV* personality disorders that are prevalent in this age group: Avoidant Personality Disorder, Obsessive-Compulsive Personality Disorder, Borderline Personality Disorder, Schizotypal Personality Disorder, Paranoid Personality Disorder.

The Psychosocial Problem Content scales evaluate various aspects of adolescent social and emotional adjustment. The following scales do not include all possible psychological problems, yet are important for clinical assessment and intervention: Self-Concept, Psychosocial Substance Use Difficulties, Introversion, Alienation-Boredom, Anger, Aggression, Interpersonal Problems, Emotional Lability, Disorientation, Suicide, and Social Adaptation.

The Response Style Indicators assess the validity and reliability of the adolescent's responses. The Lie Response scale consists of 10 items assessing the veracity of self-report as well as social desirability bias. In other words, the respondent's openness and willingness to give honest answers. The Consistency Response scale is made up of 25 item pairs that serve as a screen for random responding, inattention or low literacy. The Infrequency Response scale involves 26 items seldom endorsed by the standardization sample and represent usual or bizarre behavior, affect, and cognition. The three Infrequency Response items involving carrying or using weapons and arson are also included in the Conduct Disorder scale. While these items have low endorsement in the standardization sample, they are not uncommon among our sample of juvenile delinquents. For example, 11 juveniles were incarcerated for aggravated assault, and 27 juveniles incarcerated for possessing weapons, yet several times that number of juveniles admitted to carrying or using weapons. One hundred twenty seven (127) responded affirmatively to, "I used a weapon in a fight" and 99 juveniles admitted that they have taken a gun or weapon to school. Only three youth reported that they were charged with arson, however, 74 endorsed, "I set something on fire that I shouldn't have." We used Response Style Indicators to determine which questionnaires are invalid and should be eliminated from analysis.

The Problem Oriented Screening Instrument for Teens (POSIT) is a 139 item instrument developed through support from the National Institute on Drug Abuse for the *Adolescent Assessment/Referral System* (Rahdert, 1991). Only juveniles at the two state training schools completed this measure. The POSIT is for use with adolescents 12 through 19 years of age able to read at a sixth grade level. It is designed to identify risk for problems and potential need for services in 10 functional areas: Substance Use/Abuse, Physical Health, Mental Health Status, Family Relationships, Peer Relationships, Educational Status, Vocational Status, Social Skills, Leisure/Recreation, and Aggressive Behavior/Delinquency.

The POSIT scoring system is sensitive and interprets potential problem areas. Scores, delineated as low, middle, and high, rank an adolescent's risk level. The higher the risk level, the more likely problems exist. In addition, there are also stand alone "red flag" items that indicate the need for further assessment. That is, if an adolescent gives the high risk response to any red flag item for a given functional area, he/she should be assessed further in that functional domain. Although the POSIT does not assess clinical symptoms and thus does not indicate diagnostic criteria, youth scoring in the high risk range of any domain are in need of further assessment. However, the POSIT has proven useful for screening for substance abuse, maladaptive family functioning, and delinquency recidivism (Dembo, Turner, et al., 1995; Latimer, Winters, & Stinchfield, 1997; Santisteban, Tejada, Dominics, & Szapocznik, 1999) and has also been used to match adolescents to appropriate interventions (Babor et al., 1991).

The psychometric properties of the POSIT have been evaluated using youths from public schools, various clinical settings, and juvenile correctional institutions (Dembo, Schmeidler, Borden, Turner, Sue, & Manning, 1994; Latimer, Winters, & Stinchfield, 1997; McLaney, Del-Boca, & Babor, 1994; Melchior, Rahdert, & Huba, 1994). Internal reliability ranged from very poor (alpha = .47 for Vocational Status and Leisure/Recreation domains) to excellent (alpha = .93 for Substance Use/Abuse) in a youth sample including both non-drug users and heavy drug users (Melchior, Rahdert, & Huba, 1994). Additionally, a test-retest reliability study of the POSIT using arrested youth in a juvenile offender assessment/detention center found very high rates of youth problems at each POSIT administration and the concordance rates between Time 1 and Time 2 administration was consistently high across time intervals (Dembo, Schmeidler, Borden, Turner, Sue, & Manning, 1994). Validity has only been determined for the Substance Use/Abuse scale, which compares favorably with the Adolescent Diagnostic Inventory and the Personal Experience Inventory, two instruments with established validity for drug abuse diagnosis and drug use frequency (Latimer, Winters, & Stinchfield, 1997).

A third measure, the Juvenile Detention Interview, was used only with juveniles confined in a youth detention facility. This instrument, developed by Richard Dembo and published in *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents* (CSAT,1995), is a modification of his Prototype Screening/Triage Form for Juvenile Detention Centers. The original form collects demographic and reason-for-admission information in juvenile detainees, and obtains information on education/employment, home/living situation, gang membership, alcohol/other drug use, sexual abuse history, physical abuse history, family history, psychological/medical history and mental health. Due to Mississippi State University's Institutional Review Board concerns, sexual and physical abuse questions were removed from the interview schedule.

The modified Juvenile Detention Interview is a face-to-face structured interview with multiple choice and open-ended questions. After completing the Juvenile Detention Interview, the interviewer answered 16 questions based on their observations of the juvenile participant. These responses assessed the juvenile’s mental status as well as allowed the interviewer to formulate a diagnostic impression and any recommendations for treatment services.

Description of Subjects

A total of 482 juveniles participated including 317 detained in nine detention centers across the state of Mississippi and 165 incarcerated at the two state training schools. Sample characteristics are displayed in Table 1. Approximately 65% of the sample are males and 35% percent are females. African American youth constituted nearly 66% percent with Caucasian youth representing slightly more than 31% of the sample. Youth of other ethnic origins, including Hispanic, Asian, and Native Americans, comprised slightly less than three percent of the total sample.

**Table 1: Subject Characteristics, N= 482**

		<b>N</b>	<b>Percent</b>	<b>Mean/(SD)</b>	<b>Range</b>
<b>Gender</b>	Male	312	64.7		
	Female	170	35.3		
<b>Race</b>	White	151	31.3		
	Black	317	65.7		
	Other <sup>1</sup>	14	3.0		
<b>Age at time of assessment</b>		<b>482</b>		15.3 (1.36)	11 to 18 years
<b>Age of first involvement in Juvenile Justice system</b>		<b>463</b>		13.6 (1.9)	6 to 17 years
<b>Length of time in juvenile justice system</b>		<b>463</b>		1.7 (1.8)	1 to 9 years
<b>Length of time detained</b>		<b>312</b>		10.2 (12.2)	1 to 86 days
<b>Gang Affiliation</b>		<b>316</b>	20.3		
<b>School Suspensions</b>		<b>310</b>	84.8	5.5 (6.4)	0 to 20 times
<b>Runaway from home</b>		<b>317</b>	37.8		
<b>Put out of home</b>		<b>315</b>	19.0		
<b>Special Education</b>		<b>308</b>	19.8		
<b>Given birth/fathered child</b>		<b>314</b>	10.2		

Note 1: The other racial/ethnicity category includes American Indian = 1, Asian = 8, Hispanic = 2, and not specified = 3.

While males comprise 65% percent of our sample, they account for 79% of the training school population and 71% of the detention center population. Therefore, males are under-represented in our sample. African Americans account for 66% of our sample, 69% of juveniles detained in detention centers, and 72% of juveniles committed to training schools. Consequently, whites (31.4%) and other racial groups (2.7%) are over represented in our sample compared to training and detention center populations. In fact Asians, Native Americans, and other racial groups account for one percent of the state's juvenile incarcerated population

Delinquent behavior is often associated with gang associations and behavioral problems at school and at home. Twenty percent of the sample reported gang affiliations. Males overwhelmingly reported involvement with gangs or gang activities, in contrast, females comprised only slightly over 5% of those reporting gang ties. Nearly 85% of the adolescents participating in the study reported having been suspended from school. Thirty-eight percent of juveniles reported running away from home and 19% reported being put out of their primary residence. Approximately 20% of the subjects participating in the study were presently or had been previously enrolled in special education programs.

A substantial proportion of juveniles reported family problems or a family history of problems (see Table 2). Specifically, 52% of juveniles reported that one or more family member(s) has experienced an alcohol problem, 32% reported family member(s) drug problems and/or emotional or mental problems. Over three-quarters (77%) of juveniles we interviewed reported a family member with a history of criminal justice involvement. Of the 77% reporting a history of family criminal involvement, 90% of the family members had been jailed or held in youth detention. It was not possible to collect family history information from juveniles committed to the state training schools. However, one POSIT domain provides comparable information: 36.4% of the training school sample scored in the high risk range for family relationship problems (38.7% of males and 33.3% of females).

**Table 2: Family Problems of Juveniles in Detention Centers**

Family Problems/History	N	Percent			Gender Difference
		Total	Male	Female	
Any family member with alcohol abuse problem?	317	51.7	50.2	55.1	ns
Any family member with drug abuse problem?	315	37.5	35.3	42.3	ns
Any family member with emotional or mental problem?	315	32.4	26.3	45.9	$P^2 = 11.9, p = .001$
Any family member with history of criminal justice system involvement	317	77.9	74.9	82.7	ns
Of those with criminal involvement, were they jailed or held in youth detention	247	90.7	87.5	92.2	ns

**Table 3: Self-reported Psychiatric and Medical History of Juveniles in Detention Centers**

Psychiatric History	N	Percent			Gender Difference
		Total	Male	Female	
AOD treatment	317	14.2	15.1	12.2	ns
Mental Health treatment	316	58.2	59.4	55.7	ns
Psychiatric Hospitalization	316	25.3	23.3	29.9	ns
Ever attempted suicide	315	31.1	27.1	40.2	$P^2 = 5.4, p = .02$
Psychotropic medications: ever prescribed	315	35.6	34.9	37.1	ns
Psychotropic medications: currently prescribed	306	10.8	11.3	9.7	ns
Currently under care for Physical Health Problem(s)	310	18.1	14.7	25.8	$P^2 = 5.4, p = .02$
Medication(s) for medical condition(s)	315	17.1	13.8	24.7	$P^2 = 5.7, p = .02$

Surprisingly, almost 60% of juveniles surveyed reported that they previously received mental health treatment in the past (see Table 3). Over one third of the juveniles interviewed reported that psychotropic medications were prescribed for them, 31% reported a suicide attempt and one quarter reported psychiatric hospitalization. These adolescents are also prone to physical health problems. Eighteen percent of juveniles in detention centers reported that they are currently under a physicians care and 66.7% of juveniles in the training schools scored in the high risk range on the Physical Health domain of the POSIT.

Involvement in the juvenile system ranged from less than one year to a maximum of nine years. The average age for first arrest/referral of our sample is 13.6 years old. Average length of confinement prior to study participation was just over ten days but ranged from one to eighty-two days.

The reason for incarceration was obtained from the juvenile and not by a review of youth court records. Table 4 displays the primary reason for incarceration as reported by the juvenile. Offenses categorized as violent include manslaughter, robbery, aggravated assault, and weapons charges. Slightly over 17% said they were detained because of a violent offense. Property offenses include burglary, larceny, motor vehicle theft, forgery, fraud, and embezzlement. Twenty-five percent reported one of these offenses. Status offenses apply only to minors and include running away, curfew violation, possessing alcohol, truancy, and incorrigibility. Incorrigibility simply means not minding one’s parent(s) and can be levied against sexually active adolescent females. Indeed, 45% of the females in our sample reported that they were being securely detained for a status offense, twice the rate of males (20.7%). Although confinement of status offenders is prohibited by law, status offenders may be held in secure confinement for violation of a valid court order. Fifteen percent reported incarceration for an alcohol or drug offense and 10% reported a variety of other delinquent offenses such as disorderly conduct and trespassing.

**Table 4: Self-reported Reason for Confinement**

<b>Reason/Type of Offense</b>	<b>Female % (#)</b>	<b>Male % (#)</b>	<b>Total %</b>
<b>Violent Offenses</b>	18.5 (31)	16.8 (52)	17.4
<b>Property Offenses</b>	16.7 (28)	26.8 (83)	24.8
<b>Alcohol or Drug Offenses</b>	8.4 (14)	19.1 (59)	15.3
<b>Contempt of Court/Violation of Probation</b>	5.0 (8)	4.2 (13)	4.4
<b>Other Delinquent Offenses</b>	5.9 (10)	12.4 (38)	10.2
<b>Status Offenses</b>	45.5 (76)	20.7 (64)	29.4
<b>Total Number</b>	167	309	476

## Results

All study participants were given the APS, but not all juveniles completed the entire questionnaire. In addition, poor reading comprehension was estimated to be a problem for 12% of older males. Difficulty reading, restlessness, and short attention span was much more evident for the younger boys. To control for invalid or unreliable reports, APS scores of 80 or above on the Lie Response scale, at or above 90 on the Consistency scale, and at or above 90 on the Infrequency scale were considered suspect. Forty-five (45) juveniles or 9% of the sample met this criteria and their APS results were excluded from analysis. The percentage of juveniles scoring above cutoffs for APS Response Style Indicators are displayed in Table 5.

**Table 5: Percentage of Confined Juvenile Offenders with Invalid/Unreliable APS Protocol according to Response Style Indicator Scales, N= 482**

<b>Response Style Indicator</b>	<b>Female % (#)</b>	<b>Male % (#)</b>	<b>Total %</b>
<b>Lie Response: social desirability bias, scores <math>\geq</math> 80</b>	0 (0)	1.3 (4)	0.8
<b>Consistency Response: inconsistent or random responding, scores <math>\geq</math> 90</b>	1.8 (3)	1.0 (3)	1.4
<b>Infrequency Response: oppositional or purposely faking bad, scores <math>\geq</math> 90</b>	6.5 (11)	8.1 (25)	7.5
<b>Invalid/Unreliable APS Protocols</b>	7.6 (13)	9.9 (31)	9.1

For purposes of this study, functional impairment is reflected by APS clinical scale scores in the moderate or above range. Most (70%) study participants scored in the moderate or severe range on two or more APS clinical scales. Females averaged six APS clinical disorders in the moderate or severe range, while males averaged four. Thirty-nine percent of juveniles with two or more disorders have co-occurring mental health and substance use disorders. Almost half (49%) with two or more disorders have a Conduct Disorder.

To differentiate among multiple disorders, we assigned the APS clinical scale with the highest score as the primary diagnosis. As can be seen in Table 6, 85% of study participants met *DSM-IV* diagnostic criteria as measured by the APS. Approximately 20% of incarcerated juveniles endorsed symptoms consistent with a conduct disorder or substance abuse disorder as the primary diagnosis. Males were twice as likely to have a conduct or substance use disorder as females. Anxiety disorders accounted for 19.5% of juveniles with a primary disorder. Surprisingly only one percent of study participants obtained a mood disorder as the primary disorder. However, eating disorders, sleep disorders and somatization disorders accounted for 15.6% of primary disorders and all are associated features of major depression (American Psychiatric Association, 1994).

The percentage of study participants scoring in the moderate or severe range for each APS clinical scale is provided in Table 7. Moderate to severe Conduct Disorder is the most prevalent disorder in this sample (39.4%) and most prevalent disorder among males (43%). The most prevalent disorder for females is Separation Anxiety Disorder (43.1%). Also, a substantial numbers of girls scored in the moderate to severe range for Conduct Disorder.

**Table 6: Primary Psychiatric Diagnosis based on Highest APS Clinical Scale score above 65 or Mild Clinical Symptoms, N=435**

<b>Diagnosis</b>	<b>Female % (#)</b>	<b>Male % (#)</b>	<b>Total %</b>
No Clinical Disorder	14.1 (22)	16.1 (45)	15.4
Attention Deficit Disorder	1.9 (3)	0.7 (2)	1.1
Conduct Disorder	10.3 (16)	23.7 (66)	18.9
Oppositional Defiant Disorder	1.9 (3)	1.1 (3)	1.4
Adjustment Disorder	7.1 (11)	2.2 (6)	3.9
Substance Abuse Disorder	11.5 (18)	22.9 (64)	18.9
Anorexia Nervosa	0.6 (1)	-	0.2
Bulimia Nervosa	4.5 (7)	4.3 (12)	4.4
Sleep Disorder	7.7 (12)	4.3 (12)	5.5
Somatization Disorder	7.1 (11)	4.7 (13)	5.5
Panic Disorder	7.1 (11)	1.8 (5)	3.7
Obsessive Compulsive Disorder	1.3 (2)	1.8 (5)	1.6
Generalized Anxiety Disorder	-	0.4 (1)	0.2
Social Phobia	-	0.7 (2)	0.5
Separation Anxiety Disorder	17.9 (28)	9.7 (27)	12.6
Post Traumatic Stress Disorder	1.3 (2)	0.7 (2)	0.9
Major Depression	-	-	0.0
Dysthymic Disorder	0.6 (1)	0.4 (1)	0.5
Mania	1.3 (2)	0.7 (2)	0.9
Depersonalization Disorder	2.6 (4)	2.2 (6)	2.3
Schizophrenia	1.3 (2)	1.8 (5)	1.6
<b>Total</b>	<b>100 (156)</b>	<b>100 (279)</b>	<b>100 (435)</b>

**Table 7: Percentage of Confined Juvenile Offenders scoring 70 or higher, Moderate to Severe Clinical Range on APS Clinical Scales, N= 438**

<b>Diagnosis</b>	<b>Female % (#)</b>	<b>Male % (#)</b>	<b>Total %</b>
<b>Attention Deficit Disorder*</b>	18.6 (29)	5.1 (14)	9.9
<b>Conduct Disorder</b>	32.4 (51)	43.0 (120)	39.4
<b>Oppositional Defiant Disorder*</b>	14.2 (22)	5.4 (15)	8.5
<b>Adjustment Disorder*</b>	30.1 (47)	14.8 (41)	20.3
<b>Substance Abuse Disorder*</b>	20.8 (32)	29.8 (82)	26.6
<b>Anorexia Nervosa*</b>	9.9 (15)	0.0 (0)	3.5
<b>Bulimia Nervosa*</b>	15.6 (24)	6.9 (19)	10.0
<b>Sleep Disorder*</b>	27.0 (41)	16.3 (45)	20.2
<b>Somatization Disorder*</b>	29.7 (46)	9.3 (26)	16.6
<b>Panic Disorder*</b>	32.9 (51)	15.9 (44)	22.0
<b>Obsessive Compulsive Disorder</b>	13.5 (21)	12.7 (35)	13.0
<b>Generalized Anxiety Disorder*</b>	21.3 (33)	4.3 (12)	10.4
<b>Social Phobia*</b>	6.4 (10)	2.2 (6)	3.7
<b>Separation Anxiety Disorder*</b>	43.1 (66)	22.4 (62)	29.7
<b>Post Traumatic Stress Disorder*</b>	22.4 (35)	6.8 (19)	12.5
<b>Major Depression*</b>	18.9 (29)	3.3 (9)	8.9
<b>Dysthymic Disorder*</b>	18.6 (29)	2.5 (7)	8.3
<b>Mania</b>	13.5 (21)	6.8 (19)	9.2
<b>Depersonalization Disorder</b>	18.7 (29)	10.7 (30)	13.6
<b>Schizophrenia</b>	20.0 (31)	14.1 (39)	16.2

\* Statistically significant gender difference in percentage,  $p \leq .05$

Gender differences were significant for 15 of the 20 APS clinical scales. There were no statistically significant gender differences for the prevalence of Conduct Disorder, Obsessive-Compulsive Disorder, Mania, Depersonalization Disorder and Schizophrenia. Where gender differences were evident, prevalence was greater for females than males on all disorders except Substance Abuse. According to the National Comorbidity Study, men are much more likely to have substance use disorders and Antisocial Personality Disorder (the adult version of Conduct Disorder) than women, while women are much more likely to have affective disorders and anxiety disorders than men (Kessler et al., 1994). Girls in our study were five to seven times more likely than boys to score in the moderate to severe range on Major Depression and Dysthymic Disorder scales and

were two to five times more likely than boys to meet the criteria for an anxiety disorder. Although Attention Deficit Hyperactivity Disorder (ADHD) is more frequently found in males (American Psychiatric Association, 1994), 18.6% of incarcerated girls met criteria for ADHD compared to 5.1% of incarcerated boys.

Also noteworthy is the very high rates of somatization disorder both as the primary diagnosis (5.5% of sample) and percentage of males (9.3%) and females (29.7%) who scored in the moderate or higher clinical range. “The essential feature of Somatization Disorder is a pattern of recurring, multiple, clinically significant somatic complaints” and the prevalence ranges from 0.2% to 2% among females and less than 0.2% in males (American Psychiatric Association, 1994). Likewise, the prevalence of eating disorders in this sample seems inordinately high. While eating disorders are more prevalent among women, the rate is 1% to 3% in women compared to a rate one-tenth of that in men (American Psychiatric Association, 1994), we find similar rates of Bulimia for males and females as the primary diagnosis. We interpret these results as indicative of anxiety and depression rather than the true prevalence of Somatization Disorder and Bulimia in our sample.

### Alcohol and Drug Use

Juvenile reports of alcohol and other drug use by juveniles in detention is displayed in Table 8. Alcohol and tobacco use is common among youth in Mississippi: 76.4% and 72.7% of Mississippi high school students report lifetime alcohol use and cigarette smoking respectively (CDC, 2000). Juvenile offenders are just as likely as other youth to have tried alcohol and tobacco. The primary difference between the juvenile offenders and high school students in the use of gateway drugs involves *current* use of substances. For example, only 4.7% of Mississippi high school students report daily use of tobacco compared to 72.6% of juvenile offenders. CDC’s Youth Risk Behavior Survey defines heavy drinking as five or more drinks of alcohol on one or more occasions during the thirty days preceding the survey. 25.4% of high school students reported heavy drinking. We collected information on frequency of alcohol consumption and 13.8% of the juveniles reported daily use of alcohol. We did not collect information on the amount of alcohol consumed but did assess the problems associated with substance use.

Information on Mississippi high school students’ use of marijuana, cocaine, and inhalants is also available from the Youth Risk Behavior Survey (CDC, 2000). 36.3% of high school students compared to 75.3% of incarcerated juveniles report lifetime use of marijuana. Lifetime cocaine use was reported by 10.7% incarcerated juvenile offenders compared to 5.7% of Mississippi high school students. Reports of inhalant use is similar between high school students (12.6%) and incarcerated juveniles (10.1%). In sum, incarcerated juveniles report a high degree of alcohol and other drug usage.

**Table 8: Self-reported Alcohol and other Drug Use by Juveniles in Detention**

Drug	N	Lifetime Use (%)	Average Age of First Use	Frequency of Use (for those reporting current use)	
				Monthly to Weekly Use	Daily Use
Tobacco	315	74.3	11.9	17.3	72.6
Alcohol	315	71.4	13.1	43.3	13.8
Marijuana	316	75.3	13.0	26.6	47.7
Inhalants	317	10.1	12.7	20.0	0.0
Hallucinogens	317	15.5	14.3	27.9	9.3
Cocaine	317	10.7	14.7	40.0	8.0
Opiates	317	3.2	-	0.0	0.0
Prescription pain medication	316	9.2	14.5	32.0	24.0
Needle Use	311	1.3			

A significant number of incarcerated youth reported difficulties as a result of their substance use. The APS Psychosocial Substance Use Difficulties scale consists of 15 items measuring substance dependency, lack of control of substance use, and problems associated with substance use. 33% of females and 29.5% of males scored in the moderate or higher range on the APS Psychosocial Substance Use Difficulties scale. In addition, 26.6% of our sample met diagnostic criteria for a substance use disorder. The POSIT Substance Use/Abuse scale consists of 17 items with a cut score of 7 for high risk. 46.2% of males and 36.2% of females are at high risk for a substance abuse disorder according to the POSIT. The correlation between the POSIT Substance Use/Abuse scale and the APS Psychosocial Substance Use Difficulties scale is strong and positive ( $r = .657, p < .001$ ) indicating that the POSIT Substance Use/Abuse scale is a useful and inexpensive screening tool for juvenile offenders.

### Suicide

Information about suicidal ideation and attempts was collected in two ways. The structured interview included questions about previous suicide attempts and current suicidal thoughts and one of the APS Psychosocial Problem Content scales contains eight items regarding suicide. 9.3% of juveniles in detention centers were currently suicidal based on the interview and 9% of juveniles scored in the moderate to severe range on the APS Suicide scale, indicating that they are having suicidal thoughts and may be actively contemplating an attempt. Regardless of the measure, the potential for suicidal behavior is of serious concern for detention center and training school administrators.

## Interviewers Diagnostic Impressions

In addition to collecting the APS and conducting a structured interview on family and youth problems, interviewers evaluated the mental status of participating juveniles in detention centers and provided their diagnostic impressions. Interviewers could give up to three diagnoses (see Table 9). Interviewers were uncertain and unable to make a diagnosis on about 20% of the juveniles they assessed. This is understandable given the relatively brief amount of time allowed to question and observe the youth. Their judgements were based solely on the responses to interview questions and their observations (interviewers were not aware of APS scores). Even though interviewers did not identify as many juveniles with psychiatric disorders as did the APS, they still judged 65.7% of the juveniles to have one or more psychiatric disorders.

ADHD and other disruptive behavior disorders were most frequently identified by interviewers. 28.2% of the juveniles were classified as having a primary attention deficit or disruptive behavior disorder and over one-third of the sample (35.5%) was assessed this diagnosis. One-third of the juveniles were judged by interviewers to have substance abuse disorder. Two males, essentially one percent, were diagnosed by interviewers as having schizophrenia, a serious thought disorder. This figure is in line with the prevalence of schizophrenia in the general population. Interviewers findings were similar to the APS results for adjustment and mood disorders which increase confidence that the true prevalence of mood/depressive disorders is between 9% and 22% and anxiety disorders is between 13% and 20%. However, they diagnosed very few youth with anxiety disorders compared to APS results. An anxiety disorder was the primary diagnosis for 17.9% of juveniles according to the APS, but only 7% of the juveniles were assessed as having an anxiety disorder by interviewers. This discrepancy maybe explained by the fact that the APS has 74 questions regarding anxiety symptoms plus 24 items on related symptoms, i.e. sleep disturbance and somatic complaints, while the Juvenile Detention Interview has three semi-structured questions on mental health treatment and a 16 item mental status examination. It is also likely that juvenile endorsement of symptoms of anxiety, sleep disturbance and somatic complaints on the APS were in part a stress reaction to the conditions of confinement. Never-the-less, incarcerated juveniles are experiencing moderate to serious symptoms of anxiety and meeting *DSM-IV* diagnostic criteria for anxiety disorders. Finally, the APS does not measure mental retardation but interviewers judged four youth to be mentally retarded.

**Table 9: Interviewers' Primary Diagnostic Impression of Juveniles in Detention,  
N = 309**

Disorder Category	Frequency			Percentage	
	Primary Diagnosis	Secondary Diagnosis	Tertiary Diagnosis	Primary Diagnosis	With This Diagnosis
<b>Attention Deficit/Disruptive Behavior Disorder</b>	70	14	4	28.2	35.5
<b>Substance Abuse Disorder</b>	33	37	9	13.3	31.8
<b>Mood Disorder</b>	34	14	6	13.7	21.8
<b>Adjustment Disorder</b>	14	12	6	5.6	12.9
<b>Anxiety Disorder</b>	6	9	2	2.4	6.8
<b>Mental Retardation</b>	4	2	0	1.6	2.4
<b>Schizophrenia</b>	2	0	0	0.9	0.9
<b>Personality Disorder</b>	0	1	3	0	1.6
<b>No Psychiatric Disorder</b>	85				
<b>Unable to diagnosis</b>	61				

## Conclusions and Recommendations

A serious limitation of this study was caused by the difficulties accessing juveniles in confinement. We were able to solicit study participation from juvenile offenders in nine out of 15 detention facilities. Funding constraints and restrictions imposed by facility administrators prevented a census (assessing all juveniles) or random selection of juveniles incarcerated on a given day. We did not assess youth in the medium and maximum security units of the training schools, a subset of the confined juvenile population that is likely to be more disturbed. We were also limited to youth from counties where the judge provided court orders specifying individuals who could participate in the study. Consequently, many of the juveniles for which permission was obtained had been released from training school before researchers could approach them for study participation and 85% of the completed measures packets were released to researchers for analysis. In addition, the resulting sample of 482 youth is not demographically representative as there are more females and more non-black youth in our sample than in the juvenile justice population. Although ours is essentially a convenience sample and caution should always be exercised when making generalizations based on such samples, we believe that our findings do reflect the mental health status of incarcerated juvenile offenders in Mississippi.

Using multiple methods, we found that between 66% to 85% of the juvenile offenders assessed met *DSM-IV* diagnostic criteria for a mental disorder. Our findings are in line with other state prevalence studies that found prevalence rates between 53% and 77% and a nationally representative survey of juvenile correctional facilities where 73% of the youth reported mental health problems during screening (Abt Associates, 1994).

High rates of multiple, co-occurring mental health and substance abuse diagnoses were evident in the Georgia, South Carolina and Maryland studies. In a review of the literature, Otto et al. (1992) report that more than 50% of youth with a conduct disorder have at least one other mental disorder. We find that at least 54% of the juveniles have multiple psychiatric disorders. Conduct disorder is the most frequently identified disorder with 32% of females and 43% of males meeting diagnostic criteria. Conduct Disorder, followed by substance abuse disorders, are the most frequently co-occurring disorders in our sample. Half with two or more disorders have a Conduct Disorder and 38% have a co-occurring substance abuse disorder.

When specific diagnostic categories are examined, our results are again similar to that of other prevalence studies. Taking into account interviewers diagnostic impressions and APS clinical scale scores, we estimate that the prevalence of any disruptive disorders is 39% and the prevalence of Attention Deficit Hyperactivity Disorder (ADHD) is approximately 10% in our sample. The prevalence of substance abuse disorders is 20% to 32%, the prevalence of depressive disorders is 22%, the prevalence of anxiety disorders is 19% to 30% and psychotic disorders is 1% to 2%. We also found that 9% of juveniles in secure confinement are suicidal.

Substantial gender differences in the frequency, prevalence and types of mental disorders was observed. Females averaged six disorders, while males averaged four. Greater proportions of females than males scored in the clinical range on 15 out of 20 APS clinical disorders scales. Males were twice as likely as females to have a conduct or substance use disorder. The most prevalent disorder for females is Separation Anxiety Disorder and girls in our study were five to seven times

more likely than boys to have a depressive disorder and were two to five times more likely than boys to meet the criteria for an anxiety disorder. Although ADHD is more common among males in the general youth population, incarcerated girls in our study were three times more likely than incarcerated boys to meet criteria for ADHD.

Given the evidence of substantial rates of serious mental illness and substance abuse among Mississippi juveniles confined to detention centers and juvenile correctional programs, we strongly recommend routine mental health screening on all juveniles as they enter detention facilities. (Training schools have diagnostic and reception centers that conduct psychological and psychiatric assessments.) We found the POSIT to be an inexpensive and valid screening tool for substance abuse problems. We also recommend the use of a structured youth and family problem history interview and a mental status examination be employed on all juveniles held in detention. Detention security personnel are not appropriate to conduct mental health and substance abuse screening. Otto and colleagues (1992) recommends that screening be conducted by a bachelors/masters level mental health professional with special training and experience. Division of Youth Services counselors could be trained to perform mental health screening and to “identify juveniles with no pre-existing mental disorders who may be in crisis as the result of their entry into the system, and juveniles with pre-existing mental disorders who require continued treatment” (Otto et al., 1992, p. 26). However, because there are regional community mental health centers (CMHC) located throughout the state of Mississippi and all CMHCs are supposed to provide diagnostic and evaluation services, we recommend close collaboration between mental health and juvenile justice agencies.

This study was designed to determine need for treatment services of incarcerated juveniles not whether mental health and substance abuse services are currently available to them. We did collect information on whether juveniles had received any mental health services in the past. Almost 60% reported that they had been seen by a psychiatrist, psychologist, social worker, substance abuse or mental health counselor. What we do not know is the source of the referral for mental health assessment and/or treatment. A study of Youth Courts in Tennessee found that only 3% of offenders were referred to formal mental health services, “a rate that pales in comparison to even conservative estimates of emotional disorder among juvenile justice populations” (Breda, 2001, p. 93). The lead author has over 16 years experience in providing mental health and substance abuse treatment in Mississippi and over 5 years experience in juvenile justice research. Based on her experience working in three CMHCs and her knowledge of Mississippi Youth Courts, there are jurisdictions in Mississippi where judges who would utilize effective intervention and treatment programs have few alternatives to training schools and detention centers. We therefore recommend that children and youth mental health services be increased throughout the state, especially in rural areas.

Finally, we have recommendations for the kinds of intervention and treatment services for juvenile offenders. Research has delineated the characteristics of effective treatment programs (Gendreau, 1996; Greenwood, 1994; Lipsey, 1992; Lipsey & Wilson, 1998; Palmer, 1996). The most effective programs are:

1. Structured, and focused on changing specific behaviors, i.e. cognitive-behavioral therapy,
2. Longer in duration and provide frequent contacts between staff and youth and their families,
3. Community-based, and family centered, that is, programs that involve parents in the treatment planning process and strengthen the capacity of the family to live together and to care for the child at home,

4. Emphasize the development of or the improvement of social skills, such as self control, anger management, substance abuse resistance and interpersonal skills,
5. Use mental health professionals rather than correctional staff as treatment providers in institutional settings, and
6. Integrate substance abuse and mental health treatment for youth with co-occurring disorders.

We recommend the development of a comprehensive and coordinated system of care based upon principles and components first described in *A System of Care for Severely Emotionally Disturbed Children and Youth* (Stroul & Fiedman, 1986). A system model involves collaboration between juvenile courts, mental health service providers, public schools and other stakeholders. In a system of care, services are integrated and resources are shared across agencies. A national evaluation of comprehensive children community mental health services programs that utilize the systems of care model is being conducted. Preliminary analysis of 22 programs that began in 1993 indicate that behavioral and emotional problems of children have been reduced, that school performance has improved and that law enforcement contacts have decreased for children served by a system of mental health care (CMHS, 1998).

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## **Appendices**

## HOME LIVING SITUATION

1. How many times have you run away from home? \_\_\_\_\_  
What was the longest period? \_\_\_\_\_  
Most recent date? \_\_\_\_\_
2. How many times have you been put or kicked out of your home? \_\_\_\_\_  
Most recent date? \_\_\_\_\_  
What was the youngest age you were put/kicked out of your home? \_\_\_\_\_ years  
Most recent date? \_\_\_\_\_

## OTHER PERSONAL INFORMATION

1. Are you a member of any gang? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "yes," probe for specifics (e.g., gang name, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
  
1. Have you ever received any treatment for an alcohol or other drug abuse problems?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If "yes;" Program Name: \_\_\_\_\_  
Type: \_\_\_\_\_  
Which Drug Problem: \_\_\_\_\_  
Dates: \_\_\_\_\_  
Outcome: \_\_\_\_\_
  
2. Did you ever take any drug with a needle? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "yes," which drug? \_\_\_\_\_

EDUCATION AND EMPLOYMENT INFORMATION

Education

1. Name of school in which enrolled or last attended: \_\_\_\_\_
2. Highest grade completed: \_\_\_\_\_ GED: Yes \_\_\_\_\_ No \_\_\_\_\_
3. Date last attended: \_\_\_\_\_
- 4a. Suspended: \_\_\_\_\_ times for \_\_\_\_\_
- b. Expelled: \_\_\_\_\_ times for \_\_\_\_\_
5. Was youth ever in a special education program  
(e.g., educationally handicapped, learning disabilities)  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, get details (grades/years, reasons)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employment

Type of Job

Dates

1. Current Employment: \_\_\_\_\_
2. Previous Employment: \_\_\_\_\_
3. Vocational *Training skills*: \_\_\_\_\_

## FAMILY HISTORY

Now, I would like to ask you some confidential questions about your family:

1. Has any member of your family or household family besides yourself ever had problems with alcohol abuse?

Yes \_\_\_ No \_\_\_

If "YES" ASK: Was treatment received? Yes \_\_\_ No \_\_\_

2. Do your parents allow you to drink at home? Yes \_\_\_ No \_\_\_

3. Has any member of your family or household family besides yourself ever had problems with other drug abuse?

Yes \_\_\_ No \_\_\_

If "YES" ASK: a. What drugs? \_\_\_\_\_

b. Did they receive drug treatment?

Yes \_\_\_ No \_\_\_

4. Do your parents allow you to use drugs at home (e.g., marijuana)?

Yes \_\_\_ No \_\_\_

5. Has any member of your family or household family besides yourself ever had emotional or mental problems?

Yes \_\_\_ No \_\_\_

If "YES", ASK: a. Did they receive treatment? Yes \_\_\_ No \_\_\_

b. What type of treatment?

hospital inpatient \_\_\_ outpatient \_\_\_

both, hospital, inpatient and outpatient \_\_\_

(other specify \_\_\_\_\_)

6. Has any member of your family or household family besides yourself had involvement with the police or courts?

Yes \_\_\_ No \_\_\_

If "YES", ASK: Have any of them been?

	Yes	No	Don't Know
Arrested	___	___	_____
Held in jail or detention	___	___	_____
Adjudicated delinquent or convicted of a crime	___	___	_____
Put on community control or probation	___	___	_____
Sent to a training school or prison	___	___	_____

7. Do you have any children of your own (i.e., given birth or fathered a child)?

Yes \_\_\_ No \_\_\_

Has your use caused you any problem in the past year? (i.e. with school, friends, health, police, parents)

Type of Drug	Ever Used		First Used	Frequency of Use in the last 12 Months	Most recent use?	Has your use caused you any problem in the past year? (i.e. with school, friends, health, police, parents)	
	Yes	No				Yes	No
1. Tobacco/Cigarettes							
2. Alcohol (beer, wine, wine coolers, liquors)							
3. Marijuana/hashish (grass, pot, smoke, cheeba, joint)							
4. Inhalants (sniff gasoline, paint, aerosol sprays, shoe shine/glue/toluene, paint thinner/solvents, white out liquid, other inhalants)							
5. Hallucinogens (LSD, PCP, Ecstasy, Peyote, some types of mushrooms, other hallucinogens)							
6. Cocaine (powder-snow, blow)							
7. Crack Cocaine (rock)							
8. Heroin/Other Opiates							
9. Other Drugs:							
MPTP							
China White							
10. Steroids							
11. Non-Medical use of (c):							
Sedatives/Barbituates (downers) e.g. Seconal							
Stimulants/Amphetamines/Diet Pills (speed, uppers) e.g., Dexedrine							
Tranquilizers e.g., Valium, Librium							
Pain Killing Pills e.g., Darvon							



MENTAL HEALTH INFORMATION  
(Appearance/Presentation Based primarily on observations)

		Yes	No	Comments
1.	Does the client appear alert?	___	___	_____
2.	Are there observable speech problem?	___	___	_____
3.	Is there anything unusual about the client's appearance?	___	___	_____
4.	Are there any observable problems with body movement (difficulties or unusual movements)?	___	___	_____
5.	Is the client's mood and affect unusual?	___	___	_____
6.	Is the client's activity level unusual?	___	___	_____
7.	Does the client seem to have insight into his current problems?	___	___	_____
8.	Does the client demonstrate capability of good judgement?	___	___	_____
9.	Is client oriented to: person? place? time?	___ ___ ___	___ ___ ___	_____ _____ _____
10.	Is there any evidence of hallucinations?	___	___	_____
11.	Is there any evidence of delusion?	___	___	_____
12.	Does the client have unusual fears?	___	___	_____
13.	Does the client have trouble thinking and expressing his thoughts?	___	___	_____
14.	Does the client exercise appropriate impulse control?	___	___	_____
15.	Does the client appear depressed?	___	___	_____
16.	Is there evidence of other bizarre behavior?	___	___	_____

PROBLEM ORIENTED SCREENING INSTRUMENT FOR TEENS

1. Do you have so much energy you don't know what to do with it?..... Yes No
2. Do you brag?..... Yes No
3. Do you get into trouble because you use drugs or alcohol at school?..... Yes No
4. Do your friends get bored at parties when there is no alcohol served?..... Yes No
5. Is it hard for you to ask for help from others?..... Yes No
6. Has there been adult supervision at the parties you have gone to recently?..... Yes No
7. Do your parents or guardians argue a lot?..... Yes No
8. Do you usually think about how your actions will affect others?..... Yes No
9. Have you recently either lost or gained more than 10 pounds?..... Yes No
10. Have you ever had sex with someone who shot up drugs?..... Yes No
11. Do you often feel tired?..... Yes No
12. Have you had trouble with stomach pain or nausea?..... Yes No
13. Do you get easily frightened?..... Yes No
14. Have any of your best friends dated regularly during the past year?..... Yes No
15. Have you dated regularly in the past year?..... Yes No
16. Do you have a skill, craft, trade or work experience?..... Yes No
17. Are most of your friends older than you are?..... Yes No
18. Do you have less energy than you think you should?..... Yes No
19. Do you get frustrated easily?..... Yes No
20. Do you threaten to hurt people?..... Yes No

- 21. Do you feel alone most of the time?.....Yes No
- 22. Do you sleep either too much or too little?.....Yes No
- 23. Do you swear or use dirty language?.....Yes No
- 24. Are you a good listener?.....Yes No
- 25. Do your parents or guardians approve of your friends?.....Yes No
- 26. Have you lied to anyone in the past week?.....Yes No
- 27. Do your parents or guardians refuse to talk with you when they are mad at you?.....Yes No
- 28. Do you rush into things without thinking about what could happen?.....Yes No
- 29. Did you have a paying job last summer?.....Yes No
- 30. Is your free time spent just hanging out with friends?.....Yes No
- 31. Have you accidentally hurt yourself or someone else while high on alcohol or drugs?....Yes No
- 32. Have you had any accidents or injuries that still bother you?.....Yes No
- 33. Are you a good speller?.....Yes No
- 34. Do you have friends who damage or destroy things on purpose?.....Yes No
- 35. Have the whites of your eyes ever turned yellow?.....Yes No
- 36. Do your parents or guardians usually know where you are and what you are doing?.....Yes No
- 37. Do you miss out on activities because you spend too much money on drugs or alcohol?.....Yes No
- 38. Do people pick on you because of the way you look?.....Yes No
- 39. Do you know how to get a job if you want one?.....Yes No
- 40. Do your parents or guardians and you do lots of things together?.....Yes No

- |     |  |     |    |
|-----|--|-----|----|
| 41. | Do you get A's and B's in some classes and fail others?.....                           | Yes | No |
| 42. | Do you feel nervous most of the time?.....   | Yes | No |
| 43. | Have you stolen things?.....   | Yes | No |
| 44. | Have you ever been told you are hyperactive?.....                                      | Yes | No |
| 45. | Do you ever feel you are addicted to alcohol or drugs?.....                            | Yes | No |
| 46. | Are you a good reader?.....  | Yes | No |
| 47. | Do you have a hobby you are really interested in?.....                                 | Yes | No |
| 48. | Do you plan to get a diploma (or already have one)?.....                               | Yes | No |
| 49. | Have you been frequently absent or late for work?.....                                 | Yes | No |
| 50. | Do you feel people are against you?.....   | Yes | No |
| 51. | Do you participate in team sports which have regular practices?.....                   | Yes | No |
| 52. | Have you ever read a book cover to cover for your own enjoyment?.....                  | Yes | No |
| 53. | Do you have chores that you must regularly do at home?.....                            | Yes | No |
| 54. | Do your friends bring drugs to parties?.....   | Yes | No |
| 55. | Do you get into fights a lot?.....   | Yes | No |
| 56. | Do you have a hot temper?.....   | Yes | No |
| 57. | Do your parents or guardians pay attention when you talk to them?.....                 | Yes | No |
| 58. | Have you started using more and more drugs or alcohol to get the effect you want?..... | Yes | No |
| 59. | Do your parents or guardians have rules about what you can and cannot do?.....         | Yes | No |
| 60. | Do people tell you that you are careless?.....   | Yes | No |

- |     |  |     |    |
|-----|--|-----|----|
| 61. | Are you stubborn?.....   | Yes | No |
| 62. | Do any of your best friends go out on school nights without permission from their parents or guardians?..... | Yes | No |
| 63. | Have you ever had or do you now have a job?.....   | Yes | No |
| 64. | Do you have trouble getting your mind off things?.....   | Yes | No |
| 65. | Have you ever threatened anyone with a weapon?.....  | Yes | No |
| 66. | Do you have a way to get to a job?.....  | Yes | No |
| 67. | Do you ever leave a party because there is no alcohol or drugs?.....   | Yes | No |
| 68. | Do your parents or guardians know what you really think or feel?.....  | Yes | No |
| 69. | Do you often act on the spur of the moment?.....   | Yes | No |
| 70. | Do you usually exercise for a half hour or more at least once a week?.....                                   | Yes | No |
| 71. | Do you have a constant desire for alcohol or drugs?.....   | Yes | No |
| 72. | Is it easy to learn new things?.....   | Yes | No |
| 73. | Do you have trouble with your breathing or with coughing?.....   | Yes | No |
| 74. | Do people your own age like and respect you?.....  | Yes | No |
| 75. | Does your mind wander a lot?.....  | Yes | No |
| 76. | Do you hear things no one else around you hears?.....  | Yes | No |
| 77. | Do you have trouble concentrating?.....  | Yes | No |
| 78. | Do you have a valid driver's license?.....   | Yes | No |
| 79. | Have you ever had a paying job that lasted at least one month?.....  | Yes | No |
| 80. | Do you and your parents or guardians have frequent arguments which involve yelling and screaming?.....       | Yes | No |

81. Have you had a car accident while high on alcohol or drugs?.....Yes No
82. Do you forget things you did while drinking or using drugs?.....Yes No
83. During the past month have you driven a car while you were drunk or high? .....Yes No
84. Are you louder than other kids?.....Yes No
85. Are most of your friends younger than you are?.....Yes No
86. Have you ever intentionally damaged someone else's property?.....Yes No
87. Have you ever stopped working at a job because you just didn't care?.....Yes No
88. Do your parents or guardians like talking with you and being with you?.....Yes No
89. Have you ever spent the night away from home when your parents didn't know where you were?.....Yes No
90. Have any of your best friends participated in team sports which require regular practices?.....Yes No
91. Are you suspicious of other people?.....Yes No
92. Are you already too busy with school and other adult supervised activities to be interested in a job?.....Yes No
93. Have you cut school at least 5 days in the past year?.....Yes No
94. Are you usually pleased with how well you do in activities with your friends?.....Yes No
95. Does alcohol or drug use cause your moods to change quickly like from happy to sad or vice versa?.....Yes No
96. Do you feel sad most of the time?.....Yes No
97. Do you miss school or arrive late for school because of your alcohol or drug use?.....Yes No
98. Is it important to you now to get or keep a satisfactory job?.....Yes No
99. Do your family or friends ever tell you that you should cut down on your drinking or drug use?.....Yes No

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|------|---|-----|----|
| 100. | Do you have serious arguments with friends or family members because of your drinking or drug use?.....   | Yes | No |
| 101. | Do you tease others a lot?.....   | Yes | No |
| 102. | Do you have trouble sleeping?.....  | Yes | No |
| 103. | Do you have trouble with written work?.....   | Yes | No |
| 104. | Does your alcohol or drug use ever make you do something you would not normally do - like breaking rules, missing curfew, breaking the law or having sex with someone?..... | Yes | No |
| 105. | Do you feel you lose control and get into fights?.....  | Yes | No |
| 106. | Have you ever been fired from a job?.....   | Yes | No |
| 107. | During the past month, have you skipped school?.....  | Yes | No |
| 108. | Do you have trouble getting along with any of your friends because of your alcohol or drug use?.....  | Yes | No |
| 109. | Do you have a hard time following directions?.....  | Yes | No |
| 110. | Are you good at talking your way out of trouble?.....   | Yes | No |
| 111. | Do you have friends who have hit or threatened to hit someone without any real reason?.....   | Yes | No |
| 112. | Do you ever feel you can't control your alcohol or drug use?.....   | Yes | No |
| 113. | Do you have a good memory?.....   | Yes | No |
| 114. | Do your parents or guardians have a pretty good idea of your interests?.....  | Yes | No |
| 115. | Do your parents or guardians usually agree about how to handle you?.....  | Yes | No |
| 116. | Do you have a hard time planning and organizing?.....   | Yes | No |
| 117. | Do you have trouble with math?.....   | Yes | No |
| 118. | Do your friends cut school a lot?.....  | Yes | No |

119. Do you worry a lot?.....Yes No
120. Do you find it difficult to complete class projects or work tasks?.....Yes No
121. Does school sometimes make you feel stupid?.....Yes No
122. Are you able to make friends easily in a new group?.....Yes No
123. Do you often feel like you want to cry?.....Yes No
124. Are you afraid to be around people?.....Yes No
125. Do you have friends who have stolen things?.....Yes No
126. Do you want to be a member of any organized group, team, or club?.....Yes No
127. Does one of your parents or guardians have a steady job?.....Yes No
128. Do you think it's a bad idea to trust other people?.....Yes No
129. Do you enjoy doing things with people your own age?.....Yes No
130. Do you feel you study longer than your classmates and still get poorer grades?.....Yes No
131. Have you ever failed a grade in school?.....Yes No
132. Do you go out for fun on school nights without your parents' permission?.....Yes No
133. Is school hard for you?.....Yes No
134. Do you have an idea about the type of job or career that you want to have?.....Yes No
135. On a typical day, do you watch more than two hours of TV?.....Yes No
136. Are you restless and can't sit still?.....Yes No
137. Do you have trouble finding the right words to express what you are thinking?.....Yes No
138. Do you scream a lot?.....Yes No
139. Have you ever had sexual intercourse without using a condom?.....Yes No

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Youth's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Interviewer's Name: \_\_\_\_\_

**FINDINGS:**

\_\_\_\_ There is no evidence of a psychiatric disorder. (If marked, do not complete remainder of form.)

\_\_\_\_ Youth is suicidal or psychotic and requires immediate attention. If marked, list Youth Court/Detention personnel who was informed and recommendations made for mental health services. \_\_\_\_\_

\_\_\_\_ Youth has reported physical or sexual abuse. If marked, what action was taken: \_\_\_\_\_

\_\_\_\_ Youth has threatened to harm others. If marked, what action was taken: \_\_\_\_\_

It is the interviewers belief that the youth may meet diagnostic criteria for one or more of the following DSM-IV classification disorders (If youth has co-occurring disorders, place a 1 by the primary disorder, 2 by secondary, etc.)

- \_\_\_\_ Attention-deficit and disruptive behavior disorders
- \_\_\_\_ Mental retardation
- \_\_\_\_ Substance-abuse disorders
- \_\_\_\_ Schizophrenia and other psychotic disorders
- \_\_\_\_ Mood disorders
- \_\_\_\_ Anxiety disorders
- \_\_\_\_ Adjustment disorders
- \_\_\_\_ Personality disorders
- \_\_\_\_ I do not have enough information to make a clinical judgement.

**RECOMMENDATIONS:** Check all that apply.

A. Youth not in need of comprehensive assessment at this time. \_\_\_\_

B. Youth requires additional evaluation. \_\_\_\_

I have obtained youth's permission to make a referral for additional evaluation or treatment services: Yes \_\_\_\_ No \_\_\_\_

If yes, list type of evaluation and to whom referral is made: \_\_\_\_\_

C. Youth is recommended for referral for substance abuse treatment: \_\_\_\_

I have obtained youth's permission to make a referral for additional evaluation or treatment services: Yes \_\_\_\_ No \_\_\_\_

If yes, list to whom referral is made: \_\_\_\_\_

D. Youth is recommended for referral to a mental health agency: \_\_\_\_

I have obtained youth's permission to make a referral for additional evaluation or treatment services: Yes \_\_\_\_ No \_\_\_\_

If yes, list to whom referral is made: \_\_\_\_\_