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

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Cover Page Footnote
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Screening For Mental Health Problems among Incarcerated Youth in Nevada: Practice and Policy

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ABSTRACT

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

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

INTRODUCTION

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

While most experts agree that screening should occur at intake, it is a rare occurrence. Many systems rely primarily on a child’s history of receiving mental health services to identify an existing disorder. However, it is estimated that only about one in three juvenile detainees ever received services for a documented mood or behavior disorder prior to entry into the system (Novins et al., 1999). Further, despite considerable advances in mental health assessments for youth (Jensen et al., 1995; Schaffer et al., 1996), assessments in juvenile justice settings are still highly variable and often do not rely on instrumentation designed specifically for detention settings (Cocozza & Skowyra, 2000; LeBlanc, 1998; Nicol et al., 2000; Towberman, 1992; Wiebush et al., 1995). The lack of routine standardized screening and assessments results in inadequate and fragmented services for mental health problems that are often not recognized until the child is in crisis.

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

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

METHODS

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

Initial contact with the detention centers was made
Initial contact with the detention centers was made
in January 2003. Contact information for the Chief
in January 2003. Contact information for the Chief
Juvenile Probation Officers was received from the
Juvenile Probation Officers was received from the
State Juvenile Justice Commission. A letter
State Juvenile Justice Commission. A letter
introducing the project was faxed to each Officer by
introducing the project was faxed to each Officer by
the research team. A follow-up phone call was made
the research team. A follow-up phone call was made
to schedule time in the facility to administer the
to schedule time in the facility to administer the
questionnaires. Researchers traveled to each facility
questionnaires. Researchers traveled to each facility
between March and June to administer the
between March and June to administer the
questionnaires.
questionnaires.
The juveniles who had received parent/guardian
The juveniles who had received parent/guardian
permission to participate were brought to the
permission to participate were brought to the
facility’s classroom in groups of 15-20. One facility
facility’s classroom in groups of 15-20. One facility
staff person remained in the room throughout the
staff person remained in the room throughout the
process to monitor the behavior of the participant.
process to monitor the behavior of the participant.
When the juveniles were seated in the room, the
When the juveniles were seated in the room, the
researcher handed out the packet of questionnaires to
researcher handed out the packet of questionnaires to
each youth. The researcher introduced the survey
each youth. The researcher introduced the survey
and discussed the process of informed consent/assent
and discussed the process of informed consent/assent
with the group. Each youth was asked to read the
with the group. Each youth was asked to read the
consent form while the researcher read the form
consent form while the researcher read the form
aloud. Those who chose to participate were asked to
aloud. Those who chose to participate were asked to
sign the assent form attached to the front of the
sign the assent form attached to the front of the
packet. After the youth assent form was signed, the
packet. After the youth assent form was signed, the
form was torn off the packet and placed in a separate
form was torn off the packet and placed in a separate
evelope to maintain anonymity. Youth who chose
evelope to maintain anonymity. Youth who chose
not to participate were escorted out of the room by
not to participate were escorted out of the room by
facility staff. The survey process took about one
facility staff. The survey process took about one
hour. All completed forms were collected by the
hour. All completed forms were collected by the
researchers and placed in a sealed envelope. None of
researchers and placed in a sealed envelope. None of
the information was given to the facility staff.
the information was given to the facility staff.
The demographic questionnaire included
The demographic questionnaire included
questions regarding participant age, sex, ethnicity,
questions regarding participant age, sex, ethnicity,
and current grade in school. In addition, youth were
and current grade in school. In addition, youth were
asked several open-ended questions regarding their
asked several open-ended questions regarding their
home life, the reason they were in detention, and
home life, the reason they were in detention, and
about risk factors associated with mental health
about risk factors associated with mental health
problems such as substance use, suicide ideation, and
problems such as substance use, suicide ideation, and
violence in the home. Two screening instruments
violence in the home. Two screening instruments
were also administered, the Massachusetts Youth
were also administered, the Massachusetts Youth
Screening Instrument-Version 2 - MAYSI-2 (Grisso
Screening Instrument-Version 2 - MAYSI-2 (Grisso
et al., 2001), and the Manifestation of
et al., 2001), and the Manifestation of
Symptomatology Scale - MOSS (Mogge, 1999). The
Symptomatology Scale - MOSS (Mogge, 1999). The
focus of this paper is the MAYSI-2.
focus of this paper is the MAYSI-2.
The MAYSI-2 is a self-report inventory, designed
The MAYSI-2 is a self-report inventory, designed
for children and adolescents that contains 52
for children and adolescents that contains 52
questions with a “yes/no” response format and can be
questions with a “yes/no” response format and can be
completed in 10 to 15 minutes. Questions include
completed in 10 to 15 minutes. Questions include
“Have you had a lot of problems concentrating or
“Have you had a lot of problems concentrating or
paying attention?” and “Have you felt like life was
paying attention?” and “Have you felt like life was
not worth living?” The response scores for the
not worth living?” The response scores for the
questions create six scales that assess: Alcohol/Drug
questions create six scales that assess: Alcohol/Drug
Use, Anger/Irritability, Depression/Anxiety, Somatic
Use, Anger/Irritability, Depression/Anxiety, Somatic
Complaints, Suicidality, and Thought Disturbance
Complaints, Suicidality, and Thought Disturbance
(normed for boys only). Further, the instrument
(normed for boys only). Further, the instrument
assesses the youth’s experiences with traumatic
assesses the youth’s experiences with traumatic
incidents.
incidents.
All MAYSI-2 scores have a cut-off point for
All MAYSI-2 scores have a cut-off point for
“acceptable” and for at-risk scores coded as “caution”
“acceptable” and for at-risk scores coded as “caution”
or “warning”. All scores at or below the cut-off point,
or “warning”. All scores at or below the cut-off point,
i.e., in the “acceptable” range were assigned a zero
i.e., in the “acceptable” range were assigned a zero
(0). All scores above the cut-off point, i.e., in the “at
(0). All scores above the cut-off point, i.e., in the “at
risk” range were assigned a one (1). A summary
risk” range were assigned a one (1). A summary
score of all 0’s and 1’s was calculated for each
score of all 0’s and 1’s was calculated for each
individual. Summary scores ranged from 0 to 6
individual. Summary scores ranged from 0 to 6
depending on the test. A score of 0 means the
depending on the test. A score of 0 means the
individual scored in the acceptable range on all test
individual scored in the acceptable range on all test
components. Scores between 1 and 3 indicate the
components. Scores between 1 and 3 indicate the
individual scored in the at-risk range in one, two, or
individual scored in the at-risk range in one, two, or
three areas and probably should be evaluated further.
three areas and probably should be evaluated further.
Scores between 4 and 6 indicated the individual
Scores between 4 and 6 indicated the individual
scored in the at-risk range in four, five or all six areas
scored in the at-risk range in four, five or all six areas
and may have serious mental health issues. In order
and may have serious mental health issues. In order
to create an estimate of the overall scope of mental
to create an estimate of the overall scope of mental
health problems among Nevada’s juvenile
ehealth problems among Nevada’s juvenile
delinquents, the scales were combined for each
delinquents, the scales were combined for each
individual.
individual.
The study also included an electronic survey of
The study also included an electronic survey of
State detention facility staff and an analysis of
State detention facility staff and an analysis of
relevant state and federal policy. Survey participants
relevant state and federal policy. Survey participants
included members of the juvenile justice system in
included members of the juvenile justice system in
Nevada such as Chief Juvenile Probation Officers,
Nevada such as Chief Juvenile Probation Officers,
facility administrators, and mental health service
facility administrators, and mental health service
providers. The survey included questions about ways
providers. The survey included questions about ways
mental health problems are identified, access to
mental health problems are identified, access to
mental health care, training and development
mental health care, training and development
opportunities for staff, and policy issues. No
opportunities for staff, and policy issues. No
identifying information was collected. A review and
identifying information was collected. A review and
analysis of federal laws, recent court cases, and
analysis of federal laws, recent court cases, and
federal and state efforts to improve screening and
treatment efforts was included in the study to provide
federal and state efforts to improve screening and
treatment efforts was included in the study to provide
a framework for policy recommendations for Nevada.
a framework for policy recommendations for Nevada.

Limitations of the Data

The data collected in this assessment process have
The data collected in this assessment process have
several limitations that must be considered when
several limitations that must be considered when
interpreting the results. First, the data are self-report.
The responses may be intentionally false, or inaccurate due to difficulties remembering events or behaviors, even when the youth is trying hard to be accurate. Further, youth may respond randomly or inconsistently due to deliberate lack of caring or inattention. The data are not validated in any way to check for accuracy. Although the data represent almost the complete population of incarcerated youth at the time the study was conducted, the data should not be used to extrapolate to the general population.

RESULTS

The data set included responses and test scores from 660 adjudicated youth (547 male and 113 female) incarcerated in 12 public detention facilities in Nevada. The 660 youth include both males and females ranging in age from 11 to 18 years old with a mean age of 15.85. About 14% of the youth were less than 15 years of age and 35% were older than 16. Males outnumber females by about four to one with males representing 83% of the youth and females representing 17% of the youth. When asked to identify their race/ethnicity, 40% indicated White, 28% indicated Hispanic, 20% indicated Black, 8% indicated Native American, and 4% indicated Asian. Some of these percentages include youth who identified more than one category (i.e., mixed race).

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

<table>
<thead>
<tr>
<th>Table 1. Study population % scores on the MAYSI-2 scales by gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Angry/Irritable</td>
</tr>
<tr>
<td>Thought Disturbance*</td>
</tr>
<tr>
<td>Depressed/Anxious</td>
</tr>
<tr>
<td>Somatic Complaints</td>
</tr>
<tr>
<td>Alcohol/Drug Use</td>
</tr>
<tr>
<td>Suicide Ideation</td>
</tr>
<tr>
<td>Traumatic Experiences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2. Study population % scores on the MAYSI-2 scales by age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Youth ages 11 to 14</td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Youth ages 15 to 16</td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Youth ages 17 to 18</td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
</tr>
</tbody>
</table>

*The thought disturbance scale is normed only for boys.
Mental Health Screening

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

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

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

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

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

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

The final score on the MAYSI-2 assessment is the Traumatic Experiences scale. This scale reflects whether an individual has had greater lifetime exposure to traumatic events compared to other youth. Although the specific questions are different for boys and for girls the scores are comparable. High scores reflect exposure to specific traumatic events such as rape or beatings and also the possible presence of Post Traumatic Stress Disorder. There should be individual follow-up with youth who respond positively to any of the questions which was not possible within the scope of this study. The average score for the study population was 2.986 on a scale of 0 to 5 with 65% of youth scoring five or higher. One in six youth (17%) scored seven or higher indicating significant trauma experiences (Chi Square; P ≤ .0004).

Current screening and assessment efforts in Nevada

The study also included an assessment of current juvenile detention facilities to establish a baseline for they type of mental health problems identified among the populations, methods for identifying youth at risk, available services, and priority areas of need. Since
Nevada’s twelve public juvenile detention facilities in the state are operated by different entities rather than one overarching agency, it was hypothesized that there would be a lack of consistency between the facilities.

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

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

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

Policy Analysis

Courts across the country have been addressing the disparate treatment of incarcerated juveniles since the early 1970s. More recently, the federal government and some states have begun to address the need for adequate mental health services in juvenile detention facilities. There are generally three sources of law that are applicable in addressing the rights of incarcerated juveniles with respect to their mental health needs. These include the Constitution (particularly the 8th and 14th Amendments), the Americans with Disabilities Act, and the Individuals with Disabilities Education Act. Under these legal standards, juveniles are entitled to reasonable safety and adequate medical and mental health care. Furthermore, as noted by the United States Supreme Court in “In re Gault”, the purpose of the juvenile justice system is to determine “what is he, how has he become what he is, and what had best be done in his interest and in the interest of the state to save him from a downward career…the child was to be ‘treated’ and ‘rehabilitated’ and the procedures...were to be ‘clinical’ rather than punitive.”

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

Discussion

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

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

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

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

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

Policy Recommendations for Nevada

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

1. The state legislature should require the establishment of a statewide committee to address the mental health needs of incarcerated juveniles. The primary purpose of the committee should be to exhaustively identify available mental health services for this population and to examine the specific types of mental health services that are needed to fully address the mental health problems of incarcerated juveniles. The committee should also explore costs and means of financing a full-spectrum system of mental health services in juvenile detention facilities.

2. The state should require mental health screenings for all juveniles who enter a juvenile detention facility, regardless of the existence of outward signs of mental health problems. Further, in depth, assessments should be provided as deemed necessary by the screenings.

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

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

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

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