

**California Youth Authority
Mental Health and Substance Abuse
Treatment Needs Assessment**

Description and Preliminary Findings

August, 2000



California Youth Authority
Mental Health and Substance Abuse
Treatment Needs Assessment

Description and Preliminary Findings

Rudy Haapanen, Ph.D.
Wes Ingram, Ph.D.

Research Division
California Youth Authority

August 2000

Acknowledgments

Many people contributed directly or indirectly to the research upon which this report is based. Members of the Advisory Group and their positions when the Mental Health and Substance Abuse Treatment Needs Assessment was developed and implemented:

Dewey C. Willis, Chairperson
Superintendent, Northern Youth Correctional Reception Center & Clinic
Dr. Pablo Alvarez, Karl Holton Youth Correctional Facility
Dr. Saaed Beshid, Ventura Youth Correctional Facility
Dr. Don Broder, Heman G. Stark Youth Correctional Facility
Frank Chacon, Northern Youth Correctional Reception Center & Clinic
Dr. Elizabeth Cauffman, Stanford University
Dr. Gwendolyn Dennard, Chief of Medical Services
Elaine Duxbury, Research Division
Dr. Rudy Haapanen, Research Division
Dr. Wes Ingram, Research Division
Dr. Gary Mackelburg, N.A. Chaderjian Youth Correctional Facility
Patricia Morrison, Population Management
Dr. Lina Pastrana, Southern Youth Correctional Reception Center & Clinic
Dr. Ken Shepard, Northern Youth Correctional Reception Center & Clinic
Dr. Bill Schuweiler, O.H. Close Youth Correctional Facility
Dr. Hans Steiner, Stanford University
Jack Wallace, O.H. Close Youth Correctional Facility
Dr. Selmer Wathney, Northern Youth Correctional Reception Center & Clinic

In addition, valuable assistance was provided by other members of the Research Division: Dave Kritzberg, a graduate student assistant, who developed the scannable form; Sue Brooks, who carried the form through several revisions; and Lee Britton, who helped with compiling, editing and troubleshooting the data. Staff at the Northern Youth Correctional Reception Center & Clinic and Southern Youth Correctional Reception Center & Clinic and Ventura Youth

Correctional Facility have invested a great deal of time and effort to assessment, scoring, and forwarding the data to the Research Division for analysis. Interpretation of the data and estimation of treatment needs for cases with various scores was carried out primarily by Selmer Wathney, Saaed Beshid, Pablo Alvarez, Wes Ingram, Patricia Morrison, and Rudy Haapanen.

Executive Summary

This report presents preliminary results of a large-scale effort to fill a major gap in the Youth Authority's needs assessment process: the need for mental health treatment programs. The need for mental health treatment for individual wards is based on psychological evaluations, which are triggered by referrals from casework staff at the reception centers or treatment staff at the program institutions. In April 1997, the Youth Authority implemented a self-report, paper-and-pencil assessment process at the reception center/clinics for

- better identifying wards for psychological evaluations,
- providing automated mental health information on all wards,
- screening wards for substance abuse programs, and
- estimating the prevalence of mental health and substance abuse problems in the YA population.

The latter information would set the stage for program planning and for estimating resource needs in these areas.

This report presents findings from analyses of 4,672 valid assessments of new commitments to the Youth Authority between April 1997 and November 1999. Analyses focused on the prevalence of mental health problems and their potential implications for mental health treatment needs. The information included in the present report is preliminary, and a great deal of work remains to be done. As the assessment process is refined and additional information is gathered to aid in interpreting assessment results, the Department will be able to more accurately assess the needs of the offenders and determine the type of treatment programs they require.

At this writing, the Youth Authority is engaged in a federally-funded effort to validate the assessment process, obtain population estimates of mental health problems, and better understand the relationship between these problems and substance abuse, violence, gang involvement, and general functioning within the YA institutional environment.

Preliminary Findings

- In all, 44% of the males and 59% of the females had scores on mental health scales that indicated some need for mental health services.

- About 16% of males and 18% of females report combinations of emotional problems (Anxiety, Depressed Mood, or problems related to Traumatic Experiences), suicidal thoughts and feelings, and thought problems (such as hearing things and seeing things). These combinations suggest the potential need for intensive mental health services.
- About seven out of ten males and females reported substance abuse problems.
- There was considerable overlap between mental health and substance abuse problems, with 37% of males and 50% of females having elevated scores in both areas.

Validation Study

Research currently being undertaken on these instruments, funded by the National Institute of Justice, focuses on the validity of the assessment process, comparing assessment results with diagnostic information obtained from structured diagnostic interviews and with background and observational information obtained from case files. The goal of this study is to learn how best to use the assessment information to identify offenders in need of mental health treatment while in Youth Authority institutions and to determine the types (and levels) of treatment needed to address those needs. This effort will include the development of YA-specific "norms" and treatment need indicators that can be used in case planning.

Table of Contents

Acknowledgments.....	i
Executive Summary	ii
List of Tables	iv
List of Figures.....	iv
Introduction	1
Mental Health Screening in the CYA	1
The Prevalence of Mental Health Problems in the CYA Population.....	1
The CYA Mental Health and Substance Abuse Treatment Needs Assessment	2
Assessment Instruments	3
Achenbach Child Behavior Checklist Youth Self Report (YSR).....	3
Massachusetts Youth Screening Instrument (MAYSI)	4
Weinberger Adjustment Inventory (WAI).....	4
Drug Experience Questionnaire (DEQ).....	5
Analysis/Classification.....	5
Sample	6
Estimates of Mental Health and Substance Abuse Problems.....	8
Behavioral Problems and Mental Health Indicators	11
Conclusions and Future Directions	13
References.....	14

List of Tables

Table 1: Sample Characteristics 7
 Table 2: Disciplinary Incidents by Pervasiveness of Mental Health Problems 11

List of Figures

Figure 1: Percent of Wards with Elevated Scores on MAYSI Scales by Gender 8
 Figure 2: Percent of Wards with Elevated Scores in Major Mental Health Problem Areas
 (Emotional Problems, Thought Problems, and Suicide Ideation) by Gender 9
 Figure 3: Percent of Wards with Elevated Scores in Major Mental Health Problem Areas
 By Ethnicity and Gender 9
 Figure 4: Percent of Wards with Elevated Scores in Major Mental Health Problem Areas
 By Quarter of Assessment 10
 Figure 5: Figure 5: Percent of Wards with Elevated Scores in Major Mental Health
 Problem Areas and/or Substance Abuse By Gender 10
 Figure 6: Percent of Wards with Any Disciplinary Incidents and Incidents Involving
 Assaults on Other Wards By Number of Mental Health Problem Areas 12
 Figure 7: Percent of Wards with Disciplinary Incidents Involving Assaults on Staff,
 Suicidal Activity and Sexual Misconduct By Number of Mental Health Problem Areas 12

Introduction

In order to deal effectively with young offenders committed to their care, agencies operating institutional programs for juvenile offenders must have a clear picture of the prevalence of various treatment needs in their populations. With this information, the necessary array of programs can be determined and appropriate care can be provided to those in need. This report describes mental health treatment needs assessment generally in the California Youth Authority (CYA) and presents the results of a newly-implemented assessment process designed to assist with the identification of mental health treatment needs.

With the assistance of researchers from Stanford University, Youth Authority clinical staff and researchers developed a procedure for ongoing mental health and substance abuse screening of incoming wards. This screening was based on self-reports of mental health symptoms and substance use patterns. The screening tool was designed to provide information for program decisions regarding individual wards and to provide population data for projecting special program needs. This process is formally termed the Mental Health and Substance Abuse Treatment Needs Assessment procedure, or Treatment Needs Assessment (TNA), for short.

Mental Health Screening in the CYA

The identification of wards for CYA mental health programs is based on referral by regular treatment staff and clinical evaluations by psychologists. These programs include Intensive Treatment Programs (ITPs), for the seriously disturbed and suicidal wards, and Specialized Counseling Programs (SCPs), for the less seriously disturbed wards. These programs differ in staffing and in the type of intervention.

Mental health screening at the reception centers involves reviews of case file materials, interviews with wards by their assigned clinic caseworkers, and observation by living unit staff. Wards with histories of suicide threats or behaviors or strong indications of psychological/emotional problems are referred to clinic psychologists for individual evaluation. Current resources allow for only a small percentage of wards to receive full psychological evaluations during the clinic process.

Wards not identified or evaluated at the reception centers may be referred for psychological evaluation by institution staff at program institutions. Wards whose behavior suggests a danger to self or an inability to function in the institutional environment are evaluated for placement in one of the ITP or SCP programs. Again, due to limitations on available program resources, only the most seriously disturbed wards are referred for these evaluations. Wards whose problems are not so serious that they require immediate intervention are maintained in regular living units. Some are evaluated by psychologists assigned to the general population or by consulting psychologists or psychiatrists. Some are involved in individual or group counseling conducted by these mental health staff. Many, however, are not treated or evaluated because they have not called attention to their mental health problems through their behavior.

In April 1997, the Youth Authority implemented a self-report, paper-and-pencil assessment process at the reception center/clinics to supplement the mental health screening process. The goals of this assessment process were:

- To better identify wards for psychological evaluations,
- To provide automated mental health information on all wards,
- To screen wards for substance abuse programs, and
- To estimate the prevalence of mental health and substance abuse problems in the YA population.

The latter information would set the stage for program planning and for estimating resource needs in these areas.

The Prevalence of Mental Health Problems in the CYA Population

Prior to 1997, there was no standardized protocol used at the intake clinics or institutions specifically to assess mental health problems of all incoming wards. The size of the mental health problem in the CYA institutional population has therefore been difficult to estimate. The current process of screening wards for mental health treatment programs has focused on identifying wards with the most pressing needs in order to make the best use of scarce mental health treatment resources. Consequently, wards who are

unlikely to be admitted to a special program, but who have mental health treatment needs, may not be evaluated at all. Thus, the full extent of the problem cannot be estimated from clinical records alone.

Estimates of the proportion of the CYA population in need of mental health services were the focus of a special, point-in-time study of new admissions conducted in 1990 and a survey of institution staff in 1996. The 1990 Treatment Needs Assessment estimates were based on the Minnesota Multiphasic Personality Inventory (MMPI) and the Jesness Inventory (JI), which were administered to a three-month sample of new admissions. This study estimated that about 3% of all incoming males and 6% of all females required Intensive Treatment Programs (ITPs), with another 10% of males and 4% of females in need of the less intensive psychologically-oriented treatment offered by SCPs. Concerns about the age of the study, about the methods used to estimate treatment needs, and about the current procedures for placing wards in ITP/SCP programs prompted requests for a new study of mental health treatment needs in this population.

In the Spring of 1996, institution staff were asked to identify wards in their institutions "who have treatment needs that could best be met in ITP/SCP programs" and who were not, at the time, in one of these programs. These data indicated that there were over 700 wards in CYA institutions who were felt to need special psychological programs at least at the level of the current SCPs but who were not in them at that point in time. Adding these figures to the number already being served in these programs brought the total estimate of cases needing ITP/SCP services to 1,400 (14.0% of the institutional population at that time). Not included in this estimate were wards with less severe psychological or emotional problems who could benefit from less-intensive mental health treatment.

The results of this survey suggested the need for ongoing, objective assessment of mental health needs of incoming populations and the need for objective screening criteria to ensure that wards with psychological and emotional problems are identified and evaluated for placement in mental health programs.

The CYA Mental Health and Substance Abuse Treatment Needs Assessment

In 1996, the CYA initiated an effort to identify (or develop) an assessment package that would include a mental health/personality component and a substance abuse component. The goal was to implement a process by which standardized mental health and substance abuse information could be gathered routinely on all wards entering CYA institutions. This information would be used to make programming decisions for individual wards and to establish estimates of mental health and substance abuse treatment needs for the institution and parole populations.

Youth Authority clinical and research staff, with the assistance of researchers from Stanford University, developed and field-tested a mental health screening/assessment procedure that drew on extant, standardized, automated assessment tools. Instrument selection was based on the following criteria: capacity (or adaptability) for machine scoring, fourth-grade to fifth-grade reading level, gender and cultural neutrality, suitability for group administration, and suitability for incorporation into the clinic diagnostic process.

The assessment package was designed to gather mental health data on all new admissions (new commitments and parole violator returns) at the three reception center/clinics operated by the Youth Authority. Paper-and-pencil instruments are administered during the educational testing phase of the clinic process with 8-15 wards at a time. The assessment battery includes scales to measure potential mental health problems along a number of dimensions, such as anxiety, depression, thought problems, and suicidal ideation. These kinds of mental health problems are important because they may lead to self-destructive behavior, major difficulty coping with the CYA institutional environment, or a potential inability to benefit from CYA rehabilitative programming. The assessment process is not intended to identify individuals whose criminal behavior is "caused by" mental illness or psychological disturbance.

The questionnaires are administered by casework staff at the reception centers. They are then machine scored, using optical mark reader (Scantron) technology and a tailor-made scoring program. The scoring program produces a hard-copy printout, which is forwarded to casework staff for review. If the ward scores in the elevated range on scales indicating possible suicidal tendencies, violence potential, or thought problems, a copy is also

forwarded to a designated psychologist. These wards are interviewed briefly to determine whether the scores reflect problems that require immediate attention and/or whether there is sufficient cause for a second-level evaluation by clinical psychologists. This second level of assessment focuses on the nature of the disorder, the need for immediate treatment, and the recommended type of treatment program (based on the current array of programs available in the CYA). This process supplements other long-standing clinic processes, including file reviews, interviews by medical staff, observation by living unit staff, and interviews by caseworkers, which are also designed in part to identify wards in need of immediate intervention or psychological evaluation.

The data are also forwarded by way of the Youth Authority's Wide Area Network (WAN) to Research Division staff at CYA headquarters for review and

analysis. A central repository of TNA data is maintained to track completion rates and scores over time. Analyses are designed to establish preliminary population estimates of mental health problems and to set the stage for refinement of the assessment process, leading eventually to the development of CYA-specific norms and criteria for identifying the need for mental health treatment.

These results will eventually be used to establish and refine appropriate cut-off scores and criteria for further evaluation. The assessment of all incoming wards began at the three reception centers during the Spring of 1997. This report presents findings from analyses of 4,672 valid assessments of new commitments to the Youth Authority between April 1997 and November 1999. The remainder of this report focuses on this assessment process and the results of the assessments to date.

Assessment Instruments

The assessment battery consists of four instruments chosen to assess mental/emotional problems, substance abuse problems, and general personality. The instruments were chosen from among a number of candidate instruments based on pilot data collected at three Youth Authority facilities: O. H. Close Youth Correctional Facility, Karl Holton Youth Correctional Facility, and Ventura Youth Correctional Facility. Pilot samples involved a mix of wards from regular programs, Specialized Counseling Programs, and formalized substance abuse programs. Instruments were chosen on the basis of their focus, their ease of use by wards, their ability to discriminate between wards in these programs and wards in regular living units, and their correlation with Minnesota Multiphasic Personality Inventory (MMPI) scale scores.

Achenbach Child Behavior Checklist--Youth Self Report (YSR)

The YSR, designed by Thomas Achenbach (University of Vermont) in 1989 and revised in 1991, determines if wards have mental health problems by obtaining their views of their own functioning. It focuses on general psychopathology as well as resilience factors (ego strength). It also indicates how

the ward may manifest problems, either through "internalizing" (e.g., anxiety or depression) or "externalizing" (e.g., aggressiveness or acting out) disorders. The YSR is widely used at Community Mental Health Centers in California.

The instrument was developed by identifying items that best discriminated between youths who were referred for mental health treatment and those who were not. High scores on scales indicate the extent to which youth answer the questions similarly to youth in the referred samples. The YSR was designed for adolescents ages 11 to 18 with at least a fifth-grade reading level and takes approximately 30 minutes to administer. Each question offers three answers: *not true (0)*, *somewhat or sometimes true (1)*, and *very true or often true (2)*. Scales are created by adding the scores for each item.

The *Internalizing Scales* measure problems the ward is manifesting internally:

Withdrawn
Somatic Complaints
Anxiety/Depression

The *Externalizing Scales* measure behaviors that indicate external responses to problems:

Delinquent Behavior
Aggressive Behavior

The YSR also includes three other problem scales:

Social Problems

Thought Problems

Attention Problems

Massachusetts Youth Screening Instrument (MAYSI)

This instrument was developed by Thomas Grisso and others at the University of Massachusetts specifically for use in the juvenile justice system. It was designed as a screening instrument to identify youths at risk of serious mental or emotional disorder and those in need of clinical intervention (Grisso, Barnum, Famularo, and Kinscherff, 1996). The MAYSI assesses various types of mental/ emotional disturbance or distress that might indicate a youth is at risk for mental disorder. Like the YSR, it measures symptoms rather than disorders. The MAYSI requires a sixth grade reading level and approximately twenty minutes to administer. It consists of 52 yes/no questions. Unless otherwise indicated, all questions ask about experiences within the past few months. Scales include

Alcohol/Drug Use

Angry Feelings

Anxiety

Depressed Mood

Fighting

Somatic Complaints

Suicide Ideation

Thought Disturbance

Traumatic Experiences

The Youth Authority does not use the Alcohol/Drug Use scale of this instrument because the battery includes a more comprehensive measure of substance abuse problems (the Drug Experience Questionnaire, described below).

Weinberger Adjustment Inventory (WAI)

The WAI, developed in 1989 by Daniel Weinberger (Case Western Reserve University), measures personality traits that are predictive of institutional (correctional) adjustment on two dimensions, distress and self-restraint (Weinberger and Schwartz, 1990). It is designed to measure long-term functioning, as opposed to short-term symptoms. Because this instrument does not focus specifically on mental health problems, results are not included in this report. However, the WAI may have predictive value for understanding how wards will handle stresses and other experiences in the CYA environment. Future analyses will assess this predictive utility and determine how best to use this information in conjunction with information on mental health problems.

The Youth Authority uses a shortened version of the WAI. It has 62 items that combine into eight scales across the two major dimensions. It is written at the fourth-grade reading level, and takes approximately 30 minutes to administer.

Distress Dimension. This dimension provides information about the levels of fear, sadness, shame, and happiness the ward experiences in interactions with the environment. It is comprised of four subscales: anxiety, depression, low self-esteem, and low well-being.

Restraint Dimension. The restraint dimension complements the distress dimension by assessing how each ward is likely to react behaviorally to feelings of distress. It is comprised of four subscales: impulse control, suppression of aggression, consideration of others, and responsibility. These scales provide information about how the ward is likely to resolve conflicts, weighing immediate gratification with long-term consequences.

WAI Personality Profiles. Perhaps the most valuable information is provided when scores from the distress and self-restraint dimensions are combined to create personality profiles that provide information about both the level of distress a ward has and how he/she is likely to handle that distress. The categories used by the Youth Authority are

Non-Reactive: low Distress/low Restraint,

Repressor: low Distress/high Restraint,

Reactive: high Distress/low Restraint, and

Suppressor: high Distress/high Restraint.

Drug Experience Questionnaire (DEQ)

The DEQ provides a standardized screening tool for identifying adolescents and young adults who may benefit from drug treatment. It consists of 30 items which read at the fourth grade level. The DEQ scales are:

- Problem Severity*
- Defensiveness*
- Infrequency*

Problem Severity scores reflect the extent to which the individual is psychologically and behaviorally involved with drugs. High scores suggest

symptoms indicative of drug dependence and abuse such as use in multiple settings, loss of control, and restructuring of activities to accommodate drug use.

The Defensiveness and Infrequency scales are designed to identify wards who minimize (Defensiveness) or exaggerate (Infrequency) their substance abuse problems. They were used to identify wards who may have deliberately tried to manipulate the screening process to get referred into (or avoid) mental health or substance abuse programs. Wards scoring high on these scales were excluded from the analysis of substance abuse problems, as described below.

Analysis/Classification Methods

Assessments were analyzed to determine the overall mental health characteristics of the sample as suggested by these self-report scales. All of the mental/emotional problem areas tapped by these instruments have potential for causing significant personal distress, but some are more clearly the focus of standard mental health treatment programs, such as those offered by the Youth Authority. These problem areas include

- *Emotional Problems* (indicated by scales measuring Anxiety, Depressed Mood, and problems related to past Traumatic Experiences),
- *Thought Disturbance*, and
- *Suicide Ideation* (i.e., thoughts and feelings about suicide)

These mental health problem areas have the clearest relevance for indicating the need for mental health treatment while in Youth Authority institutions. Other problems, such as somatic complaints or impulsivity, may also be relevant for institutionalized populations, but in the absence of more traditional mental health problems are not the focus of Youth Authority programs.

Because the scales have not been validated against actual diagnostic and behavioral information (see Chapter 4: Conclusions and Future Directions), they were not used to estimate the actual mental health treatment needs of the wards in this sample. In practice, as noted earlier, certain scores trigger a

review and/or interview by a psychologist to determine actual need for mental health evaluation and services.

The present analysis focused on scores from the *Massachusetts Youth Screening Instrument (MAYSI)* and the *Drug Experience Questionnaire (DEQ)*. Initially, a typology was developed for prioritizing the mental/emotional problems of the sample that drew also on scales and/or items from the *Achenbach Child Behavior Checklist—Youth Self-Report (YSR)*. Results of these analyzes were reported to the California State Legislature in March 1998 (California Youth Authority, 1998). At the highest level of need were wards exhibiting serious thought disturbance, based on a Thought Disturbance Scale, developed specifically for this purpose, which combined items from the YSR and MAYSI. Next came wards whose scores were not above the cut-off for severe thought disturbance, but who scored high on other forms of thought problems, suicidal thoughts and feelings, anxiety, depression, or emotional/psychological difficulties associated with traumatic events in the past.

There were, however, several problems with this approach. It rested on unproven assumptions concerning which wards most needed mental health services while in the Youth Authority. The use of this typology therefore may have seriously overstated or understated the extent to which the instruments could actually identify treatment needs. The clinical experience of Youth Authority psychological staff at the reception centers also began to call the usefulness

of the YSR results into question. They reported that the MAYSI results more clearly matched their own professional judgment of the wards' mental health status than did the YSR results, which seemed to understate the level of disturbance wards exhibited in certain areas.

In an effort to simplify the analytic process, to make the results more useful to mental health staff, and to avoid overstating the accuracy of the assessment results until a validation study could be undertaken, a revised analysis scheme was developed that drew exclusively on the MAYSI scores and which did not categorize wards in terms of the type of treatment needed. Continuing analysis and refinement will establish the usefulness (if any) of the YSR information as a supplement to (or an alternative to) the MAYSI information and validate the results of both instruments.

The present analysis focused on MAYSI scales, with particular emphasis on the three major dimensions discussed earlier: *Emotional Problems* (Anxiety, Depressed Mood, and problems related to past Traumatic Experiences), *Thought Disturbance*,

and *Suicidal Thoughts and Feelings*. These mental health dimensions were analyzed separately and in combination to establish the pervasiveness of a ward's mental health problems. Analysis also focused on the co-occurrence of these problems with substance abuse problems.

Elevated MAYSI scores on scales indicating these problems were determined by cut-off scores established by the authors of the instrument from data collected during its development and early implementation. These data were obtained from delinquent populations entering various types of detention, from juvenile halls to training schools. The authors did not provide a cut-off score for the scale measuring problems associated with the effects of past traumatic events in the wards' lives (Traumatic Experiences). A cut-score for this scale was developed for CYA use by Elizabeth Cauffman, based on her research on Posttraumatic Stress Disorder (PTSD) in the CYA population (Cauffman, Feldman, Waterman, and Steiner, 1998). The cut-score was the average scale score of wards who were positive for PTSD, based on clinical interviews.

Sample

The assessment of all incoming wards began at the three reception centers in April 1997. Between that month and November 1999, there were 5,857 new first admissions to the Youth Authority (5,555 males and 302 females). Of these, assessments were obtained for 4,891 (83.2%). This figure included 4,621 (83.2%) of the males and 270 (89.4%) of the females. The present analysis included wards with valid scores on all of the MAYSI scales of interest, with validity determined by the number of unanswered questions within each scale. The final sample included 4,406 males (79.3% of all males admitted during this period) and 266 females (88.1% of all females admitted). Due to more stringent validity requirements, fewer wards had valid scores on the DEQ. Of those in the final sample, 3,507 (75.1%) had valid scores on the DEQ. Validity rates on the DEQ were similar for males (75.0%) and females (76.7%).

There were no substantial demographic differences between the wards with valid scores on the MAYSI and those who were excluded (not assessed or with invalid responses on some scales).

A full analysis has not been done to determine why wards were not assessed, but some wards were excluded because they could not read at the fourth grade level or did not read English. Based on discussions with staff, other wards were excluded because of scheduling difficulties at the reception center/clinics.

Table 1 shows the characteristics of the sample used in the analysis. The characteristics of males and females were very similar, with both samples being predominantly Hispanic (over 40%) and African American (over 25%). These wards were typically 16 or 17 years old at admission. Over half were committed for violent crimes. Slightly over half the sample was committed from Southern California counties, with roughly one in four committed from Los Angeles County. One in five were committed from counties in the San Francisco Bay Area, from Santa Clara County (San Jose) north to Mendocino and Lake Counties. Other Northern California counties, including the Central Valley counties (e.g., Kern, Fresno, Merced) and all counties north and east

Table 1
Sample Characteristics

	Male		Female	
	N	%	N	%
Total Sample	4,406		266	
Ethnicity				
White	646	14.7%	68	25.6%
Hispanic	2,191	49.7%	110	41.4%
African American	1,187	26.9%	72	27.1%
Asian	264	6.0%	5	1.9%
Native American	38	0.9%	6	2.3%
Filipino	33	0.7%		-
Pacific Islander	23	0.5%	3	1.1%
Other	24	0.5%	2	0.8%
Age (in Years) at First Admission				
12	3	0.1%		
13	35	0.8%	5	1.9%
14	184	4.2%	22	8.3%
15	561	12.7%	40	15.0%
16	1,165	26.4%	67	25.2%
17	1,735	39.4%	103	38.7%
18	658	14.9%	25	9.4%
19	54	1.2%	4	1.5%
20	8	0.2%		
22	2	0.0%		
24	1	0.0%		
Commitment Offense				
Violent	2,388	54.2%	154	57.9%
Property	1,316	29.9%	70	26.3%
Drug	234	5.3%	26	9.8%
Other Law	468	10.6%	16	6.0%
Area Of Commitment				
SF Bay Area	849	19.3%	59	22.2%
Other Northern California	1,117	25.4%	65	24.4%
Los Angeles County	1,154	26.2%	63	23.7%
Other Southern California	1,286	29.2%	79	29.7%

of the San Francisco Bay Area, contributed about

25% of the cases.

Estimates of Mental Health and Substance Abuse Problems

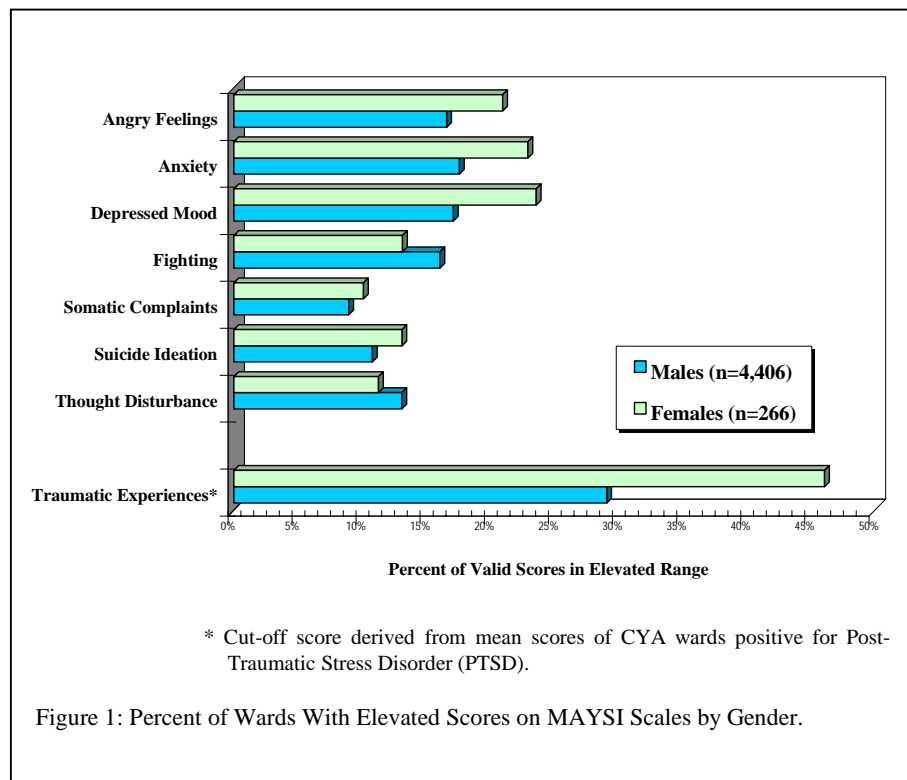
Results, based on cut-off scores provided by the MAYSI and DEQ authors, showed a large percentage of males and females in the CYA population reporting symptoms of significant mental health and substance abuse. Nearly half of the males and six in ten of the females had scores on mental health scales that indicated mental health problems. Many of these wards reported combinations of emotional problems, suicidal thoughts and feelings, and thought problems (such as hearing things and seeing things). These combinations suggest the potential need for more immediate and/or intensive mental health services. The vast majority of both males and females reported substance abuse problems, and a large proportion of the wards reported both mental health and substance abuse problems simultaneously (co-morbidity).

Figure 1 shows the number and percent of males and females in the sample who scored above the cut-off for indicating problems on the MAYSI scales. These results show a sizable percentage of the sample having elevated scores on every scale and females showing higher percentages with elevated scores than males on most scales. The percentage of incoming wards scoring in the elevated range generally fell between 10% and 20%. Based on the cut-score derived by Cauffman, elevated scores on the Traumatic Experiences Scale were found for 30% of males and over 45% of females. Overall, these data indicate that a substantial proportion of the sample present evidence of mental health problems when they enter the Youth Authority.

The scores on the MAYSI scales cannot be directly translated into a need for mental health treatment. However, self-reported problems of certain kinds and combinations of these problems may point to potential needs for

intervention. As discussed previously, these potential needs for intervention are tentatively indicated by elevated scores in one or more Mental Health problem areas: *Emotional Problems* (elevated scores on Anxiety, Depressed Mood or Traumatic Experiences), *Thought Problems or Suicide Ideation* (past thoughts or attempts).

A sizable percentage of wards (43.8% of males and 58.7% of females) had scores indicating problems in at least one of these areas. About one in six males (15.7%) and one in five females (18.1%) had elevated scores in more than one of these areas, and about one in twenty (4.7% of males and 4.4% of females) reported serious problems in all three areas. These combinations of serious problems, particularly the presence of suicidal thoughts or serious thought problems, suggest the need for more immediate intervention and may indicate the need for more intensive treatment. Female wards reported a higher prevalence of problems overall and of combinations of problems.



Analysis by ethnicity for male wards showed that the percentage of wards with scores indicating problems in at least one of the major areas differed somewhat across major ethnic groups (Figure 3). About half of white and African American wards had elevated scores in at least one of these areas, whereas only 4 in 10 of the Hispanic and Asian wards did.

Hispanic and Asian wards also had smaller percentages reporting problems in two or more areas or in all three areas. While 20% of white wards reported problems in at least two areas, only 14% of Hispanic wards did so. It is not known at this time whether these differences indicate actual differences in mental health status or differences in the ability of the TNA screening instruments to identify mental health problems for different ethnic groups. Results by ethnicity for female wards were similar, although the smaller numbers make the estimates for specific ethnic groups less reliable.

Since the implementation of this assessment process, the percentage of wards reporting problems in one or more of these major areas has not changed appreciably. As shown in Figure 4, these percentages have varied only slightly from one calendar quarter to the next, but do suggest some possible seasonal variation in the types of wards committed to the CYA.

Substance abuse problems and the combination of substance abuse and mental health problems (“co-morbidity”) were analyzed using only those wards with valid scores on both the MAYSI and the DEQ. Substance abuse problems, as indicated by elevated scores on the *Drug*

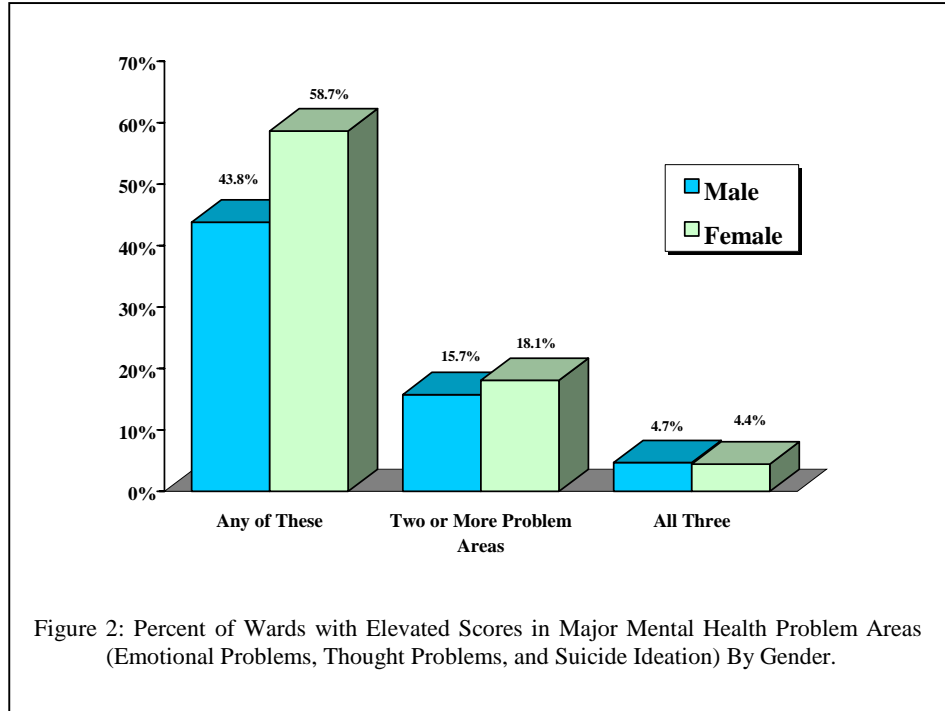


Figure 2: Percent of Wards with Elevated Scores in Major Mental Health Problem Areas (Emotional Problems, Thought Problems, and Suicide Ideation) By Gender.

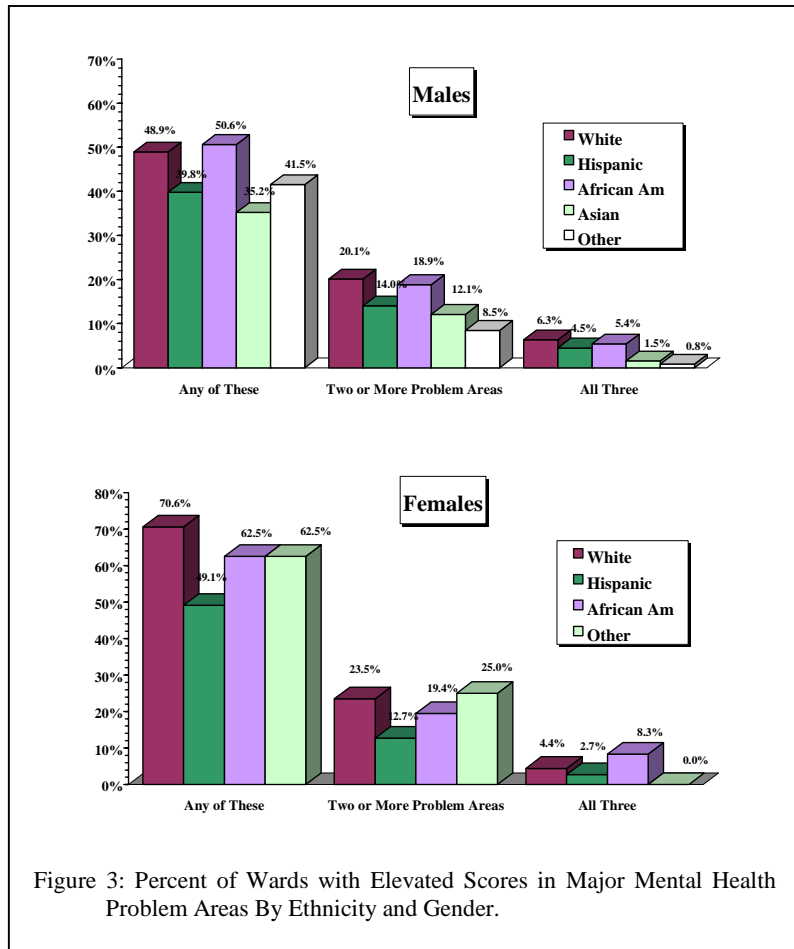


Figure 3: Percent of Wards with Elevated Scores in Major Mental Health Problem Areas By Ethnicity and Gender.

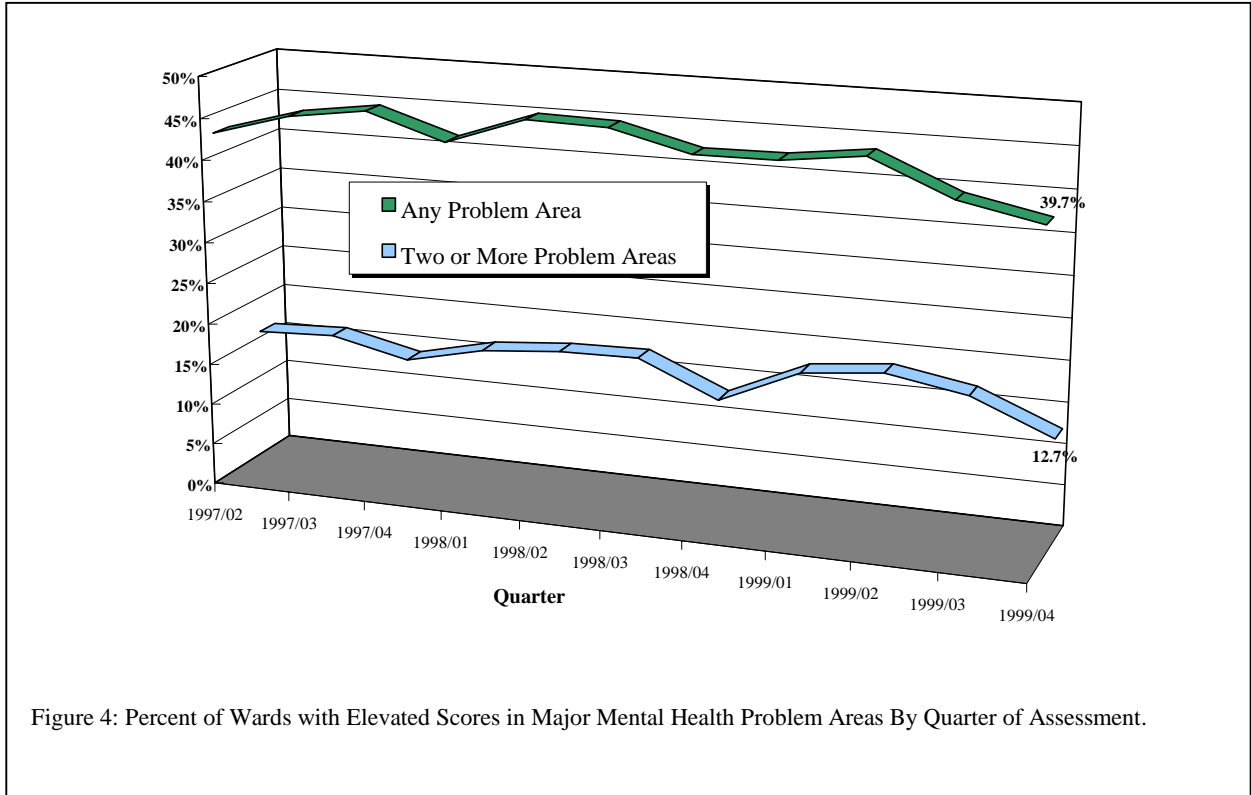


Figure 4: Percent of Wards with Elevated Scores in Major Mental Health Problem Areas By Quarter of Assessment.

Experience Questionnaire (DEQ) were found for 74% of males and 68% of females (Figure 5). Figure 5 also shows the percentage of wards with mental health problems, as indicated by elevated MAYSI scores in any of the areas discussed previously. These percentages (45% for males and 65% for females) are slightly higher for wards with valid DEQ scores than for all wards with valid scores on the MAYSI.

There was considerable overlap between mental health problems and substance abuse problems in this sub-sample. Half of all the females and 37% of the males scored in the elevated range on *both* the substance abuse instrument and one or more of the mental health areas. Fewer than one in five of the wards reported neither substance abuse nor mental health problems.

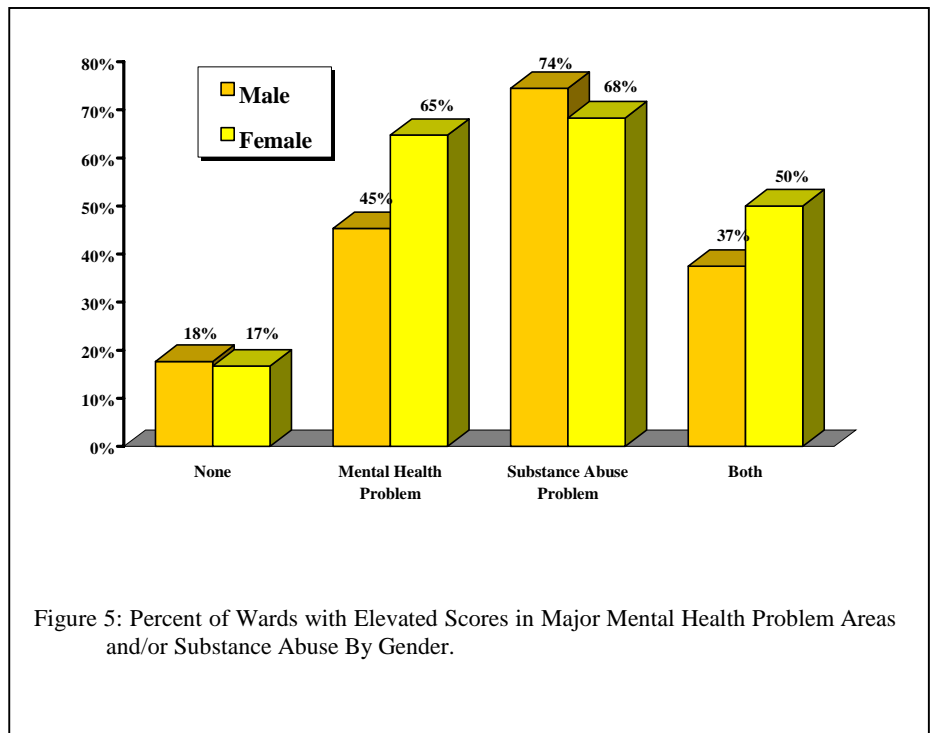


Figure 5: Percent of Wards with Elevated Scores in Major Mental Health Problem Areas and/or Substance Abuse By Gender.

Behavioral Problems and Mental Health Indicators

Information necessary for validating the MAYSI data is not available in Youth Authority automated data systems. Indications of mental health problems and difficulties functioning in the Youth Authority environment are being collected as part of a federally-funded validation study (“Assessing Mental Health Problems Among Serious Juvenile Offenders”). This study is discussed in the last section of this report. In the meantime, only information on serious disciplinary infractions is available for understanding the usefulness of the TNA results for identifying wards with behavioral problems. These data were obtained from the CYA’s Disciplinary Decision-Making System (DDMS).

The analysis focused on the number of incidents involving each ward that resulted in Level B (serious) DDMS reports during the first twelve months of his or her stay in the Youth Authority. In addition to the total number of such incidents, analysis focused on incidents involving assaultive behavior toward staff

or other wards, sexual misconduct, and suicidal behavior. Except for suicidal behavior, which was analyzed relative to the Suicide Ideation Scale of the MAYSI, the behavioral indicators were compared for groups differing in the general “pervasiveness” of mental health problems, as described earlier. Groups differing in the number of mental health problem areas they exhibited (emotional problems, thought problems, and suicidal ideation) were compared in terms of the percent that had disciplinary problems.

Shown in Table 2 are the percentages with any DDMS infractions of the various kinds and the average number of incidents recorded for wards reporting mental health problems. These figures suggest that the kinds of mental health problems being tapped by the assessment process are associated with behavioral problems of all kinds. Wards with elevated scores in one or more mental health problem areas were more likely to have DDMS reports of all kinds.

Table 2
Disciplinary Incidents by Pervasiveness of Mental Health Problems

	Problem Areas (Emotional Problems, Thought Problems, Suicidal Ideation)			
	None	One or More	Two or More	All Three
Cases	1,472	1,229	429	123
Proportion with Disciplinary Incidents				
Any Charge	61.9%	68.2%	76.5%	82.9%
Assaults on Other Wards	41.6%	44.6%	52.2%	50.4%
Assaults on Staff	2.2%	4.6%	5.4%	6.5%
Suicidal Activity	2.4%	5.5%	7.5%	11.4%
Sexual Misconduct	3.9%	5.8%	6.8%	5.7%
Other Misconduct	41.8%	46.5%	52.9%	65.0%
Average Number of Incidents				
Any Charge	1.67	2.10	2.59	2.80
Assaults on Other Wards	0.73	0.82	1.00	0.98
Assaults on Staff	0.03	0.05	0.06	0.07
Suicidal Activity	0.03	0.07	0.10	0.17
Sexual Misconduct	0.04	0.07	0.09	0.07
Other Misconduct	0.84	1.08	1.34	1.52

During the first twelve months of their CYA stays, six in ten of the wards in this sample had at least one DDMS incident reported. For those reporting mental health problems on the MAYSI, the percentage jumps to 68.2%, and the percentage increases to 76.5% for those reporting problems in two areas (Figure 6). For the more serious disciplinary infractions (Figure 7), the differences are more dramatic. While only a small percentage of wards are reported for Assaults on Staff, Suicidal Activity or Sexual Misconduct, the percentage is twice as high for those with mental health problem indicators as for those with none.

Average numbers of incidents, (Table 2) suggest that in addition to being more likely to have any DDMS reports, wards with mental health problems also have more reports, particularly in the less serious domains. These differences are not great, however.

The best predictor of suicidal behavior or gestures, however, is the MAYSI Suicidal Ideation scores (not shown). Of the 286 wards with elevated scores, 24 (8.4%) had at least one DDMS report for suicidal activity. Only 3.3% of those without elevated scores had any such incidents.

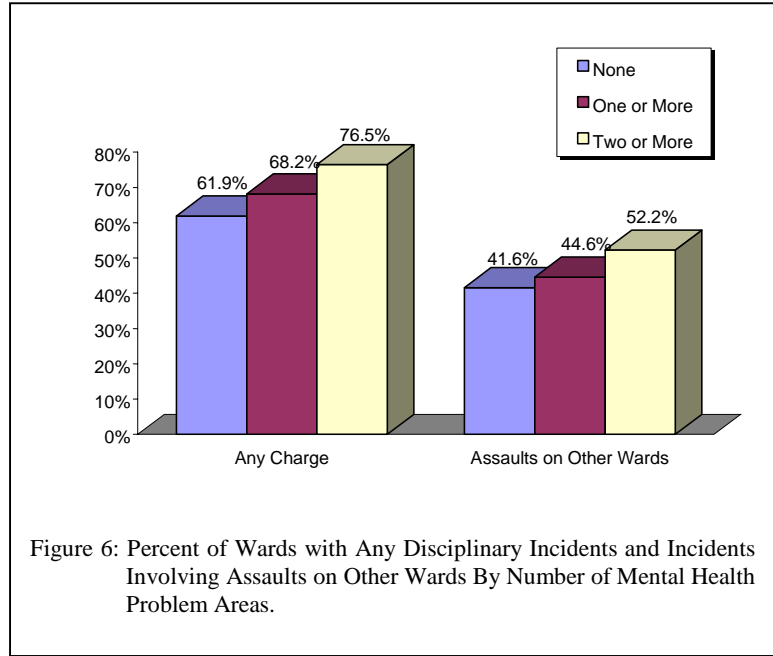


Figure 6: Percent of Wards with Any Disciplinary Incidents and Incidents Involving Assaults on Other Wards By Number of Mental Health Problem Areas.

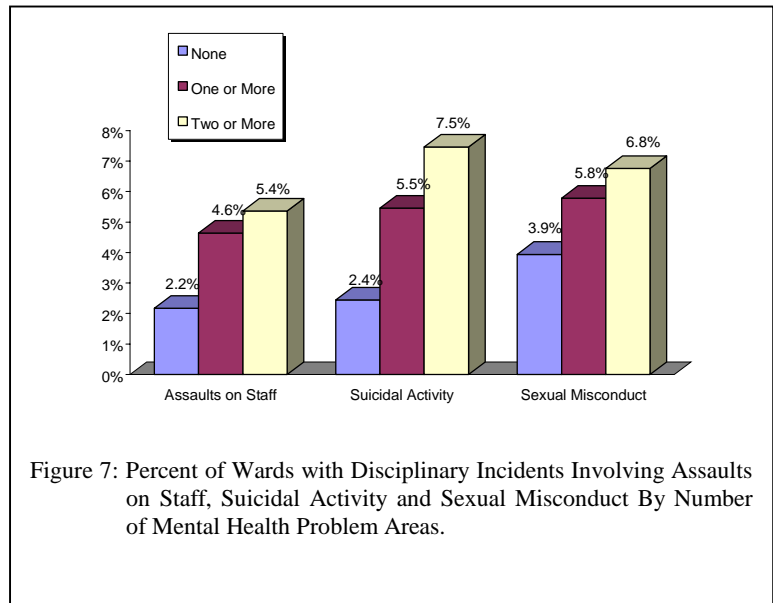


Figure 7: Percent of Wards with Disciplinary Incidents Involving Assaults on Staff, Suicidal Activity and Sexual Misconduct By Number of Mental Health Problem Areas.

Conclusions and Future Directions

Information gained from the Mental Health and Substance Abuse Treatment Needs Assessment Project so far suggests a substantial need for mental health treatment services among young offenders entering the Youth Authority. Both male and female wards reported significant levels of symptoms associated with a wide range of mental and emotional problems as well as elevated levels of substance abuse. Forty-four percent of the males and nearly 60% of the females report thoughts, attitudes, and experiences indicative of relatively serious emotional or psychological problems. Many of these wards reported combinations of emotional problems, suicidal thoughts and feelings, and thought problems, suggesting the potential need for more immediate and/or intensive mental health services. The vast majority of both males and females reported substance abuse problems, and a large proportion of the wards reported a combination of both mental health and substance abuse problems.

While a great deal of research remains to be done to establish how seriously dysfunctional wards scoring at various levels are with respect to their functioning within the CYA environment, information on disciplinary infractions indicate that wards with elevated scores do have difficulties adjusting to the institutional environment and to behavioral expectations. These data underscore the observation of many Youth Authority clinicians that the population contains a large proportion of youth with serious mental or emotional problems that hinder rehabilitative efforts. The data also suggest that females committed to the Youth Authority have a somewhat higher prevalence of mental health problems than do males. While both males and females are often committed to the Youth Authority because of a combination of mental health problems and criminality, this selection process appears to favor mental health issues more for females than for males.

Future Directions

From the beginning of this assessment process, it was recognized that both the Youth Authority population and the Youth Authority environment make it unlikely that existing national norms would be

capable of identifying wards with treatment needs during their CYA incarceration. There was a clear recognition of the need to refine the cut-points that indicate mental health problems along various dimensions and to establish how best to use the assessment data to determine who will actually require what kinds of treatment in Youth Authority institutions and/or parole. Youth Authority Research staff are currently engaged in research to address these issues and establish better estimates of population mental health treatment needs.

It is possible, for example, that some wards with emotional and/or psychological problems could function adequately most of the time in the relatively secure, structured environment in CYA institutions. Nevertheless, many can be expected to need services at some point during their stay. Some of these wards may be stabilized rather quickly and returned to regular living units. Others will require longer-term support and assistance. Still others will need to be housed in special units for the duration of their institutional stays.

Further, scores on scales measuring mental and emotional states can be expected to identify some cases who do not need treatment and miss others who do. In some cases, high scores may reflect temporary distress or disorientation, both of which can be expected in young people entering long-term incarceration. These transient states cannot be distinguished from more stable problems from the questionnaire responses alone. It is important (especially during the initial phases of development and refinement) to emphasize "sensitivity" in the screening process, so that all cases whose mental health problems may pose a danger to self and others are identified. Clinical evaluations can then determine which wards are experiencing serious mental health problems and which are experiencing more transient emotional distress. Other wards, who understate their own problems may come to the attention of mental health staff through their behavior or self-referral at a later time.

As the Youth Authority continues to study these issues, it will also be important to obtain a better understanding of the number and duration of treatment episodes that various types of wards require as well as the events or environmental characteristics that trigger the need for services. It could be, for example, that

certain types of wards find moving from one living unit to another to be extremely stressful. Being involved in (or even witnessing) conflict in the institutional setting may also trigger anxiety or depression that prevents participation in regular programming. There is some research evidence to support the idea that people in correctional settings find the anticipation of *release to parole* to be extremely upsetting and that this distress may trigger behavior designed to postpone that release (Cormier, Kennedy, and Sendbuehler, 1967). A better understanding of these “triggers” and the relative vulnerabilities of wards may serve as the basis for planning how to prevent such episodes and how best to treat them when they occur.

Some of these issues are being investigated as part of a study currently underway, funded by the National Institute of Justice (grant # 98-CE-VX-0024 “Assessing Mental Health Problems Among Serious Juvenile Offenders”). This study is designed to validate and refine the TNA battery to make it more useful in identifying wards in need of treatment while in Youth Authority institutions. This study is gathering information on institutional functioning and mental health status (based on diagnostic interviews) for a large sample of wards who have been in Youth Authority institutions for at least nine months. The information on functioning and mental health will be used as a standard against which to evaluate and

refine the scoring of the TNA information obtained when the wards entered the Youth Authority. Topics to be addressed include

- the treatment experiences of wards with various mental health profiles;
- the best use of the instruments for identifying which wards will require long-term and short-term mental health services in the institutions;
- the relationship of current mental health problems and substance abuse to prior criminal behavior, especially violence;

Topics of interest for future research studies that build upon the current research include

- the prognosis for wards with different mental health profiles, in terms of institutional adjustment and parole performance;
- the best array of treatment options for reducing the dangerousness related to serious mental problems and/or preventing these problems from getting worse; and
- the best options for maintaining the help and support of these offenders in the parole setting.

Obtaining this kind of information will require substantial data collection from ward files and long-term, rather intensive follow-up of wards through their institution and parole programs.

References

- California Youth Authority. (1998). *CYA Program and Treatment Needs: systems and Measures for Evaluating Program Effectiveness with an Increasingly Violent Youthful Offender Population*, Sacramento: California Youth Authority.
- Cauffman, E., Feldman, S., Waterman J., and Steiner, H. (1998). Posttraumatic Stress Disorder Among Female Juvenile Offenders. *J. Am. Acad. Child Adolesc. Psychiatry*, 1998, Vol. 37(11):1209–1216.
- Cormier, B., Kennedy, M., and Sendbuehler, M. (1967). Cell breakage and gage fever. *British Journal of Criminology*, Vol. 7, 317-324.
- Grisso, T. Barnum, R., Famularo, R., and Kinscherff, R. (1996). *Massachusetts Youth Screening Instrument*.