

Table of Contents

MAYSI~2 Quick Facts.....	3
Guidelines for Good Mental Health Screening Practices and Appropriate Uses of Screening Results	4
Implementation Checklist	7
Recommended Protocols	9
MAYSI~2 Implementation Manual.....	12
Guidelines for Introducing the MAYSI~2 to Youth	29

MAYSI-2 Quick Facts

What is the MAYSI-2?

The *Massachusetts Youth Screening Instrument version 2* is a standardized, 52-item (yes/no) self-report questionnaire designed to identify youth who might have mental or emotional conditions that require immediate attention, intervention, or more comprehensive evaluation.

What age is the MAYSI-2 normed for?

The MAYSI-2 can be used to screen youth between the ages of 12-17.

How long does the MAYSI-2 take to administer?

The MAYSI-2 takes about 10 minutes to administer.

How long does the MAYSI-2 take to score?

The MAYSI-2 takes about 3 to 5 minutes to score.

How is the MAYSI-2 administered?

The instructions are explained to the youth and the youth is left alone to circle his/her answers to the 52 items.

Is there an electronic version of the MAYSI-2?

Yes, there is a Web-Based Version. Please see: <http://www.nysap.us/Web%20MAYSI-2.html>

Is there a Spanish version of the MAYSI-2?

Yes, it is contained in Web-based version and in paper form in the new, 2006 MAYSI-2 manual.

How many scales does the MAYSI-2 contain?

7 for Boys and 6 for girls (Thought Disturbance isn't scored for girls). These include Alcohol/Drug Use, Angry-Irritable, Depressed-Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbance and Traumatic Experiences.

Do you need to have any special qualifications to administer the MAYSI-2?

No. You do not need to have a professional degree to administer the MAYSI-2. In some places, it is a person with a high-school diploma who is administering the MAYSI-2. It does not require that you be a clinician, but you should read the MAYSI-2 manual and if possible have a long-term MAYSI-2 user train you.

How do staff who administer the MAYSI-2 know that a youth is in need of attention?

Staff are alerted to higher-scoring youths via caution (clinically-significant score) and warning (top U.S. 10% scoring in juvenile justice programs) cut-off scores.

Guidelines for Good Mental Health Screening Practice and Appropriate Uses of Screening Results

The value of mental health screening is limited to its intended purpose—an initial identification of youth with possible mental and emotional problems needing immediate response and/or further assessment. It is unlikely that this value would be achieved without careful attention to the proper implementation of screening guidelines. This section presents guidelines for good mental health screening practices and a recommendation for the development of policies to assure appropriate use of mental health screening results.

- ***Mental health screening tools must be administered according to procedures described in the manual accompanying the tool, by persons who have received enough in-service training to be able to administer the tool in the manner described in the manual.*** When reviewing the procedural features of a standardized screening tool, one should recognize that once a tool is selected for use, its procedures must be implemented just as they are described in the manual. Altering the administration procedures of a tool, or changing the items in any way, compromises the validity and reliability of the screening results. Thus, complete and accurate in-service training of staff in the tool's administration procedures is essential for consistent ("standardized") implementation.
- ***Youth should receive an appropriate description of the purpose and uses of mental health screening, and they should have access to screening results if requested (e.g., by parents or counsel) in accordance with applicable laws.*** A standard set of instructions should be developed for use when introducing youths to the screening tool. It is important that the introduction be done in a uniform way that engages youth in the task and is straightforward and factual about why they are being asked to participate in screening. For example, tell the youth that you want to know these things because it will help you know whether the youth has any special needs and to keep the youth safe. A good introduction should also include a clear description of how the results will and will not be used.

All of the information in the instructions needs to be conveyed in a helpful, non-threatening and respectful manner using language that is simple and easily understandable to youth. Ignoring these guidelines may yield screening results that are of questionable value and are wasteful of resources. Even after a clear and respectful introduction, some youth may refuse to participate. There is nothing gained by pressuring or forcing a youth to complete a mental health screening. If the youth complies because of pressure or perceived threats, the screening is likely to result in invalid data.

If parents or the youth themselves were to ask for the results of mental health screening, the juvenile probations departments should be prepared to give them access to this information. Being prepared for such requests requires a readiness to explain the dimensions of the tool and the meaning of the results.

- ***Mental health screening results should not be interpreted as psychiatric diagnoses or personality descriptions. Results describe youths' mental and emotional states at a particular point in time, not youths' mental disorders or personality traits.*** Mental health screening does not produce a psychiatric diagnosis and does not substitute for getting the opinions of mental health professionals when youth are “screened in.” Mental health screening results might indicate a youth has depressed symptoms, but this may or may not mean that the youth has a mental disorder called “depression”. Screening results simply identify which youths are in need of professional mental health opinions or require precautions to avoid harm to themselves or to others.
- ***Mental health screening results should not be presumed to describe a youth's mental or emotional condition beyond approximately 2 to 4 weeks after the results are obtained. Some conditions may persist longer, but some screening results might represent temporary emotional states that change over time.*** After a few weeks, mental health screening results should not be trusted as much as they were when they were first obtained. This is because youths' moods may change, their stress level may change, and many things in their lives around them may change. Mental health screening tools are not psychological tests that identify the youth's set of personality traits. These tools just measure symptoms at a given point in time. This “snapshot” becomes less valid as more time passes since the youth was first screened. Given this time-limited value, mental health screening results do not have clinical value beyond their stated purpose to identify youths' short-term mental or emotional needs at the time of administration.
- ***Youth who “screen in” should receive staff responses or clinical assessments as determined by clear policies developed by the agency.*** Juvenile probation departments need to develop policies regarding how the mental health screening results (e.g., scores or ratings) will be used by staff to determine responses to youths' mental health needs. These policies should clearly describe the decision rules for which scores serve as cut-offs for “screening in” a youth for further follow-up, as well as the specific program responses that will occur when a youth meets the decision rule. In addition, it is important that these policies define staff roles and responsibilities with regard to the decision rules and program responses.

Recommendations to Avoid Misuses of Screening Results

- ***Mental health screening results obtained during the juvenile justice intake process, or while in pretrial detention, should not be used alone by probation for informal or formal dispositional planning.*** Disposition hearings take place after adjudication and involve judicial decisions about longer-term placement, rehabilitation, and treatment of the youth. These decisions require the kinds of information about a youth (e.g., diagnosis, personality traits, clinical details of the psychopathology) that assessment—not mental health

screening—provides. In addition, mental health screening tools measure symptoms at a given point in time and produce a “snapshot” of what might be the temporary moods and emotions of the youth. These moods and emotions are important in assessing the youth’s needs for a period of 2 to 4 weeks after screening. Moreover, they may identify youth who need further assessment in order to determine whether mental health services should be part of their dispositional plans. But the screening results alone are not valid for determining the youth’s needs over the long term. Therefore, it is entirely inappropriate to use the results of a brief mental health screen as the primary basis for saying that a youth should receive medication or any specific type of psychiatric treatment as part of his/her dispositional planning. Basing these sorts of long-range treatment decisions exclusively on the results of tools that were not developed for that purpose can lead to treatment that is detrimental to the youth and a poor use of resources. Developing policies that restrict the use of mental health screening results to short-range (within a few days or weeks of screening) mental health decisions can help avoid this problem. One way of addressing this issue is to clearly and conspicuously label results to indicate that they are valid for only four weeks from the point of administration. ¹

¹ Excerpted from National Center for Mental Health and Juvenile Justice. *Mental Health Screening: The Next Frontier*. Delmar, NY: National Center for Mental Health and Juvenile Justice (in press).

Implementation Checklist

The following checklist is provided to assist counties to implement a screening and assessment program within their juvenile justice system.

- ❑ **Collaboration among agencies at the earliest stages of the design and development of the screening and assessment program.** The formation of a steering/coordination committee should be considered to guide implementation and be responsible for the development of policies and protocols regarding the operation of the program. It is recommended that counties use existing structures such as the Integrated Children's Services Planning Team, Criminal Justice Advisory Board or a similar group to serve as the steering committee for the screening and assessment program. Regardless which group is utilized, the membership should, at a minimum, include representatives from: Juvenile Probation; Children & Youth; MH/MR Administrative Offices; Drug & Alcohol Administrative Offices; Managed Care Organization; District Attorney; Public Defender; Victim Advocate, Education; and Family Advocates.
- ❑ **Appointment of a Screening and Assessment Program Coordinator/Leader by the Juvenile Court Judge.** This individual will coordinate the activities of the Steering Committee and serve as a liaison to local and state officials.
- ❑ **Agreement among the Juvenile Court, District Attorney and Public Defender regarding how the information obtained from screening and/or assessment will, or will not, be used.** Protections against self-incrimination, as well as the appropriate use of the information should be considered. Please see section on "*Guidelines for Good Mental Health Screening Practice and Appropriate Uses of Screening Results.*" The Juvenile Law Center developed a monograph entitled, "*Protecting Youth from Self-Incrimination when Undergoing Screening, Assessment and Treatment within the Juvenile Justice System.*" A copy of the monograph is provided as a resource and an electronic version can be accessed at <http://jlc.org/File/publications/protectingyouth.pdf>. A template is provided in Appendix B of the monograph that provides an example of Memorandum of Understanding that outlines such protections.
- ❑ **Agreement on how the instrument/process will be used.** Issues to consider include, but may not be limited to: 1) the point in the system where the screening instrument will be administered; 2) the individual(s) who will administer the instrument and; 3) how and with whom the results will be shared.

- ❑ **Approval of the screening and assessment policy by the Court.** Ultimately, the Juvenile Court Judge will render decisions regarding the care and treatment of the youth, while also balancing the needs of the victim(s) and the community. Therefore, it is essential that the Court support and approve the policies and protocols regarding the screening and assessment program.
- ❑ **Identification of funding required to begin, as well as sustain, the screening and assessment program.** Counties planning on utilizing a screening or assessment instrument should identify ongoing funding sources that could support necessary activities.
- ❑ **Commitment to on-going training and education for users.** Initial on ongoing refresher training is critical to ensure the screening process is administered in a appropriate manner and adherence to proper policies and an protocols is maintained.
- ❑ **Commitment to providing educational seminars for local stakeholder groups and agencies that may be affected by the screening and assessment program.** These seminars will serve to inform these groups of the purpose, practices and protocols of the screening and assessment program. These groups may include community-based and residential providers, school districts, contracted drug & alcohol evaluators, psychologists, and psychiatrists.
- ❑ **Commitment to provide Information Technology support.** Issues to consider include the installation and maintenance of the instrument's software.
- ❑ **Commitment to the collection and use of data.** Counties should determine how they will use the case-specific and aggregate information for local needs and may add additional information they may need for local decisions.

Recommended Protocols

It is recommended that counties adopt local protocols for the operation of their screening and assessment program. It is important that counties and affected agencies have the opportunity to consider, and agree, how their program will operate. Several subject areas are provided below for counties to consider and address in their local policies and procedures. The recommended protocols are intended to provide a starting point for counties in the development of their screening and assessment program and are not intended to be inclusive of all protocols that counties ought to consider.

I. Establishment of a Screening and Assessment “Steering Committee”

Issues to Consider:

- ❑ Counties should articulate the purpose of their screening and assessment program, and collaboration and coordination requirements across multiple systems and agencies. A cross-systems group will enable information and resources to be shared and should improve the ability to advocate for the needs of youth identified through the screening and assessment process.
- ❑ Membership on the “steering committee” should consist of individuals who have policy and decision-making authority for their respective agencies. It is recommended that counties use existing structures such as the Integrated Children’s Services Planning Team, Criminal Justice Advisory Board or a similar group to serve as the steering committee for the screening and assessment program. Regardless of which group is utilized, the membership should, at a minimum, include representatives from: Juvenile Probation; Children & Youth; MH/MR Administrative Offices; Drug & Alcohol Administrative Offices; Managed Care Organization; District Attorney; Public Defender; Victim Advocate; Education; and Family Advocates. Care should be given to involve the perspective of families, through actual family members of youth involved in the juvenile justice system, and/or family advocates.

The Juvenile Court Judge should appoint a coordinator or lead person for the screening and assessment program.

- ❑ The steering committee should have the responsibility to recommend policies regarding screening and assessment to the Juvenile Court, and the authority to develop recommended protocols within parameters of the approved policy. Counties may also want to use the committee to review aggregate data and make recommendations regarding identified needs.

II. Use of the Screening Instrument

Issues to Consider:

- ❑ Identification of the instrument that will be utilized. Any instrument that is selected should be standardized, scientifically-sound, contain strong psychometric properties, and demonstrate reliability and validity for identifying the mental health and substance abuse treatment needs of youth in the juvenile justice system.
- ❑ Protections from self-incriminating statements obtained from the screening process in any subsequent evidentiary/adjudicatory proceeding. *Pennsylvania Act 109 of 2008* prohibits the use of any statements by, or incriminating information obtained from, the youth during screening, assessment and/or evaluation in any subsequent evidentiary proceeding in Juvenile or Criminal Court.
- ❑ The purpose of the screening instrument. (e.g. To identify the short term mental or emotional needs of youth and/or to determine the need for further in-depth assessment or evaluation.)
- ❑ Limitations regarding its use to formulate a disposition or treatment plan. (The MAYSI~2 may be used as an indicator of the need for further assessment or evaluation in identified areas but, should not be used as justification for a specified course of treatment.)
- ❑ Staff who will be responsible for the administration of the instrument and any related training requirements.
- ❑ The point in the system at which the instrument will be administered.
- ❑ The individuals and/or agencies that will receive, or have access to, the results of the screening instrument should be identified and the process by which the information will be shared.
- ❑ Where and how the results of the screening instrument will be retained and any limitations on its use after a period of time.

III. Screening Environment and Presentation of the Instrument to the Youth

Issues to consider:

- ❑ The environment in which a screening instrument is administered can affect its results. It is recommended that the administration of the screening instrument occur in a space that provides a degree of privacy, is reasonably comfortable, and is free from distractions or interruptions.
- ❑ The manner in which the MAYSI~2 is introduced to the youth is important. A “script” may include information such as: a) there are no “right or wrong” answers; b) the questions are designed to help staff understand the youth better; c) who will, or will not see the answers and how the answers will be used; d) they are encouraged to cooperate so more informed decisions can be made about them; and e) whether there any special needs or help that they may require.

IV. Responses to MAYSI~2 Results

Issues to consider:

- ❑ A response should be required and documented whenever a youth’s MAYSI~2 score falls within a caution or warning level. Counties should establish parameters for responses that are commensurate with the level of risk that youth present and may range from precautionary monitoring, to further assessment, to a referral to a crisis intervention team. Responses may be dependent upon local services and resources.

V. Data Collection and Analysis

Issues to consider:

- ❑ In addition to the MAYSI~2 results, counties should consider collecting additional information for program/service utilization, evaluation, resource allocation, planning and advocacy purposes.
- ❑ Counties should determine the manner in which they will analyze aggregate data for purposes such as program/service utilization, evaluation, resource allocation, planning and advocacy.
- ❑ Counties should submit aggregate data to the identified state-level data collection point.

**MASSACHUSETTS YOUTH
SCREENING INSTRUMENT:
SECOND VERSION**

MAYSI ~ 2

Created by:

**Thomas Grisso, Ph.D. & Richard Barnum, Ph.D.
University of Massachusetts Medical Center**

Training Manual Prepared by:

Elizabeth Cauffman, Ph.D.

***Western Psychiatric Institute & Clinic
University of Pittsburgh***

*March 2, 2000
(Updated July 2003)*

Acknowledgement

This training manual was initially used in Pennsylvania as part of the Mental Health Assessment Project of the Juvenile Detention Centers' Association of Pennsylvania (JDCAP). The project served to introduce the Massachusetts Youth Screening Instrument: Version 2 (MAYSI~2) into the Commonwealth in 2000. Many of the experiences of JDCAP and the Pennsylvania Department of Public Welfare's Youth Development Center/Youth Forestry Camp system, which subsequently adopted use of the MAYSI~2, has served to inform current efforts. The MAYSI~2 Implementation Pilot Project is grateful for the knowledge and experiences that have been shared.

MAYSI ~ 2

Brief Overview

The MAYSI-2 is designed to assist juvenile justice agencies in identifying youths 12-17 years old who may have special mental health needs. It is intended for use at any entry or transitional placement points in the juvenile justice system (e.g., intake probation, pretrial detention, state youth centers). Development of the MAYSI-2 was guided by the need for a tool that:

- can be administered routinely to all youths in probation intake interviews or within 24-48 hours after their admission to juvenile justice facilities
- requires no more than 15 minutes to administer
- alerts staff to a youth's potential mental/emotional distress and certain behavior problems that might require an immediate response--for example, immediate monitoring, additional questioning of the youth, request for a clinical consultation, or further detailed assessment for longer-range treatment planning
- can be scored and interpreted quickly without the expertise of a mental health professional

The MAYSI-2 is a computerized self-report inventory of 52 questions. Youths answer "yes" or "no" concerning whether each item has been true for them "within the past few months." Youths are read the items via the computerized voice program (the MAYSI-2 also has a fifth grade level of readability). A Spanish language version is provided.

Youths' answers contribute to 7 scales for boys and 6 scales for girls (*see next page*). Each scale has 5-9 items. Scoring requires a count of the "yes" responses to the items that contribute to a given scale. There is no MAYSI "total score." Scores on each scale are compared to cut-off scores that are suggested in this manual or that have been decided as a matter of policy by an agency or juvenile justice system. Scores above a scale's cut-off suggest that the youth may be in need of closer attention by staff, precautionary monitoring, brief counseling, or referral for mental health services (depending on policies set by one's agency).

MAYSI ~ 2 SCALES

Alcohol/Drug Use

- Frequent use of alcohol/drugs
- Risk of substance abuse or psychological reaction to lack of access to substances

Angry-Irritable

- Experiences frustration, lasting anger, moodiness
- Risk of angry reaction, fighting, aggressive behavior

Depressed-Anxious

- Experiences depressed and anxious feelings
- Risk of impairments in motivation, need for treatment

Somatic Complaints

- Experiences bodily discomforts associated with distress
- Risk of psychological distress not otherwise evident

Suicide Ideation

- Thoughts and intentions to harm oneself
- Risk of suicide attempts or gestures

Thought Disturbance

- (Boys only) Unusual beliefs and perceptions
- Risk of thought disorder

Traumatic Experiences

- Lifetime exposure to traumatic events (e.g., abuse, rape, observed violence). Questions refer youth to “ever in the past,” not “past few months.”
- Risk of trauma-related instability in emotion/perception

Alcohol/Drug Use

The *Alcohol/Drug Use* scale is intended to identify youths who are using alcohol or drugs to a significant degree, and who are therefore at risk of substance dependence and/or abuse. The scale has eight items. Five of the items are concerned with various negative consequences of substance use, and the remaining three address characteristics of substance use that are thought to represent risk factors for abuse (items #33, 37, and 40).

Alcohol/Drug Use

- 10. Have you done anything you wish you hadn't, when you were drunk or high?
- 19. Have your parents or friends thought you drink too much?
- 23. Have you gotten in trouble when you've been high or have been drinking?
- 24. If yes [to #23], has the trouble been fighting?
- 33. Have you used alcohol or drugs to help you feel better?
- 37. Have you been drunk or high at school?
- 40. Have you used alcohol and drugs at the same time?
- 45. Have you been so drunk or high that you couldn't remember what happened?

Substance abuse problems are much more frequent among juvenile offenders compared to other adolescents. The scale overall is not intended to reflect experimental substance use only. An elevated score on this scale suggests elevated risk for having or developing significant substance abuse problems. It may also alert staff to youths whose more frequent substance use makes them more at risk of having a psychological or physiological reaction to the lack of access to substances early in secure detention.

Angry-Irritable

The *Angry-Irritable* scale is intended to assess explicit feelings of preoccupying anger and vengefulness, as well as a general tendency towards irritability, frustration, and tension related to anger. The scale has nine items. Four explicitly concern angry mood and thoughts (#7, 13, 35, 42) and three others are concerned with irritability and risk of impulsive reactions (#6, 8, 39). Two items (#2, 44) pertain to behavioral expression of anger.

Angry-Irritable

- 2. Have you lost your temper easily, or had a "short fuse"?
- 6. Have you been easily upset?
- 7. Have you thought a lot about getting back at someone you have been angry at?
- 8. Have you been really jumpy or hyper?
- 13. Have you had too many bad moods?

35. Have you felt angry a lot?
39. Have you gotten frustrated easily?
42. When you have been mad, have you stayed mad for a long time?
44. Have you hurt or broken something on purpose, just because you were mad?

An angry mood, its associated tension, “touchiness,” and an impulsive reaction to annoyance or frustration are all relatively common among juvenile offenders. It is not a symptom of any particular disorder, and some youths experience irritability without having a significant disorder. But angry mood is found in association with a number of clinical conditions—for example, depression, a history of trauma, ADHD, oppositional behavior, conduct problems, poor socialization and personality problems, as well as any combination of these difficulties.

Angry-Irritable scores somewhat increase the risk that a youth will impulsively react in ways that can hurt others or themselves. However, the scale does not necessarily identify youths who habitually get into physical fights. Many youths who habitually fight do so for a variety of incentives rather than because of anger. It is also true that many youths who are typically angry manage to avoid getting into fights. But high *Angry-Irritable* scores may increase the risk that anger will be expressed impulsively in physical aggression under conditions of annoyance or frustration.

Depressed-Anxious

The *Depressed-Anxious* scale is intended to elicit symptoms of mixed depression and anxiety. The scale has nine items. Five items inquire about manifestations of anxiety (items 14, 21, 51) and inner turmoil (items 3, 35), and four items are concerned with depressed mood (items 17, 34, 41, 47).

Depressed-Anxious

3. Have nervous or worried feelings kept you from doing things you want to do?
14. Have you had nightmares that are bad enough to make you afraid to go to sleep?
17. Have you felt lonely too much of the time?
21. Has it seemed like some part of your body always hurts you?
34. Have you felt that you don't have fun with your friends anymore?
35. Have you felt angry a lot?
41. Has it been hard for you to feel close to people outside your family?
47. Have you given up hope for your life?
51. Have you had a lot of bad thoughts or dreams about a bad or scary event that happened to you?

One might imagine that there should be separate scales in an instrument like the MAYSI-2 for anxiety and for depression. However, many studies of mental and emotional disorders of adolescence have identified a “syndrome” of mixed anxiety and depression (Hammen &

Compas, 1994) that seems to come closer to describing youths' emotional disturbance than would separate scales. The depressed-anxious dimension has some of the features of clinical depression that are seen in adults, but it has a different appearance than "pure" depression because it is mixed with anxiety and tension.

Clinical observation, theory, and studies of adolescent disorders have often identified the fact that depressed-anxious feelings, anger, and suicide ideation tend to be found together in many youths who are seen for clinical problems. In the study that was conducted to develop the MAYSI-2, we did find substantial overlap for the *Depressed-Anxious*, *Angry-Irritable*, and *Suicide Ideation* scales. This does not mean that whenever a youth manifests one of these he or she will necessarily manifest the others. For example, while youths who are high on *Suicide Ideation* will usually be high also on *Depressed-Anxious*, many youths who are high on *Depressed-Anxious* may not be high on *Suicide Ideation*.

High *Depressed-Anxious* scores when a youth first enters a juvenile facility do not always mean that a youth will continue to have serious depressed-anxious feelings across time. In the study with which the MAYSI-2 was developed, some youths' *Depressed-Anxious* scores decreased after they had been in juvenile facilities for a week or two. What this means is that high *Depressed-Anxious* scores at admission to juvenile facilities describe an enduring problem for some youths, while for other youths the high score may be an emotional reaction to immediate events. As described later, this should be taken into account when deciding how to respond to youths with high *Depressed-Anxious* scores at admission.

Somatic Complaints

The *Somatic Complaints* scale includes six items that ask about various bodily aches and pains that may affect the youth, along with specific bodily expressions of anxiety. An elevated score on this scale could occur for a variety of reasons. For example, somatic complaints tend to co-occur with depression and anxiety, and sometimes they can be associated with trauma history and with thought disorder as well. On the other hand, aches, pains, and other somatic complaints may be symptoms of physical illnesses, and such complaints should not be overlooked as symptoms in their own right.

An elevation on this scale without elevations on other MAYSI-2 scales is relatively uncommon. It may reflect physical illness with variable or nonspecific manifestations. It may simply reflect a tendency to experience somatic manifestations of normal anxiety more acutely than the average youth, since all six of the items in the scale are concerned with physical sensations associated with nervousness or anxiety. However, an elevated score on this scale may also be an indication of more significant emotional problems, since somatic complaints sometimes reflect emotional distress that is not immediately apparent in other ways.

Somatic Complaints

When you have felt nervous or anxious:

- 27. have you felt shaky?
- 28. has your heart beat very fast?
- 29. have you felt short of breath?
- 30. have your hands felt sweaty?
- 31. has your stomach been upset?
- 43. Have you had bad headaches?

Suicide Ideation

The *Suicide Ideation* scale has five items. Three of them specifically address thoughts and intentions about self-harm (#11, 18, 22), and two involve depressive symptoms that may present an increased risk for suicide (#16, 47). One of the items (# 47) is shared with the *Depressed-Anxious* scale.

Suicide Ideation

- 11. Have you wished you were dead?
- 16. Have you felt like life was not worth living?
- 18. Have you felt like hurting yourself?
- 22. Have you felt like killing yourself?
- 47. Have you given up hope for your life?

Note that the items in *Suicide Ideation* do not ask for information about past self-destructive behavior. They focus instead entirely on recent and current subjective states. Currently no research has been performed to determine whether youths with high *Suicide Ideation* scores are actually more likely to attempt suicide. The aim with this scale is to elicit self-report of specific thoughts and feelings about suicide, because there is a good deal of evidence in theory and research that such thoughts and feelings are relevant for suicidal intent and risk.

Thought Disturbance (Boys)

The *Thought Disturbance* scale is intended to indicate the possibility of serious mental disorder involving problems with reality orientation. The scale has five items, four of which refer explicitly to altered perceptions of reality which are frequently associated with psychotic disorders (#9, 20, 25, 32). The remaining item (#26) refers to a condition of de-realization (“things don’t seem real”) that is a more general abnormality of perception and consciousness.

It is sometimes an early indication of a psychotic state, but it may simply arise in anxiety or dissociative states as well.

In the study with which the MAYSI-2 was developed, the various ways that we used to identify which items came together as scales did not identify a “thought disturbance” scale for girls using MAYSI-2 items. Thus the *Thought Disturbance* scale should not be applied to girls.

Thought Disturbance

- 9. Have you seen things other people say are not really there?
- 20. Have you heard voices other people can't hear?
- 25. Have other people been able to control your brain or your thoughts?
- 26. Have you had a bad feeling that things don't seem real, like you're in a dream?
- 32. Have you been able to make other people do things just by thinking about it?

A positive response to several of these items may indicate a psychotic illness such as schizophrenia or a major depressive episode with psychotic features. It may also reflect the sort of dramatic and intermittent abnormalities of perception sometimes seen in PTSD, or may sometimes be a result of an organic brain disorder.

Youths may endorse each individual item, however, for reasons that are not consistent with these serious mental disorders. For example, some youths may be recalling experiences under the influence of drugs when reporting that they have “heard voices” or “seen things” that others could not. A positive answer to “heard voices” can sometimes refer to powerful or intrusive thoughts rather than true voices. A positive answer to being able to control other people sometimes reflects a youth's awareness of being able to manipulate others by things he may say or do (rather than purely by thoughts), or may reflect a culturally specific superstition. Occasionally positive responses may reflect more subtle and chronic impairments in personality development, such as underlying suspiciousness or preoccupation with fantasy.

Because of these various possible reasons for endorsing the *Thought Disturbance* items, youths should be asked to clarify their positive responses (after they have completed the MAYSI). This helps to determine whether the youth might have endorsed the items for reasons that are not associated with mental disorder.

Traumatic Experiences

The *Traumatic Experiences* scale is intended to identify whether a youth has had greater exposure to traumatic events compared to other youths. Unlike other MAYSI-2 items, the *Traumatic Experiences* items ask for responses regarding events or feelings over the youth's entire lifetime rather than just “the past few months”. For reasons explained in Section II, separate *Traumatic Experiences* scales were developed for boys and girls.

The Traumatic Experiences scale has five items. For girls, three of the five items (#49, 50, 52) focus on exposure to specific traumatic events (abuse, beatings, rape). The remaining two items (#48, 51) provide the youth the opportunity to think of any other events that the youth experienced as “bad or terrifying” or that resulted in “bad thoughts or dreams.” These latter two items allow youths to report having been upset by experiences that might not be covered by the other items. For boys, item 52 (ever been raped) was deleted and another item added (# 46). This item (“Have people talked about you a lot when you’re not there?”) appeared to be related to the other four items in analyses of our main study on the MAYSI-2. This relation might have arisen because of a tendency for boys with more traumatic experiences to be concerned about what others may be planning to do to them. As with items 48 and 51, follow-up questioning on this item provides youths the opportunity to think of other events that might not have been covered in the main items of the scale.

Juvenile offenders disproportionately have a history of child abuse, sexual victimization, and exposure to other serious and disturbing violence in their families and communities, which can have compelling negative emotional consequences. These consequences can include Post-Traumatic Stress Disorder (PTSD), which may be short lived or may endure for years.

Traumatic Experiences (Girls)

48. Have you EVER IN YOUR WHOLE LIFE had something very bad or terrifying happen to you?
49. Have you ever been badly hurt, or been in danger of getting badly hurt or killed?
50. Have you ever been raped, or been in danger of getting raped?
51. Have you had a lot of bad thoughts or dreams about a bad or scary event that happened to you?
52. Have you ever seen someone severely injured or killed (in person - not in movies or on TV)?

Traumatic Experiences (Boys)

46. Have people talked about you a lot when you’re not there?
48. Have you EVER IN YOUR WHOLE LIFE had something very bad or terrifying happen to you?
49. Have you ever been badly hurt, or been in danger of getting badly hurt or killed?
51. Have you had a lot of bad thoughts or dreams about a bad or scary event that happened to you?
52. Have you ever seen someone severely injured or killed (in person - not in movies or on TV)?

High scores on *Traumatic Experiences*, however, should not be interpreted as indicating the presence of PTSD. During its initial development, this scale included the above items regarding

traumatic events, as well as several items that represented symptoms of PTSD (e.g., feelings of detachment, irritability, “flashbacks”). Initial psychometric investigation indicated that these two types of items did not cluster together, probably because many youths have traumatic experiences that do not result in the emotional and behavioral symptoms of PTSD. Moreover, many youths have PTSD-like affective and cognitive states (e.g., irritability, suspiciousness, avoidance) for reasons other than PTSD. Therefore, the scale was reduced to items that would simply indicate the degree to which youths had been exposed to traumatic experiences.

It can be especially useful to follow up a youth’s responses to these items with clarifying questions. Sometimes the subjectivity of the questions can lead youths to endorse the “terrifying” and “bad thoughts” items in reference to events that would usually not be considered traumatic. On the other hand, the questionnaire format often allows youths to be more open in reporting difficult past experiences than would be possible in a personal interview, so that positive responses on these questions may represent new reports by youths of past traumatic exposure.

MAYSI ~ 2 SCORING

The MAYSIWARE software is self-scoring and will generate an individual score for each youth while also compiling all scores into a separate file for analytical or management purposes. Scores for MAYSI-2 scales are the number of “yes” responses endorsed by the youth for that scale. The computer version is set up in such a way that the youth may not skip questions or leave questions unanswered.

A few of the 52 items on the MAYSI-2 Questionnaire do not contribute to any of the MAYSI-2 scales. They were involved in the original development of the MAYSI, but proved not to be useful in the final scales that are used in the MAYSI-2. (They were retained in the MAYSI-2 largely for future research purposes and for use by clinicians who may wish to examine the youth’s responses to those items for other clinical reasons.)

Once a youth’s scores on the MAYSI-2 scales are known, they can be compared to norms to determine whether the youth may have significant mental health needs in comparison to other youths. If high scores are obtained, then decisions must be made concerning how to respond to this information. The present discussion describes both of these steps.

MAYSI ~ 2

“Caution” and “Warning” Cut-Off Scores

The Scoring Summary indicates whether the youth’s score is above either of two critical scores, called the “**Caution**” and “**Warning**” cut-off scores. The following discussion describes what these thresholds mean.

Caution Cut-Off Scores

When a youth scores above the Caution cut-off score on a given scale, *the youth has scored at a level that can be said to have “possible clinical significance.”*

To set the Caution cut-off scores, we administered the MAYSI-2 to a large number of youths, and also administered to the same youths two additional measures of adolescent mental and emotional disturbances (the Millon Adolescent Clinical Inventory, and the Child Behavior Checklist-Youth Self Report). These comparison measures had certain scales that were intended to identify the same disturbances as the MAYSI-2 scales, but they had been more extensively developed than the MAYSI-2. So, for each MAYSI-2 scale, we found the score that came closest to the “clinical significance” cut-off score on the parallel scale on one of these other more extensive measures. For example, if a youth scores 4 or greater on the MAYSI-2 *Alcohol/Drug Use* scale, it is very likely that youth would have scored in the “clinically significant” range on the Substance Abuse Proneness scale of the Millon Adolescent Clinical Inventory.

The Caution cut-off scores, therefore, simply mean that youths scoring above the MAYSI-2 cut-off would probably score high enough on other tests of similar adolescent disturbances to require special attention of some kind.

Warning Cut-Off Scores

Warning cut-off scores are intended to alert staff that *the youth has scored exceptionally high in comparison to other youths in the juvenile justice system.* The Warning cut-off scores were set at the point that identifies approximately the top 10% of youths on a given MAYSI-2 scale. For example, a youth who scores 7 or higher on the *Alcohol/Drug Use* scale has scored in the top 10% of boys (or the top 12% of girls) in juvenile justice settings in our MAYSI-2 development studies.

Warning cut-off scores are higher than Caution cut-off scores. In other words, they identify a subset of youths in the Caution zone who are the most in need of attention. They should be

considered most likely to be in need of attention for mental health problems because they are reporting problems at a level that far exceeds the average for youths in juvenile justice settings. In a system that must prioritize cases to which it will respond with intervention, Warning cut-off scores identify youths whose mental health needs should be given highest priority.

Responses to High MAYSI ~ 2 Scores

How the MAYSI-2 will be used to identify which youths should receive special attention or intervention must be determined by agencies themselves as a matter of policy. That policy decision requires consideration of two broad questions:

- What cut-off scores will be used on what scales?
- What staff interventions will be made when youths exceed those scores?

The following discussions provide juvenile justice agencies with the type of information that they need to consider when making these policy decisions.

There are several cut-off criteria that a juvenile justice agency can use to identify youths for whom some sort of special attention or intervention should be made. The agency can decide to respond to youths who are above a particular cutoff:

- on at least one out of the six scales (out of five, for girls), or
- on at least any two out of the six scales, or
- on certain critical scales, or
- some other combination, depending on agency resources and policies

Moreover, the agency can decide to apply any of these three schemes using either the Caution or the Warning cutoff scores.

The choice among these criteria will have two effects. First, which cutoff scheme an agency chooses will make a difference in the *number of youths* to whom the system will have to respond with whatever type of special attention the system plans to provide. Second, the choice will influence the *degree of accuracy in identifying youths* who are truly in need of attention or intervention.

Choosing which cut-off scores to use in a screening process like the MAYSI-2 requires that an agency consider the information discussed earlier in light of three additional factors: the agency's responsibilities, responses, and resources.

What are an Agency's Responsibilities?

By **responsibilities** we mean the juvenile justice system's obligation to respond to the mental health needs of youths in its custody. National and local standards or laws typically require that juvenile justice facilities attend to the mental health needs of youths admitted to their facilities. These requirements exist for two general reasons: (a) for the welfare of the youth who is in the system's care, and (b) for the protection and safety of the youth, other youths in the facility, staff, and the community.

What are the Potential Responses?

By **responses** we mean the types of intervention that conceivably might be employed when youths are identified as having possible mental health needs. There are several types of interventions that facilities can implement in response to youths whom a screening tool identifies as possibly having special mental health needs:

- **Secondary Screening** that can disconfirm or provide further evidence that the youth has the mental or emotional problem that the instrument has identified. Sometimes additional observation raises new information that reduces the urgency of the case (it is a "false alarm"), while at other times it will suggest that the results of the screening instrument should be heeded. Secondary screening activities may be of several kinds:
 - **Monitoring**, in which staff exercise greater vigilance and attention to youth in order to make relevant observations
 - **Interviewing and collateral contacts**, in which staff engage in discussions with the youth, or with the youth's family and/or past service providers. This focuses on exploring the reasons for the youth's responses on relevant items of the MAYSI-2, as well as outside information that contradicts or is consistent with what the youth reported on the instrument
- **Clinical Consultation**, in which staff seek expertise from clinical professionals who can intervene to provide brief evaluations or emergency care
- **Evaluation Referral**, in which staff arrange for a more comprehensive psychiatric or psychological evaluation to determine the nature and source of the youth's self-reported distress or disturbance.
- **Therapeutic or Security Intervention**, in which staff act to protect the youth or others from potential consequences of the youth's condition, or to transfer the youth to a setting that can provide appropriate psychiatric services to meet the youth's immediate needs.

What Resources Does the System Provide for Responding?

By **resources**, we mean the financial and administrative support that is required to make the necessary responses or interventions. Juvenile justice agencies must provide the resources to engage in these responses to youths' mental health needs when to do so is necessary for meeting their responsibilities for a youth's welfare and the safety of others.

Weighing the "Three R's"

The MAYSI cut-off scores that an agency decides to set for use by juvenile justice staff will reflect the agency's weighing of all three of these issues. ***The choice of a cut-off score will affect what proportion of youths the agency identifies in relation to its responsibilities, which in turn will define the resources that are needed to respond in a way that meets those responsibilities.***

Difficult decisions must be made when resources are scarce. In such cases, the main questions are how to increase resources, and in the meantime, how to use existing resources in ways that will best meet the system's responsibilities. Several observations about the MAYSI scales may be of help in addressing the latter question.

A key to beginning to resolve the dilemma of Caution vs. Warning cut-offs noted earlier is to recognize that some agency responses may be expensive while others are relatively low-cost. What we call "secondary screening" may be relatively inexpensive. In the form of staff monitoring, it is performed in the routine course of one's duties in juvenile justice facilities, and it can be intensified for specific youths with little cost and little additional effort on the part of staff. Low cost is also involved in requiring that staff sit down and discuss a youth's answers to critical questions that created the "high" scores on the MAYSI-2. The answers might prove to be exactly what they seem, or the youth may have had reasons for responding "yes" that were unrelated to the problem areas the MAYSI-2 assesses.

While Caution cut-offs identify a significant number of youths who must receive a response, the cost of secondary screening as the prescribed response is relatively low. Therefore, most systems should be able to afford the use of Caution cut-offs to activate secondary screening, to determine whether more active intervention is necessary. An agency's sense of its "responsibilities" will determine which of the three criteria it will use in conjunction with Caution cut-offs: above the cut-off on "at least one scale," "at least two scales," or on "certain critical scales."

When Caution cut-offs are used in this way, the agency may wish to have in place a policy that allows or requires more extensive intervention (for example, clinical consultation) when secondary screening indicates the need for it.

Warning cut-offs might be used in a different way, to signal the potential need for more extensive responses such as clinical consultation or referral for comprehensive psychological evaluation. When the availability of these more expensive resources cannot currently be increased, one wishes to use them wisely, expending the resources on youths who are most likely to be in serious need, and using them up on as few “false alarms” as possible. In such cases, the higher Warning cut-off may be more consistent with the agency’s concerns for meeting its obligations, because it does a better job of using the more expensive intervention for youths who actually need it.

Guidelines for Introducing the MAYSI-2 to Youth

Introducing Youth to the MAYSI-2

Instruments like the MAYSI-2 must be introduced to youth appropriately. How youth respond to the questions on such instruments depends a lot on the purpose for which they think the instrument will be used. Therefore, when youth are approached to take the MAYSI-2, it is recommended that the person giving the MAYSI-2 take one or two minutes to introduce the youth to the MAYSI-2 by providing him/her with information about the instrument.

There is no single way to do this. Certainly, this calls for something more than simply pointing to the computer and saying, “Please complete this.” On the other hand, it does not require a lengthy or detailed description. What is needed is some basic information, offered in a non-threatening manner and in a way that youth can understand.

The wide range of ages of youths involved in the juvenile justice system makes it difficult to write one “script” that would be understandable or appropriate for all developmental levels. Moreover, conditions are different from one juvenile justice agency to another. Some may strictly limit how mental health screening data will be used, while others may have broader policies for who sees a youth’s MAYSI-2 results.

Below we provide a list of guidelines describing the types of information that should be included when introducing youths to the MAYSI-2, while leaving it to the agency and its staff to decide what is appropriate to say in addressing each guideline.

List of Things to Include in the Introduction

1. That the questions will help staff understand the youth better

Let youths know that you would like them to answer a set of questions that will help staff to understand them better. Describe them as questions about who they are—their thoughts and feelings about things or themselves. Tell them this includes about 50 yes-no questions. The youth should be told that this helps the staff learn whether they might have special needs that staff should know about. References to the MAYSI-2 as a test should be avoided as youth may think this means there are right and wrong answers to the questions.

2. Who will (or will not) see the youth's answers and use them for certain purposes

Youths should be told who will see their answers and/or scores. This may differ across agencies. For example, one agency might allow only agency staff to see the youths' answers and scores, so that they can determine whether the youth has special needs that require an immediate response for the youth's safety. Whatever the potential uses, the youth should be told about them. This does not have to be detailed, but it should be honest. It might include informing the youth that "this may go to an evaluator if there is a need to learn more about you." The agency's policy should clearly and specifically identify who will see the answers and scores. It should also be explained that this information will not be used to find them guilty or innocent but, will be used to determine if they may need assistance or services to help them deal with problems they may be experiencing. Pennsylvania state law (Act 109 of 2008) specifically prohibits the use of any statements or information obtained during screening, assessment or evaluation against the youth in a juvenile delinquency hearing or an adult criminal proceeding.

3. Voluntary nature of the MAYSI-2

Taking the MAYSI-2 is always "voluntary," in that youth may choose not to answer the questions and it is inappropriate to make their participation mandatory or to punish them for not answering. However, staff should encourage youth to cooperate so that more informed decisions can be made about them. The MAYSI-2 is routine (like other health and identity questions) and intended only for the youth's protection. The information is intended to help staff attend to youths' immediate safety and needs.

4. Check for special needs of youth in completing the procedure

Once the youth is ready to take the MAYSI-2, staff should assist the youth in getting started. If the program uses MAYSIWARE, this is a matter of entering the youth's background information in the computer and then, after putting the headphones on the youth, sitting with the youth while the computer program is giving the youth the initial instructions about answering the questions on the keyboard. The staff person then steps aside when the youth begins to respond, so that the youth does not feel that the staff person is looking at the responses.