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Using Implementation Outcomes to Inform Implementation of Suicide Risk Screening with Juvenile Legal-Involved Youth: Considerations for Task-Shifting Suicide Screening to Juvenile Legal Staff

Kathleen A. Kemp^{a,b}, Casey A. Pederson^c, Margaret Webb^{d,e}, Alyssa Vieira^f, Anthony Spirito^a

^aDepartment of Psychiatry and Human Behavior, Alpert Medical School, Brown University, Providence, Rhode Island, USA

^bBradley-Hasbro Children's Research Center, Rhode Island Hospital, Providence, Rhode Island, USA

^cDepartment of Psychiatry, Indiana University School of Medicine, Indianapolis, Indiana, USA

^dDepartment of Psychology, College of Humanities and Social Science, George Mason University, Fairfax, VA

^eDepartment of Criminology, Max-Planck Institute for the Study of Crime, Security, and Law, Freiburg im Breisgau, Germany

^fDepartment of Psychology, University of Houston, Houston, Texas, USA

Abstract

Background: Youth in the juvenile legal system (JLS) are at increased risk for suicidal thoughts and behaviors.

Objective: Examine the acceptability, feasibility, and appropriateness of imbedding suicide screening and intervention in the JLS.

Method: The current study involved formative semi-structured interviews with key JLS stakeholders ($n = 37$) from two states, one in the Northeast and one in the Midwest, to determine whether suicide screening and intervention could be integrated into the role of juvenile probation officers. Stakeholders discussed perspectives on the acceptability (perceived JLS staff comfort with suicide screening and a brief intervention), feasibility (improving comfort of staff, youth, and families), and appropriateness (perceived impact on youth and families).

Results: Qualitative data suggested acceptability of suicide screening was mitigated by staff comfort and perceived support of available clinical resources. Feasibility of improving staff comfort to conduct suicide screening and a brief intervention revolved around logistical, training,

Contact Information for Corresponding Author: Kathleen Kemp, Ph.D. Bradley Hasbro Children's Research Center, 1 Hoppin Street, Rm 2.104, Providence, RI 02903, Fax: 401 444-4645, Kathleen_kemp@brown.edu.

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and supervisory support. Barriers to the appropriateness of suicide screening and intervention with youth in the JLS suggest concerns about how youth's distrust of the JLS and mental health stigma might impact engagement in suicide screening and intervention efforts.

Discussion: We conclude with implementation strategy considerations to enhance successful suicide screening and intervention by JLS staff.

Keywords

suicide screening; juvenile legal system; qualitative interviews; task-shifting; youth

Introduction

Youth suicide has been a rising critical public health concern since 2011. Alongside a recent increase in the prevalence of mental health disorders among youth in the United States (deemed a “mental health crisis;” Maslowski, 2021), suicide rates among youth have also risen significantly (52% from 2000 to 2021; Centers for Disease Control [CDC], 2023). Risk of suicide is especially great among youth who are involved in the juvenile legal system (JLS) and increases with deeper involvement in the legal system, defined by more serious and frequent charges (Gray et al., 2002; Wasserman & McReynolds, 2006). Approximately 19% of youth in the community report having *ever* experienced suicidal ideation (Underwood et al., 2020) whereas at the beginning of the JLS pipeline, an estimated 10–20% of youth report experiencing suicidal ideation in the *past 6 months* (Abram et al., 2008; Cauffman, 2004; Kemp et al., 2020). For those youth more deeply involved in the system, this rate is amplified. A recent epidemiological study of youth on probation found that 30% reported some level of suicidal ideation (Kim et al., 2021) and estimates have found that as high as 52% of youth in detention report suicidal ideation in the *past 2 weeks* (Esposito & Clum, 2002).

Given these concerning data, the need for suicide screening and intervention at every contact point in the JLS has been endorsed by clinicians and policymakers alike (Kemp et al., 2016; National Action Alliance for Suicide Prevention, 2013; Scott, et al., 2015; Stokes et al., 2015). Most research on suicide intervention among JLS-involved youth has focused on youth in detention (Casiano et al., 2013; Rudd et al., 2022). Yet, probation is the most common disposition for youth in the JLS (Development Services Group, Inc., 2017). Juvenile probation represents an understudied and particularly high-risk point of system contact. When placed on probation youth remain in the community, under the supervision of a juvenile probation officer (JPO) who ensures they abide by certain rules and conditions. While remaining in the community has clear benefits in keeping youth connected to their social supports, youth who remain in the community on probation remain underserved – estimates suggest only 20% of court staff and JPOs screen for suicidal thoughts and behavior (Braverman & Murray, 2011) and only ~25% of youth on probation receive appropriate treatment (White, 2019). Simultaneously, these youth may live in the contexts that have contributed to their mental health issues (familial disruption, school disconnectedness, physical abuse, community violence, etc.; Hoge, 2002; Schwalbe, 2007; Wiebush et al., 1999), and have greater access to means for suicide than youth in detention (Wasserman et

al., 2003). Effective practices for suicide screening and intervention with youth on probation are therefore an essential part of reducing suicide among JLS involved youth.

For all youth who report suicidal thoughts and behaviors, the safety planning intervention has been identified as a best practice response by the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org) and is used widely across a variety of contexts (Scott, et al., 2015; Stanley & Brown, 2012). The safety planning intervention is a brief, stand-alone intervention based on cognitive-behavioral principles in which youth identify warning signs of an imminent crisis and develop a concrete list of coping strategies and social supports that they can utilize preceding or during a crisis, as well as ways to keep their environment safe. In some versions of the plan, youth also identify their key reasons to keep living (e.g., things they are looking forward to in the future, important relationships). The safety plan is then shared with the youth's guardians to help ensure the plan can be implemented (guardian involvement is particularly relevant for discussion of keeping the environment safe). As implementation of the safety plan is simple and brief, it has been flagged as a potential solution for the limited time and resources afforded by the JLS (Kemp et al., 2021a; Kemp et al., 2021b; Scott et al., 2015) and preliminary research on the efficacy of safety planning among youth on probation suggests that youth find the intervention to be both useful and acceptable (Kemp et al., 2021a).

Currently, screening and intervention practices in juvenile probation rely primarily on the "assess and refer" approach (Stanley & Brown, 2012; Vilhauer et al., 2004). With this approach youth are screened for mental health concerns by JLS staff using measures like the MAYSI-2 (Massachusetts Youth Screening Instrument-2; Grisso & Barnum, 2006) and are then referred to community services based on risk levels indicated by the screening tool. Youth and families have criticized this process due to the lack of responsiveness to and follow through on youth's imminent needs (Stanley & Brown, 2012). Unfortunately, clinicians receiving JPO referrals are often too overburdened to be able to respond to youth crises in an acceptable or useful time frame (O'Neil et al., 2019). As a possible solution to this bottleneck in services, it has been proposed that JPOs implement screening and intervention on a systematic and continual basis with youth in the community (Meza et al., 2022). Such an approach has been coined 'task-shifting' and has been recommended for use across JLS settings (Sheidow et al., 2020). Task-shifting would train and utilize non-clinical staff in the JLS, such as JPOs, to identify youth needs and provide necessary in-the-moment brief interventions. The safety planning intervention, specifically, has already been shown to fit well into a task-shifting approach to suicide prevention at earlier points of contact within the JLS (e.g., diverting youth away from court involvement to diversion programming; Kemp et al., 2021b). Given the success of task-shifting to JPOs in other domains (e.g., substance use intervention; Rudes, 2021, Sheidow et al., 2020; motivational interviewing; Clark, 2005; risk needs responsivity assessments; Vincent et al., 2012), there is clear potential for a task-shifting approach to suicide prevention to also work well at this point of JLS contact.

There remains some concern around whether non-clinical staff feel confident and comfortable with administering suicide assessments and assessing risk level. Some prior

studies demonstrated that when suicide assessment was task-shifted to probation officers, a sizeable minority (25–40%) did not feel competent in conducting the assessment (Vilhauer, et al., 2004; Wasserman et al., 2009). Ensuring that JPOs feel competent in conducting suicide assessments is critical as this competency predicts uptake of new interventions (Damschroder et al., 2009) and has clear down-stream effects on whether youth are provided with appropriate care (Holloway et al., 2017; Scott et al., 2015). A study evaluating JPOs perceptions of evidence-based practices (EBPs) found support to be extremely limited (8% of those surveyed) and suggested that this may be due to incorrect or incomplete implementation of the treatments resulting in a lack of promised effectiveness, as well as undereducation on *how and why* certain treatments are found to be effective (White, 2019). Results therefore suggest that adequate training on how and why suicide screening and safety planning should be implemented is key. This sentiment is echoed in official policy recommendations from the National Action Alliance for Suicide Prevention (NAASP) which state that all staff responsible for implementing screening and assessment tools should be trained about the purpose of such tools, how to understand and interpret the results, and how to appropriately follow-up after receiving certain scores (NAASP, 2013).

Effective implementation of EBPs into real-world care settings requires intentional evaluation of what strategies are required to achieve successful uptake of the EBP while ensuring client care outcomes. The Conceptual Model of Implementation Research (CMIR) provides a useful framework for conducting this kind of evaluation (Proctor et al., 2009). Within the CMIR, relevant outcomes are split into implementation outcomes (e.g., feasibility, accessibility), service outcomes (e.g., effectiveness, timeliness), and client outcomes (e.g., symptoms, satisfaction; Proctor et al., 2009). Categories of outcomes and implementation strategies are each interrelated. For example, poor uptake may drive use of a different implementation strategy. Similarly, increasing perceived appropriateness may improve acceptability which may, in turn, improve sustainability (Proctor et al., 2011). The differentiation of implementation outcomes from treatment outcomes is critical when deploying an EBP in a real-world setting as it allows for discrimination of whether a failure to observe expected results is due to inefficacy of the EBP in the new setting or due to a failure of implementation (Proctor et al., 2011). A focus only on treatment outcomes discounts the role of contextual factors that are critical to successful implementation of EBP.

For early adoption of an EBP, the CMIR recommends a focus on evaluating contextual factors related to acceptability, feasibility, appropriateness, and implementation cost (Proctor et al., 2011). *Acceptability* refers to the stakeholders' sense that the EBP reflects the organization's goals, values, and needs and fits well enough into their work environment. *Feasibility* refers to the extent to which the EBP can effectively be carried out in an organization, given context, resources, etc. *Appropriateness* refers to the perceived fit, usefulness, and relevance of the EBP. *Implementation cost* refers to the cost-benefit balance or cost-effectiveness of the EBP.

Often, organizations adopting EBPs are complex and involve multiple levels of stakeholders. Within the CMIR, gathering perspectives from all relevant stakeholders is necessary for a comprehensive evaluation of factors that may affect implementation outcomes and potential implementation strategies. Formative evaluation interviews can be an effective way of

evaluating early adoption contextual factors (e.g., acceptability, feasibility, appropriateness, and implementation cost), by working directly with stakeholders in the organization to identify potential influences on and roadblocks to implementation of the policy change (Proctor et al., 2011; Stetler, et al., 2006). In a JLS setting, this approach has rarely been used, despite clear advantages to be gained from better understanding the provisions and limitations of structure and resources of the JLS.

Understanding the context of a policy or practice change is especially important when implementing new health-related practices and policies. It is often the case that EBPs which prove effective in research settings, do not successfully translate to real-world patient care due to “blockages” in infrastructure or staff execution (Bauer et al., 2015). Pre-implementation interviews with stakeholders allow researchers to better understand where potential blockages might arise in implementing interventions and to identify solutions to these issues (Elwy et al., 2020). These interviews may also allow researchers to draw unique insights from stakeholders on implementation beyond clinician related factors, such as what obstacles and barriers to treatment might be present for the youth and families receiving the treatment. Research evaluating the implementation of safety planning in non-JLS settings has highlighted the importance of conducting interviews with relevant stakeholders for these precise reasons, reporting that valuable information is gained regarding the acceptability of a safety plan and facilitators and barriers to intervention (Kennard et al., 2015; Kodish et al., 2019; Niner et al., 2009). Given the complex factors affecting JLS-involved youth’s engagement with mental health treatment and the multifaceted relationship between JPOs and the youth that they work with, it is essential that research assessing the acceptability and feasibility of safety planning in probation be done prior to implementation.

Present Study

Guided by the framework of the CMIR, the current study aimed to leverage formative evaluation interviews with stakeholders at multiple levels of the JLS to assess whether suicide screening and intervention could be successfully integrated into the role of JPOs. Through these interviews, valuable information on the acceptability, feasibility, and appropriateness of the proposed implementation of suicide screening and safety planning with JPOs has been obtained. Three primary implementation outcomes were assessed: (1) *Acceptability*, which assessed the perceived fit and comfort of conducting suicide screening and intervention by juvenile legal staff; (2) *Feasibility*, which evaluated juvenile legal staff perceptions of how to effectively improve implementation of suicide screening and intervention; and (3) *Appropriateness*, which examined the perceived relevance and comfort of families and youth receiving suicide screening and intervention by juvenile legal staff specifically. Each outcome examined which implementation strategies –resources, support, etc. – would be necessary for successful implementation.

Materials and Methods

Participants

Court staff and community providers from two states, one in the Northeast and one in the Midwest, were presented with the opportunity to participate in qualitative interviews. The

37 participants came from a range of institutions including community-based providers ($n = 9$); juvenile probation department administrators ($n = 4$) and probation officers ($n = 11$); residential program and detention center staff ($n = 3$); and various other JLS staff including police officers ($n = 2$), public defenders ($n = 2$), as well as juvenile court diversion staff, administrators, and mental health clinic staff ($n = 6$). Seventy-three percent ($n = 27$) of the participants were from the Northeast state. Participants were 57% ($n = 21$) female.

Systems Context

Participants in this study come from a wide variety of points of contact within the JLS because youth encounter professionals at many different agencies within the JLS as well as many other separate agencies related to their legal involvement. The Sequential Intercept Model (SIM; Abreu et al., 2017; Griffin et al., 2013; Munetz & Griffin, 2006) was utilized to capture perspectives from individuals working across different intercepts which JLS involved youth may contact. These different intercepts are broken down into Intercept 0: community-based treatment, crisis call lines, schools; Intercept 1: law enforcement (e.g., police officers), emergency services (e.g., 911, ambulance); Intercept 2: first court contact, diversion programs, initial detention; Intercept 3: juvenile detention (post-adjudication), specialty courts; Intercept 4: community-based placements, re-entry; Intercept 5: probation. The goal was to capture experiences with, and perception of needs for, suicidal youth who have JLS involvement across these different intercepts. Particular attention was paid to identify individuals from Intercepts 1, 3, and 5 as a prior review showed them to be particularly relevant to JLS populations (Heilbrun et al., 2017). Because youth involved in the JLS span across all these intercepts, it is important to understand the level of training, competence, comfort, and openness to change that these institutions have regarding screening, prevention, and intervention for suicidality among justice involved youth. We also assessed which intercept participants believed was the best place to target prevention and intervention efforts.

Description of Proposed Intervention. The safety plan, for youth who were not acutely suicidal, described in this study, was developed by Stanley and Brown (Stanley & Brown, 2012) and then adapted for youth (Brent et al., 2011; Wolff et al., 2018). The interviewer explained to stakeholders that the proposed intervention, safety planning, was a one session individual- and family-based intervention. During the intervention, youth complete a structured safety plan worksheet designed to create a practical plan with a list of coping strategies, social supports, and help-seeking resources that a youth can use before or during a crisis. Restricting access to lethal means, particularly firearms, is also part of the safety plan. Caregivers are introduced to the plan by the youth with staff support. Sessions take from 30 to 60 minutes.

Procedure

All protocols and procedures were approved by the associated hospital's institutional review board. In the Northeast state, eligible participants participated in a Sequential Intercept Model mapping to identify current services, gaps, and opportunities to deflect and divert youth with mental health issues from the juvenile legal system during which research staff described the goal and purpose of the study. In the Midwest state, during

in-person or virtual staff meetings, research staff described the goal and purpose of the study. Participants then self-selected by completing a “consent-to-contact” form if they were interested in learning more about the study and scheduling an appointment. Study staff then reached out to interested participants to schedule a time for the interview at their earliest convenience. Everyone interested in participating in the study did so. Written informed consent was obtained during the appointment, prior to the interview beginning. Interviews were conducted by a master’s level clinician and took place in-person in a private room or via HIPAA compliant tele-conferencing software according to COVID-19 research procedures.

Participants took part in semi-structured individual interviews which were audio-recorded. Participants were asked about their current and prior experience with suicide screening, their comfort surrounding screening, when they think screening should take place (in which intercept), their interest in training for suicide screening and prevention, and perceived barriers. Each of these topics were addressed in the same order, however, the nature of the semi-structured interview allowed participants to elaborate on topics when they had additional comments (Willig, 2013). The interviews took up to one hour and participants were compensated with a \$30 visa gift card for their time. Some participants were unable to accept the gift cards because state legislation aimed at maintaining neutrality barred funds from outside sources. For these participants, their gift-cards were donated to organizations that served the needs of the families involved with the court.

Measures

Semi-structured formative evaluation interviews: The interviews centered around experiences with suicidal youth in the JLS, including perceptions on the acceptability and feasibility of suicide screening at different points across the JLS intercepts. Questions regarding current practices for suicide and mental health screening were asked and included questions about what measures, if any, were used and when the screening takes place. Further staff acceptability of screening for suicide as well as staff, family, and youth comfort regarding screening was assessed. Questions also probed for history of prior suicide prevention training received at, as well as outside of, their current institution. Participants were asked about their interest in, and thoughts on, the importance of future training in suicide screening. Further, perceived acceptability and interest in future training for conducting a brief suicide intervention, such as safety planning was assessed. Additionally, questions probed about prior experiences with youth suicidal thoughts and behaviors, inside or outside of the system. For each section, barriers (i.e., logistic- or resource- based) were assessed and ways to overcome these challenges were discussed.

Data Analysis: All audio recordings were transcribed and de-identified via a transcription service. Transcriptions were then reviewed by one research assistant to assure quality and accuracy as well as to review de-identification procedures for thoroughness. The software program NVivo 12 was then used for data organization, coding, and analysis (QSR International, 1999). NVivo 12 is a secure, desktop application that allows researchers to upload qualitative data in a variety of different mediums, such as full transcription files,

audio recordings, and videos, to sort data utilizing user-defined codes. This allows for easier detection and appraisal of common themes.

A combination of deductive and inductive consensus coding was used to analyze the transcriptions. Before beginning to code the interviews, the researchers worked together using a deductive approach to create a coding matrix to cover the main topics of the research questions asked during the interview. This matrix included codes separating sections of the interviews by topics, such as if certain protocols (i.e., screening, training) were present or absent in addition to the valence (i.e., positive, neutral, or negative) of insights, such as comfort and acceptability of current and proposed procedures. In addition to this predetermined approach, an inductive approach was also used to account for the occurrence of unanticipated codes that still held high relevance to the overall scope of the project given the semi-structured nature of the interview (Fereday & Muir-Cochrane, 2006; Hsieh & Shannon, 2005). During regular bi-weekly meetings, an average of five coders, including the study's first author, read and simultaneously coded each transcript using the predetermined coding matrix and approach described above. As additional codes emerged or were collapsed using the inductive process, the coding matrix was adapted, and any affected coded transcripts were recoded to adhere to the new structure. For example, many codes related to different types of comfort with suicidal risk screening were collapsed due to similarities that emerged. This process continued until all transcriptions were coded. When disagreements emerged, the section was discussed among the group until consensus was reached. Codes were simultaneously recorded within the transcription document and in the NVivo software. Upon completion of coding, a research assistant checked that the transcription documents coded by other analysts were consistent with the NVivo document. The NVivo software made it accessible to examine common themes across transcripts. Quotations that are representative of study participant's perspectives are provided for each research question. Quotations were edited for length and to enhance readability.

Results and Discussion

Acceptability: Juvenile legal staff comfort conducting suicide screening

Participants' perceptions of staff comfort asking about suicide were diverse, ranging from participants who identified several barriers to comfortability, while others expressed that they were already comfortable conducting suicide screening. Although responses were diverse, the most predominate themes were around feasibility, such as discomfort asking questions about suicidal risk and not having enough training to adequately assess suicidal risk and make subsequent clinical decisions. Generally, participants indicated that suicide was a sensitive topic that they did not know how to manage. Participants seemed familiar managing other clinically related topics with youth, but suicidal risk seemed to be considered differently. Participants noted other types of screening and assessment that occurred in their setting, such as general mental health screening (e.g., MAYSI-2), criminogenic needs assessments (e.g., Structured Assessment of Violence Risk in Youth [SAVRY]; Bartel, et al., 2002), and discussion of general life stressors; all of which might include suicidal risk but do not solely focus on the assessment of suicidal risk.

This discomfort seemed to be most closely related to their real or perceived lack of knowledge and training regarding what should happen following the disclosure of suicidal thoughts or behavior. One participant noted that even staff with a clinical degree, such as social work, might not have received training on how to ask about and manage suicidal risk. Overall, participants noted a lack of confidence in making clinical decisions following disclosure of suicidal thoughts and behavior, which might include decisions regarding the appropriate level of care (e.g., suicidal risk warranting hospitalization). It was even suggested that this concern about appropriate follow-up might prevent individuals from completing comprehensive screening because they were afraid that they will not know how to respond to a youth's disclosure of suicidal thoughts.

I mean the fact that they might say, 'Yes, I am suicidal,' makes people really uncomfortable because then they have to act. And they might not always know how to act. 118

...workers feel like, "Okay, I'm gonna ask this question, and I don't know what to do with it, and nobody's gonna help me out, or bail me out of this, like, I'm not gonna ask the question. I'm gonna ask the question, 'You're not suicidal, right?' rather than, you know, ask an open-ended response. 109

Other themes regarding staff discomfort included concerns about adding suicide screening into their existing workflow, including whether individuals viewed screening for suicide as consistent with their role within their organization. Participants noted that changing any part of the workflow of certain positions would likely result in considerable pushback.

Many participants expressed ambivalence about staff comfort and acknowledged that the level of comfort might change over time and with experience. In essence, those that expressed more neutral views regarding staff comfort noted individual differences in comfort would depend on the qualifications and/or experience of JLS staff providing the screening. In some ways, this acknowledgement of differences in staff comfort over time put previously mentioned concerns in perspective. Namely, that asking about suicide and subsequently addressing risk is a skill that can be acquired rather than a static quality that cannot be changed.

I will say, I think new staff coming in maybe feel—like, it takes a little bit for them to get a little comfortable. But the more and more they do them [suicidal risk screenings] and the more and more they observe other veteran staff do this... I think that comfortableness comes with time for anyone. 134

The importance of having additional experience and training was further emphasized by participants that expressed more positive views of staff comfort. Staff who seemed to express the most positive views of staff comfort already had experience screening for suicide themselves. Consistent with other participants who were more hesitant to endorse comfort asking questions about suicidal risk, these participants also acknowledge the importance of experience in developing comfort.

Feasibility: Improving comfort of juvenile legal staff to conduct suicide screening and brief intervention

Suggestions for improving the comfort of JLS staff were primarily logistical in nature and focused on identifying clear and specific supports for staff as they complete the screening process. The primary barrier identified by participants was the capacity to meet screening needs. Concerns seemed to center around adding additional responsibilities to already overburdened staff. Participants who commented on staff capacity to complete screening noted the impact that burnout can have on the staff's ability to provide high quality services. It was acknowledged that staff conducting the screening would need to have sufficient skills to be effective, namely training in the provision of appropriate suicide risk screening and follow-up. Challenges could be further exacerbated by having only a few staff with the skills necessary to complete high-quality suicide risk screening. Similarly, caregiver availability and adequate space and/or technology to complete the screening could be complicating factors.

...the availability of staff, space to do those interventions, the importance of those interventions. Some individuals may not fully believe, and making sure that the people providing those interventions are able to provide quality treatment, and they're not being spread too thin, I think, if an individual's spread too thin, it may decrease their ability to be fully present with the individual and provide quality intervention. 110

I do think, first and foremost, resources. So, obviously, if we don't have enough bodies- to be able to do the screen, and people who are well-trained in it; they might be missing key things. 109

Participants also mentioned that the qualities of the suicide screening tool can facilitate implementation. In particular, the importance of having a standard screener *available* to assist in suicide risk screening was noted as well as ensuring the selected screener is simple, short, and specific. The importance of assessing for suicidal risk by asking multiple, varied questions that are developmentally appropriate was noted as important, suggesting that discussing answers to different questions related to suicide risk can provide a more thorough assessment. Another participant indicated that providing screeners in the youths' preferred language was necessary and that their organization is often limited to only English or Spanish.

Having official policies and procedures in place to support suicidal risk screening also seemed to be important. For instance, a participant mentioned difficulties giving and sharing information can arise related to the youth's legal case (e.g., pre-adjudication, adjudicated). Another noted that creating an official policy was necessary for compliance with screening. These comments seem to acknowledge the influence of system-level factors that make it logistically impossible to gather and share information both across and within systems. Similarly, other participants noted the importance of clinical infrastructure in successfully completing screening. Comments seemed to reflect that staff believed having clinical support either onsite or on-call was critical for successful screening in their setting. These comments also seemed to reflect the importance participants placed on immediate

decision-making (e.g., deciding the appropriate level of care) and appropriate follow-up (e.g., connecting to mental health services.)

Further, participants viewed more and ongoing training as critical to addressing barriers and improving their comfort in administering suicide risk screening tools. Overall, participants felt that staff were open to training and felt that training is what they needed to feel comfortable with screening. In addition to initial training on suicide screening, participants suggested other elements that might enhance learning, including ongoing clinical support and supervision, offering positive reinforcement for completing screenings and attending booster training sessions. It was suggested that in addition to learning how to administer screening, it would be important to provide training on appropriate follow-up (e.g., finding appropriate services). Experiential learning was also noted as being useful for training, including engaging in role plays. Another noted the importance of continuing to use skills following the training, which could be accomplished in multiple ways (e.g., booster trainings, having cases to screen subsequent to training).

Appropriateness: Family comfort with suicide screening and intervention by juvenile legal staff

Participants readily acknowledged that caregivers were not a monolith and could have a range of reactions to the screening process, including finding the information predictable. That is, some caregivers might already be aware that their child is experiencing suicidal thoughts making discomfort with the screening process unlikely. In fact, another central theme was that caregivers had a general openness to hearing about suicidal risk and seeking services. Thus, while some families might be uncomfortable with the screening process, the majority were receptive to screening and what JLS professionals recommend as next steps (i.e., seeking services).

So I would say, majority of the time, our parents are very open, receptive to us, um, discussing, like, the results with it and that your kid has these concerns, and we really believe that your kid needs these services. 134

More than not, the parents were more supportive in regards to making sure that the kids are getting the services that they need. 136

Involving families in risk management made some staff uncomfortable despite acknowledging the importance of parent buy-in to successful screening. Caregivers minimizing suicidal risk seemed to be particularly concerning for staff. Participants also thought that caregivers might view the youth's expression of suicidal risk as an instrumental behavior used to avoid consequences for their actions or otherwise manipulating staff and caregivers to do what they want.

“Hey, this will pass.” You know what I mean? So, lack of knowledge. Or I think a barrier is, like, “I don't take it seriously enough.” Or, it's like, “Oh, yeah. He says that every day.” Or, you know, “If you were really suicidal, you wouldn't say it.” I mean, there's all kind of—I think the barriers are just, like, not taking it seriously. Not—having a bunch of wrong ideas about it. Sort-of, like, misconceptions? 102

To a lesser extent, concerns about mental health stigma were noted as a barrier to family comfort with screening. Participants felt that some caregivers might be hesitant to allow their child to engage in screening due to stigma and related concerns that they would be blamed for their child's suicidality. Comments seemed to be suggestive of perceived caregiver burnout that might occur when youth have longstanding behavioral difficulties and/or families otherwise live in stressful circumstances (e.g., poverty). Participants felt that challenges presented by caregiver burnout might affect their willingness to engage in the screening process and respond appropriately to risk management suggestions that arise from a subsequent intervention. Logistically, participants felt that caregivers might be unwilling to take the time needed to complete the screening as they could be busy with other appointments or believe that their child does not have mental health issues making screening unnecessary.

Caregivers' discomfort with or unwillingness to engage in suicide risk screening could be compounded by the distrust caregivers might feel for the JLS and its workers. One participant suggested that parents' own mistrust of the juvenile or criminal legal system might make them uncomfortable with their children being screened. Similarly, they noted caregiver discomfort could be further compounded by cultural differences between the predominantly white juvenile legal staff and people of color, noting specifically the challenges of working with undocumented youth.

Appropriateness: Perceived impact of suicide screening and intervention by juvenile legal staff with youth

Participants indicated that youth's distrust of JLS staff and mental health stigma as primary reasons that youth might be uncomfortable with suicide risk screening. Comments reflected that youth might be unsure of how their responses will be used within the system and/or whether their responses could have consequences for their case. In addition to distrusting the system, participants acknowledged that individual interactions between JLS staff and youth also impacted comfort. For instance, in JLS settings, staff might not have the benefit of developing strong, collaborative relationships with youth before asking screening questions, and youth might not be comfortable sharing personal mental health information with individuals they view as in opposition to their interests (e.g., ending JLS involvement).

I think it's more about them not trusting the people doing the screening, them not knowing, um, where the information will go, them maybe not wanting to appear vulnerable in front others. 114

Participants also noted the role of mental health stigma influencing youth's decision on whether to disclose suicidality. Comments reflected that youth did not want people in their life, especially parents, to know that they are experiencing suicidality. Participants linked the stigma associated with suicide to the belief that youth involved in the JLS want to be perceived as "tough." To be experiencing suicidal thoughts and behaviors and then sharing those thoughts and/or behaviors with others might be perceived to show "weakness, or a sensitive side." Participants also noted that having parents in the room while conducting screening adds to this discomfort and suggested that stigma might be worse for males than

females. It was indicated that male youth seem to be less likely to share their feelings with staff.

I think stigma is a big one. Um, the, you know, “I don’t want my family to know I’m suicidal.” “I don’t want, um, [you know] um, my teachers, or the other students at school to know I’m suicidal. 102

Another theme that emerged was that youth might avoid or be uncomfortable sharing suicidal thoughts and behavior with staff because they are concerned about being sent to a higher level of care. It was noted that going to a hospital setting was an undesirable outcome that youth could successfully avoid if they chose not to disclose suicidal thoughts or behavior. Similarly, it was noted that youth might also think that there could be legal ramifications for disclosing suicidal thoughts and/or behavior, including being detained.

“...kids have this idea that, ‘if I say that I’m suicidal or I’ve thought about suicide, I’m going to get in more trouble or I’m going to have to be locked up’... so I—certainly, I think that that’s a barrier.” 130

Again, participants noted that youth could have a range of reactions to the screening process, thus clarifying that screening would not be a universally adverse experience for youth. Participants shared several ideas regarding factors that impact a youth’s comfort with the screening process, including whether they have been involved in the JLS before, their rapport with the staff member, and the timing of when the screening is administered. Several participants noted that youth might not provide accurate responses, such that they will disregard the questions on the screening by providing the same answer for all the questions (e.g., all yes’s or no’s). While this type of responding was a concern for participants, many indicated that youth were agreeable to screening.

I know there are kids that they could care less, and they come in here and do just click yes or no to answer. ‘Cause the ones that have been here before, uh, they just wanna get outta here as soon as they can. They know when they’re done with the assessments, we typically call the parents. But in other times, when we do have kids that... are just really down on themselves, they actually answer honestly. And then when we have that second strain, they’re as open as they wanna be with us but still, like they still hold back. So I mean, in regards to that, I would say 70 percent of the time, it’s pretty effective. 136

In fact, another theme that emerged was that youth were generally agreeable to screening and were honest in their reporting.

Feasibility: Improving the comfort of youth and their families

Participants noted they could take several actions to would improve the comfort of youth and families involved in the screening process. Most notably, throughout the interviews, participants emphasized the role that they and their colleagues play in ensuring the comfort of the youth and families they serve. Repeatedly, participants emphasized the importance of using interpersonal skills and good communication to improve family comfort. The interaction style of the staff performing the screening was featured most prominently. Participants noted the importance of building rapport with the youth and

families. Motivational interviewing as well as engaging in an honest and genuine way with youth were both mentioned as ways staff can try to build close, productive relationships with youth and families. Similarly, participants noted that some staff within the JLS view youth as “bad kids” who need to be appropriately reprimanded or punished for their wrongdoing. This view was discussed as being detrimental to building rapport with families and, thereby, detrimental to effective screening.

I mean, to me, it’s just being honest and genuine and being empathic to a kid. Yeah. The kid is here. He probably did something not so great to get here, but he’s still a kid. He’s still a human being and not—I think especially kids and adolescents, it’s so important not to prejudge and to just, kind of, come in and say, “Oh, you screwed up. You deserve what you got. You deserve to be here.” If you do that, you’re gonna get a kid that shuts down immediately. 122

Others noted that staffs’ beliefs of mental health and the ways that mental health might impact family functioning and justice involvement can also influence their interaction style and willingness to engage in the screening process in an effective way. For example, one participant noted other staff stated they “know the person better than they [the youth] know themselves,” and another staff suggested that requiring suicidal risk screening might be contrary to a staff’s “judgment” that suicidal risk screening is required for a particular youth. Similarly, another participant indicated that some staff might not take suicidal risk seriously, such that they believe expressed suicidal thoughts or behavior is simply attention seeking. Another comment reflected that staff might have misconceptions about suicide that prevent them from asking. For instance, the belief that asking about suicide might plant the idea in the youth’s head might prevent staff from engaging in screening. These comments imply that some staff might believe there is no need to ask the youth and families directly about suicide because they “know better” than to do so with these youth.

Participants felt that privacy while responding, including keeping parents out of the room, was useful in helping youth feel comfortable. It was also noted that the use of a screening tool was useful in facilitating youths’ comfort, rather than staff asking these questions directly in an interview format.

And so rather than me asking a lotta the questions, uh—the MAYSI, for instance. The-the Columbia suicide screener, I ask those questions. But when we’re deploying the MAYSI, we actually put the questions, um, up on a huge touch-screen, and the kids are actually able to select their answers. I think that that helps the child be more upfront and honest. As opposed to me asking you ‘have you thought about harming yourself in the last 24 hours,’ you know. 128

Participants also noted the importance of conducting suicidal risk screening in a calm and comfortable manner (e.g., body language, tone of voice), as projecting discomfort might subsequently make youth uncomfortable with screening and keep them from disclosing suicidal thoughts or behavior. Preparing families for the screening process by providing thorough informed consent (i.e., limits of confidentiality) and using language that is accessible and easy for the family to understand were identified as key strategies in facilitating comfort with the screening process and possible outcomes.

Participants were also thoughtful about how they could respond to youth and families in a way that meets their preferred language and culture. Participants noted their inability to converse with youth who did not speak English as limiting their ability to perform screening and make families more comfortable. They also noted that being responsive to the cultural norms of the youth they are working with is a skill set that is beneficial to understanding and providing services to youth. Another participant noted that intellectual or developmental delays are also important to consider during the screening process.

Conclusions

The CMIR Framework highlights the interplay between implementation outcomes, such as feasibility, acceptability, and appropriateness, and implementation strategies to improve service outcomes, such as safety, effectiveness, and equity. In this study, JLS staff presented concerns about their comfort with conducting suicide risk screening and brief intervention as well as their anticipated comfort of youth and families. Despite the concerns raised, stakeholders offered several paths forward to address the concerns and offer the support required to sustainably implement suicide risk screening and intervention with a high-risk population.

At the organizational level, stakeholder feedback highlights the importance of using the exploration or preparation phase to identify the contextual supports needed for JLS staff to be successful. Thoughtful feedback from stakeholders directly experiencing day-to-day interactions with youth and families involved in the JLS was elicited about the logistical ways organizations can maintain an environment to enhance effective implementation and sustainment. Among the concerns, balancing current responsibilities with the anxiety of adding new responsibilities should not be underestimated in an already under-resourced system. Addressing logistical concerns regarding workflow for JLS staff may be critical, not only for addressing the feasibility of the intervention in a particular setting but also for garnering critical buy-in from staff to enhance implementation uptake. Yet, staff were clear about their desire to explore how to better support youth and families. Describing the role suicide risk screening and intervention has at the organizational level might help JLS staff understand the cultural relevance within their system.

Preparation and support at the initial stages of suicide risk screening and intervention might be key at the service or team level. While stakeholders emphasized the importance of having clinical support to complete suicide risk screening, it remains unclear what level of support is necessary and feasible for systems to sustain. Additional implementation research might be needed to determine whether different models of clinical team support (e.g., embedded clinician, virtual on-call clinician, co-responder clinician, clinician available for team processing of difficult cases) improve implementation and sustainment of suicide risk screening and intervention. Stakeholders highlighted that staff with more suicide screening experience report increased comfortability suggesting that team level supports may vary in the length of time required to adequately support implementation and sustainment.

Importantly, JLS participants highlighted that individual level factors beyond specific training for suicide risk screening and intervention might also improve implementation.

Perhaps taken for granted by clinicians, foundational interpersonal skills (e.g., rapport building, active listening) were noted to vary widely across JLS staff, though they recognized the importance of training (e.g., motivational interviewing) to improve not only suicide risk screening and intervention implementation outcomes, but other service outcomes as well. Finally, although mental health stigma was not a barrier among JLS staff participants themselves, as they recognized the importance of obtaining services for youth, participants expressed concerns about suicide myths and resistance persisting among caregivers in particular. Beyond interpersonal skills, suicide risk screening and intervention training would benefit from including these difficult but real scenarios which will help reduce staff anxiety and improve comfort and confidence.

Interviewing JLS staff across the system provided unique insights into factors that might impact implementation efforts to introduce suicide risk screening and intervention with JLS-involved youth. Public health approaches to suicide prevention, especially with an at-risk population of underserved and minoritized youth, require innovation to provide adequate access to needed suicide intervention services. The qualitative interviews conducted in this study add to our understanding of how to promote suicide risk screening and intervention when conducted within the JLS.

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References

- Abram KM, Choe JY, Washburn JJ, Teplin LA, King DC, & Dulcan MK (2008). Suicidal ideation and behaviors among youths in juvenile detention. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47(3), 291–300. 10.1097/CHI.0b013e318160b3ce [PubMed: 18216737]
- Abreu D, Parker TW, Noether CD, Steadman HJ, & Case B (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: *Intercept O. Behavioral Sciences & the Law*, 35, 380–395. 10.1002/bsl.2300 [PubMed: 29034504]
- Bauer MS, Damschroder L, Hagedorn H, Smith J, & Kilbourne AM (2015). An introduction to implementation science for the non-specialist. *BMC Psychology*, 3(1), 32. 10.1186/s40359-015-0089-9 [PubMed: 26376626]
- Braverman P, & Murray P (2011). Health Care for Youth in the Juvenile Justice System. *Pediatrics*, 128(6), 1219–1235. 10.1542/peds.2011-1757 [PubMed: 22123883]
- Bartel P, Borum R, & Forth A (2002). *Structured Assessment for Violence Risk in Youth (SAVRY)*. Tampa: University of South Florida.
- Brent DA, Poling KD, & Goldstein TR (2011). *Treating depressed and suicidal adolescents: A clinician's guide*. Guilford Press.
- Casiano H, Katz LY, Globerman D, & Sareen J (2013). Suicide and deliberate self-injurious behavior in juvenile correctional facilities: A review. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 22(2), 118–124. [PubMed: 23667357]
- Cauffman E (2004). A statewide screening of mental health symptoms among juvenile offenders in detention. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(4), 430–439. 10.1097/00004583-200404000-00009 [PubMed: 15187803]

- Centers for Disease Control and Prevention, National Center for Health Statistics. (2023). Multiple cause of death data on CDC WONDER. [Wonder.cdc.gov](https://wonder.cdc.gov). <https://wonder.cdc.gov/mcd.html>
- Clark MD (2005). Motivational Interviewing for Probation Staff: Increasing the Readiness to Change (Part I). *Fed. Probation*, 69, 22.
- Damschroder L, Aron D, Keith R, Kirsh S, Alexander J, & Lowery J (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*, 4, 50. 10.1186/1748-5908-4-50 [PubMed: 19664226]
- Development Services Group, Inc. (2017). Formal, Post-Adjudication Juvenile Probation Services. Literature review. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention https://www.ojjdp.gov/mpg/litreviews/Probation_Services.pdf
- Elwy AR, Wasan AD, Gillman AG, Johnston KL, Dodds N, McFarland C, & Greco CM (2020). Using formative evaluation methods to improve clinical implementation efforts: Description and an example. *Psychiatry Research*, 283, 112532. 10.1016/j.psychres.2019.112532 [PubMed: 31477261]
- Esposito CL, & Clum GA (2002). Social support and problem-solving as moderators of the relationship between childhood abuse and suicidality: Applications to a delinquent population. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, 15(2), 137–146. 10.1023/A:1014860024980
- Fereday J, & Muir-Cochrane E (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, 5(1), 80–92. 10.1177/160940690600500107
- Gray D, Achilles J, Keller T, Tate DF, Haggard LM, Rolfs RT, Cazier CF, Workman J, & McMahon WM (2002). Utah youth suicide study, phase i: Government agency contact before death. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41(4), 427–434. 10.1097/00004583-200204000-00015 [PubMed: 11931599]
- Griffin PA, Munetz MR, Bonfire N, & Kemp K (2013). Development of the Sequential Intercept Model: The search for a conceptual framework addressing criminal justice-behavioral health systems interactions. In Griffin P, Heilbrun K, Mulvey E, DeMatteo D, & Schubert C(Eds. 1), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness*. New York: Oxford University Press.
- Grisso T & Barnum R (2006). *Massachusetts Youth Screening Instrument-Version 2: User's Manual and Technical Report*. Sarasota, FL: Professional Resource Press.
- Heilbrun K, Goldstein NES, DeMatteo D, Newsham R, Gale-Bentz E, Cole L, & Arnold S (2017). The sequential intercept model and juvenile justice: Review and prospectus. *Behavioral Sciences & the Law*, 35(4), 319–336. 10.1002/bsl.2291 [PubMed: 28612513]
- Hoge RD (2002). Standardized instruments for assessing risk and need in youthful offenders. *Criminal Justice and Behavior*, 29(4), 380–396. 10.1177/009385480202900403
- Holloway ED, Cruise KR, Downs SM, Monahan PO, & Aalsma MC (2016). Juvenile Probation Officer Self-Assessed Mental Health Competency as a Predictor of Case Management Practices. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(4), 534–546. 10.1007/s10488-016-0734-5
- Hsieh HF, & Shannon SE (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277–1288. 10.1177/1049732305276687 [PubMed: 16204405]
- Kemp K, Tolou-Shams M, Conrad S, Dauria E, Neel K, & Brown L (2016). Suicidal ideation and attempts among court-involved, nonincarcerated youth. *Journal of Forensic Psychology Practice*, 16(3), 169–181. 10.1080/15228932.2016.1172424 [PubMed: 29142507]
- Kemp K, Webb M, Wolff J, Affleck K, Casamassima J, Weinstock L, & Spirito A (2021a). Screening and brief intervention for psychiatric and suicide risk in the juvenile justice system: Findings from an open trial. *Evidence-Based Practice in Child and Adolescent Mental Health*, 6(3), 410–419. 10.1080/23794925.2021.1908190 [PubMed: 34693005]
- Kemp K, Pederson CA, Webb M, Williamson S, Elwy AR, & Spirito A (2021b). Feasibility and acceptability of a brief suicide intervention for youth involved with the family court. *Behavioral Sciences & the Law*, 39(1), 26–43. 10.1002/bsl.2498 [PubMed: 33569818]

- Kemp K, Yurasek AM, Poindexter B, Webb M, & Tolou-Shams M (2020). Suicide screening among youth at first court contact. *Archives of Suicide Research*, 1–13. 10.1080/13811118.2020.1833795
- Kennard BD, Biernesser C, Wolfe KL, Foxwell AA, Craddock Lee SJ, Rial KV, Patel S, Cheng C, Goldstein T, McMakin D, Blastos B, Douaihy A, Zelazny J, & Brent DA (2015). Developing a brief suicide prevention intervention and mobile phone application: A qualitative report. *Journal of Technology in Human Services*, 33(4), 345–357. 10.1080/15228835.2015.1106384 [PubMed: 26977137]
- Kim B-KE, Gilman AB, Thompson N, & De Leon J (2021). Statewide trends of trauma history, suicidality, and mental health among youth entering the juvenile justice system. *Journal of Adolescent Health*, 68(2). 10.1016/j.jadohealth.2020.05.044
- Kodish T, Kim JJ, Le K, Yu SH, Bear L, & Lau AS (2019). Multiple stakeholder perspectives on school-based responses to student suicide risk in a diverse public school district. *School Mental Health*, 12(2), 336–352. 10.1007/s12310-019-09354-w
- Maslowski MB (2021) US Surgeon General’s Advisory: Protecting Youth Mental Health.
- Meza JI, Snyder S, & Shanholtz C (2022). Equitable suicide prevention for youth impacted by the juvenile legal system. *Frontiers in Psychiatry*, 13. 10.3389/fpsy.2022.994514
- Munetz MR, & Griffin PA (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57(4), 544–549. 10.1176/ps.2006.57.4.544 [PubMed: 16603751]
- National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). Screening and assessment for suicide prevention: Tools and procedures for risk identification among juvenile justice youth. Washington, DC: Author
- Niner S, Pirkis J, Kryszynska K, Robinson J, Dudley M, Schindeler E, De Leo D, & Warr D (2009). Research priorities in suicide prevention: A qualitative study of stakeholders’ views. *Australian E-Journal for the Advancement of Mental Health*, 8(1), 48–56. 10.5172/jamh.8.1.48
- O’Neil DS, Accordino MK, Wright JD, Law C, Nitta S, Buono D, Abbott M, Ustoyev Y, Hu J, Neugut AI, Hur C, Patel K, & Hershman DL (2019). Use of nonclinical staff to coordinate oral anticancer drug prescriptions. *Journal of Clinical Oncology*, 37(27_suppl), 72–72. 10.1200/jco.2019.37.27_suppl.72 [PubMed: 30339040]
- Proctor EK, Landsverk J, Aarons G, Chambers D, Glisson C, & Mittman B (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, 36(1), 24–34. 10.1007/s10488-008-0197-4 [PubMed: 19104929]
- Proctor E, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, Griffey R, & Hensley M (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(2), 65–76. 10.1007/s10488-010-0319-7 [PubMed: 20957426]
- International QSR (1999). NVivo qualitative data analysis software [NVivo 12]. Retrieved from <https://qsrinternational.com/nvivo/nvivo-products/>
- Rudd BN, George JM, Snyder SE, Whyte M, Cliggitt L, Weyler R, & Brown G (2022). Harnessing quality improvement and implementation science to support the implementation of suicide prevention practices in juvenile detention. *Psychotherapy*, 59(2), 150. 10.1037/pst0000377 [PubMed: 34472932]
- Rudes DS, Viglione J, Sheidow AJ, McCart MR, Chapman JE, & Taxman FS (2021). Juvenile probation officers’ perceptions on youth substance use varies from task-shifting to family-based contingency management. *Journal of Substance Abuse Treatment*, 120, 108144. 10.1016/j.jsat.2020.108144 [PubMed: 33298307]
- Schwalbe CS (2007). Risk assessment for juvenile justice: A meta-analysis. *Law and Human Behavior*, 31(5), 449–462. 10.1007/s10979-006-9071-7 [PubMed: 17211688]
- Scott M, Underwood M, & Lamis DA (2015). Suicide and related-behavior among youth involved in the juvenile justice system. *Child and Adolescent Social Work Journal*, 32, 517–527. 10.1007/s10560-015-0390-8
- Sheidow AJ, McCart MR, Chapman JE, & Drazdowski TK (2020). Capacity of juvenile probation officers in low-resourced, rural settings to deliver an evidence-based substance use intervention

to adolescents. *Psychology of Addictive Behaviors*, 34(1), 76–88. 10.1037/adb0000497 [PubMed: 31393146]

Stanley B, & Brown GK (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19(2), 256–264. 10.1016/j.cbpra.2011.01.001

Stetler CB, Legro MW, Wallace CM, Bowman C, Guihan M, Hagedorn H, Kimmel B, Sharp ND, & Smith JL (2006). The role of formative evaluation in implementation research and the QUERI experience. *Journal of General Internal Medicine*, 21(S2), S1–S8. 10.1007/s11606-006-0267-9

Stokes ML, McCoy KP, Abram KM, Byck GR, & Teplin LA (2015). Suicidal ideation and behavior in youth in the juvenile justice system. *Journal of Correctional Health Care*, 21(3), 222–242. 10.1177/1078345815587001 [PubMed: 26084946]

Underwood JM, Brener N, Thornton J, Harris WA, Bryan LN, Shanklin SL, Deputy N, Roberts AM, Queen B, Chyen D, Whittle L, Lim C, Yamakawa Y, Leon-Nguyen M, Kilmer G, Smith-Grant J, Demissie Z, Jones SE, Clayton H, & Dittus P (2020). Overview and Methods for the Youth Risk Behavior Surveillance System — United States, 2019. *MMWR Supplements*, 69(1), 1–10. 10.15585/mmwr.su6901a1 [PubMed: 32817611]

Vilhauer J, Wasserman GA, McReynolds LS, & Wahl R (2004). Probation officers' mental health knowledge and practices. *Perspectives*, 28(3), 28–32.

Vincent GM, Paiva-Salisbury ML, Cook NE, Guy LS, & Perrault RT (2012). Impact of risk/needs assessment on juvenile probation officers' decision making: Importance of implementation. *Psychology, Public Policy, and Law*, 18(4), 549–576. 10.1037/a0027186

Wasserman GA, Jensen PS, Ko SJ, Cocozza J, Trupin E, Angold A, ... & Grisso T (2003). Mental health assessments in juvenile justice: report on the consensus conference. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(7), 752–761. [PubMed: 12819434]

Wasserman GA, & McReynolds LS (2006). Suicide risk at juvenile justice intake. *Suicide and Life-Threatening Behavior*, 36(2), 239–249. 10.1521/suli.2006.36.2.239 [PubMed: 16704327]

Wasserman GA, McReynolds LS, Musabegovic H, Whited AL, Keating JM, & Huo Y (2009). Evaluating project connect: Improving juvenile probationers' mental health and substance use service access. *Administration and Policy in Mental Health and Mental Health Services Research*, 36, 393–405. 10.1007/s10488-009-0229-8 [PubMed: 19582568]

White C (2019). Treatment services in the juvenile justice system: Examining the use and funding of services by youth on probation. *Youth Violence and Juvenile Justice*, 17(1), 62–87. 10.1177/1541204017728997

Wiebush R, Wagner D & Ehrlich J (1999). Development of an empirically-based risk assessment instrument: For the Virginia Department of Juvenile Justice final report. Madison, WI: National Council on Crime and Delinquency.

Willig C (2013). *Introducing qualitative research in psychology*. Maidenhead, UK: Open University Press.

Wolff JC, Frazier EA, Weatherall SL, Thompson AD, Liu RT, & Hunt JI (2018). Piloting of COPES: An Empirically Informed Psychosocial Intervention on an Adolescent Psychiatric Inpatient Unit. *Journal of Child and Adolescent Psychopharmacology*, 28(6), 409–414. [PubMed: 29648874]