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The Oregon Mental Health Referral Checklists: Concept Mapping the Mental Health Needs of Youth in the Juvenile Justice System

Kevin Corcoran, PhD, JD

This article summarizes the development of checklists to identify the mental health needs of youth in the juvenile justice system. With concept mapping as its base, a 31-item checklist was developed in three parallel forms and assessed on three samples: youth in a locked correctional facility and parents and juvenile justice professionals of adjudicate youth who were sentenced to community service. The instruments appear to have acceptable to very good internal consistency and moderate to strong coefficients of equivalence. Total symptoms were associated with internal and external problems for youth, suggestions from a trusted friend that one might have a mental health problem, and various other mental health history variables for the youth version. The instruments appear to have acceptable to very good reliability and very good validity for the youth version; furthermore, they are useful in identifying acting-out crises and psychological crises, including harm to self, others, and property. [*Brief Treatment and Crisis Intervention* 5:9–18 (2005)]

KEY WORDS: adolescent mental health, juvenile justice, measurement tools.

The Oregon Mental Health Referral Checklists: Identifying the Mental Health Needs of Youth in the Juvenile Justice System

Practitioners in adolescent mental health and juvenile justice voice a need for a rapid assessment tool to identify the mental health needs of

adolescents. This is especially the case in juvenile justice settings, where behavioral problems are common and considerably more severe than clinical samples or samples from the general population (Achenbach, 1997; Coccozza, 1992). Concomitant with the mental health problems, youth in the juvenile justice system face a disproportionate number of crises, especially when first incarcerated or initiated into gang violence. Some crises common to youth in the justice system include harm to self, others, and property; psychotic symptomatology; running away; depression; and emotional lability, including angry outbursts.

Such an assessment tool should be available in three parallel forms for use by different

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sources for observing mental health symptomatology. The three sources of assessment should include self-observations by the youth and observations of the youth by the youths' parents and by professional staff members working with the youth. The reasons for these three sources of observations are that, one, some symptoms are best observed by the youth, such as affect or hallucinations; two, parents are a viable source, as they are likely to observe sudden or gradual behavioral changes in their child, even if subtle; and, three, professional staff members, of course, are a viable source for observations by way of mental status exams, clinical interventions, and evaluations of a client's progress in treatment. This article reviews the development and initial psychometrics of a 31-item checklist for use by youth, parents, and professional staff. The instruments are reprinted in the appendix.

Methodology

Instrument Development

The Oregon Mental Health Referral Checklist (OMHRC) was developed with a panel of 15 administrators and providers in mental health and juvenile justice.¹ The administrators comprised program directors and assistant directors from Oregon's mental health, juvenile justice, and children and family agencies. Among the providers were clinical social workers, probation officers, court counselors, and one child psychiatrist. The panel first generated a list of symptoms ($N = 84$) considered "typical" or "characteristic" of youth in the juvenile justice system; 16 were removed because they were

judged to be unobservable (e.g., a head injury) or were not relevant to mental health (e.g., hearing and vision problems).

The resulting 68 symptoms were then analyzed using concept mapping (CM), a statistical package including multidimensional scaling and cluster analysis (Trochim, 1989). CM is a quantitative process that facilitates the description of any idea or topic and then represents the idea in the form of a third-dimensional map. The procedures typically require the participants to brainstorm a set of statements or concepts; in this case, it was mental health symptoms of youth in the juvenile justice system. Participants then sort the statements or concepts into distinguishable groups and rate each on a relevant scale; in this case, it was a triage rating of the immediacy of needing a mental health referral, with scores ranging from 1 (*no need*) to 5 (*immediate need*).

These data were analyzed first with two-dimensional multidimensional scaling (MDS), which constructs a symmetric matrix of similarities by scoring items sorted into the same group as 1 and items in different groupings as 0. Scores are then summed across the number of raters for a total score, with the similarity matrix analyzed using nonmetric MDS analysis with a two-dimensional solution (Weller & Romney, 1988). The symptoms are then displayed on a two-dimensional space with more similar symptoms located closer together and with those less similar further apart.

The results of MDS configuration are then analyzed with hierarchical cluster analysis, and the average triage rating for each symptom is computed using Ward's algorithm (Everitt, 1980). The cluster analytic procedure, essentially, takes the MDS configuration of the symptoms and partitions them into nonoverlapping and distinguishable clusters. The average rating of each symptom is then calculated, and the results produce a three-dimensional map displaying the average ratings for all

¹The parallel forms of the OMHRC are not in the stream of commerce and are not intended for commercial sale. The OMHRCs are in the public domain and may be copied ad libitum.

symptoms and the averages for the separate clusters based on the symptoms in each cluster.

In summary, the CM procedure first displays each symptom on the two-dimensional plan, with similar symptoms located closer together than dissimilar ones. The distribution of symptoms is then analyzed with hierarchical cluster analysis to form distinguishable groupings. The ratings of each symptom on the 5-point triage scale are then averaged for the symptoms in the cluster, with the average rating forming the three-dimensional cluster map.

CM Results

Of the 68 mental health symptoms initially generated by the panel, the results of the MDS provide a point map with 11 meaningful clusters (Figure 1). For purposes of identifying youth in the juvenile justice that need mental health services, a 12-cluster solution was not meaningful as it simply distinguished a subset within the *antisocial/conduct* cluster. This distinction was not likely to facilitate referrals for mental health treatment as the symptoms were generally low on triage scores. Figure 2 illustrates the average triage rating for each cluster and the average of each symptom within the separate clusters.

The validity of the triage rating was estimated by comparing the scores from 15 members of the panel with the child psychiatrist's scores. It was asserted that a child psychiatrist's scores would form an appropriate comparison because of one's education, training, and specialized credentialing. The ratings of triage were extremely correlated ($r = .95$), indicating that there was 90% commonality between the scores by administrators and providers with the standard of the child psychiatrist. This finding suggests that administrators and providers in the juvenile justice and mental health systems

are very good at recognizing the triage needs of specific mental health symptoms.

The CM results are particularly meaningful for identifying mental health needs of youth in the juvenile justice system, as the distance between problems reflect symptoms germane to mental health in contrast to those germane to the juvenile justice system. The cluster at the far right of the plain in Figure 2 reflects social skill deficits, which have very low triage ratings; in contrast, the cluster at the far left reflects suicidality, which has high triage ratings. Symptoms more germane to the mental health system are distributed on the left of the map, with those of the juvenile justice system on the right-hand side. Additionally, the results are divisible on two dimensions: one ranging from internal symptoms at the top of the map (e.g., depression) to external symptoms at the bottom (e.g., tortures animals, destroys property). Symptoms in the *antisocial/conduct* cluster and *social skills* problems had low triage ratings and were not considered as those suggesting a mental health referral. All items were dropped from the instrument, except for the item *angry/argues excessively*, which was included but had the lowest of all the triage rating.

Item reduction for the final OMHRC was based on selecting those symptoms with high triage ratings within each mental health condition. Thirty-eight items survived this procedure, with the average triage rating being 2.8 or higher. This resulted in the 38-item OMHRC prototype, which was formatted as a checklist for use as a self-report by the youth or as a report of the youth by a parent or professional staff member. Scores are the total number of symptoms, although the need for a mental health referral may exist due to a single symptom, such as suicide, bizarre behavior, or hallucinations. Items are organized in descending order of triage ratings and are grouped in the CM categories, which allow for Guttman scaling.

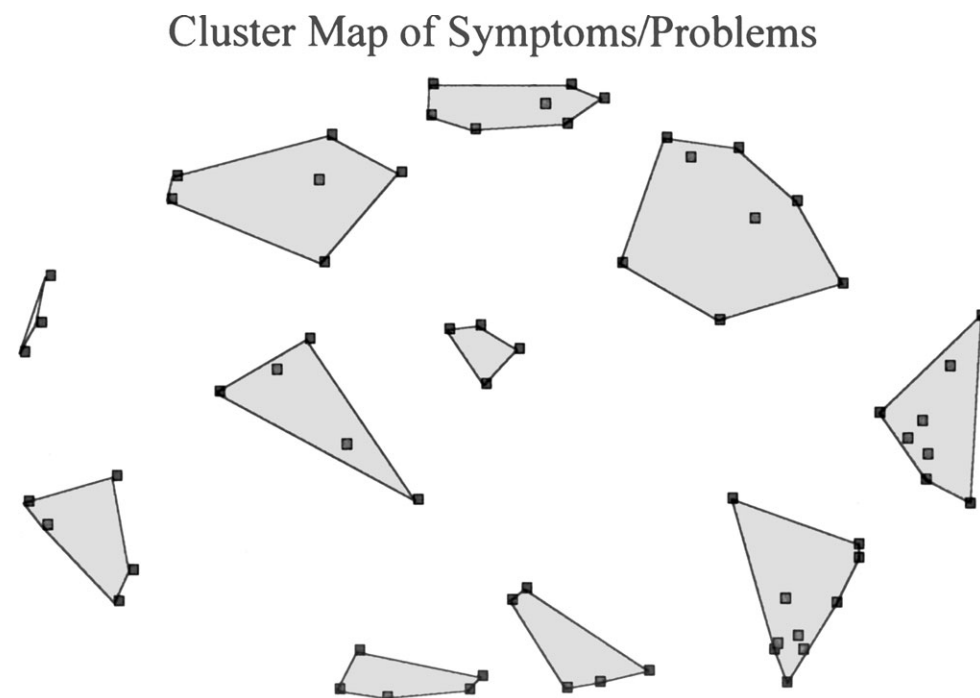


FIGURE 1
Point map of symptoms/problems.

Psychometric Analysis

Procedures and Participants

There were three samples in this study. In sum, 146 youths who were adjudicated and sentenced to community service were evaluated on the 38-item OMHRC–staff version by court counselors and probation officers. The youth were from two rural counties (one in eastern Oregon and the other on the coastal range) and a large urban county. In addition, parents from one rural county completed the OMHRC–parent version: 52 parents of rural youth completed the instrument in usable form. The youth concurrently completed the Child Behavior Checklist (Achenbach, 1997) and other measures, such as mental health history and suicidal behaviors. A third sample consisted of 83 incarcerated youth in the Oregon Youth Authority. These youth completed the final youth version of the OMHRC with the instruments noted

above. The community service youth were remunerated \$10 or 1 hour credit toward their sentence in consideration for completing the instruments, whereas the incarcerated youth were remunerated a \$2 value in a group activity, as possession of money was prohibited in the prison.

Results

Estimates of reliability of the 38 items derived from the concept mapping were assessed for internal consistency. Thirty-one items produced the highest reliability coefficients at .91, .72 and, .92 for the parent, staff, and youth versions, respectively. As parallel forms with the parent and staff versions, youth version scores had very good coefficients of equivalence—.51, $p < .01$, and .69, $p < .01$, respectively—but there was only moderate equivalence between the parent and staff versions, .36, $p < .05$.

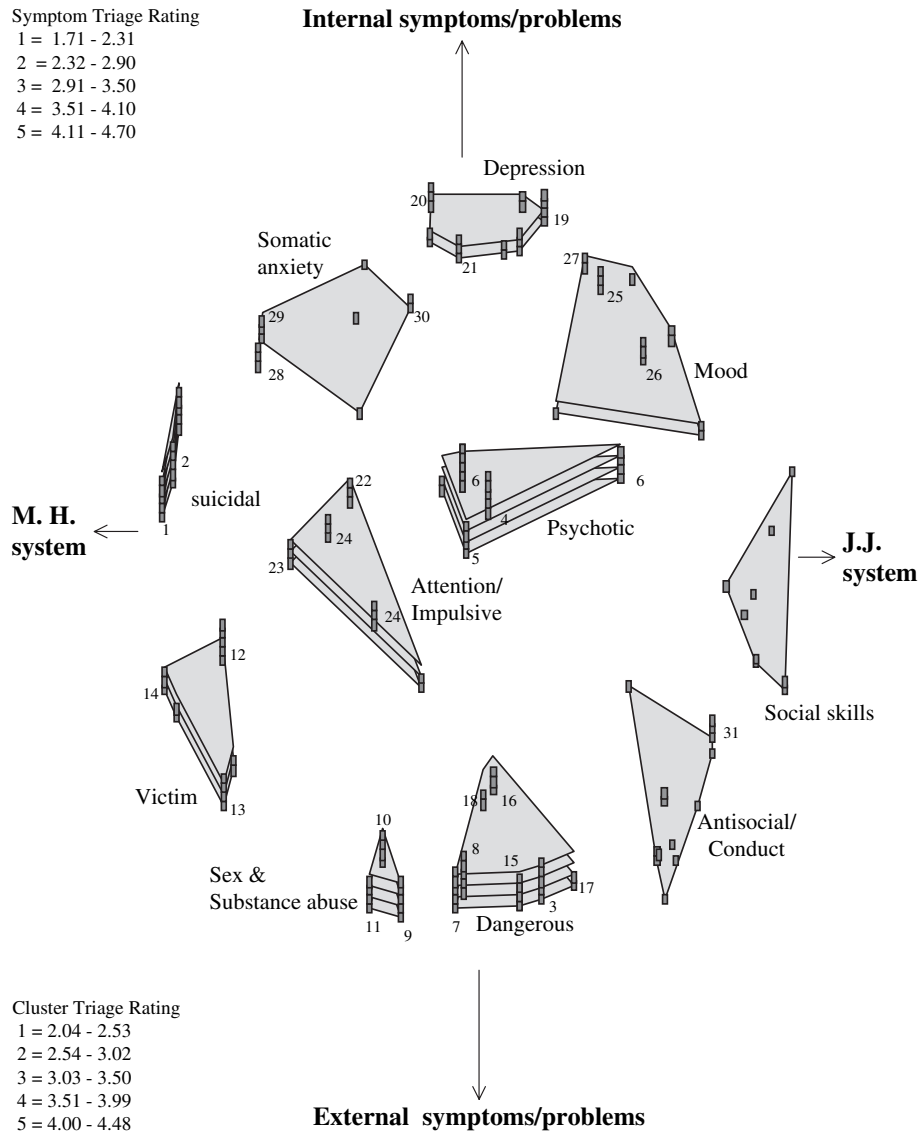


FIGURE 2
 Three-dimensional cluster map.

The validity of the 31-item OMHRCs for all three samples was estimated first with known-groups procedures. Based on the youth’s response to the dichotomous item “Has anyone you trust ever suggested that you might have an emotional or mental problem?” youth responding *yes* were compared to those endorsing *no*. The former were considered to have higher mental health needs than the latter.

For the parent version, youth saying *yes* had an average OMHRC score of 19.4 (*SD* = 8.4), while those saying *no* had an average score of 12.6 (*SD* = 9.0), which was significantly different, $t = 2.7, p < .05$. The staff version scores were also distinguished by this variable ($M = 16.6, SD = 9.5; M = 13.4, SD = 6.9$, for *yes* and *no* groups, respectively; $t = 2.1, p < .05$). For the incarcerated youth, the results for this

TABLE 1. Known-Groups Validity for Low and High Mental Needs on OMHRC–Youth Version

	No, low need		Yes, high need		t test	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>
Trusted other recommended treatment	7.2	5.7	12.4	8.3	3.1	.01
Have seen mental health professional	7.5	5.2	9.2	9.2	3.7	.01
Need to see mental health professional now	7.8	5.3	13.8	9.0	3.6	.01
Suicidal ideations	5.9	4.3	15.6	7.5	6.8	.00
Suicidal plan	10.2	7.9	16.2	7.3	2.8	.01

procedure, with four others criteria, were significant and are displayed in Table 1. The results support the assertion that total OMHRC scores distinguish youth with more mental health needs from those with fewer needs.

Concurrent validity was estimated by correlating OMHRC scores with internal and external problems scores of the Achenbach's (1997) Child Behavior Checklist. The parent version correlated significantly only with external problem scores ($r = .49$, $p < .05$) and were not significant for internal or external measures with the staff version. The youth version, however, had good concurrent validity coefficients, correlating with internal problem scores ($r = .67$) and externality problem scores ($r = .65$), significant at the .01 level. These findings suggest that parents are able to make somewhat accurate observations of external mental health problems needing mental health referrals, whereas the better source of assessment originates from the youth, who is accurate in observing symptoms associated with internal and external problems.

Summary and Limitations

The results of the concept mapping and the psychometric estimates suggest that the OMHRC is an acceptable tool to assess the mental health needs of youth in the juvenile justice system. It

seems that administrators and providers are about 90% as accurate as a child psychiatrist is in triaging symptoms but are not accurate in observing internal or external mental health symptoms. The assessment has been based on total symptomatology, yet all three instruments may identify a mental health need from a single item (e.g., hallucinations or suicide). As indexes of mental health symptoms, the OMHRC is particularly useful in identifying crises common to youth entering the juvenile justice system for the first time, whether first arrest or first incarceration.

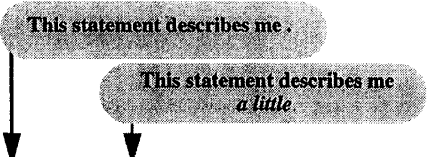
This study is not without limitations, of course. First and foremost, the sample sizes were not huge. Therefore, generalizing too widely is unwarranted. Additionally, the staff version was restricted to court counselors and probation officers, who may not be the most keenly trained professionals in recognizing the mental health symptoms of youth. It remains to be seen if the instrument is psychometrically sound with mental health professionals, school personnel, or other professionals. In spite of these shortcomings, the initial results suggest that the three versions of the OMHRC are consistent instruments to identify mental health symptoms of youngsters. The most accurate observations are limited to parents observing external problems, whereas youth are accurate in observing internal and external symptoms.

Appendix: Three Versions of the OMHR Checklist

OMHR CHECKLIST - YOUTH VERSION

What is your name? _____
 How old are you? _____ Sex M F
 What agency gave you this form? _____
 What is your medical card #? _____

What is today's date? _____/
 What is your race? _____
 Who do you typically see at that agency? _____
 What is your case #? _____



INSTRUCTIONS

Below are 32 statements that might describe you. Please check the **black circle** for each item which describes you. Unless told otherwise, consider whether each item describes you **within the past 6 months**. If the phrase only describes you a little, please check the **gray circle**.

- | | | |
|-----------------------|-----------------------|---------------------------------------------------------------------------------------------------------------|
| <input type="radio"/> | <input type="radio"/> | I have made a plan to commit suicide. |
| <input type="radio"/> | <input type="radio"/> | I have attempted suicide at least once in my life. |
| <input type="radio"/> | <input type="radio"/> | I feel like killing somebody. |
| <input type="radio"/> | <input type="radio"/> | I have had hallucinations (seen or heard things that weren't there when not on drugs or alcohol). |
| <input type="radio"/> | <input type="radio"/> | I have a strong belief that something is true when most people say it isn't (e.g., someone is out to get me). |
| <input type="radio"/> | <input type="radio"/> | While not on drugs or alcohol, have you lost touch with reality (felt "crazy")? |
| <input type="radio"/> | <input type="radio"/> | Have you intentionally harmed or injured an animal? |
| <input type="radio"/> | <input type="radio"/> | Have you started a fire that was dangerous or could have done harm or damage? |
| <input type="radio"/> | <input type="radio"/> | Have you sexually assaulted another or taken sexual advantage of another in the past 6 months? |
| <input type="radio"/> | <input type="radio"/> | I have used drugs or alcohol in the past 6 months. |
| <input type="radio"/> | <input type="radio"/> | Have you had frequent sex with people, or used sex to start a relationship? |
| <input type="radio"/> | <input type="radio"/> | I have physically harmed myself (such as cutting yourself, or putting a cigarette out on your skin)? |
| <input type="radio"/> | <input type="radio"/> | Have you ever been abused sexually or forced into a sexual activity? |
| <input type="radio"/> | <input type="radio"/> | Have you seen horrible/traumatic things or severe violence, including domestic violence? |
| <input type="radio"/> | <input type="radio"/> | I have threatened or intentionally harmed others. |
| <input type="radio"/> | <input type="radio"/> | I have explosive outbursts or sometimes throw fits. |
| <input type="radio"/> | <input type="radio"/> | I have intentionally destroyed someone else's belongings/property (e.g., vandalism). |
| <input type="radio"/> | <input type="radio"/> | Have you run away from your home or residence in the past 6 months? |
| <input type="radio"/> | <input type="radio"/> | I feel depressed most of the time. |
| <input type="radio"/> | <input type="radio"/> | I feel a sense of grief or deep loss for no reason at all. |
| <input type="radio"/> | <input type="radio"/> | I feel out of control of my emotions. |
| <input type="radio"/> | <input type="radio"/> | I frequently feel confused or get distracted easily and get off task. |
| <input type="radio"/> | <input type="radio"/> | I feel overactive or hyperactive. |
| <input type="radio"/> | <input type="radio"/> | I have thoughts I can't get out of my mind or behavior I can't stop. |
| <input type="radio"/> | <input type="radio"/> | On a typical day my moods are extreme and change dramatically (e.g., going quickly from happy to sad). |
| <input type="radio"/> | <input type="radio"/> | My moods seem extreme or different from others in the same situation. |
| <input type="radio"/> | <input type="radio"/> | I feel withdrawn or isolated from others. |
| <input type="radio"/> | <input type="radio"/> | I have difficulty sleeping, including nightmares. |
| <input type="radio"/> | <input type="radio"/> | I have lost/gained a noticeable amount of weight in the past 6 months. |
| <input type="radio"/> | <input type="radio"/> | I feel anxious or worried most of the time. |
| <input type="radio"/> | <input type="radio"/> | I feel angry much of the time or argue a lot. |
| <input type="radio"/> | <input type="radio"/> | Do you need to see a mental health counselor? |

Please return this to the juvenile justice counselor or mental health counselor, unless told otherwise.

OMHR CHECKLIST - PARENT VERSION

Child's name _____
 Child's age _____ Sex M F
 What agency gave you this form? _____
 What is the child's medical card #? _____

What is today's date? _____/
 Race _____
 Who is your contact person at that agency? _____
 What is your relationship with the youth? (please specify) _____

I know or am fairly certain this item describes this youth.

This item is probably descriptive of this youth.

INSTRUCTIONS

Below are 32 behaviors you may have observed with this child. Please check the **black circle** for each item which you **know** or are **fairly certain** describes this youth. Unless told otherwise, consider the youth **within the past 6 months**. If you have your suspicions or a hunch that an item describes this child, then please check the **gray circle**.

- | | | |
|-----------------------|-----------------------|-----------------------------------------------------------------------------------------------------------|
| <input type="radio"/> | <input type="radio"/> | He/she seems actively suicidal/suicide risk. |
| <input type="radio"/> | <input type="radio"/> | Has this youth ever made a suicide attempt? |
| <input type="radio"/> | <input type="radio"/> | The child expresses a desire to kill another person(s). |
| <input type="radio"/> | <input type="radio"/> | He/she appears to have hallucinations (acts as if see or hear things when not on drugs or alcohol). |
| <input type="radio"/> | <input type="radio"/> | The child expresses bizarre ideas/strong beliefs that are not true (e.g., someone is out to get him/her). |
| <input type="radio"/> | <input type="radio"/> | While not on drugs or alcohol, this child seems out of touch with reality/incoherent |
| <input type="radio"/> | <input type="radio"/> | Has intentionally harmed or injured an animal. |
| <input type="radio"/> | <input type="radio"/> | Has intentionally set a fire. |
| <input type="radio"/> | <input type="radio"/> | Sexually assaulted another or has taken sexual advantage of another in the past 6 months? |
| <input type="radio"/> | <input type="radio"/> | Has used drugs or alcohol in the past 6 months. |
| <input type="radio"/> | <input type="radio"/> | Sexually acts out, such as frequent sex with people or uses sex to start a relationship. |
| <input type="radio"/> | <input type="radio"/> | Physically harmed him/herself (such as cutting self with razor or burn self with cigarette). |
| <input type="radio"/> | <input type="radio"/> | Has this child ever been sexually abused or forced into a sexual activity? |
| <input type="radio"/> | <input type="radio"/> | Has he/she ever witnessed a traumatic event or severe violence (e.g. domestic violence)? |
| <input type="radio"/> | <input type="radio"/> | He/she threatens others or has intentionally harmed others in the past 6 months. |
| <input type="radio"/> | <input type="radio"/> | Has explosive outbursts/throw fits. |
| <input type="radio"/> | <input type="radio"/> | Intentionally destroyed property. |
| <input type="radio"/> | <input type="radio"/> | Frequently runs away from home. |
| <input type="radio"/> | <input type="radio"/> | Has seemed depressed most of the time in the past 6 months. |
| <input type="radio"/> | <input type="radio"/> | Expresses grief/loss for no reason. |
| <input type="radio"/> | <input type="radio"/> | Has seemed out of control of his or her emotions in the past 6 months. |
| <input type="radio"/> | <input type="radio"/> | Seems frequently confused. |
| <input type="radio"/> | <input type="radio"/> | He or she is overactive or hyperactive. |
| <input type="radio"/> | <input type="radio"/> | Has had repetitive thoughts or repetitive behaviors. |
| <input type="radio"/> | <input type="radio"/> | He/she has had dramatic mood swings. |
| <input type="radio"/> | <input type="radio"/> | His/her moods have been inappropriate (e.g. extreme or different from others in the same situation). |
| <input type="radio"/> | <input type="radio"/> | This child has been detached or withdrawn. |
| <input type="radio"/> | <input type="radio"/> | He/she is having difficulty sleeping (too much or too little). |
| <input type="radio"/> | <input type="radio"/> | I've observed noticeable weight gain or weight loss. |
| <input type="radio"/> | <input type="radio"/> | He/she has been very anxious/nervous or worries most of the time. |
| <input type="radio"/> | <input type="radio"/> | He/she is angry or has argued excessively during the past 6 months |
| <input type="radio"/> | <input type="radio"/> | In your opinion, does this youth need to see a mental health counselor? |

Please return this to the juvenile justice counselor or mental health counselor, unless told otherwise.

OMHR CHECKLIST - STAFF VERSION

Youth's Name _____
 Age _____ Sex M F
 Initiating Agency _____
 Medical Card # _____

Today's Date _____ / _____ / _____
 Race _____
 Contact Person _____
 Phone # _____
 Case # _____

INSTRUCTIONS

Below are 32 problems or symptoms descriptive of youth who might need a mental health referral. Please check the **black circle** for each item which you *know* or are *fairly certain* describes this youth. If you have a suspicion or hunch that an item is *probably descriptive*, then please check the **gray circle**.

I know or am fairly certain this item describes this youth.

This item is probably descriptive of this youth.

Notes you wish to share about your observations:

Actively suicidal/suicide risk	<input type="radio"/>	<input type="radio"/>	
Any prior suicide attempts	<input type="radio"/>	<input type="radio"/>	
The child has desire to kill another person(s)	<input type="radio"/>	<input type="radio"/>	
Appears to have hallucinations	<input type="radio"/>	<input type="radio"/>	
Expresses bizarre ideas or delusional	<input type="radio"/>	<input type="radio"/>	
Out of touch with reality/incoherent while not on drugs or alcohol	<input type="radio"/>	<input type="radio"/>	
Intentionally harms or injures animals	<input type="radio"/>	<input type="radio"/>	
Fire setter	<input type="radio"/>	<input type="radio"/>	
Sexually offends	<input type="radio"/>	<input type="radio"/>	
Substance abuse	<input type="radio"/>	<input type="radio"/>	
Sexually acts out	<input type="radio"/>	<input type="radio"/>	
Physically harms self	<input type="radio"/>	<input type="radio"/>	
Ever sexually abused	<input type="radio"/>	<input type="radio"/>	
Ever witnessed traumatic event or severe violence (e.g. domestic violence)	<input type="radio"/>	<input type="radio"/>	
Threatens others or intentionally harms others	<input type="radio"/>	<input type="radio"/>	
Explosive outbursts/throws fits	<input type="radio"/>	<input type="radio"/>	
Destroys property	<input type="radio"/>	<input type="radio"/>	
Frequently runs away	<input type="radio"/>	<input type="radio"/>	
Depressed	<input type="radio"/>	<input type="radio"/>	
Expresses grief/loss	<input type="radio"/>	<input type="radio"/>	
Feels out of control	<input type="radio"/>	<input type="radio"/>	
Frequently confused	<input type="radio"/>	<input type="radio"/>	
Overactive or hyperactive	<input type="radio"/>	<input type="radio"/>	
Repetitive thoughts or repetitive behavior	<input type="radio"/>	<input type="radio"/>	
Dramatic mood swings	<input type="radio"/>	<input type="radio"/>	
Inappropriate moods	<input type="radio"/>	<input type="radio"/>	
Detached or withdrawn	<input type="radio"/>	<input type="radio"/>	
Difficulty sleeping	<input type="radio"/>	<input type="radio"/>	
Noticeable weight gain/loss	<input type="radio"/>	<input type="radio"/>	
Anxious	<input type="radio"/>	<input type="radio"/>	
Angry or argues excessively	<input type="radio"/>	<input type="radio"/>	
Does this youth need a mental health referral?	<input type="radio"/>	<input type="radio"/>	

Sent to: _____
 Name of HMO/MH Agency

Date Sent _____

Phone # _____

Acknowledgment

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