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Feasibility and acceptability of a brief suicide intervention for youth involved with the family court

Kathleen Kemp[1,2], **Casey A. Pederson**[3], **Margaret Webb**[1,2], **Shannon Williamson**[1], **A. Rani Elwy**[2,4], **Anthony Spirito**[2]

[1]Rhode Island Hospital Bradley Hasbro Children's Research Center, Providence, Rhode Island, USA

[2]Alpert Medical School of Brown University, Providence, Rhode Island, USA

[3]Department of Pediatrics Adolescent Behavioral Health Research Program, Indiana University School of Medicine, Indianapolis, Indiana, USA

[4]Center for Healthcare Organization and Implementation Research, VA Bedford Healthcare System, Bedford, Massachusetts, USA

Abstract

As efforts to develop models for suicide prevention and intervention in the juvenile justice (JJ) system continue to grow, research to understand the feasibility and acceptability of implementing these models is critical. Examining organizational readiness for implementation, ensuring leadership and staff buy-in for delivering the intervention, and planning for sustainability of staff participation in implementation efforts is essential. The current study involved semi-structured formative evaluation interviews with key JJ stakeholders ($n = 10$) to determine perspectives on the acceptability (perceived need and fit of the intervention) and feasibility (organizational readiness for change) of a proposed brief safety planning intervention for youth with suicidal ideation delivered by nonclinical staff and integrated into the existing system. Qualitative data revealed stakeholders' perceived need for the intervention in the family court context and their agreement that the aims of the intervention were congruent with the goals of the family court. Some barriers to successful implementation were noted, which, addressed through selection of appropriate implementation strategies, can be overcome in a future test of the safety intervention.

1 | INTRODUCTION

For several decades, adolescent suicide in the United States has persisted as a public health crisis. Suicide remains the second leading cause of death among people 10 to 24 years of age (Hedegaard, Curtin, & Warner, 2018). Since 2010, death by suicide among adolescents ages 15–19 has increased by one-third in males and doubled in females (Simon, 2017). In 2019, 18.8% of high school students reported experiencing serious suicidal ideation (SI) and 8.9%

Correspondence: Kathleen Kemp, Bradley Hasbro Children's Research Center, 1 Hoppin Street, Rm 2.104, Providence, RI 02903, USA. Kathleen_kemp@brown.edu.

CONFLICT OF INTEREST

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reported at least one suicide attempt during the past year (Ivey-Stephenson et al., 2020). The rates of SI and suicide attempts are even more prevalent among vulnerable populations, such as youth involved in the juvenile justice (JJ) system (Gray et al., 2002; Wasserman & McReynolds, 2006). Among youth in JJ facilities, the suicide rate has been estimated to be 21.9 per 100,000 people, whereas the suicide rate among youth in the general population was seven per 100,000 at the time (Gallagher & Dobrin, 2006). Furthermore, reported prevalence and recency of SI among juveniles at court intake reveals a concerning elevation in suicide risk among JJ involved youth. As early as their first point of contact with the system 14.2% of youth report SI within the previous week (Rohde, Seeley, & Mace, 1997), and 10.3% to 20.7% of youth report SI within the previous 6 months (Abram et al., 2008; Cauffman, 2004).

Given these data, a general consensus has been reached among clinicians and policymakers that juveniles should be screened for suicide at every contact point in the JJ system, especially at their initial intake appointments (Kemp et al., 2016; Scott, Underwood, & Lamis, 2015; Skowyra & Cocozza, 2007). At this contact point, youth are often administered a screening tool (e.g., Massachusetts Youth Screening Instrument-2; Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001) and follow-up questions to inquire about current SI, current/past suicide attempts, mental health issues, experience of a recent significant loss and friends'/family members' suicidal behavior (Hayes, 2009). When a juvenile exhibits an elevated and clinically significant risk for SI, the individual receives additional screening for imminence (Scott et al., 2015) and is often transported to a local hospital and brought into an emergency department (Scott et al., 2015). However, if hospitalization is not clinically necessary, the juveniles are typically given referrals to outpatient mental health clinics, often with long wait times (Allen, Forster, Zealberg, & Currier, 2002). This process, referred to as the "assess and refer" approach (Stanley & Brown, 2012, p. 256), has been criticized by patients and families because clinicians may fail to hospitalize youth who need an immediate intervention and because many suicidal youth who are referred to outpatient mental health clinics fail to attend their appointments after their ED visit (Stanley & Brown, 2012).

As an alternative to the assess and refer approach, safety planning, which has been cited by mental health professionals as best practice in suicide risk and assessment (Higgins, Morrissey, Doyle, Bailey, & Gill, 2015), has been recommended for youth in the JJ system. Stanley and Brown (2012) outlined the key components of an effective safety planning intervention: (1) recognizing the warning signs of SI and an impending attempt, (2) teaching coping mechanisms, (3) distracting oneself from suicidal thoughts with social settings and contacts, (4) utilizing family and friends as a way to alleviate the suicidal crisis, (5) contacting mental health professionals or agencies, and (6) restricting access to lethal instruments/weapons. Safety planning is also brief in nature (Scott et al., 2015), making its use ideal in settings and systems with limited time and resources.

When resources are limited, the responsibility of conducting brief interventions may be assigned to nonclinical staff (Christl et al., 2010; Sharp, Pineros, Hsu, Starks, & Sales, 2004). Often called *task shifting*, this practice has been used to lighten the workload of clinicians and other providers (O'Neil et al., 2019) and has recently been expanded to

JJ settings (Sheidow, McCart, Chapman, & Drazdowski, 2020). It has been recommended that nonclinical staff and JJ stakeholders (e.g., probation officers, bachelor's level social workers, legal professionals, etc.) be trained to understand the protective and risk factors for suicidal behavior among the JJ population, respond to warning signs by administering suicide screenings, follow emergency protocols, and conduct brief interventions (Kemp et al., 2016).

There is a concern, however, about nonclinical staff's confidence level with administering such assessments and assessing risk level; a few studies have found that, when suicide assessment is task-shifted to probation officers, 25-40% do not feel competent in conducting the suicide assessment (Vilhauer, Wasserman, McReynolds, & Wahl, 2004; Wasserman et al., 2009). Low self-efficacy and lack of confidence about new tasks impact implementation and uptake of new interventions (Damschroder et al., 2009). To mitigate this issue, the National Action Alliance for Suicide Prevention (NAASP) has recommended that all staff (both clinical and nonclinical) responsible for implementing screening and assessment tools be trained about the purpose of such tools, the meaning of the results, and the proper protocol to follow after receiving certain results/scores (NAASP, 2013).

To date, little to no work has examined the implementation of brief evidence-based interventions for SI in JJ settings. The study reported here begins this examination by surveying nonclinical staff's attitudes toward such interventions. Consistent with Proctor's Implementation Outcomes Framework (Proctor et al., 2011), the study assumes that it is important to gain an understanding of "Organizational Readiness" prior to implementation of an intervention. One way of doing this is through conducting formative evaluation interviews, which is a rigorous assessment process designed to identify potential and actual influences on the potential implementation of an intervention (Stetler et al., 2006). In this study, the formative evaluation involved pre-implementation interviews with identified stakeholders to assess their perceptions of the safety intervention in the JJ system using two metrics. *Acceptability*, defined as the perception among stakeholders that a given treatment, service, practice or innovation is agreeable, palatable or satisfactory in their work environment and fits the goals, values and needs of that workplace (Proctor et al., 2011), was one key component of the formative evaluation. An intervention perceived as acceptable is likely to also be perceived as needed, a good fit and aligned with an organization's goals and values. *Feasibility*, defined as the extent to which a new treatment, or an innovation, can be successfully used or carried out within a given agency or setting (Proctor et al., 2011), was assessed because it is critical for determining whether an organization and its employees are ready to incorporate changes in their workplace and perceive that they are able to do so.

Several studies have highlighted the importance of conducting such interviews of key stakeholders who might participate in safety planning, in order to identify their perceptions about implementing the intervention as well as potential barriers and their solutions (Kennard et al., 2015; Kodish et al., 2019; Niner et al., 2009). For instance, Kennard et al. (2015) conducted qualitative interviews to assess parents', psychiatrically hospitalized adolescents' and clinicians' perceptions of the feasibility of a mobile-app safety plan implemented for suicidal adolescents and got different feedback based on the stakeholder group. As a result of interviewing stakeholders, valuable information regarding the

acceptability of a safety planning intervention, while assessing the facilitators and barriers to intervention feasibility, was collected.

Oftentimes health practices that are effective in research settings fail to be as successful in actual patient care (Damschroder et al., 2009; Proctor et al., 2011) because interventions may develop “blockages,” which prevent evidence-based practices from being effectively implemented outside of research settings (Bauer, Damschroder, Hagedorn, Smith, & Kilbourne, 2015). By interviewing stakeholders, researchers can assess how acceptable and feasible they believe the intervention to be and can identify solutions to any issues that these stakeholders may have with implementing these interventions (Elwy et al., 2020). In addition, these interviews may serve as an opportunity to identify necessary resources, as well as barriers and obstacles to treatment, an invaluable component of implementing any intervention. The use of qualitative interviews with stakeholders is especially important in nonclinical settings, such as at the initial contact points within the JJ system, to gain a better understanding of the acceptability and feasibility of implementing mental health interventions such as safety plans in settings that do not typically have the experience or infrastructure to do so.

2 | CURRENT STUDY

Youth in contact with the JJ system are a vulnerable population at heightened risk for SI and suicide attempts, the latter due, at least in part, to their easier access to lethal means, which is not the case for incarcerated youth (Farand, Chagnon, Renaud, & Rivard, 2004). Yet only about half of these youth are engaged in treatment (Kemp et al., 2020). Nonclinical diversion staff are in a unique position to provide suicide screening and intervention for this group, if they have adequate tools for doing so.

Use of mental health screeners for youth in the JJ system is already widespread (Vincent, Grisso, Terry, & Banks, 2008). However, there is a clear need for additional research on suicide screening and intervention at initial JJ system contact (Gray et al., 2002), particularly with respect to obtaining stakeholder feedback on its acceptability and feasibility. As part of a larger ongoing mixed-methodology study (blinded for review), the current study aimed to determine if a brief intervention for youth with SI conducted by nonclinical staff could be integrated into the existing JJ system. To our knowledge, the present study is the first to explore implementation of a suicide intervention among JJ-involved youth during juvenile diversion appointments. By conducting qualitative formative evaluation interviews with key stakeholders, invaluable information on the acceptability and feasibility of the proposed implementation of a brief suicide intervention provided by nonclinical staff in a juvenile court diversion program was obtained. The following implementation outcomes among JJ staff were assessed to determine perceptions of acceptability and feasibility of the safety intervention.

1. ***Acceptability***. *Perceived Need* for and *Fit* of a brief suicide intervention at juvenile diversion: Do JJ court staff believe diverted youth are at increased risk for suicidal thoughts and behavior and would benefit from a brief intervention at the time of the assessment? Do court staff feel that conducting brief suicide

interventions for the purpose of reducing suicide risk is an acceptable role for the JJ system? Assuming that the brief intervention can be integrated into court practices, how willing are nonclinical court staff to accept their role in the process?

2. ***Feasibility***. Court staff *Readiness for Change*: What training and supervision strategies do the staff think are needed to help them implement the intervention, and to what extent do they think the proposed strategies will work?

3 | METHOD

3.1 | Participants

Court staff at a Northeastern family court were presented with the opportunity to participate in qualitative formative evaluation interviews at an information session about the research program. The information session included a discussion of the goal of the interviews as well as compensation for their time. Participants self-selected by filling out a consent-to-contact form with the research assistant. The research assistant then followed up to schedule interview appointments at a later date.

All 10 family court staff, representing a range of positions within the juvenile diversion department, were interviewed, including one administrative assistant, six juvenile intake workers, and three magistrates (no one refused to be interviewed). Participants were 60% female. They reported an average of 10.4 years (SD = 9.2; range 3 months to 34 years) working at the family court. We interviewed a range of stakeholders so that we could assess readiness and buy-in potential of the intervention from multiple levels of the court structure. Even if some stakeholders may not actually be administering the intervention, they may be involved in critical decision-making that leads to whether an intervention is allowed to be implemented (e.g., a magistrate), or help us understand how an intervention is perceived by others (e.g., an administrative assistant).

3.2 | Family court context

The participants in this study were all employed by a family court. As a part of this family court's standard procedure, youth entering the diversionary program as a result of wayward (i.e., status or misdemeanor offense) or delinquency (i.e., felony) charges are administered a mental health screening–the Massachusetts Youth Screening Inventory Version 2 (MAYSI-2; Grisso et al., 2012). The MAYSI-2 is comprised of seven subscales: (1) Alcohol/Drug Use, (2) Anger/Irritability, (3) Depression/Anxiety, (4) Suicidal Ideation, (5) Somatic Complaints, (6) Thought Disturbance, and (7) Traumatic Experiences. Regarding SI, if a youth scores above the cut-off score of 2, their intake worker completes a secondary screening with them. The secondary screening involves reviewing the individual items that the youth endorsed on the SI subscale to identify if additional action needs to be taken. Intake workers conduct these screens on their own. However, in cases of significant concern court staff are able to directly refer youth to a licensed mental health clinician in the family court mental health clinic for further consultation or evaluation.

3.3 | Description of proposed brief safety planning intervention

The current safety plan, for juveniles who were not acutely suicidal, was developed by Stanley and Brown (Stanley & Brown, 2012) and then adapted for youth (Brent, Poling, & Goldstein, 2011; Wolff et al., 2018). The interviewer explained to stakeholders that safety planning was a one-session individual- and family based intervention for youth who endorsed two or more items on the SI scale of the MAYSI-2 but did not require an emergency evaluation. The participants were also informed the intervention would be implemented by nonclinical court staff. During the session, the youth would complete a structured safety plan worksheet designed to create a practical plan with a list of coping strategies, social support resources, and help-seeking activities that a youth can use before or during a crisis. The youth, with staff support, would then share the plan with their caregivers to discuss ways to enhance access and reduce barriers to the plan. Sessions were estimated to be up to 1 h in length.

3.4 | Procedure

All protocols and procedures were approved by the associated hospital institutional review board. Court staff participated in audio-recorded, semi-structured interviews regarding their views of the acceptability and feasibility of the safety planning intervention, with questions specifically addressing the perceived needs of court-involved youth regarding suicide screening and intervention (acceptability), the fit of a safety planning intervention conducted by nonclinical court staff (acceptability), and readiness of the court system and staff to implement this intervention (feasibility). All interview topics were addressed in the same order; however, the semi-structured nature of the interviews allowed participants to elaborate on their experiences and opinions fully while maintaining interview focus (Willig, 2013).

Interviews took place at the family court in the participant's office or a conference room. Informed consent was obtained prior to the interview. The interviews took up to 1 h and participants were compensated with a $30 Visa gift-card for their time. Some of the participants were unable to accept the gift-cards due to state legislation aimed at maintaining neutrality, which barred acceptance of funds from outside sources. These gift-cards were donated to organizations that served the needs of families involved with the court.

3.5 | Measures

3.5.1 | Semi-structured formative evaluation interviews—Participants were first asked about their overall awareness and understanding of current court practices relating to suicide risk screening and assessment, prior training related to suicide, and experience dealing with suicidal youth. The formative evaluation interview itself was split into three main areas of inquiry. The *Acceptability: Perceived Need* section started by asking participants to elaborate on their own experiences with suicidal youth and their perception of the relevance of suicide risk to court-involved youth: "Part of this study is to figure out whether a suicide intervention is needed in the court. Tell me about your experiences with suicidal youth." Questions then focused on the *Perceived Need* for addressing suicide in the context of the court, for example "How related is addressing suicide to meeting the needs of youth and families who come to family court?" Questions then probed for perceptions

of the court's role in addressing suicide, for example "What role do you see for court staff with youth who have suicidal thoughts?" For higher-level court employees, such as judges and magistrates, the interviewer was instructed to probe about their perception of the relative importance of assessment and brief intervention with suicidal youth as compared with the other, competing, goals and role of the family court.

At this point in the interview, the interviewer described the brief safety planning intervention adapted for nonclinical staff delivery. The section on *Acceptability: Fit* assessed the individual's perception that the brief suicide intervention could be well integrated into the existing juvenile court in terms of goals, content, length, and tasks. The interviewer was also instructed to probe for perceived barriers to successful integration. Questions in this section included a lead question of "What do you see as the benefits and challenges in implementing this one-session suicide intervention called safety planning?" Follow-up questions were then asked, such as: "What logistical and other challenges do you see with implementing a suicide intervention program by family court staff?"

The final section, *Feasibility: Readiness for Change*, aimed to understand what court staff felt they would need to feel competent in implementing the intervention themselves. Lead questions included: "If safety planning is implemented, what resources do you think you would need to implement safety planning if you were providing it at the court?" The interviewer then probed for specifics on initial and/or ongoing training and supervision as well as logistical elements (such as space, technology, time, etc.). Following this section, participants were given the opportunity to share any additional feedback they felt might be relevant.

3.6 | Data analysis

Every audio-recorded interview was transcribed by one research assistant. Audios and transcriptions were then reviewed simultaneously by another research assistant to assure quality. The software program NVivo 12 was used for data organization 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–for example, full transcription files, audiorecordings, video–and to categorize data by user-defined codes. This allows for easier identification and evaluation of common themes.

Using a combined inductive and deductive consensus coding approach to qualitative analysis, transcripts were coded iteratively. This type of analysis allows for a deductive coding process through the use of a predetermined coding structure based on the research questions, as well as for the inductive emergence of unanticipated codes that are not part of the predetermined coding framework but are important concepts identified by the analytic team (Fereday & Muir-Cochrane, 2006; Hsieh & Shannon, 2005). During regular, weekly meetings, four analysts read and simultaneously coded each transcript using the predetermined coding structure and approach described above. Coding for each transcript was discussed until the four members of the research team, including the principal investigator, reached consensus on the applicable codes. The coding process began by using a coding matrix[1] based on the key research questions. As additional codes emerged through the inductive coding process, the coding matrix was adapted, and previously coded

transcripts were recoded to adhere to the new matrix. For example, the code "Juvenile Intake Staff Role" emerged as a separate, more specific code from the original code "Court Staff Role." This process continued until all transcripts were coded. When disagreements emerged, the group discussed the codes in question until consensus was reached.

Once all transcripts had been coded, a research assistant replicated the consensus codes digitally in the NVivo 12 software. References to codes across transcripts were then consolidated and a thematic analysis was conducted across all data. Within each broader research question, responses were analyzed for themes based on content. Members of the research team then reviewed the consolidated output codes and identified how specific codes coalesced into unifying themes across transcripts. Once a theme was identified, the research team rated the theme as present/absent in the data. Quotations representative of study participants' perspectives are provided to illustrate the dominant themes related to acceptability and feasibility. Quotations were edited to enhance readability.

4 | RESULTS

4.1 | Acceptability: perceived need based on prior experience with suicidal youth at family court

All participants ($n = 10$) described their overall awareness and understanding of current practices relating to the screening and assessment of SI at the family court. Most participants[2] ($n = 8$) knew that the MAYSI-2 was used to screen for SI as a part of youths' involvement in the family court. A majority ($n = 6$) of participants described a process by which youth were given the MAYSI-2 to assess SI and referred to a mental health clinic for follow-up and risk assessment as needed, which could result in hospitalization for that youth.

> …giving the MAYSI, I've seen the scores and how youth are feeling. I've ended up making a referral to the clinicians here. Then the clinicians make the referral to call the authorities for the ambulance ride to the hospital cause they felt that they were a danger to themselves (Participant 5).

Two participants stated that mental health clinic staff already performed safety plans as a part of the screening process, with these same participants noting that they would make referrals to other mental health professionals should the suicide risk appear imminent.

> …if we're feeling like "oh, I'm not sure" you know what I mean? This kid seems really at risk right now, those are the ones I would refer to the clinician here at the mental health clinic to do a safety assessment and a safety plan (Participant 7).

Regarding prior training in areas of suicide, half of the participants ($n = 5$) noted having no formal training in the assessment and treatment of SI. Four participants noted some exposure to the assessment of SI but no formal training.

[1]For more information about the coding matrix, please contact the corresponding author.
[2]Although we realize that the information could be useful, we have not broken down the answers by participant occupation due to confidentiality concerns.

> I wouldn't say trainings, but different programs through [the hospital] (Participant 2).

> …no specific training through an organization or an agency, but trainings here within our own mental health clinic, so [mental health staff] has run some of those. They're more psycho-educational rather than prolonged two or three day trainings (Participant 6).

Only two participants noted having formal training in the area of suicide, including one receiving training through their position at the family court and one receiving more specific training through the military.

4.2 | Prior experience with youth who report suicide

A majority of the participants ($n = 8$) described encountering youth who reported SI during the course of their job at the court. They noted being aware of the extent to which youth experienced SI through the MAYSI screening process. However, staff's perceptions of the frequency with which they came into contact with youth experiencing SI varied. While some juvenile court staff noted SI as a frequent occurrence ($n = 3$), others noted that youth reporting SI was infrequent ($n = 2$).

> …the majority of them flag for suicide, most of them are passively suicidal, not actively suicidal. I have never had any kid tell me that they have an active plan (Participant 4).

> For me it's been a couple a year, but around here everything seems to be feast or famine; you might not get any for a while, then you might get a couple right in a row so (Participant 5).

4.3 | Acceptability: perceived need of and family court role in addressing suicidal ideation

4.3.1 | Perceptions of youth and family need for safety planning—The majority of court staff ($n = 8$) expressed that youth and families needed and benefitted from safety planning as a clinical service provided by the court. Court staff ($n = 5$) linked the frequency at which youth reported SI with the need for a safety planning service. Two participants noted the honesty with which youth report SI as indicative of the need for services amongst JJ youth.

> I think I am amazed at just at how honest the youth are in regards to the answers to the questions. And that gives me the idea that if they're answering honestly, it's because they know they need assistance… (Participant 1).

In contrast, only two staff suggested little to no need for a safety planning intervention through the court, primarily citing that few youth would actually require the service. One participant elaborated that many youth already have therapeutic services in place and that referring to community based services would suffice to address youth and family needs.

> …I find that in most of the cases parents already have service providers in place. Some of the kids we see here are also involved with the DCYF, and we also have the ability to make referrals for clinical services (Participant 7).

4.3.2 | Family court's role in addressing suicide—

The majority of court staff (n = 6) indicated that implementing a safety planning intervention was within the purview of the family court. Two of these staff noted that it is the responsibility of the family court to follow up with youth who screen positive for SI. Other staff (n =2) noted the convenience for families who are already at the court to have services in place.

> I think it is important, especially if we're asking these questions, we need to know how to follow up…. If the child does flag for suicide, I think everybody collectively needs to know how to handle that situation. So, I think it's important that we have something to implement (Participant 4).

> I think it would be beneficial for the families; usually this is their first point of contact with somebody from the state…. I think that's one of the benefits of the court, allowing us to give the mental health screenings, so we can get a glimpse of anything that may be bothering the youth at the moment (Participant 10).

Additionally, staff (n = 2) noted that mental health services were already integrated into the family court setting, making safety planning a component of a larger mental health service initiative within the family court.

> I think that having our director of the mental health clinical here fulltime now, having our chief judge, who is very mental health focused, and having our department head, who's also our deputy court administrator, who is also very mental health focused, and very supportive all the innovations that are happening both within our department and within our clinic. I think that would really benefit what we're hoping to do here if we are indeed hoping to do this [safety planning] (Participant 6).

4.4 | Family court staff's role in addressing suicide

Perspectives on the role of specific family court staff in addressing youth experiencing SI were more mixed. While two staff stated that it would be their role to address these issues with youth, an equal number of staff directly expressed that they do not view this to be their role within the family court. Others (n = 2) noted that it was staff's role to address SI, although they did not identify specific staff that would assist youth. Notably, two staff stated that it is the role of clinical staff to address these issues with youth.

> I think it's the purview of the mental health clinic here to address a youth that's possibly at risk, and then a determination can be made. They would do a safety plan for a kid that they think is safe to go home. If there's still some concerns, they also can hospitalize a youth or at least have a youth evaluated at the hospital (Participant 7).

4.5 | Acceptability: fit of safety planning implemented by juvenile court staff

4.5.1 | Overall fit—

Half of court staff (n = 5) indicated that a brief suicide intervention, such as safety planning, could be successfully integrated into the court process by nonclinical court staff. All staff believed a brief suicide intervention would benefit the youth and family.

> I would say that if a youth flags as being potentially suicidal, then yes safety planning should be implemented (Participant 9).

> It's a fantastic idea. I think if we could work it, we should. It's all about the kids. If I can get a kid safe to go home, that's what we want to do. I don' want to lose anybody (Participant 2).

4.5.2 | Benefits and disadvantages of a brief suicide intervention in the court setting—All participants (n = 10) identified promising positive attributes of a brief suicide intervention being implemented when a youth flags for suicide at a diversionary court hearing. Perhaps not surprisingly, all court staff (n = 10) identified helping youth or keeping youth safe as the primary motivator to implement safety planning–even when the court staff member was not familiar with providing clinical interventions. Two participants elaborated that, for some youth, the first time they disclose suicidal thoughts may be at the time of their justice involvement.

> In my experiences, this may be the first time that they're ever telling anybody that this is how they're feeling. When somebody's actually listening to them and hearing them and providing them with just that one hour of "this is how we're gonna help and this is what you can do" and providing them with resources, it is helpful (Participant 4).

A second theme that emerged was the added benefit of an immediate intervention, compared with the delays typically experienced by families in accessing treatment (n = 7).

> so by doing these right up front with the intake workers, the intake worker is the person that this child has already disclosed these thoughts to. So instead of sending them off to a provider who they may not see for another week, or two weeks, we're meeting with this person right then and there (Participant 6).

For a broad perspective, participants were specifically queried about any perceived negative impact that a brief suicide intervention might have in the court setting. Eight participants generated a diverse array of potential concerns. The most common contrary theme (n = 4) was the impact of additional time needed to complete the intervention requiring families to remain at the courthouse, thus impacting potential plans to return to work, attend school, or facilitate childcare.

> We get a lot of blowback from parents on how long this process is gonna take, I gotta get to work… we're gonna have a problem. Workers are gonna have a problem with this (Participant 4).

Two other adverse themes were concern that some parents were either not supportive of youth and/or had personal issues leaving them unable to be supportive during an intervention (n = 3) and concern about the negative emotions (e.g., anxiety, frustration) families experience when attending court hearings and the subsequent impact on willingness to engage in a brief intervention (n = 2).

> …they're nervous about coming in, some of them are, right? They're kinda nervous about coming in to begin with just about, to deal with the police charge (Participant 7).

> …some parents have their own problems, so it all depends on the parents. I mean you've got your supportive parents that come through here and, sometimes you have parents that just come through and they play a lot of lip service too so (Participant 5).

4.6 | Challenges and barriers

4.6.1 | Staff comfort—For participants ($n = 7$) who discussed feeling comfortable with implementing a brief suicide intervention, comfort level differed between those who were newer to their positions (less than 3 years) and those with more experience (10 years or more). Three staff who had been employed by the court for less than three years ($n = 3$) expressed confidence in their ability to learn and implement a brief intervention, whereas staff ($n = 3$) who had been employed for more than 10 years were much less confident. Only one respondent was unclear about comfort level.

> I don't know if training would ever alleviate my comfort level, probably not. An hour of training verses years of schooling, I'm trusting the years of schooling… My training would have to be extreme for me to feel comfortable letting a youth go after a safety plan without a clinician's approval (Participant 2).

> I think I'd be pretty comfortable. I think they'd be agreeable for the benefit of the kids (Participant 5).

4.6.2 | Family comfort—The comfort and reaction by families, as perceived by court staff, varied within and across conversations. Most individuals ($n = 9$) identified multiple likely responses (positive, neutral, and/or negative) within the same conversation, depending on characteristics and dynamics of the family. Only one court staff described solely positive reactions by families. The most common reason staff felt families would be positive was that families would support any intervention that helped keep youth safe in the community ($n = 7$). Staff also believed that parents would feel supported ($n = 2$). No other positive reasons (e.g., youth feeling heard) were mentioned more than once.

> It'll be addressed in a way that they can understand. We're not really giving them a long term focus on it, but that's sort of an initiative for the parents to be informed about it, for the youth to understand their feelings and thoughts do matter. And whatever they disclose in the MAYSI is of importance regardless of if the parent thinks so or not (Participant 10).

Neutral responses ($n = 6$) emphasized that some families may have engaged in treatment already and, thus, feel indifferent to needing an additional intervention at that moment. Two main themes of potential family discomfort emerged. The first centered around youth discomfort with parents' participation ($n = 4$). Staff anticipated that a precipitating factor, such as undisclosed family trauma, gender or sexual identity stressors, and/or lack of parent cultural support for mental health, might affect the degree of comfort.

> …one of my juveniles is struggling with identity and transgender issues and they have a parent that, I would say, education is not there at this point in topics related to that. If that is one of the issues that's causing some depression and some suicidal

> thoughts and you have a parent that maybe isn't understanding, it could also be tense (Participant 8).

Importantly, two participants considered whether families might believe a brief suicide intervention was not within the scope of the court staff's role ($n = 2$). However, one participant expressed an opposing perspective, stating that utilizing clinical staff instead of court staff could make families uncomfortable.

> I think they might feel reserved because they've spent over 45 minutes to an hour with the [court staff], so having somebody else come here who doesn't know about the case, who doesn't know about what went on during the informal hearing, and just focusing on the mental health component, the family might feel a little bit uncomfortable about it (Participant 10).

4.6.3 | Logistical—Within this conversation, the primary refrain ($n = 8$) was additional burden on staff time. Participants specifically discussed challenges with spacing out appointments to accommodate a brief suicide intervention. Due to location and age of the court, concerns regarding the limitations of office space ($n = 4$) to accommodate individual interventions and the added financial burden on families to pay for longer parking were also discussed ($n = 4$). Finally, the extent to which staff cultural and gender diversity matched client diversity ($n = 4$) arose as an important consideration for implementing a brief suicide intervention.

> a female might be more comfortable talking to a female compared to talking to a male depending what the issue they might be having. Sometimes a guy might be more interested in talking to a man than a woman. That could be a little bit of a snag…safety assessment makes not necessarily a longer day but just a more hectic day (Participant 5).

4.7 | Feasibility: readiness for change and overcoming challenges to conduct a brief suicide intervention

4.7.1 | Staff comfort—All participants discussed the importance of initial training ($n = 10$) as well as continuous training and supervision ($n = 8$). Even with training and supervision, many expressed doubts that their comfort would ever allow for complete independence from in-the-moment clinical support ($n = 6$), which was the second main theme. In-person clinical support available during a brief intervention was a priority for most. However, one staff proposed a more collaborative solution.

> Certainly, if they don't feel comfortable doing it, a lot of people work to help each other out. So certainly if somebody is more comfortable, and have more, not qualified, but have more experience doing it with their own youth then certainly it would be natural to ask somebody else if they can do the intervention with the family instead of not doing it at all (Participant 10).

At the same time, this participant noted that colleagues may be more inclined to provide the intervention if there was a top down approach.

> If it's a mandatory thing then they will do it, but if it's something they have the option to do or not, I think some might be more lenient to use it, others might not think of it as something that's needed to be done, but it's always an option for them. There are different opinions about addressing different things. They might just stick to the old way of just doing the secondary screen and then getting the mental health person inside the office to address that (Participant 10).

4.7.2 | Logistical—Most individuals (n = 7) who raised logistical barriers responded with possible solutions. For example, five participants recognized that the burden on staff time could be balanced by spreading out court appointments if support was provided by the administration.

> So the timing is not the biggest issue. It would take some adjustment on our end, and administration would make sure we made that adjustment (Participant 2).

Similarly, some staff (n = 3) who raised parking as an issue were hopeful funds could be allocated to help support families with financial needs, though there were no firm solutions. Regarding the impact of additional time on family obligations (work, school, childcare), one participant suggested notifying families in advance of the maximum time an appointment might require. However, another participant noted that families are not provided with any time frame for their original appointment so there is less likelihood that family conflicts will arise.

5 | DISCUSSION

The current study involved qualitative formative evaluation interviews designed to examine stakeholders' perceived acceptability and feasibility of a brief safety planning intervention conducted by nonclinical, court staff for youth within the JJ system. The main issues assessed were staff perceptions of perceived need for suicide risk prevention, the fit of the intervention with the JJ system, and the court system's readiness for change in conducting such interventions with JJ youth. Court staff were interviewed regarding their prior experiences working with youth reporting SI, their perceptions of the need for a safety planning intervention in the court setting, the fit of safety planning within the court system, and the anticipated challenges and possible solutions to incorporating safety planning into existing court procedures.

The interviewees described several barriers to the implementation of the safety plans, including, but not limited to, staff comfort with delivering a suicide intervention, and several logistical issues (i.e., office space, parking, child care). Despite these barriers, the interviewees also noted several ways to mitigate these issues, such as emphasizing the need for initial training and supervision to improve staff comfort and spacing out appointment times. Thus, court staff overall were positive about the inclusion of a safety planning service within the juvenile court system. Specifically, most court staff viewed a safety planning intervention as needed and acceptable within the family court, with all staff describing benefits and many acknowledging that safety planning would be consistent with the role and objectives of the family court.

The overall positive perception of implementing safety planning was likely related to court staff's knowledge of existing screening and referral procedures for SI in the court. Generally, staff were able to correctly describe the process by which youth were screened for SI and other mental health concerns via the MAYSI-2 for SI and then referred, as needed, to clinical staff at the family court for further evaluation. Involvement in this process may have resulted in greater awareness of youth mental health needs, greater efforts by court staff to obtain appropriate mental health services for JJ youth, and greater likelihood of implementing appropriate precautions for youth expressing SI (Aalsma, Schwartz, & Perkins, 2014; Models for Change, 2011). In turn, this prior integration of mental health screening into the role of nonclinical court staff may have primed them to recognize the benefits of a safety planning intervention. In particular, staff often noted the frequency with which youth endorse clinically meaningful levels of SI on the MAYSI-2, which may have resulted in their view that a safety planning service through the court would be useful and acceptable.

Consensus on the acceptability of the intervention and its fit within the family court philosophy may also be attributable to organizational level factors, which can have a significant impact on implementation of evidence-based practices (Aarons, 2004). Court staff interview responses indicated beliefs consistent with the traditional rehabilitative philosophy of the juvenile court system. This general climate seems to have established the foundation for implementing a safety planning intervention within this court setting at the diversion level. The overwhelming primary benefit of the intervention, as stated by those interviewed, was the safety and support of youth and families. Staff described genuine concern for youth welfare as *the* motivating factor to implementing a brief suicide intervention. Thus, the intervention appears acceptable within this family court culture.

Organizational contextual factors, defined as culture, climate, and work beliefs, may also influence the successful accommodation and uptake of an intervention within an organization (Cabassa & Baumann, 2013; Glisson, Green, & Williams, 2012). Relevant here is our finding that the proximate timing of the intervention to the identification of SI was perceived by most staff as an acceptable and important additional benefit of the intervention. Delays in accessing timely treatment are a systemic problem across the United States (Institute of Medicine, 2005) and were highlighted by stakeholders during the course of the interviews.

While the interviews demonstrated initial support for elements of both organizational culture (e.g., helping youth) and beliefs (e.g., about the disadvantages of delays in accessing treatment), there was a sharp split among court staff around staff role and comfort with implementing the intervention. While the majority of staff appeared to agree that adopting a safety planning intervention was consistent with family needs and family court goals, there was less agreement about who was to take responsibility for conducting the intervention. Only two staff observed that it would be their responsibility to conduct safety planning. Perhaps not surprisingly, other staff expressed that it was not their responsibility to conduct a clinical intervention, citing the clinical staff present at the court as being most suited to do so.

Family court staff, especially when employed for longer periods of time, were concerned about their ability to learn and independently conduct a brief suicide intervention without clinical support. The potential for change in, or addition to, their staff role had less impact on staff who had been employed only a few years. This finding may suggest that more resources and/or different implementation strategies will be needed for longer-term staff. A strategic roll out of intervention deployment with newer staff incorporating these tasks into their daily functions first, with more experienced staff to follow, might increase uptake. Staff who were hesitant about the new process did not necessarily distinguish between a brief suicide intervention and brief interventions more generally. However, court staff were most concerned about "letting a youth go" without a sign-off by a clinician rather than conducting the intervention itself. This may suggest that staff could be comfortable implementing the intervention if they were able to consult with clinical staff, who they viewed as experts, prior to youth leaving their appointment.

Understanding and addressing staff comfort will impact the degree to which court staff find the intervention acceptable and are willing to participate in the implementation process. Conversations with staff generated possible adaptations to the implementation process that might improve comfort. Agreement on the importance of initial training (i.e., educational) was universal. There was also almost complete agreement on the necessity of ongoing training and supervision (i.e., quality management) after implementation to develop the skills and comfort level for conducting the intervention. Court staff also promoted the development of clear and detailed step-by-step policies and procedures (i.e., planning). However, several staff acknowledged that, even with these implementation strategies, change will be challenging and likely nonlinear. There was one comment suggesting that a mandatory top-down approach might be the primary way to gain adherence to implementation procedures. Nonetheless, staff buy-in through planning, educational, and quality management implementation tools, identified in advance through qualitative interviews and then deployed throughout implementation efforts, may better address barriers over time (Bunger et al., 2017).

Having clinical staff integrated into the structure of the family court appears to offer both benefits of and challenges to the acceptability of a safety planning intervention conducted by nonclinical court staff. The introduction of safety planning for nonclinical staff may face resistance from staff who do not view it within the scope of their role in the family court, especially when clinical staff are also employed by the court. However, having access to clinical staff may also make nonclinical staff feel that they can refer a suicidal youth to clinical staff if they do not feel comfortable conducting the intervention. Alternatively, nonclinical staff may be willing to conduct the intervention if the ultimate responsibility for the disposition decision is made in conjunction with, or solely by, clinical staff. In this sense, having clinical staff readily available for consultation, supervision, and training appears to be an asset in enhancing the comfort of staff implementing the intervention. Thus, providing training and supervision resources through a mental health clinic may serve to enhance the effectiveness and sustainability of a safety planning service.

Family court staff thoughtfully considered the multiple possible outcomes that a brief suicide intervention administered by court staff might have on youth and their parents/

caregivers. Overall, staff perceived the family court's and family's goals as overlapping, that is, staff perceived that parents/caregivers would also support any intervention that kept youth safe in the community. Staff identified youth apprehension about parent participation as a possible barrier to the implementation of safety planning. Specific concerns included previously undisclosed gender or sexual identity issues, parents' mental health issues impacting their ability to support the youth, and parent cultural norms refusing to recognize the existence of mental health issues. Prior research on safety planning has stressed the importance of youth/parent collaboration during the process to improve use of plans (Kennard et al., 2015). The identification of these perceived barriers can inform the development of educational and quality management implementation strategies to help improve staff comfort, fidelity, and uptake of the intervention. These perceived concerns also highlight the potential challenge of implementing an intervention with fidelity. Addressing potential youth and family discomfort during training may help improve staff confidence and improve fidelity to the intervention.

5.1 | Limitations

To our knowledge, this is one of the first studies to examine perspectives from nonclinical JJ staff on providing a brief suicide intervention with youth involved in the family court system. Nonetheless, there are several limitations to the study. Because participants were recruited through one particular site, their perspectives may differ from those in other jurisdictions depending on organizational culture and context. The generalizability of these findings may also be limited by the stage of JJ processing (e.g., court diversion program) in which staff were employed. Finally, the fact that some of the interviewees would not be called upon to engage in the proposed program must be taken into account.

5.2 | Future directions

In addition to replication of these findings with court diversion staff in other jurisdictions, future research should examine these constructs with other nonclinical JJ staff (e.g., probation officers and detention center staff) throughout the JJ continuum who are likely to deliver a brief suicide intervention, such as safety planning. Second, perceived youth and family reactions to safety planning versus experienced reactions should be explored to understand possible areas of discomfort prior to implementation. Post-implementation interviews with both staff and families may further elucidate intervention fit and acceptability by nonclinical JJ staff. After implementation, acceptability and feasibility ratings may change once staff have experience conducting the intervention. Third, the current study focused on the implementation of one specific type of brief intervention by nonclinical JJ staff. Future research could also examine the implementation of general evidence-based practices by nonclinical JJ staff.

Building on stakeholders' concerns about the perceived need of the safety planning intervention, its fit within the JJ system, and the court system's readiness for adopting such an intervention, future work should identify specific implementation strategies, defined as "methods or techniques used to enhance the adoption, implementation, and sustainability of a clinical program or practice" (Proctor, Powell, & McMillen, 2013), to enhance the adoption of safety planning intervention at the time of rollout within the JJ court system. To

increase buy-in to the safety intervention, in a future study the formative evaluation data on perceptions of acceptability and feasibility of implementing the safety planning intervention in the JJ system will be mapped onto a list of 73 evidence-based implementation strategies, to determine which of these may be most appropriate to use in the court system (Powell et al., 2015).

6 | CONCLUSION

By interviewing key stakeholders, we were able to develop a more in-depth understanding towards their involvement in a brief suicide intervention, safety planning. A majority of the stakeholders indicated the benefit of safety planning at the initial intake appointment over making a referral for a mental health evaluation, citing youth safety as the need for an immediate intervention. Because nonclinical staff are increasingly asked to learn and conduct clinical interventions, these qualitative interviews add to our understanding of how to promote the implementation of public health interventions.

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