Juvenile Probation Officers’ Lived Experiences of Collaboration with Clinical Mental Health Counselors: An Interpretive Phenomenological Analysis.

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I am submitting herewith a dissertation written by Henrietta Gantt entitled "Juvenile Probation Officers' Lived Experiences of Collaboration with Clinical Mental Health Counselors: An Interpretive Phenomenological Analysis." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Counselor Education.

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(Original signatures are on file with official student records.)
Juvenile Probation Officers’ Lived Experiences of Collaboration with Clinical Mental Health Counselors: An Interpretive Phenomenological Analysis.

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ABSTRACT

Juvenile offenders (JO) are at high-risk due to significant mental health challenges. We review the importance of collaboration between the mental health providers and juvenile justice system (JSS) and identify that more research regarding collaboration experiences between clinical mental health counselors (CMHC) and juvenile probation officers (JPO) would be beneficial. Using interpretive phenomenological analysis (IPA) we explored JPO’s lived experiences of collaborating with mental health professionals (MHP). The aim of the study was to unveil more nuance and description of collaboration efforts to better support JO. Our findings offer a systemic understanding of collaboration as well as the catalysts and antagonists of its success. Findings include three higher constructs, three super-ordinate themes and six subordinate themes. The higher constructs identified are a system of multiple parties and arenas, a screening and referral process, and antagonists to collaboration. Super-ordinate themes include intentional initiation (subordinate themes: networking and setting relational expectations), consistent and responsible communication (subordinate themes: reporting information and problem solving), and culturally and systemically aware counseling (subordinate themes: connection with JO and family and reducing barriers). We provide direct implications for CMHC, JPO, and future researchers.

Keywords: Juvenile Offenders, Multidisciplinary Collaboration, Clinical Mental Health Counseling, Social Justice, Advocacy
# TABLE OF CONTENTS

**INTRODUCTION** ........................................................................................................... 1
  Mental Health Impacts in the Juvenile Justice System ................................................. 2
  Mental Health Services ............................................................................................... 4
  Mental Health and Juvenile Justice Collaboration ...................................................... 6
  Purpose ....................................................................................................................... 7

**CHAPTER I: Counselor Advocacy through Collaboration in the JJS** ............................. 8
  **ABSTRACT** ........................................................................................................... 9
  Counselor Advocacy and the ACA ACC .................................................................... 10
    Micro Level ............................................................................................................. 11
    Meso Level ............................................................................................................. 13
    Macro Level ........................................................................................................... 14
  Conclusion ............................................................................................................... 16
  **REFERENCES** ..................................................................................................... 18

**CHAPTER II: Empirical Manuscript** ......................................................................... 24
  **ABSTRACT** .......................................................................................................... 25
  Introduction ............................................................................................................... 25
  Clinical Mental Health Counselors ............................................................................ 26
  Juvenile Probation Officer ......................................................................................... 28
  Purpose of the Study .................................................................................................. 29
  Methods .................................................................................................................... 29
    Participants ............................................................................................................ 30
    Procedures ............................................................................................................. 30
    Data Analysis ......................................................................................................... 32
    Data Quality .......................................................................................................... 33
  Findings .................................................................................................................... 34
    Higher Constructs .................................................................................................. 34
      A System of Multiple Parties and Arenas ............................................................. 34
      The Screening and Referral Process .................................................................... 36
    Antagonists to Collaboration .................................................................................. 37
    Super-Ordinate Theme 1: Intentional Initiation ...................................................... 38
      Sub-Ordinate Theme 1a: Networking .................................................................... 39
      Sub-Ordinate Theme 1b: Setting Relational Expectations ..................................... 40
    Super-Ordinate Theme 2: Consistent and Accessible Communication .................... 40
      Sub-Ordinate Theme 2a: Problem Solving ........................................................... 41
      Sub-Ordinate Theme 2b: Reporting Information .................................................. 42
    Super-Ordinate Theme 3: Culturally and Systemically Aware Counseling ............... 43
      Sub-Ordinate Theme 3a: Lack of Judgement ....................................................... 43
      Sub-Ordinate Theme 3b: Reducing Barriers .......................................................... 44
  Discussion .................................................................................................................. 44
  Implications ............................................................................................................... 47
    Counseling Practice ............................................................................................... 47
    Systemic Change .................................................................................................... 48
  Limitations and Future Research .............................................................................. 50
  Conclusion ................................................................................................................ 51
  **REFERENCES** .................................................................................................... 53


APPENDICES ........................................................................................................ 58
APPENDIX A: Informed Consent ............................................................................. 58
APPENDIX B: Recruitment Email .......................................................................... 62
APPENDIX C: Participant Survey ........................................................................... 63
CONCLUSION ....................................................................................................... 64
VITA .................................................................................................................... 65
LIST OF TABLES

Table 1: Participants .................................................................................................................... 30
LIST OF FIGURES

Figure 1: Findings .................................................................................................................. 41
INTRODUCTION

The long-term effects of systemic racism in the Juvenile Justice System (JJS) is acutely reflected through the concept of the School to Prison Pipeline. This concept describes the overrepresentation of Black people and people of color in the justice system starting from youth into adulthood (McCarter & Durant, 2022). Early experiences of arrests and juvenile charges are more likely to lead to immediate arrests and sentencing in early adulthood to late adulthood, tied to subsequent employment and financial difficulties (McCarter & Durant, 2022; Wojchiechowski, 2023). Even more devastating, death or poor health outcomes are higher with Black youth or young adults due to over policing or police brutality (Jindal, 2023). These long-term consequences have also been associated with the overrepresentation of mental illness in this population of youth and lack of appropriate services (McCarter & Durant, 2022; Wojchiechowski, 2023). Therefore, early identification and treatment of these concerns and proactive services for reducing barriers can help to interrupt the pipeline.

According to the Office of Juvenile Justice in Delinquency Prevention (OJJDP), in 2020 police arrested 424,300 youth under the age of 18. Arrests included, but were not limited to, charges of murder and nonnegligent manslaughter, burglary, assault, drug abuse, and disorderly conduct. Juvenile offenders (JO) are a large and diverse population defined by being under the age of 18 and by being charged with a criminal offense. JO may be on court-ordered probation living at home, placed in a residential treatment center or within the state foster-care system, or withheld in a juvenile detention center. JO have higher rates and severity of mental health disorders, are more likely to be impacted by Adverse Childhood Experiences, and are more likely to be people of color, have low socioeconomic status, or have a diagnosed disability (Astridge et al., 2023, Bealdry et al., 2021, Crosby et al., 2017; Jindal, 2023). Additionally, JO
are often not referred to or receive appropriate mental health services (Lopez & Nuño, 2016; White, 2016; Zeola et al., 2017). However, JO who receive mental health services, especially JO of color or JO with disabilities, have positive mental health impacts and reduced recidivism rates (Applegrath et al., 2022; Burke et al., 2015; Zeola et al., 2017).

Although mental health needs for JO are high and the effectiveness of mental health treatment is documented, commensurate referrals are lacking, and many JO do not receive mental health treatment (Swank & Gagnon, 2017). JO literature describes how local, state, and federal programs can facilitate adequate mental health care for JO through interdisciplinary and community collaboration (Barrett & Olle, 2016; Kapp et al., 2015; Quarishi & Benton, 2015). CMHC are well positioned to collaborate with the juvenile justice system (JJS) to help JO receive treatment. The purpose of this article is to use the ACA ACC (Toporek & Daniels, 2018) to guide CMHC in professional and social justice advocacy for JO.

**Mental Health Impacts in the Juvenile Justice System**

The degree of mental health concerns among JO is illustrated through the high prevalence of mental health concerns layered with comorbidity, substance use, trauma/adverse childhood experiences, further involvement within the justice system, and racial/cultural disparities. Quantitative studies and periodic reports provide evidence for the high mental health needs of JO indicating that at least 70% have a diagnosable mental health condition (Baglivio et al., 2016; Beadry et al., 2021; Burke et al., 2015). Researchers most often report mood and conduct related disorders with oppositional defiant disorder and conduct disorder being the most prevalent with males and major depression and posttraumatic stress disorder being most prevalent with females (Beadry et al, 2021; Burke et al., 2015, Underwood & Washington, 2016). Other concerns include attention deficit hyperactivity disorder, substance use disorders, anxiety disorders, and
bipolar disorders (Beadry et al., 2021; Burke et al., 2015). It is clear the mental health needs of this population are diverse and complex.

JO mental health concerns are further complicated due to a higher likelihood of comorbidity and substance-use related disorders compared to youth not involved in the JJS (Beadry et al., 2021; Burke et al., 2015, OJJDP, 2017). Likewise, trauma and adverse childhood experience reports are significantly higher for this population (Astridge et al., 2023; Baglivio et al. 2016; OJJDP, 2017), with increased adverse childhood experience scores being related to increased chances of recidivism (Astridge et al., 2023). Unfortunately, more offenses and more involvement with the JJS have been related to more severe mental health concerns and increased recidivism (Astridge et al., 2023; OJJDP, 2017; Underwood & Washington, 2016). This cycle of recidivism keeps youth in the court system or detained, inhibiting opportunities for success in their community.

Disproportionate diagnostic rates for JO with marginalized identities and barriers to mental health care for these youth lead to social injustice (Baglivio et al., 2016; White, 2016). Youth with first time offenses and Black youth experience the most positive impact from mental health services (Burke et al., 2015; Zeola et al., 2017); however, youth of color are less likely to receive treatment than White youth (Baglivio et al., 2016; White, 2016). Likewise, JO with disabilities are under-referred for mental health services despite their high needs (Crosby et al., 2017. Similarly, Latinas have unique mental health needs with trauma and mood disorders overlapping, but they receive low frequency of mental health referrals and treatment that may not attend to their culture (Lopez & Nuno, 2016). Appropriate screenings, referrals, and services relevant to JO cultural identities also need to be developed (Lopez & Nuno, 2016; White, 2016).
Overall, these studies have revealed the imminent need for mental health referrals, diagnoses, and provision of effective treatment for JO with marginalized identities.

**Mental Health Services**

Mental health services potentially interact with various elements of the JJS including incarceration, probation, and reentry. JO receive roughly 5% of mental health services received by adolescents overall, with JO commonly needing more intensive treatment (Duong et al., 2021). Mental health services in Juvenile Corrections Facilities (JCF) typically include counseling programming, case management, therapy, and treatment planning (DiCaltado et al., 2017; Swank & Gagnon, 2016). JO may receive care in school-based therapy, inpatient services, in corrections, outpatient, and home-based services (Duong et al., 2021). Clinical staff, including CMHC, psychologists, and social workers report that around 70% of JO receive information regarding access to mental health services while in JCF (Swank & Gagnon, 2016). Therapeutic approaches include multisystemic therapy, cognitive approaches, behavioral approaches, trauma focused approaches, and family services (Wangari et al., 2023). Likewise, clinical staff shared their perceptions that mental health services in JCF are accessible and appropriate for the specific needs of JO (DiCaltado et al., 2017; Swank & Gagnon, 2016).

JO on probation typically access mental health services after receiving a referral to outside mental health agencies (Aalsma et al., 2014; Beadry et al., 2021; Zeola et al., 2017). Referrals correlate with lower rates of recidivism and a greater latency period before recidivism occurs (Zeola et al., 2017). However, overall referral rates across race and sex have been found to be as low as 20% (Burke et al., 2015). Many JO and their caregivers have reported a lack of knowledge of or referral to mental health services despite their expressed interest (Aalsma et al., 2014; Burke et al., 2015; Elkington et al., 2020). This disconnect between mental health needs
and mental health services received is described as “falling between two systems of care” (Elkington et al., 2020, p. 1).

Reentry is the process of JO returning to their community after prolonged detention within a detention facility or treatment center. Intentional reentry includes providing services that assists with successful reentry and avoiding recidivism (Aalsma et al., 2014; OJJDP, 2020, Swank & Gagnon, 2017). Reentry does not necessarily include mental health services, but is most successful when it does. Reentry is even more effective when services begin before the juvenile exits detention and should be modified to target individual and community needs (OJJDP, 2020; Stamidis, 2022). More funding through the BJA and OJJDP has been offered since the Second Chance Act was renewed in 2018, with regular applications for services to support juveniles and adults (BJA, 2022). Mental health professionals are qualified and competent personnel to apply for and provide these services.

The cycle of mental health concerns and recidivism is vicious, but appropriate implementation of mental health services can redirect this cycle. Researchers have recently conducted meta-analysis and intervention studies to determine that psychological therapeutic intervention and behavioral interventions can reduce overall mental health concerns and risky behaviors (Beadry et al., 2021; Skeen et al., 2019). Quantitative methodological studies have suggested that multisystemic therapy and cognitive approaches have been found to be most successful (Applegrath et al., 2022; Wangari et al., 2023), while a qualitative study identified that individualized and wraparound approaches with family services were most impactful (Sadimis, 2022). Furthermore, mental health services appear to help reduce recidivism rates or behaviors that may lead to arrest (Applegrath et al, 2022; Skeen et al., 2019). The potential
impacts of successful mental health treatment could be monumental in altering the long-term consequences JO face.

**Mental Health and Juvenile Justice Collaboration**

Intentional and effective collaboration between mental health providers and JJS may be the key to ensuring JO receive well matched and adequate mental health services. While mental health services can be successful (Applegrath et al., 2022; Wangari et al., 2023), insufficient collaboration appears to influence the overall low rates of treatment and referrals (Elkington et al., 2020). The need for better collaboration is repeatedly identified; therefore, more formal collaboration efforts and partnerships are being developed to provide more opportunities for mental health care for individuals in the JJS (OJJDP, 2020; Quarishi & Benton, 2014, Shufelt et al., 2010). Similarly, grant funding is being offered to help establish more formal working alliances across disciplines (OJJDP, 2020; Bureau of Justice Assistance, 2022). The call for CMHC and other mental health providers (MHP) to learn about and engage in collaborative efforts within the JJS is clear.

Programs developed so far include tools and programming for mental health screening and funding for free and accessible mental health services for JO (BJA, 2022; Quarishi & Benton, 2014). Some of these programs include Medicaid’s Early Periodic Screening Diagnosis and Treatment Program, the Individuals with Disabilities Education Act (IDEA), and Section 504 of the Rehabilitation Act of 1973 (Section 504) (Quarishi & Benton, 2014). Recently, the Bureau of Justice Assistance in the US Department of Justice, developed the FY 2022 Improving Adult and Juvenile Crisis Stabilization and Community Program. This program was developed to offer funding to non-profit organizations or local and state governments to develop services and partnerships to reduce disparities in mental health treatment for adults and JO (BJA, 2022). The
OJJDP developed a similar initiative in 2020 offering funding to develop formal collaborative partnerships between JJO and mental health agencies (OJJDP, 2020).

Juvenile justice officials (e.g., judges, probation officers, defense attorneys, and district attorneys) and MHP can serve as advocates by increasing JO access to mental health services (Kapp et al., 2013; Shufelt et al., 2010; Quarishi & Benton, 2014). This form of advocacy is illustrated through researching and implementing these federal, state, or local programs and engaging in intentional efforts of collaboration between these court officials and MHP (Kapp et al., 2013; Quarishi & Benton, 2014; Shufelt et al., 2010). Quarishi and Benton (2014) described optional collaboration as having multidisciplinary teams or conferences to identify the strengths and needs of specific JO to ensure referrals to appropriate mental health services or community programs. The purpose of these collaborations is to provide more effective support for JJO and to reduce overall recidivism.

**Purpose of this Study**

It is timely and important to explore the actual experiences of collaboration between JPO and CMHC to better understand its efficacy, process, and outcomes. Therefore, the purpose of this study is to explicitly explore the experience of that collaboration through the perspective of JPO. The findings of this study will help CMHC better understand how to advocate through collaboration within the JJS, specifically with JPO. Findings may help CMHC and JPO better collaborate so that JO and their families may receive more comprehensive support and needed mental health services. The specific research questions guiding the study are: what are the JPO’ lived experiences of collaborating with CMHC?; and how do JPO and CMHC collaboration experiences support
CHAPTER I: Counselor Advocacy through Collaboration in the Juvenile Justice System
ABSTRACT

Using the American Counseling Association (ACA) Advocacy Counseling Competencies (ACC), this article describes how clinical mental health counselors (CMHC) can advocate for juvenile offenders (JO) across the micro, meso and macro service levels. The importance of collaboration between the mental health system and juvenile justice is described throughout, alongside the importance of intentional collaboration across all levels of the ACA ACC. The specific needs of the JO population including severity of mental health, high rate of marginalized identities, and impact of systemic racism are described, indicating this population as highly vulnerable. We offer specific suggestions for using the ACA ACC for CMHC in various settings.

Counselor Advocacy through Collaboration in the Juvenile Justice System

Advocacy is an integral part of professional counseling. The ACA Code of Ethics (2014) and the multicultural and social justice competencies highlight the specific need to advocate for vulnerable populations including marginalized individuals and groups experiencing severe mental health concerns. CMHC have an ethical duty to understand clients within the context of a large and interactive system and respond with appropriate advocacy efforts to promote wellbeing inside and outside of counseling sessions (ACA, 2014).

The high prevalence of JO mental health needs and long-term detrimental consequences easily identifies this population as a vulnerable group (Burke et al., 2015; Carrola & Brown, 2018; Jahdil, 2023). Furthermore, researchers who have explored mental health disparities for marginalized youth in the JJS have explicitly called for social justice efforts to reduce these disparities (Lopez & Nuno, 2016; White, 2016; Jahdil, 2023). CMHC have an ethical obligation to advocate for the quality of mental health care and treatment for these individuals and are well positioned to do so (Carolla & Brown, 2018).
On a community-based level, CMHC should engage with the relevant supportive individuals within institutions who can influence the experiences or services of marginalized clients. This call is reiterated by numerous attempts of state and federal agencies calling for and offering funds to support intentional collaboration between mental health professionals and JJS. Concepts of social justice advocacy are encouraged through the ACA ACC (Barrett & Olle, 2016; Lopez & Paylo, 2010; Toporek & Daniels, 2018), and can be further enhanced by embracing these competencies through collaboration with both JO and JJO. CMHC should consider how they can integrate advocacy and collaboration to support JO.

**Collaborative Advocacy and the ACA ACC**

CMHC can use the ACA ACC (Toporek & Daniel, 2018) as a guide for serving this population on many different levels. The ACA ACC range across three levels of intervention: *micro*, *meso*, and *macro*, based on the different needs of JO vs. the overall population, and on a spectrum of the extent of client involvement: either *in collaboration with*, or *on behalf of* a specific client, group, or population (Toporek & Daniels, 2008). CMHC may use this spectrum to decide when to exert energy towards direct systemic intervention if they are advocating on behalf of a vulnerable client and when to exert more energy towards supporting a specific client, group, or an existing organization.

The JJS is a complex system that was not initially designed to meet the mental health needs of those involved (Quarishi & Benton, 2014; Shufelt et al., 2010). CMHC can engage in systemic advocacy by engaging in collaborative efforts to combat the systemic barriers affecting this population (Lopez & Paylo, 2010). Across all domains and levels, intentional advocacy based on the needs of the JO or their supporting systems should be determined through clear communication. Previous researchers have specifically highlighted systems advocacy and
community collaboration as powerful forces in social justice advocacy, particularly related to juvenile justice collaboration (Barrett & Olle, 2016; Lopez & Paylo, 2010). However, collaboration should be involved within each integration of the ACA ACC.

**Micro Level**

The micro level of the ACA ACC includes client empowerment and client advocacy (Toporek & Daniels, 2008). Client empowerment might include communicating in session with the JO to help them use their own locus of control and awareness of strengths and barriers to self-advocate for their needs. Client advocacy on the microlevel includes communicating with relevant parties, which may be a JJO, public defender, or school principal to communicate the needs of the JO and to develop an action plan to meet those needs. A CMHC supporting a JO on the microlevel should engage directly with the JO or individuals close to the JO who have influence on their wellbeing or success to communicate and create plans of navigating barriers to their wellness.

Working with the JO on the microlevel should be centered around cultural sensitivity. Because of the racial discrimination many JO experience, as well as the unique cultural considerations of this diverse group, services provided by CMHC should be individualized to their needs with recognition of the systemic barriers they may face (Astridge et al., 2023; Lopez & Nuno, 2016; Wangari, 2023). However, CMHC should not assume barriers or experiences with discrimination, but allow the JO to explain their experiences, as the expert. Furthermore, CMHC should also provide information on screening JO for mental health treatment with recognition of racial or cultural needs to JJO that are responsible for referring JO for treatment.

Within the microlevel, CMHC should make conscious and consistent efforts to create and improve relationships and collaborations with relevant personnel in the JJS including, but not
limited to, probation officers (Kapp et al., 2013, Quarishi & Benton, 2015). The CMHC can attend larger meetings or create smaller meetings with relevant officials. It is important to initiate and maintain contact to encourage collaboration and referrals (Kapp et al., 2013; Shufelt et al., 2013). CMHC working in the court should set up individual and group meetings to discuss their role in the court system and how they hope to work together to support JO. CMHC should offer JJO information about their role as CMHC and discuss how the JJO’s expectations may be met.

Intentional initiation and maintenance should be included to facilitate successful collaboration. Past researchers identified the importance of initiating collaboration for CMHC in and out of the court system (Kapp et al., 2013; Shufelt et al., 2010). CMHC working with JO outside of the court could initiate meet and greets. For example, CMHC could arrange introductory meetings that allow both parties to share their backgrounds, purposes, contact information, expertise, and reimbursement methods. Shufelt et al. (2013) and Kapp et al. (2013) also highlighted the importance of consistency to maintain these relationships. So, CMHC should make it a regular practice to follow up and check in with JJO even if they do not have a client together currently. Maintaining collaboration should also include advocating through for the JO by providing brief progress reports to JPO, sitting in on child family team meetings with state custody personnel, or explaining grounding techniques to JJO, to help assist clients. Content of regular progress reports should be based on expectations set through initially meeting with the JO. CMHC can maintain collaboration by communicating with probation officers or JJO to let them know that the JO has been consistent and engaged with counseling consistent with informed consent and prior conversations with JPO regarding their expectations.
**Meso Level**

The meso-level of the ACA ACC offers insight to the heart of the collaboration between the juvenile justice and mental health system. The meso level competencies, community collaboration and systems advocacy, offers guidelines for CMHC supporting JO within the community and within specific systems such as schools or juvenile courts (Toporek & Daniels, 2018). Community collaboration refers to allying with the relevant organizations in the community that are already supporting this population or address a specific issue (Toporek & Daniels, 2018). Whereas, systems advocacy refers to CMHC facilitating systemic change on behalf of JO within a specific system, including the JJS but not excluding schools or the community (Toporek & Daniels, 2018).

Court affiliated CMHC can be involved within the mesosystem by changing protocol with the system and building more formal collaboration through systems advocacy. To counter the lack of appropriate screenings and referral for JO mental health services (Elkington et al., 2020), CMHC can develop a specific referral and follow up process between CMHC and JJO. CMHC may also advocate for a process or position to be accessible and available in the courtroom to screen for clients needing mental health treatment, gain knowledge during court about client mental health concerns and community issues, and provide immediate resources to the JO or family. This is similar to Recovery Court procedures for offenders impacted by substance use disorders (Stamidis, 2022). The court counselor may advocate to change protocol to be included in more staff meetings or court cases so the mental health perspective can be provided more often, or JO in need of mental health services can be identified and referred more often.
CMHC have unique opportunities to engage in collaboration as a community resource. The heart of community collaboration includes grassroots approaches to support vulnerable groups through already existing organizations (Toporek & Daniels, 2018). CMHC may partner with community organizations or programs that already support this group to or offer wellness or mental health psychoeducation courses or services for the youth or their families. For example, CMHC can build a relationship with the community gym or YMCA for discounted rates for clients of the juvenile court.

If there is a gap in existing community resources or services, CMHC at a community mental health agency can develop programs for court affiliated youth or youth at risk of offending. Programs should only be developed through collaboration with the community to understand the unique and local needs. CMHC can research local, state, or grant funding to create these programs or positions. Programs particularly dedicated to reentry have significant support by federal funding (BJA, 2022). As Stamidis (2022) suggested, services should begin while the JO is detained to help prepare them for the process of reentry, and explore their supports and barriers before they leave detention. Then the CMHC can work with schools and school counselors to help with the reentry process into the school system. Meso level advocacy must consider all of the different systems including, school, court, family, community, religion to help with successful reentry.

**Macro Level**

The macro level of the ACA ACC is related to advocacy within the public arena and larger policies (Toporek & Daniels, 2018). CMHC may engage in collective action by advocating in partnership with an existing group or organization to inform the public and policy makers on issues and policies. Similarly, if a CMHC is advocating specifically through the
social/ political advocacy competency, then they are advocating for and spreading awareness on issues related to JO on behalf of the relevant needs of this population. JOs’ identity is a direct product of policy and law making; likewise, their mental health and long-term success is impacted by policing and legal consequences (Jindal, 2023). Therefore, macro level advocacy is extremely important and should be handled with sensitivity. Knowledge of the extreme vulnerability with this population, calls all counselors, regardless of their setting, to engage in macro level advocacy to support this population.

Both collective action and social/ political advocacy can influence research, policies, and laws. CMHC should consider how JO prefer to be perceived in this sociopolitical climate and what lawmakers are proposing that could help or hinder them. More research on how to support JO can help to reduce stigma, systemic racism, or systemic barriers and can better serve their longitudinal success and influence policies and laws. CMHC can conduct research directly with JOs to learn about how they want to be perceived and how CMHC can further support them. Some research has begun to explore the positive outcomes of CMHC services with JO, but more should be conducted to support evidence for their potential success.

Alongside more research, CMHC must be aware of and involved with relevant laws or policies on the local, state, or federal level. Knowledge of this population and their barriers are directly related to law and policies (Carolla & Brown, 2018, Jindal, 2023). For example, “tough on crime” policies may have impacts that keep JO with mental health concerns detained rather than given a chance for rehabilitation. The school to prison pipeline demonstrates how damaging laws and oppression keep youth of color or from disadvantaged backgrounds from finding success (Jindal, 2023; McCarter & Durant, 2022; Wojciechowski, 2023). Research already conducted should be shared now to help influence law and policy making.
Before engaging in collective action, CMHC should review existing organizations aimed for supporting JO. The Annie E. Casey Foundation (2023) identifies several organizations that are centered around supporting JO through cultural sensitives, wellness and mental health, and rehabilitation over criminalization. When keeping up with current lawmaking, CMHC should seek involvement in any law or policy referencing “juvenile reform,” as this typically indicates significant impact in the laws and policies that will impact youth at the risk of committing a crime. CMHC should seek to understand how the law or policy considers cultural considerations and mental health and whether it is supportive of rehabilitating youth rather than further oppressing or discriminating. CMHC have unique opportunity to speak up against harmful laws based on our unique and qualified training in mental health, wellness, and cultural sensitivity. Changes in laws and policies has the potential for significant impacts on the success of this population.

**Conclusion**

JO have highly prevalent mental health needs (Bealdry et al., 2021, Burke et al., 2015). Provided mental health services can be successful in reducing mental health symptoms, risky behaviors, and recidivism rates (Applegrath, 2022; Bealdry et al., 2021; Steen et al., 2019); however, overall referral and treatment rates for mental health are lacking (Aalsma et al., 2014; Burke et al, 2015; Elkington et al, 2020). The prevalence of mental health diagnoses has also been correlated with more severe legal consequences, especially for JO of color (White, 2016). Furthermore, the disproportionate rates for mental health diagnoses and number of treatment referrals made for JO of color, particularly Black and Latinx JO, is evident (Burke et al., 2015; Lopez & Nuno, 2016; White, 2016; Zeola et al., 2017) implying they are less likely to receive referral and adequate care. Adding to this frustration, JO of color who receive mental health
services experience benefits including reduced mental health concerns and lower recidivism rates (Baglivio et al., 2016; White, 2016).

CMHC can advocate for this population through interdisciplinary collaboration (Barrett & Olle, 2016; Kapp et al., 2013; Lopez & Paylo, 2016). Effective collaboration is an important strategy for increasing referrals and overall treatment rates for JO (Elkington et al., 2020; Quarishi & Benton, 2014; OJJDP, 2020). Collaboration includes initiating and maintaining contact with other professionals to best support the treatment and wellbeing of clients across multiple systems (ACA, 2016; Lopez & Paylo, 2016; Quarishi & Benton, 2014). CMHC may use the ACA ACC (Toporek & Daniels, 2018) as a guide to support JO across all domains, in ways that are collaborative with JO and other relevant professionals and organizations so that advocacy efforts are congruent with the needs of this population and have the potential to make an impact through a team effort. The suggestions made in this article are conceptual; researchers should explore and describe the experience of collaboration to provide an evidence base for how CMHC can support this population and work with the relevant stakeholders and gateway providers.
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CHAPTER II: Juvenile Probation Officers’ Lived Experiences of Collaboration with Clinical Mental Health Counselors: An Interpretive Phenomenological Analysis
**ABSTRACT**

This study uses Interpretive Phenomenological Analysis to explore Juvenile Probation Officer’s lived experiences of collaborating with counselors. Findings reveal an understanding of the system involved in collaboration and what works and does not work in collaboration. Findings include three higher constructs (a system of multiple parties and arenas, a screening and referral process, and antagonists to collaboration), and 3 super-ordinate themes and 6 subordinate themes. Super-ordinate themes include intentional initiation (subordinate themes include networking and setting relational expectations, Consistent and responsible communication (subordinate themes include reporting information and problem solving), and culturally and systemically aware counseling (subordinate themes include no judgement and reducing barriers). Direct implications for practicing counselors and future research are provided.

**Juvenile Probation Officers’ Lived Experiences of Collaboration with Clinical Mental Health Counselors: An Interpretive Phenomenological Analysis**

Juvenile offenders (JO) qualify as an exceptionally vulnerable group in the United States. As youth, they are significantly more likely to experience severe mental health needs, have histories of trauma and adverse childhood experiences, and hold a marginalized identity (Astridge et al., 2023; Beadry et al., 2021; Underwood & Washington, 2018). Consequently, they face significant long-term consequences associated with their identity as JO (Jindal, 2023; McCarter & Durant, 2022; Wojchiechowski, 2023). Consequences include poor health outcomes, prison sentences, and poor job security in adulthood. With knowledge of this population's vulnerability and the understanding of the School to Prison Pipeline as it affects youth of color in
the US, it is timely and important to consider how we can better support this population and prevent dangerous long-term consequences.

Unfortunately, higher prevalence and severity of mental health disorders in JO is related to a higher likelihood of repeat offenses (Astridge et al., 2023; Swank & Gagnon, 2016; Zeola et al., 2017). This correlation suggests a vicious cycle that catalyzes the long-term consequences with this population. However, JO who were referred to mental health services had reduced levels of recidivism (Zeola et al., 2017), implying that counseling and other mental health services can support an overall decrease in crime rates among youth. Unfortunately, many JO are not receiving needed mental health services (Aalsma et al., 2014; Baglivio et al., 2016; Elkington et al., 2020). Moreover, racial minority JO and JO with disabilities are even less likely to be referred for mental health services (Baglivio et al., 2016; Cosby et al., 2017). Despite their success with mental health treatment, JO are continuously falling through the cracks.

Clinical Mental Health Counselors

Clinical mental health counselors (CMHC) are well positioned and have strong potential for making connections with and impacting the juvenile justice system (JJS) (DiCaltado et al., 2021; Swank & Gagnon, 2016). The need for mental health services with this population is evident, and CMHC are qualified to provide mental health services for JO in outpatient, detention, and residential settings (Carrola & Brown, 2018; Duong et al., 2021). CMHC working with JO conduct intakes, develop treatment plans, conduct group or individual therapy, help with reentry, and use a multitude of therapeutic approaches (DiCatado et al., 2021; Duong et al., 2021; Kubek et al., 2020).

CMHC are called to constantly engage with and uphold the standards of the multicultural and social justice counseling competencies developed by Ratts et al. (2016). Carolla and Brown
(2018) illustrated how these competencies are especially applicable to counseling within the justice system. Racial disparities, diagnostic bias, and gaps in mental health care are indicators of the social injustice clients in the justice system experience (Carrola & Brown, 2018; Elkington et al., 2020; Jindal, 2023). Professional standards call for CMHCs to advocate and take active efforts to address and alleviate disparities impacting client and community wellbeing (ACA, 2014; Ratts et al., 2016).

The heart of advocating for the JO population lies in collaboration. Due to the clear disparity in mental health care for both juvenile and adult offenders, the Office of Juvenile Justice Delinquency and Prevention (OJJDP, 2020) and other large organizations, including the Bureau of Justice Assistance (BJA, 2022), have called for and offered funding for more efforts and programming that will encourage collaboration between mental health professionals (MHP) and the JJS. These organizations have recognized the benefits of mental health services with this population and have identified that effective collaboration between the two systems can support this population and reduce recidivism. Their calls indicate the current need and support for CMHC and other Mental Health Providers (MHP) to respond. This manuscript is intended for CMHC; however, previous researchers used MHP. Therefore, I will alternate use of terminology to be consistent with original sources.

Previous researchers recognized the importance of collaboration between these two systems and have conducted studies to explore barriers and facilitators leading to successful collaboration. The barriers to collaboration between MHP and JJS include different goals, perspectives, and educational backgrounds of the different disciplines and different policies and programmatic structures of different offices and agencies (Kapp et al., 2013; Shufelt et al., 2010). Factors specific to MHP, including high turnover rates in MHP and the MHP initiating
contact with the JJO impacted the successful initiation of collaboration (Kapp et al., 2013; Shufelt et al., 2010). Facilitators include formal programming connecting MHP to juvenile justice officials and contact initiated by the MHP (Kapp et al., 2013; Shufelt et al., 2010).

**Juvenile Probation Officers**

Juvenile Probation officers (JPO) hold many different roles and complete a variety of tasks in their work with JO. JPO may supervise JO involved with the court system, offer counsel or consultation, provide referrals for treatments and community programs, and serve as liaison or informant for the court system (Schwalbe & Maschi, 2011; Viglione et al., 2018). The services JPO provide in their various roles to JO are important. JO have a variety of needs and concerns that the JPO must consider. Simultaneously, JPO must also provide the supervision required by the court system to decrease repeat offenses and uphold completion of sentencing (Maschi & Swalbe, 2012).

JPO play a key role in referring JO for mental health services, qualifying them as gateway providers (Aalsma et al., 2013; Holloway et al., 2013). Gateway providers are professionals who are not MHP, but who make referrals to MHP for JO (Holloway et al., 2013; Jung et al., 2020). Therefore, JPO are responsible for recognizing JO’s need for mental health services, providing the appropriate referral, and following up (Jung et al., 2020; Wasserman et al., 2009). JPO’s attitudes, perceptions, and knowledge of mental health impact the referral process (Jung et al., 2020; Wasserman et al., 2009). The relationship link and collaboration between JPO and MHP has been recognized and suggested as a critical element to supporting JO (Aalsma et al., 2014; Elkington et al., 2020; Holloway et al., 2013).
Purpose of the Study

The collaboration between CMHC and the JJS functions as a critical link to supporting JO by connecting them to and increasing the mental health care for this vulnerable population (Kapp et al., 2013; OJJDP, 2020). Researchers have used grounded theory and program review studies to investigate the barriers and facilitators leading to collaboration (Kapp et al., 2014; Shufelt et al., 2010). To date, researchers have not yet explicitly explored the relationship or collaboration between JPO and the mental health system. It is timely and important to explore the experiences of collaboration between JPO and MHP to better understand its efficacy and process. Because of their critical role, this study aims to explore JPO experiences of collaborating with MHP to better understand the collaboration between the mental health and juvenile justice systems. The specific research question guiding the study is: what are the JPO’s lived experiences of collaborating with MHP?

Methods

We used interpretive phenomenological analysis (IPA) to capture the lived experiences of JPO collaborating with MHP. JPO offered insider perspectives to the juvenile justice system that we describe in the findings, then we interpreted themes and implications for CMHC to better understand the juvenile justice perspective and experience of collaboration. IPA is unique in its rigor as it requires a clear experiential and grounded approach, with strict criteria for the participants, a clear definition of the phenomenon, and a structured data analysis process (Miller et al., 2018; Smith et al., 2009). This methodology offers a comprehensive form of qualitative inquiry to obtain a surplus of information on this topic.
**Participants**

Participants included eight JPO \( n = 8 \) (Table 1) from the same geographic region in a southern Appalachian state. Many participants had formal titles in their court system as “Youth Service Officers,” but each identified as a JPO as they met the requirements of providing supervision to youth on probation. Participants were eligible based on (a) having a JPO title or a similar title defining the same role; (b) working in one of the 12 counties in the eastern region of the state; (c) having the experience of collaborating with MHP in their role as JPO; and (d) having continued engagement with a MHP by referring at least one client for mental health services and having followed up on these services.

**Procedures**

After receiving IRB approval, we recruited 8 participants (see Table 1) with purposeful sampling methods. Sampling was purposeful based on the IPA criteria of having participants in a small, homogenous sample \( n = 5-10 \) who had experience of the phenomenon (Smith et al., 2009). We first contacted the juvenile court or probation directors to request participation from JPO and determine participant eligibility. Then we contacted JPO to inform them of the study, request their participation, and schedule an interview. Each participant received a $25 Amazon gift card as an incentive. Their personal experience of this phenomenon was critical for conducting IPA and for our benefit of understanding their unique experience and perspective (Miller et al., 2018; Smith et al, 2009).

The first researcher collected data through a general demographic survey and semi-structured interview. The entire participation process lasted approximately one hour, including completing the survey and interview. Interviews utilized open-ended questions exploring the
### Participant Demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Race</th>
<th>Age</th>
<th>Gender</th>
<th>Education</th>
<th>Frequency of Contact with MHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>White</td>
<td>52</td>
<td>Female</td>
<td>Bachelor’s</td>
<td>Weekly</td>
</tr>
<tr>
<td>2</td>
<td>Black</td>
<td>48</td>
<td>Male</td>
<td>Master’s</td>
<td>Daily or Weekly</td>
</tr>
<tr>
<td>3</td>
<td>Black</td>
<td>45</td>
<td>Female</td>
<td>Master’s</td>
<td>Weekly</td>
</tr>
<tr>
<td>4</td>
<td>Black</td>
<td>42</td>
<td>Female</td>
<td>Bachelor’s</td>
<td>Weekly</td>
</tr>
<tr>
<td>5</td>
<td>Black</td>
<td>35</td>
<td>Female</td>
<td>Master’s</td>
<td>Twice a week</td>
</tr>
<tr>
<td>6</td>
<td>White</td>
<td>58</td>
<td>Female</td>
<td>Associate's</td>
<td>Twice a week</td>
</tr>
<tr>
<td>7</td>
<td>White</td>
<td>56</td>
<td>Female</td>
<td>High school</td>
<td>Daily</td>
</tr>
<tr>
<td>8</td>
<td>White</td>
<td>28</td>
<td>Female</td>
<td>Some Bachelor’s</td>
<td>Weekly</td>
</tr>
</tbody>
</table>
phenomenon of collaboration with the mental health system through conscious experiences by asking questions using “what,” “how,” and “why” (Høffding & Martiny, 2016, p.2). These process oriented questions, plus probing and rapport building, elicited the thick descriptions required of phenomenological research and meaning making by the participants (Gbrich, 2013; Høffding & Martiny, 2016, Miller et al., 2018). Constructivist methods (i.e., “so what I’m hearing is…. Does that sound right?”) were included throughout the interview to model and practice collaboration and to ensure accurate representation of the participants’ experience and meaning making (Gbrich, 2013; Høffding & Martiny, 2016).

**Data Analysis**

We followed a six-stage process for data analysis devised by Smith et al. (2009). We began the data analysis process after the first interview, and the process continued for approximately two months. The first author completed the first stage by transcribing reviewing and analyzing all transcripts before they underwent data analysis. The transcripts were split between the third and fourth author for multiple perspectives and increased rigor. Each transcript was reviewed, memoed, and analyzed by two researchers. Each researcher completed the second stage of analysis by memoing with comments on the transcripts to identify questions, reactions, and linguistic clarifications. Following memoing, we moved into the third stage of data analysis by identifying emerging themes for each transcript in an organized online spreadsheet. Our research question guided our theme identification.

Clear and concise themes began to materialize in the fourth through six stages. After analyzing the first two transcripts, we began stage four of identifying cluster themes in a separate table in the spreadsheet that represented the connections across themes. We continued with stage five as we completed this process with each transcript, organizing themes with our cluster theme
table. Finally, in stage six, the first author led the research team in collapsing the cluster themes to search for patterns and divergence to offer a concise, clear, and organized picture of the participants’ shared data through three higher constructs, three super-ordinate themes, and six subordinate themes. Research team members were critical in this stage to ensure that participants’ descriptions and meaning making were represented in the final findings.

**Data Quality**

Data quality is of the utmost importance in qualitative research to ensure that appropriate methods, analysis, and dissemination of findings are congruent with the standards of empirical studies. The data quality indicators that best meet the epistemology and methods of this study are related to positionality, reflexivity, rigor, and ethical considerations. IPA must imperatively reflect interpretivist epistemology to increase awareness of biases as we interpret the results (Smith et al., 2009). Therefore, the research team engaged in constant reflexive practices including pre and post journaling, memoing, and group discussion. Our positionality impacts our subjective understanding of our results. The research team includes: Etta, a white, cisgender female from the Southern US with a background in court related and correction counseling; Myia, a Black, cisgender female from Ohio with a background working with low income families of color at a sexual assault agency; and Jennifer, a white, cisgender female from the Southern US with a background in trauma focused and substance use counseling.

We demonstrated our credibility consistent with phenomenology through member checking, thick descriptions of data, and multivocality (Cain et al., 2022; Hays & Wood, 2013). We presented our findings predominantly through thick descriptions to capture all the facets of the complex phenomenon and multivocality to capture the actual words and experiences of all participants, rather than just a select few. Rigor in qualitative research means having a detailed
and clear research design (Cain et al., 2022). We were intentional and consistent using IPA, including the specific data analysis steps provided by Smith et al. (2009) and engagement with interpretivist epistemology. We monitored ethical considerations through this study with strict adherence to the university’s IRB protocol. We further ensured ethical considerations, including relational dynamics and cultural sensitivity through our regular reflexive practices. Because our participants are located in the juvenile courts and reference juvenile offenders, we repeatedly discussed confidentiality throughout the recruitment process. Therefore, we report details of participants and findings in aggregate.

Findings

Our findings are illustrated across three higher constructs, three superordinate themes, and six subordinate themes (see Figure 1). The higher constructs are the patterns that were consistent across all themes and set the stage for understanding the collaboration between juvenile justice and mental health systems through JPO’s lived experiences. The following themes are best understood as situated within the higher constructs. Our superordinate themes provide the processes of collaboration which include initiation and maintenance and culturally responsive counseling services. Our subordinate themes offer the nuts and bolts of the collaboration, with examples of successful collaboration between JPO and MHP, including CMHC.

A System of Multiple Parties and Arenas

Participants regularly referred to complex multidisciplinary collaboration. Collaboration on behalf of one juvenile client regularly included navigating and working with a multitude of parties. Participants regularly mentioned working with MHP, judges, attorneys, state service workers, teachers, principals, and school counselors. Likewise, participants described different
Figure 1

Findings
arenas housing these parties and the juveniles and their families: court system, school system, mental health, insurance, and community. Within the mental health system, providers worked in several settings including in-home services, intensive outpatient, individual counseling, residential behavioral, inpatient, and alcohol and drug specific, anger management, or family services. One participant described the complexity and difficulty of navigating so many parties while collaborating. She stated:

the juvenile court is a complex, different type of setting. It’s not as cut and dry as the adult system. you've got to deal with parents and, oh my God, teachers and all these other people, and it gets difficult and kind of blurry, a little convoluted, at times. If you're not careful you lose focus on what's necessary to help that child and family.

Some participants believed the court system needed to be placed at a priority in collaboration because of the unpredictable and fast pace, severe consequences and impacts, and requirement to uphold the law and safety of clients and the community. Participants' daily routine often revolved around crises and arrests. For example, one participant shared, “one of our clients could be arrested overnight, or over the weekend, and then we have to prepare everything for court that day.” One participant explained the importance of them being alerted first of issues from MHP. She shared, “We typically need to be notified of an issue first because we monitor release conditions and probation, and if the children and the parents aren't following those things, the court needs to be aware.”

**Screening and Referral Process**

The screening and referral process was the most mentioned construct across participants. Participants regularly discussed to whom, why, and how they made referrals and its importance in the collaborative process. All participants reported that they screened JO for mental health...
services, and most of their clients were receiving mental health services. Participants described the screening and referral process as having regular impact on collaboration at large because of the consistent back and forth and potential relationship building that can happen between JPO and MHP. Therefore, the screening and referral process extended through all three superordinate themes.

Screenings and referrals included both formal and informal processes. Every county used a specific statewide assessment for measuring risk factors in JO that offered guidelines for service referrals. Two participants in one county described “in-house” mental health personnel located in the court system that completed most mental health evaluations and made recommendations for JPO to make referral decisions. Occasionally, participants would refer to a general agency that determined the appropriate level of care and offered the matched services. At times, participants referred to several different agencies or services until they found the appropriate level of care for JO. The efficiency of the referral process designed by mental health agencies made a difference as well. One probation officer reported:

I'm not gonna lie, sometimes, if I’m in a scurry, whoever I know I can get the referral done fastest for may be my choice. Some require you to fill out extensive paperwork and have some records to be able to try to send over to them while others only need a name, phone number, date of birth, and social [security number] and take care of the rest.

**Antagonists to Collaboration**

While many participants described successful aspects of collaboration, it is important to recognize aspects participants identified as not working. Concerns for imperfect collaboration were relevant across all interviews. The most predominant concerns related to a lack of follow through from MHP. Participants regularly described frustrations with having poor
communication with MHP including having to “hound them” for reports and information or not getting regular follow-up contacts. Other antagonists included role confusion between the MHP and JPO and a general distrust of the mental health system. Participants described distrust of the system and expressed beliefs that MHP were not prepared to work with many of their JO clients, concern that high turnover rates of MHP hinder building relationships with JO and JPO, and recognition that some agencies may not want to refer out for other levels of care because of their need to make money. One participant did not believe MHP had the best interests of their youth at heart, noting “it seems like they want to pick and choose one kid if they want to provide services to. It’s very frustrating because we don't get to pick and choose.”

Participants further reiterated their lack of trust in the mental health system with beliefs that MHP or services could not meet the cultural needs of their clients. For example, one participant stated:

I really don’t think XX agency has the right personnel to deal with the type of children we service here in our county. We deal with mostly Black boys and their (MHP) always makes it seem like they don’t want to work with the clients they say they are willing to work with.

Related to mental health services, a JPO serving in rural counties stated, “the court is always requiring anger management services, but we can’t find any of that around here.” Both accounts described participants' experiences of not believing MHP or their services meet the needs of their clients and community.

**Super-Ordinate Theme 1: Intentional Initiation**

The process of initiating collaboration involved the first contact between MHP and JPO and the process of clarifying roles and setting expectations. Participants described initiation as
most successful when MHP were clear, intentional, and provided a comprehensive overview of the services they can offer.

**Sub-Ordinate Theme 1a: Networking**

Several participants described the process of getting to know about mental health services in their area through networking. Participants described networking as both formal and informal. Three participants from one court described a regular networking event, “service provider meetings,” where they learned about new and existing services in the community. Other participants described how some MHP would come to the court to introduce themselves to judges, JPO, or other JJO. One participant described how offering swag or treats helped them remember and respect providers,

Some service providers reach out more than others. They make an effort to come here and bring cookies or pens. That stuff keeps reminding you about them and you’re like, “I haven't forgotten about you because you make an effort.”

JPO identified several factors as being important indicators in networking. These factors included information about insurance and payment for JO, types of services offered, the referral process, how many JO they can see, and their mission. The importance of understanding insurance was highly relevant because complications with coverage was one of the most reported barriers JO faced in receiving services. Likewise, one participant explained how knowing the service mission of the organization helps with referrals. She said, “XX’s mission is all about serving the underprivileged youth. I know I can refer to them and they are ready to work with those kids.” One participant was clear that she needed a comprehensive understanding of the various service offerings from different providers so she could make strong referral decisions.
She said, “as much information they can give me, I appreciate it, because it does help when you've got a child that's really in crisis and trying to find somebody.”

**Subordinate Theme 1b: Setting Relational Expectations**

Participants often reported a disconnect of the expectations between JPO and MHP. Participants reported that they “wished” they had more conversations about clarity of roles and setting expectations at the beginning of the collaborative process, but that it “doesn’t happen often.” One participant explained that when there was a failed communication attempt, she understood it was because the MHP probably did not know better. She reflected, “sometimes it's just that they don't know they were supposed to communicate. When you have so many people involved (court, DCS, etc.) who do they have to notify? And, do they have to notify everybody?” This insight demonstrated empathy for MHP not understanding the complexity or priorities of the court system.

When participants described setting expectations with MHP, it usually happened through networking or when an MHP reached out to JPO to sign a release of information. One JPO described a formal meeting with a provider. In the meeting they, “talked about the things that we needed, and what they needed, so that we were on the same page to understand how we can best help our kids.” Setting expectations at the beginning of a working relationship includes offering and discussing confidentiality, how often they need reports, information provided in reports, and goals for the JO or family. Nearly all of the JPO could recite the confidentiality terms verbatim and knew that they did not need to know all of the details of the session.

**Super-Ordinate Theme 2: Consistent and Accessible Communication**

While lack of follow through was a defined antagonist, JPO repeatedly identified constant communication as the most important factor when asked, “What does work when
collaborating?” Participants described successful communication as consistent in its regularity and accessible, or easily understood, so they could make timely and informed decisions.

**Sub-Ordinate Theme 2a: Problem Solving**

Participants described problem solving as a regular component of their communication with MHP. They described problem solving related to an individual JO and to their working relationships. Participants described the focus of problem solving for individual JO as navigating crises, identifying underlying issues, and recommending other services. Most problem solving included communicating by phone when a crisis arose or through child family team meetings when working through more systemic issues. Communicating back and forth about different issues helped to keep everyone in the loop and provide more comprehensive care. One participant described the constant back and forth, as follows: “They may reach out and say, ‘Hey what do you see as the needs of the family? I'm coming up with a plan to address them?’ and I may call them again later on when something new has surfaced.”

Some problem solving involved navigating issues within the working relationship between JPO, the court, and MHP. One participant described how they scheduled a meeting with a commonly used residential service provider to work out some of their issues related to wait times for JO. The JPO described how they came up with a solution:

We explained we have a very limited amount of time to serve these clients. They are already in crises when they come, see us, and if you wait a month… they might not make it. So, that's when they kind of carved off a set amount of counselors to kind of help us with our cases, and they rotate them out. And from us… they asked for patience.

Successful collaboration that helped meet the needs of JO included identifying solutions beyond one client by identifying solutions for the working relationship and referral process to help JO.
Sub-Ordinate Theme 2b: Reporting Information

Participants identified formal reports as regular components of communication. Participants differentiated between “progress reports” that offered current insight to JPO’s treatment and “discharge summaries” that described JO’s treatment and progress overall and offered recommendations for the next steps following discharge. Every participant was clear that progress reports needed to include the JO’s level of participation and violations of probation (e.g., failing drug screens in alcohol and drug treatment). Most participants stated they preferred reports to be consistent (biweekly) and sent through email, but more time sensitive updates were appreciated over the phone. Some participants appreciated reports that described JO triggers so that they can be more sensitive to JO trauma.

Participants appreciated reports that explained JO skill development and stressed the importance of them being accessible or written in “layman’s terms.” One JPO described a very good report from a MHP:

They talked about how the kid built their critical thinking skills and could determine whether or not a consequence was worth the action. They talked about the skills that they've gained to refrain from using illegal substances. It was helpful because I was able to follow up on these things with the child before they get off probation.

Other participants described appreciating similar descriptions of progress including development of coping skills and processing of grief or trauma. However, participants described needing more detailed descriptions about mental health related issues. One JPO shared that she made a referral to the wrong level of care after receiving a mental health report and not understanding how severe the diagnoses were. Unfortunately, due to inadequate reporting information, she lamented that the JO continued to regress until placed in services better matched to address her diagnoses.
Super-Ordinate Theme 3: Culturally and Systemically Aware Counseling

Participants described successful collaboration contingent upon successful counseling. Participants described the most appropriate clinicians, agencies, and services as connecting with the JO and their families without judgment and helping them to reduce barriers to services and to their overall wellness.

Sub-Ordinate Theme 3a: Connecting with JO Clients and Families

As described in the higher constructs, cultural mismatch was identified as a major antagonist to collaboration when MHP or mental health services did not match the needs of JO, especially when it came to factors such as urbanness, Blackness, rurality, and social class. However, participants identified successful counseling when MHP made efforts to relate to and engage with JO without judgment. One participant described a successful MHP who was empathic and had similar experiences as many of the JO. Another JPO described a MHP connecting with JO by finding common ground even if they were different in many ways. When describing the MHP she said, “she was super nice and friendly and she wasn't scared or judgmental… it seemed like she could relate to them and she would find things that they would have in common to help them [the JO] to open up.”

Three participants from a predominantly rural area described successful counseling that met the needs of their youth when the MHP lived in the same rural areas that their clients did and better understood their experiences. Three participants from one county were very pleased when a grassroots organization developed in their area whose mission was working with the inner-city youth and their families. Because the organization was built by members of the community, participants felt they could trust the organization more. They especially appreciated that the organization offered mentorship services along with counseling.
Sub-Ordinate Theme 3b: Reducing Barriers

Participants described several barriers JO face including barriers to transportation, insurance, and lack of resources. One participant described discovering a JO was having difficulties at school and getting into fights because he had no running water at his house for months. She was able to connect him with a mental health agency that started by addressing basic needs of the JO and the family to help them get their water turned back on and stabilize this aspect of their life. Transportation was another issue identified by participants, especially in the more rural counties. One JPO was the only officer for three counties encompassing several hundred miles, and she made an effort to drive to all of her clients’ homes to ease their transportation issues. She often referred JO to services that are walkable or in-home. Two JPO worked mostly in the school system and highlighted the importance of having mental health services in the schools because of accessibility, addressing transportation barriers.

Participants identified some organizations that helped reduce barriers related to accessing insurance coverage successfully and efficiently. They described several agencies that had applied for state or grant funding to offer free services to JO clients. Participants described that these grants often “come and go” which creates a revolving door of services, but that they are usually the best options for the clients. Some participants described additional barriers for youth and families with private insurance and the high costs of intensive outpatient or residential facilities. Agencies that served families qualified for state insurance or held pro bono spaces specifically for JO clients helped to reduce these barriers.

Discussion

Previous research regarding collaboration between the juvenile justice and mental health systems has emphasized the screening and referral process, cultural considerations of the JO
population, and barriers and facilitators to collaboration. Our findings related to each of these areas with increased description and nuance. Our use of phenomenological methods and organization of findings allowed for thick descriptions to fill in many gaps highlighted in other studies. Many of the previous studies offered insight to the barriers and facilitators of collaboration, and our study allowed JPO to describe with more detail how to successfully maintain collaboration, offers more concrete suggestions for understanding the entire collaborative process.

Previous research has shown that mental health referrals from JPO are inconsistent or low in volume (Aalsma et al., 2014; Elkington et al., 2020; Wasserman, 2009). Particularly, Wasserman et al. (2009) reported that mental health referrals and follow through by JPO seldom happened. Our findings differed as all participants described routine mental health screening of every JO they have on their caseload, with nearly all receiving some type of services. JPO found the screening and referral process to be most efficient when the referral process was streamlined, easy to complete, and the JPO was aware of the provider’s insurance policies and services they could provide. Participants shared that the screening and referral process was more successful when an agency had multiple services and levels of care for JO and could provide an in-house assessment to determine which services were most appropriate. These findings may offer insight for more successful referral practices between the JJS and mental health system.

Previous research described barriers to building relationships for successful collaboration because of the high turnover rates in mental health staff (Kapp et al., 2013) and a distrust of the mental health system (Elkington et al., 2020). Several participants highlighted the difficulties of working with the mental health system because of the constant turnover in MHP. They described the “good ones” as getting promotions and moving into administration roles, and many not
staying at a facility for long periods of time. Similarly, JPO in our study described not trusting that some MHP or agencies had the best interests of their clients. They believed that many MHP did not want to work with their clients because of their charges, backgrounds, or needs, and that some agencies would not refer JO to appropriate levels of care because they needed their JO clients as numbers for their grants. Our findings substantiated that high turnover rates and a general lack of trust of the mental health system inhibit collaboration.

Facilitators to successful collaboration described in past research included formal processes between systems that helped to organize more efficient collaboration (Elkington et al., 2020; Kapp et al., 2013; Shufelt et al., 2010). Our study had similar findings. Participants from one county emphasized the benefits of having an in-house department that provided mental health evaluations, referrals, and treatment in the court system. Participants from another county described the benefits of having regular service provider meetings to keep strong relationships with mental health agencies. Additionally, the court required monthly meetings with MHP when working with their highest risk clients. One county utilized their JO in the school system with school-based mental health providers. All participants who had shared spaces with mental health were adamant about its benefits.

The unique and vulnerable needs of this population are evident and highly substantiated in past literature, particularly including high rates of ACE, severe mental health concerns, and disproportionate rates and consequences for marginalized JO (Baglivio et al., 2016; Beadry et al., 2021; Jadin et al., 2023). These factors emerged in our findings as participants described complex issues they had to problem solve such as abuse, neglect, and lack of resources for JO and their families. Furthermore, a cultural mismatch between MHP and the services they offered to JO and the community was identified as a major antagonist. However, participants described
MHP as more successful when working with their clients of color or clients from low SES or very rural areas when MHP or mental health agencies focused on reducing barriers, attended to basic needs, and interacted with JO and families without fear, or judgment. Our findings suggest that the cultural competence and humility of MHP can have large impacts on the success of counseling and supporting JO, which further supports successful collaboration.

**Implications**

The findings of this study inform implications for various areas including CMHC practice and systemic solutions. Findings related to communication, screening and referrals, antagonists to collaboration, and areas of growth support clear implications for counseling practice and systemic change. These implications give practical suggestions for developing and maintaining successful collaboration between the mental health and juvenile justice systems.

**Counseling Practice**

Implications for CMHC include guidelines for networking, communicating, and reducing burnout. Participants described the importance of “constant” and “honest” communication and the benefits of having clinical insight to detect underlying issues and offer new solutions. Participants expressed the importance of communication so they can be aware of and respond to problems more preventatively and can stay in adherence with court and legal proceedings timeline. Findings related to initiating and maintaining collaboration offer guidelines for successful networking, setting expectations in the relationships, and reporting information.

CMHC that serve JO should engage in regular and constant networking. Based on our findings, they may want to schedule ongoing meetings with JPO or other JJO to describe the services they offer. They may also set up a booth at their conferences. Simple gestures such as offering “swag” that includes pens with service provider info or treats demonstrated a
commitment to serving the JO population. While networking, CMHC should provide information regarding their mission, the clients they can serve, the services they offer, their referral process, and their insurance and payment policies. They may offer this information through a presentation, handout, or infographic. As they initiate professional relationships when working together regarding a specific JO, they should reach out to initiate collaboration. Upon reaching out they should offer a release of information and discuss confidentiality, the documentation the court may need from the MHP, how often they need reports, and their role as a counselor. They should also engage the JPO with identifying unique needs or concerns related to the JO and their family.

The subordinate theme reporting information highlights the importance of providing regular reports that offer enough information required of the court while upholding confidentiality standards for the JO client and being accessible for personnel without mental health training. CMHC should offer regular reports that include explanations of participation, probation violations, experiences of crises, underlying issues, triggers, or ACEs. Progress indicators should describe development of coping skills, decision making skills, emotional regulation, substance related progress, or trauma/ grief processing. Discharge summaries must include indicators of progress, the reason for discharge, and recommendations for next steps (i.e., different level of care, family services, follow-ups). CMHC working with JO regularly should create models for appropriate progress reports and discharge summaries based on these suggestions to use with their accompanying juvenile court.

**Systemic Change**

The findings yield implications and suggestions for changes in both the mental health and juvenile justice systems. These include developing formal processes for screening, referral, and
assessment, creating more “in-house” court mental health positions, increasing the influence of mental health policies, training, and screenings overall in the juvenile justice system, and offering more training and support for CMHC working with JO. Nearly all participants described wanting to have more mental health influence and collaboration overall in the juvenile justice system. To help meet this need, formal protocols and initiatives may create more convenient collaborative processes that engrain mental health in the juvenile justice system.

Participants referred to screenings and referrals so often that they were categorized into a higher construct. More efficient screening and referral processes may reduce the circular process of trying to get JO into the appropriate services. Streamlined processes might have a directory of all current service providers, the services they offer, the information they need for referrals, and efficient referral documentation. One example could include a website that offers this information with simple online referral submissions. A streamlined process may better and more quickly match JO to appropriate services.

When JPO responded to inquiries about areas of growth for the collaboration between the two systems, nearly all hoped for more in-house MHP (even those in counties with in-house MHP) and more training on mental health. Increasing in-house MHP in the court system could increase mental health training, screening, and immediate treatment without insurance complications. Two participants from one county were located in the school with school based mental health personnel; a full-service school could provide an arena for collaboration that houses school, mental health, and the JJS (Kubek et al., 2020). In-house mental health services could also increase trust in the mental health system compared to the service providers outside of the system. CMHC and JJO can advocate for these changes.
Participants emphasized and repeated high turnover rates as a concern throughout this study. Substantiated with the reports of both high burnout rates and turnover rates in past literature (Elkington et al., 2020; Kapp et al., 2013), systemic change within the mental health system and counselor education could help to reduce these antagonists. Increased funding and benefits for CMHC working in the juvenile justice system, as well as increased training, supervision, and research to prepare CMHC to work within the courts, corrections, or JJS could improve wellness and longevity in the field. With reduced turnover, relationships and trust between CMHC, JO, and CMHC may improve.

Limitations and Future Research

The researchers followed the ethical guidelines of their University IRB and the distinct protocol of IPA (Smith, 2009) to complete this study. While the rigor of this study has been described, all studies have their limitations. Limitations in this study include sample size, regional location of participants, and isolation of participants as JPO. IPA calls for a homogenous and small sample size, which offers for rich and descriptive analysis and themes but limits the generalizability of findings across regions and populations. More research should be conducted on JPO in other areas to compare and contrast findings. Also, studies that explore MHP’s and/or dually explore both JPO and MHP’s lived experiences of collaboration could provide more in depth and universal understandings of successful collaboration across systems.

The recruitment process with JPO proved to be the most challenging step in conducting this study. JPO participants were very busy fulfilling job responsibilities (e.g., responding to constant crises, attending court proceedings). When we initially emailed directors in the first four counties, we experienced low and slow response rates. Those who did respond indicated they did not have time to participate. We adjusted our recruitment process when we reached out to the
remaining counties. We telephoned county probation or juvenile court directors to verbally explain the study and ask for accurate JPO emails (many of the online databases were not updated). Also, we streamlined the data collection process to complete the survey, informed consent, and interview in one hour. These changes helped to increase participation and may provide guidance to future researchers. Court directors had many inquiries, especially related to confidentiality, and one required a court specific confidentiality agreement. Including them early in the process seems prudent.

Lastly, due to our interpretivist approach analyzing JPO lived experiences and their impressions of MHP and working relationships, our findings do not express the experiences of MHP in this collaborative process. JPO’s understanding of aspects related to the mental health system (i.e., screenings, referrals, insurance, and wait times) are likely skewed and could be missing key details. Future research on collaboration should include MHP perspectives to gain insights from their perspective, reduce informational gaps, and provide more nuance from the other collaborative lens. Increased research on professional identity of CMHC working with JO could also help to understand this collaboration and offer insight to their high turnover rates.

**Conclusion**

The need for better collaboration between the juvenile justice and mental health systems is abundantly clear. CMHC offer a unique ability to offer services to and advocate for JO through collaboration. This study revealed how CMHC and other MHP can successfully collaborate for JO through intentional initiation, constant communication, and culturally sensitive counseling. The experiences described by JPO helped to describe the complex and unique process of multidisciplinary collaboration and the factors they experienced as antagonizing or contributing to successful collaboration with MHP. Based on these findings,
CMHC can embrace new ways to advocate including strong networking skills, regular and accessible reports, and reducing barriers.
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APPENDICES
APPENDIX A: Informed Consent

Consent for Research Participation

Research Study Title: Exploring Juvenile Probation Officers’ Experiences of Collaboration with Mental Health Professionals

Researcher(s): Henrietta Gantt, University of Tennessee, Knoxville
Joel F. Diambra, University of Tennessee, Knoxville

Why am I being asked to be in this research study?

We are asking you to be in this research study because you are a juvenile probation officer in East Tennessee.

What is this research study about?

The purpose of this research study is to better understand juvenile probation officers’ experiences of collaboration with mental health professionals. We want to hear about your unique experiences of collaborating with mental health professionals so that we, as counselors, can learn more about how to work more cooperatively and effectively with you to meet the needs of juvenile offenders and their families.

How long will I be in the research study?

If you agree to be in the study, your total participation will take about one hour total including a brief demographic survey, the interview itself, and reviewing/affirming your interviewing transcript. Reviewing the transcript may take 5-10 minutes.

What will happen if I say “Yes, I want to be in this research study”?  

If you agree to be in this study, we will ask you to participate in a brief survey (i.e., information about you, juvenile justice services in your county, and the youth you serve), and an approximately 45 minute interview at your juvenile court office, on zoom, or in a private room at the University of Tennessee. The interview will be audio and video recorded and then transcribed by a research team member. During the transcription process, all names and identifying information will be removed from the interview. All recordings and transcriptions will be kept in a password protected online folder to which only the research team has access. After the interview, you will be asked to review the transcribed interview for accuracy purposes. will send you a copy of your transcript via UT Vault to check for accuracy. UT Vault is a secure file transfer service that allows users to send and store files via encrypted HTTP securely.
What happens if I say “No, I do not want to be in this research study”?

Being in this study is up to you. You can say no now or leave the study at any time. Either way, your decision won’t affect your relationship with the researchers or the University of Tennessee. We appreciate you considering our request and respect your decision.

What happens if I say “Yes” but change my mind later?

Even if you decide to be in the study now, you can change your mind and stop at any time. If you decide to stop before the study is completed, you may contact me, Henrietta Gantt, at hgantt@vols.utk.edu to inform me that you desire to withdrawal. In this case, I will delete and remove your data from all hard drives and storing devices.

Are there any possible risks to me?

It is possible that someone could find out you were in this study or see your study information, but we believe this risk is small because of the procedures we use to protect your information. These procedures are described later in this form. Before analyzing any of the interviews, we will remove identifying information to protect your identity. A key code that identifies participants will be kept separate from the interviews in a password protected online folder and only seen by the two researchers indicated above.

Are there any benefits to being in this research study?

We do not expect you to benefit from being in this study. Your participation will help us to learn more about collaboration across juvenile probation officers and mental health counselors. We anticipate the knowledge gained from this study will inform counselors to effectively collaborate and engage juvenile probation officers to better meet the needs of juvenile offenders.

Who can see or use the information collected for this research study?

All documentation, recordings, and transcriptions collected during this study will be kept in a password protected online folder to which only the four researchers have access. The key that identifies participants will be kept separate from the other research documents. Only one researcher will have access to this material during and after the study.

We will protect the confidentiality of your information by removing your name and identifying information from the interviews prior to transcription. In addition, any documents with your name will be kept separate from the interviews.

If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.
We will make every effort to prevent anyone other than the two researchers from knowing that you participated in this study and/or from identifying information you provided. Although it is unlikely, there are times when others may need to see the information we collect about you. These include:

- People at the University of Tennessee, Knoxville who oversee research to make sure it is conducted properly.
- Government agencies (such as the Office for Human Research Protections in the U.S. Department of Health and Human Services), and others responsible for watching over the safety, effectiveness, and conduct of the research.
- If a law or court requires us to share the information, we would have to follow that law or final court ruling.

### What will happen to my information after this study is over?

We will not keep your information to use for future research or any other purpose. Your name and other information that can directly identify you will be deleted from the research data collected as part of the study.

### Will I be paid for being in this research study?

All participants will receive a $25 Amazon gift card. Participants will receive the gift card upon completion of the survey and beginning the interview, but participants do not complete the interview or later withdraw from the study. Gift cards will be issued via email after the data collection process has been completed. Participants will be required to provide information, including name and email address, so that the gift card may be purchased and delivered.

### Will it cost me anything to be in this research study?

It will not cost you anything to be in this study. We will meet at a location comfortable and secure for you.

### What else do I need to know?

We anticipate approximately 10 people taking part in this study. Because of the small number of participants, it is possible that someone could identify you based on the information we collected from you and the description of the region in which we are conducting research. We will take the measures described previously to protect your identity.

### Who can answer my questions about this research study?

If you have questions or concerns about this study, or have experienced a research related problem or injury, contact the researchers, Henrietta Gantt, hгантt@vols.utk.edu, 803-427-3305 or Joel Diambra, jдиambra@utk.edu.
For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact:

Institutional Review Board
The University of Tennessee, Knoxville
1534 White Avenue
Blount Hall, Room 408
Knoxville, TN 37996-1529
Phone: 865-974-7697
Email: utkirb@utk.edu

STATEMENT OF CONSENT

I have read this form and the research study has been explained to me. I have been given the chance to ask questions and my questions have been answered. If I have more questions, I have been told who to contact. By signing this document, I am agreeing to participate in this study. I will receive a copy of this document after I sign it.

_________________________ _______________________________ _______________________________
Name of Adult Participant Signature of Adult Participant Date
APPENDIX B: Recruitment Email

Hi (individual name)!

I’m Etta Gantt and I’m a PhD student at the University of Tennessee, Knoxville and a previous counselor at the Knox County Juvenile Court. I’m interested in participating in a research study/interview about your experiences collaborating with/working with mental health professionals! As a juvenile probation officer, you are a key figure in connecting youth to mental health services, so I’m very interested to learn about your experiences having worked with mental health professionals. Overall, I’m asking for about one hour of your time to complete the brief survey, interview, and to have the opportunity to review and affirm your interview transcript.

Everyone who participates in this research project will receive a $25 Amazon gift card as a thank you. Attached to this email is a survey and informed consent document. The informed consent provides detailed information about the research project and attempts to answer questions about the project. Please review the informed consent and direct any questions you have to me. If you are eligible to participate, please review the informed consent and let me know if you have any questions. You can return the informed consent to me if we meet in person. Or, I can provide instructions so you can return it electronically through UT Vault.

Please complete the 1 minute participation eligibility survey (link here:xxxxxxx). If you are interested but still have questions, please email me back at hgantt@vols.utk.edu with those questions. I will respond ASAP. Thank you for the support and services you provide to you and their families and for considering my request.

Respectfully,

~Henrietta (Etta) Gantt
APPENDIX C: Participant Survey

Participant Survey

What is your job title (select the best match)
- Juvenile Probation Officer
- Juvenile Probation Officer Clinical Director
- Click to write Choice 3

Please Describe Your Job Duties
Please describe your frequency of contact with mental health professionals related to your job as a juvenile probation officer

What is your educational background?

What is the county that you work in?

What is your typical case load of clients?

What is your race/ethnicity?
- Male
- Female
- Non-binary / third gender
- Prefer not to say

What is your age?

How would you describe your knowledge of clinical mental health agencies in your community?
- Aware of most clinical mental health agencies in my community
- Aware of some clinical mental health agencies in my community
- Aware of no clinical mental health agencies in my community

What are the racial demographics of your current client caseload?
What are the SES demographics of your current client caseload?
CONCLUSION

Juvenile Offenders are a vulnerable group in need of support to help reduce the long term consequences that follow youth who have been convicted. The need for better collaboration between the juvenile justice and mental health systems is abundantly clear. Clinical Mental Health Counselors offer a unique ability to offer services to and advocate for JO. The ACA AC inform guidelines for practicing CMHC in advocating for this population through collaboration while the phenomenological study provides empirical evidence to further inform CMHC with their efforts. This study revealed how CMHC and other mental health professionals can successfully advocate for JO through intentional, consistent, and culturally sensitive advocacy. The experiences described by JPO’s helped to describe the complex and unique process of multidisciplinary collaboration and what they experienced as factors contributing to successful collaboration with mental health professionals. Based on these findings, counselors can embrace new ways to advocate including regular and accessible reports, reducing barriers, and strong networking skills.
Henrietta (Etta) Gantt is a committed counselor who is passionate about working in the court and corrections system to support people facing chargeable offenses. Etta was born in Camden, South Carolina and went to the University of South Carolina to pursue an Bachelor’s degree in Experimental Psychology. Etta then moved to Tennessee to follow her passion of becoming a counselor. After completing two years in the M.S. in Clinical Mental Health Counseling Program, she decided to continue onward with her academic journey to receive a PhD in Counselor Education and Supervision. She hoped that the PhD would help her to both support developing counselors and better serve and advocate for vulnerable clients. While pursing her PhD, she also worked towards her License of Professional Counseling by serving as a part time counselor at the University of Tennessee, Knox County Juvenile Court, Compassion Counseling in Maryville, Tennessee, and Morgan County Correctional Complex. She submitted her application for licensure one month prior to defending her dissertation. Following her dissertation defense, she plans to move to Charleston, SC with her new husband to practice as a mental health counselor at the county detention center and continue to conduct research to support offender clients.