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Exploring Mental Health in Justice Involved Youth: Relevance for Policy and Practice

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Abstract

Over the past two decades, awareness of the prevalence of mental health problems in young offenders (ages 12 to 17 years) has grown, with estimates suggesting significantly higher rates compared to the general population. While experiencing poverty does not cause crime, recent research drawing from the Social Psychology of Crime suggests that individuals who experience poverty tend to live in adverse social environments, which can facilitate exposure to modeling and/or reinforcement that is related to antisocial behaviour. In the present study, archival data were drawn from 281 young offenders' files from an urban-based court clinic to examine how the youth's socioeconomic and mental health status and offending history interacts, to inform how services can be offered to best suit the needs of these youth. From the current study, over three quarters of a court clinic sample had at least one mental health diagnosis, with over half reporting at least two separate diagnoses. One in five of the offenses that were committed by a youth leading to their court clinic referral were directly related to a mental health disorder. A larger proportion of youth who live in moderate to high levels of poverty were more likely to have experienced persistent mental health concerns. These findings are discussed as they relate to intervention strategies for youth and their families.

Keywords: youth justice, mental health, offending, poverty.

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Introduction

Youth Criminal Justice

For over a century Canadian youth involved in the justice system have been separated from adults for purposes of criminal justice processing. The *Youth Criminal Justice Act (YCJA)* of 2003 is applicable for youth ages 12-17 years and advocates for the protection of society while aiming to prevent crime and promote rehabilitation while delivering meaningful consequences and timely interventions (Statistics Canada, 2013). Statistics Canada (2013) reported that in 2011/2012, Canadian youth courts completed an estimated 48,000 cases, the lowest incidence of youth court cases since data were first collected in 1991/1992.

Recent research indicates that the seriousness of Canadian police-reported youth crime has substantially decreased over the past 28 years, while coincidentally reflecting more violence (Carrington, 2013). When examining statistics from 1984-1997 in comparison to 1998-2011 it is evident that assault, which is the most prevalent violent offence, increased from 7.1% to 11.5%, whereas less violent offences such as break and enter or theft have decreased from 15.7% to 7.9% and 31.1% to 22.1%, respectively. Carrington (2013) ascribed the change in this trend to the decrease in the number of youth who are committing break and enters, which are classified as a serious offence, while there was a proportionate increase in youth committing less serious offences such as common assault, cannabis possession, and administration of justice offences. which are classified as minor offences.

Despite encouraging findings related to decreases in youth court processing, concern remains for certain youth who experience serious mental health concerns in combination with their antisocial behaviour while living conditions that place them on the margins of poverty. The current study investigated how the mental health status of youth referred to an urban based court

clinic for assessment interacts with poverty to further understand the nature of services required in order to benefit these youth and their families.

Literature Review

Theoretical Approaches

Two major theoretical approaches are drawn on to explain the relationship between youth crime and mental health: the first being the social psychology of crime and the second based on the youth's psychopathology.

The Social Psychology of Crime

The *Social Psychology of Crime* conceptualizes why and how people engage in criminal activity. Social psychology of crime evolved from Bandura's social learning theory and characterizes the process through which people develop the motivation and skills to commit crime based on their environment through social modeling and reinforcement. Andrews and Bonta (2003, as cited in Andrews, Bonta, & Wormith, 2006) identified eight factors that may influence how an individual will interact with their social environment and affect the probability of them committing crime. These responses reflect a combination of attitudes, beliefs, and personality that interact differentially with the eight identified risk factors (Andrews et al., 2006).

Risk Factor. A risk factor reflects the presence of certain conditions that influence the probability of a relative outcome. In the current context, it can influence the probability of offending or reoffending. The criminogenic factors related to potential risk to commit crime include: (1) behaviour, (2) personality, (3) cognitions, (4) associates, (5) substance abuse, (6) family/marital relationships, (7) school/work, and (8) prosocial recreational activities (Andrews et al., 2006). Previous research also outlines the first four factors as being predictive of criminal behaviour, whereas factors five through eight are correlated but not predictive of criminal

behaviour. Research suggests that mental illnesses are a likely predictor of criminal behaviour if the individual also presents with antisocial cognitions, antisocial personality pattern, and substance abuse (Andrews et al., 2006).

Social Psychology of Crime in the Context of Poverty. Although experiencing poverty does not cause crime, recent research drawing from the Social Psychology of Crime suggests that individuals who experience poverty live in adverse social environments which in turn may facilitate exposure to modeling and/or reinforcements that are strongly related to antisocial behaviour (Skeem, Manchak, & Peterson, 2011). Individuals who experience poverty are at an increased risk to experience physical and mental health challenges, as they struggle everyday to meet their basic needs due to a lack of sufficient income (e.g., food insecurity, unsafe living conditions, unable to afford pharmacare)(Canada Without Poverty, 2017). Public Safety Canada (2012) reported that youth who live in poverty appear in court ten times more frequently than the general youth population. Skeem et al. (2011) suggest that poverty can mediate the relationship between mental health and offending in establishing a series of risk factors that influence the probability of future offending. For example, the relationship between a mental health concern and committing crime may be better understood by examining the degree of poverty that a youth and their family may experience.

Mental Health and Offending. A review of the literature indicates that the prevalence of mental illness among youth involved in the criminal justice system is significantly higher than the general population with estimates ranging from 50-100% (Chitsabesan & Bailey, 2006), whereas it is estimated that 10-20% of youth in the general population experience mental illness (Canadian Mental Health Association, 2016). The relationship is considered to be bi-directional (Vermeiren, 2003). For example, experiencing child and youth violence victimization (i.e.,

family or school based) can increase the likelihood that a child may develop mental health concerns. Conversely, the presence of a mental health disorder can increase the likelihood that a child may act violently (Leschied, 2011).

Risk, Need, and Responsivity Model

There is strong empirical support outlining the most effective approaches to reduce recidivism. However, there is less empirical data regarding how to manage offenders with mental health needs (Davis, Peterson-Badali, Weagant, & Skilling, 2015). Andrews, Bonta, and Hoge (1990) propose that the most effective way to reduce recidivism among offenders is through rehabilitation. These researchers outlined three guiding effective principles in determining the level, target(s), and type of rehabilitation that offenders need. Collectively, these principles comprise the Risk-Need-Responsivity (RNR) model of offender rehabilitation (Andrews et al., 1990). In this context, mental health needs are considered to be a responsivity factor.

Responsivity Principle. A responsivity factor suggests that mental health status can influence an offender’s ability to engage in treatment for their criminogenic needs reflected in procriminal attitudes and substance abuse. While mental health is not considered a primary target of service in lowering the risk for offending, it does play a critical role in engagement within the treatment process that can lead to more successful outcomes (Hoge & Andrews, 2002; Schlager & Pacheco, 2011). The responsivity principle characterizes how to provide the intervention services and fits under two categories: general and specific. The general responsivity principle describes the influence of various treatment strategies, whereas the specific responsivity principle tailors treatment to fit with the individual (Andrews et al., 1990).

Risk Principle. The risk principle reflects who should be treated in the context of which factors to prioritize including the assessment of both static (e.g., criminal history) and dynamic

(e.g., deviant peer association, employment) risk factors (Andrews et al., 1990). A meta-analysis has identified that dynamic (relative to static) risk factors in childhood and adolescence are related to involvement in the criminal justice system during adulthood (Leschied, Chiodo, Nowicki, & Rodger, 2008). Additionally, the risk principle stipulates that the level of risk should be matched to the level of service intensity. In other words, low-risk offenders should benefit from lower intensity services, whereas high-risk offenders require more intense services in order to reduce recidivism (Andrews et al., 1990). Moreover, Bonta, Wallace-Capretta, and Rooney (2000) note that mismatched level of services can actually increase the risk of an offender's antisocial behaviour.

Need Principle. The need principle refers to the importance of targeting criminogenic risk factors for intervention. Criminogenic needs are changeable risk factors that contribute to offending behaviours, such as procriminal attitudes and substance abuse. Non-criminogenic factors are less influential on criminal behaviour and include self-esteem and lack of ambition (Andrews & Bonta, 2010).

Psychopathology Model

A second way to conceptualize the role of mental health needs in criminogenic risk is reflected in the *Psychopathology Model*. In contrast to RNR theory, the psychopathology perspective assumes that since mental illness is present in the criminal justice population, treatment should focus directly on mental health interventions (e.g., psychotherapy) in an effort to achieve rehabilitation (McCormick, Peterson-Badali, & Skilling, 2015). Disciplines that assume this approach include: psychiatry, psychology, nursing, and public health and use formal diagnostic labels as a precursor to relevant treatment targets (McCormick et al., 2015). Although psychological treatment in this context is critical, there is uncertainty surrounding how this

targeted service program influences recidivism among young offenders (Rawana, Gentile, Gagnier, Davis, & Moore, 2015). McCormick et al. (2015) suggest it is unclear whether viewing mental disorders in youth involved in the justice system as a responsivity factor contrasted with targeting mental health disorders in the psychopathology perspective to contribute differentially to the future risk for recidivism.

Combining RNR and Psychopathology Explanations. A third possible way to view offending, mental health, and poverty is through a combination of both the RNR and Psychopathology Models. Some work has already considered the combination of these two approaches in relation to long-term antisocial and clinical outcomes in the context of persistent versus limited offending and mental health issues (McCormick et al., 2015).

Relating Mental Health to Offending

The relationship between mental health status and offending can be direct or indirect. Davis et al. (2015) classified a *direct relationship* between mental health status and offending when the offence occurred during an occurrence of mental health distress such as a psychotic episode. An *indirect relationship* was identified if the offender was facing mental health difficulties, but that difficulty was not primarily associated with the offence. In these latter cases other factors such as peer associates and/or pro-criminal attitudes made a stronger contribution in the moment of offending. The broader research reflects that mental illness tends to be indirectly related to offending and only in a small proportion of individuals who experience a mental illness, is their mental health considered to be directly related to their offending (Skeem et al., 2011).

It is important to consider these direct and indirect relationships when planning intervention strategies for youth involved in the criminal justice system. In particular, if mental

health is directly related to offending, it is important to plan intervention strategies that target mental health in an effort to reduce the likelihood of future offending. On the other hand, if the relationship is indirect it is important to plan interventions that target both mental health and criminogenic needs (Davis et al., 2015). Skeem et al. (2011) report that offenders with or without a mental illness are equally as likely to be re-arrested; however, offenders with a mental illness are more likely to be re-arrested for technical violations (reflected in administrative offenses) versus criminal offences, and as a result are re-incarcerated and have their community sanctions suspended or terminated.

Assessment Strategies and Youth Mental Health

In regards to the assessment and consideration of youth mental health and criminality, the RNR and psychopathology perspectives both contain pros and cons for offender rehabilitation. The RNR perspective considers mental health as a responsivity factor in assessing risk and managing cases, and relates to effective services being offered within correctional settings (Bonta, Law, & Hanson, 1998). On the other hand, the psychopathology perspective, while often entailing a lengthy assessment process, enables clear communication between professionals in guiding treatment planning that targets mental health (Abram, Paskar, Washburn, & Teplin, 2008). McCormick et al. (2015) suggest that these two perspectives, both assessing mental health serve different functions. The RNR approach is beneficial to assess risk and manage cases, while the psychopathology approach helps direct mental health treatment planning. Moreover, the literature separates youth and adult offending by highlighting the type of disorders and the prevalence of mental illness will be significantly different for youth offenders, who are less likely to have well documented mental illnesses due to their developmental course (McCormick et al., 2015).

Youth Justice Assessment. Under Canadian law in Section 34 of the *YCJA* the court may require a youth to undergo a medical or psychological assessment by a qualified professional who will then report the results to the court. The results from the assessment will then inform the court proceedings by providing recommendations (Youth Criminal Justice Act, 2002). A study conducted in Toronto, Canada examined the most prevalent mental illnesses in youth offenders, and results indicate that over half (56%) of youth referred for a court-ordered forensic assessment were diagnosed with at least one mental illness. The most prevalent diagnosis, excluding Conduct Disorder, was Attention Deficit/Hyperactivity Disorder (35%), followed by Substance Use Disorder (16%), and Mood and/or Anxiety Disorder (14%). Overall, there were no diagnostic differences between males and females with the exception of females more likely to be diagnosed with a Mood/Anxiety disorder (Peterson-Badali, Skilling, & Haqanee, 2015).

Another recent Canadian study examining Toronto's first youth mental health court found that the most frequent mental health diagnosis in youth was a Mood/Anxiety disorder (54%), followed by Attention Deficit/Hyperactivity Disorder (28%). Noteworthy, a significant proportion of youth (18%) proceeding through the mental health court had no prior mental health diagnosis (Davis et al., 2015). Youth involved in the Mental Health Court, while not requiring a formal diagnosis, were nonetheless identified as experiencing some form of mental health need and thus could be referred by any of a number of sources including duty counsel, defence lawyers, and crown attorneys. Participants were then screened for mental or emotional disturbances using the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2); considering numerous aspects of the case the crown attorney would then determine eligibility (Davis et al., 2015).

Mental Health Programs for Justice-Involved Youth

Abram et al. (2008) found that justice-involved youth who were identified as being in need of mental health services tended to consider the services both unimportant and inaccessible. In regards to what treatment services are available for justice-involved youth with mental health needs, data from Toronto's first mental health court reflected that approximately one third (32%) of the referrals were made to counselling services, approximately one quarter (22%) were referred for intensive mental health treatment, and a smaller proportion (16%) were referred for substance use treatment. Lower frequency mental health treatment referrals included referrals for assessments, anger and aggression, social support including both family and community, educational, and developmental disability supports. Half of the referrals were made by the youth mental health court worker during the court proceedings, whereas the other half were referred to agencies in which the youth was already accessing treatment prior to being involved in the court (Davis et al., 2015). Youth who had a mental health diagnosis were more likely to complete treatment and also present with higher treatment motivation relative to youth with no mental health disorder. This study also indicated that the youth's mental health problems were indirectly related to their offences, suggesting the need for the court to address both criminogenic and mental health needs. In this study, only half of the youth received treatment that targeted their mental health needs (Davis et al., 2015).

In order to reduce recidivism and promote rehabilitation, the youth justice system should provide interventions for all offenders that target their specific needs, both criminogenic and mental health in nature. However, in order to create successful intervention strategies, researchers first need to understand the experiences and challenges that youth are experiencing. This is the goal of the present study.

In regards to additional gaps in the literature, McCormick et al. (2015) proposed that there is a need for research to examine mental health in justice-involved youth. In particular, there is a need to promote understanding regarding the characteristics in the youth including the RNR perspective and/or borrowing from the psychopathology perspective, mental health disorders and how these may contribute to reoffending. Researchers also proposed that looking at long-term criminal and clinical outcomes such as persistent and limited offending in comparison to persistent and limited mental health issues would advance the literature by identifying justice involved youth subgroups. For example, there is a need for research to examine how persistent versus limited offending may relate to persistent versus limited mental health issues. In addition, research should examine how mental health status interacts with supervision, compliance with treatment, and treatment planning for Canadian youth involved in the justice system (McCormick et al., 2015). As mentioned previously, recent research has found that youth with a mental illness presented higher treatment motivation and completion; however, this needs to be examined further in the regular youth court system and not just in the mental health court system (Davis et al., 2015).

Persistent and Limited Offending and Mental Health Concerns. For the purposes of the current study, persistent offending and persistent mental health problems reflected youth who demonstrated offending behaviours and mental health problems prior to the age of twelve years. Limited offending and limited mental health problems reflected youth who demonstrated offending behaviours and mental health problems after the age of twelve years.

Importantly, in the current study, mental health was also considered in the context of poverty. It was hypothesized that the prevalence of mental health problems in an urban-based court clinic youth justice sample would be significantly higher than the general population, and

mental health problems would generally be indirectly related to youth offending. Based on the literature it was suspected that the relationship between mental health and offending would be mediated by a third variable that included poverty or social learning that contributes to establishing risk factors for committing crime.

The Present Study

The overall intent of this research was to inform researchers, practitioners, and policy makers about the youth who had been referred for assessment to an urban based court clinic where assessment would provide input in regards to treatment approaches based on their socioeconomic and mental health status in an effort to reduce offending and create successful academic and vocational outcomes for youth offenders. The present study is a descriptive field study drawing on archival data from files reflected a vast amount of information that included: prior criminal records; youth justice and children's service histories; and family, educational, and psychological information regarding the youth. The current study is a portion of a broader study that also looked at gender differences, peer associates, and social determinants of health. This portion focused on:

1) The prevalence of mental illnesses including features and disorders that were documented with the sample of justice-involved youth;

2) How mental health, including features and disorders, relate to youth offending;

3) How patterns of persistent vs. limited offending is related to persistent vs. limited mental health problems;

4) How the socioeconomic status on these youth and their families *in the context of the youth's mental health status and offending* interacts to inform how services can be offered.

Based on the literature, hypotheses focused on the prevalence of mental health problems in a sample of urban-based court clinic youth. It was hypothesized that mental health problems will be significantly greater when compared to the general population; and mental health problems will generally be indirectly related to youth offending. Moreover, based on the literature, investigation also focused on the relationship between mental health and offending and the potential mediating role by a third variable, poverty. Finally, this investigation also examined on a post-hoc basis, regarding how persistent vs. limited offending relates to persistent vs. limited mental health problems.

Method

Participants

Participants in the present study were 281 young offenders age 12-23[1] from an urban-based court clinic in London, Ontario who were referred by a youth court judge under section 34 of the *Youth Criminal Justice Act (YCJA)* (2002) to undergo psychological assessment by a qualified professional. These reports resulted in an assessment to inform the court proceedings through a series of recommendations.

Materials

File-based data. For the current study, data were extracted from two primary sections contained within the offenders' file: (1) Intake Questionnaire, and (2) Clinical Findings Report. Young offenders who were referred proceeded through an intake process as a first step in clinicians completing a psychological assessment. This included having the youth's legal guardian complete an intake questionnaire. The intake questionnaire contains the following information; charges/court involvement, school history, social behaviours/peer relationships,

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[1] While the Youth Criminal Justice Act [YCJA] applies to youth between the ages of 12-17, certain individuals can appear before the youth court after they turn 18 if their offence occurred before their 18th birthdate.

agency involvement, family life, developmental history, parental history, and presenting problem. Whereas the Intake Questionnaire was used to extract information related to the offender's history (e.g., charges/court involvement, agency involvement, developmental history), the Clinical Findings Report was completed by clinicians at the urban-based court clinic and reported on the offender's psychological history, current psychological findings, and other demographic variables including previous findings of guilt, education, and recommendations. The typical length of the Clinical Findings Report ranged from ten to fifteen pages.

Procedure

Archival Data Collection. First, the present study employed a descriptive field design to collect archival data that included offending histories, risk assessment, and mental health difficulties. Ethical approval was obtained for the conduct of the study through the Western University Research Ethics Board. Second, four research members involved in the broader study obtained a Vulnerable Sector Police Record Check and signed the London Family Court Confidentiality Agreement. Third, following the completion of these clearance protocols, data retrieval began. Prior to opening the participant's file, the research team members ensured that the youth and a legal guardian had provided a signed consent to participate in research which was indicated in the Letter of Understanding that appeared in the offender's file.

A Data Retrieval Manual was developed to ensure that all data were recorded accurately. A copy of this Manual appears in Appendix 1. Primary sources of data included: The Intake Form for Accompanying Adult; the Clinical Findings section of the file that held psychological risk assessments; reports from outside agencies; and descriptions of the youth's involvement in the criminal justice system. See Table 1 for complete demographic statistics.

Age. The average age of the participants was 15.94 years (*SD* = 1.50). In regards to gender, 82% identified as male (*n* = 229), 17% identified as female (*n* = 48), 1% identified as transgender (*n* = 3), and one individual reported being unsure of their gender.

Geographic Locale. Over half (58%; *n* = 164) of the youth were classified as living in an urban geographic location, whereas the remainder identified as living in a rural geographic location.

Ethnicity. The majority of the young offenders' files did not state their ethnicity (65%; *n* = 182), whereas the files that did report ethnicity indicated these youth were Euro-Canadian (19%, *n* = 54), Native-Canadian (8%; *n* = 23), Mixed-Ethnicity (3%; *n* = 8), African-Canadian (3%; *n* = 7), Hispanic-Canadian (2%; *n* = 5), and Asian-Canadian (1%; *n* = 2).

Socioeconomic Status. In order to reflect the youth and their family's poverty status, data was extracted from the youth' files that related to socioeconomic status (SES). Variables associated with SES were then weighted differentially depending how closely they were associated with poverty. The range of weighted variables that are potentially associated with poverty was made on the basis of a scale ranging from 1 to 4; lower scores are associated with lower correlations with poverty and higher scores more strongly related to poverty. These ratings were made by experts who were both knowledgeable of the relevant literature and had experience reading related files from the agency. Variables that defined poverty included: refugee status (weight = 2); caregivers marital status (weight = 2); teen pregnancy (weight = 2); caregiver education (eight = 2), housing conditions (weight = 2); caregiver employment (weight = 3); caregiver receiving financial support (weight = 3); youth is living in a shelter (weight = 4); and youth is homeless (weight = 4). This data yielded a total score of poverty that allowed for classifying SES as a range extending from 0 to 24. Based on the aforementioned weights, a

tertile split was conducted that grouped youth who experienced lower levels, moderate levels, and higher levels of poverty into three distinct categories.

The vast majority of the sample was classified as living in lower levels of poverty (80%; *n* = 226), followed by almost one-fifth living in moderate levels of poverty (18%; *n* = 50), and a small portion living in high end poverty (2%; *n* = 5).

Living Arrangements. At the time of referral the living arrangements of the youth were diverse, with most residing with their parents (42%; *n* = 119). This was followed by residence in a detention facility (24%, *n* = 67); group home (16%, *n* = 46); relative's home (8%; *n* = 21); foster home (5%; *n* = 15); independently living (3%, *n* = 7); shelter (1%; *n* = 4); and homeless (.4%; *n* = 1). In most instances the youth's legal guardian was a biological parent (74%; *n* = 209, missing *n* = 2).

Offending Histories. In regards to charges, the majority of these youth had previous charges (60%; *n* = 169), whereas for the remaining (40%; *n* = 112) the current charge was their initial formal charge. The total number of past and current charges ranged from 1- 65 (*M* = 6.81, *SD* = 7.29). Overall, the most common current charge (*n* = 142) was an administrative offence (i.e., breach of probation, failure to comply), followed by property offences (*n* = 120), violent offences (*n* = 119), weapons offences (*n* = 50), sexual offences (*n* = 30), disorderly conduct (*n* = 15), and drug offences (*n* = 15). The most frequent length of time involved in the youth justice system was less than a year (48%; *n* = 134), followed by greater than a year (21%; *n* = 59); greater than three years (16%; *n* = 45); and lastly greater than two years (14%; *n* = 38, missing 2%; *n* = 5). Including both past and current charges, the majority of offenders (67%; *n* = 188) were lone offenders, followed by both co- and lone- offenders (18%, *n* = 51), and lastly, solely co-offenders (14%; *n* = 39).

Table 1

Descriptive statistics for justice involved youth

Variable	Male (n = 229)	Female (n = 48)	Total Sample (N = 281)
Age (years)	15.89	15.96	15.94 (12-23)
Ethnicity			
Euro-Canadian	18%	25%	19%
Native-Canadian	7%	17%	8%
African-Canadian	3%	2%	3%
Asian-Canadian	1%	0%	1%
Hispanic-Canadian	2%	2%	2%
Mixed Ethnicity	3%	4%	3%
Not Stated	68%	50%	65%
Geographic Locale			
Urban	59%	56%	58%
Rural	41%	44%	42%
Socioeconomic Status			
Low Poverty	82%	73%	80%
Moderate Poverty	18%	19%	18%
High Poverty	.4%	8%	2%
Living Arrangements			
Parents	45%	31%	42%
Detention Facility	25%	19%	24%
Group Home	14%	27%	16%
Relatives Homes	8%	6%	8%
Foster Home	4%	10%	5%
Independently Living	2%	4%	3%
Shelter	1%	2%	1%
Homeless	.4%	0%	.4%
Psychiatric Facility	.4%	0%	.4%
Offending Histories			
Previous Charges	58%	65%	60%
First Charge	42%	35%	40%
Involved in Justice System			
< than a Year	48%	50%	48%
> than a Year	22%	17%	21%
> than Two Years	14%	13%	14%
> than Three Years	14%	21%	16%

Offender Type			
Lone Offender	66%	67%	67%
Co-Offender	14%	15%	14%
Both Co and Lone	18%	19%	18%

Note: Due to missing data in some instances, not all percentages will add up to 100%

Results

The focus for analyses in the current study was to examine mental health status in a sample of justice-involved youth in an effort to better understand how mental health status relates to offending in the context of poverty. Participants' mental health status including disorders and features, offending histories and patterns, and socioeconomic status were examined in accordance with the rationale for the current study.

Mental Health Profile of Young Offenders

Seventy-seven percent (n = 216) of the youth had at least one mental health diagnosis, with over half of the sample (56%; n = 156) having two or more diagnoses. An almost equal number of males (78%; n = 179) and females (73%; n = 35) had at least one mental health diagnosis. Table 2 provides a summary of Clinically Diagnosed Disorders and Table 3 summarizes the Clinical Features reported by a clinician in the assessment report.

Clinically Diagnosed Disorders. Clinically diagnosed disorders were placed into broader categories and included neurodevelopmental disorders, emotional (internalizing) disorders, externalizing disorders, neurocognitive disorders, personality disorders, schizophrenia spectrum and other psychotic disorders, and trauma and stress related disorders.

The number of total diagnoses ranged from 0-10 (M = 2.28, SD = 2.05). Of these, the most commonly diagnosed were externalizing disorders (67%; n = 188; 69% of males, 58% of females), neurodevelopmental disorders (65%; n = 182; 67% of males, 57% of females), and emotional (internalizing) disorders (30%; n = 85; 28% of males, 38% of females). Almost one in four of these youth (23%; n = 64; 20% of males, 31% of females) had been diagnosed with both externalizing and internalizing disorders. Less commonly diagnosed disorders included trauma and stress related disorders (8%; n = 23; 6% of males, 17% of females), personality disorders

(6%, *n* = 18; 5% of males, 13% of females), schizophrenia spectrum and other psychotic disorders (6%; *n* = 16; 5% of males, 6% of females), and neurocognitive disorders (2%; *n* = 6; 2% of males, 2% of females). Data that was not available included somatic and substance use disorders.

Clinical Features. Also examined were clinically relevant features in these youth in contrast to formal diagnostic labels as reported by a clinician. The number of psychological features ranged from 0-25 (*M* = 6.61, *SD* = 4.09) and these features are included under broader categories below. These included the following: neurodevelopmental features; emotional (internalizing) features; somatic features; externalizing features; personality features; schizophrenia spectrum and other psychotic features; trauma and stressor related features; and substance abuse and addictive features.

The most common features identified were emotional (internalizing) features (88%; *n* = 247; 87% of males, 94% of females) and externalizing features (82%; *n* = 230; 81% of males, 85% of females), with 74% (*n* = 208; 72% of males, 83% of females) demonstrating both emotional and externalizing features. Other common features included substance abuse and addictive features (48%; *n* = 135; 47% of males, 52% of females), trauma and stressor related features (38%; *n* = 108; 34% of males, 56% of females), personality features (23%; *n* = 64; 22% of males, 23% females), somatic features (13%, *n* = 37; 12% of males, 17% of females), schizophrenia spectrum and other psychotic features (3%; *n* = 8; 2% of males, 4% of females), and neurodevelopmental features (2%; *n* = 6; 2% of males, 0% of females). Data that was not available included neurocognitive features.

Table 2

Clinically diagnosed disorders for youth in the current study (*N* = 281) *based on gender*

Disorder	Male %	Female %	Total Sample % (N)
Mental health diagnosis	78%	73%	77% (216)
Comorbid diagnoses	54%	63%	56% (156)
Neurodevelopmental	67%	57%	65% (182)
Emotional (Internalizing)	28%	38%	30% (85)
Externalizing	69%	58%	67% (188)
Both Emotional and Externalizing	20%	31%	23% (64)
Neurocognitive	2%	2%	2% (6)
Personality	5%	13%	6% (18)
Trauma and Stress Related	6%	17%	8% (23)
Schizophrenia Spectrum and Other Psychotic	5%	6%	6% (16)

Notes: Missing from analyses included somatic and substance use disorders

Table 3

Clinical features of a disorder for youth in the current study (*N* = 281) *based on gender*

Features	Male %	Female %	Total Sample % (N)
At Least One Clinical Feature	94%	98%	95% (266)
Neurodevelopmental	2%	0%	2% (6)
Emotional (Internalizing)	87%	94%	88% (247)
Externalizing	81%	85%	82% (230)
Both Emotional and Externalizing	72%	83%	74% (208)
Substance Abuse and Addictive Features	47%	52%	48% (135)
Personality	22%	23%	23% (64)
Somatic	12%	17%	13% (37)
Trauma and Stress Related	34%	56%	38% (108)
Schizophrenia Spectrum and Other Psychotic	2%	4%	3% (8)

Notes: Missing from analyses included neurocognitive features

Offending and Mental Health. The current study examined the extent to which mental health was related to offending. This included examining whether the offence(s) on which the youth was referred for assessment was directly, indirectly, or unrelated to the youth's mental health status.

Results indicated that almost one in five of the offences committed (18%; n = 50) was directly related to the youth's mental health status. The directly related offences reflected for example a substance use disorder that was related to theft for a drug purchase (15%; n = 42); psychoses at the time of the offence (2%; n = 5), and not taking medication (1%; n = 4). Half of the offences (49%; n =138) were indirectly related to the offenders' mental health status. One third (32%; n = 91) of the offences committed were unrelated to any mental health concern.

Persistent and Limited Offending and Mental Health. The current study examined both limited and persistent offending patterns (i.e., offending patterns beginning prior or after the age of 12 years), and limited and persistent mental health issues (i.e., mental health issues beginning prior to or after the age of 12 years). The average age of concern for offending related behaviours to emerge in the current sample was approximately 10 years of age (M = 10.21, SD = 4.04, Range = 1-17), whereas the average age of mental health concerns were first identified at approximately 9 years of age (M = 9.31, SD = 4.23, Range = 1-23) as reported by the youths' caregivers.

The majority of these youth (61%; n = 170) were classified as being persistent offenders, with the remainder classified as limited offenders (39%; n = 110). The majority of the sample (69%; n = 195) was classified as having persistent mental health concerns, while almost a quarter (22%; n = 62) were classified as having limited mental health concerns. A smaller portion (6%; n

= 18) was identified as having no mental health concerns. A small number were missing relevant data (3%; $n = 9$).

A chi-square test was performed to examine the relationship between limited and persistent mental health issues and offending patterns. These data are reflected in Figure 1. Results revealed significant between-group differences in youth categorized as having limited, persistent, or no mental health concerns; however, the assumptions were violated and the likelihood ratio was employed as a correction ($X^2 (4) = 79.080$, $p < .001$). Results revealed that those with persistent mental health concerns were more likely to display persistent offending patterns in comparison to limited offending patterns (77% vs. 23%, respectively). Youth identified as having limited mental health concerns were more likely to display limited offending patterns in comparison to persistent offending patterns (81% vs. 19%, respectively) and youth with no mental health concerns were more likely to demonstrate limited offending patterns in comparison to persistent offending patterns (73% vs. 27%, respectively).

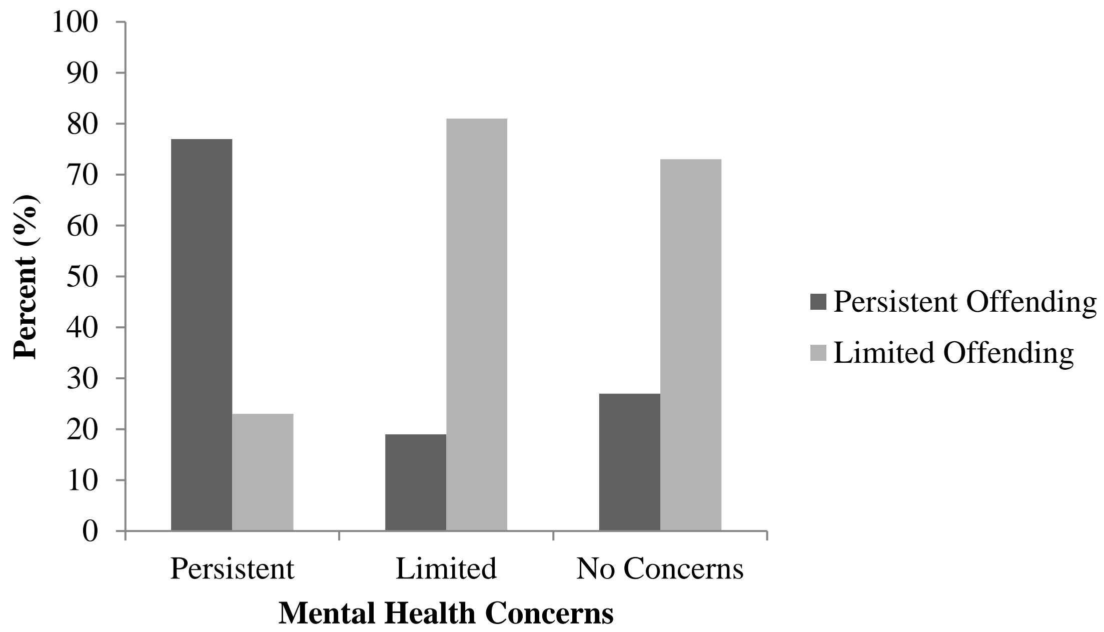

Figure 1. Offending patterns as a function of participants' mental health status.

Poverty and Mental Health. Ninety-four percent ($n = 263$) of the youth experienced some degree of mental health challenges (e.g., diagnoses, features), whereas 6% ($n = 18$) were classified as having no mental health concerns. Of the six percent with no mental health concerns, all were classified as experiencing low levels of poverty in comparison to moderate or higher levels of poverty. More specifically, based on the poverty score generated, youth with no mental health concerns were living in less severe poverty in comparison to those with mental health concerns ($M = 2.28$, $SD = 2.21$ versus $M = 3.70$, $SD = 3.81$; $t\ (25) = 2.487$, $p < .021$). A larger proportion of youth who lived in moderate to high levels of poverty were more likely to have experienced persistent mental health concerns (86%; $n = 43$ and 80%, $n = 4$, respectively). In comparison, it was less likely that youth who experienced moderate to high levels of poverty were classified as having limited mental health concerns (12%, $n = 6$ and 20%, $n = 1$, respectively). Two percent of data was missing for individuals in moderate levels of poverty in regards to mental health status.

Mental Health, Poverty, and Offending. A Pearson Product Moment correlation examined the relationship between offending (i.e., number of past and current charges), mental health challenges experienced (i.e., total of psychological symptoms), and degree of poverty experienced (i.e., overall poverty score). The correlation was significant and offending was correlated with mental health challenges ($r = .152$, $p < .012$) and the degree of poverty experienced ($r =.123$, $p < .040$).

Linear Regression examined the effects of mental health status and degree of poverty on overall offending. Results revealed that mental health challenges accounted for 26% of the variance in offending ($\beta = .15$, $p < .015$). More specifically, for each additional mental health challenge, there was a 26% increase in the likelihood of a youth committing another offence. The

total effect of the degree of poverty on offending was significant ($\beta = .12$, $p < .05$), and accounted for 24% of the variance in offending. The mediation model for examining the effect of mental health challenges on overall offending through the degree of poverty was significant overall, $F(2, 276) = 5.228$, $p < .006$; however, the total effect of the degree of poverty on overall offending became non-significant when mental health status was included in the model, ($\beta = .12$, $p = .053$). The aforementioned results reflect that the degree of poverty (PE = .053, BC 95% CI = -.002 to .452) did not significantly mediate the relationship between mental health (PE = .015, BC 95% CI = -.053 to .470) and offending. This meant that the relationship between mental health challenges (predictor) and offending (criterion) could not be better explained by looking at the degree of poverty experienced (potential mediator). More specifically, adding in the degree of poverty did not improve the predication of the relationship between mental health challenges and offending.

Discussion

The current study examined the mental health status in a sample of justice-involved youth. In particular, the current study reported on mental health disorders in comparison to mental health features, the relationship between mental health status and offences committed, the association between persistent and limited offending and persistent and limited mental health concerns, and mental health concerns and offending in the context of poverty. Two hundred and eighty-one youth who were referred to an urban-based court clinic were explored in this study. Data relevant to their demographic characteristics; prior criminal records; youth justice and children’s service histories; and family, educational, and psychological information were collected and analyzed for this research. Overall, findings suggested that youth involved in the justice system had comorbid mental health challenges both diagnosed and undiagnosed. Those

who displayed persistent mental health patterns were more likely to display persistent offending patterns and lastly, the degree of poverty a youth experiences is an important factor to consider when examining mental health and offending in justice-involved youth. This discussion will explore the relevance of these findings in the context of previous research, relevance for clinicians and policy makers, and recommendations for future research.

Relevance to Previous Research

In an effort to better understand the results of the present study, it is important to first understand the mental health profile of youth offenders in the current study. For the most part, the mental health profile of these youth represented a significantly higher prevalence rate of mental illness in comparison to the general population and with a wide range of psychological disorders and features. As a result, the findings of the current study present a consistent representation of how pervasive mental health problems are within this sample of youth involved in the justice system in the context of previous literature (i.e., Chitsabesan & Bailey, 2006; Davis et al., 2015; Peterson-Badali et al., 2015; Rawana et al., 2014; Vermeiren, 2003). Findings from the present study should act as a guide in planning for mental health services for this particular youth sample based on the most frequent challenges based on mental health diagnoses and features.

Formal Diagnoses and Psychological Symptoms. Importantly, the current study reflected different rates of mental illness based on formal diagnoses (i.e., psychopathology perspective) and psychological features (RNR perspective). As mentioned previously, estimates of significantly higher rates of mental health disorders for youth in the justice system relative to the general population has grown over the past two decades (Schubert et al., 2011). The prevalence of mental health challenges range from 50-100% in a review of the literature on

youth justice and mental health (Chitsabesan & Bailey, 2006; Vermeiren, 2003). Correspondingly, when considering formal diagnostic criteria, seventy-seven percent of youth in the current study experienced mental health challenges. Alternatively, including features of mental illness reflected in the clinic's report suggests that ninety-four percent of these youth experience mental health challenges to varying degrees. McCormick et al. (2015) reported that it is unclear whether viewing mental disorders in youth involved in the justice system as a responsivity factor such as within the RNR perspective in comparison to a targeted focus on mental health disorders in the psychopathology perspective contributes differentially to the future risk for recidivism. In the current study, if the psychopathology model were considered over the RNR model in providing treatment, almost one out of five of these youth (17%) would not receive the mental health treatment that they need. Although it can be argued that the psychopathology perspective includes youth with more severe mental health challenges due to the existence of a formal diagnostic label, there may be numerous barriers (e.g., poverty) for the seventeen percent of youth without formal diagnoses that hinders access to services that could provide a formal diagnostic label. Based on the aforementioned results, it is important that, regardless of diagnostic labels, these young offenders should be provided mental health services that target their individual mental health needs in an effort to reduce offending and promote rehabilitation. Based on the high rates of comorbidity in this sample, tailored treatment based on the individual is recommended.

Offending and Mental Health. Consistent with previous literature (i.e., Skeem et al., 2011), results revealed that half of the offences committed by this sample were indirectly related to the offender's mental health status. This result stresses the importance for treatment to address both criminogenic needs (e.g., antisocial peers, procriminal attitudes) that are influencing

offending behaviour while also addressing mental health needs in an effort to reduce the likelihood of future offending. On the other hand, one fifth of the offences were *directly* related to the youth's offending (e.g., addiction, psychoses, medication) and therefore in these instances, mental health treatment is warranted in an effort to reduce the risk of future offending (Davis et al., 2015). Finally, a third of these youths' offences were unrelated to any identified or reported mental health concern and therefore treatment approaches should target criminogenic needs to promote rehabilitation (Andrews & Bonta, 2010).

Persistent and Limited Offending and Mental Health. McCormick et al. (2015) suggested that it would be beneficial for research to identify justice involved youth subgroups such as persistent and limited offending and mental health concerns. In the current sample, there is a higher rate of youth who display both offending patterns and mental health issues *prior to the age of twelve years* reflecting patterns of persistent offending and mental health concerns. In order to decrease the likelihood of involvement in the criminal justice system, early intervention (i.e., prior to age 12) when these patterns are established is highlighted. Youth with limited offending patterns (i.e., after the age of twelve) are more likely to have limited rather than persistent patterns of mental health issues. Lastly of relevance, the proportion of youth with no mental health issues in this sample were more likely to demonstrate limited offending patterns, suggesting that during the age period between 12-18, a youth's criminogenic risk is changing and thus, offending behaviour commences. For these youth, treatment of their individual criminogenic needs is critical based on the RNR perspective (Andrews & Bonta, 2010).

Mental Health Status and Poverty. When examining the relationship between mental health status and poverty, descriptive results revealed that those living with a higher degree of poverty (i.e., moderate and higher levels) were more likely to experience persistent rather than

limited mental health concerns. The aforementioned result suggests that youth who live with increased levels of poverty experience mental health challenges at an earlier age. In addition, if there are also criminogenic risk factors present, it can then increase the likelihood of persistent as opposed to limited offending patterns, as the Social Psychology of Crime would suggest (Andrews et al., 2006).

Previous research has suggested that poverty may mediate the relationship between mental health and offending (Skeem et al., 2011); however, the mediation model in the current study was not supported when considering the combined effects of mental health, poverty, and offending. At the basic level, mental health features accounted for twenty-six percent of the variance in offending and the degree of poverty the youth experienced accounted for twenty-four percent of the variance in offending. The mediation model for examining the effect of mental health challenges on overall offending through the degree of poverty was significant overall; however, the total effect of the degree of poverty on overall offending became non-significant when mental health status was included in the model. As a result, the hypothesis that the degree of poverty can mediate the relationship between mental health and offending was not supported in the current study (Skeem et al., 2011).

The literature indicates that experiencing poverty or mental health challenges does not in itself cause crime (i.e., Skeem et al., 2011); however, the previously noted findings from the current study explain how experiencing poverty or mental health challenges does significantly relate to offending. It should be considered that based on the aforementioned results, youth who live in a greater degree of poverty are more likely to also experience significant mental health concerns in relation to persistent versus limited mental health concerns, which in conjunction is related to an increase in offending. However, the degree of poverty experienced does not

improve the explanatory value of the relationship between mental health challenges and offending. Due to the significant correlation between poverty and offending it remains important for future interventions to mitigate the effects poverty on youth (e.g., addressing the barriers to accessing services, access to basic living necessities, and safe housing conditions) as it may in turn help reduce recidivism and create successful educational and vocational outcomes for youth involved in the criminal justice system.

Recommendations for Future Research

Future research would benefit by continuing to examine how clinically diagnosed disorders and clinical features (i.e., RNR and Psychopathology perspectives) may relate to future offending. It would also be important to further explore mental health status and offending and how these variables contribute to the result of specific interventions and future offending. More specifically, there is a need for better understanding of youth that examines approaches to interventions using the RNR, the psychopathology perspectives, or combined approaches, and how these may contribute to the outcome of specific interventions. For example, research could examine interventions that target mental health coincidental with criminogenic needs to determine if it is more effective in reducing recidivism in comparison to treating criminogenic needs alone. Additionally, it would be important to examine interventions that draw from both perspectives in the literature, targeting mental health and criminogenic needs together.

Another area of investigation should focus on the relationship between persistent mental health problems and persistent offending patterns. Continuing to examine the aforementioned relationship could provide insight for potential early intervention opportunities (i.e., prior to age 12) and thus, may decrease the likelihood of a child becoming involved in the justice system after the age of twelve years. Additionally, further consideration of the relationship between

socioeconomic status and offending is also warranted in an effort to better support these youth that experience additional barriers.

Future research could also examine intervention prognosis, compliance, and motivation in the context of the youth's mental health status. Better understanding of youth offending can inform researchers, practitioners, and policy makers about this specific population and influence treatment approaches for youth involved in the criminal justice system based on their mental health status in an effort to reduce recidivism and create successful academic and vocational outcomes for youth offenders.

Limitations in the Current Study

It should be noted that the data for the current study were collected from a single urban-based court clinic in Southern Ontario. Although a relatively large sample size, the sample population may not be representative of other court clinics in various geographic locations across Canada. As a result, the generalizability of the current findings should be considered as a limitation.

Second, various information from the participants' files including, the Intake Form for the Accompanying Adult; the Clinical Findings section of the file that held psychological risk assessments; reports from outside agencies; and descriptions of the youth's involvement in the criminal justice system was completed by various professionals who worked with these youth. As a result, written reports were based on various professionals' personal understanding of offending and mental health characteristics. Therefore, the reporting of some variables examined in the current study might be inconsistent across the sample.

Third, the Intake Form for Accompanying the Adult was a self-report measure based on a caregiver or an adult's perspective on information concerning the youth involved in the justice

system. With this in mind, some accompanying adults may have more thorough and accurate information regarding the youth than others and this should be noted when considering the findings of the current study. Additionally, in some cases the caregiver did not complete the Intake Form or skipped variables of interest, which resulted in missing data in the current study.

Fourth, it should be noted that caregivers' annual salary was not reported in files. Therefore, in order to reflect the youth and their family's poverty status data was extracted from the youth' files that related to socioeconomic status and were weighted differentially depending how closely they were associated with poverty. It should be noted that the poverty variables generated in the current study might not accurately reflect the degree of poverty the youth and their family experienced.

In addition, the data retrieval instrument used for data collection was constructed based on existing participants' files and therefore may not include all possible variables that may be relevant to the current study. Furthermore, a research team consisting of four members over the time span of five months collected the data for the current study. Although inter-rater reliability was examined and discussed on multiple occasions there is the possibility of inconsistent reporting for variables in the current study. More specifically, the research team collected data together and was able to discuss coding on an ongoing basis to ensure inter-rater reliability; however, there still could've been inconsistent coding and reporting of variables. As a result of the stated limitations, discretion needs to be taken in understanding the findings of the current study.

Summary

Notwithstanding the aforementioned limitations to the current study, the findings of the present study are unique indicating that the extent of poverty that a youth experiences is a

useful factor to consider when working with justice-involved youth. Young offenders who experienced greater degrees of poverty tended to display mental health challenges prior to the age of twelve years. The presence of a mental health challenge for these youth in the context of living in poverty combined to increase the likelihood that those youth would enter and remain in the youth justice system as persistent offenders, than youth who did not experience mental health challenges prior to the age of 12 years and did not live in poverty. The majority of youth who displayed persistent mental health patterns before the age of twelve years regardless of the degree of poverty were apt to also display persistent offending patterns, demonstrating the need to target both mental health and criminogenic needs to reduce recidivism. It is evident that the vast majority of these youth have comorbid mental health challenges and some youth were characterized with numerous mental health symptoms but were not formally diagnosed.

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Appendices

Appendix 1: *Data Retrieval Manual.*

Appendix 2: *London Family Court Clinic Confidentiality Agreement.*

Appendix 3: *Letter of Understanding (Youth/Parent Consent Form).*

Appendix 4: *Sample of Intake Form for Accompanying Adult (Caregiver).*

Appendix #1
Data Retrieval Manual

Data Retrieval at the London Family Court Clinic: Poverty Reduction Project

AGENCY INFORMATION - A

1. **ID – ID Number** [Numerical] (Var: 0000000)
2. **YrAss – Date Information was received:**
   [year] (Var: 2010; 2011; 2012; 2013; 2014; 2015; 2016; 2017; 2018; 2019; 2020)

IDENTIFYING INFORMATION - B

3. **Age – Age at time of assessment** [Numerical 00-99]
4. **Gender - at the Time of the Assessment – Gender**
   [1= male; 2=female, 3=unidentified; 4=transsexual; 5=intersex; 6=Unsure]
5. **SexOrien - Sexual Orientation at the Time of the Assessment–**
   [1=Heterosexual; 2=Homosexual; 3=Bi-Sexual; 4=Queer; 5=Pan Sexual; 6=Asexual; 7=Questioning; 8=Unidentified; 9=Not Stated]
6. **Preg - Pregnant?** [1=Past; 2=Current; 3=No; 4=N/A]
7. **Geo – Originates from Urban or Rural Area** [1=Urban; 2=Rural]
8. **Home – Currently living** [1=Parents; 2=Group Home; 3=Foster Home; 4=Homeless; 5=Detention; 6=Independent; 7=Relative’s Home; 8 =Shelter]
9. **Lang – First Language** [1=English; 2=French; 3=Spanish; 4=Arabic 5=Farsi; 6=Chinese; 7=Polish; 8=Portuguese; 9=German; 10=Italian; 11=Korean; 12=Dutch; 13=Greek; 14=Other]
10. **Relig – Religion** [1= Non-religious; 2=Roman Catholicism; 3=Christian; 4=Islam; 5=Hinduism; 6=Mennonite; 7=Buddhism; 8=Indigenous Faith 9=Other; 10=Not Stated]
11. **Ethnicity –** [1= Euro-Canadian (Caucasian); 2= Native-Canadian; 3= Black/African; 4= Asian-Canadian; 5= Hispanic-Canadian; 6= Mixed Ethnicity; 7= Other; 8= Not Stated]
12. **Native – Native Heritage** [1=Aboriginal; 2=Metis; 3=Inuit; 4=Other; 5=N/A; 6=Not Stated]
13. **LegBio – Is legal guardian biological parent?** [1=Yes; 2=No]
14. **YEmploy - Youth employed?** [1=Yes; 2=No]
15. **YHomeless - Youth Ever Been Homeless?** [1=Yes; 2=No]

CHARGES AND COURT INVOLVMENT - C

Present Charge (type) – Most serious offense at the time of referral:

16. PCtheftu - Theft under 5,000.00 [1=Yes; 2=No]
17. PCthefto - Theft Over 5,000.00 [1=Yes; 2=No]
18. PCfailtocom - Failure to Comply [1=Yes; 2=No]
19. PCfailAtt - Failure to Attend Court [1=Yes; 2=No]

20. PCbreach - Breach of Probation [1=Yes; 2=No]
21. PCdt - Uttering a Death/Harm Threat [1=Yes; 2=No]
22. PCSexA - Sexual Assault [1=Yes; 2=No]
23. PCSexInt – Sexual Interference [1=Yes; 2=No]
24. PCLoit - Loitering [1=Yes; 2=No]
25. PCAssBH - Assault Causing Bodily Harm [1=Yes; 2=No]
26. PCMisch - Mischief [1=Yes; 2=No]
27. PCAttThe - Attempt Theft [1=Yes; 2=No]
28. PCObstPol - Obstructing Police [1=Yes; 2=No]
29. PCPossWep - Possession of a Weapon for a Dangerous Purpose [1=Yes; 2=No]
30. PCCauDist- Causing Disturbance [1=Yes; 2=No]
31. PCUttThr - Uttering a Threat to Cause Bodily Harm [1=Yes; 2=No]
32. PCPossIS - Possession of an Illegal substance [1=Yes; 2=No]
33. PCSubAbT - Sub Ab Trafficking [1=Yes; 2=No]
34. PCProst - Prostitution [1=Yes; 2=No]
35. PCGenAss - General Assault [1=Yes; 2=No]
36. PCFirstMur - First Degree Murder [1=Yes; 2=No]
37. PCSecoMur - Second Degree Murder [1=Yes; 2=No]
38. PCAssWea - Assault with a Weapon [1=Yes; 2=No]
39. PCTruanc - Truancy [1=Yes; 2=No]
40. PCFireSett - Fire Setting [1=Yes; 2=No]
41. PCStalking - Stalking [1=Yes; 2=No]
42. PCRobbery - Robbery [1=Yes; 2=No]
43. PCFraud - Fraud [1=Yes; 2=No]
44. PCPosUn – Possession Under $5000 [1=Yes; 2=No]
45. PCPosOv – Possession Over $5000 [1=Yes; 2=No]
46. PCBreak – Breaking and Entering [1=Yes; 2=No]
47. PCOther – Other charge [1=Yes; 2=No]

Aggressive Offense against (Hands-on offenses only):
48. OffFam- family member [1=Yes; 2=No]
49. OffFriend – friend [1=Yes; 2=No]
50. OffAcqu – acquaintance [1=Yes; 2=No]
51. OffStran – stranger [1=Yes; 2=No]
52. OffAuth- Authority [1=Yes; 2=No]
53. OffFos-Foster family member [1=Yes; 2=No]
54. OffGroup - Group Home resident [1=Yes; 2=No]

55. CoOrLone - Co-offender or Lone offender for Current charge
[1=Co-offender; 2=Lone Offender]
56. YouthResp - Youth's response to charge
[1=Evidence of Remorse; 2=Indifferent; 3=Defensive; 4=Denying Culpability; 5=Pride; 6=Blame the Victim; 7=No Response]
57. ParResp - Parents response to charge [1=Disappointed; 2=Indifferent; 3= Blame others; 4=Defensive; 5=Minimizing; 6=Threatened; 7= No Response]

58. **FirstChar - First charge** [1=Yes; 2=No]
59. **NumChar - How many previous and current charges?** [Numerical - 00-999]
60. **NumGuilt - Number of Previous and Current findings of guilt?** [Numerical - 00-999]
61. **PrevCoLone – Previous and current pattern of CJH suggests** [1=Co-offender; 2= Lone offender; 3=Both Co and Lone Offender; 4=N/A]
62. **InvolPol – Number of involvements with police** [Numerical 00-999]
63. **YrsYJS – Length of time involved in the YJS?** [1= <1 year; 2= >1 Year; 3= >2 years; 4= >3 years]

Previous Experience in YJS:

64. **PrevAltMes - Alternative Measures** [1=Yes; 2=No]
65. **PrevComServ - Community Service Order** [1=Yes; 2=No]
66. **PrevProb - Probation** [1=Yes; 2=No]
67. **PrevCus - Custody** [1=Yes; 2=No]
68. **YTC - Mental Health Court** [1=Yes; 2=No]
69. **Det - Detention** [1=Yes; 2=No]

Previous Placement in YJS:

70. **PrevOpenD - Open Detention** [1=Yes; 2=No]
71. **PrevSecD - Secure Detention** [1=Yes; 2=No]
72. **PrevOpenC - Open Custody** [1=Yes; 2=No]
73. **PrevSecC - Secure Custody** [1=Yes; 2=No]
74. **YrsDet – Months spent in detention** [Numerical 0-99]

<u>SCHOOL HISTORY - D</u>

75. **School – Registered in school** [1=Yes; 2=No]
76. **Grade – Present grade** [Numerical 00-12]
77. **CredsCom – High school, how many credits completed** [Numerical 00-99]
78. **AttSchool – Does youth attend school** [1=Yes; 2=No]
79. **AbSchool – If no, why**? [1=Negative attitudes towards school; 2= Family Circumstances; 3= Suspended; 4=Family Not Encouraged 5= Psychological issues; 6= Other; 7=N/A]
80. **FailGr – Failed a grade** [1=Yes; 2=No]
81. **ReasFail – Reasons why failed?** [1= Not attending school; 2= Intellectual Disability; 3=Incomplete Work; 4=Transition; 5= Other; 6=N/A]
82. **AcadAss – Ever formally assessed academically** [1=Yes; 2=No]
83. **Excep – Identified as exceptional** [1=Yes; 2=No]

If yes to above was it:

84. **Gifted - Giftedness** [1=Yes; 2=No]
85. **LearnDis - Learning Disability** [1=Yes; 2=No]
86. **DevDis - Developmental** [1=Yes; 2=No]
87. **Behav - Behavioural** [1=Yes; 2=No]
88. **SpecEd – Special education program or specialized help?** [1=Yes; 2=No]
89. **SpecHelp – If so, describe (homework group, etc.)**

[1= IEP; 2= homework group; 3= tutor; 4= EA; 5= N/A]

90. **SchoDif – Do you find school difficult** [1=Yes; 2 =No; 3 = Sometimes]
91. **WhySchoDif – If so, why?**
    [1= Intellectual Disability; 2= Trouble with Peers; 3= Difficulty with authority; 4=No Interest; 5= History of being Bullied; 6= Other; 7= School Hard; 8= N/A]
92. **NumSchAtt – Number of schools attended since kindergarten?**
    [Numerical 00-99]
93. **WhyNumSch – Primary reason for school changes?**
    [1= Family Moves; 2=Expelled; 3= Problems with Peers; 4=Victim of Bullying; 5=Involvement in Justice System, 6=Trauma; 7=N/A]
94. **DifTeach – Difficulty with teachers?** [1=Yes; 2=No]
95. **Suspend – Ever been suspended** [1=Yes; 2=No]

SOCIAL BEHAVIOURS / PEER RELATIONSHIPS – E

96. **Friend – Do you have friends?** [1=yes; 2=no]
97. **Older - Older friends** [1=yes; 2=no; 3 = N/A]
98. **Younger – Younger friends** [1=yes; 2=no; 3 = N/A]
99. **SameAge - Same age friends** [1=yes; 2=no; 3 = N/A]
100. **SameSex - Same sex friends** [1=yes; 2=no; 3 = N/A]
101. **OppSex - Opposite sex friends** [1=yes; 2=no; 3 = N/A]
102. **GoodInf- Good influence friends** [1=yes; 2=no; 3 = N/A]
103. **PoorInf- Poor influence friends** [1=yes; 2=no; 3 = N/A]
104. **IntPartner – Do they have an intimate partner** [1=yes; 2=no]
105. **LeadOrFoll – Youth a leader or follower?** [1=leader; 2=follower]
106. **SexConc – Concerns about sexual behaviour/attitudes?** [1=yes; 2=no]
107. **DesSexConc – Describe sexual concerns:** [1=Prostitution; 2=Unprotected Sex; 3=Exposure to Pornography; 4=Inappropriate Sexualized Comments; 5=Sexual Preoccupation and Distress; 6=Promiscuity; 7= Other; 8= N/A]
108. **OrganActi – Youth participates in organized activities?** [1=yes; 2=no]
109. **DesActNum – Describe activities:** [Number of Activities] [00-99]
110. **Hobbies – Hobbies or Interests?** [1= yes; 2= no]
111. **DesHobb – Describe Hobbies or Interests?**
     [1= Alone; 2= With Peers; 3=Family; 4=N/A]
112. **FamTime – Spend time with family?** [1= yes; 2=no]
113. **DesFamTim – Describe family time?**
     [1= positive; 2=negative; 3=neutral; 4= N/A]
114. **SocOfTies – Social ties outside family?** [1=yes; 2=no]
115. **KindOfTie – Social ties?** [1= positive; 2= negative; 3= both; 4= N/A]
116. **SibStatus - Sibling Status**
     [1= Youngest; 2= Eldest; 3= Middle Child; 4=Only Child]
117. **SibAndLaw - Has sibling(s) been involved in the law** [1=yes; 2=no; 3= N/A]
118. **HalfSibLaw - Has half sibling(s) been involved in the law**
     [1=yes; 2=no; 3= N/A]

AGENCY INVOLVMENT – F

Ever involved with:

119. AgOut - Child/Youth Mental Health Agency (Outpatient) [1=Yes; 2=No]
120. AgIn - Child/Youth Mental Health Agency (Inpatient) [1=Yes; 2=No]
121. AgBoth- Child/Youth Mental Health Agency (In and Outpatient)
[1=Yes; 2=No]
122. AgProbatio - Previous Probation [1=Yes; 2=No]
123. AgDare - Project DARE [1=Yes; 2=No]
124. AgClinical - Clinical Supports Program [1=Yes; 2=No]
125. AgHosp - Hospital for mental health [1=Yes; 2=No]
126. AgGroup - Group Home [1=Yes; 2=No]
127. AgPolice - Police [1=Yes; 2=No]
128. AgChildWel – Child Welfare [1=Yes; 2=No]
129. AgAddict - Addiction Treatment Facility [1=Yes; 2=No]
130. AgDetent - Detention [1=Yes; 2=No]
131. AgComPsych – Community Psychiatrist [1=Yes; 2=No]
132. AgCommCouns – Community Counselling [1=Yes; 2=No]
133. AgDevDisabil – Developmental Disability Agency [1=Yes; 2=No]
134. AgResTSexD – Residential Treatment Sexual Disorder [1=Yes; 2=No]
135. Youth Treatment Court [1=Yes; 2=No]
136. CSCN – Community Services Coordination Network [1=Yes; 2=No]
137. AgTotalN [Numerical 00-99]

CHILD WELFARE SYSTEM INVOLVMENT – G

138. ChildWel - Child Welfare [1=Yes; 2=No]
If yes to Child welfare was it:
139. CWelCouns – Counselling [1=Yes; 2=No; 3=N/A]
140. CWelComm - Community Supervision [1=Yes; 2=No; 3=N/A]
141. CWelTemp - Temporary Care Agreement [1=Yes; 2=No; 3=N/A]
142. CWelCrown - Crown Ward Status [1=Yes; 2=No; 3=N/A]
143. CWelKin - Kinship Care Arrangement [1=Yes; 2=No; 3=N/A]
144. AdoptCAS- Adoption through CAS [1=Yes; 2=No; 3=N/A]

FAMILY LIFE - H

145. FamCurLiv – Currently living with
[1 = mother; 2=father; 3=both; 4=common-law; 5=step mother; 6=step father; 7=Alone; 8=Extended Family Member; 9=Sibling; 10=N/A]
146. Moves – How many family moves since birth?
[1=1; 2=2; 3=3; 4=4; 5=5-9; 6=10>]
147. MoveThem – If more than 5, indicate theme?

[1= Occupation; 2= Economic; 3=Social Service transfer; 4= Removed from home; 5= Criminal Charges; 6=Evicted/Unsanitary; 7=Poor Housing Conditions; 8=Gang Influence; 9=Relationship Conflicts; 10=CAS Inter; 11=N/A]

148. **Adopt – Adopted** [1=Yes; 2=No]
149. **Refugees - Refugee Status** [1=Yes; 2=No]
150. **FamVio - History of or current family violence** [1=Yes; 2=No]
151. **Shelter - Did family ever reside in a shelter** [1=Yes; 2=No]
152. **SeeViolen - Evidence of child being present at the time of partner violence** [1=Yes; 2=No]
153. **SexAbasPerp / Youth as Perpetrator - History of sexual abuse?** [1= yes; 2=no]
154. **SexAbasVict / Youth as Victim - History of sexual abuse?** [1= yes; 2=no]
155. **SexAbFam - sexual abuse intra- or extra-familial where youth is victim** [1= intra; 2=extra; 3=both]
156. **SexEx – Evidence of ever being sexually exploited/sex trade** [1=Yes; 2=No]
157. **Neglect - Evidence of neglect?** [1=-yes; 2=no]
158. **EmotTra - Evidence of emotional trauma** [1=yes; 2=no]
159. **PhysAbuse – Evidence of physical abuse?** [1=yes; 2=no]
160. **AgeConcern - Age at which parents first identified concern** [Numerical 00-18]
161. **PerOrLimOff - Persistent or limited offending (when did offending-like behaviours begin?)** [1=persistent equal to or <12 age; 2=limited>age 12]

DEVELOPMENTAL HISTORY - I

162. **DevStatus – Cognitive / Developmental Status** [1= Low; 2= Moderate; 3= Severe; 4=Average Range; 5=Above Average; 6=N/A]
163. **SerChIll – Serious Childhood Illness** [1= yes; 2=no]
164. **SerChAcci – Serious Childhood Accidents** [1= yes; 2=no]
165. **HeadInj – Head Trauma / Injuries** [1= yes; 2=no]
166. **Hospital – Any Hospitalization** [1= yes; 2=no]

If hospitalized, what for?

167. **HospMental - Mental health reasons** [1=Yes; 2=No]
168. **HospPhys – Physical health reasons** [1=Yes; 2=No]
169. **HospBothMP – Both mental and physical health reasons** [1=Yes; 2=No]
170. **ComPregBir – Complications during pregnancy/birth of youth** [1=Yes; 2=No]

MENTAL HEALTH STATUS INFORMATION - J

171. **DiaFASD - Diagnosis of FASD** [1=Yes; 2=No]
172. **AgeFASD - If yes to FASD, at what age** [Numerical 00-18]

Formal Psychiatric diagnoses:

173. **ADHD** [1=Yes; 2=No]
174. **ODD** [1=Yes; 2=No]

175. CD - Conduct Disorder [1=Yes; 2=No]
176. DiaAnxiety - Anxiety [1=Yes; 2=No]
177. DiaDepress - Depression [1=Yes; 2=No]
178. BPD - Bi Polar Disorder [1=Yes; 2=No]
179. PTSD [1=Yes; 2=No]
180. APD - Antisocial Personality Disorder [1=Yes; 2=No]
181. NARCISS - Narcissism [1=Yes; 2=No]
182. Psychosis [1=Yes; 2=No]
183. SleepCompl - Sleep Complaints [1=Yes; 2=No]
184. SchizoAff - Schizoaffective Disorder [1=Yes; 2=No]
185. DisrupMoodD - Disruptive Mood Dysregulation Disorder [1=Yes; 2=No]
186. TotDia - Total number of different diagnoses [Numerical 00-99]

Findings from Psychological Testing (Check as many as applicable – elevation noted in clinical report)

187. SocIn – Socially Inhibited [1=Yes; 2=No]
188. EmoIn – Emotionally Insecure [1=Yes; 2=No]
189. PWP – Problems with Peers [1=Yes; 2=No]
190. PsychAnx – Anxiety [1=Yes; 2=No]
191. PsychDep – Depression [1=Yes; 2=No]
192. SocAnx – Social Anxiety [1=Yes; 2=No]
193. PoorSE – Poor Self Esteem [1=Yes; 2=No]
194. Suicide – Suicidal [1=Yes; 2=No]
195. Agg_Peers – Aggression towards peers [1=Yes; 2=No]
196. Agg_Adults – Aggression towards adults [1=Yes; 2=No]
197. Agg_Fam - Aggression towards family members [1=Yes; 2=No]
198. Agg_PA – Aggression towards peers and adults [1=Yes; 2=No]
199. Autism – Autism [1 = Low, 2 = Medium, 3 = High, 4 = None]
200. PsycPTSD – PTSD [1=Yes; 2=No]
201. Somatic – Somatic Complaints [1=Yes; 2=No]
202. CDTraum – Complex Developmental Trauma [1=Yes; 2=No]
203. PsychSubA - Substance Abuse [1=Yes; 2=No]
204. PreoccSexTh - Preoccupation with Sexual Thoughts [1=Yes; 2=No]
205. SocialInsens - Socially Insensitive [1=Yes; 2=No]
206. HomicIdea - Homicidal Ideation [1=Yes; 2=No]
207. PsychAPD - Antisocial Personality Disorder [1=Yes; 2=No]
208. PersonDis - Personality Disorder [1=Yes; 2=No]
209. SocioPTend - Sociopathic Tendencies [1=Yes; 2=No]
210. EatDisorder - Eating Disorder [1=Yes; 2=No]
211. NSSI-Non Suicidal Self Injury [1=Yes; 2=No]
212. Dysthymia - Dysthymia [1=Yes; 2=No]
213. SubInPsychD - Substance Induced Psychiatric Disorder [1 =Yes; 2=No]
214. AttachD - Attachment Disorder [1=Yes; 2=No]
215. AvoidPersD - APD-Avoidant Personality Disorder [1=Yes; 2=No]
216. BodyImageC - Body Image Concerns [1=Yes; 2=No]
217. Hypervigil – Hypervigilance [1=Yes; 2=No]

218. Apathy – Apathy [1=Yes; 2=No]
219. PsychTTotal – Total number of different psychological areas of concern
[Numerical 00-99]

220. MoodMed – Ever Prescribed Mood Alterant Medication [1=Yes; 2=No; 3=N/A]
If yes to mood alterant medication (current or past}, was it for:
221. MedADHD – ADHD [1=Yes; 2=No]
222. MedDep – Depression [1=Yes; 2=No]
223. MedAnx – Anxiety [1=Yes; 2=No]
224. MedBPD – Bi Polar Disorder [1=Yes; 2=No]
225. MedSD – Sleep Disorder [1=Yes; 2=No]
226. MedPsych – Psychosis [1=Yes; 2=No]
227. AgeofSym – Age when mental health symptoms were first identified
[Numerical 00-99]
228. AgeofDia – Age when first diagnosed with mental health disorder
[Numerical 00-99]

CAREGIVER HISTORY – J (Parent #1 – Most involved caregiver)

229. A_Relation – Relationship to youth
[1 = mother, 2= father, 3= Stepmother, 4 = Stepfather, 5 = foster mother, 6 = foster father, 7= grandparent, 8 = other family member, 9= other, 10= adoptive mother, 11= adoptive father]
230. A_TeenPar – Teen Parent of the Child being Assessed
[1 = Yes, 2 = No, 3 = N/A]
231. A_TimeWCh – Length of time living with child (Years) [Numerical 00-99]
232. A_MarStat – Marital status [1 = Married, 2 = Cohabiting 2 = Single]
233. A_DivSep – Ever divorced or separated? [1 = Yes, 2 = No]
234. A_CEdu – Caregiver Education Completed [1= None; 2= Elementary; 3= Highschool; 4 = Undergraduate; 5 = Above; 6= College]
235. A_Employ – Caregiver Employed [1=Yes; 2=No]
236. A_Finance – Financial Support [1 = EI, 2= OW, 3= ODSP, 4= Child Support]
237. A_Youth - Financial support received by youth
[1 = EI, 2= OW, 3= ODSP, 4= Child Support]
238. A_FreqInv – Frequency of Parental Involvement (Rated on scale of 1-5: 1=no-little involvement; 5= very involved) [Numerical 1-5]
239. A_DomVio – Domestic Violence [1 = Yes, 2 = No]
240. A_PhyAg – Physical Aggression [1 = Yes 2 = No]
241. A_VerbAg – Verbal aggression [1 = Yes, 2= No]
242. A_PolCall – Police being called [1 = Yes, 2 = No]
243. A_Crisis – Caregiver Personal Crises [1 = Yes, 2 = No]
Was crisis a:
244. A_Death - Death [1 = Yes, 2 = No]
245. A_Sep - Separation [1 = Yes, 2 = No]
246. A_EmoIll - Emotional illness [1 = Yes, 2 = No]
247. A_PhysIll - Physical illness [1 = Yes, 2 = No]

248. A_Nerves - Problems with "nerves" [1 = Yes, 2 = No]
249. A_SubUse - Issues with drugs/alcohol [1 = Yes, 2 = No]
250. A_FinStra - Financial strain [1 = Yes, 2 = No]
251. A_Law - Conflict with the law [1 = Yes, 2 = No]
252. A_FamSep - Separation from family [1 = Yes, 2 = No]
253. A_MentalH – Presence of Mental Health History [1 = Yes, 2 = No]
254. A_FamMenH – Extended family mental health present [1 = Yes, 2 = No]
255. A_Med – Medications [1 = Yes, 2 = No]
256. A_Impact – Is it thought that crises has impacted youth? [1 = Yes, 2 = No]

CAREGIVER HISTORY – K (#2 – Second most involved caregiver)

257. B_Relation - Relationship to youth [1 = mother, 2= father, 3= Stepmother, 4 = Stepfather, 5 = foster mother, 6 = foster father, 7= grandparent, 8 = other family member, 9= other, 10= adoptive mother, 11= adoptive father]
258. B_TeenPar – Teen Parent of the Child being Assessed [1 = Yes, 2 = No, 3 = NA]
259. B_TimeWCh – Length of time living with child (Years) [Numerical 00-99]
260. B_MarStat – Marital status [1 = Married, 2 = Cohabiting 3 = Single]
261. B_DivSep – Ever divorced or separated? [1 = Yes, 2 = No]
262. B_CEdu – Caregiver Education Completed [1 = None 2= Elementary, 3= Highschool 4 = Undergraduate 5 = Above; 6= College]
263. B_Employ – Caregiver Employmed [1=Yes; 2=No]
264. B_Finance – Financial Support [1 = EI, 2= OW, 3= ODSP, 4= Child Support]
265. B_Youth - Financial support received by youth [1 = EI, 2= OW, 3= ODSP, 4= Child Support]
266. B_FreqInv – Frequency of Parental Involvement - Rated on scale of 1-5: 1= no-little involvement; 5= very involved) [Numerical 1-5]
267. B_DomVio – Domestic Violence [1 = Yes, 2 = No]
268. B_PhyAg – Physical Aggression [1 = Yes 2 = No]
269. B_VerbAg – Verbal aggression [1 = Yes, 2= No]
270. B_PolCall – Police being called [1 = Yes, 2 = No]

Caregiver Personal Crises:

271. B_Death - Death [1 = Yes, 2 = No]
272. B_Sep - Separation [1 = Yes, 2 = No]
273. B_EmoIll - Emotional illness [1 = Yes, 2 = No]
274. B_PhysIll - Physical illness [1 = Yes, 2 = No]
275. B_Nerves - Problems with "nerves" [1 = Yes, 2 = No]
276. B_SubUse - Issues with drugs/alcohol [1 = Yes, 2 = No]
277. B_FinStra - Financial strain [1 = Yes, 2 = No]
278. B_Law - Conflict with the law [1 = Yes, 2 = No]
279. B_FamSep - Separation from family [1 = Yes, 2 = No]
280. B_MentalH –History of Mental Health Issues [1 = Yes, 2 = No]
281. B_FamMenH – Extended family mental health issues present [1 = Yes, 2 = No]

282. B_Med – Medications [1 = Yes, 2 = No]
283. B_Impact – Is it thought that caregiver crises have impacted youth? [1 = Yes, 2 = No]

CAREGIVER HISTORY – L (*Absent or Noncustodial Parent*)

284. C_Relation – Relationship to youth [1 = mother, 2= father, 3= Stepmother, 4 = Stepfather, 5 = foster mother, 6 = foster father, 7= grandparent, 8 = other family member, 9= other, 10 = deceased parent, 11= adoptive mother, 12= adoptive father]
285. C_TeenP – Teen Parent of the Child being Assessed [1 = Yes, 2 = No]
286. C_MarStat – Marital status [1 = Married, 2 = Cohabiting, 3 = Single]
287. C_Edu – Caregiver Education Completed [1 = None; 2= Elementary; 3= Highschool; 4 = Undergraduate; 5 = Above; 6= College]
288. C_Employ – Caregiver Employment [1 = Yes, 2 = No]
289. C_Finance – Financial Support [1 = EI, 2= OW, 3= ODSP, 4= Child Support]
290. C_Impact – Crises of this parent thought to impact youth [1 = Yes, 2 = No]
291. C_MentalH – Presence or history of mental health issues [1 = Yes, 2 = No]
292. C_ConStop – Has contact stopped? [1 = Yes, 2 = No]

PRESENTING PROBLEM LEADING TO THE LEGAL SYSTEM - M

Cause of Problem [Parent Perspective]:
293: MH – Mental health issues [1 = Yes, 2 = No]
294. Impuls - Impulsivity [1 = Yes, 2 = No]
295. DrugAlch - Drug and Alcohol [1 = Yes, 2 = No]
296. SexBeh - Inappropriate Sexual Behaviour [1 = Yes, 2 = No]
297. SchoInt - No interest in school [1 = Yes, 2 = No]
298. Neg_Peer - Negative Peers [1 = Yes, 2 = No]
299. GangAct- Gang Activity [1 = Yes, 2 = No]
300. Account - Lack of Accountability [1 = Yes, 2 = No]
301. PSuper - Lack of Parental Supervision [1 = Yes, 2 = No]
What help parent(s) believe youth need:
302. Limits – Setting of limits (consequences) [1 = Yes, 2 = No]
303. Bound – Setting of boundaries [1 = Yes, 2 = No]
304. LawUnder - Clear understanding of the law [1 = Yes, 2 = No]
305. AggCons - Consequences for aggression [1 = Yes, 2 = No]
306. MH_Res - MH Residential Treatment [1 = Yes, 2 = No]
307. SubInter - Substance abuse interventions [1 = Yes, 2 = No]
308. Counsel - Ongoing Counselling [1 = Yes, 2 = No]
309. Mentor - Mentor [1 = Yes, 2 = No]
310. AppMed - Appropriate Medication [1 = Yes, 2 = No]
311. IDK - Doesn't know [1 = Yes, 2 = No]
Previous Unsuccessful Efforts:
312. PUEbadpeer - Staying Away from bad peers [1 = Yes, 2 = No]

313. PUEdrugs - Staying Away from Drugs [1 = Yes, 2 = No]
314. PUEcouns - Counselling [1 = Yes, 2 = No]

315. Drug – Drug Use [1 = Yes, 2 = No, 3=N/A]
316. Alch – Alcohol Use [1 = Yes, 2 = No]
317. Pyro – Fire Setting [1 = Yes, 2 = No]
318. Gang – Gang Activity [1 = Yes, 2 = No]
319. SexVict – Sexual Victimization [1 = Yes, 2 = No]
320. Bully – Bullying [1 = Yes, 2 = No]
321. EmoDist - Emotional Distress [1 = Yes, 2 = No]
322. Harm – Thoughts of Harming Self or Others
[1 = Self; 2 = Others; 3 = Self and Others; 4 = No]

<u>YOUNG OFFENDERS STRENGTHS - N</u>

323. StrenPhys - Physical [1 = Yes, 2 = No]
324. StrenSoc - Social /Interpersonal [1 = Yes, 2 = No]
325. StrenCog - Cognitive [1 = Yes, 2 = No]
326. StrenEmo - Emotional [1 = Yes, 2 = No]
327. StrenAcad - Academic [1 = Yes, 2 = No]
328. StrenProsoc - Prosocial Attitude/Behaviour [1 = Yes, 2 = No]
329. StrenPosAtt - Positive Attitude Towards Help Seeking [1 = Yes, 2 = No]
330. StrenOther - Other [1 = Yes, 2 = No]
331. NumStren - Number of strength areas [Numerical 0-7]

<u>ALCOHOL / SUBSTANCE USE INFORMATION - O</u>

332. AlcAb – Is there the presence of alcohol abuse? [1= Prior Use; 2= Current Use; 3= Prior and Current Use; 4= No evidence of alcohol use]
333. SubA - Substance Use [1= Prior Use; 2= Current Use; 3= Prior and Current Use; 4= No evidence of substance use]
Drugs used:
334. Cannabis - Cannabis [1=Yes; 2=No]
335. Hash - Hashish [1=Yes; 2=No]
336. Cocaine - Cocaine [1=Yes; 2=No]
337. Meth - Methamphetamine [1=Yes; 2=No]
338. LSD - LSD [1=Yes; 2=No]
339. Heroine - Heroine [1=Yes; 2=No]
340. MDMA - MDMA [1=Yes; 2=No]
341. Steroids - Steroids [1=Yes; 2=No]
342. PresAbuse - Prescription Abuse [1=Yes; 2=No]
343. ntoxInhal - Intoxicative Inhalant [1=Yes; 2=No]
344. Oxy – Oxycodone(Oxtcontin) [1=Yes; 2=No]
345. TotDrugs - Total number of drugs used [Numerical 1-100]

<u>RISK / NEED ASSESSMENT INFORMATION - P</u>

346. RNA - Was there a RNA on file? [1=Yes; 2=No]
If yes to RNA complete the following:
347. RNAFam - Family Circumstance and Parenting
[1= low; 2= med; 3=high; 4 = N/A]
348. RNAEd - Education [1= low; 2= med; 3=high; 4 = N/A]
349. RNAPRel - Peer Relations [1= low; 2= med; 3=high; 4 = N/A]
350. RNASubA - Substance abuse [1= low; 2= med; 3=high; 4 = N/A]
351. RNARec - Leisure / recreation [1= low; 2= med; 3=high; 4 = N/A]
352. RNAPer - Personality [1= low; 2= med; 3=high; 4 = N/A]
353. RNAAtt - Attitudes [1= low; 2= med; 3=high; 4 = N/A]
354. RNASum - Summary of RNA [1= low; 2= med; 3=high; 4 = N/A]
355. RNATotS – Total Risk Score [1= low; 2= med; 3=high; 4 = N/A]
Assessment of Other Needs from the RNA:
356. RNASigFamT - Significant family trauma [1=Yes; 2=No; 3=N/A]
357. RNALearnD - Presence of a Learning disability [1=Yes; 2=No; 3=N/A]
358. RNAVicNeg - Victim of Neglect [1=Yes; 2=No; 3=N/A]
359. RNADepress - Depression [1=Yes; 2=No; 3=N/A]
360. RNAPSocSk - Poor Social Skills [1=Yes; 2=No; 3=N/A]
361. RNAHisSPAs - History of Sexual/Physical Assault [1=Yes; 2=No; 3=N/A]
362. RNAAsAuth - History of assault on authority figures [1=Yes; 2=No; 3=N/A]
363. RNAHisWeap - History of use of weapons [1=Yes; 2=No; 3=N/A]
364. CaseMAs - Case managers assessment of Overall Risk
[1 = Low, 2 = Moderate, 3 = High, 4 = Very High]
365. ClinOver - Was clinical override used [1=Yes; 2=No]
366. ClinOverRisk - If yes to clinical override was it
[1=Lower Risk; 2= Higher Risk; 3=N/A]

RECCOMMENDATIONS FROM ASSESSMENT - Q

367. Custody - Custody [1=Yes; 2=No]
368. CustType - If Custody was it.. [1= Secure; 2 = Open; 3 = No Custody]
369. CustDur - If Custody, how long? [1 = less than one week; 2 = one month; 3 = 2-6 months; 4 = 7-12 months; 5 = 12+ months; 6 = N/A]
370. Probation - Probation [1=Yes; 2=No]
371. ComServOrd - Community Service Order [1-Yes; 2= No]
372. OutPCoun - Outpatient Counselling [1=Yes; 2=No]
373. ResTreat – MH Residential Treatment [1=Yes; 2=No]
374. AddictTreat - Treatment for Addictions [1=outpatient; 2=residential; 3=No]
375. SexOffTreat-Treatment for Sex Offending [1=outpatient; 2=residential; 3=No]
376. PsychInt- Psychiatric Intervention [1=Yes; 2=No]
377. AttendCen- Attendance Centre [1=Yes; 2=No]
378. IIS - Intensive Intervention Service [IIS] [1=Yes; 2=No]
379. IRS – Intensive Reintegration Service [IRS] [1=Yes; 2=No]
380. IntHom- Intensive Home Based Intervention [1=Yes; 2=No]
381. AltSchProg- Alternative School Programming [1=Yes; 2=No]

382. ReinPlan - Reintegration Planning [1=Yes; 2=No]
383. IndigInt- Indigenous Based Intervention [1=Yes; 2=No]
384. MHCourt- Mental Health Court [1=Yes; 2=No]
385. FurtherAss-Further Specific Assessment [1=Yes; 2=No]
386. EquineT - Equine Therapy [1=Yes; 2=No]
387. FamCouns - Family Counselling [1=Yes; 2=No]
388. SupEmpOpp - Supporting Employment Opportunities [1=Yes; 2=No]

MENTAL HEALTH COURT INVOLVEMENT - R

389. MHCrt - Was youth's case heard in the Mental Health / Youth Treatment Court? [1=Yes; 2=No]

Relevance of Mental Health in the Committal of the Offense(s):

390. MHrelate - In the opinion of the assessor was the presence of a mental health disorder related to the committal of any of the youth's offenses? [1=Directly Related; 2=Indirectly Related; 3=Not related]
391. DirectRel - If directly related is it [1=Medication; 2=Psychoses; 3=Intoxication at the time of the offense; 4=Offense linked to the specific nature of the Psychiatric Diagnoses; 5=Offense Pattern linked to Abuse History/Obtain Drugs; 6=N/A]
392. HistLFCC - History with London Family Court Clinic Number of Assessments [Numerical 00-99]

Additional notes regarding DRI:

Mental Health Grouping based on distinct categories from the literature and what variables are available in the DRI (i.e., formal diagnoses and clinical features):

1) **Neurodevelopment Disorders (**Intellectual disability, Language disorder, social communication disorder, Autism, ADHD, specific learning disorder)
   a. Diagnoses: ADHD, LD

   b. Features: Autism

2) **Emotional (internalizing) Disorders** (Depressive, anxiety, OCD, trauma/stress related disorders, dissociative disorders, eating disorders, sleep, concentration, withdrawal, unexplained physical symptoms)
   a. Diagnoses: Anxiety, Depression, PTSD, Psychosis, Schizoaffective

   b. Features: Sleep complications, Social inhibition, Emotional inhibition, Psych Anxiety, Psych Depression, Social Anxiety, Poor Self-Esteem, Suicide, PTSD, Somatic complaints, CD trauma, Sexual Thinking, Eating Disorders, NSSI, Dysthymia, Attachment Disorder, Body Image, hyper-vigilance, Apathy

3) **Somatic Disorders** (Somatic symptom Disorder)
   a. Diagnoses: N/A

b. Features: Somatic

4) **Externalizing Disorders** (ADHD, ODD, CD, ASPD, Explosive mood, substance-related, continuous rule breaking)
    a. Diagnoses: ADHD, ODD, CD, Disruptive Mood Disorder

    b. Features: Aggression, Social insensitivity, Homicide ideation, Sociopathic Tendencies, Substance Abuse, Substance induced psychosis

5) **Neurocognitive Disorders** (Delirium, Neurocognitive disorders due to traumatic brain injury/substance use/medical condition)
    a. Diagnoses: FASD

    b. Features: N/A

6) **Personality Disorders** (All personality disorders)
    a. Diagnoses: Borderline Personality Disorder, Antisocial Personality Disorder,

    b. Features: Antisocial Personality disorder, Personality Disorder, Avoidant personality disorder, Narcissism Personality Disorder

7) **Schizophrenia Spectrum and other Psychotic Disorders** (Psychosis, schizophrenia, schizoaffective, substance induced psychosis, psychosis due to medical condition)
    a. Diagnoses: Schizoaffective Disorder, Psychosis

    b. Features: Substance induced psychosis

8) **Trauma and Stressor Related Disorders** (Reactive attachment disorder, disinhibited social engagement disorder, PTSD, Acute stress disorder, adjustment disorder, other specified trauma and stressor related disorder)
    a. Diagnoses: PTSD

    b. Features: Attachment Disorder, CD trauma, hyper-vigilance, PTSD

9) **Substance-Related and addictive disorders** (substance use disorders, substance-induced disorders)
    a. Diagnoses: N/A

    b. Features: Substance Abuse, Substance induced psychosis

Weighted Variable List in Relation to Poverty: Poverty Reduction Fund Youth Justice Project

[The range of weighted variables that are potentially associated with poverty was made on the basis of a scale ranging from 1 to 4; lower scores are associated with lower correlations with poverty and higher scores more strongly related to poverty. These ratings were made

by experts who were both knowledgeable of the relevant literature and experienced reading related files from the agency]

Variable	**Weight**
Refugee Status	2
Marital Status	2
Teen Pregnancy	2
Parent Education	2
Housing Conditions	2
Caregiver Employment	3
Caregiver Financial Support	3
Shelter	4
Youth Homeless	4

Appendix #2
London Family Court Clinic Confidentiality Agreement

London Family Court Clinic
Policy/Training Signature Sheet

Confidentiality

Association with LFCC may require that you are privy to information that is of a personal and confidential nature.

This includes information about services users, donors and supporters, volunteers and staff of LFCC.

Information about individuals who are affiliated with LFCC may include such information as medical condition and/or treatment, finances, living arrangements, employment, sexual orientation, alcohol or drug use, and/or relationships with family members.

I understand the confidential nature of the work I will be doing with LFCC and with all individuals associated with the Clinic's services.

I am aware that there is a written policy that outlines in detail the terms and conditions of this confidentiality agreement. I have been advised by my supervisor regarding how to access this policy and I take responsibility for reading and understanding the policy.

I agree that I will not disclose information to any person who is not affiliated with LFCC and authorized by LFCC to have such information, without the specific written consent of the individual to whom such information pertains, regardless of the manner in which such information becomes available to me.

Should I come in contact with clients' names with whom I am acquainted or related, I agree to advise my supervisor and not proceed further with the task involving the client's file unless directed to do so by my supervisor or designate.

By signing this document I am confirming that I have read, understand and agree to follow the Policies and Procedures of LFCC. I also agree to review the Policies and Procedures of LFCC on a regular basis.

Staff/Consultant/Student's Name please print | Signature | Date

Supervisor's Name (please print) | Supervisor's Signature | Date

Revised December 3, 2013 *Page 1 of 1*

Appendix #3

Letter of Understanding (Youth/Parent Consent Form)

LETTER OF UNDERSTANDING
REGARDING THE ASSESSMENT PROCESS
ASSESSMENT SERVICES FOR
YOUTH IN CONFLICT WITH THE LAW

Name: ______________________ ______________________

1. This assessment was ordered by the Court and the report we prepare will be given to the Court. The Court is our client. This means that:
   - This is not like therapy where things are kept private.
   - Whatever we discuss and learn about you is not confidential.
   - In Court, information may be discussed openly in front of you, and others who are present.
2. There are also times when other people may need to be involved and information must be shared, by law. For instance:
   - If you told us that you wanted to harm yourself or someone else.
   - If you told us that someone is abusing a minor or causing them harm.
   - If you told us that you have been sexually abused by a licensed health care professional in Ontario (such as a physician, chiropractor, psychologist, nurse); however, we can do this without using your name.
   - If your file is subpoenaed by Court, we must provide the Court with a copy of the file.
   - If the College of Psychologists asks for the file in order to investigate a psychologist or ensure a psychologist is maintaining the appropriate standards or practice, then we must provide the College with that file.
3. From this assessment, we make recommendations to the Court that are expected to help stop you from getting into further trouble with the law.
4. While completing the assessment, the assessors may consult with other professionals at the Centre.
5. You should understand that it is your responsibility to obtain legal advice.
6. Should you have any concern with respect to the assessment process, you can initially discuss the matter with the assessor and/or, when necessary, the Clinic's Director.
7. The Clinic maintains non-identifying information about all referred cases as it is a research and training based agency.
8. You may be contacted in the future as a follow-up so we can get your feedback on the services and the outcome of the court process.
9. All information related to your services here is kept in a locked file. We follow the guidelines of the Personal Health Information Protection Act (PHIPA) and the Personal Information Protection and Electronics Documents Act (PIPEDA)
10. Your personal information may be shared if your file is selected for review by an on-site team, as part of the CCA (Canadian Centre for Accreditation). You have the right to choose not to participate in having your personal information disclosed.
11. Your signature below indicates you understand the above and agree to this assessment.

DATED at ______________, Ontario this ____ day of ______________, 20____.

______________________ ______________________ ______________________

Signature of Witness *Signature of Youth* *Signature of Parent/Guardian*

Appendix #4

Sample of Intake Form for Accompanying Adult (Caregiver)

Intake Form for Accompanying Adult (Caregiver)

Section 1 – ** *filled out by Agency Staff* **

Intake Worker: ______________________

Intake Date: ______________ Date Information was received: ______________

File Number: ______________

Names of Person(s) filling out information: ______________________

Relationship(s) to youth: ______________________

Instructions:

Please answer the following questions to the best of your ability. Please feel free to write on the back of the sheets if necessary. The assessment process involves gathering information that will help us to formulate a recommendation to the Youth Court around sentencing. It is important for us to better understand this youth's life circumstances, challenges, and strengths. Thank you for taking the time to be here to assist us with this task.

Section 2 – Identifying Information:

2a. Youth

Youth's Name: ______________________

DOB (day/month/year): ______________ Age: ______________

Address: ______________________

Phone Number: ______________________

Where is youth currently living? ______________________

With whom are they living? ______________________

If currently in detention, date youth entered detention: ______________

City of Birth: ______________ Language (spoken at home): ______________

Religion: ______________ Practising (yes/no) : ______________

Lawyer's Name: ______________ Phone Number: ______________

Native Heritage: yes: ________ no: ______

2b. Parent(s)/Guardian

Legal Guardian(s): ______________________

Address: ______________________

Phone Number: ______________ Cell #: ______________

if different than above

Mother: ______________

Address: ______________

Phone Number: ______________ Cell #: ______________

Can you be contacted at work? YES NO Work Phone #: ______________

Father: ______________

Address: ______________

Phone Number: ______________ Cell #: ______________

Can you be contacted at work? YES NO Work Phone #: ______________

Section 3 – Charges/Court Involvement:

3a. Present Charges:

Please list all present charges, any details about charges (eg. events that led up to charge, whether youth committed charge alone or with others, youth's response to charges, your response to charges:

____

____

____

____

____

____

3b. Previous Charges:

Please list all previous charges, circumstances that led to charges, outcome of court in relations to charges:

____

____

____

____

____

____

3c. Previous Police Involvement:

Please list any contact this youth may have had with the police or police family consultants in the past that did not result in any charges:

3d. Is there a Probation Officer (PO) involved at present: YES NO *If yes ...*

Name of PO: City:

Length of order: Date of termination:

3e. Has probation been involved in the past: YES NO *If yes ...*

Name of PO: City:

Length of order: Date of termination:

Section 4 – School History:

4a. Is the youth registered in school? YES NO

Present grade: If in High School, how many credits does student have:

4b. Present School: Previous School:

School Board : Previous Board:

4c. Does the Youth attend school? YES NO

If no, please state reason:

4d. Has the youth ever failed a grade? YES NO

If yes, please explain: ____

____

____

____

4e. Has youth been in a specialized education program or received special help? YES NO

If yes, please describe: ____

____

____

____

4f. Does youth find school difficult? YES NO

If yes, please describe: ____

____

____

____

4g. How many schools has this youth attended, since Kindergarten?

1 2 3 4 5 or more

If more than 5, please indicate reason for the many changes: ______________________

____

____

____

4h. Does youth have difficulty getting along with teachers? YES NO

If yes, please describe: ____

____

____

____

Section 5 – Social Behaviours / Peer Relationships

5a. Does the youth have friends: YES NO

If yes, please circle all that apply:

older	younger	same age	same sex	opposite sex
	good influence		poor influence	

Is this youth seen as a leader or a follower in a group of peers? ____________

5b. Are you concerned about sexual behaviour / attitude? YES NO

If yes, please describe your concerns: ____________

5c. Does the youth participate in organized activities? YES NO

Please list: ____________

5d. Does the youth have any interests or hobbies? YES NO

Please list: ____________

5e. Does the youth spend time with family? YES NO

Please describe: ____________

5f. Does the youth have any significant social ties to other adults outside immediate family? YES NO

Please describe: ____________

Section 6 – Agency Involvement

Please list any agency / organization that has had involvement with this youth.

(for example include: Psychiatrists, Psychologists, Children's Aid Society - CAS, Child Mental Health Agencies, Police, Hospital, Detention Facility, Doctor, Educational Institutions, Probation, Group Homes, etc.)

Agency / Organization	Time of Involvement	Contact Person / Worker

6a. Has your family been involved with CAS? YES NO

If yes, is your family still involved with CAS? YES NO

Length of Involvement: ______________________________

Name of Worker: ______________________________

Location: ______________________ Phone Number: ______________________

6b. Has your family been involved in Family Court? *(eg. For custody and access, separation / divorce reasons)* YES NO

____

____

____

6c. Has your son / daughter been caught in the middle of the court issue? YES NO

Please describe: ______________________________

____

____

____

____

Section 7 – Family Life:

7a. Does the youth reside with? *(please circle)*

Mother	Father	Both	Common-law Partner
Step-mother	Step-father	other: ________	

7b. How many times has the youth moved since birth?

1 2 3 4 5 or more 10 or more

If more than 5, please indicate reason for so many changes: ______________

____

____

____

7c. Does this youth have a Brother(s) or Sister(s)? YES NO

If yes, please list

Name	Age	Gender	Full / half / step sibling	Are they in conflict with the law?	Relationship with youth *(eg. close, good, average, fight)*

7d. Please describe youth's relationship with family members: ____________

____

____

____

____

Section 8 – Developmental History

8a. At what age did the child begin to walk? ____________

At what age did the child begin to talk? ____________

At what age was the child toilet trained? ____________

Has the youth had a serious illnesses? YES NO

Has the youth had any serious accidents? YES NO

Any head injuries? YES NO

Were there any complications during pregnancy/birth with youth? YES NO

Were there family problems at the time of birth? YES NO

Has the youth ever been hospitalized? YES NO

If yes, what hospital(s): ____________

____

____

____

If you answered yes to any of the above questions, please explain: ___

8b. Has youth ever had a psychiatric/psychological assessment? YES NO

If yes, please describe reason for this assessment and name of the assessor(s): ___

8c. Is the youth currently taking any medication? YES NO

If yes, specify type, amount, when and reason for medication: ___

8d. Has youth previously taken medication? YES NO

If yes, specify type and length of time: ___

Section 9 – Parental History

9a. Parent:

Your relationship to the youth (eg. biological mom, step-father etc.): ___

Name: ___

D.O.B.: ___ Age: ___ Place of Birth: ___

Length of time living with child: ___

Current Marital Status:

Married	Single	Separated	Divorced	Common-law

Dates of Marriages/Separations/Divorces/Common-law unions: ____________

____

Date(s) of changes in parent's custody of child: ____________

____

Religion: ____________ Language: ____________

Education Completed:

1-8	9-10	11-13	College	University

Current occupation: ____________

Employer: ____________

Other means of Financial Support:

EI	OW	ODSP	Child Support

9b. How many partners have you been involved with since the youth's birth?

1	2	3	4	5 or more

9c. Have any of these relationships involved:

Domestic violence YES NO

Aggression YES NO

Verbal aggression YES NO

Police being called YES NO

If yes to any of these, please explain: ____________

____

____

____

____

____

9d. Please describe any significant personal crisis in <u>your</u> life:

(include things such as death, separation, emotional illness, physical illness, problems with "nerves", issues with drugs/alcohol, financial strain, conflict with the law, separation from family etc.)

9e. Any mental health issues, presently or in the past:

9f. Are there members of your extended family with mental health problems?

9g. Medications for above:

9h. How do you think these crisis may have impacted this youth?

9i. What do you like best about this youth:

Section 10 – Parental History

(Please fill out the following for the second parent/parent figure living in the home *with the youth.)*

10a. Biological Parent or Step-Parent

Their relationship to the youth (eg. biological mom, step-father etc.): ____________

Name: ____

Age: ____________ Place of Birth: ____________________________

Length of time living with child: ____________________________

Marital Status:

Married	Single	Separated	Divorced	Common-law

Religion: ____________________ Language: ____________________

Education Completed:

1-8	9-10	11-13	College	University

Current occupation: ____________________________________

Employer: ____

Other means of Financial Support:

EI	OW	ODSP	Child Support

10b. Please describe any significant personal crisis in this person's life:

(include things such as death, separation, emotional illness, physical illness, problems with "nerves", issues with drugs/alcohol, financial strain, conflict with the law, separation from family etc.)

____

____

____

____

____

____

____

10c. Any mental health issues, presently or in the past: ____________________

10d. Medications for above: ____________________

10e. How do you think these crisis may have impacted this youth? ____________________

10f. What do you like best about this youth: ____________________

Section 11 – Parental History

(Please fill out the following for a Biological or Step-Parent that no longer lives with the youth.)

11a. Non-custodial or Absent Parent

Their relationship to the youth (eg. biological mom, step-father etc.): ____________

Name: ____________________

Age: ____________ Place of Birth: ____________

Current address (City, town, Province etc.): ____________

Marital Status:

Married	Single	Separated	Divorced	Common-law

Religion: ____________ Language: ____________

Education Completed:

1-8	9-10	11-13	College	University

Current occupation: ______________________

Employer: ______________________

Other means of Financial Support:

EI	OW	ODSP	Child Support

11b. Please describe any significant personal crisis in this person's life:

(include things such as death, separation, emotional illness, physical illness, problems with "nerves", issues with drugs/alcohol, financial strain, conflict with the law, separation from family etc.)

____

____

____

____

____

____

11c. Any mental health issues: ______________________

____

____

11d. Please describe youth's current contact and relationship with this person: ______________________

____

____

____

11e. If youth no longer sees this parent, when was the last contact? ______________________

____

____

11f. Why did contact stop? ______________________________

Section 12 – Presenting Problem

(Leading to youth's involvement with the legal system)

12a. What do you see as this youth's major problem? ______________________________

12b. When did this youth's problems begin? ______________________________

12c. In your opinion, what sort of help does this youth need? ______________________________

12d. What has not worked in the past, please describe why you think it has not been successful? ______________________________

12e. Do you have a reason to believe this youth is involved in or experiencing any of the following?

Drug use	YES	NO
Alcohol use	YES	NO
Fire setting	YES	NO
Gang activity	YES	NO
Sexual victimization	YES	NO
Bullying	YES	NO
Emotional distress	YES	NO
Thoughts of harming self or others	YES	NO

Please explain: ______________________________

Section 13

13a. Is there anything else that is important for us to know about the family and/or the youth?

____

Section 14

14a. Please tell us what you see as this youth's strengths: ______________________________

VITA

Name:	Angelina Sarah MacLellan	
Post-secondary Education and Degrees	Western University, London, Ontario, Canada M.A. Counselling Psychology	2015 – 2017
	St. Francis Xavier University, Antigonish, Nova Scotia, Canada B.A. Honours Psychology Special Concentration in Forensic Psychology	2011 – 2015
Related Work Expereince	Psychology Internship Thames Valley District School Board (TVDSB) London, Ontario	2016 – 2017
	Student Group Facilitator Merrymount Family Support and Crisis Centre London, Ontario	2016
	Practicum Student Nova Institution for Woment Truro, Nova Scotia	2013 – 2015
	Disicipline Committee St. Francis Xavier University Antigonish, Nova Scotia	2013 – 2015
	Practicum Student Antigonish Town & County Crime Prevention Association Antigonish RCMP Detachment, Nova Scotia	2013 – 2014
Research Experience	Research Assistant London Family Court Clinic London, Ontario	2015 – 2016
	Reseach Assistant Clinical and Forensic Psychology Lab St. Francis Xavier University Antigonish, Nova Scotia	2014 – 2016
	Reseach Assistant Social and Developmental Psychology Lab St. Francis Xavier University, Antigonsih, Nova Scotia	2014